

BATHROOM EMERGENCY GUIDE / BOOK 3 OF 11



The Teal Book — Calm Guide

Reduce the volume enough to choose the next useful action.

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

- What is signal and what is forecast?
- What can become quieter?
- Do I stay, return, or leave?

What this book does

Reduce alarm and overload enough to notice, choose, and complete one safe action.

What it hands off

Does not explain away bodily red flags, active threats, or unsafe environments.

Contents

- Right now
- A pause needs no legal brief
- The 90-second landing
- Route the problem before solving it
- Change one variable
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- Stress does not obey a cinematic decay curve
- Yerkes–Dodson

- Polyvagal language

You made it here. That counts. Not because a bathroom solves anything, but because you noticed you needed a pause and went and found one.

Calm isn't silence inside your body. It's enough bandwidth to notice more than one thing and pick between two actions. Your heart can still be going; the room can still become usable. Your nervous system is running kernel panic, not delivering a moral verdict — we're only restarting enough services to make the next decision.

Anxiety merges sensation, prediction, memory, and obligation into one enormous notification. Separate them. Change one variable. The blanket stays.

Right now

[calm.1]

If you only read one part of this book, read this one.

1. **Put your body somewhere stable.** Sit or lean.
2. **Look outward.** Notice three ordinary things in the room.
3. **Breathe normally.** If it is comfortable, let the exhale run a little longer.
4. **Reduce one variable.** Noise, light, tight clothing, heat, information, audience, or one unfinished demand.
5. **Choose one next action.** Not the whole solution. One visible action.

You do not have to feel good before acting. The target is smaller than that: enough bandwidth for one safe choice.

Anything below this line is here to help when that is not enough. None of it is required first.

A pause needs no legal brief

[calm.2]

You're allowed to take a pause without first proving it is medically, philosophically, or economically optimal.

A bathroom can offer:

- a door;
- running water;
- a stable surface;

- a mirror that is not currently required to have an opinion;
- one small interval in which nobody gets a performance.

Serenity is optional. We are aiming lower than that on purpose: reduce the number of things demanding you at once until exactly one next action is visible.

The 90-second landing

[calm.3]

1. Make contact

Sit or lean somewhere stable. Feel the floor, wall, or sink taking your weight. Unclench your jaw. Drop your shoulders one centimetre—not spiritually, literally.

2. Orient outward

Find:

- 5 visible objects;
- 4 contact points with your body;
- 3 sounds;
- 2 colours;
- 1 next action.

Grounding is an attention task. It doesn't need to produce enlightenment. It only has to give your alarm system something ordinary to chew on.¹

3. Breathe comfortably

Try a quiet inhale and a slightly longer, unforced exhale. No giant gulps, no competition, no heroic breath-holding. Stop deliberate breathing if it makes you dizzy, tingly, or more frightened and return to normal breathing.

That is the whole instruction. Anything more technical about breathing is optional reading at the back.

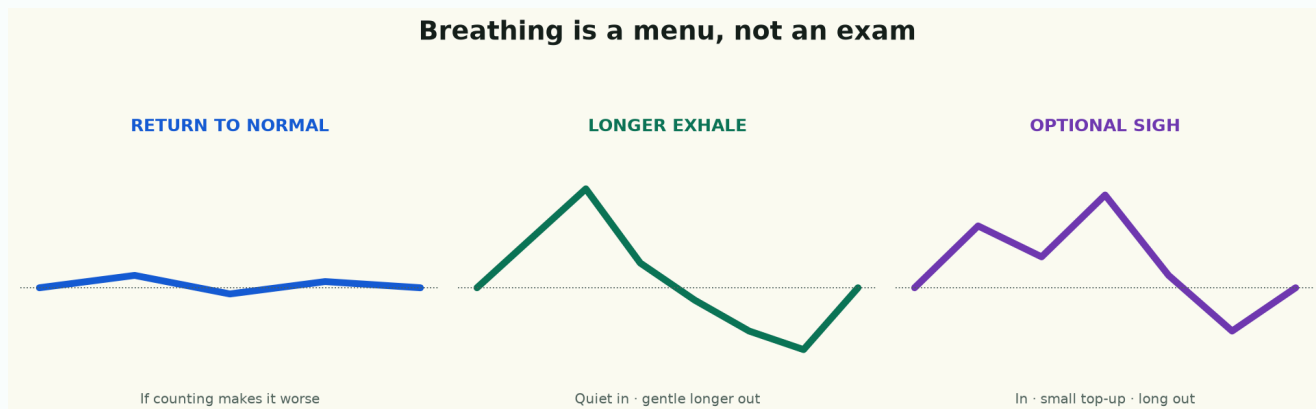
Three optional breathing patterns

[calm.fig.2]

How do the three optional breathing patterns differ in timing?

