Psychological Early Intervention

Co-funded by the Erasmus+ Programme of the European Union

Psych.E.In. Case Studies

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Psych.E.In. Case Studies Collection

Targeted to Psychologists, Psychotherapists and Psychoanalysts

Contents

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Introduction

Psychological Early Intervention (Psych.E.In.) Collection of Case Studies is targeted to psychologists, psychotherapists and psychoanalysts and presents six case studies which present different methodological approaches applied to different emergency contexts.

Psych.E.In. partners' experience is enhanced by the description of case studies directly treated or taken from the literature. The case study is a highly adaptable and personalized learning method that involves problem-based learning and promotes the development of analytical skills, going beyond the recall of knowledge for analysis, evaluation and personal application. Similarly, case studies can facilitate interdisciplinary learning, as recommended in the Early Psychological Intervention, and can be used to highlight connections between content and real-world applications. Case studies have been reported to enhance adults' personal learning by promoting and enhancing professional performance in assessments and skills.

The Psychological Early Intervention emergency settings described in the Collection of cases are:

- Setting 1: sanitary humanitarian emergencies (such as epidemic and pandemic)
- Setting 2: natural disasters humanitarian emergencies (such as earthquake, tornado, fire, natural-induced Technological)
- Setting 3: health traumatic event
- Setting 4: technological disasters humanitarian emergencies (such as chemical or nuclear accidents, NBC)
- Setting 5: social humanitarian emergencies (such as terrorist attacks, riots, forced migrations with a strong presence of refugees and asylum seekers, conflicts and war, delinquent acts, physical violence or suicide, violent death, missing, kidnapped, tortured people)
- Setting 5: accidents (such as serious road, work or school accidents)
- Setting 6: global impact humanitarian emergencies (conflicts and war, terrorism, economical break crisis).

Psychological Early Intervention (Psych.E.In.) Collection of Case Study offers a comprehensive overview of different approaches that are rarely found in Psychological Early Intervention. The methods described by the cases are:

- Family Therapy (Case 1)
- Cognitive behavioral - Cognitive restructuring and acceptance (Case 2 - Case 4)
- EMDR (Eye Movement Desensitization and Reprocessing) (Case 3)
- Transcultural psychology (Ethno-clinical psychology) and Group Analytic (Case 5)
- Bio-psycho- social psychodynamic method (Adlerian method) (Case 6)

Each case provides global interdisciplinarity prospective taking charge of all phases of the emergency. To know more, please consult Psych.E.In. website: Case studies page and see further good practices at the link: https://psychein.pixel-online.org/gp_CaseStudies.php

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Case study 1

Grief Counseling Therapy Techniques & Interventions

***Responsible partner**: Jan Kochanowski University (PL)*

***Author**: Ackerman Courtney E.*

***Keywords**: Pandemic, Grief, Counseling Therapy Techniques*

1. Description of the event

During the Covid-19 pandemic, a family consisting of a mother (50 years old), daughter (22 years) and son (16) came to the Center for Crisis Intervention and Psychotherapy for Prevention and Education in Kielce. Two months earlier, the father of the family (56 years old) died due to covid-19 and respiratory failure. The death was sudden. The man was ill for two weeks. Death occurred suddenly in the hospital. The intervention team consisted of 2 people (psychologists).

2. General conditions

Mother, Mrs. Anna, was very badly functioning. She had sleep disorders, she could not eat, within a month she lost more than 5 kg. She would wake up at night, she would have a lot of different negative and bad thoughts. Her mood dropped, she felt very tired and weak. She had difficulty concentrating. Throughout the day she had severe anxiety. She feared for her future and the future of her children. She also experienced a strong sense of guilt. She blamed herself for her husband's death: "If I had called a doctor earlier, my husband might have been able to continue living." She was very close to her husband. They formed a good marriage and a good family. They were close to each other. They had plans for the future. The pandemic and death took it all away.

Daughter Elżbieta is a student. He studies marketing. She is very afraid for her mother. He doesn't know how to help her. She herself also has trouble sleeping. The mood is also depressed. However, there are no problems with food. At home, she took over all the duties. Mom can't do them. Mrs. Elżbieta does the shopping, makes sure that the bills are paid. He is very afraid for the future. Initially, family and friends often visited them. Now fewer and fewer people visit them. They were left alone with their misfortune. Mom doesn't want to go anywhere. He is currently not working and does not perform any duties.

Son Mateusz studies in the 2nd grade of high school. He was deeply affected by the death of his father. He hadn't expected this. He was close to his father. He is very worried about his mother. He's afraid he'll do something bad to himself. Mateusz currently sleeps well, there are no problems with eating. He goes to school. There are no problems at school. However, he often thinks of his father. He constantly wonders, "Why did this happen?" He cannot come to terms with his father's death.

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Matthew is sometimes explosive and angry with other people and the whole world. Then he sits down at the computer and plays. Sometimes he plays for several hours. At home, they don't talk about what happened. It is too painful. They are afraid that the conversations will make their mother's condition even worse. Nor do they talk about the future. There are many things to do. Mom, however, is not able to take care of them. Matthew worries about what will happen next.

The interveners met with the whole family. They assessed the functioning of each family member. The worst functioning is mother, Mrs. Anna. She has depressive symptoms: sleep disorders, eating disorders, depressed mood, negative thoughts about herself, negative thoughts about the future, resignation thoughts (without suicidal thoughts). She withdraws from daily activities, does not work, does not perform household duties. It isolates itself from people. The daughter, Mrs. Elżbieta, took over household duties. She does the shopping, cooks, cleans. She also has depressive symptoms and a reaction to trauma, but not as strong as her mother's. The daughter goes to classes and is active. Now he mainly worries about his mother, thinks less about what happened. Son Mateusz psychophysically functions quite well. However, he escapes from mental pain by playing on the computer. He doesn't leave the house very much because he's afraid for his mother. He goes to school, there are no problems with learning.

The family found itself in a highly traumatic situation related to the death of their father and the pandemic. It consists of three people: mother, daughter and son. The mother has strongly depressive symptoms, the daughter has taken over household duties, the son escapes into computer games.

Communication in the family very narrow. Family boundaries are now rigid. There was a restriction of contact with people outside the family. Family members strongly support each other, show mutual care, but mainly in the relationship of children to mother. The mother functions badly in life roles. Children function reasonably well at school, but they have limited social contacts.

3. Intervention

The first meeting with the family. The family came to the center for help. It was directed by Anna's sister, who arranged a family by phone. The first meeting was led by two interveners. Despite the pandemic and the recommendations for online contact, it was decided to contact directly, face to face. A cooperation with the family was established for the meeting, providing understanding and support. A problem diagnosis was carried out. The functioning of each family member as well as the entire family system was evaluated. The family's expectations regarding the goals and forms of assistance were also established. The family consultation was aimed at increasing safety and stability in a traumatic situation. Safe conditions were created to talk about the trauma experienced. For the first time since the father's death, the mother and children spoke together about the incident and the current situation. They could also safely express their emotions and fears. They expressed their readiness for further meetings. The interveners proposed separate meetings for each family member and common meetings for the whole family. First of all, a meeting of Mrs. Anna with a doctor was arranged in order to improve sleeping. Individual meetings with three different interveners took place once a week. Joint family meetings were held once a month. Intervention work is planned for six months. Individual work with mother, Mrs. Anna, was aimed at improving her functioning and reducing depressive symptoms. The next goal was to work through the loss and grief. Working with children focused on their problems and needs not only in the context of the loss of their father, but also their fears for their mother. Family meetings focused on experiencing mourning together and improving the functioning of the family system.

