PSYCHOLOGICAL INTERVENTION GUIDE

INTERVENING IN THE CONTEXT OF INFECTIOUS DISEASE OUTBREAKS

This guide was produced as part of the Ebola Virus Disease and Community Mental Health project funded by

IDRC | CRDI
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SSHRC CRSH

IRSC CIHR
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“If you happen to fall down,

learn quickly to ride your fall.

May your fall become the horse you use to continue the journey!”

Franckétienne

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FOREWORD

Initially developed as part of the improvement of psychosocial care in communities affected by the Ebola Virus Disease (EVD), this guide is being made available to professionals in the current global pandemic context of SARS-Cov2 - also known as Covid-19. It is the result of an extensive assessment of needs, both of populations affected by infectious disease outbreaks and of mental health professionals (psychologists, social workers, nurses, psychosocial workers, etc.). These assessments have led us to understand that the mental health of the sick individuals and their loved ones, bereaved families, affected communities, health and hygiene professionals, and all those who are on the front lines of response (including those who organize safe and dignified burials) can no longer be sidelined. Indeed, our research has helped us understand that taking care of the mental health of patients and their families can save lives. When a psychologist in a CUBE in Béni or Mbandaka offers an intensive psychotherapy service to respond to the anxiety of an Ebola virus patient, he not only gives him the opportunity to strengthen his individual resilience and improve his ability to fight and and make it through (Cénat et al., 2019), but also creates the conditions for collective resilience. Thus, when psychosocial workers accompany families through the trial of Ebola or Covid-19, they offer them the possibility of having the best preventive attitudes and a listening ear adapted to the context of uncertainty and anxiety. However, examinations have allowed us to observe that low- and middle-income countries (LMICs) have few psychologists or other mental health professionals. Moreover, the cases encountered by the few mental health professionals and psychosocial workers often exceed what can be addressed with the mental health first aid trainings received (Cénat et al., 2020). Finally, epidemic contexts directly jeopardize the safety of responders and, indirectly, the safety of their loved ones, which may give rise to justified fears, but also conflicts of loyalty between their professional mandate and their family role. These issues must be thought out as a team for them not to become a source of paralysis for the clinician. This guide, for which online training modules will subsequently be created, offers key support to mental health professionals.

FOREWORD

This guide contains 9 modules, some of which must be completed over several sessions. The module 1 presents psychological first aid, which is very useful in an epidemic situation and helps to meet people's immediate psychological and social needs during an epidemic. The second module offers the possibility of extensively assessing the needs of the people being cared for and several possibilities for mental health professionals. In the appendices, a set of assessment tools allows users to evaluate the mental health problems most frequently observed during epidemics of infectious diseases. The next 6 modules address psychotherapy techniques and assisted resilience. The last module addresses self-care because working during an epidemic situation comes with its share of anxiety for mental health professionals themselves and it was essential to take this into account to address their own well-being. If necessary, these modules can be repeated and adapted. For each module, we offer several possibilities to users, depending on the age of the patients and the clients, the difficulties presented, the social supports available, and their particular needs. It is a guide rooted in the work of mental health professionals during epidemics of infectious diseases.

Based on empirical data, this guide is intended to be transcultural. We are committed to evaluating it equally in various locations around the world where it will be used in order to continue to improve and adapt it to the real needs of communities and their cultural specificities. We encourage all those who use it to contact us to continue to enrich, criticize, and improve it. We have planned measures to enable them to do this important work of transcultural evaluation and validation.

To conclude, we would like to express our thanks to all the health (and mental health) professionals who agreed to respond to our interviews and focus groups, as well as to the administrators, community leaders, orphans, widows and widowers, families of sick individuals, and healed who agreed to share their many valuable experiences with us. We would also like to thank the entire team who worked on this guide in Canada, the Democratic Republic of Congo, France and elsewhere, especially those at the University of Ottawa, the University of Kinshasa, the University of Lubumbashi, McGill University, and the Université de Bourgogne Franche-Comté.

