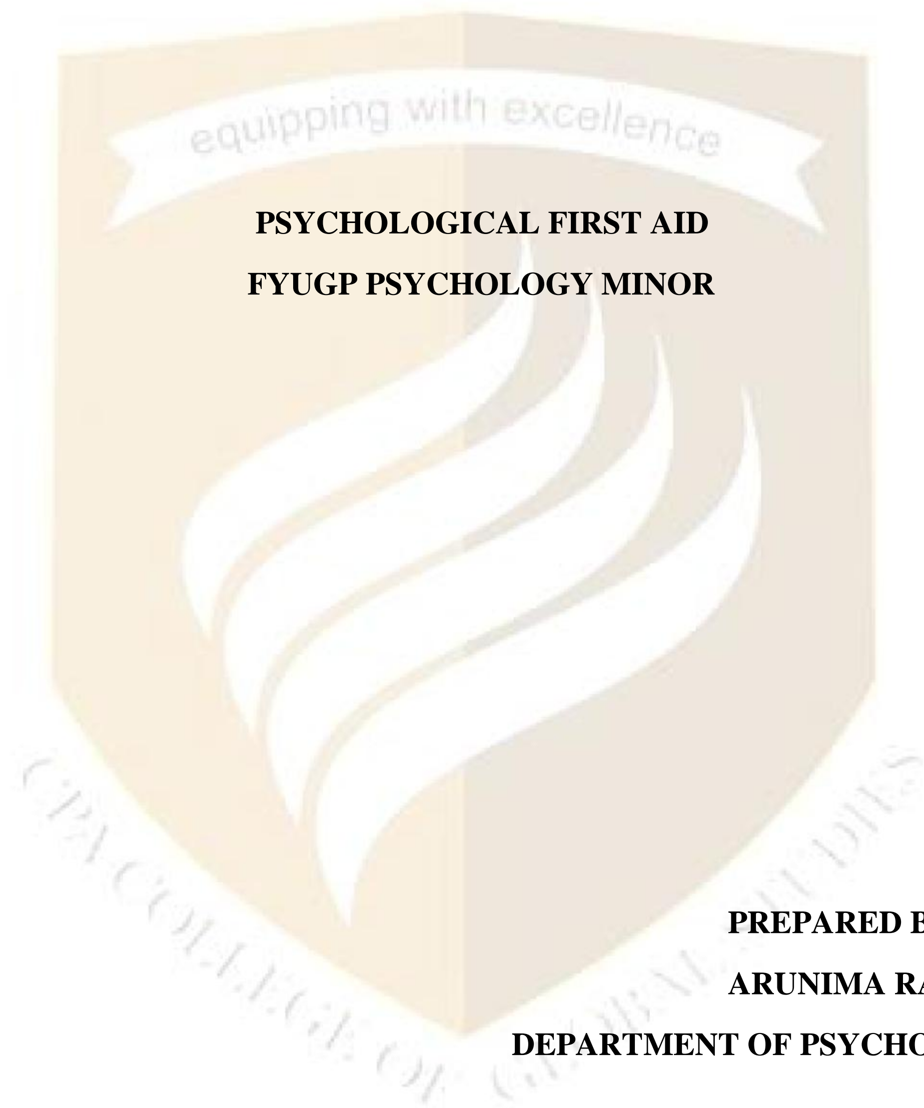
CALICUT UNIVERSITY

THIRD SEMESTER

FOUR-YEAR UNDERGRADUATE PROGRAMME(CU-FYUGP)



PSYCHOLOGICAL FIRST AID

FYUGP PSYCHOLOGY MINOR

PREPARED BY

ARUNIMA RAJ

DEPARTMENT OF PSYCHOLOGY

CPA COLLEGE OF GLOBAL STUDIES ,PUTHANATHANI

MINOR GROUP 3-AVENUES OF PSYCHOLOGY

Programme	B. Sc. Psychology				
Course Title	**Understanding Psychological First Aid**				
Type of Course	Minor with Practicum				
Semester	II				
Academic Level	100 – 199				
Course Details	Credit	Lecture per week	Tutorial per week	Practicum per week	Total Hours
	4	3	-	2	75
Pre-requisites	Nil				
Course Summary	The course explains the set of skills and knowledge that can be used to help people who are in distress. It also describes self-care practices which help the students to apply in their own lives..				

