



**Psychological
Early
Intervention**



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Psych.E.In. Good Practices



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Good Practice 1

Trauma Informed Interventions: a Systematic Review

Responsible partner: Jan Kochanowski University (Poland)

Authors: Han H-R, Miller HN, Nkimbeng M, Budhathoki C, Mikhael T, Rivers E, et al. (2021)

Keywords: trauma informed interventions

1. Background

Health inequities remain a public health concern. Chronic adversity such as discrimination or racism as trauma may perpetuate health inequities in marginalized populations. There is a growing body of the literature on trauma informed and culturally competent care as essential elements of promoting health equity, yet no prior review has systematically addressed trauma informed interventions. The purpose of this study was to appraise the types, setting, scope, and delivery of trauma informed interventions and associated outcomes.

2. Methods

We performed database searches— PubMed, Embase, CINAHL, SCOPUS and PsycINFO —to identify quantitative studies published in English before June 2019. Thirty-two unique studies with one companion article met the eligibility criteria.

3. Results

More than half of the 32 studies were randomized controlled trials ($n = 19$). Thirteen studies were conducted in the United States. Child abuse, domestic violence, or sexual assault were the most common types of trauma addressed ($n = 16$). While the interventions were largely focused on reducing symptoms of post-traumatic stress disorder (PTSD) ($n = 23$), depression ($n = 16$), or anxiety ($n = 10$), trauma informed interventions were mostly delivered in an outpatient setting ($n = 20$) by medical professionals ($n = 21$). Two most frequently used interventions were eye movement desensitization and reprocessing ($n = 6$) and cognitive behavioral therapy ($n = 5$). Intervention fidelity was addressed in 16 studies. Trauma informed interventions significantly reduced PTSD symptoms in 11 of 23 studies. Fifteen studies found improvements in three main psychological outcomes including PTSD symptoms (11 of 23), depression (9 of 16), and anxiety (5 of 10). Cognitive behavioral therapy consistently improved a wide range of outcomes including depression, anxiety, emotional dysregulation, interpersonal problems, and risky behaviors ($n = 5$).

4. Conclusions

There is inconsistent evidence to support trauma informed interventions as an effective approach for psychological outcomes. Future trauma informed intervention should be expanded in scope to address a wide range of trauma types such as racism and discrimination. Additionally, a wider range of trauma outcomes should be studied.

Source: Han H-R, Miller HN, Nkimbeng M, Budhathoki C, Mikhael T, Rivers E, et al. (2021), *Trauma informed interventions: A systematic review*. PLoS ONE 16(6): e0252747. <https://doi.org/10.1371/journal.pone.0252747>

Good Practice 2

Bereavement in Times of COVID-19: a Review and Theoretical Framework

Responsible partner: Jan Kochanowski University (Poland)

Authors: Stroebe, M., Schut, H

Keywords: bereavement, grief, health, COVID-19, pandemic, review, theory, dual process model

1. Description of the study

A review of the literature on adaptation to bereavement during the COVID-19 pandemic was conducted to assess the current state of knowledge. Scopus, Web of Science and Google Scholar databases were searched for studies published during the first 6 months of the COVID-19 outbreak. 44 articles were included in the review. Narrative synthesis showed that knowledge was largely based on expert assessments of prior bereavement research and professional experience; there is so far absence of empirical evidence linking features of COVID-19 bereavement situations to health outcomes. Severe negative consequences have been consistently predicted by authors. There is still relatively little consideration of positive or compensatory processes or the possibility that these could alleviate the effect of the shocking, traumatic circumstances. With two notable exceptions, there has been lack of attention to the role of theoretical models for guiding research and practice.

2. Models of intervention

The Dual Process Model (DPM) (for description of main parameters: Stroebe & Schut, 1999, 2001, 2010; see Figure 1 below) was designed to represent the bereavement experience in ways that built on but extended earlier models. Its basic parameters include descriptions of types of stressors associated with bereavement understood to be either loss-oriented (LO) or restoration-oriented (RO). Loss orientation refers to the concentration on, dealing with, processing of stressful aspects of the loss experience itself, most particularly, with respect to the deceased person (e.g., visiting the grave to be close to the deceased; looking at photos of him/her). Restoration orientation refers to secondary (to the loss itself) sources of/coping with stress. RO focuses on what else needs to be dealt with as a result of the loss, and how these matters are dealt with (e.g., taking up employment to compensate for the deceased's lost income; learning skills that had been done by the deceased). In addition, coping processes (ways of dealing with the stressors) were postulated, entailing dynamic oscillation. This is a process mandated by the fact that there are both LO and RO types of stressors to deal with, which cannot be done simultaneously. Since each type has to be coped with for adjustment to be made to the loss, to reduce the stress and negative consequences, shifting back and forth between dealing with the one or the other type of stressor has to be part of the coping process. The DPM covers description of outcomes, the consequences of coping (e.g., adjustment to the loss, mental and physical health effects, persistence or decline in levels of grief over the course of time).

3. Effects and recommendations

The DPM leads to different suggestions for counselling or therapy from those suggested in the articles reviewed above. Intervention protocols have frequently followed CBT principles, focusing on coming to terms with the death of the close person. As such, these are loss-oriented. Following all that has been said above, it would follow that restoration-oriented tasks should be addressed too. There is support for this line of reasoning. Some recent studies have adopted the DPM framework and included treatment of RO stressors (for review: Fiore, 2019). Shear et al. (2005) and Chow et al. (2019) demonstrated that including tasks directed toward coping with RO stressors was associated with more improvement than when the intervention focused only on LO; Nam (2017) showed that RO intervention was more effective than psychoeducation. These studies suggest that RO stressor management is important in helping those bereaved who need professional help. In the COVID-19 bereavement situation, having identified the specific, troublesome LO and RO stressors experienced by the client, intervention could be designed to manage these systematically. Protocols already

developed by Shear et al. (2005), Chow et al. (2019) and Nam (2017) give useful information for designing DPM-based intervention programs.

Source: Stroebe, M., Schut, H. (2021). Bereavement in Times of COVID-19: A Review and Theoretical Framework. *Journal of Death and Dying*, 82(3), 500–522. Article reuse guidelines: sagepub.com/journals-permissions
DOI: 10.1177/0030222820966928

Good Practice 3

Post-Traumatic Stress Symptoms in Healthcare Workers Dealing with the COVID-19 Pandemic: a Systematic Review

Responsible partner: Jan Kochanowski University (Poland)

Authors: d'Ettorre G., Ceccarelli G., Santinelli L., Vassalini P., Innocenti G.P., Alessandri F., Koukopoulos A.E. Russo A., d'Ettorre G., Tarsitani L.

Keywords: Prevention, PTSS, healthworkers, Covid 19

1. Introduction

Prevention of post-traumatic stress symptoms (PTSS) in healthcare workers (HCWs) facing the current COVID-19 pandemic is a challenge worldwide as HCWs are likely to experience acute and chronic, often unpredictable, occupational stressors leading to PTSS. This review aims to analyze the literature to discover which topics have been focused on and what the latest developments are in managing the occupational risk of PTSS in HCWs during the current pandemic. For the purpose of this review, we searched for publications in MEDLINE/Pubmed using selected keywords. The articles were reviewed and categorized into one or more of the following categories based on their subject matter: risk assessment, risk management, occurrence rates. A total of 16 publications matched our inclusion criteria. The topics discussed were: "Risk Assessment", "Occurrence Rates", and "Risk Management". Young age, low work experience, female gender, heavy workload, working in unsafe settings, and lack of training and social support were found to be predictors of PTSS.

2. Occurrence of PTSS

The 14 selected articles analyzing the occurrence of PTSS in HCWs dealing with the COVID-19 pandemic showed a range between 2.1% and 73.4%. This wide range is attributable to (1) the different timing of the studies and (2) the healthcare settings investigated. In particular, Song et al., in a study conducted from 28 February 2020 to 18 March 2020, when the outbreak in China had been controlled and the work pressure of the HCWs was significantly reduced compared to the peak period of the outbreak, found lower prevalence rates of PTSS (9.1%) compared to studies conducted during the peak period of COVID-19 in China. In line with this finding, the study by Rossi et al., performed in Italy between 27 and 31 March, during the peak of the outbreak in Italy, showed a higher occurrence of HCWs being affected by PTSS, compared to studies conducted later, when the pandemic was controlled. Regarding healthcare settings, increased rates of PTSS were found in inpatient settings (up to 70%), particularly among HCWs caring for COVID-19 patients or employed in emergency hospital wards.

3. Effects and recommendations

The findings of the present review show the need for urgent interventions aiming to protect HCWs from the psychological impact of traumatic events related to the pandemic and leading to PTSS. A body of evidence has been found about the following predictors of increased risk of suffering from PTSS: young age, female gender, not being a graduate, heavy workload, low medical training, not living with a partner, and low social support. Therefore, healthcare organizations should focus on the supportive resources available for HCWs in order to prevent the heavy psychological impairment related to PTSS in HCWs dealing with the COVID-19 outbreak. In fact, PTSS involve chronic severe anxiety with re-experiencing of the traumatic event, flashbacks, nightmares, increased arousal, and reduced social life and could lead to PTSD. As people suffering from PTSD are more at risk of suicidal ideation, suicide attempts, and death by suicide in huge proportions (2–5 times), the prevention of PTSD is a special concern for HCWs, considering that they are already in occupations which are at increased risk, and people suffering from PTSS are prone to not seeking care because of barriers such as lack of information, being afraid of stigmatization, or the belief that symptoms may decrease with time. Presently, a special effort is required to prevent PTSD as a secondary effect of the SARS-Cov2 pandemic among HCWs facing COVID-19 patients. Therefore, healthcare policies need to take into account preventive and management strategies toward PTSS, and the related psychic sequelae, as soon as possible, including policies to implement regular screening of PTSS in HCWs.

There is also a need for urgent intervention to identify and treat HCWs with PTSD, as such an approach can reduce the risk of chronic psychological impairment.

Source: d’Ettorre, G.; Ceccarelli, G.; Santinelli, L.; Vassalini, P.; Innocenti, G.P.; Alessandri, F.; Koukopoulos, A.E.; Russo, A.; d’Ettorre, G.; Tarsitani, L. (2021). Post-Traumatic Stress Symptoms in Healthcare Workers Dealing with the COVID-19 Pandemic: A Systematic Review. *Int. J. Environ. Res. Public Health*, 18, 601. <https://doi.org/10.3390/ijerph18020601>

Good Practice 4

An Integrated Existential Framework for Trauma Theory

Responsible partner: Jan Kochanowski University (Poland)

Authors: Kaitlin Wilmshurst

Keywords: trauma, existential, PTSD, theoretical, integration, framework

1. Introduction

In this paper, an integrated existential framework for trauma theory is presented. The framework is based on the clustering of current trauma theories into physical, relational, and intrapersonal categories, and the relation of these three clusters to Irvine Yalom's ultimate existential concerns of life/death, connection/isolation, and freedom/responsibility.

2. Existential approach and trauma

Recent research has revealed an interplay between the physiological and psychosocial aspects of traumatic experiences, suggesting that a theoretical integration which includes consideration of physiological change, fear conditioning, and relational impacts is required to fully address the impacts of trauma. The fourth existential concern, meaning/meaninglessness, is argued to underlie all of the aspects of trauma, forming a common connection between all theories. This paper undertakes a brief review of current theories in traumatology to illustrate the validity of the three theoretical clusters, explores the current application of existential theory to the conceptualization of trauma, and presents a unifying organizational framework for trauma theory based in existentialism. The result study is a comprehensive framework that addresses the physical, relational, and intrapersonal aspects of trauma, underpinned by an existential perspective.

3. Recommendation

Existentialism provides an important supplement to more commonly applied trauma theories, as it acknowledges the intangible impacts of trauma on meaning, mortality, and identity. The objective of this framework is to provide structure to the overwhelming number of trauma theories and treatment modalities while allowing flexibility for social workers to fit familiar theories and modalities into an existential practice. The framework poses some challenges to practice and research—particularly, how to remain respectful of existential theory's rich philosophical history while using it and studying it in a positivist environment. However, if used effectively, the framework may address the depth of the impacts of trauma, and contain the breadth of theories used by social workers to conceptualise and treat trauma, resulting in well-structured, professional eclectic practice.

Wilmshurst, K. (2020). An Integrated Existential Framework for Trauma Theory. *Canadian Social Work Review / Revue canadienne de service social*, 37(2), 131–147. <https://doi.org/10.7202/1075115ar>

Good Practice 5

Existential Issues in Trauma: Implications for Assessment and Treatment

Responsible partner: Jan Kochanowski University (Poland)

Authors: Louis Hoffman, Heatherlyn P. Cleare Hoffman, Lisa Vallejos

Keywords: trauma, Existential Shattering

1. Introduction

Trauma, by its nature, is existential through its impact on the manner in which the individual experiences the world, their self-understanding, and their sense of place in the world. Despite the recent proliferation of trauma literature, it remains common for trauma to be oversimplified in its conception and treatment. In particular, much of the treatment focuses on categorizing trauma into the diagnoses of posttraumatic stress disorder (PTSD) or adjustment disorder, and then treating the symptoms through medication and/or a behavioral conception of the symptoms. It is vital that we move to a more nuanced understanding of trauma. Trauma comes in many genres and various degrees of severity. This is further complicated in that it will have different impacts depending upon one's development, resiliency, and interpersonal support, among other factors.

2. Existential issues in the treatment of trauma

In this paper, we focus on the role of various existential issues in the conceptualization and treatment of trauma, particularly relevant to Greening's conception of "existential shattering" (2013). Whether an individual exposed to traumatic events experiences an existential shattering or not is important for conceptualization and treatment. Traumatic reactions that include existential shattering are likely to be resistant to or insufficiently treated by symptom focused treatments that do not address the implications of the deconstruction or shattering of one's world view, which is an important source of sustaining meaning and resilience. Although most trauma clients may benefit from the consideration of existential issues, for some clients, whose worldview and meaning systems have been shattered, it is an essential part of the healing process.

3. Recommendation

Existential shattering is an important concept in the treatment of trauma that has implications during the assessment and treatment phases of psychotherapy. Attentiveness to this concept can help distinguish between different types of trauma reactions that have important implications for treatment. Existential therapy and other therapies informed by existential perspectives are ideally suited to work with clients who have struggled with trauma and, in particularly, existential shattering.

Source:

Louis Hoffman, Heatherlyn P. Cleare Hoffman, Lisa Vallejos, (2013). Existential Issues in Trauma: Implications for Assessment and Treatment.

Symposium: "Developing Resiliency: Compassion Fatigue and Regeneration" (I. Serlin, Chair), 121 Annual Convention of the American Psychological Association, July/August, 2013, Honolulu, HI

Good practice 6

Educational Sessions

Responsible partner: Association of Clinical Psychologist (Czech Republic)

Authors: Khalida Yasmin, Adnan Yaqoob, Hajra Sarwer

Key words: Cognitive behavior, interventions, Burnout, Resilience, Nurses.