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MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

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OBJECTIVES

- Making the initial contact
- Carry-out a brief assessment of how the crisis is affecting the patient and their family
- Provide psychological first aid

MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

DEFINITIONS

Psychological First Aid (PFA): Psychological First Aid (PFA) describes both humane and supportive assistance provided to a person who is suffering and may need support (WHO et al., 2012).

Active listening: Non-directive relational skill and technique aimed at facilitating communication between the caregiver and the person being cared for.

Listen to act: Defined as offering, in addition to active listening, concrete help to the person to allow them to face the crisis they are experiencing. This may involve helping the person obtain information, services, resources, and social support.

MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

1 THE INITIAL CONTACT

2 BRIEF ASSESSMENT

3 PROVIDING PSYCHOLOGICAL FIRST AID

MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

1 THE INITIAL CONTACT

The Initial contact varies depending on whether the person in question is sick. Precautions should be taken to protect oneself or an uninfected family member, health care professional, etc. First contact and psychological first aid in a crisis situation remain the same, except with the sick. Indeed, for the sick individuals, it depends on the contagion level of the disease in question. We know that Ebola virus disease and COVID-19 are highly contagious infections and mental health professionals must take precautions to avoid becoming infected.

A

How do you introduce yourself to a person during an outbreak of a highly contagious disease? There are many strategies that can be used. One technique that has helped during outbreaks of EVD is to have a picture of yourself in a protected container that is only used for that purpose. This is a good way to break the ice.

B

In cases where people have been unconscious, whose physical health has not allowed for psychological intervention, and who are worried about their families, a picture of the therapist with their family members can make a big difference.

C

In any case, be humble, present yourself as someone who is there to listen and help, not as someone who will solve all problems.

MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

2 BRIEF ASSESSMENT

Carry-out a **brief assessment** of how the crisis is affecting the patient and their family.

A

First, determine the patient's profile. You may already know this information before intervening, otherwise it must be quickly determined.

- Is it a family member of a sick patient?
- Is it a family or family member grieving the death of a loved one who passed away from the infectious disease?
- Is it a health or hygiene professional?
- Is he a member of a safe and dignified burial team?
- Also establish a sociodemographic profile

NOTE: Psychological distress differs according to the patient/client's profile. In patients and relatives of patients, anxiety and a high level of stress and fear are the dominant feelings; whereas in families who have recently lost a loved one to an infectious disease, profound feelings of sadness, despair, being overwhelmed, being disoriented and feeling cut off from reality, symptoms of depression, and the first signs of the grieving process are present. In health care professionals, feelings of helplessness, being overwhelmed, stress, anxiety, and despair are also very present.

MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

2 BRIEF ASSESSMENT

B

Carry-out a brief assessment of health and risk of infection

- What is the patient's current condition?
- What is the patient's family's health status?
- This assessment is even more important in cases of community intervention.
- In a facility-based intervention, this assessment remains important to ensure that patient and family contacts are evaluated to reduce the risk of infection.

C

Assess the social support and resources of the patient/client

- Is the family present? What kind of support can the family provide (psychological, social, financial, etc.)?
- Are there friends who can provide support?
- What resources are available in the community?

MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

2 BRIEF ASSESSMENT

D

Assess the person's concerns and listen for symptoms of potential mental health problems

- First, assess the person's concerns
- Next, assess the level of stress and anxiety, feelings of hopelessness, sadness, etc.
- Finally, assess personal and family history of mental health problems

E

Evaluate aspects related to culture and traditions

- First of all, try to detect which of our practices could potentially offend the person
- Next, assess how the culture and traditions could hinder psychological care
- Finally, assess how the culture and traditions can be used to facilitate psychological intervention
- Feel free to use the Cultural Formulation Interview in the appendix. It is a tool that will give you the opportunity to see the person's perspective through their own concerns.

MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

2 BRIEF ASSESSMENT

F

Assessing the patient's strengths

- Assessing resilience, both individual, and community-based
- Self-efficacy
- Look at previous experiences where trauma was overcome

MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

3 PROVIDING PSYCHOLOGICAL FIRST AID

Provide psychological first aid to the person. For the purpose of this guide, we have divided psychological first aid into three main components:

3.1 Be an active listener and bring comfort to the person

3.2 Listen to act

3.3 Use culture and traditions as guides to better adapt

MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

3 PROVIDING PSYCHOLOGICAL FIRST AID

3.1 Be an active listener and bring comfort to the person

A

Do not forget that you are working with people who are going through or have just gone through a difficult experience and who may feel disoriented, anxious, stressed, sad or guilty. Listen to the person with **respect** and free of judgement. Some people will not want to talk right away, respect their silence and the non-verbal expression of their emotions. Be, first and foremost, present for people; sometimes a glass of water or a comforting act will go a long way. Remember to stay aware of your gestures and attitudes. Do not forget to take into account traditions and cultural aspects related to the age, customs, and religion of the person and their community.

MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

3 PROVIDING PSYCHOLOGICAL FIRST AID

3.1 Be an active listener and bring comfort to the person

B

Empathize with the person and the difficult experience they are going through, but also seek to understand how they are feeling within. This allows you to stay in touch with their emotions during the intervention. At this stage, the person needs, above all, to be listened to and understood.

C

Don't be prescriptive, on the contrary, listen, reflect on their feelings, and rephrase. Keep in mind these words of Carl Rogers: “When I have been listened to and heard, I have become able to perceive my inner world with new eyes and move forward. It's amazing how feelings that used to be frightening become bearable as soon as someone listens to us. It is amazing to see that problems that seemed impossible to solve become solvable when someone hears us.”

NOTE: It is important to be informed about the situation before starting an intervention. This will help you better respect the suffering of the person or family. For example, if you are intervening with a healthcare professional who has lost a patient who was once a colleague, ensure that this information is conveyed to you first. This allows you to better empathize from the very start.

MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

3 PROVIDING PSYCHOLOGICAL FIRST AID

3.2 Listen to act

A

Make sure the person is safe

In an epidemic situation, it is important to ensure that the person is safe. Make sure that the person does not pose a health risk to their family or community. Depending on the concerns expressed by the person, it may be useful to inquire about suicidal ideation and other related issues. In all cases, ensure that the person is safe and does not pose a risk to themselves or others.

MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

3 PROVIDING PSYCHOLOGICAL FIRST AID

3.2 Listen to act

B

Help the individual obtain useful information

In epidemic contexts, information is important as it can save lives. In fact, having access to information can make people less anxious. It becomes necessary to take time to inform the person, their families or help them gain access to people holding information.

C

Help the individual obtain services and resources

- It is important to find out about the person's needs and to connect them with the proper resources and services. In the context of an epidemic, this should be done in order of priority. For example, finding out if the person has eaten or has the resources to get food, and making sure their children have something to eat as well. Also, health services may be overwhelmed, it becomes important to inform the person in an ethical manner about services available, while keeping in mind individuals with priority: pregnant women, children, people with disabilities, people at risk, etc.
- It is important to remember the person's loved ones. Although a parent may receive the best services, they will remain worried if they are uninformed of their children's safety and care.

MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

3 PROVIDING PSYCHOLOGICAL FIRST AID

3.2 Listen to act

D

Avoid the breakdown of social support and focus on strengthening it

- It is important to provide clear information to the person about their family's situation. For example, a person who has been infected with Ebola needs to know the status of their spouse, children, parents, etc. Allow the individual to talk to them, and if this is not possible, you can ask them what messages they would like you to pass along to their family.
- The person needs to be able to communicate with their loved ones as quickly as possible. In the case of people who are hospitalized for an extended period of time or people who have been unconscious, one technique that has proven to be helpful during Ebola outbreaks is for therapists to take pictures with family members. In fact, this can be a good way to introduce yourself to the person, especially when you have to dress in protective gear and the patient does not see your face.
- Help the person maintain contact with family and friends, especially in the event of hospitalization.
- Create connections between people that are infected and affected. This will create mutual support that can be sustainable over time.

MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

3 PROVIDING PSYCHOLOGICAL FIRST AID

3.2 Listen to act

Culture must be considered at every step of your interventions

- From the initial contact, to the end of the intervention, taking into account cultural aspects and traditions is essential for the success of psychological first aid.
- Use the Cultural Formulation Interview as a guideline to ensure you are making the situation better and not worse. It is also a good way to use cultural factors and traditions as a lever for the success of your intervention.
- For example, if the person finds the support of religious leaders important, try to facilitate this as much as possible. Instead of a face-to-face meeting, it may be a moment on the phone.
- Do not neglect aspects related to the spirituality of the person.

NOTES:

- Do not force the person to talk. If the person is not ready, just being there constitutes an important support.
- Psychological first aid is not a therapy; the origin of psychological distress is only narrowly explored at this stage. It allows the person to feel heard and comforted. It also reinforces the type of listening that enables you to help the individual by means of action and helping them obtain information, services, resources, and social support.

MODULE 1: PROVIDING PSYCHOLOGICAL FIRST AID: INTERVENING DURING THE CRISIS

REMEMBER:

- Psychological first aid may vary slightly depending on whether it is meant for the sick, families of the sick, bereaved families, or health professionals and other response personnel. However, in all cases, offering the type of listening that enables you to act by providing help and resources to the person is the most important element.
- Often, mental health professionals (and psychosocial workers) wonder where and when to provide psychological first aid. We first answer these questions by stating that psychological first aid should take place during the crisis or immediately afterwards. This can occur in the patient's room, in the patient's CUBE (in the case of Ebola disease), at home or at school. In all cases, the intervention should take place in a safe space that offers some peace and quiet for the person in crisis.

MODULE 2

EVALUATING AND DEFINING AN INTERVENTION PLAN

MODULE 2: EVALUATING AND DEFINING AN INTERVENTION PLAN

SUMMARY OF OBJECTIVES AND ACTIVITIES

OBJECTIVES	GUIDELINES	RECOMMENDED TOOLS
➢ Build a comprehensive profile of the individual and their current situation. ➢ Evaluate the person's experience with EVD, COVID-19 or another disease and identify the impacts (psychological, social, material, etc.) of this experience. ➢ Integrate the principles of observation and listening proposed in psychological first aid, during the initial assessment. ➢ Identify the resources currently available to the individual and explore solutions to fill the gaps. ➢ Define the objectives for the intervention plan. ➢ Define the intervention plan.	Assess the person's physical symptoms. Identify the problem: ➢ Identify the person's motivation for seeking psychological care. Sociodemographic and contextual data: ➢ Assess the physiological needs of the individual and their family (food, housing, health care, etc.). ➢ Identify the cultural aspects that influence the individual's resources, norms, roles, and attitudes (e.g., bereavement practices, religious practices, willingness to seek help, etc.). Lived experience: ➢ Assess the traumas experienced by the individual and their family (including deaths, injuries, bereavement, psychological and social harm.) ➢ Assess the individual's perceptions of the disease, including its cause, perceived consequences, etc.	➢ Quality of Life (WHOQOL-Bref); *A* ➢ Life Events Checklist (LEC); *A, C* ➢ Ebola Virus Disease Exposure Scale; *A* ➢ Ebola Virus Disease-Related Stigma; *C* ➢ Cultural definition of the problem; cultural perception of the cause, the context, and the support; social factors affecting coping and willingness to seek help in the past (based on DSM-5 Cultural Formulation Interview); *A, C* ➢ General Self-Efficacy Scale; *A, C* ➢ Multidimensional Scale of Perceived Social Support; *A, C*

N.B. The italicized letters appearing after the name of the tools indicate the population with which the tool can be used, i.e., *A*: Adults or *C*: Children.

