BY ORDER OF THE
SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 44-153

29 AUGUST 2011

Medical

TRAUMATIC STRESS RESPONSE

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: Publications and forms are available for downloading or ordering on the e-Publishing website at **www.e-Publishing.af.mil.**

RELEASABILITY: There are no releasability restrictions on this publication.

OPR: AFMSA/SG3OQ

Certified by: AF/SG3
(Col James D. Collier)

Supersedes: AFI44-153, 31 March 2006

Pages: 20

This Instruction implements Air Force Policy Directive (AFPD) 44-1, *Medical Operations*. It establishes the requirement and guidance for Traumatic Stress Response (TSR) teams at all active duty Air Force (AF) installations, integrating resources and efforts of the Air Force Reserve (AFR) and Air National Guard (ANG). It interfaces with DoDD 6490.5, *Combat Stress Control (CSC) Programs;* DoDI 6200.03, *Public Health Emergency Management Within the Department of Defense;* and AFI 44-109, *Mental Health and Military Law*. This AFI may be supplemented at any level, but all supplements must be routed to AFMSA/SGOC for coordination prior to certification and approval. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication*; route AF Form 847s from the field through the appropriate functional's chain of command. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of in accordance with Air Force Records Disposition Schedule (RDS) located at **https://www.my.af.mil/afrims/afrims/afrims/rims.cfm**.

SUMMARY OF CHANGES

This publication is updated to bring it in compliance with DoDI 6200.03, *Public Health Emergency Management Within the Department of Defense* and the *Air Force Follow-On Review: Protecting the Force: Lessons from Fort Hood*. Major changes include monitoring secondary trauma in team members, participating in annual installation emergency management exercises, integrating TSR team activities with the Medical Contingency Response Plan, procuring resources in the event an installation doesn't have the personnel or resources to support a TSR team, requiring standard operating procedures on the TSR plan for team

activation, planning for installation needs assessment, surveillance during and after a traumatic event, pre- and post-deployment training (Airman Resilience Training) and updated references.

Chapter 1—TRAUMATIC STRESS RESPONSE **3**

1.1. General. 3
1.2. Definition. 3
1.3. Purpose. 3

Chapter 2—RESPONSIBILITIES **4**

2.1. Installation or Wing Commander at an installation with a military treatment facility (MTF). 4
2.2. Geographically separated units (GSUs) and bases without an MTF. 4
2.3. AFRC and ANG units. 4
2.4. Installations without local TSR personnel or resources. 4
2.5. Command Post. 4
2.6. Unit Commander. 4
2.7. TSR Team Chief. 4
2.8. TSR Team. 5

Chapter 3—PROGRAM **6**

3.1. TSR Team membership. 6
3.2. TSR Services. 6
3.3. Air or ground mishaps that involve loss of life or major injury. 6
3.4. Hostage Negotiation Situation. 7
3.5. Search and Rescue Activities. 7
3.6. Combat Stress Control (CSC). 7

Chapter 4—TRAINING **8**

4.1. TSR Team: 8
4.2. Pre-Exposure Preparation (PEP). 8
4.3. Enhancing Resilience. 8

Attachment 1—GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION **10**

Attachment 2—TRAINING OUTLINE FOR TRAUMATIC STRESS RESPONSE (TSR) TEAM MEMBERS **12**

Chapter 1

TRAUMATIC STRESS RESPONSE

1.1. General.

1.1.1. Many types of events have the potential to produce traumatic stress responses. Most individuals exposed to potentially traumatic events will not experience long-term adverse effects. Exposure to potentially traumatic events may result in short-term symptoms (i.e., normal responses to an abnormal event). Traumatic Stress Response (TSR) services can mitigate these symptoms and prevent potential longer term problems. TSR teams provide TSR services, in close coordination with unit leaders. Pre-Exposure Preparation (PEP) services are provided by TSR teams to unit and community members whenever potentially traumatic events are anticipated.

1.1.2. It is important to differentiate between TSR interventions and interventions focused on grief response. The primary focus of TSR is with individuals who either directly witnessed or were involved in a potentially traumatic situation. There may be occasions where the TSR team is contacted for an intervention with an individual or group who were not directly involved with a traumatic event, like a unit suicide or the death of a unit member. In those instances intervention is at the discretion of the TSR team chief, with appropriate referral to Chaplain Corps services when indicated.

1.2. Definition. TSR is a coordinated response initiated by unit leaders in which the TSR team engages in the provision of services to individuals and groups who may have or who have had direct exposure to a potentially traumatic event.

1.3. Purpose. TSR fosters resilience in those who are, or may be exposed to, potentially traumatic events. This is accomplished through preparatory education for those likely to experience those events, and through education, intervention, screening, psychological first aid, and referral for those exposed.

Chapter 2

RESPONSIBILITIES

2.1. Installation or Wing Commander at an installation with a military treatment facility (MTF).

2.1.1. Ensures establishment of a TSR Team.

2.1.2. Appoints a privileged Mental Health provider as the TSR Team Chief.

2.1.3. Identifies the TSR Team Chief to the Command Post to ensure required notification in the event of a potentially traumatic event.

2.1.4. Ensures an effective notification and activation process for the TSR team to be contacted in the event of a potentially traumatic event.

2.1.5. If outside resources (other installations, Guard, Reserve, non-military), are required, formal agreements for provision of personnel and/or resources will be secured by the installation.

2.1.6. Installations with multiple wings are not required to have more than one TSR team.

2.2. Geographically separated units (GSUs) and bases without an MTF. Ensures a TSR team is available to respond by arranging with other bases or MAJCOM.

2.3. AFRC and ANG units. Develop and utilize their own resources when possible. Partnership between the regular component and between other military resources is encouraged.