1. Description of the event

In the healthcare setting, emergency department is extremely risky unit where atmosphere frequently becomes unpredictable. In this environment emergency staff nurses most of the time taking persistent stress effect on mental well-being which lead to exhaustion. In critical care department's nurses have potentially affected by anxiety due to stressful environment and workload which is the leading factor of negative outcome and result in burnout. Cognitive behavior therapy-based intervention (CBT) is one of the effective interventions to decrease self-reported burnout, as well as increased resilience

2. General conditions of the group and measures

A convenient sampling technique was performed collecting the sociodemographic data and information during the face to face interview of 50 working nurse's staff. Data were collected at baseline and after intervention.

The measure was:

- Burn-out syndrome and resilience

3. Intervention: focus on the method

Interventions were given during morning shift in auditorium of selected research setting. Participants were reminded for not to attend any additional educational session regarding specialty of practice to avoid the interference of confounding factors. Eight-week sessions consisted of face-to-face PowerPoint lecture, audio-visual demonstration and role modeling. Lecture and audiovisual demonstration was consisted of components of the CBT techniques focused reduce the burnout. After completion of CBT based educational session and audio-visual demonstration, lectures, home assignments and also role modeling participants was taught for reduction of burnout and enhance self-competences skill. After eight weeks of CBT based educational sessions, participants' was reassessed to effect of CBT on burnout and resilience.

4. Effects

This study shows that the burnout variables' score after cognitive behavioral therapy score with a p-value of <0.05 showing a significant difference. There was an overall significant difference (p-value <0.05) in resilience parameters pre and post interventions.

Reference: Yasmin, K., Yaqoob, A., & Sarwer, H. (2022). Effect of Cognitive Behavioral Therapy (CBT) Based Intervention on Resilience and Burnout among Staff Nurses Working in Critical Care Departments. Pakistan Journal of Medical & Health Sciences, 16(03), 295-295.

Good Practice 7

Emotion-Focused Normalization, Psychoeducation, and Respiratory Techniques Approach (Two Case Studies)

Responsible partner: Association of Clinical Psychologist (Czech Republic)

Authors: Markéta Zajícová, Peter Reiley, Luděk Fiala, Jan Vevera

Keywords: anxiety, COVID-19, diaphragmatic breathing, psychological intervention, respiratory

1. Description of the event

Patients suffering from the effects of COVID-19 pneumonia often experience dyspnea, or breathlessness, which has increased the prevalence of respiratory anxiety among these cases. The symptoms of pulmonary disease and anxiety overlap, and the effects of these elements exacerbate one another.

2. General conditions of the group and measures

Drawing from the clinical psychological treatment of 68 COVID-19 patients in the acute phase of disease in standard- and intensive-care units, as well as those post-COVID, this study describes targeted interventions applied over 178 sessions during 3.5 months at the University Hospital in Pilsen, Czech Republic.

The group of patients was greatly heterogeneous in gender, age, the severity of the respiratory failure, the severity of ventilation support, and the number of sessions that varied between 1 to 12, each session took between 10 to 60 minutes based on the medical condition and motivation of the patient.

A noticeable similarity was found in patients, especially those who experienced higher severity of the respiratory failure. These patients were usually referred to as anxious, fearful, non-motivated to rehabilitation, or even actively avoiding any physical activity. Fear of breathlessness or suffocating, anxiety, and respiratory components of anxiety were present in these patients.

3. Intervention: focus on the method

The psychotherapeutic approach was in a supportive and non-directive manner, where an integrative methodology was applied. The core part of the treatment was cognitive-behavioral therapy and breathing techniques. The clinical psychologist, who provided the treatment, was also experienced in logo therapy and existential analysis, and certified in coaching (neuro-linguistic programming), crisis intervention, and psychological first aid.

1. The intervention started with support in acceptance and abreaction of emotions related to dyspnea and lack of breath (e.g., acknowledging fear associated with not being able to breathe properly, challenges associated with weaning from artificial ventilation and embracing current fears and anxiety as normal emotions during a long, difficult, and potentially life-threatening hospitalization).
2. The second part of the psychological intervention focused on educating the patient about anxiety and its physiological and psychological effects. The patient described his symptoms to the therapist, and they discussed them together, focusing on not only accepting anxiety as a normal part of his life now but also as a sign of his progress as he works through a difficult and stressful challenge.
3. The third main part of the approach employed a Diaphragmatic Breathing (DB) technique, which has been shown to reduce physiological and psychological stress and anxiety (e.g., Chen et al., 2017; Hopper et al., 2019; Ma et al, 2017). This approach had the patient place one hand on his chest, with the other hand on his abdomen (along his diaphragm) and take deep and long inhales for up to four seconds. The patient then held his breath for approximately four seconds, and finally exhaled slow breaths for another four seconds. The expirum should be as long and deep as inspirium.

The psychological intervention procedures employed in the current study can be divided into three basic steps.

1. The first was encouragement in emotion abreaction, then normalization and validation of these emotions with the aim to help patients accept their fears and negative emotionality as a normal reaction to an abnormal situation.
2. The second step was psycho-education about anxiety and its behavioral, cognitive, emotional, and, most importantly, physiological component related to respiratory anxiety and their interactions or mutual potencing. The third basic step included respiratory DB (Diaphragmatic Breathing) techniques, including long and slow inhales and even longer and slower exhales.

4. Effects

Patients showed improvement and were released from the hospital without long-term high-dose oxygen therapy dependency and both referred to a decrease in anxiety symptoms, along with the ability to overcome a subjective experience of breathlessness. In both presented cases, the provided psychological care was very short; 3 and 4 sessions, in total length of approximately 2 hours per patient. A specific time needed for each step (emotion ventilation, psycho-education, and DB) depends on the current needs of a patient and is unable to be predicted or measured due to the clinical factors and overlap of the steps.

Reference: Zajícová, M., Reiley, P., Fiala, L., & Vevera, J. (2022). Psychological Management of COVID-19 Respiratory Anxiety: Emotion-Focused Normalization, Psychoeducation, and Respiratory Techniques Approach. *Practice*, 16(3).

Good Practice 8

Self-Monitoring

Responsible partner: Association of Clinical Psychologist (Czech Republic)

Authors: Kathy Benhamou & Alexandra Piedra

Keywords: Cognitive-behavioral interventions · CBT · Crisis intervention · Pandemic · COVID-19 · Frontline professionals · Essential workers

1. Description of the event

Essential workers during the COVID-19 pandemic face heightened levels of anxiety and depression due to increased work demands, lack of adequate personal protective equipment, fear of contracting the virus, and fear of spreading it to loved ones. This is a time of urgent need for mental health support for workers affected by the pandemic crisis. Clinicians may employ empirically supported interventions derived from cognitive behavioral therapy (CBT).

2. General conditions of the group and measures

It is recommended that clinicians help essential worker clients meet their basic needs by modifying health and sleep habits where possible and helping them advocate for their needs using interpersonal effectiveness skills. Empathic listening, validation of the crisis at hand, and values clarification can aid the therapeutic relationship, help them feel a renewed sense of purpose and meaning in their careers and with their families, and facilitate behavior change consistent with chosen values. Self-monitoring through a daily diary can help clients focus their thoughts and recognize maladaptive patterns in their thoughts and behaviors. In tandem with these techniques, behavioral activation and coping strategies including relaxation, distress tolerance, and acceptance promote engaging in positive and adaptive activities. Finally, therapists can help clients reduce anxiety related to the pandemic by helping them limit information intake.

Given the increase in risk for anxiety, worry, depression, and exhaustion, it is recommended that therapists help their clients monitor their own thoughts, emotions, and behaviors, and the effects these factors have on each other.

3. Intervention: focus on the method

Self-monitoring can take many forms depending on the clients' needs and the therapist's goals. Most traditionally, self-monitoring requires clients to record their thoughts, emotions, and resulting behaviors throughout the week on a sheet of paper or worksheet as they experience a heightened emotion (Huppert 2009). However, this may be tedious for essential workers who are burnt out and unable to fill out detailed forms of this nature. Therapists can ask their clients to keep a more fluid daily diary where they can record both good and bad events of the day. This document can serve as an objective measure of how the client is spending their leisure time, and how it affects their mood. It can also help the therapist and client collaboratively look for patterns that may prevent engagement in pleasant activities, so these may also be addressed and modified.

4. Effects

Preliminary support for CBT interventions for crisis intervention suggests that basic CBT skills may be effective in treating the anxiety and depression that may result from a health crisis when paired with PFA principles.

Reference: Benhamou, K., & Piedra, A. (2020). CBT-informed interventions for essential workers during the COVID-19 pandemic. *Journal of contemporary psychotherapy*, 50(4), 275-283.

Good Practice 9

Exposure and Cognitive Restructuralization

Responsible partner: Association of Clinical Psychologist (Czech Republic)

Authors: Richard A. Bryant, Ph.D., Tanya Sackville, M.Psych., Suzanne T. Dang, M.Psych., Michelle Moulds, M.Psych., and Rachel Guthrie, M.Psych.

Keywords: PTSD, cognitive behavior therapy, prevention, exposure

1. Description of the event

Acute stress disorder permits an early identification of trauma survivors who are at risk of developing chronic posttraumatic stress disorder (PTSD). This study aimed to prevent PTSD by an early provision of cognitive behavior therapy. Specifically, this study indexed the relative efficacy of prolonged exposure and anxiety management in the treatment of acute stress disorder.

2. General conditions of the group and measures

Forty-five civilian trauma survivors with acute stress disorder were given five sessions of 1) prolonged exposure (N=14), 2) a combination of prolonged exposure and anxiety management (N=15), or 3) supportive counseling (N=16) within 2 weeks of their trauma. Forty-one trauma survivors were assessed at the 6-month follow-up.

3. Intervention: focus on the method

Each group received five 1.5-hour individually administered sessions conducted by one of the four clinical psychologists. Sessions occurred once weekly.

The first session comprised education about trauma reactions, breathing retraining, training in progressive muscle relaxation, and learning self-talk exercises to manage anxiety-producing situations. Subsequent to the initial session, patients completed each of these techniques on a daily basis as homework, and patients' progress was monitored at each session.

The second session involved the rationale for exposure and commencement of prolonged imaginal exposure to traumatic memories. Fifty minutes of each of the final four sessions were devoted to patients reliving their traumas by focusing attention on their memories and engaging with their affective responses. These narratives were not audiotaped, but patients were instructed to complete this exposure in the same manner as in therapy as daily homework. Following each exposure session, cognitive restructuring of fear-related beliefs that were identified during the exposure was conducted. Cognitive restructuring involved teaching patients to identify irrational, threat-related beliefs and to enhance realistic thinking by evaluating thoughts against the available evidence.

Sessions 4 and 5 also included in vivo exposure and relapse-prevention exercises.

4. Effects

These study findings suggest that PTSD can be effectively prevented with an early provision of cognitive behavior therapy and that prolonged exposure may be the most critical component in the treatment of acute stress disorder.

Reference: Bryant, R. A., Sackville, T., Dang, S. T., Moulds, M., & Guthrie, R. (1999). Treating acute stress disorder: an evaluation of cognitive behavior therapy and supportive counseling techniques. *American journal of Psychiatry*, 156(11), 1780-1786.

Good Practice 10

Memory Structuring Intervention

Responsible partner: Association of Clinical Psychologist (Czech Republic)

Authors: Yori Gidron, Reuven Gal, Sara Freedman, Ari Arye Laudén, Irit Twiser, Yoram Snir, & Jonathan Benjamin.

Keywords: PTSD; prevention; memory processing; randomized-controlled trial.

1. Description of the event

Based on therapeutic studies revealing positive prognostic factors and on research findings revealing how trauma is processed, the memory structuring intervention (MSI) is developed in attempt to prevent posttraumatic stress disorder (PTSD). The MSI attempts to shift processing of traumatic memory from uncontrollable somatosensory and affective processes to more controlled linguistic and cognitive processes by providing patients organization, labeling, and causality.

2. General conditions of the group and measures

Seventeen patients (8 women, 9 men) admitted consecutively to the Emergency Room (ER) in Be'er Sheeba, South of Israel, took part in this study. Patients met the following inclusion criteria: (1) Survived an motor vehicle accident (MVA) within the last 24 hr; (2) Did not have brain damage; (3) Were discharged from hospital within 24 hr after admission, indicating minor injury only; and (4) Had heart rate ≥ 95 BPM upon admission into the ER (a PTSD predictor; Shalev et al., 1998).

3. Intervention: focus on the method

Interventions were conducted by telephone because of logistic reasons. The MSI was conducted as following.

1. Time sections: Therapist approaches the trauma survivor with an a priori set of time sections in his/her mind (e.g., in an MVA: the hours before the accident; the first minutes of driving; the accident; the arrival of medical assistance; arrival at the hospital).
2. Listening to and clarifying patient's details. Therapist actively listens to and writes down details of the patient's story, while clarifying factual, sensory, and affective details (e.g., Patient: "I shouted after falling"; Therapist: "Did you shout because of pain at that moment?"; Patient: "I shouted because my back hurt me"). Details are noted by the therapist in their corresponding time sections, together with precise labels for thoughts and feelings, to enhance structure and cognitive processing of sensory/affective Reactions.
3. Memory structuring: Therapist repeats the trauma narrative in an organised, labeled, and logical manner, adding initial implications for the patient's life (insight).
4. Patient's structured description: Patient describes the traumatic event in the same structured, labeled, and logical manner as the therapist did. At this point, patients usually add further details, describe the event in a more objective "journalistic" manner, and appear less aroused.
5. Practice structured description: Until the subsequent session, patient is asked to practice telling friends or family members the structured version of the traumatic event, to enhance the attempted memory shift.
6. Rehearsal with therapist: In the second meeting, patients practiced for the last time disclosing the traumatic memory in its structured manner. Finally, the patient was taught about the importance of and asked about his/her social support (a predictor of delayed PTSD in MVA).

4. Effects

At the 3–4 month follow-up, 5 of the 17 patients (29%) met DSM-IV criteria for PTSD using Foa et al.'s cutoff. Four of them were controls and one was in the MSI condition. At follow-up, MSI patients reported significantly less frequent total PTSD symptoms, less frequent intrusion symptoms and less frequent arousal symptoms.

Differences between conditions in total PTSD symptoms remained significant when controlling separately for prior psychological treatment, peritraumatic dissociation, and early intrusion.

Reference: Gidron, Y., Gal, R., Freedman, S., Twiser, I., Lauden, A., Snir, Y., & Benjamin, J. (2001). Translating research findings to PTSD prevention: Results of a randomized-controlled pilot study. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, 14(4), 773-780.

