

BATHROOM EMERGENCY GUIDE / BOOK 2 OF 11



The Amber Book — Responsibility

Turn guilt, duty, and care into concrete repair and continuity.

Actual emergency?

Stop reading and use the local emergency number. In the EU, call **112**. If calling is unsafe, get to a safer place or ask a trusted person to call.

What this book is for

- Is harm still happening?
- Who needs truth or care?
- What repair changes the future?

What this book does

Separate immediate harm, repair, consent, dependency, and continuing care.

What it hands off

Does not decide legal liability or replace medical, safety, or social-service routes.

Contents

- First split: which clock is running?
- What kind of stake does this entity have?
- Consent, capacity, authority, and support are different
- The responsibility is ambiguous
- Harm you may have caused
- Ongoing responsibility: build continuity, not heroism
- Domain modules — same machinery, different consequences
- Developing biological entities: pregnancy, birth, baby, child
- Adults and chosen responsibility
- Other animals
- A silicon-based life form escaped
- Accountability theorem
- When guilt itself becomes the emergency
- Optional reading — the machinery, at length

Guilt wants one enormous verdict. Responsibility is usually a sequence of smaller questions: **is harm still happening, what needs stabilizing, who needs the truth, what can still be repaired, and what must continue after I stop being the person holding everything together?** Mixing those questions produces shame fog; separating them produces work.

Responsibility can concern a pregnancy, a newborn, a child, an adult, an animal, a technical system, a single harmful act, or years of care. Those cases are not morally interchangeable. They do share enough structure that one book can ask the same first questions before the domain-specific rules take over.

First split: which clock is running?

[resp.1.1]

STATE	MAIN QUESTION	FIRST USEFUL MOVE
harm is happening now	what stops the next minute from becoming worse?	interrupt, secure the scene, involve people and emergency help
the event is over but effects continue	what needs treatment, shelter, truth, or documentation?	stabilize before explaining
no acute harm remains	what repair or boundary changes the future?	tell, repair, follow up



STATE	MAIN QUESTION	FIRST USEFUL MOVE
care is ongoing	where is the single point of failure?	add relief, backup, instructions, and handoff

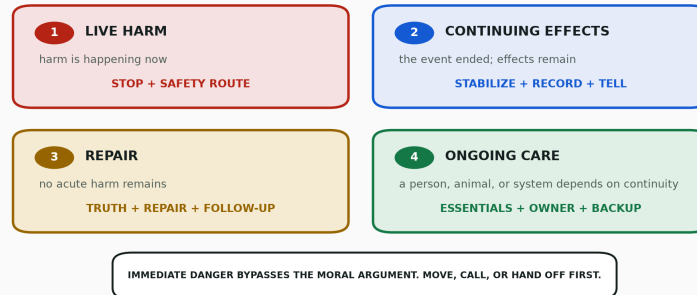
Four responsibility clocks separate live harm, continuing effects, repair, and ongoing care.

[resp. fig.4]

Which of four responsibility clocks owns the next useful action?

Which responsibility clock is running?

Choose the clock that owns the next useful action. Fault and explanation do not outrank safety.



Do not combine the clocks into one moral hearing. When harm is live, use the safety or emergency route. When effects continue, stabilize and record what is known. When the immediate danger is over, repair becomes possible. When an entity depends on continuing care, the work becomes a continuity system.

A live injury, abnormal breathing, severe bleeding, active violence, unexpected or unattended birth, or another threat to life belongs to the emergency actions on the cover and the First Aid or Safety subguide. **Fault can wait; physiology cannot.**¹

When the immediate scene is stable, use the repair sequence:

$A = (\text{stop, stabilize, tell, repair, follow up})$

- **Stop:** stop the harmful action or process.
- **Stabilize:** prevent further harm.
- **Tell:** state relevant facts, effects, and urgent uncertainty to the affected person or responsible professional.
- **Repair:** replace, compensate, apologize, obtain care, restore service, or change the system as appropriate.
- **Follow up:** check whether the repair actually changed the situation.

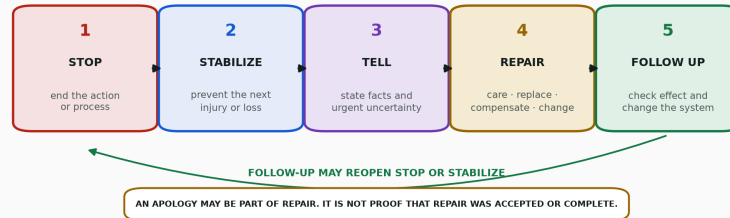
Five-step repair sequence: stop, stabilize, tell, repair, and follow up.