2.4. Installations without local TSR personnel or resources. Request Mental Health and Chaplain Corps assets, as needed, through their MAJCOM Integrated Delivery System (IDS).

2.5. Command Post. Notifies the TSR team chief as part of required notification protocol when the local command post becomes aware of a potentially traumatic event.

2.6. Unit Commander. May consult with TSR Team regarding potential and actual traumatic events and pre-exposure training.

2.7. TSR Team Chief.

2.7.1. Ensures implementation of TSR training and services.

2.7.2. Coordinates with the Airman and Family Readiness Center, and other agencies as appropriate, to arrange TSR to family and community members at installations impacted by a potentially traumatic event.

2.7.3. Ensures TSR team is included as an integral member of the Emergency Family Assistance Control Center (E-FACC) in disaster response, in order to identify populations needing intervention and community needs that can be met by TSR resources.

2.7.4. Integrates TSR team preparedness and response plans with other installation response plans and the Medical Contingency Response Plan (MCRP).

2.7.5. Establishes ongoing training and exercise requirements for primary, alternate, and augmentee TSR team members to maintain proficiency and function effectively as a team.

2.7.6. Ensures all TSR team members and augmentees receive the training material contained in **Attachment 2** to provide education, screening, and referral services as required.

2.7.7. Maintains knowledge of local mental health support services and coordinates with local resources in the aftermath of mass-casualty incidents in order to ensure coordinated delivery of services and effective use of resources.

2.7.8. Monitors TSR team members for signs of secondary trauma, burnout, and vicarious traumatization in prolonged TSR situations.

2.7.8.1. Formulates a plan of operations that will regularly assess team member's psychological health.

2.7.8.2. Ensure resources are effectively utilized so that there is sufficient downtime for individual team members to enable effective intervention and minimize potential adverse reactions in team members, as much as possible.

2.8. TSR Team.

2.8.1. Provides services primarily for individuals who either directly witnessed or were involved in a potentially traumatic situation.

2.8.2. Establishes standard operating procedures that include, at a minimum, an assessment of local conditions and high-vulnerability groups, a survey of locally trained resources, a response plan for team activation, and a plan for conducting TSR needs assessment and surveillance during, and after a traumatic event.

2.8.3. Consults on the development and execution of the Medical Risk Communication plans for Chemical, Biological, Radiological and High-Yield Explosive (CBRNE) events.

Chapter 3

PROGRAM

3.1. TSR Team membership. Minimum Team Membership and Formation:

3.1.1. **Mental Health (MH).** Psychiatrist, psychologist, social worker, mental health nurse, 7-level MH technician, or fully-trained 5-level if assigned with one of the above. 3-level MH technicians can provide assistance with appropriate oversight. A privileged MH provider serves as the TSR team chief.

3.1.2. **Spiritual Support.** Chaplain (and chaplain assistant as indicated).

3.1.3. **Airman and Family Readiness Center.** Community readiness consultant.

3.1.4. **Alternate members for each role.** Identification and training is required to ensure continuous availability.

3.1.5. **Qualified AFRC/ANG personnel.** If available, consider for membership when forming TSR teams on active duty installations.

3.1.6. **Appropriate career fields.** Representatives may serve as TSR members on either a long-term or short-term basis.

3.2. TSR Services.

3.2.1. All individuals directly involved in a potentially traumatic event should be provided the opportunity to access TSR services.

3.2.2. Participation in TSR interventions is voluntary, though unit leaders may require affected personnel receive TSR education.

3.2.3. Medical or mental health record documentation is not required for TSR team services, to include PEP, education, screening and referral, since they are not medical services.

3.2.4. Personnel Reliability Program (PRP) status members exposed to trauma will be referred to Competent Medical Authority (CMA) for evaluation and follow-up as needed per DoDI 5210.42, *Nuclear Weapon Personnel Reliability Program*. When providing TSR to those on PRP status, PDI should be reported as 'information only' to the CMA and certifying official, with the explanation that TSR is educational and not medical treatment. Report any decrement in functioning to their Certifying Official.

3.2.5. Following a potentially traumatic event, individuals can seek up to four one-on-one meetings with any member of the TSR team.

3.2.5.1. One-on-one meetings are for the purpose of education and consultation and not for medical assessment and treatment; therefore, they are not documented.

3.2.5.2. PRP personnel: Potentially Disqualifying Information must be passed to a Competent Medical Authority per existing regulatory guidance. Prior to sessions, members will be informed that regulations on Potentially Disqualifying Information or safety issues still apply, especially as concerns individuals on PRP, flying status, security clearances, or other special duties.

3.3. Air or ground mishaps that involve loss of life or major injury.

3.3.1. The commander should consult with a TSR team leader to determine whether there is a need for TSR support. Then, if the commander subsequently requests service, the nature of those services should be developed by the commander in collaboration with the TSR team leader.

3.3.2. Services provided will vary depending on the nature of the mishap and the needs of the personnel involved in the mishap.

3.4. Hostage Negotiation Situation.

3.4.1. TSR team may serve in a consultation role to the on-scene commander.

3.4.2. Unless the TSR team member has had specific training in hostage negotiation consultation, their role is to provide coordination and advice on TSR resources and processes.

3.4.3. Mental Health members of the TSR team should provide consultation on mental health issues consistent with their training to the hostage negotiation team.

3.5. Search and Rescue Activities. Individuals participating in search and rescue activities, including professional personnel (i.e., forensic pathologists and mortuary personnel) should have the opportunity to receive TSR services.

3.6. Combat Stress Control (CSC).

3.6.1. TSR Teams in deployed environments implement CSC programs that seek to prevent or minimize adverse effects of Combat and Operational Stress Reactions (COSR) through primary, secondary, and tertiary prevention efforts.

3.6.2. Coordinate with Public Health programs to ensure deployed members receive appropriate screening and education after arriving to, and prior to departing from, the deployed environment.