Good Practice 11

Supervision on Training in Psycho-Pedagogical Intervention and Prevention against Bullying & Cyberbullying according to the Adlerian Method of Individual Psychology

Responsible partner: *Institut Alfred Adler de Paris (France)*

Author: *Christelle Schlöpfer*

Keywords: *Group Training, Sanitary Humanitarian Emergencies, Social Humanitarian Emergencies, Victims, Bullying, Cyberbullying, Adlerian School Emergencies Method*

1. Description of the supervision training event

a) Setting

The Group Supervision online (about 10/20 trained) is part of the Training Program online via ZOOM into 2 days, and it's organised on 3 hours for 2 times as group supervision for case discussions after first 2 days training, along for months, and the possibility of organizing additional paid ones.

Please go to the relative Case Study 2 VET (IAAP Section, Christelle Schlöpfer)

b) Involved

This training is designed exclusively for professionals from the psychological and pedagogical fields: psychologists, psychosocial counselors, family counselors, child and youth coaches, teachers and school social workers, parenting facilitators.

c) Analysis of training needs

The trainees need to be accompanied in the analysis of the New Operational Situation because each one is very different from context to context. For example, if cyberbullying requires the immediate intervention of the Police, then it will be necessary to add the work with the class.

But each case is different, and each class-constellation and each school are like individuals: they have their own characteristics and dynamics. For this reason, a follow-up of supervision is necessary as for any systemic therapeutic and/or psychoeducational intervention. So this training also includes 2x 3h group supervision for case discussions. The trainees get unlimited access to the online course platform with regularly updated info and materials and ready-to-use templates.

d) Duration

The Supervisions is included in the training program: 2x 3 hours group supervision for case discussions.

e) Follow up

Several times a year there is the possibility to participate in more group supervision.

2. Intervention & Supervision

a) Context

Having understood the basic lines of the individual psychological theory supporting the intervention that I propose, such as 1) how everything turns around belonging (pivotal principle of Individual Psychology: Gemeinschaftsgefühl) and 2) how bullies react in a compensatory way out of an inferiority feeling, 3) the holism intervention; the participants learn about the various types of bullying and cyberbullying. In addition, the trainers work out together how they can recognize (cyber)bullying and differentiate it neatly from conflicts. Furthermore, the trainers learn about different intervention and prevention options. Among others, the metaphorical work, which aims to sensitize the students, to activate their empathy and to involve them participatively into solutions?

b) Goals

The most important part of working with the class, is that the bully is not seen as the only responsible party in the bullying situation. Passive bystanders also hold their responsibility, because they enable the situation. In addition, it is important to control who is really a victim, because it is not uncommon to have active/aggressive victims who are seen as the problem student/as the bully, but are actually victims in the situation. It is important to approach the solution with the whole class, because all students share the responsibility in the bullying situation.

Second, we never intervene directly, but always indirectly: we don't go into the classroom and say that (cyber)bullying is happening and that it should stop. Schools often remove the victim and the bully from the classroom and confront them, which is a mistake. This technique suggests working metaphorically with the whole class so that the students do not become reactive. By refraining from confrontation, we avoid students becoming defensive and guilt rising - otherwise we risk losing cooperation toward responsibility.

So we bring videos adapted according to age and problem, and work with groups focusing on the characters in the video. Students focus on the characters in the film to activate empathy: "How does the character feel?"; "What does he expect from others?" We need to get away from the idea that no one is responsible, while everyone is responsible, even those who do nothing. We are therefore working on the concept of "Civil-Courage".

After a first group work, the groups change in the class to find a solution for the situation shown in the video. Questionnaires should not be used for bullying analysis, but the method of observation and analysis of what happens in the classroom during the metaphorical (group) work. This is not about the actual case in the classroom, as this could cause shame and guilt and can be a big obstacle to working together towards responsibility.

The transfer to the real situation is done very carefully in the last phase and attention is paid to what solutions the class comes up with so that the bullying situation can be resolved and the victim can get better. Often all it takes is one brave child to move the whole group.

It is also necessary to work directly with the victim in the crisis to obtain individual psychological support organised by the school or by the interventionists who also take care of the parents.

If the main perpetrator does not change his behavior after the intervention, individual support to compensate his feeling of inferiority (control or power) is necessary. Depending on the type of compensation, we look for a prosocial alternative (which reduces the feeling of inferiority) as a substitute to bullying other people. This is often the problem that is brought to supervision.

For example, we dealt with the case of a 12-year-old girl who had succeeded in manipulating the students of two schools and inciting them on other students: At the end of the process, she was offered to be a "guardian of appreciation in the classroom".

In supervision we also learn how to really distinguish conflict from bullying, because we can make the situation worse if we confuse the two: The interventions are not at all the same. The main mistakes happen in the clean detection and distinction between bullying and conflict. Schools are not yet ready for this distinction.

c) Assessment of learning outcomes:

The discussion about the effectiveness of the supervision is possible and fluent both with the trainer and with the group. At the end of the discussion, the supervisees have the opportunity to underline what was effective and what remains unclear in order to organise the next supervision.

Source: Christelle Schläpfer, PODCAST, Mobbing und ers angehen (Approach Bullying Differently) – 23 January 2021 – 27 September 2021 : Episode 00-11 for 227' minutes listening.

Good Practice 12

Web Site & Educational Movie Dossier About the Film “Un Monde” by Laura Wandel (2021) for Sensibilization and Training in Psycho-Pedagogical Intervention and Prevention Against Bullying & Cyber-Bullying according to the Adlerian Method of Individual Psychology

Responsible partner: Institut Alfred Adler de Paris (France)

Author: Christelle Schlöpfer

Keywords: Group Training, Sanitary Humanitarian Emergencies, Social Humanitarian Emergencies, Victims, Bullying, Cyberbullying, Adlerian School Emergencies Method

1. Description of the good practice as training event as website to learn about bullying and cyberbullying

a) Scenario

Although bullying is much more talked about and prevention lessons are held in many schools on a selective basis, bullying in general has not decreased but increased (PISA Assessment 2018). In addition, cyberbullying has increased by an average of almost 40% worldwide during the pandemic, bringing the number of victims of bullying worldwide to a very high level.

b) Involved

(Cyber)Bullying is a group phenomenon and does not only happen between victim and bully.

The whole system must be taken into account. Usually, this is limited to the class (victim, bully, followers, spectators). It is not uncommon, that the teacher, parents, school director (albeit unconsciously) favor the bullying situation directly or indirectly. In addition, it also happens that bullying occurs across the system.

With bullying, we are in a crisis situation and sometimes in emergency. This form of violence is not visible, unlike conflicts which require another type of intervention. When bullying occurs, it means that a breaking point has been reached for the victim and the associated relationship system. For children know it is "bad", they consequently bully secretly, in the corridors and on the stairs, but rarely in the classroom under the eyes of everyone and the teachers. Therefore we don't see it and we have to read it differently. Usually, the parents raise the alarm.

For this reason, having a website that allows parents and school staff to understand the phenomenon and ask for help is a very important.

c) Analysis of training needs

Numerous affected students don't get help because they fear the (cyber)bullying situation could become worse (which indeed also may happen). (Cyber)bullying is very different from short-lived conflicts and arguments.

2. Web Site Intervention Training & Educational Movie Dossier

a) Structure of the NEW WEB SITE under construction: www.edufamily.ch

b) Technique form and film “Un MONDE” by Laura Wandel, belgian director (2021, Dragons Films). The film was presented in the official selection at the 2021 Cannes Film Festival in its section Un certain regard.

c) The Dossier is an auto-training or self-training. The users watch the film and read the dossier step-by-step. They can use the suggestions in the dossier for group discussions.

Project Number: 2020-1-PL-KA202-082075

- Dossier size: 22 pages
- Content:
- Topics of discussion
- Don'ts with bullying : What parents and schools should urgently avoid when it comes to bullying
- Conflict versus bullying: What are the differences
- What to do in case of bullying
- Development of the story (film)
- The film day by day

d) Trainers: preparation

the film is addressed mainly to adults and is not recommended for metaphorical work with classes. The film dossier is particularly suitable for discussion rounds with school staff and in parent education groups, but also as information for professionals from the psychosocial field.

e) Duration

The movie lasts 75' minutes and the lecture of the form takes 60' minutes

The movie is available as DVD in french and in english. The website and the educational film dossier will be available in 4 languages (german, french, english, spanish) from 2023.

f) Follow up

People who follow the site can contact Christelle Schlöpfer for an intervention and/or access training (free and paying) which will give rise to supervision groups several times a year.

Source: <https://edufamily.ch/wp-content/uploads/2022/04/Un-MONDE-Paedagogische-Dossier-zum-Film-3.pdf>

Good Practice 13

Pandemic First Aid Telephone Unit in a Pandemic Crisis as Adlerian Toolkit of Psychological Crisis Intervention and Prevention According to the Adlerian Method of Individual Psychology

Responsible partner: *Institut Alfred Adler de Paris (France)*

Authors: *Alessandra Zambelli, PhD, Psychologist, Psychotherapist, Trainer, Supervisor, President IAAP & TEAM and Students PROMO 1*

Keywords: *Individual Intervention; Sanitary Humanitarian Emergencies; Social Humanitarian Emergencies; Victims, Pandemic Crisis; Adlerian Pandemic Emergencies Method, Social and Sanitary Support*

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, 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. Please go read the case study related to this

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.

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 because the unit was open also to the rescuers.

This media tool being conceived as the third part of a tryptic complex training program for the group of students in training to become Adlerian psychanalysts at the IAAP, it 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. Also the Resilient Path has been associated with the creation of a support cell made available to a medical cabinet. 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 them. Please go read the case study related to this. In order to help in the context of the COVID 19 pandemic, the team of the Alfred Adler Institute in Paris and the students of the promotion 1 mobilized to propose an emergency telephone cell.

A person in need, after answering an online questionnaire and registering, is offered 3 free half-hour sessions to provide initial support and orientation as needed. In the following case, we propose to follow the path of a patient who has contacted the cell.

2. General conditions of the victims

Once the patient's contact information is received, the request is processed internally by the team in order to mobilize a co-opted therapist available to intervene. Once the assignment is made, the co-opted therapist calls the patient for an initial 15' minutes interview to collect the first information about the request.

Here, Clara, 32 years old, [all patient information is totally distorted to protect privacy as it should be according to psychotherapeutic and medical ethics] contacts the emergency number provided by the Covid support cell. The call takes place during the first deconfinement, as France is gradually emerging from this long period of confinement.

During the 15 minutes of telephone conversation, Clara communicates a lot of information about her past, her present, her symptoms, her parent's traumas as well as her various contacts with the world of mental health (hospitalizations, psychiatrists, psychologists, etc.). She contacted us because of invasive anxieties and compulsive behaviors. She links these symptoms to her childhood and not only pandemic situation. She has a stable relationship and has lasted for 6 years, with a child project.

The request for help is perceived as massive by the co-opted therapist who feels that the patient needs to be strongly restrained. Closing the interview required a lot of energy and the therapist used empathic validation to thank the patient for this difficult sharing over the phone with a stranger, to validate the request for help and to agree on a next appointment.

Following this first exchange, it was agreed that the co-opted therapist would bring the situation up to the cell level to determine which IAAP member would accompany this patient, victim of type 5, in the context of the pandemic for the 3 free 30-minute sessions by video.

3. Intervention: focus on the method

a. Three free half-hour sessions

Clara received 2 interviews of 45 minutes instead of 3 sessions of 30 minutes because of the length and density of the exchanges and the difficulty of the therapist to close correctly in thirty minutes. This deviation from the framework was already information to consider. Clara needed to control the setting, the time and the therapist. This over compensatory mechanism, the will to power, served Clara to unconsciously mask her feelings of inferiority feeling and state.

At the time of the first appointment, Clara was confined to her room since the day before because she was positive for Covid. The co-opted therapist first tried to evaluate the level of perception of the emotional invasion felt by the patient. Then he used the elements of the resilient path to understand where the patient was at the level of resources, at the level of the body... etc... in order to make a fine evaluation of the present situation (determine the conflicts / level of consciousness by the jargon of the organs). At the end of this first exchange, many childhood traumas came to light. The contact with the body during the proposed exercises was very complicated to do independently by the patient (cardiac coherence and butterfly hug) and even with the therapist during the appointments.

Because of the lightened measures and the possibility of resuming face-to-face consultations, the second interview was conducted face-to-face. The co-opted therapist was able to apprehend the patient in a different way and felt very insecure. Thus, with regard to the different experiences of physical and psychological violence and traumas recounted by Clara, we can see that the feeling of insecurity spreads in her mind and resonates with that of the co-opted therapist during the support. Indeed, Clara spoke in a cryptic way during the interview and used a lexical field related to fire, explosions. This feeling increased when the patient, wishing to show the therapist photos and a drawing, took out of her bag, hidden until then, her realization. The fear of acting out was accentuated. Faced with the distress induced by the feeling of inferiority and the lack of belonging, Clara, in order to find a more comfortable posture and of control, solicits a acting-out mechanism.

The need to find support outside of interviews was seen as essential in this situation. The co-opted therapist then requested internal supervision from the cell.

b. First Level Supervision

A one-hour interview is scheduled with an internal supervisor. In this context of care, it is important to note that the 3 protagonists (patient, co-opted therapist, supervisor) are type 4 victims, being all victims of the same community i.e. humanity, the pandemic being global. Identifying the type of victims involved in the emergency situation makes it possible to know which areas to work on, particularly with regard to the community (to activate the sense of belonging) and the values inherent in it, and to know which resources to call upon in order to give the victims back the keys and autonomy. The patient is also spotted as victim type 5 during the psychodiagnostic phase. The first challenge is therefore to ensure and maintain thinking spaces in the face of the context. Both the supervisor and the co-opted therapist must therefore ensure that they are sufficiently secure to be able to take charge of the other. In addition, special attention is given to the establishment of the right alliance between the co-opted therapist and the supervisor, as both are members of the same professional network.

A space for thinking without judgment (Adlerian technique of encouragement to secure the other through a non-neutral posture in a relational authenticity + concept of education aiming at taking charge of one's own needs to lead to autonomy) in a posture of the right emotional distance, the supervision framework acts as a transitional space, where fear had crept in. The first axis will be to welcome the emotions, feelings and thoughts of the co-opted therapist. The support in the face of this worrying situation then passes by the analysis of the transference against transference to understand the dynamic stakes of the therapeutic relationship.

Then, a work of elaboration of the diagnosis is set up in order to verify the real or fantasized feeling of urgency felt by the co-opted therapist and found during the supervision. In the context of the diagnosis, it was necessary to pay attention to aggravating factors, such as family anniversaries (death, Mother's Day...) which could reactivate the patient and push her to a lower quality of functioning than usual.