MODULE 2: EVALUATING AND DEFINING AN INTERVENTION PLAN

SUMMARY OF OBJECTIVES AND ACTIVITIES

OBJECTIVES	GUIDELINES	RECOMMENDED TOOLS
	Assess the current state of mental health: ➢ General mental health assessment. ➢ When needed, specific mental health assessment (e.g., PTSD, depression, anxiety, alcohol and substance use, etc.). ➢ Assess signs of distress and dysfunction in the person's everyday life.	➢ General Health Questionnaire (GHQ12); *A* ➢ Kessler Psychological Distress Scale (K10); *A, C* ➢ Suicidal ideations and behaviours; *A, C* ➢ Resilience Scales *A, C* ➢ Coping Strategies (brief COPE); *A, C* ➢ Religious Coping (Brief-RCOPE); *A, C* If necessary: ➢ Beck Anxiety Inventory (BAI); *A, C* ➢ Substance Use Scale; *A, C* ➢ Peritraumatic Distress Inventory (PDI); *A, C* ➢ PTSD checklist (PCL-5); *A* ➢ The Child PTSD Symptom Scale for DSM-V (CPSS-V SR); *C* ➢ Beck Depression Inventory-Short Form; *A* ➢ Children Depression Inventory; *C*

N.B. The italicized letters appearing after the name of the tools indicate the population with which the tool can be used, i.e., *A*: Adults or *C*: Children.

MODULE 2: EVALUATING AND DEFINING AN INTERVENTION PLAN

SUMMARY OF OBJECTIVES AND ACTIVITIES

OBJECTIVES	GUIDELINES	RECOMMENDED TOOLS
	Assess the current state of mental health (continued): ➢ Identify any disruption to the individual's social ties and network (e.g., loss of remaining family members, decreased participation in religious activities, etc.). Current resources and deficiencies: ➢ Identify existing social support structures. ➢ Identify any other current resources that promote resilience. ➢ Identify deficiencies in the individual's current psychosocial resources. Intervention objective: ➢ Issue a diagnosis if one exists. ➢ Establish an intervention objective with the individual. ➢ Propose additional resources to the person.	

MODULE 2: EVALUATING AND DEFINING AN INTERVENTION PLAN

DEFINITIONS

Assessment: The assessment consists of an examination conducted by a psychologist to determine a diagnosis and inform a treatment or intervention plan. The assessment is conducted during the client's or patient's first visits. It may take the form of a structured or semi-structured interview and may include testing.

Case conceptualization: Conceptualization is the application of evidence-based theories to the client's problems while relying on a comprehensive profile of the individual. Case conceptualization is done by the psychologist and allows for the development of the treatment plan.

Treatment plan: A set of intervention methods that will be used in a predefined order for the treatment of the person. The treatment plan includes the objectives of the therapy, the therapeutic approach, and the various activities that will be completed during the sessions.

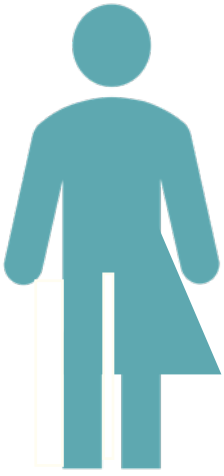
MODULE 2: EVALUATING AND DEFINING AN INTERVENTION PLAN

MODULE 2: EVALUATING AND DEFINING AN INTERVENTION PLAN

1 MODULE OBJECTIVES

The main objective of Module 1 is to conduct a holistic assessment with the aim of conceptualizing the case and to establish, in collaboration with the client (and family, in the case of a child and whenever necessary), an individualized treatment plan that takes into account physical (if infected or not) and psychopathological symptoms, cultural factors, client resources, and social and physiological aspects. This is achieved by ***identifying the primary problems that prompted the client to seek psychological help and by building a comprehensive profile of the person and their current situation by gathering information on:***

Their physiological needs



Their social needs (e.g., food, housing, health care, etc.).

Their psychological difficulties (e.g., symptoms of anxiety, post-traumatic stress disorder, depression, obsessive compulsive disorder, prolonged bereavement symptoms, etc.).