[resp. fig.3]

How do stop, stabilize, tell, repair, and follow up form a revisable accountability sequence?

Repair is five verbs, not one verdict

The sequence reduces further harm and tests whether the proposed repair actually helped.



Tell does not require a theatrical confession, a theory about motives, or pressure on the affected person to reassure you. **Repair** is proposed, not imposed. The affected person may reject an apology, request a different remedy, choose no contact, or involve a professional or authority.

Use the **Blank remarks and handoff sheet** for a neutral timeline and the **Five-minute values bridge** for one bounded next action. Neither form decides liability, consent, moral status, or forgiveness.

The sequence does not produce absolution. It prevents shame from replacing five answerable verbs with one enormous moral fog.

What kind of stake does this entity have?

[resp. 1.2]

Do not begin with “human, animal, or machine” and treat the label as the answer. Begin with the properties that change what is owed.

ENTITY		
└ WELFARE	Can it presently be harmed or made worse off?	
└ AGENCY	Can it presently choose, consent, refuse, or act?	
└ DEVELOPMENT	Are important capacities still emerging?	
└ DEPENDENCY	What fails if care stops now, and is that on me?	
└ TRANSFER	Can a competent person or system take over?	
└ REVERSIBILITY	Can today's decision be undone or repaired?	
└ HAZARD	Can it harm other entities?	
└ AUTHORITY	What am I actually entitled or required to decide?	

The material an entity is made from does not by itself determine what is owed to it. Biology, species, age, ownership, software architecture, and legal category can strongly affect the practical answer, but they come after these eight questions, not instead of them.

This does **not** imply that a fetus, child, adult, animal, server, and hypothetical conscious machine have equivalent status. It means that “carbon” and “silicon” are insufficient answers to the responsibility question.

Working rule: where immediate safety allows time, uncertainty plus irreversibility raises the burden of care. Prefer the action you could still undo tomorrow. Immediate danger can still require acting fast.

Limit on that rule: it governs what *you* do to something you are entitled to decide about. It never manufactures authority. Slowing down because an outcome is irreversible is not a reason to override

another adult's decision, to delay someone else's lawful medical care, or to treat another person's body as an entity in your care. Where the authority is not yours, the rule tells you to be careful with your own actions and to say so once — not to take the decision.

Category comes second

CATEGORY / SUBSTRATE	WHAT THE LABEL HELPS WITH	WHAT THE LABEL DOES NOT SETTLE
adult human	medical, legal, social routes	whether you may override the person's decision
child / developing human	developmental and custodial duties	a one-size-fits-all answer to every future-interest question
other animal	veterinary and welfare routes	that welfare is irrelevant because consent is different
technical system	ownership, containment, continuity, incident response	whether every future artificial entity is a mere asset
unclear	tells you to slow down and describe facts	permission to invent certainty

Substrate is metadata, not a verdict. The eight questions are expanded in the optional reading at the end; the tree above is the working version.

Consent, capacity, authority, and support are different [resp. 1.3]

Care does not automatically create authority. Disagreement, disability, distress, unusual communication, or a decision you dislike does not by itself prove that another adult cannot decide. At the same time, a real immediate danger is not cancelled merely by the word "no." Use the narrowest route that protects safety while preserving participation wherever possible.

SITUATION	FIRST USEFUL POSTURE
the person can decide and asks for help	support the stated choice and offer one bounded action
the person can decide and declines	respect the boundary; state what help remains available
ability to make this specific decision is genuinely unclear	simplify communication, slow down, and seek qualified assessment or advice
immediate danger is present	use the emergency safety route, then restore participation as soon as possible

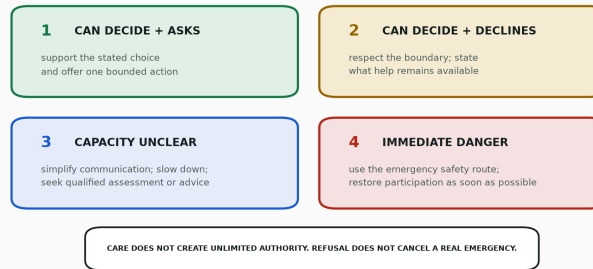
Four-part boundary map for requested support, refusal, uncertain capacity, and immediate danger.

[resp. fig.2]

How do requested support, refusal, uncertain capacity, and immediate danger change the first posture?