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4. Effects

After three months, the functioning of mother, Mrs. Anna, improved. The doctor recommended antidepressants. Thanks to this, her sleep and activity improved, depressive symptoms decreased. Mrs. Anna returned to her household duties and work. Thanks to this, the daughter could become more involved in life outside the family. The son, Mateusz, began to control his playing on the computer, began to contact his friends more often. Family meetings helped a lot in experiencing mourning. During these meetings, the family was able to express their feelings together, both sadness and fear of the future. An important moment in working with the family was writing a farewell letter to father (6 months of therapeutic work). They wrote a joint letter. But everyone also wrote a letter to their father. They took these letters to the cemetery, to my father's grave.

Resource: Ackerman Courtney E. (2018). 3 Grief Counseling Therapy Techniques & Interventions. https://positivepsychology.com/grief-counseling/

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Case study 2

Severe COVID-19 and PTSD symptoms: Individual CBT approach with stressing cognitive restructuring and acceptance

***Responsible partner**: University of Presov (SK)*

***Author**: Ľubica Zibrínová*

***Keywords**: COVID-19, PTSD, cognitive restructuring and acceptance*

4. Description of the event

1. Scenario

The patient, Peter, 53 years of age, comes to the intervention after having undergone a COVID-19 - severe degree with necessary induction of artificial sleep for a period of about 1 month. After withdrawal from artificial sleep and the ability to move independently, he comes on the advice of his GP and relatives. He complains of a number of fears left in him by his hospitalization. The strongest fear stems from his distrust of doctors. He believes that they do not have sufficient professional skills and knowledge, which is why people suffer and die. He has trouble going with himself to the check-up, he fears that they will mess something up again and this time he will die. His wife is a cancer patient, he has a strong fear for her life and the influence of doctors on her health. When he sees the news or the doctor he shudders and memories of the hospital and has a strong feeling of helplessness and finality come back.

2. Intervention Team

Trained CBT therapist.

5. General conditions

The patient became infected with COVID-19. He was very worried about his wife's life, not assuming that he himself would be in danger, given that his wife was a cancer patient and he had been healthy so far, without any dispensation. Symptoms of covid disease set in, which in the early stages he managed reasonably well. After the incubation period, a symptomatic stage developed with uncharacteristic symptoms of respiratory tract infection (similar to influenza). The typical symptom was a temporary loss of taste and smell.

The early pulmonary stage was manifested by dyspnea on days 5-8 of the illness. The condition did not improve; on the contrary, fever persisted and dyspnea was associated. At this stage, the virus had already caused damage to the lungs (viral pneumonia) and the unregulated immune reaction with all its consequences, the so-called cytokine storm, was gradually escalating. The disease progressed to the late pulmonary stage. COVID-19 symptoms described:

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- severe shortness of breath
- strong, incessant pressure in the chest
- severe chest pain
- loss of speech, confusion on waking
- coughing up blood
- increased temperature, fever
- dry cough
- fatigue
- chills
- loss of smell or taste
- headache
- muscle or joint pain
- sore throat

Subsequently, he was put into artificial sleep, for about 1 month, then awakened. After the interruption of artificial sleep, significant confusion, disorientation, loss of ability to recall the past, loss of mobility, and severe muscle pain throughout the body. Despite intensive anti-inflammatory treatment, an intense cough is present. Anger was combined with fear and helplessness. Subsequently stabilized and discharged to home care. Recommended intensive rehabilitation to regain mobility. This phase lasted approximately 5 months. During this phase, he was cared for by his wife (she suffer from cancer). He discussed in his mind that he was worse off than her as he was dependent on her help. He was unable to sleep at night, afraid that he would not wake up. At every mention of doctors, hospital, and illness, he shuddered, unable to control his fear, and vivid images of the moment after waking came back to him. Subsequently, posttraumatic symptomatology developed:

- nightmares
- scary thoughts
- sweating and shaking
- refusal to discuss the event
- avoidance of things reminding the event
- feeling detached and alienated from others
- inability to recall some aspects of the event
- decreased interest in life
- difficulty concentrating
- difficulty falling asleep or waking up and being unable to fall asleep
- moodiness
- irritability
- outbursts of anger
- excessive vigilance against potential danger
- experiencing destructive feelings during similar events
- feelings of guilt
- phobias
- anxiety disorder
- severe depression
- headaches
- chest pain
- physical anxiety and pain
- weakened immune system
- problems in basic functionality

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6. Intervention

The use of controlled breathing combined with exposure to memories and current events and cognitive restructuring - with the aim of accepting real life with the presence of possible illnesses even of a very serious nature.
In the first phase of the intervention, we just had the client talk and asked for facts to support his cognitive functions. We then administered a short diagnostic battery aimed at orienting him to the weak points in the psychological mechanism that needed to be strengthened in therapy. We applied Young's maladaptive schemas-the YSQ-S3 SK-90-item questionnaire, the Impact of Event Scale-Revised (IES-R), the PHQ-9 for depression symptoms, and the seven-item Generalized Anxiety Disorder Scale (GAD-7). Intervention will be described in 7 intervention steps (sessions):

1. Intervention – Using stabilization techniques to train in the here and now

Stabilization techniques were used to bring the overwhelmed anxiety/tension into the "here and now" state, i.e., in the present. We used: **counting from 100-7** ('switching on' cognitive functions); **compassionate mindfulness**: sitting and observing what sensations arise in the body. When I notice them, I can have thought: welcome; **breathing into the square**: inhale through the nose for 4 seconds. Holding your breath for 4 seconds. Exhale through the nose for 4 seconds. Hold for 4 seconds. In the mind, so we go around the square. We recommended doing the exercise in sitting and later in walking.

2. Intervention – Using techniques to improve the concentration of attention

- list everything that is in the room (or what everything in the room is green, etc.) The procedure helps the brain to extend perception to other things.
- I sit in a chair, eyes closed, and just notice and observe: Which body parts are touching the chair? Where is there more pressure? Which parts of the body are warm and which are cold? What sounds are coming to me from outside and inside the body? What smells come to me? What taste is in my mouth? I open my eyes and observe what colors are coming to me - To stop, to withdraw from what is happening. In my mind's eye, I imagine a "drone" position and just observe this distance.

3. Intervention – Negative emotion acceptance meeting- finding a positive relationship to a negative emotion

The **RAIN technique** for coping with unpleasant feelings and for accepting the emotion without the patient internally dealing with it.
1. R - RECOGNIZE - to recognize his feelings, and emotions, that they are happening to him, to become aware of them.
2. A - ALLOW - to allow the experience to be as it is, to accept these feelings. To let them be as they are in the moment. This kind of permission will allow him to be more in touch with himself and not stay in aversion/resistance.
3. I - INVESTIGATE - kindly explore, and turn your curiosity to the experience at hand. Simply ask yourself the question "What is happening to me? What is asking for my attention? How am I feeling this in my body?"
4. N - NATURAL AWARENESS or NON-ACCEPT - the natural awareness of not identifying with the unpleasant feeling or thought. Our SELF is not limited by temporary emotions, and therein lies freedom.

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4. Intervention

- The patient felt an irrational need to be reassured and in control of what was happening so we sought new opinions and attitudes about real events.
- Constructive viewpoints: Providing a constructive perspective on what we are experiencing. We looked for resources in each situation that can be used. We have tried to support what we can do.
- Focused on the here and now: we have no control over what will happen. All the plans have been broken. The important thing is to focus only on this day, on the "here and now". On what is here, what is within my reach.