3.6.3. Consults with line commanders about surveillance and prevention, identification, and management of COSR in units and individuals before and after deployments.

3.6.4. Uses Module A2 from the Department of Veterans Affairs/Department of Defense (VA/DoD) *Clinical Practice Guideline (CPG) for the Management of Post-Traumatic Stress* to manage COSR (see **Attachment 2**).

Chapter 4

TRAINING

4.1. TSR Team: (see **Attachment 1** for a list of training reference material)**.**

4.1.1. Able to apply the principles outlined in **Attachment 2** is required.

4.1.2. Formal course attendance that provides certification is not required**.**

4.1.3. Meets at least quarterly to train and when possible, should train and exercise as a team.

4.1.4. Focuses training on preparation to respond to real world circumstances that could produce traumatic stress responses.

4.1.5. Long-term team members will participate in all team training.

4.1.6. Augmentees used for single incidents will receive just-in-time training.

4.1.7. All team augmentees must have sufficient training to assist with education, screening, and referral activities.

4.1.8. Coordinates with base agencies, such as security forces, to participate in exercises involving potentially traumatic scenarios, and to participate annually in installation emergency management exercises.

4.2. Pre-Exposure Preparation (PEP).

4.2.1. PEP training helps individuals and units prepare for potentially traumatic events. TSR Teams are available to provide pre-exposure consultation to units and communities who expect to face trauma.

4.2.2. PEP emphasizes resilience and typical stress reactions under abnormal circumstances. A list of material used for conducting pre-exposure preparation training can be found in A**ttachment 1,** *Training References***.**

4.2.3. PEP training should be coordinated between unit leaders and the TSR team chief. It should only occur when both unit leader and TSR team chief agree such training is necessary. PEP training should be tailored to specific unit requirements and should not duplicate existing training.

4.3. Enhancing Resilience.

4.3.1. Airmen are trained to excel under stressful conditions. The AF has implemented a targeted, tiered approach to resilience that is graduated based on the level of risk an individual has for developing post traumatic stress symptoms.

4.3.2. All Airmen receive training in basic resilience skills through accessions training, PME, and mentoring. There are a number of military and non-military helping services available to military personnel that also assist in promoting resilience.

4.3.3. Airman Resilience Training (ART) is a standardized set of briefings available through AFMSA/SG3OQ that is recommended both pre- and post-deployment IAW AFI 10-403,

Deployment Planning and Execution. For units that deploy frequently for shorter duration, AFI 10-403 allows exceptions based on these factors.

4.3.4. For the highest risk career fields with regular exposure to life threatening situations or casualties, a deployment transition center may be used to facilitate reintegration and long term resilience.

CHARLES B. GREEN
Lieutenant General, USAF, MC, CFS
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

DoDD 6490.5, *Combat Stress Control (CSC) Programs,* February 23, 1999

DoDI 6200.03, *Public Health Emergency Management Within the Department of Defense,* March 05, 2010

DoDI 5210.42, *Nuclear Weapon Personnel Reliability Program,* October 16, 2006

AFPD 44-1, *Medical Operations*, September 01, 1999

AFI 10-403, *Deployment Planning and Execution,* January 13, 2008

AFI 44-109, *Mental Health and Military Law,* March 01, 2000

AFI 90-501, *Community Action Information Board and Integrated Delivery System,* August 31, 2006

Air Force Follow-On Review: Protecting the Force: Lessons from Fort Hood, **http://www.af.mil/shared/media/document/AFD-100930-060.pdf**, October 01, 2010

Training References

DoD/VA Clinical Practice Guideline for Management of Traumatic Stress, **http://www.healthquality.va.gov/Post_Traumatic_Stress_Disorder_PTSD.asp**, 2010

Mental Health Response to Mass Violence and Terrorism: A Training Manual. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Washington DC 20015. **http://store.samhsa.gov/product/SMA04-3959**, January, 2004

National Institute of Mental Health. *Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence: A Workshop to Reach Consensus on Best Practices* NIH Publication No. 02-5138, Washington, D.C.: U.S. Government Printing Office **http://www.nimh.nih.gov/health/publications/massviolence.pdf**, 2002

Psychological First Aid, Field Operations Guide, National Center for PTSD **http://www.ptsd.va.gov/professional/manuals/psych-first-aid.asp**, April 13, 2006

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

Abbreviations and Acronyms

AFRC—Air Force Reserve Command

ANG—Air National Guard

ART—Airman Resilience Training

CBRNE—Chemical, Biological, Radiological and High-Yield Explosive

CMA—Competent Medical Authority

COSR—Combat and Operational Stress Reaction

CPG—Clinical Practice Guideline

CSC—Combat Stress Control

E-FACC—Emergency Family Assistance Control Center

GSU—Geographically Separated Unit

IDS—Integrated Delivery System

MAJCOM—Major Command

MCRP—Medical Contingency Response Plan

MH—Mental Health

MTF—Medical Treatment Facility

NIMH—National Institute of Mental Health

PEP—Pre-Exposure Preparation

PRP—Personnel Reliability Program

TSR—Traumatic Stress Response

VA—Veterans Affairs

Terms

Potentially Traumatic Event—Direct exposure or personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity.

Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disaster, severe automobile accidents, or being diagnosed with life—threatening illness. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts.

Pre—Exposure Preparation—A preventive approach prior to exposure to a potentially traumatic event that uses an educational approach to emphasize the typical and normal stress responses and basic techniques in stress management.

Traumatic Stress Response—A coordinated response initiated by unit leaders in which TSR teams engage in the provision of services to individuals and groups who may have or who have had direct exposure to a potentially traumatic event.

Traumatic Stress Response Teams—Designated teams that provide pre-exposure preparation training, consultation to unit commanders and leaders, screening, psychological first aid, education and referral in order to foster reliance to potentially traumatic events.