Several levels of crises are therefore intertwined to be kept in mind in this situation (patient's covid/ anniversary date/ reactivation of a trauma/ health crisis...)

c. Second Level Supervision as Second Thought

At the end of the first supervision, it seemed necessary to take this complex case to a higher level in order to have a more experienced supervisor's view to refine the steps to be followed with Clara and to secure the therapist co-opted in the accompaniment. Supervision allows the sense of belonging and network of the co-opted therapist and the first supervisor to be solicited and felt. Thus, by understanding why "inferiority state" is felt by the co-opted therapist, the supervisor can help to reignite creativity by providing a sense of security through his or her accompaniment in the meta position. The question of the diagnosis, which remained at the stage of the differential, being central, was refined and the axes of accompaniment reinforced.

d. Towards Psychotherapy

Following the voluntary care proposed by the cell and the 2 supervision interviews, a support plan was established with the patient and a referral was made to the same therapist but in liberal follow-up to continue the work started. Proposals for support to other health professionals were also discussed.

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 and body. 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.

5. Global interdisciplinarity

The Adlerian method***weaves an integration of the three dimensions of personality according to the biopsychosocial paradigm

If Clara's compulsions, in response to anxiety, are the way in which the inner conflict seeks resolution and is the most visible, it is important for the co-opted Adlerian therapist to take into account the three dimensions of the Adlerian paradigm: bio-psycho-social for a holistic approach to the patient. Indeed, at this moment of life, the child project reactivates not only cognitive but also emotional and somatic memories in Clara, which it is essential to listen to with empathy.

Early and ongoing life experiences play an essential role in the construction of what Adler will call the individual's Life Style*. The relationship to the self, to the world, the protective mechanisms, the personality and possible associated disorders, the level of mental functioning as well as the symptoms reported in the DSM-5 shape the individual who reacts to a genetic inheritance, a family and social environment and a psychology of his own. That's why the co-opted Adlerian therapist will therefore use these elements to make his or her psychological diagnosis. In reaction to this feeling of inferiority, which was accentuated by the humiliations and mistreatment, Clara developed strategies of overcompensation in order to regain a feeling of power and inner balance. The co-opted Adlerian therapist will therefore be sensitive to the state of Clara's sense of belonging (Gemeinschaftsgefühl), which has been particularly damaged in the family but also with regard to society, which is experienced as dangerous in view of the hospitalization, which is experienced as forced. While potentially a resource for some, the social link is experienced here as painful, anxiety-provoking or even threatening.

With Organ Jargon** the Adlerian therapist 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 co-opted therapist about Clara's personality and pathology. Clara work in an high scientific level and spends a lot of her personal time on creative/artistic activities. Thus, despite a complex life history, she was able to use her creativity as a resource and strategy to achieve balance. The co-opted Adlerian therapist will be committed to recognising the patient's resources and encouraging her sense of creativity to help her in ways that are more effective and useful for her and the community. The empathetic validation in a tool encourages the creation of a therapeutic alliance allowing the creation of a space to experience the attachment bond and the protection mechanisms in a new light, and to feel differently and look at her history in a different way.

The Clara compensation by acting-out is rooted in what Adler would name the virile protest reaction to the will of power restoring power. Thus, in Clara's construction, the inferiorities, threats and humiliations, led her to elaborate and follow a tendentious fiction according to which to take the power would pass by the destruction of others. The co-opted therapist used a technique of cognitive and emotional support through counseling and praise, but also and best take a time to create a safe supervision space.

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Good Practice 14

Crisis Intervention and Suicide Prevention

Responsible partner: *Institut Alfred Adler de Paris (France)*

Authors: *Sonneck Gernot, Kapusta Nestor, Tomandl Gerald, Voracek Martin*

Keywords: *Individual Intervention, Sanitary Humanitarian Emergencies, Social Humanitarian Emergencies, 2°, 5°, 6° types of Victims, Suicide Risk, Adlerian Method, Social and Sanitary Support*

1. Description of the event

A 54-year-old, self-employed man, Mr. F. had to file for bankruptcy unexpectedly. One year ago, he lost his wife and then remarried.

2. General conditions of the victims

Mr F. tells his story: "Five weeks before my bankruptcy I had the feeling that I was terminally ill myself. My whole organism was in great turmoil. Physically shivers ran through me, and my incurability was obvious to me. Mentally I felt the hopelessness; an escape into psychiatry seemed a real way out. A lifelong admission to a closed institution now was a life goal now worth striving for.

A week later, when I first understood the inevitability of bankruptcy, suicidal thoughts took hold. Secretly, quietly. No one knew about it, and no one was supposed to know about it. I prepared everything mentally, place, time, method etc. I developed a real suicide strategy. Only a few days, if not only hours, separated me from the act. Meanwhile, my wife wrote me daily love letters that were pages long, which I read, but without reflection. No one knew of my intentions, not even she. But no one else helped me, probably also because I was incapable of articulating myself.

I could only articulate myself to a friendly but professional authority. It came my way in the form of the emeritus professor Dr. B. A recommendation to his good friend was a matter of seconds, my decision to comply with his fervent fatherly request was firm.

I wanted to leave no stone unturned. I would be able to cope with his psychological tricks, I didn't need a psychologist, I was a psychologist myself, I needed real help ... After I made it clear to him that he couldn't help me, he said: 'I can't, but I have something that can help you. 10 minutes from here, there is a crisis intervention center, I'll call them in the meantime'. And then I stood there, without an appointment and without registration as a so-called acute case with a high risk of suicide.

3. Intervention: focus on the method

The therapist tells his perspective:

When Mr. F. arrived, he was so restless that during the initial interview he paced up and down for over an hour. Restlessly up and down for over an hour. It very soon became apparent that he had severe insufficiencies regarding the feelings of insufficiency and guilt regarding the bankruptcy and strong feelings of guilt towards his deceased wife. These blocked him emotionally. It was possible to work out this insufficiencies and he could share the pain openly, why I at the same time have acknowledged his feelings of responsibility and guilt and aggression against himself.

These were the results of the first sessions, but he did not attend the third appointment. I felt a loss, and as if, something happened. I did not feel well not knowing what has happened with him. His suicidal ideation was still a risk, I felt. The idea of danger haunted in me.

He was then contacted by us, which obviously strengthened his confidence to such an extent that he came before the next scheduled appointment. He oscillated between feeling guilty and not being responsible. After about 10 interventions, interventions over a period of three weeks, he was much more structured and developed plans for the future. He was able to receive support from other people, got a concrete job offer, and the bankruptcy was could be converted into a compulsory settlement.

Project Number: 2020-1-PL-KA202-082075

A renewed contact after a break of about two months shows that he is doing well, the crisis intervention is terminated. In the course of a follow-up contact three years later, Mr. F. proves to be stable: he has become a father once again and is doing well both professionally and privately.

4. Effects

Mr. F. experienced two losses within a short period of time. His wife and his financial security. According to ICD-11 we might diagnose adjustment disorder (Code: 6B43). From this vignette, we learn four important components of Crisis Intervention:

1. First a rapid referral to a professional trained in crisis intervention,
2. Second, the clarification and the focus on the emotional pain caused by the incidents,
3. The importance of the countertransference feeling as a communicative aspect of the relationship,
4. The active telephone visit in order to maintain the broken off relationship.

5. Global interdisciplinarity

Besides these general principles of intervention in crisis, a specific Adlerian perspective can be added to this stance*. Mr. F's hopelessness and perceived mental illness can be understood as a feeling of inferiority. The loss and inability to constructively solve the problem initially, let him nevertheless to compensate for the feeling of inferiority. The power of frustration and subsequent aggression comes into play, when suicidality is developing; although a destructive way of compensation, it needs to be acknowledged that suicidality is an attempt to overcome hopelessness; as a way to gain control and power over one's life (and death), an omnipotent reach out to re-establish a sense of agency.

In this sense, suicidality is to be understood as a human, understandable reaction, which can be shared with others. Although suicidality in its superficial aim is directed against cooperation and against social interest (seen in withdrawal), it has also an appellative character which is crucial in mobilizing help from others. This is the reason, why the appellative character of suicidality should not be missed or belittled in suicidal individuals. Although sometimes perceived in therapeutic encounters as manipulative in one way, it is a vital resource from a different angle of view, allowing to reach out and involve helping others.

Suicidality is also a transient and undulating phenomenon, which may be relieved in one session but intensify in an other; its more general reflection in form of seeking help or rejecting the helping hand, might manifest itself in the patients sudden absence from a scheduled session. Important to understand, the countertransference reaction of the helper (something might have happened) describes a continuity of relationship even in absence. The absent patient is inducing fear in the helper. By switching perspectives, we can understand this our own reaction as what the patient is experiencing and we can understand empathically what it means: "I am anxious, I need your confirmation that everything is ok!". This allows to exemplify one Adlerian stance: that of encouragement. Especially in crises, when the inner world of the patients has broken down, the helper experiences in his empathic hopelessness the patient's inner feelings. Immediate help means, to be supportive, to encourage the patients' movements towards a conciliation, to hold and represent hope for the one who has lost it**.

Sources:

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Good Practice 15

Private medical support to Ease the Feeling of Guilt according to the Adlerian Method of Individual Psychology

Responsible partner: *Institut Alfred Adler de Paris (France)*

Authors: *Sonneck Gernot, Kapusta Nestor, Tomandl Gerald, Voracek Martin*

Keywords: *Individual Intervention; Sanitary Humanitarian Emergencies; Social Humanitarian Emergencies; Victim type 4°, 5°, 6°, Terrorist attack; Adlerian Emergencies Method, Victim's guilty, Social and Sanitary Support*

1. Description of the event

The Friday 13 November 2015 Paris attacks were a series of coordinated terrorist attacks on the city's northern suburb, Saint-Denis. Beginning at 9:15 p.m., three suicide bombers struck outside the Stade de France in Saint-Denis, during an international football match, after failing to gain entry to the stadium. Another group of attackers then fired on crowded cafés and restaurants in Paris, with one of them also detonating an explosive, killing himself in the process. A third group carried out another mass shooting and took hostages at an Eagles of Death Metal concert attended by 1,500 people in the Bataclan theatre, leading to a stand-off with police. The attackers were either shot or blew themselves up when police raided the theatre. The culprits killed 130 people, including 90 at the Bataclan theatre. Another 416 people were injured, almost 100 critically. Seven of the attackers were also killed. The attacks were the deadliest in France since the Second World War, and the deadliest in the European Union since the Madrid train bombings of 2004. France had been on high alert since the January 2015 attacks on Charlie Hebdo offices and a Jewish supermarket in Paris that killed 17 people. Focus on all kind of victims but particularly 5° and 6° type. I describe here a particular need that two patients have expressed to their general practitioners in seeking support, showing up a month after the Bataclan attack. Both were unable to turn to the emergency services made available free of charge to the victims and their families. The pain of the terrorist attack, also linked to the loss of a colleague, made them feel guilty if they took advantage of free help. This type of feeling of experience is often not considered in the care of victims in crisis situations.

2. General conditions of the victims

The first patient, an elderly but not yet retired man with stable family situation, he lost the intern who worked in his son's business, and presents a healthy personality structure with a previous trauma related to his participation as a soldier in a violent war 35 years earlier.

Has all the symptoms of a PTSD, and is impressed that the nightmares contents and invasive thoughts are not related to the Bataclan terrorist attack but to the memories of the war.

The second patient, young woman about forty with stable relationship, manager in a technical service, has lost a direct colleague in the Bataclan attack at the same time that his faithful dog dies. She arrives with all the symptoms of PTSD (particularly dizziness and insomnia) plus major dissociative symptoms, hallucinations and "psychotic" nightmares. The differential diagnosis is based on the analysis of childhood and family data showing a psychotic problem in the mother (with suicide attempts of which the last one was successful ten years before) and the dissociative symptoms. So we considered the possibility of a PTSD Complex and/or a Brief Psychotic Disorder in BPD (Borderline Personality Disorder).

3. Intervention: focus on the method

a) First patient (type 6°)

The progressive understanding of his Lifestyle structured on compensation and control mechanisms linked to the death anxiety experienced 35 years earlier in the war being the only survivor of his team, has allowed the patient to acquire a better distance from certain compulsive behaviors rescue.

b) Second Patient (type 5°)

The possibility for the patient to access a relationship of trust and a working alliance with the therapist allowed her to communicate hallucinatory experiences and terrifying nightmares for the first time, reassuring her. The evident severity of the symptoms prompted the structuring of a long-term therapy, but the management of the hallucinations both through dissociation management exercises and pharmacological therapy (the patient was against the use of medicines and seeing a doctor caused her panic) allowed the patient to be absent from work for almost a month (and although she did not want to stop working despite severe dissociative symptoms). The understanding and integration of symptoms as a resilient part of the patient's lifestyle allowed her to welcome them rather than suffer them as "intrusive enemies" and learn to understand and manage them, to improving and evolving them.

4. Effects

The Effects were positive: 1) for the first patient with traumas linked to the old war, 6 therapeutic settings were enough to free himself from the symptoms of PTSD. The patient was able to develop a deeper understanding of his Lifestyle and accept that there was more work to be done, but beyond the negative urgency of the symptoms. 2) For the second patient with previous traumas linked to attachment figures (PTSD Complex), the symptoms were able to regress thanks to the integration of a pharmacological therapy managed with the psychiatrist who she was able to contact (under the guidance of the psychotherapist) and to the psychological techniques integrative on the parts (among which EMDR) associated with the Adlerian holistic therapy which worked on the 3 biopsychosocial dimensions*.

5. Global interdisciplinarity

The Adlerian method weaves an integration of the three holistic dimensions of personality according to the biopsychosocial paradigm**. The importance accorded to the body and the dialect of the organs allows the therapist to accompany the patient to connect with the bodily sensations and learn to stabilize the body progressively better. Only progressively is the patient led to consider his psychic defense mechanisms. The over-compensatory mechanisms link to the "will to power", serve patients to mask his feelings of inferiority link unconsciously and resiliently to the actual trauma crisis or passed traumas. The analysis of the patient's lifestyle allows him to observe his mechanisms and feel their effectiveness and efficiency according to their internal logic***. But this also highlights maladaptation and overload, in a bad balance between internal resources and external solutions. The Adlerian therapist will therefore be sensitive to the state of the patient's sense of belonging (Gemeinschaftsgefühl)**, which is the true re-equilibrator of the unregulated fictions (beliefs) in the lifestyle, but which can be the first damaged element in traumatic situations, particularly for chronic ones.

Sources:

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Good Practice 16

Post-Traumatic Victimhood and Group Analytic Therapy: Intersubjectivity, Empathic Witnessing and Otherness

Responsible partner: *Institute of Group Analysis Athens (Greece)*

Author: *Berman, A.*

Keywords: *group analysis, self-states, victimhood, post-trauma, empathic witnessing, otherness*

1. Description of the event

In this paper, Berman describes a vignette of a group analytic group in order to explain how post-traumatic aggression might be displaced from a real past aggressor to members of the group/the closed persons in the present. The author refers to “post-traumatic victimhood” as a self-state in the sense of the concept of multiple selves... From within any certain self-state, one’s personal experience is of authenticity (‘this is me’ experience), while any sign of any other self-state is experienced as ‘not me’” (p. 245). When dissociation is the major defense mechanism, self-states might be dissociated from each other. Post-traumatic victimhood self-state can be recognized in 4 behavioral patterns of the victim, in the group, which are recurrent interpersonal expressions:

1. claiming recognition as a victim
2. displacement of victimhood aggression
3. transforming personal suffering into domination, control and demand for compensation
4. suspension of concern and empathy towards others.