MODULE I: INTRODUCTION TO PSYCHOLOGICAL FIRST AID(HOURS: 10)

Defining Psychological First Aid,Core Competencies of Psychological First Aid ,Community-Based Psychological First Aid,Art of Helping – Characteristics of Helpers.

MODULE II: PSYCHOLOGICAL CONSEQUENCES OF TRAUMA AND REACTIONS TO DISASTERS(HOURS: 12)

Post Traumatic Stress Disorder,Substance Abuse, Depression, Panic Disorder, GAD ,Types of Disasters ,Natural Disasters ,Human-made Disasters,Technological Disasters –,War-related Syndromes

MODULE III: RAPID MODEL(HOURS: 15)

When and How to Refer – RAPID Model, Reflective Listening ,Assessment ,Psychological Triage,Intervention Tactics to Stabilize and Mitigate Acute Distress,Disposition and Facilitating Access to Continued Care

MODULE IV: SELF-CARE(HOURS: 8)

Need for Self-Care,Vicarious Traumatisation ,Secondary Traumatic Stres Burn Out,Compassion Fatigue,Self-Care Practices – Organisational Practices,Basic Self-Care Behavioural Elements,Spiritual/Religious Care

MODULE V: PRACTICUM(HOURS: 30)

•Demonstration of Breathing Technique

•Demonstration of PFA (Relevant videos and practical session)

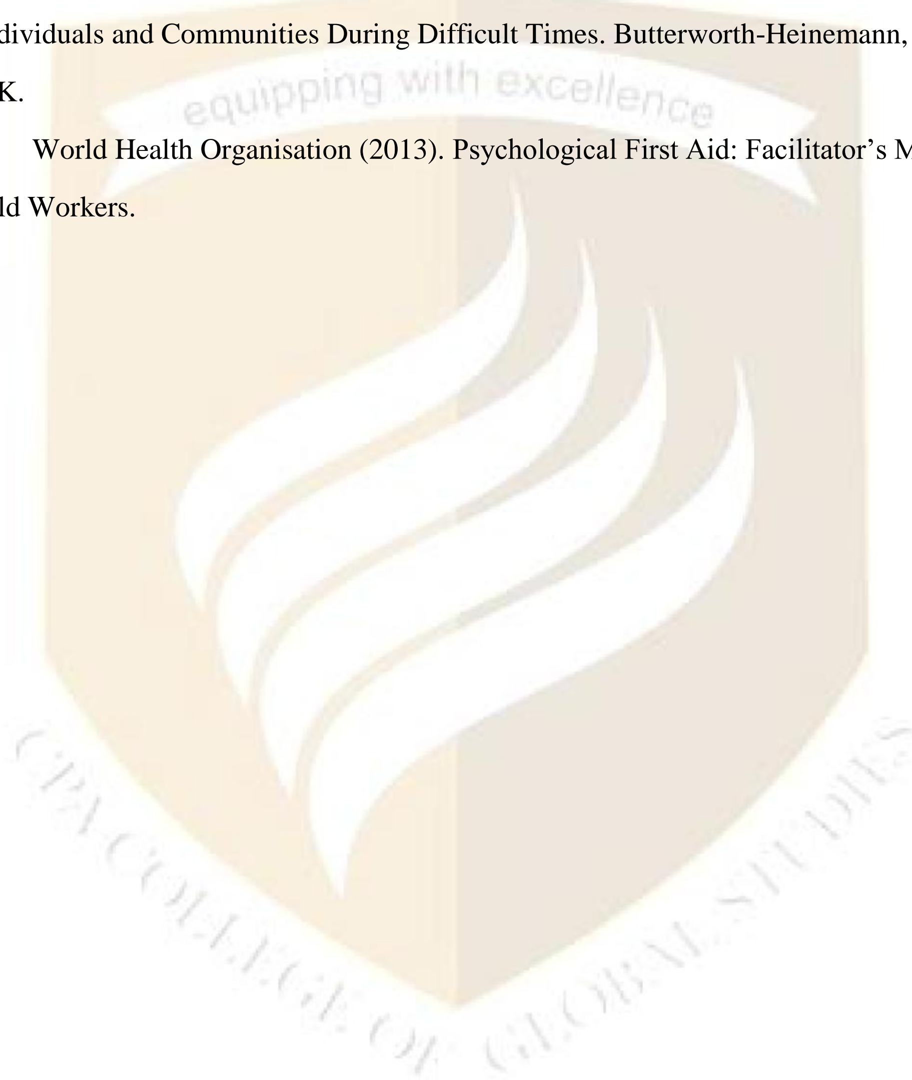
•RAPID Model (Relevant videos and practical sessions) and prepare a self-report based on both PFA