Attachment 2

TRAINING OUTLINE FOR TRAUMATIC STRESS RESPONSE (TSR) TEAM MEMBERS

A2.1. TSR team chiefs are responsible for ensuring: TSR team members have reviewed all information contained in this attachment. TSR training, which must be accomplished and documented at least quarterly, will ensure all TSR team members are familiar with the key principles of: PEP, early interventions after mass violence, and clinical practice guidelines for traumatic stress management. All team members should be able to provide consultation, education, screening, psychological first aid, and referral in response to potentially traumatic events.

A2.2. PRE-EXPOSURE PREPARATION (PEP). PEP education is the primary preventive function of TSR teams. Community education regarding the functions of the TSR teams and PEP should be accomplished on a regular basis through briefings and articles in base publications. Education regarding the services of the TSR teams should not wait until a potentially traumatic event is anticipated or has occurred. Pre-exposure guidance should be offered to all individuals for whom exposure to a potentially traumatic event is anticipated. The following information can be shared with units or individuals who may be exposed to potentially traumatic events, to enhance resilience.

A2.3. TRAUMA-RELATED STRESS.

A2.3.1. **What to expect when exposed to a potentially traumatic event:** Responses to a potentially traumatic event vary from person to person, depending on a number of factors, including previous life experiences and personal experience of the actual event. Research has shown most stress-related symptoms, when present, are short-term in duration. However, sometimes symptoms persist, and should be addressed to prevent long-term problems.

A2.3.2. **Typical and Normal Stress Responses:** Feeling keyed up, on edge, and restless; hyper-vigilance; exaggerated startle response; irritability or outbursts of anger; sadness and crying; fatigue; difficulty concentrating, preoccupation with the traumatic event; muscle tension; sleep disturbances (difficulty falling or staying asleep, or restless unsatisfying sleep); appetite disturbances (forgetting to eat or drink).

A2.3.3. **Keys Concepts to know when dealing with Traumatic Stress:** Trauma-related stress reactions are normal reactions to abnormal situations Airmen are specially selected and trained to perform under highly stressful circumstances. Coping with and surviving a traumatic event enhances resilience and self-confidence.

A2.3.4. **Effective Coping Strategies for Stress:**

A2.3.4.1. Talking about feelings of stress with others

A2.3.4.2. Attention to basic needs: sleep, diet, exercise, social, spiritual needs

A2.3.4.3. Helping others who are in need

A2.3.5. **When and Where to Seek Assistance from Professionals**

A2.3.5.1. Seek immediate referral when the following symptoms are present: Suicidal or homicidal ideation, intention, or plans; hallucinations or delusions; severe depression; alcohol or drug abuse

A2.3.5.2. Seek assistance when the following symptoms last for over a month, and/or impact work or social functioning: Persistent avoidance of reminders of the trauma and emotional numbing; persistent loss of interest in friends, family and activities; feelings of detachment from others; restricted range of affect (e.g., unable to have loving feelings); flashbacks; feeling as if the traumatic event were recurring; feelings of worthlessness or excessive guilt; depressed mood most of the day, nearly every day, with persistent crying, feelings of emptiness and sadness.

A2.4. KEY OPERATING PRINCIPLES OF EARLY INTERVENTION FOLLOWING MASS VIOLENCE.

A2.4.1. The following information is adapted from National Institute for Mental Health (NIMH) Recommendations. These recommendations apply to intervention efforts following episodes of mass violence.

A2.4.2. Training for early interventions should address preparation, planning, education, training, service provision, and evaluation of efforts to assist those affected by mass violence and disasters. Early intervention policies should be based on empirically defensible and evidence-based practices. An ethical duty exists to discourage the use of ineffective or unsafe techniques.

A2.4.3. **Key Components of Early Intervention.** Through exercises and training, TSR members will know how to implement the following key components in the event of mass exposure to trauma:

A2.4.4. **Basic Needs**

A2.4.4.1. Orient survivors to the availability of services/support

A2.4.4.2. Communicate with family, friends, and community

A2.4.5. **Psychological First Aid**

A2.4.5.1. Protect survivors from further harm

A2.4.5.2. Reduce physiological arousal

A2.4.5.3. Mobilize support for those who are most distressed

A2.4.5.4. Keep families together and facilitate reunions with loved ones

A2.4.5.5. Provide information and foster communication and education

A2.4.5.6. Use effective risk communication techniques

A2.4.5.7. Assess the current status of individuals, groups, and/or populations and institutions/systems. Ask how well needs are being addressed, what the recovery environment offers, and what additional interventions are needed. No requirement for a formal mental health evaluation unless there is a red flag in the initial screening.

A2.4.5.8. **Rescue and Recovery Environmental Observation**

A2.4.5.8.1. Observe and listen to those most affected

A2.4.5.8.2. Monitor the environment for stressors

A2.4.5.8.3. Monitor past and ongoing threats

A2.4.5.8.4. Monitor services that are being provided

A2.4.5.8.5. Monitor media coverage and rumors

A2.4.5.9. **Outreach and Information Dissemination**

A2.4.5.9.1. Offer information/education and "therapy by walking around"

A2.4.5.9.2. Invite community members to bring in other people that may be affected, but were not able to be involved in early interventions

A2.4.5.9.3. Use established community structures

A2.4.5.9.4. Distribute flyers; encourage those not initially identified to seek services

A2.4.5.9.5. Host web sites

A2.4.5.9.6. Conduct media interviews and programs and distribute media releases in conjunction with Public Affairs

A2.4.5.10. **Technical Assistance, Consultation, and Training:**

A2.4.5.10.1. Improve capacity of organizations and caregivers to provide what is needed

A2.4.5.10.2. Reestablish community structure

A2.4.5.10.3. Foster family recovery and resilience

A2.4.5.10.4. Provide assistance, consultation, and training to relevant organizations, other caregivers and responders, and leaders

A2.4.5.11. **Fostering Resilience and Recovery**

A2.4.5.11.1. Foster, but do not force, social interactions

A2.4.5.11.2. Provide coping skills training

A2.4.5.11.3. Provide risk assessment skills training

A2.4.5.11.4. Provide education on stress responses, traumatic reminders, coping, and normal versus abnormal functioning, risk factors, and services

A2.4.5.11.5. Offer group and family interventions

A2.4.5.11.6. Foster natural social supports

A2.5. CLINICAL PRACTICE GUIDELINES FOR TRAUMATIC STRESS MANAGEMENT.