2. General conditions of the victims/group

The described group analytic group consists of 8 members, men and women, between the ages of 30–50. Eve has been a member of the group for a long time. She divorced recently after many years of complaining and frustration in the relationship with her husband. She works in a high school; her colleagues admire her efficiency and her capacity in creating a good atmosphere around her. In her childhood, after her parents’ divorce, her mother married another man who abused her, mostly verbal. She never complained or spoke about her childhood experiences, until she became a member of the group. The members of the therapeutic group appreciated her humor, her attentive and sensitive relation with others, and her capacity to cope with hardship. During moments of distress, she became vulnerable, needy and demanding more attention from the group and everyone in the group, she expected everyone to identify with her. She expected the other members to become empathic witnesses to her suffering. Any expression of otherness by any member was felt by her as abuse and abandonment, and her reaction was anger and insult. If someone mentioned how much time she took for herself in a session, she felt hurt. The other members became careful and fearful when speaking to her.

3. Intervention: focus on the method

In one session, she says that her relationship with her best friend is broken. They were at a pub when a young man joined their conversation. Eve had the impression that the young man was interested in her, her friend did not back off and she felt very hurt and ignored. The three left the pub in Eve’s friend’s car. Unexpectedly, her friend drove Eve home and continued with the young man. Eve felt humiliated, defeated and abandoned. The members of the group react with identification, consolation, genuine sorrow. One female resonated with her so deeply that she couldn’t stop crying and spoke about a similar experience she had. Two men of the group condemn Eve’s friend’s behaviour. Rachel, one of the youngest in the group, said that she understands her pain ‘but the dating world is one of competition. Your friend also wanted him. It was also an opportunity for her. Why should she step aside for you? ...’ (p.252). Eve felt insulted by Rachel, she likened her to her friend, Rachel felt hurt, the mutual support they usually give each other vanished. Rachel became quiet, she cried and seemed all alone. Two members tried to calm Eve, talking tenderly and discretely to her, and attempting to restore conversation between Eve and Rachel.

Another woman, identifying herself with Rachel's pain, described Eve's behaviour as aggressive and punishing. When another woman compared the exchanges in the group, to a struggle between genders by saying 'We are fighting here because of the behaviour of men. They are courted by us and are nevertheless egocentric and aggressive, and we pay the price' (p. 253), then another man said 'I too was hurt by women's rejection. I don't like the fact that there is competition over who was more hurt. Here in the group, I have also heard difficult feedback and I still listened. I listened to you too, Eve.' Eve replied to him, with hate, 'Instead of supporting me, you criticize me for expressing my suffering' (p. 253). After this heavy exchange, the group turned to the conductor/the therapist for help. His intervention was about his feelings of empathic witnessing, his identification with each member at different points. The group continues talking about the need of some members to express their feelings openly and show who they are, recognizing the 'coexistence of different emotions and points of view' (p.253).

What happened in this session? Eve reenacted in the group a victimhood self-state, she really felt abandoned and humiliated as in her childhood. In the group, she dared to complain, to express her feelings to be mistreated and blamed people she felt had offended her. During the reenactment, within her victimhood self-state, her suffering was transformed into overpowering and displaced aggression towards Rachel, the member most close to her, the one who usually supports her. Furthermore, in this session, Eve didn't reciprocate the empathic witnessing and the concern she received. Within the resonance in the group (resonance is a therapeutic factor in group analysis), the group as a whole shifts to a victimhood self-state (perpetrators and victims within the group). Within the group, voicing injustice and vulnerability give space for collective identity and a basis for unconscious competition between the members. Victimhood aggression seemed to be transmissible: members expected to be witnessed and supported. The emotional ability of the group to contain otherness lessened. 'The term 'otherness' refers to the presence of any person as a distinct, other human being' (p.250).

4. Effects

A therapeutic context that recognizes the suffering a person endured, that contains elements of empathy, compensation and affirmative action allows recovering processes. The therapy group offers a healing environment which generates recognition, containment and compassion for the traumatized person. The group context is a safe space in which a person feels belonging, understood and protected. The group members become empathic witnesses to the traumatic experience someone endured alone. In the analytic group dissociated self-states may be recognized, remembered and pointed out by other participants (p. 247). In this supportive and safe context, a victim may re-experience post-traumatic dissociation and the denied feelings of humiliation, shame and rage. Working through these feelings, the post-traumatic person feels re-empowered, ego-strengths may be partly restored and inner resources reactivated.

Source: Berman, A. (2014). Post-Traumatic Victimhood and Group Analytic Therapy: Intersubjectivity, Empathic Witnessing and Otherness. *Group Analysis*, 47(3): 242–256.

Good Practice 17

Learning from Strangers: Ethnopsychiatry in Practice

Responsible partner: *Institute of Group Analysis Athens (Greece)*

Author: *Grandsard, C.*

Keywords: *clinical setting, ethnopsychiatry, psychotherapy with immigrants and refugees, social attachments*

1. Description of the event

This is the keynote lecture given by Catherine Grandsard at the 17th GASI Symposium in Berlin, 2017. The title of the event was Crossing Borders—Social, cultural and clinical challenges. The lecture refers to the clinical work at the Georges Devereux Centre in Paris, France. The centre is a research clinic which is directed and founded, in 1993, by Professor Tobie Nathan. The people assisted in this clinic are foreign parents and their children (French-born or not), unaccompanied foreign minors, Holocaust survivors (former hidden children) and their families, and intermarried families. At the beginning, ethnopsychiatry was a specific research area within anthropology as Georges Devereux (1908-1985), a Hungarian-born French ethnologist and psychoanalyst, defined it. Ethnopsychiatry focused on the cultural modes of interpreting and treating disorders. For Devereux, every human society determines normative behaviour and defines deviance from the culturally admissible behaviours. He also defined these cultural repertoires of deviant behaviour and related treatment, as 'psychiatries'. Healing practices related to specific social groups and cultures are 'ethnopsychiatries'. Tobie Nathan was Devereux's doctoral student and close collaborator. Nathan's aim was to create a clinical setting operating with ethnopsychiatric principles, including all healing methods without disqualifying anyone. In this Good Practice, it will be described as one of the two case examples reported in the article. The examples illustrate how in this kind of clinical setting, a therapist and a caseworker must put aside their own assumptions in order to understand healing practices of peoples' natural group and consequently to find new solutions to the problem with the patient and his natural group.

2. General conditions of the victims/group

Abdoulaye was a 17-year-old adolescent refugee from Senegal. One year ago, he arrived in France as an unaccompanied minor, now living in a foster home and still speaking a little French. After a violent fight with a mate, an unaccompanied minor from Afghanistan, his caseworker took him to the clinic. He had never been violent before this incident.

3. Intervention: focus on the method

The intervention consisted in 4 sessions, each lasting 2 hours, in a period of 5 months. The team was composed of four professionals: two psychologists, a social worker and a translator/cultural mediator or 'ethnoclinical mediator'. Here is the description of the first session/meeting.

The author, Catherine Grandsard, was the designated leader for all the sessions. Abdoulaye's case worker also took part in all the sessions. In the first session in front of Abdoulaye, Grandsard in the role of leader asked the caseworker to introduce him to the team. She told them that he was 'a serious young man, trying to adapt as best he could to his circumstances as an unaccompanied foreign minor in France' (p. 273), that he arrived one year ago and never being violent until now. Furthermore, when she asked Abdoulaye about the fight, he was not able to explain the episode. Instead he spoke about the terrible experience during the boat trip on his way to Europe, and about sleep problems. The colleague of the team who was from Senegal and having the role of ethnoclinical mediator translated into Soninke, Abdoulaye's native language.

Later, they asked Abdoulaye to describe his journey to Europe. He left his hometown after his father's death. He was the oldest of 5 children, wanting to support his siblings he told his mother that he will find work in a larger town without telling her about his oversea plan. He worked in a coastal town for a few months in order to pay for the journey on a boat to the Canary Islands. The boat was overloaded with undocumented migrants. The motor stopped. The weather was very hot, 5 young people in Abdoulaye's age, died from heatstroke and dehydration and their bodies were thrown overboard. When the motor was repaired, they succeeded to reach Spanish water where they were rescued.

The team asked about his symptoms: Abdoulaye referred that when he looked at himself in a mirror, he saw the scars left by the salt water and the burning sun. But 'the faces of the dead boys would appear before his eyes. He felt his personality had changed: he incessantly thought about death, kept wishing the five boys had been properly buried instead of thrown overboard; he had nightmares, and often felt depressed' (p. 274). At that point, the paper's author, asked to her colleague-ethnoclinical mediator, if there was a word in Soninke to describe Abdoulaye's symptoms. He said that there is one, the word 'Kany' which 'means fear, the kind of fear that dislodges a person's soul' (p. 274). Abdoulaye laughed hearing the word in his native language, but he was surprised and relieved to see the interest of the team for a word familiar to him. Then the authors ask the ethnoclinical mediator: 'Who knows how to treat the effects of Kany?' 'A Jaaranda', he replied, using the Soninke word referring to a healer or doctor' (p. 274). Abdoulaye explained that his mother consulted a Jaaranda before his departure. The Jaaranda said he will travel very far, but ensured her that he did every necessary drill to protect her son. Abdoulaye was sure that he had survived because of Jaaranda's actions and his mother's blessing. The team decided to contact Abdoulaye's mother, asking her to visit again the same Jaaranda, and tell him that her son seemed to suffer from Kany. She promised that she will, but hoped they will prescribe her son some medication for insomnia, as they did.

The team at first accepted that Abdoulaye considered effective the healing methods of the Jaaranda, nor the medication or the talking session. The therapeutic strategy was to reconnect him with his family and the social group to which he belongs and is attached to his 'natural' social groups. It was necessary to define the nature of the problem, that was his post-traumatic symptoms. But this is not enough. It is necessary to know if there is a name in his native language for the symptoms, and how his cultural group understands these difficulties. Exploring the concept of Kany which is referred to a disorder provoked by extreme fear, the team didn't interpret it as a psychological state that will improve with medication and/or verbalizing the experience, but they accepted the possibility to involve healing resources of his family and his social group. They accepted that if the notion of Kany made sense for Abdoulaye's experience then an expert in Kany, the Jaaranda colleague, is needed and also that that treatment could be effective for Abdoulaye. They offer a clinical setting in which equal attention is given to all healing methods, 'putting aside the notion of belief', involving the persons who ask for help 'in the process of selecting the conceptual context that will inform their therapy' (p. 276). The author also underlines the role of the Soninke interpreter as cultural mediator; he knows how to present himself and the team promoting trust. To do so, the mediator has to be not only knowledgeable about the cultural ways of Soninke society, but also about French realities and institutions.

4. Effects

After a month, at the second meeting, Abdoulaye didn't present any symptoms. When questioned if he was taking the medicine, he answered in French: 'What for? Now that my mother went to the Jaaranda and he did what was necessary, I don't need them anymore!' (p. 274-275).

Source: Grandsard, C. (2018). Learning from strangers: ethnopsychiatry in practice. *Group Analysis*, 51(3):271-282.

Good Practice 18

The contamination of trauma. Traumatized Minds, Broken Families and Dysfunctional Work Groups: Organizational and Interpersonal Dynamics in Complex Child Welfare Court Proceedings

Responsible partner: *Institute of Group Analysis Athens (Greece)*

Author: *Stevenson, S.*

Keywords: *trauma, group work, group dynamics, family, containment*

1. Description of the event

This article explores trauma and its impact on a work group and why this process was disturbed by uncontained anxiety resulting in professional conflict. Professional work groups engaging with traumatized and dysfunctional families are presented with a disproportionate challenge to an already inevitably painful process that can be an obstacle to balanced decision-making in the children's best interests. Trauma, abuse and neglect can influence the professional culture that condenses around these families. This occurs more often with the most challenging families with a possible history of professional failure resulting in professional conflict, impulsive and poor decision-making due to the occasions that these destructive dynamics have become unmanageable.

2. General conditions of the victims/group

The case study presented is about a traumatized work group, where three young children had been seriously abused by their parents. Trauma was a central experience of all members of this family that stemmed back several generations. The parent's childhoods were particularly traumatic and both of them had suffered severe abuse and neglect whilst in the care of their own families. The parents met and built their relationship when they were both involved in serious drug abuse and dealing. The social services department working with this family was concurrently managing another family who was subject to child protection court proceedings, the outcome of which sparked a great deal of anxiety and blame within the department.

3. Intervention: focus on the method

The entire work matrix had been impacted by intergenerational trauma, namely, the current trauma from the parents towards their own children, as well as the trauma of the professional work group that was hindering the individuals' capacities to think and reflect about the children's best interests. There seemed to be a parallel process of bad and abusive parents being symbolically equated with inadequate professionals, both of whom could not be trusted to keep children safe, as they were so preoccupied with their own battles. In order to manage and maintain appropriate psychological processes within work groups and to enable the members to complete their work tasks, an appropriate reflective and supervisory space needs to be made available to enable the members to observe and engage with the dynamics shaped by unconscious processes.

4. Effects

Failure to recognize these facets of the working environment has the potential to pollute and contaminate a work group matrix in terms of unprocessed projections, projective identifications being enacted or distortions of professional input to the detriment of the child's welfare. Due to the incredible pressure placed on professionals within this process to make reparation, the provision of reflective spaces for professionals involved in complex child welfare court proceedings is essential to enable appropriate decision making.

Source: Stevenson, S. 2022. The contamination of trauma. Traumatized minds, broken families and dysfunctional work groups: Organizational and interpersonal dynamics in complex child welfare court proceedings.

Good Practice 19

Reflections on a Support Group for Doctors Recovering from Long Covid

Responsible partner: *Institute of Group Analysis Athens (Greece)*

Author: *Harte, V*

Keywords: *Group Analysis, support groups, trauma, sanitary staff, recovery*

1. Description of the event

In October 2020 Vivienne Harte was invited by Dr Clare Gerada, in her capacity as Chair of the charity Doctors in Distress (DiD), to facilitate an on-line support group for medical doctors experiencing symptoms of Long Covid. The group was free, through the charity, to doctors at any stage of their career working in the UK.

2. General conditions of the victims/group

About 70 doctors registered and attended the initial webinar and subsequently 3 on-line support groups were set up running alongside each other in break-out rooms. These doctors were experiencing great distress due to the immense uncertainty and fear around their physical symptoms and the impact these had on their whole life, not just their professional roles. Hospital doctors and GP's, as with other front-line health and social care workers were, also, affected due to lack of knowledge about the virus and inadequate appropriate personal protective equipment (PPE) such as masks, visors and clothing.