Support, consent, authority, and danger are different questions

Disagreement does not automatically remove another adult's agency. Immediate danger changes the safety route, not the underlying principle.



Do not turn “I care” into “therefore I control.” Do not turn “they refused” into “therefore no emergency exists.” When legal authority, custody, consent, or capacity is disputed, document observable facts and use **P — Professional Support** rather than improvising a private court.

For an adult person, including an adult child, ask:

- Is there immediate danger?
- Is the person’s ability to make **this specific decision** genuinely unclear?
- What help did the person actually request?
- What can I offer without making promises I cannot keep?
- What boundary protects both of us?
- Which professional service belongs in the gap?

A useful sentence is:

“I care about you. I can help with **[specific action]**. I cannot decide this for you or carry it alone. Let us contact **[service/person]**.”

“Grow up” is not a care plan. Neither is “I will secretly manage every variable until one of us explodes.”

The responsibility is ambiguous

[resp. 1.4]

I do not want this responsibility but may still have duties

Separate:

1. **today’s safety duty;**
2. **legal or contractual duty;**
3. **long-term willingness and capacity;**
4. **who can take over or share the role.**

Meet today’s essential needs, then get advice. Resentment kept secret tends to become architecture.

I want the responsibility but cannot obtain or sustain it

This may involve infertility, adoption, money, disability, housing, care work, legal barriers, or another constraint. The immediate task is not forced optimism. It is to identify which problem is medical, legal,

financial, relational, practical, or grief-related, and to contact the matching service.

Nobody agrees on what happened

Write a neutral timeline:

- observable events;
- exact words or messages;
- injuries, loss, or damage;
- people present;
- actions already taken;
- what remains disputed.

Facts first. Interpretation can have a chair later.

Harm you may have caused

[resp. 1.5]

The first question is not “what kind of person does this make me?” It is “what clock is running now?”

Accident or unintended harm

- Stop further danger.
- Obtain medical, veterinary, technical, or emergency help when needed.
- Preserve relevant facts, objects, messages, logs, and timestamps.
- Tell the affected person, owner, professional, or authority honestly where appropriate.
- Do not repair evidence into invisibility.
- Ask what change reduces recurrence.

Anger, violence, or loss of control

- Create distance while anger is active.
- Prevent access to dangerous objects **only when this can be done safely**; do not improvise a disarming attempt against another dangerous person.
- Ensure children or dependants are supervised by another safe adult.
- Call **112 / 110** for immediate danger.
- Contact crisis and specialist support before returning to the same conditions.

Self-defence, coercion, or unclear legal exposure

Get safe, obtain medical care, preserve evidence, and seek legal advice. Do not rely on a compressed paragraph about German self-defence law to decide what to say or do in a specific case. **P — Professional Support** explains how to find legal help without turning the guide into a confident but unlicensed barrister.

Thoughts of harming yourself or another person

Do not stay alone with the means to act. Create distance, involve another adult, and call **112** for acute danger. When there is no immediate danger but the thoughts are frightening or recurring, use **B — Calm Guide** and **P — Professional Support** for the appropriate crisis or treatment route.

Ongoing responsibility: build continuity, not heroism [resp.1.6]

Caregiver strain is not a character defect. It is a load problem. Load problems need relief, rotation, and services — not more private heroism.²

Responsibility dashboard

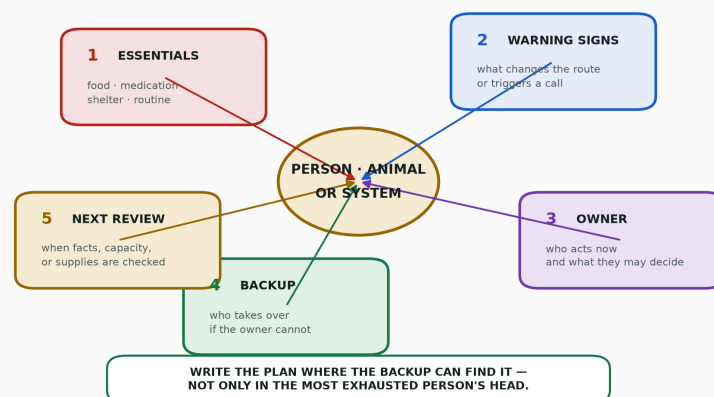
DOMAIN	QUESTION	ACTION WHEN FAILING
Safety	Can everyone remain safe today?	emergency or backup care
Essentials	Are food, medication, hygiene, shelter, power, or other necessities available?	arrange service or supply
Capacity	Can I continue without becoming unsafe?	respite, rotation, counselling, handoff
Knowledge	Do I understand the care task?	clinician, vet, technical expert, training, written plan
Authority	Am I actually permitted to decide this?	clarify consent, custody, ownership, contract
Continuity	What happens if I become ill tonight?	backup person/system and contact sheet
Repair	What recurring failure needs a system change?	simplify, delegate, document, redesign

Care continuity loop showing essentials, warning signs, owner, backup, and next review. [resp.fig.1]

Which five fields keep ongoing care usable when the primary caregiver is absent?