5. Intervention – Cognitive restructuration

<u>This method serves:</u>

1. to become aware of negative thoughts that have an impact on the emergence of negative mood
2. to explore the validity of the thoughts
3. to find rational thoughts
4. to test the validity of a rational response in real situations

Using Socratic questioning, we explored the validity of thoughts:

- doctors cannot be trusted, they have neither knowledge nor sufficient professional skills
- I can't fall asleep when I fall asleep I won't wake up
- my wife has cancer, and I'm worse off than her
- If I go to the doctor, he will hurt me and I will die
- I'm sick, I'll never be functional again

<u>Followed questions (topics) were explored:</u>

1. What does that say for? What is against?
2. Are there other possible explanations?
3. What would someone else think in such a situation?
4. Is this idea based on a feeling or on reality
5. What are the advantages or disadvantages of thinking this way?
6. What logical errors does he make?
7. Does he forget some important facts and overestimate the importance of trifles?
8. Does he not think in extreme terms-all or nothing?
9. Does he not deal with questions that cannot be answered?
10. Doesn't he make more stringent demands on himself than on others?
11. Does he not overestimate the probability with which a particular event is likely to occur?
12. Even if what the patient fears were to happen-what would be so terrible?
13. Doesn't the patient also take responsibility for events beyond his or her control?

6. Intervention - Acceptance of reality, acceptance of illness as a possible part of life

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John Leach said: "Casualties have been recovered from lifeboats equipped with emergency boxes (flares, food, first aid kit, and more) which no one has even opened and the important contents have not been used. Someone just gives up too soon".

In challenging situations, everyone has a limited amount of resources. The important thing is to manage resources well and look for creative solutions - ones that we wouldn't think of at first. Combine different options, and replace resources with something else...

Suggested exercises have given the current options:

- Given the motor instability, read 1 hour a day - can be implemented even in the sick.
- To strengthen motor stability, build a model airplane, regardless of the quality of the result- can be implemented even by a sick individual.
- To start learning a foreign language- memory training - can be done by a sick individual.
- Helping the sick- at the end of the therapy, the patient took a massage course to be helpful to sick, infirm people, in order to relieve the pain of others and to see the importance of helping.
- Diversion on self-analysis to help others. To persevere means "not to give up", no matter how difficult things may get.

7. Intervention - Searching for the positive meaning of trauma in the patient's personal growth.

4. Effects

1. Result indicators (e.g. IES-R)
   Significant improvement PTSD, depression, and anxiety symptoms measured with IES-R, PHQ9, GAD-7.

2. Symptomatology
   Significantly reduced PTSD symptomatology as well as depression and general anxiety symptoms. Change in life situation perspective. Increasing in life appreciation and thankfulness that his life was saved and that others helped him. This perspective leads to more openness to others and to more willingness to help others.

3. Social functioning
   Becoming more open to others, reduce his hostility and significantly decrease in social isolation. Increasing in everyday functioning. Changing his job after 13 years for a job that is more adequately matching his abilities, needs, and education. Looking for the possibilities of how he can help others as a volunteer in a hospital. Better acceptance of life changes (e.g., having new neighbors).

5. Global interdisciplinarity

This case study can be a good example of step-by-step work with a client who has experienced trauma. Through managing the symptoms of acute stress, e.g. through training in regulated breathing and grounding techniques, and then changing one's perspective on the trauma through cognitive restructuring and acceptance of the traumatic experience and its consequences, which helps to integrate the experience into one's life. The techniques presented in the case study can also be used separately in different phases of stress and across different approaches and by different individuals providing trauma-focused intervention. Describing each intervention step in the context of a specific case allows for a better understanding of how these intervention steps can be helpful in processing posttraumatic reactions, integrating the traumatic experience, and in the process of posttraumatic growth.

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Resource: Ľubica Zibrínová. Individual CBT interventions with client suffered with severe COVID-19. Casa study from own clinical practice. Ambulance of Clinical Psychology, Presov, Slovakia.

Case study 3

Critical Incident Interventions

***Responsible partner**: Associazione per l'EMDR in Italia (IT)*

***Author**: Roger M. Solomon*

***Keywords**: Emergencies, EMDR intervention*

Method: EMDR

1. Description of the event

Scenario

A community tragedy impacts a number of individuals, where community infrastructure has been destroyed and other issues take the forefront in the immediate aftermath (shelter, food, safety, etc.).

2. General conditions

1. General conditions of the victims/group. Symptoms according to ICD 11

In critical event victims can be affected by:

- Acute stress disorder (ASD)
- Depression
- Complicated bereavement reactions
- Fear, anxiety, physiological arousal at a level that interferes with functioning
- Anger control problems
- Severe dissociative states
- Functional disability
- Substance abuse
- Relationship disturbance

2. Effect of the general current level of functioning of the victim

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Initially survivors may be in shock, so low-key interventions that focus on stabilization are most appropriate. These are interventions that promote a sense of safety, lower arousal, and provide education and support for adaptive coping strategies.

3. Intervention

It is important to take a longitudinal approach and to provide a continuum of psychological interventions to meet changing needs over time and according to the unfolding phase of recovery people are experiencing. In the aftermath of a critical incident in terms of three broad, overlapping clinical goals that change over time:

Stabilization (first 48 hours or longer),
Coping and Resource Identification (24 hours to 12 weeks),
and *Recovery Support* (2 weeks to 52 weeks).

Intervention strategies can be developed according to:

1. Target population—Who needs intervention?
2. Type of incident—Which interventions are appropriate?
3. Timing—When?
4. Themes—What are the facts of the incident, issues, and concerns?
5. Resources—Who are the best resources available to provide the services?
6. Ongoing evaluation.

1. Description of the **initial phase – first 48 hours** (triage/outreaching... emergency relieve, assessment of the damage).

Stabilization is the goal of interventions in the first 48+ hours. The transitional state after the event, when the person tries to validate, verify, and understand their experience, is a critical period where traumatized people are suggestible and prone to dissociate when cued. The goal of psychological intervention in the immediate aftermath is stabilization—emotional containment and provision of constructive coping strategies to decrease arousal, increase control, and prevent distress or impairment from getting worse. Exposure to arousing stimuli should be minimized.

2. First psychosocial intervention (stabilization, access to resources, temporary shelter and/or accommodation)

Assessment of Functioning/Needs. Assessment of functioning/needs (triage) is conducted to determine what is needed. An assessment should be conducted to evaluate the impact of the event and what is needed.

Psychological First Aid. Psychological first aid (PFA) is the use of pragmatic-oriented interventions delivered during the immediate impact phase to individuals who are experiencing acute stress reactions or who appear unable to regain sufficient functional equilibrium by themselves (Young, 2006). The intent of PFA is to aid adaptive coping and problem solving. PFA includes interventions geared toward 1. Safety. 2. Calming/stabilization. 3. Connectedness to others. 4. Increasing self-efficacy and empowerment. 5. Hope

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3. Individual Interventions

Individual Crisis Intervention. When a person is particularly upset, an individual session, as opposed to a group intervention, is warranted. Exposure to other people's stories can intensify that person's reactions. With appropriate caution, EMDR can be used in a crisis intervention context (Solomon, 1998) and is further elaborated upon in the articles by Kutz and by E. Shapiro and Laub in this issue.

4. Group interventions: Psychosocial intervention on the family network, community...school, organisation, department

Crisis Management Briefings (Mitchell & Everly, 2000), also called Critical Incident Stress Orientation (Solomon & Macy, 2003). This intervention is like a town hall meeting and can be applied to large groups of people. The meeting is informational in nature and focuses on providing the facts about what happened and teaching about normal reactions and coping skills. Getting together with others in a secure, safe environment provides structure, reinforces group cohesion and reduces isolation, and provides an opportunity for triage.

Demobilization (Mitchell & Everly, 1996, 2000). This intervention is usually provided to emergency service personnel after a large-scale event when there are too many people in- volved to provide more personalized services. It is designed to be a quick informational and rest session after the event. After being relieved from the scene of the incident, units can report to a place where they receive a brief information session (e.g., 10 minutes) on critical incident stress and coping and have a few minutes (e.g., 20 minutes) for food and rest. The provider of psychological services can be available to offer the brief in- formation and informally screen for individuals who may need further assistance.