A2.5.1. The following flow charts provide an overview of the Department of Veterans Affairs/ Department of Defense (VA/DoD) Clinical Practice Guideline (CPG) on Management of Traumatic Stress. TSR team members can use this CPG to screen and refer individuals who have been exposed to potentially traumatic events. The first flow chart depicts a core module that can be used to screen any individual who has been exposed to a potentially traumatic event. The remaining charts provide guidance on management of

individuals with acute stress reactions, combat and operational stress reactions, and those who are referred to primary care or MH for further assessment.

A2.5.2. Medical and MH providers are encouraged to review the entire VA/DoD CPG for the Management of Post-Traumatic Stress (see References in **Attachment 1**).

Figure A2.1. Initial Evaluation and Triage.

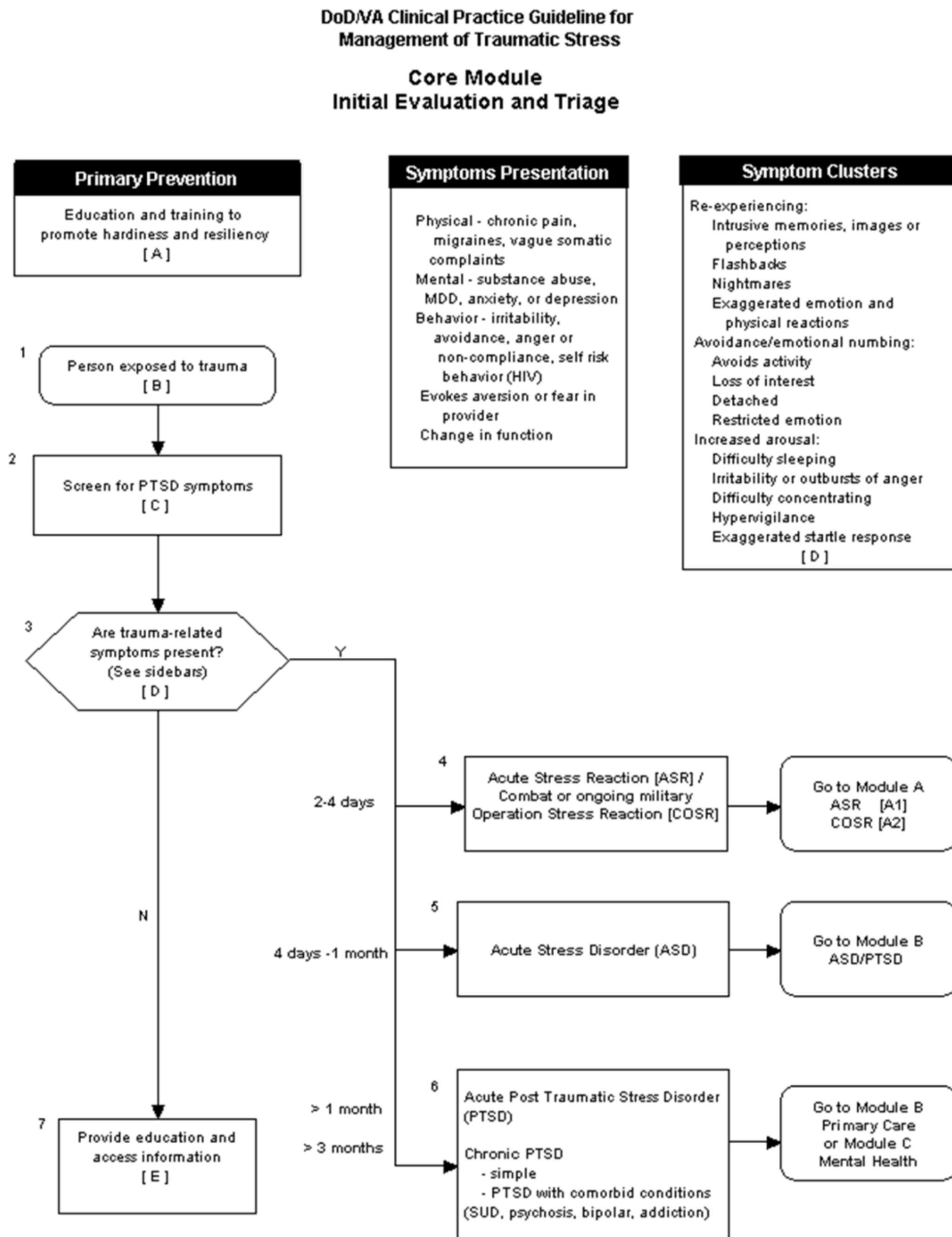


Figure A2.2. Management of Traumatic Stress: Acute Stress Reaction.