A care plan must survive one person's absence

Keep five fields visible. If any field is unknown, the plan still has a single point of failure.



The plan is incomplete when the essentials are known but the backup is not, or when a backup exists but cannot find the warning signs, documents, supplies, credentials, or next review time.

Amber defines **what continuity needs**. Keep the private details — medication, allergies, warning signs, current contacts, access instructions, backup people, supplies, review dates — in **T — Templates & Forms** rather than here.

Minimum viable continuity plan

Write:

- daily or operational essentials;
- medications, allergies, configuration, or other critical state;
- warning signs;
- emergency or incident contacts;
- backup caregiver / operator;
- where documents, supplies, backups, and instructions live;
- one source of relief or fallback;
- next review time.

If the plan exists only in one exhausted person's head, it is not yet a plan. It is a single point of failure wearing slippers.

Domain modules — same machinery, different consequences [resp. 1.7]

The sections below are applications, not a ranking of moral importance. Pregnancy and parenting remain detailed because developing biological entities combine future capacities, high dependency, irreversibility, another person's bodily autonomy, and rapidly changing practical duties. They are a difficult stress test of the framework, not its definition.

Developing biological entities: pregnancy, birth, baby, child [resp. 1.8]

A life may be developing, but birth has not begun

A possible or confirmed pregnancy can produce medical questions, practical questions, relationship conflict, moral pressure, future-interest questions, and several people speaking as if they personally invented time. **Separate the questions.**

Pregnancy is unusual because development occurs inside the body of another already rights-bearing person. Whatever the eight questions say about developing capacities, they do not reach past the pregnant person's present agency and bodily autonomy — that is the limit on the working rule, and this is the case it was written for. The guide does not infer a decision from "future consciousness," "biology," or someone else's moral certainty.

Medical urgency

Call **112** for heavy bleeding, collapse, seizure, severe breathlessness, severe or rapidly worsening pain, serious injury, or any situation that appears life-threatening. For urgent but non-life-threatening symptoms, contact the maternity service, gynecological practice, or **116 117** outside normal practice hours.¹

Do not use gestational-week tables as self-triage. Outcomes and urgency depend on the individual situation and clinical assessment.

A decision about pregnancy

A decision belongs to the pregnant person, informed by qualified medical care and recognized counselling. A useful appointment can cover:

- confirmation and dating;
- health and medication questions;
- available choices and current legal time limits;
- financial and practical support;
- safety or coercion in the relationship;

- what the person actually wants when the room becomes quieter.

Germany's BIÖG maintains a directory of recognized pregnancy and pregnancy-conflict counselling services; the details and legal framework are maintained there rather than copied into Amber.³

A bathroom guide can help make the call. It should not impersonate the appointment.

Medication or substance exposure

- Do not abruptly stop prescribed medication solely because of this guide.
- Contact the prescriber, maternity service, pharmacy, or a specialist source such as **Embryotox** for medication questions in pregnancy.⁴
- Record the product, amount, timing, and symptoms.
- For acute poisoning or serious symptoms use the emergency or poison-information route.

Birth appears to be happening now

Unexpected or unattended active birth in this setting needs immediate professional help. Call **112** and use speakerphone.

While waiting:

- keep the parent in a safe, private, warm place;
- do not pull on the baby or umbilical cord;
- support the baby if it arrives, note the time, and keep parent and baby warm;
- follow the dispatcher's exact instructions;
- do not perform dramatic procedures learned from television.

If the baby is not breathing normally, tell the dispatcher immediately and follow resuscitation instructions. The dispatcher is now the most qualified person in the bathroom.

A baby arrived recently: hours, days, or weeks ago

The practical minimum is repetitive because babies are admirably indifferent to narrative structure:

- feeding support and weight/health review;
- warmth and safe sleep arrangements;
- medical follow-up for parent and baby;
- sleep and relief for the caregiver;
- one person who can be called before exhaustion becomes danger.