Defusing (Mitchell & Everly, 1996, 2000). Defusing is a group meeting or discussion about a critical incident con- ducted within the first few hours following an event. This is not an appropriate intervention for a mass disaster. Typically, those who share the same perspective are put in the same group, e.g., a work group, those at the scene or those who share a particular perspective. This reinforces the benefits of group cohesion and identification and reduces isolation. Groups can be very helpful in validating and normalizing experience. A defusing is typically 20–45 minutes in length. The goals are to mitigate the impact of the event, reduce symptoms, promote the recovery process, and assess need for further services. Containment, rather than opening up, is emphasized. The appropriately trained provider can lead the defusing.

Referral. If people are severely impacted and not coping well, a referral for further assessment and treatment is needed. Prime examples of conditions requiring referral include the list of symptoms described in the paragraph 2.

5. Description of the acute phase 24 hours-12 weeks (coping and resources identification).

An important part of recovery is the identification of available resources that can help promote recovery. These resources include social network (friends and family), community services, professional services, religious institutions, medical services, etc. An assessment to determine what interventions are appropriate, and when, should be conducted after a few days.

Critical Incident Stress Debriefing (CISD) (Mitchell & Everly, 1996, 2000). A voluntary, confidential, nonevaluative discussion of the involvement, thoughts, and reactions resulting from the incident. The leader is a mental health professional. Trained peer support personnel often assist in debriefings provided

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to emergency service workers. A CISD also provides education and discussion regarding stress and coping. It is conducted with homogeneous groups (i.e., groups that share the same perspective on the incident) after an incident is over. It is usually provided 1–14 days postcrisis but may be later depending on the situation. Hence, a CISD may not be immediately applicable after a mass disaster where there is prolonged and continuing im- pact. The goals of a CISD are to mitigate acute symptoms, assess need for follow-up, promote recovery, and if possible, facilitate psychological closure.

Further, the CISD pro- vides an opportunity to assess who may need a referral for further services. CISD is not a trauma treatment but a crisis intervention modality that needs to fit in a comprehensive framework. CISD has been somewhat controversial. Exposure to other people's stories can increase distress and may be contraindicated (Wessely, Rose, & Bisson, 1998). For example, people showing significant signs of dissociation, acute distress, and agitation, or people who are isolating themselves may be negatively impacted from exposure to other people's stories and may benefit more from psycho- logical first aid or individual sessions. Although CISD can provide extraordinary support and learning for groups impacted by a critical incident, mandatory CISD may actually increase arousal and avoidance symptoms.

Individual Intervention/Stabilization. Survivors experiencing significant symptoms may benefit from individual sessions where issues can be dealt with in more depth. The provider can screen/triage for significant symptoms and provide the opportunity for individualized intervention.

Family Services. Family members may have their own stress reactions to the event, impinging on the family atmosphere and interfering with recovery. Special workshops and information sessions for family members, as well as individual and family sessions, can be very beneficial.

EMDR. The earliest point at which the author usually utilizes EMDR is when the emotional impact has started to be experienced, and often later. Initially after a critical incident there may be shock, numbness, denial, dis- sociation, and other psychological mechanisms that serve to ward off overwhelming emotions (Solomon & Macy, 2003). At some point, the reality of what happened, the meaning, and the emotions start to be experienced. This is when EMDR may be useful. This can be a day or two following the incident, up to several months, depending on the response of the survivor. The Recent Event protocol (Shapiro, 2001) has been found to be useful (see Colelli's article in this issue), and the Israelis have further elaborated on early EMDR interventions for recent events (see Kutz, and E. Shapiro & Laub's articles in this issue).

6. Description of the follow up phase 2 weeks-52 weeks (recovery and resolution).

Follow-up support and services may need to be continually available, and ongoing assessment should be conducted. Follow-ups should be conducted on the referrals that were made.

The impact and the meaning of the incident change with time. The provider can offer further debriefings and group meetings that can foster integration of the incident, support adjustment to a world now perceived as different, and enhance resilience to strengthen an individual and group's ability to cope.

Postcritical Incident Seminar. The postcritical incident seminar (PCIS) is a multiday (e.g., 3–4 days), multimodal group intervention utilized by a number of organizations for follow-up support. After several months have passed and there is some psychological distance from the event, follow-up may be helpful to deal with the longer- term consequences of the event. The multiday format al- lows sufficient time to tell one's story, to interact with other people who have experienced a critical incident (which is extremely

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helpful in validating and legitimizing reactions to the incident), to receive education on typical reactions and coping skills, and to further work through the incident. This format has been effective for lowering trauma symptoms (Solomon & Kaufman, 2002). The addition of EMDR to this structure has been found to result in greater symptom reduction than having the workshop only (Solomon & Kaufman, 2002).

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4. Effects

1. Result indicators

When dealing with a tragedy, it is important to remember that not all signs and symptoms of acute distress are pathological. Further, people who have experienced a critical incident may have good coping skills and good social support systems that enable a healthy recovery. The cultural values, jargon and technical language, job functions, inherent stressors, and types of trauma inherent in the occupation need to be understood by the intervener. On a broader level, it is important to be flexible when dealing with different ethnic cultures

2. Symptomatology

Assessment test (e.g. IES-R) are used to check the main symptomatology. In the aftermath of a tragedy, it is important to take a longitudinal approach and provide a continuum of interventions to meet changing needs over time. Too often clinicians provide “one-shot” interventions in the days following a tragedy and fail to deal with longer-term psychological consequences. The “menu” of interventions described here was designed to augment normal recovery processes in normal populations, having normal reactions to abnormal events, over a normal period of time. These interventions were never intended to be therapy (with the exception of EMDR) or a substitute for therapy. However, by utilizing a comprehensive and longitudinal approach, these methods can help mitigate the impact of the event, promote recovery, and provide an opportunity for screening those in need of further treatment.

5. Global interdisciplinarity

To sum up, Critical Incident Intervention described by Roger Solomon takes into account a longitudinal, prospective, interdisciplinary and global perspective.

Longitudinal and prospective in the terms in which it is developed three different phases of the emergency (the acute phase immediately preceding the critical incident, the acute phase and the follow-up phase), emphasizing the need to ensure continuity of work in all phases of intervention and avoiding "one shot" interventions.

Critical Incident Intervention is **interdisciplinary** for the ability to integrate multi layers interventions that take into account the diversity of victims' needs. Specifically, psychosocial needs (primary biological needs such as food, housing) safety needs (care, physical safety), psychological needs (calm, relationships with social network, sense of control, processing of traumatic experience).

Last but not least, Critical Incident Intervention is **comprehensive**, because it implies a bio-psycho-social approach, referring to an intervention that takes into account the cultural, social, economic, and spiritual context of the victims. It also refers to all types of victim degrees (direct victims, indirect victims, rescuers, and fragile victims).

Reference: Solomon, R. M. (2008). Critical incident interventions. *Journal of EMDR Practice and Research*, *2*(2), 160.