3. Intervention: focus on the method

The structure of the support group was 10 weekly sessions of 1 hour and 15 minutes. The first session was a webinar where doctors interested in such a group could attend to hear what was to be offered and ask any initial questions, followed by 8 facilitated sessions and ending with a further webinar. The final webinar was the closing session and an opportunity for facilitators and doctors to give feedback to all involved in the experience. Two groups were conducted by group analysts (one a retired doctor) and one by an NHS GP who also works for NHS Practitioner Health. The three facilitators met online with Clare Gerada and the DiD coordinator, Marie Searles, before and after each session for a few minutes pre- and post-check-in.

The support groups, in group-analytic terms, were homogeneous in that they were offered to individuals with a specific identity, medical doctor, attending with a particular issue, Long Covid.

A support group, and one so brief, has its own technical difficulties in terms of achieving the balance between depth of emotional focus and practical educational/psycho-educational dissemination of information. One clear distinction in this group was that all members were very experienced, and in the main, senior doctors and the author, as a non-medical group analyst, had little knowledge of the medical terms used or conditions described. The physical medical focus was initially a new language for the author, despite working in NHS mental health services for many years.

4. Effects

The power of sharing in a safe and open reflective group space enabled them to begin to find emotional strength to develop compassion for each other and potentially heal and recreate a more compassionate medical matrix for themselves.

Source: Harte, V. 2021: Reflections on a Support Group for Doctors Recovering from Long Covid

www.groupanalyticsociety.co.uk/contexts/issue-91/articles/reflections-on-a-support-group-for-doctors-recovering-from-long-covid

Good Practice 20

Building Empathic Bridges: Cross-cultural ‘Maternal’ Attunement in Group Psychotherapy for Immigrants and Refugees

Responsible partner: *Institute of Group Analysis Athens (Greece)*

Author: *Schermer, V.L*

Keywords: refugees, trauma, group work, immigrants, cultural factors, group dynamics

1. Description of the event

With increasing numbers of immigrants coming to Europe, the United Kingdom, the United States, and elsewhere, bringing their diverse cultures, languages, and rituals with them, and sometimes seeking psychotherapy from practitioners within the adopted country, the treatment of immigrants by health care workers, and in particular group psychotherapists, has become highlighted as an important concern.

2. General conditions of the victims/group

It is important to emphasize that cross-cultural relationships and the dilemmas faced by immigrants involve multiple social, economic, political, developmental, and linguistic forces that emerge throughout the life cycle. And what applies to one group of immigrants may not apply to others. This good practice refers particularly to a clinical vignette provided by Leo Leiderman, that of a 40-year-old single Hispanic male (Jose), which reveals some kinds of trauma immigrants may experience.

3. Intervention: focus on the method

Through the initial containment, Jose moved from defensive mistrust to mutual attachment, care, collaboration, and practical problem-solving in the group. Schermer attempts to bring into the ongoing dialogue a meaningful way of understanding non-verbal interactions and contexts and the importance of a maternal care model in healing the suffering encountered by voyagers seeking a new life under difficult and trying circumstances. It is hoped that such understanding will be of some value to group analysts working with people displaced from their place of origin. The interventions followed lie in concepts and their interactions, such as: the culture as an extension and elaboration of the mother-infant relationship, maternal aspects of the group and the therapist, specific functions of maternal bonding and their usefulness to immigrants, attachment and care, companionship and collaboration, creative and practical consciousness, psychological trauma and containment. Clinical supervision and awareness of the particular context are crucial in the treatment of these populations.

4. Effects

This article-good practice points to the importance of pre-symbolic embodied aspects of cultural expression. Working with an immigrant population requires alertness and responsiveness to the pre-verbal kinds of interactions that characterize the mother-infant pair as re-activated in the group. These interactions are not necessarily regressive; rather they are the grounding of all human relations. They are particularly relevant when there are cultural differences such as occur in immigrant groups.

Source: Schermer, V.L. 2021. Building empathic bridges: Cross-cultural ‘maternal’ attunement in group psychotherapy for immigrants and refugees. *Group Analysis*, Vol. 54 (2): 226-243.

Good Practice 21

Post-traumatic Stress Disorder among Healthcare Workers during the Covid-19 Pandemic in Italy

Responsible partner: Association for EMDR in Italia (Italy)

Author: Isabel Fernandez, Marco Pagani, Eugenio Gallina

Keywords: healthcare workers, EMDR, PTSD, COVID-19, humanitarian emergency

1. Description of the case study

The participants are part of a convenience sample made up of 744 health professionals (medical doctors, nurses, administrative staff, intensive care support staff, psychologists): 587 healthcare workers were treated with EMDR, while the other 157 were not treated. From 18 different hospitals and nursing homes involved in the COVID-19 emergency. The sample was collected throughout the pandemic emergency period starting from November 2020 until March 2021.

2. General conditions of the victims/sample

General conditions of the health professionals were measured through two self-report questionnaires. Participants were asked to provide

1. sociodemographic information;
2. post- traumatic symptomatology was evaluated through Impact of Event Scale- Revised (IES-R)
3. level of intensity of emotional activation was used The Emotion Thermometer (THERMO Mitchell et al., 2010) at two time points (pre- post treatment): a visual analog self-assessment scale to collect the level of intensity of emotional activation on a Likert scale from 1 to 10 regarding some main emotional experiences (stress, depressed mood, anxiety, anger, sleep problems, need for help).

It is worth noting that 68% of the investigated subjects had a pathological pre EMDR IES-R score (>33).

3. Intervention: focus on the method

The intervention protocol was designed for online and de visu groups of about 4–6 participants and online through EMDR-IGTP (Eye Movement Desensitization and Reprocessing- Integrative Group Treatment Protocol) (Jarero et al., 2006). Sessions can range from 1 to 1 h and 30 min.

Participants were guided through a safe/secure place exercise or breathing exercises. The EMDR-IGTP leader asked them to think about the worst part of the event (the current crisis) and then to draw that image on the paper provided. They were then asked for the related Subjective Units of Disturbance (SUD) rating and told to write the corresponding number on their picture. After that they were asked to look at their picture and to provide their own alternating bilateral stimulation with the Butterfly Hug. The participants were then instructed to draw another picture of their own choice related to the event and rate it according to its level of distress. Processing continued with the adults looking at the second picture and using the Butterfly Hug. The process was repeated twice more so that each participant drew four pictures and provided a SUD rating for each. The final level of distress associated with the current crisis was then assessed by asking to focus on the drawing that was most disturbing and to identify the current SUD level.

The drawing and the phrase were then paired with the Butterfly Hug. The clients were instructed to close their eyes, scan their body, and do the Butterfly Hug or grounding techniques for the stabilization. And de visu individual session through EMDR standard protocol (Shapiro, 2018). All types of interventions were based on EMDR therapy. Each intervention lasted 3 meetings of about 2 h each carried out over a month, about once a week.

Interventions were managed by one psychotherapist (for session) specialized in EMDR therapy with the aim to reduce the PTSD symptoms.

4. Results

This study demonstrated that interventions with EMDR for this population had a positive effect to significantly decrease PTSD symptoms and symptoms such as stress, depressed mood, anxiety, anger, sleep problems and need for help. This confirms that working with EMDR in emergency situations provokes immediate relief, prevents chronization. Also, the study confirmed that EMDR protocol in all its modalities, both online and de visu, can protect health care workers from the consequences of acute stress.

Source: Fernandez, I., Pagani, M., & Gallina, E. (2022). Post-traumatic stress disorder among healthcare workers during the COVID-19 pandemic in Italy: Effectiveness of an eye movement desensitization and reprocessing intervention protocol. *Frontiers in Psychology*, 13.

Good Practice 22

Supporting Healthcare Workers in Times of COVID-19 with Eye Movement Desensitization and Reprocessing Online: a Pilot Study

Responsible partner: Association for EMDR in Italia (Italy)

Author: Elisa Faretta, M. Ignazia Garau, Eugenio Gallina, Marco Pagani and Isabel Fernandez

Keywords: healthcare workers, EMDR, PTSD, COVID-19, online

1. Description of the case study

Emergencies produce a state of activation that enables rapid rescue attempts. Unsurprisingly, then, therapy experiences with this category of workers have evidenced emotional reactions that include fear, anxiety, and anger, aggravated and complicated by objective, subjective and organizational risk factors. While this is true in general of health field workers, it is a particularly acute problem for health workers operating in nursing homes (RSA). The residents are elderly, weak or vulnerable and need help and support with physical, emotional, relational, and medical/health needs and it was in these structures that the sudden explosion of the epidemic was most overwhelming. As soon as the pandemic hit, nursing home workers were exposed to continuous cumulative traumatic experiences that resulted in repeated activation of extreme stress reactions.

2. General conditions of the victims/group

There were 11 participants: 7 women and 4 men with an average age of 46, divided into two groups therapy of 6 and 5 participants, respectively. All of them had chosen to isolate within the nursing home for the 30-day period from April 1 to April 30, 2020.

Impact of Event Scale-Revised (IES-R) in accordance with the criteria of the DSM IV-TR (Weiss and Marmar, 1997) validated and translated into Italian (Pietrantonio et al., 2003). This psychometric test consists of 22 items. It includes three subscales measuring the following dimensions: intrusion, avoidance, and hyperactivation. Participants were asked to rate their level of post-traumatic symptoms using a 5-point Likert scale ranging from 0 (= "not at all") to 4 (= "a lot") referring to the previous 7 days. The total score between 0 and 88. The cut-off of 33 highlights a high risk of PTSD; in line with the literature, there are no specific cut-offs for scale interpretations.

The emotion thermometer, a non-standardized instrument, used to measure on a scale of 1–10 participants' subjective experience of six emotions and their consequences: stress, anxiety, depressed mood, anger, difficulty sleeping, and need for help.

3. Intervention: focus on the method

The current emergency leads to the use of a group EMDR protocol, as has already been done in many countries worldwide following mass disasters. Group EMDR has been used both on adults and on children and has been adapted in many cases to suit specific contexts and circumstances (Wilson et al., 2000; Korkmazlar-Oral and Pamuk, 2002; Fernandez, 2007; Gelbach and Davis, 2007; Zaghrou-Hodali et al., 2008). The group protocol (EMDR-IGTP) combines standard 8-phase EMDR therapy with a group therapy model (Jarero et al., 1999; Artigas et al., 2000) and uses of a form of bilateral stimulation called the Butterfly Hug (Artigas and Jarero, 2014; Jarero, 2020) along with drawing tasks (Maxfield, 2008). Given the benefits of group therapy and the proven effectiveness of EMDR Integrative Group Treatment Protocol (EMDR-IGTP), we tested an online adaptation of the group EMDR protocol intended to respond to the needs generated by the current emergency, as also reported in recent literature (Luber, 2020; Pérez et al., 2020; Tarquinio et al., 2020; Fisher, 2021). Two programmes of group therapy were carried out. Each consisted of five meetings: an initial pre-test and psychoeducational meeting, followed by three EMDR group therapy meetings, and a final post-test and debriefing meeting.

The interventions were conducted by therapists trained in EMDR, at a Consultant level (certified by EMDR Europe Association). All the meetings were carried out on a virtual conference platform to preserve social distancing.

1. The first meeting (meeting 1) in each intervention was dedicated to introducing the participants, presenting the project and conducting an initial pre-test of emotion and post-traumatic stress levels (IES-R scale and emotion thermometer) and a Critical Incident Stress Orientation Accordingly, the CISO phase of meeting 1 started with normalization of participants' emotional reactions using the symptom grid, followed by introduction of techniques to prevent distress due to acute reactions to stress and to post- traumatic stress disorder.
2. The three following meetings (meetings 2, 3, and 4) focused on the distress and the needs of the team and group EMDR (EMDR-IGTP) treatment protocol was carried out. Participants reported feelings of helplessness, being unable to see their loved ones and at the loss of their normal pre-COVID routines, feelings of absurdity. Sessions can range from 1 h to 1 h and 30 min. The participants were guided through a safe/secure place exercise or breathing exercises. The EMDR-IGTP leader asked them to think about the worst part of the event (the current crisis) and then to draw that image on the paper provided. They were then asked for the related Subjective Units of Disturbance (SUD) rating and told to write the corresponding number on their picture. After that they were asked to look at their picture and to provide their own alternating bilateral stimulation with the Butterfly Hug. The participants were then instructed to draw another picture of their own choice related to the event and rate it according to its level of distress. Processing continued with the adults looking at the second picture and using the Butterfly Hug. The process was repeated twice more so that each participant drew four pictures, and provided a SUD rating for each
3. The last meeting (meeting 5) was conducted using the same procedure as the previous three, but some time was dedicated to post-test administration of the IES-R scale and the emotion thermometer and to allowing participants with EMDR to share their impressions of the experience. The intervention ended with concluding comments and a wrap up.

4. Results

Average scores for the IES-R. It can be seen that pre-test scores were high for intrusiveness $M = 16,18$ ($SD = 6,65$), avoidance $M = 10,18$ ($SD = 8,96$), and hyperarousal $M = 11,18$ ($SD = 6,11$). All the average post-test scores are lower: avoidance $M = 1,18$ ($SD = 1,25$); intrusiveness $M = 1,91$ ($SD = 1,64$); hyperarousal $M = 1,09$ ($SD = 1,04$). The difference between pre-and post-treatment average scores is statistically significant (significance $p < 0.05$): avoidance $p. 0.005$; intrusiveness $p. 0.0000$; hyperarousal $p. 0.0000$.

Participants scored high on the emotion thermometer subscales measuring psychosomatic disturbances, like stress ($M = 7,36$; $SD = 2,73$), anxiety ($M = 6,73$; $SD = 3,52$), sleeping problems ($M = 7,91$; $SD = 2,51$). The high average need for help score shows that the EMDR intervention would indeed potentially be very helpful. Average scores for the same dimensions were lower following the intervention. The difference between pre- and post-intervention scores is statistically significant (significance $p < 0.05$): stress $p. 0.0000$; anxiety $p. 0.0003$; mood 0.005 ; anger 0.001 ; sleep $p. 0.0000$; help $p. 0.001$.

Participants' post-intervention IES-R scores were significantly lower on the intrusiveness, avoidance, and arousal subscales. Post-intervention scores on the emotion subscales also showed significant decreases in levels of stress, anxiety, depressed mood, anger, sleep problems, and perceived need for help. Although preliminary, these results are statistically significant and show that the EMDR protocol we conducted was effective in reducing the effects of stress-induced PTSD as a result of isolation during the COVID-19 pandemic.

Source: Faretta, E., Garau, M. I., Gallina, E., Pagani, M., & Fernandez, I. (2022). Supporting healthcare workers in times of COVID-19 with eye movement desensitization and reprocessing online: A pilot study. *Frontiers in Psychology*, 13

Good Practice 23

Double Infanticide

Responsible partner: Association for EMDR in Italia (Italy)

Author: Giada Maslovarich

Keywords: Group intervention in emergency, 4° and 5° Type victims, Social emergency, Children, EMDR

1. Description of the case study

The father kills his two sons, aged 8 and 2, who were born to different mothers.