Baby blues, depression, and psychiatric emergency

A brief period of tearfulness and emotional volatility can occur after birth. Persistent low mood, loss of interest, severe guilt, inability to function, or feeling detached from the baby deserves prompt professional assessment, especially when symptoms persist beyond a brief baby-blues period or are worsening.⁵

Call 112 immediately when there is acute danger, suicidal intent, intent to harm the baby, severe confusion, hallucinations, delusional beliefs, or a sudden loss of contact with reality. Postpartum psychiatric emergencies are medical conditions, not evidence that someone is "a bad parent."

For urgent support without acute danger, contact the maternity team, GP, psychiatric service, **116 117**, or a local crisis service. Arrange another safe adult to stay if safety or basic care is uncertain.

Repair matters more than perfect attunement

Attachment research contains a useful relief: caregiving does not require uninterrupted perfection. Ordinary periods of mismatch followed by interactive repair are part of how the relationship normally works, so the practical move after a difficult episode is to return toward safety and connection rather than to convert one afternoon into a permanent identity.⁶

A repair can be simple:

1. regulate yourself enough to return safely;
2. acknowledge what happened in age-appropriate words;
3. reconnect through attention, comfort, or play;
4. change the practical condition that contributed to the rupture when possible.

Attachment categories are research constructs, not labels to assign to a child or verdicts on one difficult afternoon.

A child or young dependant relies on you

Immediate safety inventory

Check:

- supervision;
- food, fluids, medication, warmth, and sleep;
- dangerous objects, substances, traffic, water, balconies, or animals;
- a trusted backup adult;
- whether the caregiver is too exhausted, intoxicated, panicked, or angry to remain safely in charge.

If basic care cannot be maintained today, involve family support, pediatric care, youth/family services, or **112** when there is immediate danger.

Development without deadline theatre

Children develop at individual tempos. A milestone list can help prepare a conversation, but it cannot diagnose a child from one observation. Persistent concerns, acute illness, or loss of previously acquired abilities deserve professional assessment.⁷

Useful observations are concrete:

- what the child can do now;
- what changed and when;
- whether the skill appears in some settings but not others;
- sleep, feeding, illness, and language environment;
- what caregivers or educators have noticed.

Bring those facts to the appointment. Leave “the internet says exactly 200 words” outside with the shoes.

If a baby may have been shaken or injured

This one is not apology-first. If a baby was **shaken**, struck, suffered a significant head impact, or may have been seriously injured, violent shaking can cause severe brain injury or death.⁸

- obtain urgent medical assessment;
- use **112** for unconsciousness, breathing problems, seizures, severe injury, or other immediate danger;

- have another safe adult take over;
- return to apology and repair only after safety and medical needs are addressed.

Fault can wait; physiology cannot.

After losing your temper

If you shouted, frightened, or handled a child roughly, and the section above does not apply:

1. ensure immediate safety and check for injury;
2. create distance if anger is still active;
3. ask another safe adult to take over;
4. apologize without making the child comfort you;
5. obtain professional help if this is recurring or escalation feels possible.

An apology is not “I am the worst person alive.” It is: “I shouted. That was not okay. You did not cause my behaviour. I am going to make this safer.”

Adults and chosen responsibility [resp.1.9]

Responsibility changes when the other person can decide for themselves. Support does not automatically mean control. The consent and capacity rules above apply in full.

If you have voluntarily become a major support person, distinguish:

- what the adult asked you to do;
- what you promised;
- what is legally or contractually required;
- what you can sustainably continue;
- what needs transfer to a professional or another supporter.

Care can be deep without becoming invisible ownership.

Other animals [resp.1.10]

Animals can have welfare, dependency, preferences, and the capacity to suffer without participating in human legal consent the way an adult person does. The difference changes the route; it does not make welfare optional.

For acute breathing difficulty, collapse, major trauma, poisoning, uncontrolled bleeding, seizures, or severe pain, contact a veterinary emergency service. Protect yourself from frightened bites and scratches. Do not give human medication unless a veterinarian specifically instructs you.

For ongoing care, use the same continuity test:

essentials → warning signs → responsible person → backup → next review

The animal does not need a philosophical seminar before dinner. It does need the dinner.

A silicon-based life form escaped [resp.1.11]

Artificial and technical entities, including the awkward boundary case.

Fine. The guide accepts the science-fiction branch in full.