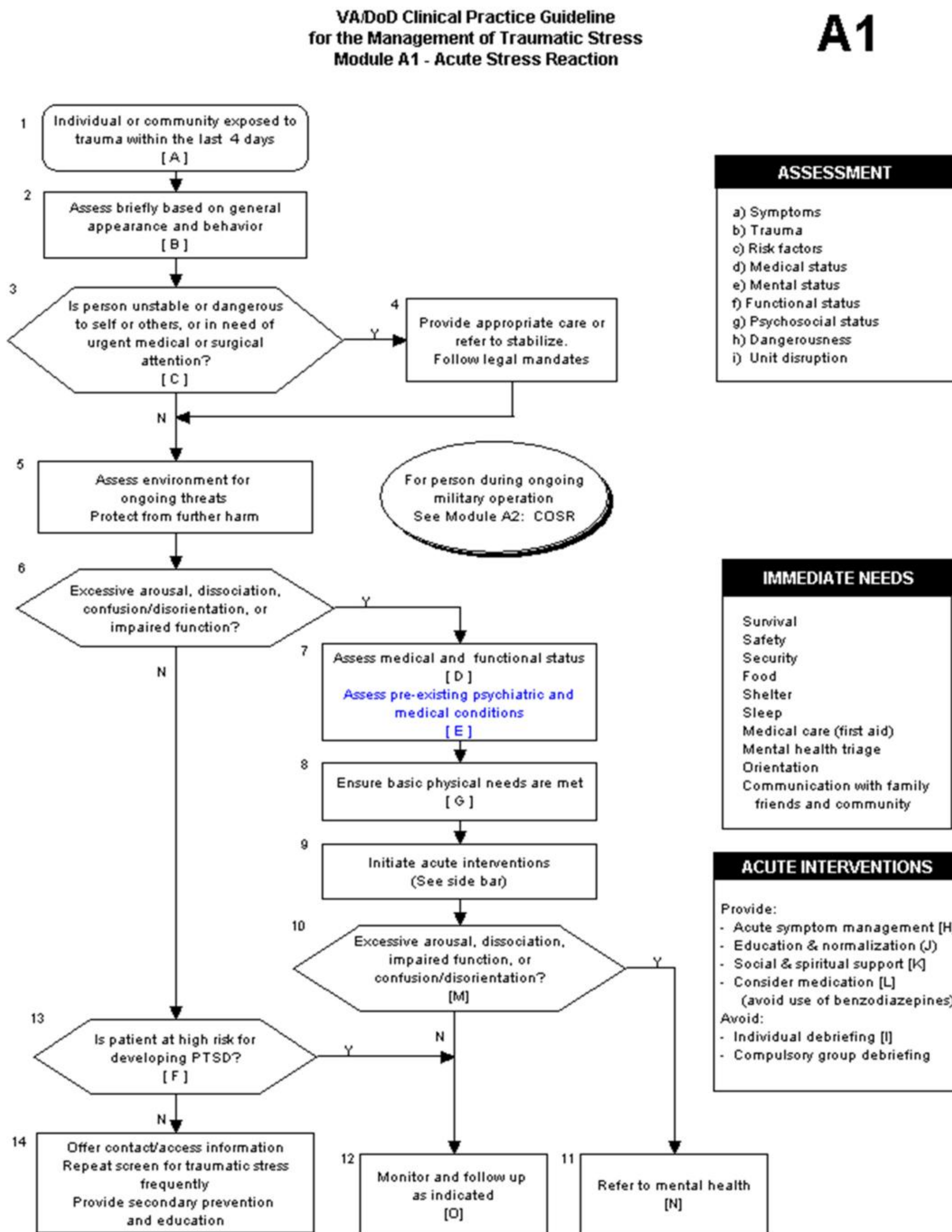
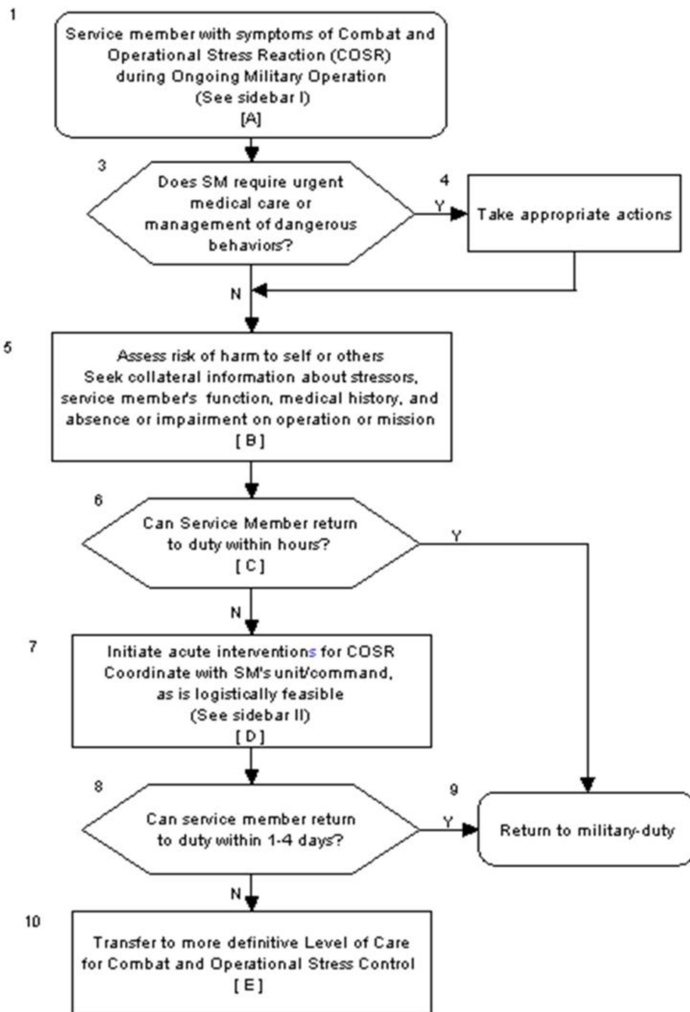


Figure A2.3. Management of Combat and Operational Stress Reaction (COSR) During Ongoing Military Operations.