•Develop different plans for self-care

•Develop a module of psychological first aid in case of various emergencies with reference to Kerala context

BOOKS AND REFERENCES

- Everly, G.S. Jr., & Lating, J.M. (2017). The Johns Hopkins Guide to Psychological First Aid. Johns Hopkins University Press, Baltimore.
- Jacobs, G.A. (2016). Community-based Psychological First Aid – A Practical Guide to Helping Individuals and Communities During Difficult Times. Butterworth-Heinemann, Oxford OX5 1GB, UK.
- World Health Organisation (2013). Psychological First Aid: Facilitator's Manual for Orienting Field Workers.



MODULE 1: INTRODUCTION TO PSYCHOLOGICAL FIRST AID

DEFINING PSYCHOLOGICAL FIRST AIDPerhaps the best way to conceptualize PFA is as the mental health analogue to physical first aid. PFA may be simply defined as a supportive and compassionate presence designed to stabilize and mitigate acute distress, as well as facilitate access to continued care. PFA does not entail diagnosis, nor does it entail treatment.

World Health Organisation(WHO) defined PFA as humane supportive and practical response to people who are suffering and who may need support from it.

Main aim is providing immediate support addressing basic and psychological needs and fostering resilience.

Main goals is to meet basic needs,stabilise acute distress, impairments or dysfunction to assist in the recovery of some degree of adaptive functionality,foster natural coping and resilience mechanism,facilitate access to continued support or higher level care.

PURPOSE OF PSYCHOLOGICAL FIRST AID (PFA):

1. Reduce Immediate Distress

2. Promote Safety and Comfort

3. Support Adaptive Functioning and Coping

4. Connect Individuals to Social and Professional Resources

CHARACTERISTICS OF PSYCHOLOGICAL FIRST AID (PFA)

Psychological First Aid (PFA) is a humane, supportive, and practical response to individuals who are suffering and may need support after a crisis or disaster. Its core characteristics include:

1.Immediate and Early Intervention.

2.Non-Intrusive and Respectful.

3.Supportive and Compassionate

4.Practical Assistance

5.Promotes Safety and Comfort

6.Fosters Hope and Coping

SITUATIONS WHERE PFA IS APPLIED

1.Natural disasters

2.Human made disasters

3.Technological crisis

4.Personal trauma

MAIN GOALS OF PFA

1.Immediate Support

2.Emotional Support

3.Practical Assistance

4.Strengthening Resiliene

CORE COMPETENCIES IN PSYCHOLOGICAL FIRST AID (PFA)

1. Active Listening

• Paying full attention to the speaker.

• Listening with empathy and without judgment.

• Using nods, short verbal cues (like "I understand"), and open body language.

• Helps the person feel heard and valued.

2. Effective Communication

• Speaking clearly, calmly, and respectfully.

• Using simple language that is easy to understand.

• Being mindful of tone, pace, and body language.

• Encourages trust and cooperation.

3. Situational Awareness

• Being alert to the environment and people's behavior.

• Recognizing signs of distress, danger, or urgent needs.

• Understanding the cultural and social context of the situation.

• Helps in making appropriate and safe decisions.

4. Problem Solving

• Helping the affected person identify their immediate needs.

• Working together to find practical, short-term solutions.

• Encouraging use of existing strengths and coping skills.

• Supports recovery and self-efficacy.

5. Resource Linking

• Connecting individuals with needed services (medical, shelter, mental health, etc.).

• Informing them about available supports in the community.

• Facilitating access to social support networks.

• Ensures continuity of care and long-term recovery.

6. Emotional Regulation

• Managing one's own emotions in high-stress situations.

• Staying calm, composed, and supportive under pressure.

• Modeling emotional stability to help calm others.

• Prevents burnout and ensures effective support.