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Case study 4

CBT restructuring, visualization and reliving in women with PTSD symptoms

***Responsible partner**: Association of Clinical Psychologist (CZ)*

***Authors**: Susan Ayers, Kristie McKenzie-McHarg, & Andrew Eagle*

***Keywords**: individual, PTSD, perinatal*

Method: Postnatal PTSD and usage of cognitive restructuring and other CBT techniques

1. Description of the event

Scenario

Sarah was 35 years old. Her daughter was born 14 months previously and was the result of a planned pregnancy. Sarah had a termination of an unwanted pregnancy when she was 19 years old, which she kept a secret for 16 years because she thought people would judge her negatively. Sarah was very anxious during pregnancy because she was scared of disclosing the abortion and worried that something might go wrong with the pregnancy as retribution for having an abortion. During her pregnancy Sarah had frequent bleeding and a colposcopy was carried out to investigate. Sarah's waters broke before term and her labour was induced three days later. There was confusion over the induction and Sarah arrived at hospital for what she thought was a routine check and was immediately admitted for induction. At this point she panicked because she was unprepared, had no personal belongings with her, and her husband was not present. The midwife attending Sarah's birth was not sympathetic to Sarah's high levels of anxiety. Following a painful internal examination during which Sarah cried and asked the midwife to stop, the midwife said "if you think that's painful, what are you going to be like giving birth?" From this point onwards Sarah's labour and delivery was characterized by pain, very high levels of distress, and fear of the midwife who continued to be brusque and unsympathetic towards Sarah. Sarah said 'the midwife was barking at me…I brought my barriers up completely and was petrified… I didn't know what was right and what was wrong'. After 25 hours Sarah was only one centimeter dilated so her daughter was delivered by emergency caesarean section, during which Sarah thought she might die. Sarah reported starting to feel the caesarean half way through the procedure and was given morphine. She reported dissociating during the caesarean and cannot remember anything for 12 hours after the delivery.

2. General conditions

1. General conditions of the victims

Sarah described first few months after the birth as they "are a blur" and it took her a year to bond with her daughter. The main themes of Sarah's birth experience seemed to be

- feeling terrified, vulnerable and out of control;
- high levels of confusion and later dissociation;
- confirmation of her belief that others will judge her and hurt her through her experience with the midwife.

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2. Effect of emotional, somatic, cognitive, behavioral crises

- **Emotions**: It was very difficult for her to bond with her daughter. She experienced a lot of self-blame and anger against herself. She was fixated on past failures, and felt worthless.
- **Soma**: Sarah experienced lack of energy, tiredness, even small tasks took her extra effort. Also sleep disturbances were present.
- **Cognition**: Troubles in concentrating, remembering thinks, and frequent and recurrent thoughts of the labour.
- **Behavior**: She cried a lot, during the first days after the labour she rested in bed and she was not able to do any ADL (activities of daily living).

3. Symptoms according to ICD 11

PTSD symptoms:

- Flashbacks
- Nightmares
- Strong physical and emotional reaction to any reminder of the birth
- Emotional numbness
- Crying

Mild depressions symptoms:

- Lack of energy
- Sleep disturbances
- Crying
- Slef-blame

4. Effect of the general current level of functioning of the victim

Four months after birth Sarah was diagnosed with postnatal depression by her primary care physician. She was treated with antidepressants and attended a local support group for postnatal depression. This helped her a lot to remain functioning in her role as a mother.
In comparison with her previous level of functioning, she assessed it as a decrease, especially regarding level of energy and enthusiasm to “make things done”.

3. Intervention

1. Description of the initial phase

She was sent to the psychological support team by her GP (general practitioner).
During this first session she appeared to be reliving the birth experience and was frightened, crying and shaking. Her flashbacks were about seeing herself lying in the delivery room, feeling helpless and terrified, with the midwife coming in through the door.

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2. First psychosocial intervention

Support in **emotion ventilation and normalization**, acceptance of Sarah as a mother who is trying her best as being here and trying to work on herself.

Breathing exercise to calm down whenever she feels emotionally overwhelmed.
Psychological **education** about the symptoms of depression and PTSD.
Setting a **contract** – she wants to feel better a be efficient in her life again.

3. Intervention

Core beliefs and negative thoughts: Sarah had core beliefs about herself as being stupid and a failure; and about others that they would judge her and hurt her. Sarah's beliefs were reinforced by the abortion, her birth experience, and being diagnosed as having postnatal depression, which she interpreted as meaning she was a failure and couldn't cope. Sarah therefore had conditional beliefs such as "If I tell people about the abortion/birth/depression they will judge me", "If I am upset people will think I am weak". Sarah had frequent negative automatic thoughts that were congruent with her core beliefs such as "I can't cope", "I am a failure" and about others, such as "they don't want to know", "how could they not care?" Sarah's compensatory strategies were to conceal the abortion, birth, or mental health problems to avoid being judged.

- An anonymous survey was carried out of other's opinions of Sarah's abortion to challenge her belief that others would judge her. This survey described the circumstances under which Sarah fell pregnant and had an abortion and asked people what they would think of her, whether they would judge her, and what they would do in the same situation. 16 people who did not know Sarah completed the survey and responses included proabortion and anti-abortion views. This survey dramatically changed Sarah's beliefs about herself, the abortion, what others would think of her, and the importance she placed on other's views.

Reliving exercises: Sarah went over the events of the birth. Hotspots (particularly emotive events during the birth) were identified. The main hotspot was around the midwife's actions and Sarah's continued fear of the midwife. Exercises were therefore used to change Sarah's appraisals of these events, such as using a role-play to act out confronting the midwife and reduce Sarah's fear. A visit was made to the labour ward to also help Sarah overcome her fear and avoidance.

Visualization exercises: were used to rescript her flashbacks (e.g. imagining different healthcare professionals in the delivery room with her, instead of the midwife) and positive reformulation was used to consolidate changes in Sarah's beliefs.

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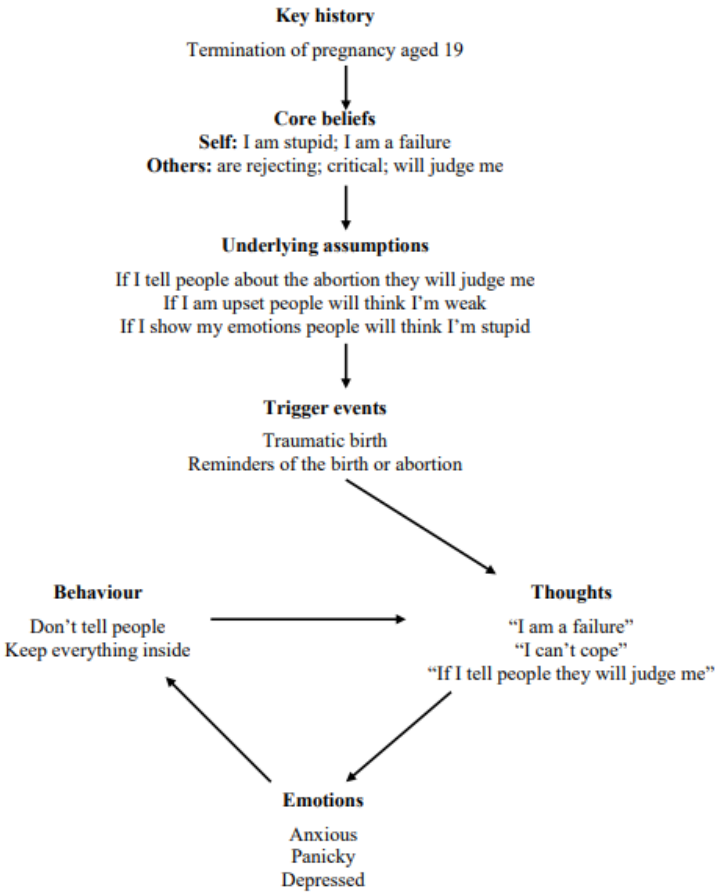
Sarah's formulation of the situation in the CBT:



4. Psychosocial intervention on the family network, community, etc.

Sarah did not want her family know about these issues.

5. Follow up

Ten sessions of trauma-focused CBT was performed.

4. Effects

1. Result indicators

No measurements were evaluated, besides her level of functioning.

2. Symptomatology

Sarah's PTSD symptoms disappeared and her beliefs about herself and others has been modified.

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3. Social functioning

Sarah's level of functioning reached the previous level.

5. Global interdisciplinarity

This case report can be a good resource for a detailed understanding of working with cognitive and emotional symptoms in a person with PTSD. It very vividly shows the work with negative automatic thoughts and core beliefs, which is supplemented by reliving and visualization techniques.