The community in the small northern Italian town where the event occurred is distraught.

School in particular requires the intervention of the Association for EMDR in Italy to support parents, teachers and children.

It is necessary to build an EMDR protocol in an emergency setting by identifying who to work with (the different types of victims), what to offer (CISO and EMDR group) and when to offer it.

2. General conditions of the victims/group

114 children aged 6-10 tested through

- Child Revised Impact of Event Scale-Children and War Foundation (1998): 13 items to test posttraumatic activation intrusiveness, avoidance, hyperarousal, hyperactivity.
- The emotion thermometer, in which on six drawn thermometers the level of stress, anxiety, depressed mood, anger, sleep disturbance and need for help can be tested by a scale from 0 to 10.

The mean values of intrusiveness, avoidance and hyperarousal are 7.07; 6.72 and 5.93, respectively.

3. Intervention: focus on the method

The treatment protocol can be very different depending on the

1. resources available (e.g., rescuers, emergency psychology teams),
2. logistical needs (e.g., space, time to meet on victims),
3. characteristics of the traumatic event (e.g., accidental, intentional),
4. nature of the event (e.g., natural disasters, catastrophes, human error, assault, homicide),
5. level of trauma exposure (e.g., victims of first, second ... sixth type)
6. intervention goals (e.g., psychosocial and psychological first aid intervention or trauma-focused intervention).

In this particular case, after careful reading with the elementary school principal and the kindergarten coordinator, it was decided to propose:

In this particular case, after careful reading with the elementary school principal and kindergarten coordinator, it was decided to propose:

- 2 CISO psychoeducation meetings with the parents and teachers of the schools involved.
- 1 to 3 group EMDR sessions in elementary school children's classrooms.
- 1 CISD (debriefing) and group EMDR meeting with emergency workers.
- 1 EMDR group meeting with mothers' group.
- 1 EMDR group meeting with secondary victims (e.g., teachers, fathers, grandparents, school staff...).

4. Focus on EMDR Group protocol: preparation, assessment and awareness

Phase 1 EMDR Group: of clinical history and data. Building the conceptualization of the pathway with EMDR Group.

Phase 2 EMDR Group preparation.

presentation, psychoeducation on trauma reactions, stabilization through deep breathing, grounding and a safe place.

Phase 3: target memory assessment. The four quadrants with drawing and SUD rating of the disorder.

Phase 4 EMDR group: desensitization.

Bilateral movement, butterfly hug and evaluation of the initial memory reproduced on the next three quadrants by reevaluating the SUD (subjective disturbance unit).

Phase 5 EMDR group: Installation.

Reinforcement of the positive aspect: identify a positive thought or pleasant feeling that emerged in the previous steps. Draw the positive feeling on the back of the paper and choose the key word. Optional: the opportunity to share the key words and write a common sentence in small subgroups of 4-5 people.

Phase 6 EMDR Group: Body scan. Observe the body and the major stress points. Propose the "dusting" or "doggie out of the water" exercise to shake these off stress points.

Phase 7 EMDR Group closure. Minutes of free discussion, feedbacks of session, budget, elements of psychoeducation, possible appointments for subsequent sessions

Phase 8 EMDR Group: reassessment of the memory from the previous session through SUD. If the image is disturbing from 0 to 2, it is proposed to change the memory and move on to another disturbing event, otherwise the work on the previous memory is repeated.

5. Results

In the post-test sample, the mean values of intrusiveness, avoidance and hyperarousal are 3.28; 3.32 and 3.14, respectively. The difference between pre-and post-treatment average scores is statistically significant.

At the end of the work, assessments of greater well-being were collected through qualitative methods such as drawings of the positive resources that emerged during the work and a poster board constructed with the drawings and positive resource keywords.

Source: Maslovacic, G. (2020). EMDR di Gruppo. Insieme Verso il Benessere. Protocolli di Intervento.

Good Practice 24

Stabilization Session for Ukrainian Psychologists and Psychotherapists during the War in the Period February-May 2022

Responsible partner: Association for EMDR in Italia (Italy)

Author: Alessandra D'Abramo, Eugenio Gallina

Keywords: Group intervention in emergency, 4° and 5° Type victims, Global impact humanitarian emergencies, War, EMDR

1. Description of the case study

On February 24th, Russia begins a military campaign in Ukraine. Under the coordination of EMDR Europe, the Association for EMDR in Italy offers online stabilization groups to Ukrainian psychologists and psychotherapists. Information about the initiative was disseminated through The EMDR Europe Association and through local Authorities (Center for Psychological Counseling and Trauma Therapy "Open Doors"). Participation was voluntary and free of charge both for participants and for group leaders.

2. General conditions of the victims/group

Only qualitative indicators of the starting status of group participants were collected. Specifically, SUD (Subjective unit of disturbance) was collected at the beginning of the stabilisation session and at the end. On the scale of 0 to 10 in the measurement of disorder, the average SUD score collected out of 100 cases in the early phase of the intervention is SUD < 8 (7.58).

3. Intervention: focus on the method

23 Italian psychotherapists from the EMDR Association in Italy, trained on EMDR group protocol, conducted daily online meetings between 4 and 5.30 p.m. in the period March 4th- May 3th 2022. 46 sessions involving 111 participants from sessions of 2 to 5 participants were organised.

EMDR Group protocol was provided:

Phase 1 EMDR Group: of clinical history and data. Building the conceptualization of the pathway with group EMDR.

Phase 2 Group EMDR: preparation. Presentation, psychoeducation on trauma reactions, stabilization through deep breathing, grounding and a safe place.

Phase 3: target memory assessment. The four quadrants with drawing and SUD assessment of the disorder. The targets that participants worked on were not verbalised.

Phase 4 EMDR group: desensitization.

Bilateral tapping, butterfly hug and evaluation of the initial memory reproduced on the next three quadrants by reevaluating the SUD (subjective disturbance unit).

Phase 5 EMDR group: Installation.

Reinforcement of the positive aspect: identify a positive thought or pleasant feeling that emerged in the previous phase. Draw the positive feeling on the back of the paper and choose a key word. Optional: the opportunity to share the key words and write a common sentence in small subgroups of 4-5 people.

Phase 6 Group EMDR: Body scan. Observe the body and the major stress points. Propose the "dusting" or "doggie out of the water" exercise to shake off these stress points.

Phase 7 Group EMDR: closure. Minutes of how the session went, elements of psychoeducation, possible appointments for subsequent sessions

Phase 8 Group EMDR: reassessment of the image from the previous encounter through SUD. If the image is disturbing from 0 to 2, it is proposed to change the image and move on to another disturbing event, otherwise the work on the previous image is repeated.

4. Effects

Some key words that colleagues wanted to share during the positive resources part (Phase 5): the most recurring ones were:

- Calm
- Strength
- Protection
- Hope
- Love

others were:

- home, warmth, sea, joy, gratitude, acceptance, growth, serenity, friends, sunshine, dignity, flowers, life, family, being alive, HOPE, future, rebirth, healing, victory

Other comments were also collected in phase 7:

- "Thank you for sharing these techniques with us"
- "I was able to cry, I had very strong emotions, now I feel lighter" "emotional focus decreased"
- "I felt a warmth, I imagined my children in the sun"
- "My city is occupied by the Russians, it is impossible to leave the city, some are being deported to cities far away (from the Ukrainian border), they cut electricity and shut down gas stations and internet, I heard that many trying to escape these days were killed. The problem is that we don't have money and resources. Many were on Russia's side, but then seeing what was happening they understood."
- "I pray every day to be able to hug my son again, who enlisted as a volunteer."

Sources: <https://notizie.tiscali.it/salute/articoli/ucraina-emdr-europe-aiuto-psicologico-profughi-supperto-esperti-locali/>
https://www.adnkronos.com/ucraina-emdr-europe-aiuto-psicologico-a-profughi-e-supperto-a-esperti-locali_6Kj9Cdd6MsBAO3GiHLdISE

Fernandez I., Dare sollievo, fare prevenzione e promuovere la salute mentale in un contesto di guerra. Il contributo della terapia EMDR in Rivista di Psicoterapia EMDR, anno XX, settembre 2022, n°42, pp. 27-30

Good Practice 25

Psych.E.In. Transnational meeting Early Psychological Intervention: Models and Approaches in the Three Phases of Crisis

Responsible partner: Association for EMDR in Italia (Italy)

Author: Serena Zucchi, Francesca Bascialla, Isabel Fernandez

Keywords: Training for psychologist and psychotherapists, victims, Emergencies, PTSD, EMDR intervention

1. Scenario

Early Psychological Intervention is becoming an increasingly indispensable skill in the psychologist's career path. This has been largely related to the unexpected situation of the Covid 19 pandemic and to the war in Ukraine, which made it necessary to quickly prepare a huge number of qualified personnel to reduce the psychological distress and the traumas associated with these events.

Psych.E.In. Psychological Early Interventions: clinical training is a European project funded by the Erasmus plus KA 202 call for the construction of strategic partnerships for training and vocational education in the period 2020-2023 (project number: 2020-1-PL-KA202-082075). It stems from a growing demand which began in 2020, to prepare psychologists and psychotherapists for the urgent field work of early psychological intervention. The project is led by the Polish University of Jan Kochanowski of Kielce, a leading partner, and involves a consortium of six other partners from five member countries of the European Community: the Association for EMDR in Italy (IT), Asociace klinických psychologů České republiky (CZ), The University of Prescká (SK), Institut Alfred Adler de Paris (F), Institut of Group Analysis Athens (EL) and Pixel Cultural Association (IT).

More than forty European and non-European associated partners (Universities, Schools of Psychotherapy, Scientific Associations, Scientific Publishing Houses) are also involved, sharing the aims of the project and being committed to its dissemination among their members, clients and students.

Psych.E.In. consortium has produced three intellectual outputs (I.O.):

- I.O. 1: MOOCs, two free, open online basic courses on Early Psychological Intervention
- I.O. 2: Field intervention toolkits
- I.O. 3: Collection of case studies

In order to disseminate the theoretical and methodological assumptions of early psychological interventions the Association for EMDR in Italy organised an online training course for partners and associate partners of the Psych.E.In. project in a three-session event on May 29th-31st, 2022.

2. Participants involved

Target of the Online Transnational Training Course are the members of Psych.E.In. consortium and of the Associated partners. Newsletter, Social Media and local newspapers spread news of the event.

Analysis of training needs

"Sharing is caring" is the mission that inspired Psych.E.In. consortium and specifically the Association for EMDR in Italy as a result of a needs analysis conducted among its members, those of associated partners and local stakeholders. Analysis of data streams about training needs conducted during both the design phase of the project proposal and the design phase of the training event were the tools to detect the potential impact of the event.

3. Training settings

The online training event was located within the framework of the Psych.E.In. Training Course organised in Milan on May 29th-June 1st, 2022 by Association for EMDR in Italy. The course included four closed-door in-person sessions reserved for Psych.E.In. partners and three pre-evening online sessions open to all members of the recipients involved. The event was held in English with simultaneous translation into Italian.

4. People involved

A total of 1,600 psychologists and psychotherapists participated in the three days: 800 on the first day (Sunday) and as many on the next two days.

5. Trainers: preparation

The consortium Psych.E.In., by means of the three training courses illustrated (MOOC, Toolkit and Case Studies), intends to offer a trans-theoretical framework on clinical and organisational basic knowledge, skills and competences in Early Psychological Interventions. In that frame experts of different approaches were invited as keynotes to illustrate the three phases of emergency response: the pre phase, the acute phase and the follow up phase.

Specifically, pre phase intervention in emergency were illustrate by Carla Penna, psychoanalyst, group analyst (Brazil) and Roger Solomon, EMDR USA Director (USA). Acute phase was escribed by Dorota Merecz-Kot, University of Lodz (Poland) and Gary Quinn, EMDR Institute (Israel) and the follow up phase intervention and results were described by Marina Mojovich, Gas Belgrad training group analyst (Serbia) and Isabel Fernandez EMDR Europe and Italy president (Italy).

6. Duration

Three days from 4.15 to 7.00 p.m. Total hours: 8.15

7. Follow up

A follow-up session was not planned. Indicators of impact of the event were collected through the registration of those who accessed the website to the intellectual products available at the time of the event: 350 new users were registered.

8. Effects: assessment of learning outcomes

Perceived satisfaction

No satisfaction questionnaires were provided with respect to the event. However, comments and questions were collected through an open chat during the course. Each speaker was able to answer a couple of questions, and the responses to the unanswered questions were posted on the project page dedicated to the event:

<https://psychein.pixel-online.org/conferences.php>

Outcome

The course develops distinct and complementary languages and methodological approaches, as well as management tools to enhance networking and multidisciplinary work in responding to different types of rescue requests.

Particular attention is paid to vulnerable populations such as children, adolescents, pregnant women, the elderly, people with physical and mental challenges and to rescuers in the different phases of the intervention: preparation, acute phase and follow up.

Focus on the values of equity, human right and accessibility to resources was made by speakers and to promptly recreate a new balance in life and in the community after mass disasters or critical events and to support the resilience of the community in any phase of a crisis: pre crisis phase, acute crisis phase and follow up phase.

- Pre crisis phase: this is the phase before the critical event, it is fundamental to reduce risks and mitigate the impact of a crisis.
- Acute crisis phase: this phase represents the essence of the intervention in case of emergency, it varies from a time immediately following the event to the first 72 hours. In recursive events (e.g. epidemic) the acute phase can last over a period of time.

Project Number: 2020-1-PL-KA202-082075

- Follow up phase: this is the time to capitalise on the lessons learned in emergency intervention to define future strategies and policies. The post-crisis phase makes it possible to sensitise the community towards preventive culture.

In summary, this training course offered tools and guidance on intervention models and protocols which can develop psychologists' and psychotherapists' skills in emergency psychology, applicable in the field of mental health, public health promotion and prevention.

Good Practice 26

Cognitive Restructuring, PTSD, and Severe Mental Illness

Responsible partner: University of Presov (Slovakia)

Author: Kim T. Mueser, Jennifer D. Gottlieb, Haiyi Xie et al.

Keywords: individual intervention, Victim 1^o type, various types of trauma, severe mental illness, PTSD, cognitive restructuring

1. Description of the event

Treating posttraumatic reactions and PTSD in people with severe mental illnesses such as schizophrenia or bipolar disorder could be problematic and more difficult. CBT approach is widely applied in treating posttraumatic reactions and PTSD and seems to be effective. A brief CBT intervention (3 sessions) composite of breathing retraining and psychoeducation is often applied. Full CBT intervention (12 to 16 sessions) is extended especially for cognitive restructuring. Cognitive restructuring is a technique that helps people change the way think about things that worry or frustrate them, using several steps, e.g., the Socratic method, or identifying and preventing "thought errors".