CORE COMPETENCIES IN PSYCHOLOGICAL FIRST AID (EXPANDED LIST)(JOHN HOPKINS MODEL)

1.Stabilisation

2. Assessment

3. Psychological Triage

4. Acute Intervention

5. Supportive Communication

6. Facilitation of Access to Continued Support or Care

7. Practice of Buddy Care

COMMUNITY BASED PSYCHOLOGICAL FIRST AID

Four main supporting skills

1. Active Listening: Fully concentrating, understanding, and responding to what someone is saying.

2. Problem Solving : Helping individuals think through practical steps to manage their current difficulties.

3. Practical Assistance: Helping individuals meet basic needs and access available services.

4. Coping with Stress: Supporting individuals in using healthy strategies to manage emotional reactions.

Special focus area

1. Loss and Grieving

2. Referral Needs and Alarm Bells

3. Children

4. Older Adults and People with Disabilities

5. Privacy, Ethics, and Cultural Sensitivity

6. Self-Care for Helpers

ART OF HELPING: CHARACTERSTICS OF HELPERS

1.Approachability

• Being friendly, open, and easy to talk to

• Having a calm and welcoming attitude

• Making others feel safe and not judged

2. Active Listening

• Giving full attention to the speaker

• Using eye contact, nods, and gentle responses like "I understand"

• Avoiding distractions or interruptions

3. Kindness

• Showing genuine care and compassion

• Using gentle words and helpful actions

• Small acts of kindness can create big emotional relief

4. Empathy

• Trying to understand what the other person is feeling

• Not feeling sorry for them, but feeling with them

5. Commitment

• Being reliable and available when help is needed

• Taking your role as a helper seriously

• Sticking with people through their ups and downs

ACCEPTING YOURSELF IN THE ROLE OF A HELPER

1.Rudeness and Rejection

2. Concern That Your Own Skills May Not Be Adequate

3. Fear of Being Intrusive

4. Fear of Learning Embarrassing or Disturbing Details

5. Fear of Personal Danger

MODULE 2: PSYCHOLOGICAL CONSEQUENCES OF TRAUMA AND REACTIONS TO DISASTERS

Trauma is a psychological response to a deeply distressing or disturbing event that overwhelms a person's ability to cope.It can affect thoughts, emotions, and behavior, and may lead to long-term mental health challenges.According to the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders).

Types of Trauma

1. Acute Trauma – results from a single incident (e.g., a car accident)

2. Chronic Trauma – repeated and prolonged exposure (e.g., domestic violence)

3. Complex Trauma – exposure to multiple traumatic events, often early in life

What are Disasters?

Definition:A disaster is a sudden, catastrophic event that causes significant disruption, destruction, and loss, often affecting large groups of people.From a psychological perspective, disasters are stressors that can trigger trauma responses in individuals and communities.

1. POST TRAUMATIC STRESS DISORDER

PTSD is exposure (either directly, witnessing, learning of the event, or repeated exposure to aversive event details, such as first responders excavating bodies) to at least one traumatic event (e.g., actual or threatened death, serious injury, violence, torture) and the occurrence of symptoms after exposure to the event. PTSD symptoms must cause distress and dysfunction and are organized into the following four criteria:

1. Experiencing intrusive symptoms (e.g., distressing dreams, intrusive flashbacks)

2. Avoiding, often deliberately, stimuli associated with the event (e.g., thoughts, feelings, people, places)

3. Developing negative alterations in cognitions and mood (memory difficulties, exaggerated negative personal beliefs, fear, guilt, decreased interest in activities, and an inability to feel positive emotions)

4. Developing altered arousal (e.g., exaggerated startle response, quick tempered, hypervigilance, decreased concentration, sleep difficulties; American Psychiatric Association, 2013).

SYMPTOMS OF PTSD: SYMPTOMS TYPICALLY FALL INTO FOUR CATEGORIES:

1. Intrusive Thoughts

2. Avoidance

3. Negative Changes in Thoughts and Mood

4. Changes in Physical and Emotional Reactions

2. SUBSTANCE ABUSEPeople use a wide variety of both legal and illegal mood-altering substances in the wake ofdisaster, trauma, and general adversity. It's a form of self-medication designed to lessen thenegative impact of the adversity. The DSM-5 identifies 10 classes of drugs (e.g., alcohol,caffeine, hallucinogens, inhalants, opioids, sedatives, hypnotics and anxiolytics, stimulants, tobacco, and other, often unknown substances), some of which are illegal, that an individual continues to use despite problematic cognitive, behavioral, and psychological symptoms. Common features of substance use include impaired control over amounts and frequency, a desire to cut down on use, energy expended on acquiring the substance, cravings, impairment (social, occupational), risky use, continued use despite problems, increased tolerance, and withdrawal symptoms.