LARGE PRINT / TEXT ROUTE FOLLOWS

Breathing is a menu, not an exam



Route the problem before solving it

[calm.4]

Different kinds of overload need different tools, and you do not have to read this book in order.

RIGHT NOW IT FEELS LIKE...	GO TO
I cannot think	The 90-second landing
Everything became urgent at once	Traffic control
One frightening thought is running the machine	Unhook from the thought
I can think, but I cannot pick a next step	The bathroom control panel
I am calmer and need a direction	The five-minute values bridge
I am ready to move, return, or leave	Re-entry or exit
I am getting worse, unsafe, or medically unsure	When calm is not enough

Change one variable

[calm.5]

Pick **one**. This is not a wellness programme.

AREA	ONE CHANGE
Body	sit; loosen tight clothing; drink normally if thirsty; eat something familiar

AREA	ONE CHANGE
Room	reduce one light; reduce one sound; cool or warm the room safely; look away from the mirror
Social	tell one person; ask for ten quiet minutes; leave the audience
Information	stop searching symptoms; silence notifications; write one task down
Exit	decide where you go next

If it helps a little, that counts. If it does not, change a different variable rather than deciding the whole attempt failed.

What is actually happening

[calm.6]

Split the experience before trying to solve it

Anxiety arrives as a bundle. Separate four layers:

LAYER	EXAMPLE	USEFUL OBSERVATION
sensation	racing heart, nausea, tingling	where, when, wave or steady?
emotion	fear, shame, dread	one word is enough
prediction	"this will become unbearable"	event, or forecast?
impulse	flee, check, text, hide	what happens if it waits one minute?

Four-channel alarm map separating sensation, emotion, prediction, and urge

[calm.fig.1]

How can an anxiety bundle be separated into observable sensation, emotion, prediction, and urge channels?

LARGE PRINT / TEXT ROUTE FOLLOWS

One alarm bundle, four observable channels

S SENSATION	E EMOTION	P PREDICTION	U URGE
heart · breath · nausea · tingling	fear · shame · dread	'This will be unbearable.'	flee · check · text · hide
Where? Wave or steady?	One word is enough.	Event or forecast?	Can it wait one minute?

Change one channel, compare after one minute. New, severe, unusual, or worsening physical signs stay on the medical route.

The image and table express the same decomposition. Nothing here asks you to *deny* a sensation. It asks which channel you can observe and alter without pretending that the other three vanished. This is a control panel, not a verdict.

Then change one variable: sit, loosen clothing pressure, turn down one sound, look away from the mirror, or contact one person. Compare after a minute. The point is not to win an argument with anxiety; it is to stop four different phenomena from impersonating one enormous fact.

New, severe, unusual, or rapidly worsening physical symptoms belong to medical assessment rather than an anxiety experiment. Otherwise continue with Ch.4.

Panic attack — when anxiety goes supernova

Panic can include racing heart, chest discomfort, dizziness, tingling, trembling, sweating, nausea, derealization, fear of losing control, or fear of dying. The sensations are real even when the cause is panic.

The difficulty is that some emergency conditions can feel similar. Therefore:

- new, severe, unusual, or rapidly worsening symptoms get medical assessment;
- known recurrent panic with no red flag may use the calm sequence;

- uncertainty is allowed to escalate to **112** or **116 117**.

Do not make “prove this is only panic” your first task. Your nervous system has already opened enough tabs.

GAD-7 severity spectrum

The GAD-7 asks how often seven anxiety symptoms occurred during the previous **two weeks**. Scores are commonly grouped as:

SCORE	CONVENTIONAL LABEL	APPROPRIATE USE
0–4	minimal	describe recent symptom burden
5–9	mild	consider monitoring and discussion if impairment exists
10–14	moderate	professional assessment is reasonable
15–21	severe	prompt professional assessment is reasonable