Management of Stress Reactions
Combat and Operational Stress Reaction(COSR)
During Ongoing Military Operations

A2



COSR SYMPTOMS

Possible Syndrome:
- exhaustion/burnout
- hyperarousal and anxiety
- somatic complaints (GI, GU, MS, CV, respiratory, NS)
- depression/guilt/hopelessness
- conversion disorder symptoms
- amnestic and/or dissociative symptoms
- behavioral changes
- emotional dysregulation
- anger/irritability
- brief, manageable "psychotic symptoms" (e.g., hallucinations due to sleep deprivation, mild "paranoia")

COSR does not require a specific traumatic event and can be a result of accumulating stress

COSR ACUTE INTERVENTIONS

Treat according to service member's prior role and not as a "patient"; avoid a hospital setting

Assure or provide the following, as needed:
- o Reunion or contact with primary group
- o Respite from intense stress
- o Thermal comfort
- o Oral hydration
- o Oral food
- o Hygiene (toileting, shower, shave, and female needs)
- o Sleep (to facilitate rest and restoration)
- o Encourage talk about the event with supportive others

Reserve group debriefing for members of pre-existing and continuing groups (Voluntary attendance)

Assign appropriate duty tasks and recreational activities that will restore focus and confidence and reinforce teamwork

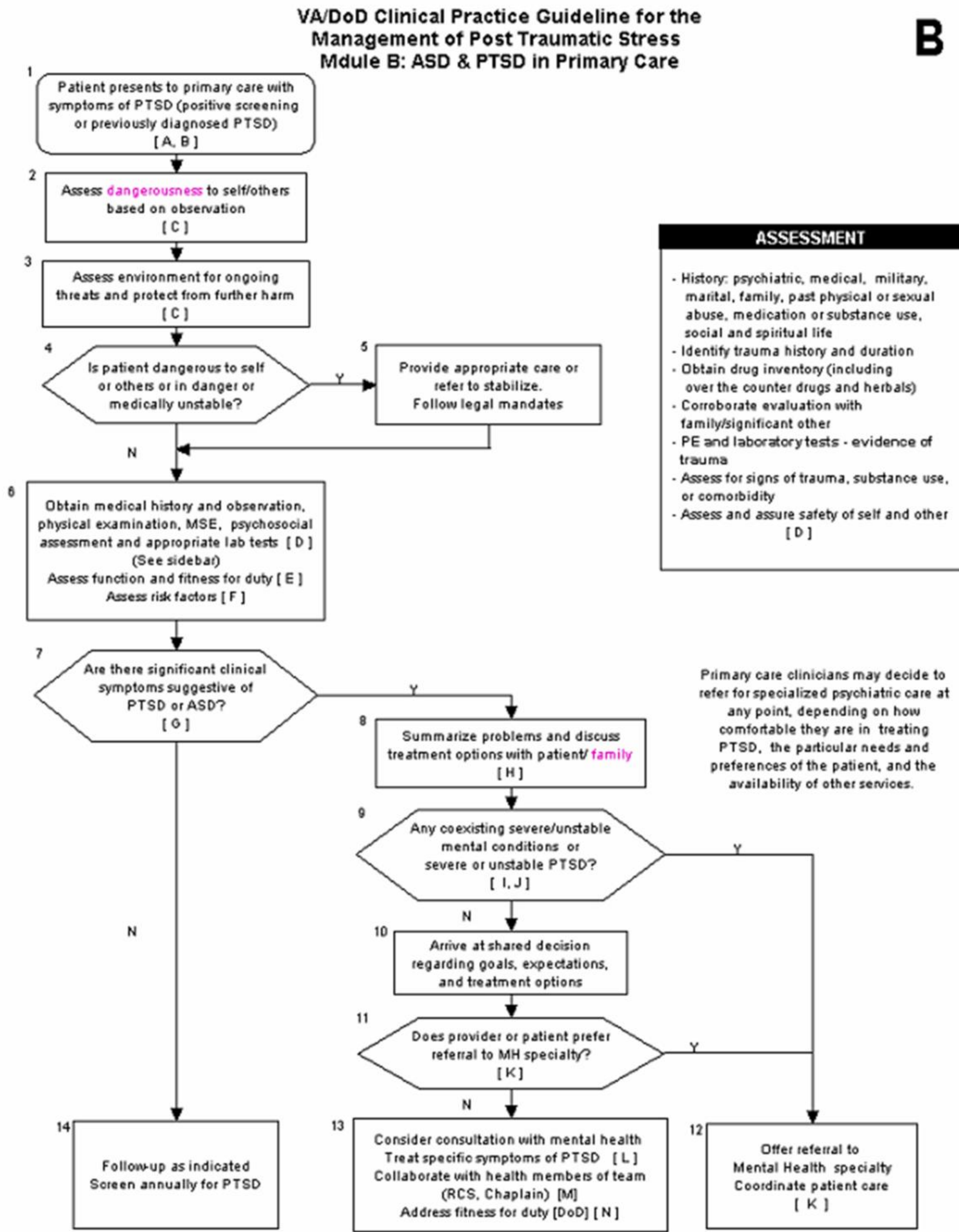
Avoid further traumatic events until recovered for full duty