Diagnosis (According to DSM-5)

Substance Use Disorder (SUD) is diagnosed based on:

• Impaired control

• Social impairment

• Risky use

• Pharmacological criteria (tolerance and withdrawal)

Key Characteristics of Substance Abuse

• Repeated use despite negative consequences.

• Cravings or strong urges to use the substance.

• Failure to meet responsibilities (work, school, family).

• Risky use (e.g., driving under influence).

• Tolerance and withdrawal symptoms may develop.

Causes / Risk Factors

• Biological: Genetic vulnerability, changes in brain chemistry.

• Psychological: Trauma, stress, low self-esteem, poor coping skills.

• Social: Peer pressure, family environment, lack of supervision.

• Cultural: Social norms and availability of substances.

Psychological Effects of Substance Abuse

• Cognitive impairment: Memory loss, poor judgment, confusion.

• Emotional effects: Mood swings, depression, anxiety, aggression.

• Behavioral changes: Impulsivity, criminal behavior, withdrawal from social activities.

.

3. DEPRESSION

The DSM-5 refers to clinical depression asmajor depressive disorder (MDD). MDD is defined by an unregulated mood that also entails symptoms resulting in clinically significant distress or impairment wherein an individual experiences five or more symptoms for at least two weeks. These symptoms represent a change from a previous level of functioning, and the symptoms are not attributable to another medical condition (American Psychiatric Association, 2013). These symptoms are

1. Depressed mood most of the day,

2. Diminished interest or pleasure in activities (i.e., anhedonia),

3. Significant weight loss or weight gain,

4. Insomnia or hypersomnia,

5. Psychomotor agitation (e.g., pacing, inability to sit still) or retardation (e.g., slowed

Speech or movements),

6. Fatigue or loss of energy,

7. Feelings of worthlessness or excessive guilt,

8. Diminished ability to concentrate or indecisiveness,

9. Reoccurring thoughts of death or suicidal ideation.

4. PANIC DISORDER

Like fear, panic is often confused with anxiety. Anxious people can indeed have a panic attack, but panic disorder (recurrent disabling panic attacks) is the syndrome of apprehension and arousal that reaches a whole different level of intensity and clinical challenge. The DSM-5 describes panic disorder as recurrent unexpected (i.e., no obvious cues or triggers) panic attacks (American Psychiatric Association, 2013). A panic attack is an abrupt surge of intense arousal that reaches an apex within minutes and entails symptoms such as heart pounding, sweating, shaking, chest pain, nausea, and fear of dying. To receive a diagnosis of panic disorder, the panic attack, which is not a mental disorder, is accompanied for at least one month by either persistent worry about having additional attacks, maladaptive changes in behavior related to the attacks (e.g., avoidance of places or situations that might evoke an attack), or both; is not attributable to drugs or medications; and is not explained more parsimoniously by another diagnosis (e.g., social anxiety or a specific phobia; American Psychiatric Association, 2013)

DSM-5 Criteria for Panic Disorder

equipping with excellence
COLLEGE OF GLOBAL STUDIES

A. Recurrent unexpected panic attacks:A panic attack is a sudden surge of intense fear or discomfort that reaches a peak within minutes, and during which at least 4 of the following symptoms occur:

1. Palpitations or fast heart rate

2. Sweating

3. Trembling or shaking

4. Shortness of breath

5. Feelings of choking

6. Chest pain or discomfort

7. Nausea or abdominal distress

8. Dizziness or light-headedness

9. Chills or heat sensations

10. Numbness or tingling (paresthesia)

11. Feelings of unreality (derealization) or being detached from self (depersonalization)

12. Fear of losing control or "going crazy"

13. Fear of dying

B. At least one attack has been followed by 1 month or more of:

1. Persistent concern or worry about additional attacks or their consequences

2. Significant maladaptive behavior change (e.g., avoiding unfamiliar situations)

5. *GENERALIZED ANXIETY DISORDER*

Anxiety is different from fear. This point is confusing. Fear is stimulus specific, causing arousal and apprehension—a fear of snakes, for example. Anxiety is generalized apprehension and arousal, free floating and less associated with a highly defined specific stimulus. DSM-5 classifies general anxiety disorder (GAD) as a set of symptoms that result in clinically significant distress or impairment and includes excessive anxiety (anticipation of future threat) and worry (apprehensive expectation) that occur more days than not for six months about a potentially wide array of events or activities and results in difficulty controlling the worry.Anxiety and worry in adults are associated with at least three of the following symptoms being present (only one needs to be present for children):

(1) Restlessness,

(2) Being Easily Fatigued

(3) Difficulty Concentrating

(4) Irritability

(5) Muscle Tension

(6) Sleep

TYPES OF DISASTERS

1. Natural Disasters:

Caused by natural forces (e.g., earthquakes, floods, cyclones, tsunamis).