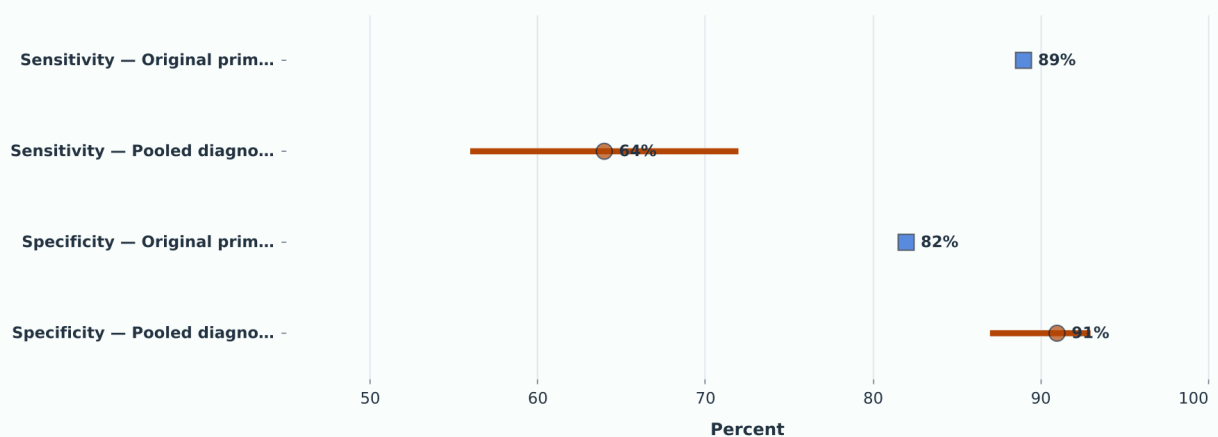
The score is a screening and communication tool. It is **not** an acute panic triage score, cannot exclude a physical emergency, and does not turn a person into one of four coloured rectangles.²

One cut-off, different observed accuracy

[calm.fig.5]

How did GAD-7 accuracy at cut-off 10 differ between its original study and a pooled diagnostic review?

LARGE PRINT / TEXT ROUTE FOLLOWS



What to notice: Accuracy changed across samples and settings; a screen supports assessment but neither diagnoses nor handles acute triage.

Limit: A screen is not a diagnosis, does not exclude a medical emergency, and varies by population and reference standard.

The original 2006 primary-care study reported **89% sensitivity** and **82% specificity** at a cut-off of 10. A later Cochrane diagnostic-accuracy review found a pooled **64% sensitivity** (95% CI 56–72%) and **91% specificity** (95% CI 87–93%) for detecting generalized anxiety disorder at the same recommended cut-off or the nearest available one.³

That is not a contradiction requiring a duel between bar charts. It is what happens when one instrument leaves its development sample and meets different settings, populations, and reference standards. The practical conclusion is modest: a high score supports assessment; a low score does not prove absence; neither result handles acute medical triage.

What the stress response is doing

Threat detection can increase heart rate, breathing, muscle tension, vigilance, and the urge to flee, fight, freeze, appease, or hide. Attention narrows toward possible danger. This is useful when a tiger has entered the bathroom and less useful when the tiger is an email.

A useful distinction:

LAYER	QUESTION	EXAMPLE ACTION
Body	What is the alarm system doing?	sit, orient, breathe comfortably
Environment	Is danger actually present?	check door, smoke, person, symptoms
Thought	What prediction is looping?	"I notice the thought that..."
Action	What helps in five minutes?	water, call, leave, medical help
Pattern	Is this recurring or shrinking life?	arrange professional support

A single alarm during a strange event is an episode. An alarm that predictably returns, cancels plans, or narrows daily life is a pattern. Patterns often respond better to structured help than to another argument with willpower.

When it is overload, not anxiety

[calm.7]

Overload often feels like every task became urgent at once. Usually several queues have lost their labels: danger, deadline, discomfort, guilt, and unfinished trivia all arrive at the same mental counter. The first intervention is not motivation. It is traffic control.

Cognitive load — why the brain is crashing

A practical conceptual model is:

$$L = I + E + S$$

where:

- I = intrinsic difficulty of the task;
- E = avoidable clutter, interruptions, and ambiguity;
- S = stress, pain, fatigue, hunger, or emotional load.

Let K denote the capacity available *right now*, and define conceptual headroom as $H = K - L$. If $L > K$, headroom is negative. This is not a measurement scale or clinical law; it is a bookkeeping theorem for the page: reliable control requires reducing, supporting, or offloading at least one term before demanding more performance. Adding an unlabeled task cannot improve the inequality.