The report highlights the importance of increasing the patient's insight into the situation, e.g. by creating his own recording sheet with a description of the difficulties and their interconnectedness, which gives the patient the opportunity to realize and understand the issues of his situation and thus gives him the opportunity to start working on it.

This approach can be useful across the approaches when it is necessary to raise awareness of thought patterns and create distance for the client from the situation.

Reference: Ayers, S., McKenzie-McHarg, K., & Eagle, A. (2007). Cognitive behaviour therapy for postnatal post-traumatic stress disorder: case studies. *Journal of Psychosomatic Obstetrics & Gynecology*, *28*(3), 177-184.

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Case study 5

Developing a "micro-cosmo": the experience of children and adolescent refugees in a community setting.

***Responsible partner**: Institute of Group Analysis Athens*

***Authors**: Francesca Giuseppina Bascialla, Alexandra Nikolara, Charalambos Sidiropoulos, Paris Papageorgiou*

***Keywords**: individual, PTSD, perinatal*

Method: A Community-based intervention for refugees: type I or II victims (children/adolescents, women/mothers, families)

1. Description of the event

1. Scenario

In a city of about 85,851 population in the region of Central Macedonia in Greece, PERICHORESIS NGO, a humanitarian & nonprofit association established in 2016, started organizing an English-and-Greek-language learning/training program along with life & job-coaching meetings for refugees (adults, children and adolescents), ensuring provision support for the families, and teaching support for the children/adolescents who were, also, admitted to study at local public schools. At the beginning, participants were coming mostly from refugees' camps at the first stage of the post-migratory phase, in an attempt to escape from ongoing wars in Middle East or Asian countries. Their families were enrolled in housing programs. In 2022, with the invasion of Ukraine, a new refugee crisis started anew. The Hellenic Red Cross, UNHCR, and the Ukrainian consulate in Thessaloniki asked for help concerning accommodation from the organization mentioned above. All of the refugees involved are victims of type I or II. Considering that linguistic and cultural barriers, plus discrimination issues, are central issues in the post-migratory phase, the non-governmental organization, along with the help of mental health professionals, organized sociotherapeutic group interventions for children, adolescents and parents, and, furthermore, non-structured community-based social activities. All interventions were provided in a multicultural, multi-religion and multilingual environment.

2. Intervention Team

The intervention team consisted of a pedagogist, a child psychiatrist-psychodramatist-family therapist, a sociologist, teachers, and translators.

2. General conditions

Witnessing violence and experiencing traumatic events are factors associated with mental health problems in children and adolescents (Ellis et al, 2008; Im 2018). Not only individual, family and societal risk factors contribute to the risk for impaired mental health in children/adolescents, but also impaired mental health

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of the main caregivers have an impact on them. There is evidence that mental health problems have higher prevalence also in young refugees resettled in high-income countries (Barghadouch et al, 2018).

I. During their enrollment, children, adolescents, women and mothers involved in the program described here, have mental health needs due to their traumatizing experiences during pre and post-migratory phase (exposure to violence, stress, uncertainty, anxiety, exclusion, discrimination).

II. Difficulties in integration in a new and unknown environment, in which they are resettled.

III. Tendency to isolation, avoidance of social contact, a more passive participation at school. Parents avoid involvement in community life, they prefer to stay at home.

3. Intervention

In the morning, children and adolescents are regularly attending the local public school. In the afternoon they attend educational support lessons for the school program and language training (English and Greek). Also, in the afternoon, the organization provides open peer support groups, hosted by a facilitator and with the help of a translator. The participation in the support groups for the refugees is not mandatory. More specifically, since May 2022, a group of 12 children (8 girls and 4 boys, 4 to 12 years old) are meeting for 90 minutes once a week. Since November 2022, a group of 7 adolescents (3 girls and 4 boys, 13 to 16 years old) are also meeting for 90 minutes once a week. They come from 3 different countries of 2 continents, and 3 different religious backgrounds. Another facilitator is running a group for children's and adolescents' parents, participating in the peer group. The same facilitator is also running a support group of women singles or mothers, who searched for help from the association. The languages in the groups, out of Greek, are 3 and the translator speaks all these languages. The facilitator and the translator for each group are always the same persons for all the sessions of the year. Each member has to inform the facilitator in case of delays or incapability to be present. These are open groups, meaning that members change over time. Many refugees' families involved in the program are waiting for resettlement, sometimes in another country, but usually they stay in the host country for at least one year. All participants of these groups are, also, involved in refugee-led and community-based activities, together or not with the local population, and always invite each other (e.g., organizing social events, an event for the celebration of the New Year, birthday parties etc.). During the first 3 months of the participation in the support groups, the refugees talked about their traumatic experience before migration, their journey and their losses. The children expressed them with painting. After this period, the themes discussed in the groups were more about problems at school, difficulties in learning new languages, concerns about other family members (children for their parents and vice versa) with whom they lived or others with whom they have lost contact, but also a great need to relate with people in the new hosting environment has arisen.

Community-based activities with locals, enlargement and opening the refugees' family into the community network and connection with others families. The program is still ongoing. The groups are open groups meaning that new members will be introduced and others members may leave the groups because of resettlement in another city or country.

Intervention: focus on the method

The community constitutes the enlarged setting of this intervention for refugees' families seeking for resettlement. The non-governmental organization, also, offers a place for group activities. Having ensured a home for the families, provision of food/hygiene/cleaning supplies, early access to language training, ongoing educational support for the youngest and a job for the adults, the staff organized a multi-modal

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and multi-layered psychological intervention aiming to their integration in the local context, enhancing social connection. The method is based on the principles of group-analytic group psychotherapy and therapeutic community. These two approaches allowed more social exchanges and interpersonal connections. The adolescent peer group is the setting where they can express freely, in a non-critical context, their thoughts and feelings about the present, but also about their history. As there is not a predefined subject of discussion, starting from their daily experience at school adolescents reminisce about their previous schoolmates, friends, their country and express nostalgia for that time.

The past can be recalled without re-traumatization, the relationships in the group provide such a supporting peer network that they can copy with their trauma. There is also the possibility to have recreational activities for adolescents, e.g., table games, playing music, singing and organizing birthday parties inviting their parents, schoolmates, teachers and people from the neighborhood. The group for children has different types of activities, such as painting, collage, reading fairytales and playing games. In some sessions they may use all these three modalities of expression, they might listen to a fairy tale, paint about it and then write all together their thoughts. The mothers of the children are waiting in another room, a kind of a socializing space for everyone who wants to meet others in the building. The group for women singles or mothers and the other group for mothers who have children participating in the groups, are support groups, where they can talk about their past experiences, their losses, daily issues of their family living, but also about practical issues.

From time to time there are unstructured activities, such as cooking together some traditional foods, typical from each country, and eating together. In the context of the organization, the staff creates events where all people, who are involved in some activities, meet together for some celebration, the refugees are asked to choose and propose what to celebrate, and, undertaking a more active role, they organize the event as they would have done in their country. These are moments of exchanging their personal history as citizens and, moreover, they open the door to the citizens of the hosting country. In case a family is relocated in another city or country, then a farewell event is organized. The closing is another difficult but inevitable phase of human life, saying farewell makes the separation easier.

Good practices:

- Provision of ongoing educational support
- Early access to language training
- Refugees-lead and community-based recreational and cultural activities
- Peer group support with the group analytic model
- Multi-modal and multi-layered intervention

4. Effects

The staff involved in the intervention has also the task to maintain a communication with the school. It is relevant that, in a period of few months of participation in support groups, teachers at school have underlined a clear improvement in learning activities, collaboration and socializing with the others and a reduction in disturbing behaviors in children and adolescents. Mothers report better relationships between family members, but also with local people. Even the youngest children invited their schoolmates to the recreational activities at the organization place. There was also an increase in the participation of fathers and husbands, who at the beginning were very hesitant about the whole program.