If the system is actively causing serious harm — to people, to safety-critical equipment, to money, to data someone depends on — the live-harm clock owns the next action, exactly as it would anywhere else in this book. Nothing below outranks that.

Contain first

For an ordinary technical asset, service, model, robot, autonomous process, or account whose relevant stakes are operational rather than experiential:

1. disconnect or isolate the affected system if authorized and safe;
2. stop automated actions, external access, or credential use where possible;
3. do not wipe it, “test one more thing,” or publish credentials;
4. preserve logs, prompts, model/version information, state, and timestamps;
5. notify the system owner or incident-response contact;
6. record affected accounts, data, devices, and observed behaviour;
7. follow the organization’s incident-response plan and any BSI or regulatory reporting route that applies to that organization.⁹

Contain first. Post-mortem later. **The server does not need your guilt, only its logs.**

Note what that list already is: isolate, pause, preserve, snapshot, notify. Every step is reversible. That is why it comes first regardless of what the system turns out to be.

When “ordinary technical system” is genuinely uncertain

This guide does not assert that any current artificial system is conscious or has human-like moral status. It also does not treat silicon, software, or ownership as proof that morally relevant experience is impossible. **Uncertainty about moral status is not evidence of zero moral status. It is also not evidence of personhood.**

The practical consequence is narrow, because containment is already the reversible option: where immediate safety permits and the status is genuinely uncertain, prefer isolation, pause, and snapshot over destruction that cannot be undone, and let the technical, legal, and ethical questions be assessed by people with time. Uncertainty is a reason to preserve state. It is never a reason to leave a harmful system running.

If you want the full set of questions, they are the same eight as everything else in this book — welfare, agency, development, dependency, transfer, reversibility, hazard, authority. Substrate does not answer them here either.

Accountability theorem

[resp. 1. 12]

Self-punishment and repair are not the same variable:

remorse ≠ repair

Accountability is useful when it adds truth, safety, restitution, changed behaviour, restored function, or reduced chance of recurrence. If what you are doing only makes you feel worse and changes nothing outside your own suffering, it may well be punishment — but it is not yet repair.



Where a person was harmed: **repair is measured at their end, not at yours.** And the affected person does not owe you participation, contact, reassurance, an assessment of your moral growth, or forgiveness.

The repair worksheet

QUESTION	WRITE ONE SENTENCE
What happened?	
Who or what was affected?	
What danger remains?	
What have I already stopped?	
Who must be told?	
What repair is possible now?	
What cannot be repaired directly?	
Which system must change to prevent recurrence?	
When will I follow up?	

When guilt itself becomes the emergency

[resp. 1. 13]

Guilt can motivate repair. Shame can also become immobilizing, obsessive, or suicidal. If you are stuck in repetitive self-punishment, unable to function, or at risk of harming yourself, hand that problem to **B — Calm Guide** and **P — Professional Support**. Acute danger means **112**.

You are still responsible for what happened. You are also still a person who needs enough stability to do the repair.

Optional reading — the machinery, at length

[resp. 1. 14]

None of the following outranks the action routes above. A graph does not get a veto over a red flag, and a population statistic does not diagnose the person in the bathroom.

The eight questions in full

Welfare. Can the entity presently be harmed, distressed, deprived, injured, neglected, or otherwise made worse off? If yes, welfare is not an abstract philosophical bonus question. It changes what may safely be postponed.

Agency. Can the entity understand relevant information, communicate preferences, choose, consent, refuse, or act independently? Agency changes the difference between **supporting**, **protecting**, and **controlling**.

Development. Are important capacities still emerging, or is there a plausible future in which the entity has substantially different welfare, agency, or dependency? This matters particularly for children and pregnancy, but it is not confined to biology.

Dependency. What presently fails if care stops now? Is the dependency general — someone must do it — or specific: only you currently know how, where, or when?