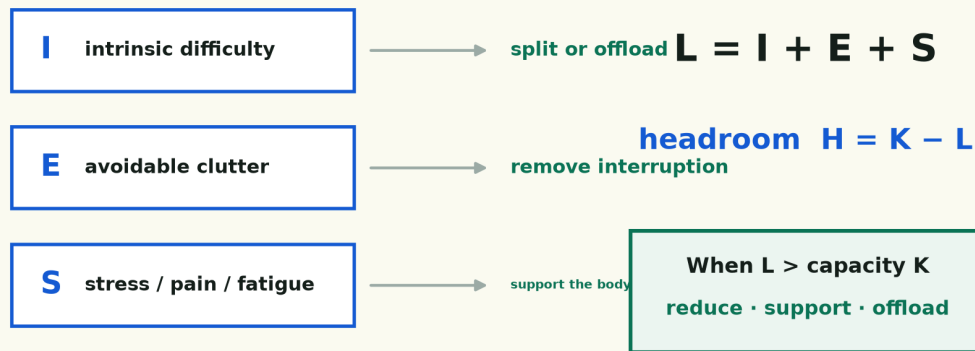
Overload control map showing intrinsic, avoidable, and stress loads with the headroom inequality

[calm.fig.4]

Which load terms can be reduced, supported, or offloaded when conceptual load exceeds current capacity?

LARGE PRINT / TEXT ROUTE FOLLOWS

Load control — make headroom before demanding performance



Conceptual units only. Safety, shelter, medication, dependants, and today's deadline remain first in the queue.

The complete text fallback is the equation and three levers above: split or offload intrinsic difficulty, remove avoidable clutter, and support stress, pain, fatigue, hunger, or emotional load. Safety-critical work stays first.

You may not be able to reduce I immediately. You can often reduce E or S : close tabs, silence notifications, write the task down, drink normally, eat if needed, sit, ask another person to hold one responsibility, or stop trying to solve Thursday while it is still Tuesday.⁴

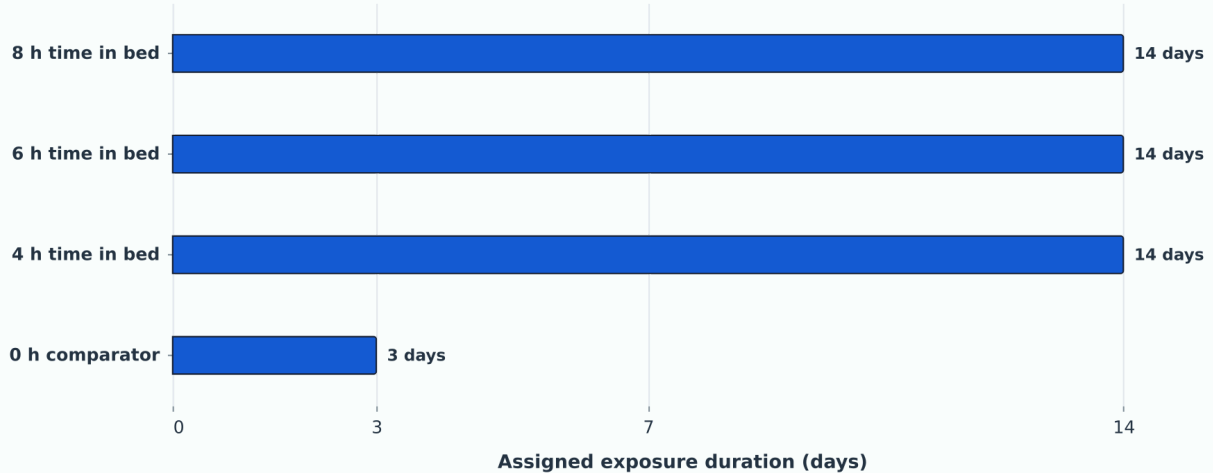
Sleep debt can hide behind confidence

What the sleep-restriction study actually assigned

[calm.fig.6]

What time-in-bed conditions and exposure durations did the controlled sleep study compare?

LARGE PRINT / TEXT ROUTE FOLLOWS



What to notice: The chronic 4-, 6-, and 8-hour conditions lasted fourteen days; the zero-hour comparator was a separate three-day condition.

Limit: Small controlled study in healthy adults; use as a warning about cumulative impairment, not as a personal calculator or emergency rule.

A controlled study enrolled 48 healthy adults. The four-, six-, and eight-hour time-in-bed groups were followed for 14 days, while a separate zero-hour comparison group underwent total sleep deprivation for three days. The four- and six-hour chronic-restriction conditions produced cumulative, dose-dependent performance deficits. Subjective sleepiness rose early but then changed less clearly than objective impairment; people did not become accurate judges merely by becoming familiar with feeling tired.⁵

This small laboratory study is not a personal impairment calculator. It does support a polite operational rule: after repeated short sleep, reduce complex choices, write down handoffs, double-check medication and driving decisions, and borrow a second alert brain where possible. Coffee may attend the meeting; it does not get voting rights on whether you are fully restored.