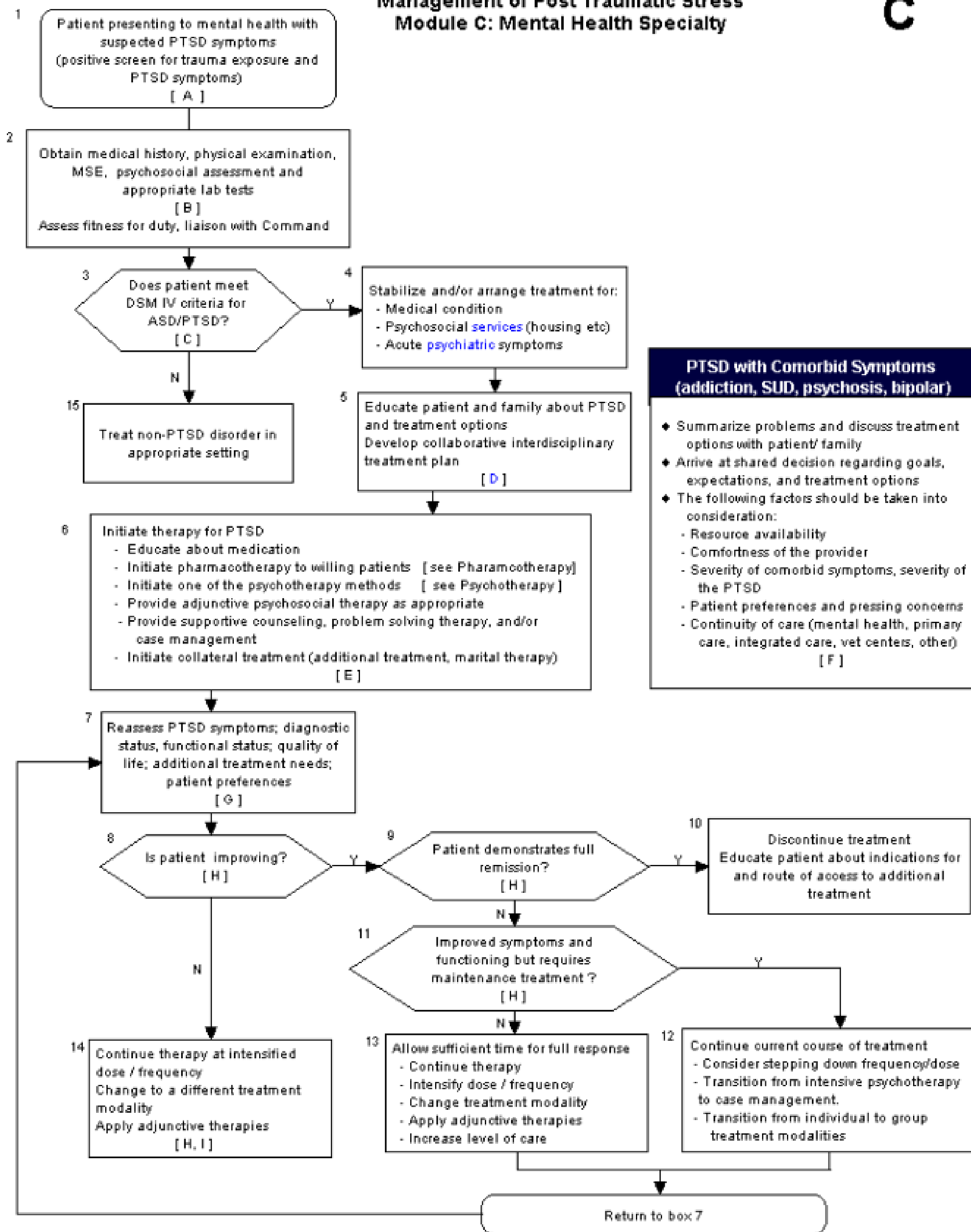
Evaluate periodically

Consider using a short course of medication targeted for specific symptoms

10-15-03

Figure A2.4. Management of Post Traumatic Stress in Primary Care.




VA/DoD Clinical Practice Guideline for the
Management of Post Traumatic Stress
Module C: Mental Health Specialty
C
1
Patient presenting to mental health with suspected PTSD symptoms (positive screen for trauma exposure and PTSD symptoms) [A]
2
Obtain medical history, physical examination, MSE, psychosocial assessment and appropriate lab tests [B] Assess fitness for duty, liaison with Command
3
Does patient meet DSM IV criteria for ASD/PTSD? [C]
Y
N
4
Stabilize and/or arrange treatment for: - Medical condition - Psychosocial services (housing etc) - Acute psychiatric symptoms
15
Treat non-PTSD disorder in appropriate setting
5
Educate patient and family about PTSD and treatment options Develop collaborative interdisciplinary treatment plan [D]
PTSD with Comorbid Symptoms (addiction, SUD, psychosis, bipolar)
Summarize problems and discuss treatment options with patient/ family
Arrive at shared decision regarding goals, expectations, and treatment options
The following factors should be taken into consideration:
- Resource availability
- Comfortness of the provider
- Severity of comorbid symptoms, severity of the PTSD
- Patient preferences and pressing concerns
- Continuity of care (mental health, primary care, integrated care, vet centers, other)
[F]
6
Initiate therapy for PTSD
- Educate about medication
- Initiate pharmacotherapy to willing patients [see Pharamcotherapy]
- Initiate one of the psychotherapy methods [see Psychotherapy]
- Provide adjunctive psychosocial therapy as appropriate
- Provide supportive counseling, problem solving therapy, and/or case management
- Initiate collateral treatment (additional treatment, marital therapy)
[E]
7
Reassess PTSD symptoms; diagnostic status, functional status; quality of life; additional treatment needs; patient preferences [G]
8
Is patient improving? [H]
Y
N
9
Patient demonstrates full remission? [H]
Y
N
10
Discontinue treatment Educate patient about indications for and route of access to additional treatment
11
Improved symptoms and functioning but requires maintenance treatment ? [H]
Y
N
14
Continue therapy at intensified dose / frequency Change to a different treatment modality Apply adjunctive therapies [H, I]
13
Allow sufficient time for full response - Continue therapy - Intensify dose / frequency - Change treatment modality - Apply adjunctive therapies - Increase level of care
12
Continue current course of treatment - Consider stepping down frequency/dose - Transition from intensive psychotherapy to case management. - Transition from individual to group treatment modalities
Return to box 7
11-1