Psychological impact: fear, trauma, PTSD, grief due to loss of life and property.

2. Human-Made Disasters:

Caused by human actions (e.g., terrorism, riots, mass shootings, arson).Often involve violence and intentional harm; may lead to intense fear, anger, and long-term trauma.

3. Technological Disasters:

Result from system or machine failures (e.g., industrial accidents, nuclear leaks, chemical spills). Lead to confusion, mistrust, health concerns, and anxiety.

4. War-Related Syndromes:

Associated with war and conflict (e.g., bombings, displacement, torture).Psychological effects: PTSD, depression, survivor’s guilt, war trauma (e.g.,shell shock in soldiers).

equipping with excellence
CPA COLLEGE OF GLOBAL STUDIES

MODULE 3 RAPID MODEL

R—Rapport and reflective listening. Effective psychological crisis intervention is predicated on gaining rapport with the person in distress.Rapport may be considered interpersonal "connectedness," which serves as a platform for the remaining aspects of the model.

A—Assessment. The term assessment is used liberally and consists of screening (Is there any evidence of need for PFA or other types of intervention?) and appraisal (What is the severity or gravity of need?). This information is generated, not through psychological tests or mental status examinations but, rather, through listening to the person's story of distress.The story consists of what happened (the stressor event) and the person's reactions (signs and symptoms) in response to the event.

P—Prioritization. Having heard the story, you must determine whether the need for intervention is urgent. This becomes an exercise in psychological triage.

I—Intervention. Having heard the story and the associated reactions, making some effort to stabilize and mitigate the adverse reactions is often recommended, if not expected.

D—Disposition. Having heard the story and responded with an appropriate intervention, you now must determine what to do next. Where do we go from here? is a question you should ask yourself and might even ask the person you've assisted. Is the person capable of attendingto his or her responsibilities or is a referral to some higher level of care indicated?

R-ESTABLISHING RAPPORT AND REFLECTIVE LISTENING

Establishing some degree of rapport is the first objective for the psychological firstaid (PFA) provider. Rapport may be thought of as some degree of interpersonal connectedness, understanding, and even trust. Rapport begins with presence. Rapport is built on the perception of the present interventionist (i.e., having a physical and/or emotional presence) and is sometimes what the person in distress needs most. Many care providers have referred to this as a ministry of presence. Ministry does not refer to a religious presence but, rather, to caring attention for another person.Staying Calm—Equanimity,Communication Styles are important skills needed here.

MECHANISMS OF ACTION

1. Non verbal behaviour
2. Paralinguistic Behaviors(voice & silence)
3. Questioning Techniques
4. Reflective Listening
5. Action Directives

A-ASSESSMENT

The Purpose is To quickly understand the person's psychological state and immediate needs so you can respond effectively. Assessment encompasses two dynamic processes: (1) screening and (2) appraisal. These evaluative processes are designed to differentiate functionally discrete subsamples of PFA recipients according to magnitude of need for PFA intervention

SCREENING:The first step in assessment entails screening. Screening consists of an attempt to answerprefatory, or qualifying, binary (yes-no) questions

APPRAISAL:If the screening process indicates that additional inquiry is warranted, then you transition from binary screening to dimensional appraisal. Appraisal poses dimensional questions Lists of potential signs, or indicia, of distress and dysfunction follow. They are not comprehensive but, rather, list potential examples. They are divided into cognitive,emotional, behavioral, spiritual, and physiological indicia.