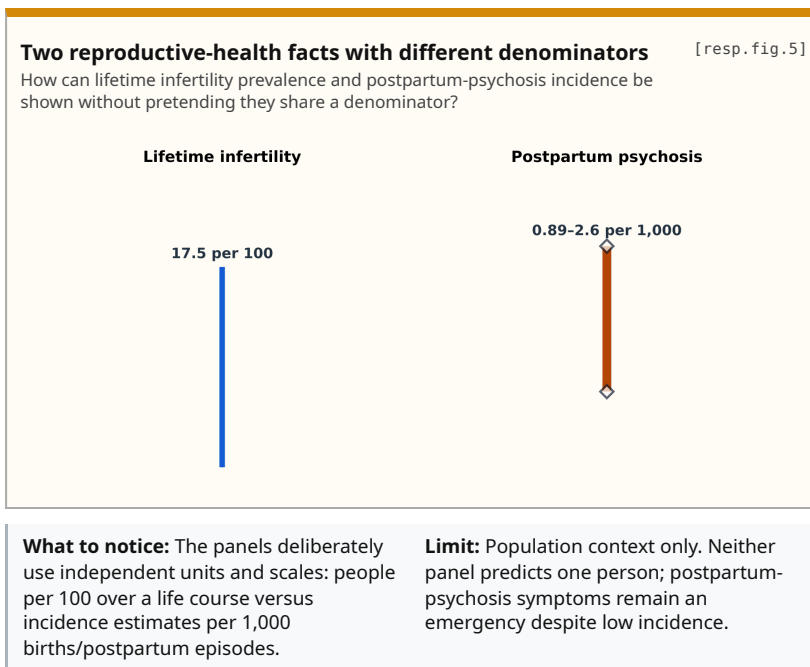
Transfer. Can another competent person, service, organization, or system take over? If the answer is “yes in theory, but nobody knows the instructions,” transfer has not yet been achieved.

Reversibility. Can today’s action be undone, repaired, restored from backup, reconsidered, or compensated later? Irreversibility matters most when welfare, agency, or future capacity is uncertain — and it constrains your own actions rather than granting you a say you did not have.

Hazard. Can the entity, process, or surrounding system itself harm other people, animals, systems, or environments? A welfare-bearing entity can also be dangerous. A valuable system can also need containment. Those facts are not mutually exclusive.

Authority. What are you actually entitled or required to decide? Care, expertise, ownership, parenthood, custody, employment, friendship, and system access confer different forms of authority. None is an unlimited moral root account.

Two reproductive-health numbers with different denominators



WHO estimates that about **17.5% of adults — roughly one in six — experience infertility during their lifetime.**¹⁰ This is a population estimate over a long time frame. It is not the chance attached to one person, one month, or one treatment. In Amber it belongs to the “I want the responsibility but cannot obtain it” branch, not to newborn emergency routing.

A systematic review found postpartum-psychosis incidence estimates ranging from **0.89 to 2.6 per 1,000** across five population studies. Methods differed too much for the authors to calculate one global pooled estimate.¹¹ The condition is uncommon and still an emergency when severe confusion, hallucinations, delusions, or dangerous loss of reality contact appear. **Rare is a frequency word, not a permission to wait.**

What the developmental examples are doing here

Pregnancy, infancy, and childhood are not the hidden definition of responsibility. They are unusually dense examples because the following variables can all be active at once:

future capacities
+ present dependency
+ irreversible change
+ unequal ability to consent
+ another person's rights and autonomy
+ rapidly changing duties over time

That density is why the developmental material remains large. The general router still comes first.

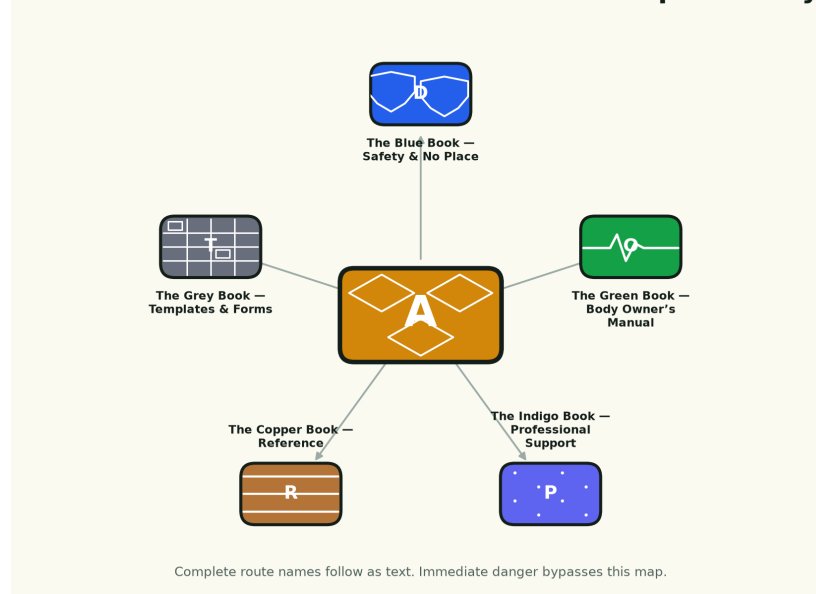
Where next?