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5. Global interdisciplinarity

The intervention started in the context of the humanitarian emergency in 2016. With the invasion of Ukraine in 2022, refugees from this country were accepted in the program. The refugee population involved in the intervention is always changing over 1-2 years, due to the fact that resettlement might not be the permanent one. This Case Study describes the intervention starting during the first period of the war in Ukraine. The core of the intervention is multidisciplinary; humanitarian, educational and mental health professionals are working in collaboration. The psychological intervention is based on the approach of group analysis and therapeutic community. Working with refugees (mental health professionals with refugees: children/adolescents, parents, women/mothers, family), constitutes the first level of the intervention. The second level involves other professionals and other activities (teachers/students: education support and new languages). Altogether, it can be described as a level inside the organization. Refugees need to be involved in the regular life of the city of resettlement, and this is a third level. Professionals have to make and maintain contact with the neighborhoods where refugees live at, with the school, with the workplace and with whatever other structure may a person attend, e.g. gym, basketball team. This is a more community-based intervention: organizing activities and refugees-led activities in the community, but also by the community. The coordination of all this intervention is obtained through regular reflective practice meetings of all the personnel involved. It is an example of interdisciplinarity that allows containment of the emotional burden while working with trauma, and reinforces the capability of taking care of all emergencies appearing within an emergency framework.

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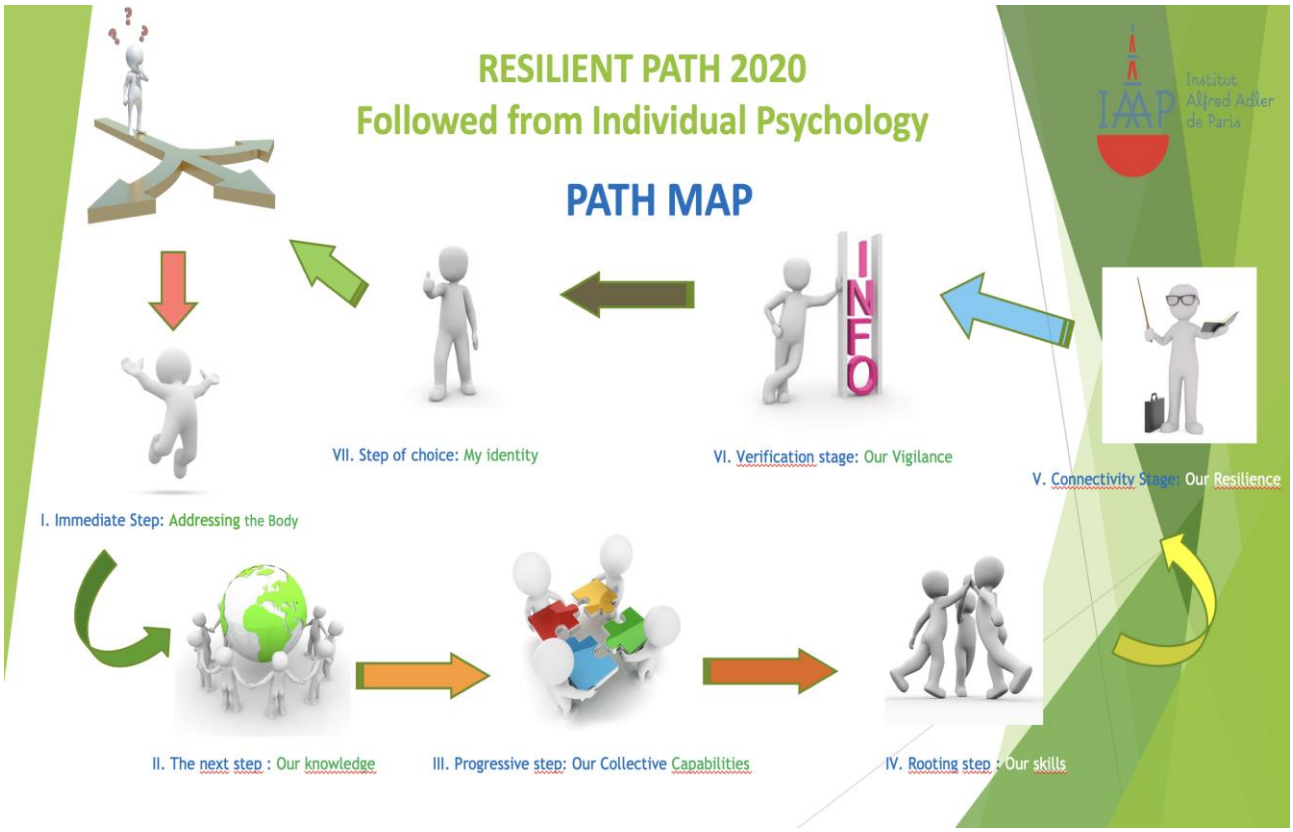
Case study 6

Resilient path in a pandemic crisis: first online resilient path in a pandemic crisis as Adlerian Toolkit of Psychological Crisis Intervention and Prevention, according to the Adlerian method of Individual Psychology

***Responsible partner**: IAAP – Institut Alfred Adler de Paris (FR)*

***Author**s: Alessandra Zambelli & IAA P TEAM and Students CLASS 1*



1. Description of the event

a) IAAP Tripartite Structure for psychological first aid and emergency according to the Adlerian method of Individual Psychology: Training in Psychological First Aid & Emergency

Implementation of a theoretical and practical online training module (with supervision and co-vision) in the context of Emergency Psychology in general.
Training by videoconference on the following subjects: Teaching through 200 theoretical slides; Initiation to the Resilience Pathways; Initiation to first telephone support protocols; Exercises, scenario-based role play,

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and simulations; Clinical focus on concrete cases; Pair work and supervision. Theoretical highlights: Organizational requirement; Outreaching: clinical features; Specificities of interlocutors and contexts; Priorities and specificities of the care given to first-aid and medical staff; Characteristics of COVID-19 and the SARS-CoV-2.

b) Resilient Path in a pandemic, followed BY INDIVIDUAL PSYCHOLOGY

An on-line, step-by-step, instruction manual to assist people in emotional distress to develop coping skills, using integrative method to provide the users of the pathway with the possibility to reconnect with themselves, body and psyche, in order to reconnect with the world, and with others afterwards.

c) Pandemic First Aid Unit
In the first lockdown we worked only in coordination with the *Centre Médical Clémenceau*, Noisy-Le-Sec (93 department, Paris neighbor). In 2021 year we tried with the social networks to reach more people because the psychological problems involved and seemed that the Covid familiar violence is the first problem. So the Beneficiaries were : Proxy /vicarious trauma; Burnout syndrome; Covid Outpatient; Relatives of sick or deceased persons; Anxiety, stress, Impulsiveness and decompensation; Apparent indifference leading to risk-taking behavior.

2. General conditions

General conditions of the victims

Focus on all kind of victims: Community and Individual do not touch directly from the pandemic crisis, but also for the directly victim if not in urgence state, so almost all kind of victims.
This media tool was conceived as part of an already more complex training program for the group of students in training to become Adlerian psychanalysts at the IAAP.

3. Intervention

The Resilient Pat was conceived as a deepening of the psychoanalytic training already in progress and also had the purpose and role of keeping the class of students and the community connected to it cohesive in this pandemic so new and telluric in its harmful dimension.
This same resilient path has been associated with the creation of a support cell made available to a medical cabinet in which two members of the IAAP work, including the President, to alleviate the psychological burden that customers brought during the pandemic.

The students themselves created the contents and the shape of the resilient path, following the structural and conceptual indications that their trainers had created and submitted their.