The bathroom control panel

[calm.8]

Check the boring variables:

VARIABLE	TINY CORRECTION
Temperature	loosen clothing; cool or warm the room safely
Water	take a normal drink if thirsty and swallowing is safe
Food	eat something familiar if you have not eaten and can do so safely
Noise/light	reduce one source
Clothing	loosen anything tight; add a warm layer if cold
Medication	take only as prescribed; do not improvise doses
Contact	tell one person what is happening
Information	stop searching symptoms for ten minutes
Exit	identify where you will go next

Comfort inventory

[calm.9]

Comfort is not a biochemical cheat code. It is a pile of ordinary conditions that quietly lower the load you are carrying.

RESOURCE	AVAILABLE?	PRACTICAL USE
phone and charger	☐	maintain contact and access to help
drinking water	☐	ordinary hydration if safe
warm layer or blanket	☐	reduce cold and create physical comfort
cool cloth or fresh air	☐	reduce heat and sensory overload
familiar music or quiet	☐	choose whichever lowers demand
book, comic, or simple game	☐	gentle external attention
notebook and pen	☐	move thoughts out of working memory
safe person or pet	☐	companionship without a mandatory speech

RESOURCE	AVAILABLE?	PRACTICAL USE
medication plan	☐	follow prescribed plan only
safer next room or outdoor place	☐	give the exit a destination

Avoid candles, smoke, incense, or strong scents when there may be gas, chemical exposure, asthma, migraine, sensory sensitivity, or a general shortage of oxygen and judgement.

Comfort inventory, without a score

Do not count the boxes. There is no validated number of them that proves anything, and one resource is still one resource. If you checked none at all, that is not a verdict either — it just means your next action is probably to go get one: contact, water, warmth, medical help, or a safer room.

Traffic control

[calm.10]

The three-line triage

Write:

1. **Must prevent harm today**
2. **Must happen soon**
3. **Can survive being ugly**

Now choose one action under five minutes.

The congestion board

TASK	HARM IF DELAYED	DEADLINE	OWNER	NEXT PHYSICAL ACTION
	low / medium / high			
	low / medium / high			
	low / medium / high			

A “next physical action” is visible and executable: “open the letter,” “call the practice,” “put the keys in the bag.” “Fix life” is not yet an action.

Five-minute reboot

1. Put every task on paper. The paper can hold more than working memory can.
2. Circle anything involving safety, shelter, medication, children, animals, or a deadline today.
3. Pick one circle.
4. Do only the first visible action inside it.
5. Reassess after five minutes.

If basic care is repeatedly failing, involve professional, social, or practical support. Productivity advice is not a substitute for treating depression, ADHD, burnout, sleep deprivation, pain, or crisis.

Unhook from the thought

[calm.11]

Try the WHO phrasing:

"I notice the thought that ..."

Not "the thought is false," not "I must defeat it." You are just putting one grammatical layer between you and the sentence, which is enough to stop it reading as a bulletin. Then ask:

- What is the thought predicting?
- What fact do I know right now?
- What action fits the person I want to be for five minutes?

Example:

"I notice the thought that everyone will hate me. The fact is that I left the room because I was overloaded. My next action is to text one person and say I need ten minutes."

The five-minute values bridge

[calm.12]

When the immediate alarm has reduced slightly:

1. Name one value: safety, honesty, kindness, dignity, rest, responsibility.
2. Choose one action under five minutes that expresses it.
3. Do not require the action to solve the whole situation.

Values are directions, not performance scores.

Re-entry or exit

[calm.13]

You cannot live in here indefinitely. The logistics deteriorate, and the towels begin to form opinions.

The three-line exit plan

1. **Destination:** "I am going to the sofa / outside / to another person."
2. **Sentence:** "I got overloaded and needed a minute."
3. **Backup:** "If I spike again, I will step out and call X."

Open the door only when the next environment is safe. If the bathroom is the safe place during violence, use Ch.3D and Ch.7 instead.

Conversation strategies

Choose one:

1. **Deflection:** "Just needed a minute."
2. **Honest-lite:** "I got overwhelmed, but I am taking care of it."
3. **Boundary:** "I cannot discuss this right now. I can talk tomorrow."
4. **Request:** "Could you sit with me for ten minutes without solving it?"
5. **Exit:** "I am done for today. I am going home."

All five are complete sentences. None require a PowerPoint.

The option of leaving

Leaving a social situation is allowed. You can say:

- "I am heading out."
- "I do not feel well enough to stay."
- "Thank you; I need quiet now."
- "I will message tomorrow."

An "Irish goodbye" may be appropriate when explanation increases overload and leaving is safe. During danger, however, tell a trusted person where you are if possible.