- ***COGNITIVE INDICIA***
  Distress:Temporary confusion, time distortion, dyscalculia (difficulty doing math),Inability to concentrate,Reduced problem-solving capacity,Feeling overwhelmed, overloaded, Obsessions,Reliving the event, Nightmares
  Dysfunction:Incapacitating confusion, diminished cognitive capacity ,Hopelessness,Suicidal thoughts,Homicidal thoughts,Hallucinations,Paranoid delusions,Inability to prioritizeimportant tasks,Evidence of dissociation (rule out acute psychosis)
- ***EMOTIONAL INDICIA***
  Distress:Fear,Sadness,Irritability,Anger,Frustration,Bereavement–loss ,Anxiety
  Dysfunction:Panic attacks,Immobilizing depression, Affective/emotional numbing,Acute or posttraumatic stress disorder
- ***BEHAVIORAL INDICIA***
  Distress: Temporary phobic avoidance ,Compulsions,Hoarding,Sleep disturbance,Eatingdisturbance,Easily startled,Reticence (being reserved)
  Dysfunction:Persistent avoidance,Immobilizing compulsions,Aggression-violence,Reclusiveness,Impulsiveness, risk taking,Self-medication,Alcohol use,Using prescription drugs,Using energy drinks,Inability to speak or respond to cues,
- ***SPIRITUAL INDICIA***
  Distress:Questioning faith,Questioning God's actions
  Dysfunction:Cessation of faith-related practices , Projecting faith onto others
- ***PHYSIOLOGICAL INDICIA***
  Distress:Disturbance in appetite,Disturbance in libido,Psychogenic headaches,Psychogenic muscle aches/spasms,Decreased immunity (increased colds, infections last longer)
  Dysfunction: Changes in cardiac function,Changes in gastrointestinal function,Detection of occult blood (blood in the stool not visible to the naked eye) ,Unconsciousness,Chest pain,Dizziness,Numbness/paralysis (especially of arm, leg, face)

P—PSYCHOLOGICAL TRIAGE PRIORITIZATION

In emergency medicine, triage urgency is determined by the demand for survivability. More specifically, triage refers to a qualitative selection process based on the severity of a wound or illness, coupled with the overall suitability for treatment or intervention. In PFA,psychological triage is more complicated. Survivability is certainly a key determining factor,but there are other considerations.

The A-B-C Model Of Psychological Triage

A = Important and urgent

B = Important not urgent, or urgent not important

C = Neither important, nor urgent

A—People who are highly impaired, dysfunctional, and suffering psychologically or physically. They are mostly in need of PFA and perhaps other types of support.

B—People who are resilient in the wake of adversity. They experience increased distress, even possible acute dysfunction that resolves with respite and informal support. Mostsurvivors will be in this category.

C—People who are resistant to adversity. They are functional, if not often heroic.From the PFA perspective, you should directly attend to As, monitor Bs, and leave Cs alone.

I—INTERVENTION TACTICS TO STABILIZE AND MITIGATE ACUTE DISTRESS

Goals of Intervention

• To reduce acute emotional and physiological arousal

• To restore basic coping capacity

• To normalize and reframe stress reactions

• To strengthen adaptive supports and resources

• To instill hope and prevent long-term dysfunction

STRESS MANAGEMENT

Stress Management in Critical Incidents

• Stress and Sleep

• Nutrition and Lifestyle

• Coping and Control

• Cognitive Strategies

• Relaxation Techniques

• Exercise

ENLISTING THE SUPPORT OF FAMILY AND FRIENDS

Interpersonal support when adversity and trauma strike may be the single most powerful factor to foster resilience. Enlisting the support of friends and family of those affected by

adversity can be not only effective but also highly efficient as well. When using PFA, you should always ask what interpersonal resources the person in crisis has available and how they can be accessed. This becomes especially important in the next phase of the RAPID model.

Delay making any life-altering decisions/changes

It is counterproductive to “argue” with distressed individuals about how they should feel or think. Change is often a delicate process. When you encounter someone who is on the verge of a self-defeating action, or just a bad decision, one of the best things you can do, rather than argue, is to advocate a delay before making any important or life-changing decisions.

Faith-based intervention in PFA

• Prevalence & Role:86% of Americans believe in God or a universal spirit After 9/11, 59% sought support from a spiritual counselor, more than from physicians or mental health professionals

• ***Pastoral Crisis Intervention (PCI)***: Defined as the integration of psychological crisis intervention and disaster mental health response with faith-based pastoral care/support Parallel: crisis intervention is to counseling/psychotherapy as PCI is to pastoral counseling/pastoral psychotherapy.