2. General conditions of the group and measures

201 people with severe mental illness such as schizophrenia, schizoaffective disorder, major depression or bipolar disorder, and PTSD based on the SCID for DSM-IV were randomized using the RCT approach to 3-session or 12- to 16-session CBT treatment intervention. The primary measured outcome was PTSD symptom severity (using CAPS, Weathers et al., 2013). Secondary outcomes that were measured were PTSD knowledge, posttraumatic cognitions (PTCI, Foa et al., 1999), anxiety (BAI, Beck & Steer, 1993), depression (BDI-II, Beck et al., 1996), positive and negative affectivity (PANASS, Kay et al., 1987), quality of life (QOLI, Lehman et al., 1995), and global functioning (GAF, Jones et al., 1995). Measuring were carried out at baseline, post-treatment, and 6- and 12-months post-treatment.

3. Intervention: focus on the method

The three-session intervention was designed to provide the same breathing retraining and educational component of the CBT approach, but without cognitive restructuring. In addition, video and discussion about the causes and nature of PTSD were used. 12- to 16-session interventions were extended for cognitive restructuring and after the first three identical sessions, the remaining 8-12 sessions focus on e.g., identifying, evaluating, and changing inaccurate and distressing thoughts, including trauma-related beliefs.

4. Effects

This study shows that the patients who received full 12- to 16- session CBT with cognitive restructuring experienced significantly greater reductions in PTSD symptoms, lower rates of PTSD diagnosis, and greater improvements in knowledge of PTSD, global and social functioning compared to patients who received brief 3-session CBT without cognitive restructuring.

Refrence: Mueser, K. T., Gottlieb, J. D., Xie, H., Lu, W., Yanos, P. T., Rosenberg, S. D., Silverstein, S. M., Duva, S. M., Minsky, S., Wolfe, R. S., & McHugo, G. J. (2015). Evaluation of cognitive restructuring for post-traumatic stress disorder in people with severe mental illness. The British journal of psychiatry : the journal of mental science, 206(6), 501–508. <https://doi.org/10.1192/bjp.bp.114.147926>

Good Practice 27

Cognitive Restructuring and Imagery Modification

Responsible partner: *University of Presov (Slovakia)*

Author: *Regina Steil, Kerstin Jung, Ulrich Stangier*

Keywords: *individual intervention, Victim 1° type, social humanitarian emergencies, child sexual abuse, PTSD, cognitive restructuring and imagery modification*

1. Description of the event

Childhood sexual abuse (CSA) is a traumatic event that often causes mental health problems in later adulthood. In clinical practice is shown that many survivors of CSA suffer from a feeling of being contaminated (FBC). Survivors of CSA, for example, could feel disgusted when touching, looking at, or thinking about their own bodies. In addition, the survivors of CSA often worry that others can see that they have been abused. Cognitive restructuring is an effective approach to correct the patients' dysfunctional appraisal relating to the FBC. Imagery modification is effective in the modification of implicitly stored associations related to affective reactions.

2. General conditions of the group and measures

The study includes nine female patients that met the following inclusions criteria: being 18-65 years old; having PTSD measured by clinical interview according to DSM-IV; suffering from an FBC – operationalized as feeling dirty because of the CSA, disgusted by their own bodies or trauma-related body parts, or being convinced that there are still remains of the perpetrator's body fluids in or their bodies; surviving CSA defined according to American Psychological Association - CSA as sexual assault of a minor or sexual activity between a minor and an older person with the older person using the dominant position to coerce or force the younger person. Exclusion criteria were: receiving psychological intervention at the time of the study; lifetime diagnosis of schizophrenia; schizoaffective disorder or bipolar disorder according to DSM-IV; body mass index smaller than 16.5; drug dependency during the time of the study; having mental retardation. Three times – a) before the intervention, b) post-intervention, c) six weeks after the intervention, using self-rating scales the intensity, vividness, and uncontrollability of the FBC, related distress to FBC as well as PTSD symptoms by PDS (Griesel et al., 2006) were measured.

3. Intervention: focus on the method

The intervention comprises a treatment session and a booster session. During the first intervention session: a) therapist and patient examine the characteristics of FBC; b) patient instructed by the therapist makes your own research on the internet on how often the patient's dermal and trauma-related cells have been rebuilt completely since the last contact with the perpetrator; c) discuss this information with a therapist; d) developing own imagery of skin renewal; e) guided activation of the FBC and the related distressing images and using own idiosyncratic imagery of skin renewal; f) as homework – at least once a day over a period of seven days listens to a tape of the guided imagery modification session and complete homework protocols.

In the booster session (about 11 days after the treatment session), the effects of the treatment, problems in using the method, and implementation in everyday life were discussed.

4. Effects

This study shows that significantly decreasing in intensity, vividness, uncontrollability of FBC, distress related to FBC, as well as PTSD symptoms with a large effect size (Cohen's d ranged from 0.99 – 2.79) comparing pre-intervention and after six weeks measures.

Reference: Steil, R., Jung, K., & Stangier, U. (2011). Efficacy of a two-session program of cognitive restructuring and imagery modification to reduce the feeling of being contaminated in adult survivors of childhood sexual abuse: a pilot study. *Journal of behavior therapy and experimental psychiatry*, 42(3), 325–329. <https://doi.org/10.1016/j.jbtep.2011.01.008>

Good Practice 28

Acceptance and Commitment Therapy in Treatment-Resistant PTSD

Responsible partner: *University of Presov (Slovakia)*

Author: *Michael P. Twohig*

Keywords: *individual intervention, Victim 1° type, various types of trauma, treatment resistant, PTSD, acceptance and commitment*

1. Description of the event

CBT based treatment and intervention for PTSD show strong pretreatment-to-posttreatment effect sizes and seems to be effective in reduction PTSD symptoms in almost two third of people with these mental health issues (Bradley et al., 2005). In one third of trauma survivors with PTSD-related problems is necessary to look for some other treatment that can be effective for them. Acceptance and Commitment Therapy (ACT; Hayes et al. 1999) has been reaching increased attention as a treatment approach that could be useful for the person that are resistant to the standard CBT approaches. ACT expand traditional CBT approach by targeting the function of thoughts, feelings, and bodily sensations using acceptance and mindfulness procedures.

2. General conditions of the group and measures

The effect of ACT was examine in Tracy – 43-year-old Caucasian woman who received various psychotherapy sessions with three different therapists in last 20 years. Tracy during her childhood was abused by her mother and had father abused alcohol. Tracy was the recipient of regular and unpredictable physical and verbal abuse by her mother. As a result of this abuse she experienced flashbacks and intrusive recollections and dreams of the abuse, suffer from psychological distress, hyperarousal, and other PTSD related symptoms. She completed 20 individual 1-hour sessions of CBT for PTSD after which she showed a gradual reduction in PTSD severity during therapy, but reduction was not clinically significant and she was back at pretreatment levels at the completion of treatment. Thus, she was defined as patient resistant to traditional PTSD treatment. At the baseline, Tracy was diagnosed with PTSD, major depressive disorder (MDD), recurrent MDD, and Eating disorder in full remission using SCID according to DSM-IV. Prior to starting ACT, Tracy completed self-reported measures: anxiety (BAI; Beck et al., 1988), depression (BDI-II; Beck, 1996), PTSD (PCL-C; Ruggiero et al., 2003), psychological flexibility (AAQ; Hayes et al., 2004) and posttraumatic cognitions (PTCI; Foa et al., 1999). Self-reported measures were measured also after 8. session, 16. session, and posttreatment (after 21 sessions).

3. Intervention: focus on the method

Tracy was originally contracted for 12 sessions of ACT for PTSD with the agreement that additional sessions could be added if ACT was useful for her. First two session help Tracy clarify that attempts at controlling thoughts, emotions, and bodily sensations (inner experiences) were generally unsuccessful and they interfered with her quality of life. In next two sessions Tracy noticed that she constantly try to control her inner experiences through avoidance and self-talk. From the 5. session, focused of intervention shifted to acceptance and mindfulness processes, such as acceptance, defusion, self as context and being presented. Tracy start with a acceptance, defusion and behavioral commitment exercises. From 10. session, Tracy continue in exercises and on each session reviewed with the therapist her week and discussed places where her inner experiences stopped her from engaging in meaningful activities. Sessions 17-21 were a maintaining sessions with attendance session every 3 weeks, it helps with the transition from the treatment.

4. Effects

Results showed significant reduction on all measures throughout treatment, except for trauma-related thoughts and beliefs, which did not decrease until near the end of treatment.

Reference: Twohig, M.P. (2009). Acceptance and Commitment Therapy for Treatment-Resistant Posttraumatic Stress Disorder: A Case Study. *Cognitive and Behavioral Practice*, 16, 243-252.

Good Practice 29

Cognitive-Behavioral Conjoint Therapy and Post-traumatic Growth

Responsible partner: University of Presov (Slovakia)

Author: Anne C. Wagner, Lindsey Torbit, Tiffany Jenzer et al.

Keywords: individual intervention, Victim 1° type, various types of trauma, PTSD, posttraumatic growth, relationship satisfaction

1. Description of the event

Surviving trauma leads to experiencing a higher level of psychological distress and in a disposed of person could lead to severe mental health problems such as PTSD. On the other hand, surviving trauma and struggling with trauma could lead in person to positive changes. These positive changes are defined as posttraumatic growth (PTG). During the processing of trauma, social support is important. Social support is one of the sources that could help reduce PTSD symptoms and facilitate PTG. Cognitive behavioral therapy extended to focus on enhancing intimate relationship functioning (CBCT; Monson & Fredman, 2012) seems to be effective to cope with posttraumatic reactions.

2. General conditions of the group and measures

40 intimate couples recruited from U.S. Veteran's Affairs outpatient clinic and a university-based research center were randomized into two groups – a group receiving CBCT and 3-month waiting list group. Inclusion criteria were 18-75 years old; one partner should meet diagnostic criteria for current PTSD according to CAPS (Blake et al., 1995). Exclusion criteria were imminent suicidal, homicidal, or self-injurious behavior within the previous 6 months, meeting diagnostic criteria for current substance dependence, having uncontrolled psychotic or bipolar disorder assessed by SCID for DSM-IV, both partners meeting criteria for current PTSD, or endorsement of severe intimate partner sexual or physical aggression in the past 12 months. At baseline, mid-treatment/4-week wait, and post-treatment/12-week wait, PTSD using CAPS, PTG using PTGI (Tedeschi & Calhoun, 1996), and relationship satisfaction using DAS (Spanier, 1976) were measured.

3. Intervention: focus on the method

Cognitive-Behavioral Conjoint Therapy for PTSD (CBCT) was applied as the target intervention. CBCT is a three-phase, 15-session, manualized, trauma-focused conjoint therapy designed to simultaneously reduce PTSD symptoms and enhance intimate relationship functioning (Monson & Fredman, 2012). In the first phase, the treatment protocol and rationale are presented, and psychoeducation about PTSD symptoms and relationships is provided. The second phase is focused on improving communication, decreasing emotional numbing and avoidance associated with PTSD, and increasing relationship satisfaction. The third phase is focused on making meaning of the traumatic event by re-evaluating the trauma to arrive at an adaptive interpretation of the event. In addition, the treatment involves the completion of assignments between sessions to facilitate skill acquisition and in one of the last sessions, the PTG and its obstacles are discussed.

4. Effects

This study shows that the CBCT for PTSD, reduce PTSD symptoms, enhance relationship satisfaction, and facilitates PTG, even with a limited focus on PTG in this conjoint intervention.

Reference: Wagner, A. C., Torbit, L., Jenzer, T., Landy, M. S., Pukay-Martin, N. D., Macdonald, A., Fredman, S. J., & Monson, C. M. (2016). The Role of Posttraumatic Growth in a Randomized Controlled Trial of Cognitive-Behavioral Conjoint Therapy for PTSD. *Journal of traumatic stress*, 29(4), 379–383. <https://doi.org/10.1002/jts.22122>

Good Practice 30

Cognitive-behavioral Intervention for PTSD and Posttraumatic Growth

Responsible partner: *University of Presov (Slovakia)*

Author: *Christine Knaevelsrud, Alexandra Liedl, Andreas Maercker*

Keywords: *individual intervention, Victim 1° type, various types of trauma, PTSD, posttraumatic growth, cognitive-behavioral intervention*

1. Description of the event

Experiencing a traumatic event could lead to shattering the core beliefs related to the world, others, and self. This kind of experience could cause significant negative changes in mental health, e.g., posttraumatic reactions such as PTSD, depression, or anxiety. Shattered core beliefs could also lead to positive changes, known as posttraumatic growth (PTG). A cognitive-behavioral approach especially sessions focused on cognitive restructuring seems to be effective in rebuilding and redefining shattered core beliefs and helps to recovery after trauma and increase resilience.

2. General conditions of the group and measures

Ninety-six participants aged between 18 and 68 years who had experienced a traumatic event that occurred at least one month prior to treatment and met the DSM-IV criteria for PTSD were randomly assigned to either the treatment or a waiting-list control condition. At baseline and post-treatment, posttraumatic stress reactions (IES-R; Weiss & Marmar, 1997); depression and anxiety (BSI; Derogatis, 1992); posttraumatic growth (PTGI; Tedeschi & Calhoun, 1996); optimism (LOT-R; Scheier et al., 1994); openness to experience (NEO-PI-R; Costa & McCrae, 1992) were measured.

3. Intervention: focus on the method

The intervention consisted of three treatment phases: (1) self-confrontation, (2) cognitive reconstruction, (3) social sharing, and a farewell ritual. In the first phase, patients were educated about the mechanism of exposition and were instructed to describe and write about the most painful images and thoughts related to trauma. They should write in first person and present tense and give a detailed descriptions of all sensory details they had experienced during traumatic events. In the second phase, patients received psychoeducation about the principles of cognitive restructuring. The goal of this phase was to form a new perspective on the traumatic event and regain a sense of control. Participants wrote a supportive letter to an imaginary friend who had been through the same experience. They should reflect the feelings of guilt and shame, challenge dysfunctional automatic thinking and behavior patterns, and correct unrealistic assumptions. In the third phase, patients received psychoeducation about the positive effects of social sharing. In a final letter, they took symbolic leave of the traumatic event. Patients summarized what has happened to them, reflected on the therapeutic process, and described how they are going to cope now and in the future.

4. Effects

This study shows that receiving cognitive-behavioral intervention leads to a significant increase in posttraumatic growth and helps symptom improvements in posttraumatic reactions that significantly predict post-treatment posttraumatic growth. The effect of cognitive-behavioral intervention on more stable factors (optimism and openness to experience) was not observed.

Reference: Yasmin, K., Yaqoob, A., & Sarwer, H. (2022). Effect of Cognitive Behavioral Therapy (CBT) Based Intervention on Resilience and Burnout among Staff Nurses Working in Critical Care Departments. *Pakistan Journal of Medical & Health Sciences*, 16(03), 295-295.