Seeking help: how to ask

Use a specific request:

"I am going through something. I do not need advice right now; I need **[listening / distraction / company / transport / help making a call]**. Can you **[specific action]** for **[time]**?"

Examples:

- "Can you stay on the phone for ten minutes?"
- "Can you drive me to the on-call practice?"
- "Can you take over with the children for an hour?"
- "Can you help me call the landlord or shelter?"
- "Can you remove the medication from the room and stay with me?"

Specificity turns concern into something another person can actually do.

Being yourself is allowed

You are not required to perform okay-ness. Awkwardness is not a medical emergency. The person you fear is judging you has also left a room, hidden in a bathroom, forgotten a name, cried at an inconvenient time, or said "you too" to a waiter who said "enjoy your meal." The republic continues.

Smalltalk toolkit

Smalltalk is a skill, not a personality category.

Three low-effort openings:

1. **Food:** "What is actually good here?"
2. **Pets:** "Do you have animals?"
3. **Media:** "Seen or read anything good lately?"

A simple conversation loop:

listen → reflect → respond

- listen to the actual sentence;
- reflect one useful part back;
- add one small piece.

You do not need to prepare your closing argument while the other person is still describing their cat.

Nice places and activities after the bathroom

Choose low-demand, reversible actions:

- sit in the most comfortable chair;
- step outside or near an open window when safe;
- make tea or a simple snack;
- look through a visual book or comic;
- draw with whatever is available;
- fold laundry or wash one cup;
- listen to one familiar track;
- shower only if you are medically safe and not faint;
- ask someone to sit nearby without conversation.

The activity does not need to become a hobby, identity, or monetized content stream. It may simply occupy seven minutes without making things worse.

Nice-place map

[calm.14]

Fill this before a crisis if possible:

NEED	PLACE OR ITEM
quiet	
another person nearby	
fresh air	
warmth	
low light	
charger	
simple food	
safe exit	

When calm is not enough

[calm.15]

Seek professional help when:

- episodes recur or become more intense;
- avoidance is shrinking daily life;

- sleep, eating, work, care, or hygiene is deteriorating;
- substances are becoming the main coping tool;
- trauma symptoms persist;
- you are frightened of what you might do;
- grounding and breathing make things worse rather than better;
- physical symptoms need assessment.

Use **116 117** for urgent non-life-threatening medical help, **116 123** for crisis conversation, a local social psychiatric service, or a psychiatric emergency department. Use **112** for acute self-harm, other-endangerment, severe confusion, or medical danger.

My known-good settings

[calm.16]

Fill this in on an ordinary day, when the answers are cheap. On a bad day they are expensive, and you will not want to derive them from first principles while sitting on a bathroom floor.

It is allowed to be embarrassingly specific. “Tea, second shelf” is a better answer than “self-care”.

PROMPT	MINE
Person I can contact without explaining much	
Place that reliably lowers the demand on me	
Food or drink that is easy when nothing is easy	
Sound, music, or silence that helps	
Safer next room, or outside place	
Medication plan I already have	
One thing I should stop doing when overloaded	
A sign that I should ask for help rather than wait	

One sentence I can send, so I do not have to compose it later:

“I am overloaded and need _____. Can you _____ for _____?”

One sentence for leaving a room:

"I got overloaded and needed a minute. I am going to ____."

This is not a contract, and nothing here has to be used. It is cached configuration for a day when working it out live is too expensive.

A calm plan for another person

[calm.17]

When supporting someone else:

1. Ask whether they are safe and whether medical danger may exist.
2. Reduce noise, audience, and unnecessary questions.
3. Offer choices: sit here or there, water or no water, silence or company.
4. Ask before touching.
5. Do not force breathing exercises.
6. Help make one call.
7. Stay within your own limits and involve professionals.

The goal is not to become their entire nervous system. That position has poor hours and no pension.

More breathing patterns

[calm.18]

The default is still the one in the landing: **breathe normally**, and let the exhale run a little longer only if that is comfortable. Everything here is a menu, not an exam.

Here is the pacing written the way a physiologist would write it, for anyone whose nervous system is improved by algebra. Call your inhale time t_i and your exhale time t_e . One full cycle takes

$$T = t_i + t_e, \quad f = \frac{60}{T}$$

where f is breaths per minute. **Which means:** breathe in for 3 seconds and out for 5, and one cycle is 8 seconds, so $f = 60/8 \approx 7.5$ breaths per minute. That is the entire equation. It is arithmetic in a lab coat.

It describes a pattern; it does not prescribe the correct one. Comfort and the absence of dizziness outrank the number every time.