• Components of Faith-Based PFA:Scriptural education, ventilative confession, prayer, faith-based social supportnetworks, rituals/sacraments, belief in divine intervention/forgiveness, ethos of pastoral interventionist..

D—DISPOSITION AND FACILITATING ACCESS TO CONTINUED CARE

• Disposition: an attitude or general state of being.It is the final phase of the RAPID model in the crisis intervention process.

• **ENCOURAGEMENT**:A big challenge associated with the disposition phase is encouraging people to seek further support. They are often hesitant because they might believe accepting further assistance is a sign of weakness or may be stigmatizing. At this point, it is often helpful to remind them that seeking further assistance may be a means of helping those who depend on them more than a form of direct assistance for them. Sometimes the timing is simply not right. Therefore, it may be advisable to follow up after a reasonable time and offer to facilitate access tocontinued care.

• **RESOURCES**: The resources available for further psychosocial support in the wake of adversity vary greatly. Friends, family, and coworkers are possibilities. Workplace- based employee assistance programs (EAP) can be extremely effective resources,especially if the EAP counselors have received specialized crisis intervention training.

MODULE 4: SELF CARE

It is important to be aware of some of the negative emotional reactions a psychological first aid (PFA) provider might experience while working with individuals following critical incidents. To help mitigate their impact, we also will describe the construct of self-care and offer ways to develop, to foster, and to engage in this important protective mechanism.

- ***Vicarious Traumatization*:**Vicarious traumatization refers generally to the process of cognitive changes in beliefs that occurs from continual interactions with trauma survivors These cumulative experiences can have deleterious effects on those who provide care and require ways for providers to mitigate their impact.
- ***Secondary Traumatic Stress*:**Secondary traumatic stress, which emphasizes behavioral symptoms one experiences as compared to intrinsic cognitive changes that are the hallmark of vicarious traumatization, may result from creating an empathic relationship with an individual who is suffering
- ***Burn out:***Depletion or exhaustion of a person’s mental and physical resources attributed to his or herprolonged, yet unsuccessful striving toward unrealistic expectations, internally or externallyderived.
- **Compassion Fatigue**:Compassion fatigue generally describes the aggregate experience of emotional and physical fatigue that a helper can experience as a result of the protracted use of empathy expended when exposed to another person’s actual or anticipated emotions when discussing distressing stories or events.

SELF-CARE

Self-care is considered an ongoing, if not lifelong, process that entails self- awareness and self-regulation in balancing psychological, physical, and spiritual needs that enhance our connection with our self and others. The essence of self-care is to promote wellness and effective functioning. It is intended to be infused within a productive lifestyle, so it is not meant to be an added burden or obligation that one “needs” to do.

Organizational Practices

Once you are trained to provide PFA, you become part of a large family of other PFA providers, who, not surprisingly, are typically accomplished, eager helpers. One of the best ways to practice preventative self-care as a PFA provider is to develop and foster consultative, supervisory, or more personal mentoring relationships with those who are seasoned PFA providers.

PASS is used more frequently when the PFA provider is a novice in implementing the RAPID model and is then most effectively used on an as- need basis when the PFA provider is experienced. However, regardless of how seasoned a PFA provider becomes, PASS should continue to be used to foster self-care and to counter professional isolation or to check in with a colleague to process the emotional impact of PFA work.

Basic Self-Care Behavioral Elements

Self-care often starts with attending to the most basic physiological needs, such as maintaining adequate amounts of sleep, nutrition, and exercise. These basic physiological needs were covered in as part of intervention suggestions youwould most often give to others.

Spiritual/Religious Self-Care

spirituality generally refers to one's personal connection with realities larger than oneself, religion in essence formalizes and organizes through rituals or behaviors what the spiritual individual might be experiencing . "it is possible to be religious without being spiritual and spiritual without being religious."

Other Self-Care Strategies

• Take a quiet, relaxing walk

• Write in a journal

• Listen to music

• Find opportunities to laugh

• Take a bath instead of a quick shower

• Connect with a friend via telephone or e-mail

• Cultivate a hobby

• Spend time outdoors

• Play with your children

• Develop a practice of mindfulness

• Implement and practice other relaxation strategies

• Make plans to get away from work to spend time with family or friends

• Be proactive in making plans with others

• Take your vacation time

• Manage your time better to schedule interruptions and breaks

• Take time for reflection

• Sleep in when you can

• Maintain clear personal and professional boundaries