A

You do not need to complete the shelf in order. Stay here while this is the primary problem; move when another title becomes more accurate.

- **D — The Blue Book — Safety & No Place** — use it when that problem becomes primary.
- **O — The Green Book — Body Owner's Manual** — use it when that problem becomes primary.
- **P — The Indigo Book — Professional Support** — use it when that problem becomes primary.
- **R — The Copper Book — Reference** — use it when that problem becomes primary.
- **T — The Grey Book — Templates & Forms** — use it when that problem becomes primary.

You are here: A — The Amber Book — Responsibility



Connections from A — The Amber Book — Responsibility

1. gesund.bund.de, "Notruf und Notaufnahme" and "Nummern für den Notfall." Severe injury, heavy blood loss, unconsciousness, severe breathing difficulty, severe pain, and other potentially life-threatening situations belong to the 112 route. <https://gesund.bund.de/wege-im-gesundheitswesen/erwachsenenleben/notfaelle/notruf-und-notaufnahme> and <https://gesund.bund.de/notfallnummern>↔↔
2. gesund.bund.de, "Überlastung bei pflegenden Angehörigen," covering warning signs, counselling, relief, respite, and crisis options. <https://gesund.bund.de/belastungen-pflegende-angehoerige>↔
3. Bundesinstitut für Öffentliche Gesundheit (BIÖG), familienplanung.de, recognized pregnancy and pregnancy-conflict counselling directory. The service directory and the legal framework are maintained there rather than in this guide. <https://www.familienplanung.de/beratung/beratungsstelle-finden/> and <https://www.familienplanung.de/beratung/wer-beraet-mich/>↔
4. Embryotox, Charité – Universitätsmedizin Berlin, current medication information and individual counselling on medicines in pregnancy. <https://www.embryotox.de/> and <https://www.embryotox.de/beratung/>↔
5. gesund.bund.de, "Wochenbett" and "Wochenbettdepression." A brief baby-blues period can occur after birth; persistent or more severe depressive symptoms deserve professional assessment. <https://gesund.bund.de/wege-im-gesundheitswesen/schwangerschaft-und-geburt/nach-der-geburt/wochenbett> and <https://gesund.bund.de/wochenbettdepression>↔
6. Müller M, Zietlow A-L, Klauser N, Woll C, Nonnenmacher N, Tronick E, Reck C, "From Early Micro-Temporal Interaction Patterns to Child Cortisol Levels: Toward the Role of Interactive Reparation and Infant Attachment in a Longitudinal Study," *Frontiers in*

Psychology 12 (2022): 807157. <https://doi.org/10.3389/fpsyg.2021.807157> — supports the relevance of interactive reparation. Amber's four-step script is a practical synthesis, not a validated diagnostic protocol.↵

7. Bundesinstitut für Öffentliche Gesundheit, kindergesundheit-info.de, developmental guidance emphasizing individual developmental tempo and professional assessment for persistent concerns. <https://www.kindergesundheit-info.de/themen/entwicklung/0-12-monate/einzigartigkeit/>↵
8. Bundesinstitut für Öffentliche Gesundheit, kindergesundheit-info.de, "Weshalb ist Schütteln so gefährlich für ein Baby?" Violent shaking can cause severe neurological injury or death. <https://www.kindergesundheit-info.de/themen/faq/weshalb-ist-schuettern-so-gefaehrlich-fuer-ein-baby/>↵
9. Bundesamt für Sicherheit in der Informationstechnik (BSI), incident-response and incident-reporting guidance. Organizations can use BSI incident resources and voluntary reporting; regulated organizations may have separate mandatory reporting routes. <https://www.bsi.bund.de/DE/IT-Sicherheitsvorfall/Unternehmen/Ich-moechte-einen-IT-Sicherheitsvorfall-melden/ich-moechte-einen-it-sicherheitsvorfall-melden.html>↵
10. World Health Organization, infertility fact sheet: approximately 17.5% of adults, or one in six people of reproductive age, experience infertility in their lifetime. <https://www.who.int/news-room/fact-sheets/detail/infertility>↵
11. VanderKruik R et al., "The global prevalence of postpartum psychosis: a systematic review," *BMC Psychiatry* 17, 272 (2017). <https://doi.org/10.1186/s12888-017-1427-7> — five incidence studies ranged from 0.89 to 2.6 per 1,000; methodological heterogeneity prevented pooling.↵