Technique 1 — longer exhale

Inhale gently for about 3 counts and exhale for about 4 or 5. Repeat only while comfortable. Skip counting if counting becomes another supervisor.

Technique 2 — box breathing

Use equal phases such as inhale 4, pause 4, exhale 4, pause 4. The exact count is not sacred. Shorten it, omit pauses, or stop if breath-holding feels bad, causes dizziness, or conflicts with medical advice.

Technique 3 — 4-7-8 as an optional structure

The familiar pattern is inhale 4, hold 7, exhale 8. It is not necessary, and the long hold can feel unpleasant. Use a shorter ratio or no hold. Do not use the pattern as proof that symptoms are harmless.

Technique 4 — physiological sigh

One inhale, a small second top-up inhale, then a long gentle exhale. One to three rounds is plenty.

The usual explanation: the second small inhale reopens air sacs that have gone slightly flat, so the long exhale carries out more carbon dioxide. Whether or not that is the whole story, it is easy and safe to try. Biology, not magic — it merely works faster than most things sold as magic.

What the 2023 breathwork trial actually tested

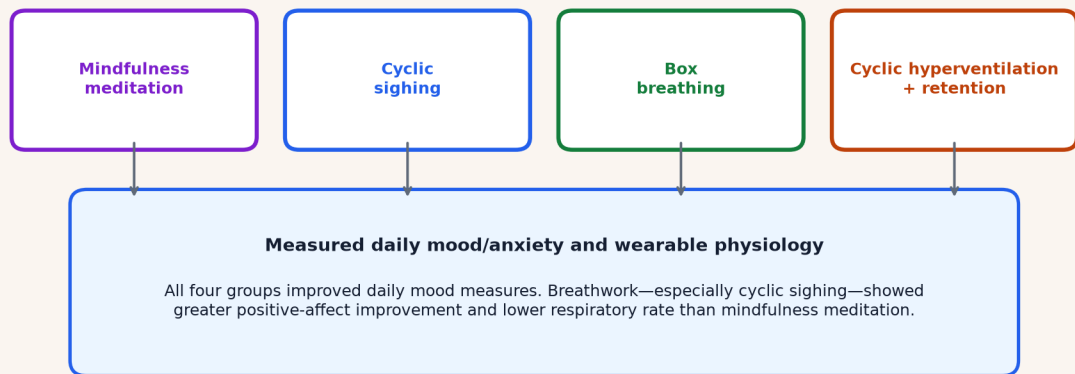
[calm.fig.3]

What did the breathwork trial actually compare and measure?

LARGE PRINT / TEXT ROUTE FOLLOWS

Breathwork trial: what was actually tested

108 adults included · 5 min/day · 28 days · remote randomized design



Interesting? Yes. Universal emergency cure? The study did not test that sentence.

SOURCE · Balban MY et al. Brief structured respiration practices enhance mood and reduce physiological arousal. Cell Reports Medicine. 2023;4:100895.
LIMIT · Five minutes daily for 28 days in a remote study; not proof that one sigh treats panic or makes alarming symptoms safe.

A 2023 remote randomized study included 108 adults in four groups: mindfulness meditation, cyclic sighing, box breathing, and cyclic hyperventilation with retention. Participants practised for five minutes per day over 28 days. All four groups improved daily mood measures; breathwork—especially cyclic sighing—showed greater improvement in positive affect and lower respiratory rate than mindfulness meditation.⁶

That is an interesting trial, not a licence to compress it into “one sigh cures panic.” People practised daily for a month, the sample was small, and nothing in it establishes that breathing exercises can rule out chest pain, asthma, poisoning, or any other medical danger. A study is evidence about a group over time, not a promise about you in the next ten minutes.

Technique 5 — no technique

Normal breathing while noticing external objects is a valid choice. The best breathing exercise is the one that does not turn breathing into another exam.

Stress does not obey a cinematic decay curve [calm.19]

You may have met a tidy exponential “cortisol decay curve” somewhere. It is fiction, and we are not going to print it. Human arousal is not a bath plug: stress chemistry, interpretation, pain, safety, sleep, substances, and whatever happens next all interact.

Here is an honest model instead — deliberately a much cruder one:

$$A_{k+1} = A_k - \delta_k + \varepsilon_k$$

- A_k — how activated you are right now, at step k ;
- δ_k — the small amount some useful action just took off;
- ε_k — whatever the world just added back.

Which means: you do a thing, it helps a little, the world puts some back, and you go again. Notice it predicts no numbers at all — that is the point. A formula that admits what it does not know is doing more work than one that guesses to two decimal places.