The structure of the Resilient Path follows the principles of Individual Psychology, after one Introduction, through 7 steps, with colored text and media material, images, links, and videos and dynamic support:

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Introduction:

The Resilient Path offer to the user/patient to follow, step by step, a real instruction manual to acquire, by oneself, the ability to cope with the: CORONAVIRUS (viral family name), COVID-19 (name of the disease) and SARS-CoV-2 (virus name).

To learn and practice how to alleviate one's feelings of anxiety by rediscovering the path of inner calm and free thought, reconnecting effectively to one and to others. Between denial and panic, let's seek to find the right attitude to find the path to inner calm and liberated thought. Calming is formed in the mind but begins in the body and is rooted in connection to oneself and to others (Alderian Holistic Principle).

1) I. Immediate Step: Addressing the Body
Soothe the emotion and stabilize the mind through the body.
The corporal aspect in a holistic Adlerian dimension of the personality and therefore is a priority in this psychological approach, particularly in urgent and emergency situations Adler spoke of the language of the organs that the psychotherapist and the doctor had to be able to understand first of all and talk /interact with it.

2) II. The next step: Information to understand and better defend oneself.
Knowledge as an ego stabilizer thanks to the lowering of insecurity linked to ignorance and the unknown.
This stage responds to the Adlerian psychic principle of the feeling of inferiority which destabilizes the personality and is stimulated by all situations of real or perceived insecurity. Shared knowledge with an expert is the second step in promoting stabilization and the alliance towards more likely cooperation. Let's feed our knowledge of the virus to develop confidence. The virus, its origin, its spread, its means of action, its vulnerabilities. What behavior to adopt, what precautions to take, where to document ourselves? Taking ownership of protective measures to address risks.

3) III. Progressive step: Our Collective Capabilities. Our knowledge step-by-step:
Knowledge of collective behaviors implemented as an ego stabilizer thanks to the concrete vision of belonging that predisposes to an alliance with the environment.
This stage applies the Adlerian principle regulating the Feeling of belonging: it deeply contrasts and not as a compensation the feeling of inferiority. Taking ownership of collective measures to improve cooperation. Let's understand our individual and collective adaptive capacities, such as confinement, barrier measures, social distancing. Let us know our rights, our duties, the aid and resources put in place by the State and the communities.

4) IV. Rooting step: Our skills. Reassure about collective skills and the organization in place to start awakening the feelings of belonging. Rely on collective intervention capacities, this stage is also an implementation of the Adlerian principle of the feeling of belonging: but in the sense of receiving help rather than in the previous version of cooperating. Even the choice to place it after the active posture (precedent step) is an Adlerian psychic stabilization principle linked to the creative power principle.
Let us understand the role of the public emergency and security services at our disposal: the police, the fire brigade, the army, civil security, hospital staff. Let's find out about the psychological and psychiatric support services available in lockdown.

5) V. Connectivity Stage: Our Resilience. Building on our creative and social resourcefulness. It is the stage of creativity, connected to the concept of Adlerian creative power, which solicits agency and pleasure, and through those the basis of Adlerian resilience: a feeling of belonging and creative power.

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Using our creative resources to properly organize our “wheel of the healthy mind” (Siegel Daniel, 2015, Mind your Brain), which needs to satisfy different areas of our personality such as: sleep, movement, concentration, relational, playful, idleness, reflection/mediation of interiority (mindfulness and meditation).
Let's find out why confinement is difficult, alone or in cohabitation.
Let's set up a new organization and new habits.
Let's disconnect and cultivate our inner space.
Let's set a goal, start a project.

6) VI. Verification stage: Our Vigilance. How develop vigilance with information.
This stage corresponds to the Adlerian concept of the human fictional mind that always needs a directive purpose, but that this can be fictional. This psychic plasticity is at the basis of the symbolic resilience of the mind, but also of its hypnotic and pathological aspect. Uncertainty and fear are fertile ground for imagination and fake news. Manipulations, rumors, sterile controversies, infobesity, conspiracy theories... let's learn to take the necessary distance not to believe or relay everything and anything.
It is therefore individual and collective responsibility to carefully check the information received, never passive posture, particularly in the age of numerical information.

7) VII. Step of choice: My identity step of choice: Reconnecting to yourself the resilient method. This last step leads us to connect with ourselves by kindly recognizing our uniqueness. By going through 4 areas, let's take stock of our real **needs**, our personal **resources** and the **values** that are important to us to guide us in our **choices** which are the right ones because they are ours.
This last step is linked to the Adlerian concepts of Creator power of individuality for the review of one's Lifestyle and its reorganization to go beyond crisis or trauma and face adaptive change. This is the most therapeutic stage, where it is indicated that it is perhaps appropriate in certain cases to be accompanied.

4. Effects

The Assessment of the learning outcomes on the students and of the effect on the users was carried out in an empirical and direct way through discussion both with the students and with the patients who turned to the Support Cell.

The Effects were positive: 1) for the students it was a practical exercise to concretize concepts that had remained abstract* (being at the end of their last year of studies and at the beginning of their internship and last year) and which therefore gave great support to their theoretical work with great satisfaction.

2) Patients who presented themselves to the Support Cell had already been referred to the Resilient Pathway pending the appointment. Everyone felt the importance of the path on their ability to reconnect with themselves and attempt stabilization on their own. For some, understanding and execution was not immediate. The support of the Support Cell with 3 free sessions was able to better accompany those who needed them.

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5. Global interdisciplinarity

The Adlerian method weaves an integration of the three dimensions of personality according to the biopsychosocial paradigm as holistic approach**. With the term **Organ Jargon** the Adlerian method emphasizes the fundamental importance of understanding the holistic connection with the body, including somatic reactions. The inability to hear what the body is saying informs the therapist about patient personality and pathology. The body is the first to reaction at the trauma situation. That is also the first stage of the Resilient Path. Empathic listening begins with the patient's body and with the therapist's body.
The patient's lifestyle impacts on the traumatic present with somatic memories but also with the experiences related to feelings of inferiority collected and the success of the feeling of belonging. The patient's **Lifestyle** impacts on the traumatic present with somatic memories but also with the experiences linked to the collected **feelings of inferiority** and the success of the **feeling of belonging (Gemeinschaftsgefühl)*****. The compensations and overcompensations of the patients' personalities are woven between these two conscious and unconscious poles, determining resources or inhibitions, adaptive or deviant postures. Stages 2 and 3 try to stimulate the sense of belonging and its security to calm the feeling of inferiority that the crisis situation develops. The **Creative Power** is stimulated in the 5th stage because it is a central Adlerian element in the psychic balance to reduce overcompensations and make the person more in touch with his external and internal reality, integrating rather than developing unconscious defenses**. The patient is ready for a new contact with the more mature external reality: verification and constructive criticism are the objective of the 6th stage. The last stage, the seventh, leads the patient to understand that a crisis situation requires a radical change of his own personality too, but without losing it: it is the stage of choosing the new lifestyle that he proposes to the energy of the **Will to Power** as an internal instance deeply structuring the personality***, to revisit oneself by probing the feeling of inferiority with more belonging. Communication is always empathetic (not cute) because it focuses on encouraging autonomy as listening to oneself for true autonomy, despite the harshness of the test that one lives*.

*Ferrero Andrea, *The Adlerian Psychodynamic Psychotherapy (APP): A Psychopathological-based treatment,* Adlerian Society UK & Institute for Individual Psychology Published, 2018 (2014, l'Harmattan, France; 2009, Italie, new Italian edition being published)
** Zambelli Alessandra, *Adler face à Freud : une différence à sauvegarder,* l'Harmattan, Paris, 2014
*** *Gisela Eife, The Development of Alfred Adler's Individual Psychology Theory of Personality, Psychopathology, Psychotherapy, Vandenhoeck & Ruprecht GmbH & Co. KG, Göttingen, 2019.*

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