So: not physiology. A teaching model for one practical fact — several small reductions can add up, even when calm refuses to arrive in a single magnificent wave accompanied by tasteful strings.

Yerkes–Dodson [calm.20]

PRINCIPLE *some arousal helps; too much jams the controls*

The classic Yerkes–Dodson relationship is usually drawn as an inverted U: too little arousal and you are not really engaged, some arousal and you are alert and capable, too much and the controls jam. Where the top of that curve sits moves with the task, your experience, and you — and complicated tasks generally tolerate less arousal than simple ones.

Which is worth saying plainly: the guide is not trying to get you to zero. Zero is the left-hand side of the curve, and nothing gets done there either.

Practical use:

- do not demand zero stress before taking action;
- reduce arousal enough for the task at hand;
- simplify the task when arousal cannot be reduced quickly;

- use external checklists for complex decisions.

This is a broad performance principle, not a meter hidden behind your left ear.

Polyvagal language

[calm.21]

PRINCIPLE *useful metaphor, limited certainty*

People sometimes describe states as:

- socially connected and able to think;
- mobilized for fight or flight;
- shut down, numb, or collapsed.

The language is genuinely useful for naming what is happening to you. The stronger anatomical claims built on top of it are still argued about, so treat the three states as descriptions rather than as a diagnosis. You do not need to settle the exact cranial nerve politics before asking a friend to sit nearby.

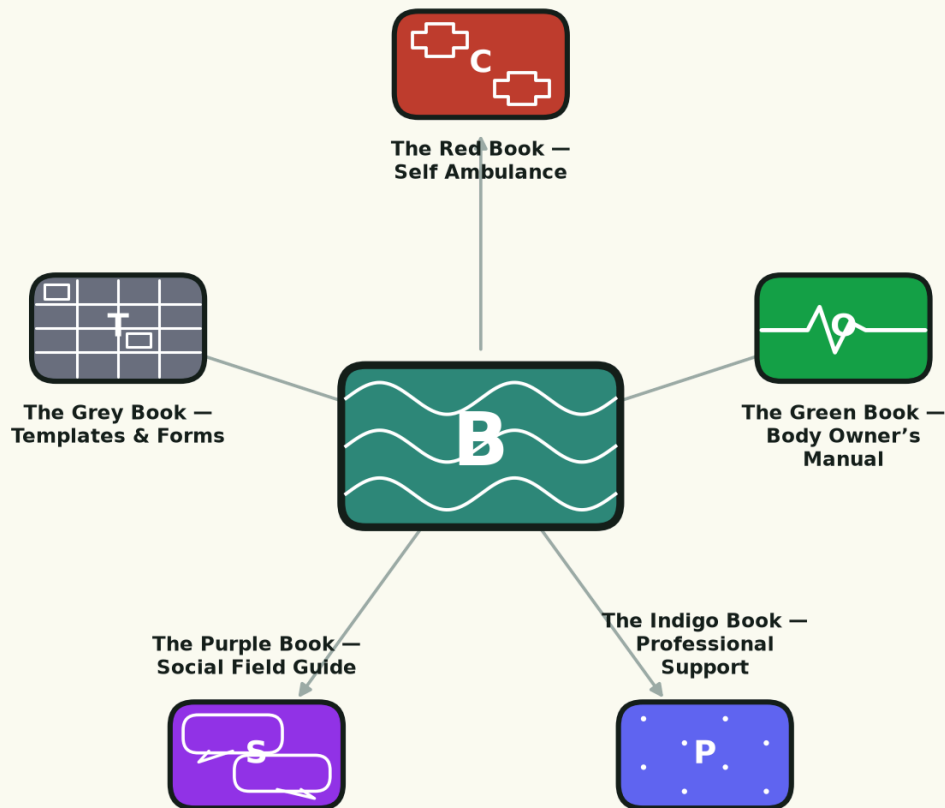
Where next?

B

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.

- **C — The Red Book — Self Ambulance** — 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.
- **S — The Purple Book — Social Field Guide** — use it when that problem becomes primary.
- **T — The Grey Book — Templates & Forms** — use it when that problem becomes primary.

You are here: B — The Teal Book — Calm Guide



Complete route names follow as text. Immediate danger bypasses this map.

Connections from B — The Teal Book — Calm Guide

1. World Health Organization, *Doing What Matters in Times of Stress* (2020): <https://www.who.int/publications/i/item/9789240003927>↵
2. Spitzer RL et al., "A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7," *Archives of Internal Medicine* 166 (2006): 1092–1097. <https://doi.org/10.1001/archinte.166.10.1092>↵
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