Physical Symptoms
What is their physical condition and symptoms? Have they been infected? Are there people around them who have been infected?

The needs of their family that are currently met and unmet

MODULE 2: EVALUATING AND DEFINING AN INTERVENTION PLAN

1 MODULE OBJECTIVES

Assess cultural factors that may play a key role in conceptualizing the case and developing the treatment plan, including:

- **Identify cultural factors** (e.g., bereavement practices, religious practices, beliefs, and taboos related to seeking help, etc.) **that may play a role in the development and maintenance of symptoms;**

- **Gather information on the client's and their family's perspective of the mental health issues presented using the cultural formulation interview (CFI) from the appended DSM-5** (APA, 2013);

- **Identify cultural factors that can be used as therapeutic levers and include them in the treatment plan.**

MODULE 2: EVALUATING AND DEFINING AN INTERVENTION PLAN

2 WHAT NEEDS TO BE ASSESSED IN MENTAL HEALTH?

Remember that the assessment of mental health problems is the key element for conceptualizing the case and developing an individualized treatment plan. In order to meet this goal, it is important to formally assess the person's mental health, as well as the signs of dysfunction in their everyday life. Mental health assessment is based on the person's complaints and comorbid disorders (for example, in the case of severe symptoms of PTSD, it is important to assess depressive and psychosomatic symptoms). It is important to **assess the client's and their family's experience with Ebola virus disease (EVD), COVID-19 or other diseases.**

Type of exposure to EVD, Covid-19 or other diseases:	Explore possible grief:

➢ Have they been infected themselves? Or Has a family member been infected?
➢ Have they been hospitalized?
➢ Are they a member of a health care team?
➢ Are they a member of a safe and dignified burial team?
	➢ Do they have any relatives who died of the disease?
	  ➢ Family members?
	  ➢ Friends?
	  ➢ Colleagues?

Identify the impact of the disease on the quality of life of the client and their family:	**Identify the impacts of the disease on physical health:**
➢ Did the person lose any material assets? ➢ Did the person lose their house? ➢ Did the person lose their job? *The questionnaire assessing the quality of life in the appendix can be used for this purpose.*	➢ What are the physical consequences left by EVD, COVID-19, in cases where the person was infected?
Assess the client's perceptions of the disease:	**Assess the different forms of stigma related to the disease experienced:**
➢ Including the perceived cause of the disease and infection.	➢ Social Support. ➢ Access to services.

MODULE 2: EVALUATING AND DEFINING AN INTERVENTION PLAN

2 WHAT NEEDS TO BE ASSESSED IN MENTAL HEALTH?

It is also important t***o assess the psychological impacts (including past trauma, such as loss of life, bereavement, etc.) of the EVD, Covid-19 or others.***

This involves carrying out a psychological assessment that takes into account the person's complaints.

In addition to the interview, a number of assessment tools are provided in the appendix. They assess the symptoms of the most prevalent disorders among people affected by EVD and other infectious diseases: depression, anxiety, post-traumatic stress disorder, obsessive-compulsive disorder, etc. You don't have to use them all. Use them as needed.

Remember to ***assess the protective factors available to the client and family.***

The toolkit in the appendix also includes measures for assessing social support, resilience, self-efficacy, etc. Feel free to use them to learn about your client or patient's strengths. Remember that building on the client's strengths is always a good therapeutic lever.

MODULE 2: EVALUATING AND DEFINING AN INTERVENTION PLAN

3 OBSERVE AND LISTEN

Integrate the principles of observation and listening, proposed in the psychological first aid, during the initial assessment.

DEFINITIONS

Observation: Through observation, note the urgency of their needs and the level of distress.

Listening: During each session of the assessment process, set aside time for listening in the form of an unstructured interview. Be attentive to the person's needs and concerns.

MODULE 2: EVALUATING AND DEFINING AN INTERVENTION PLAN

4 IDENTIFY

Identify the resources currently available to the person

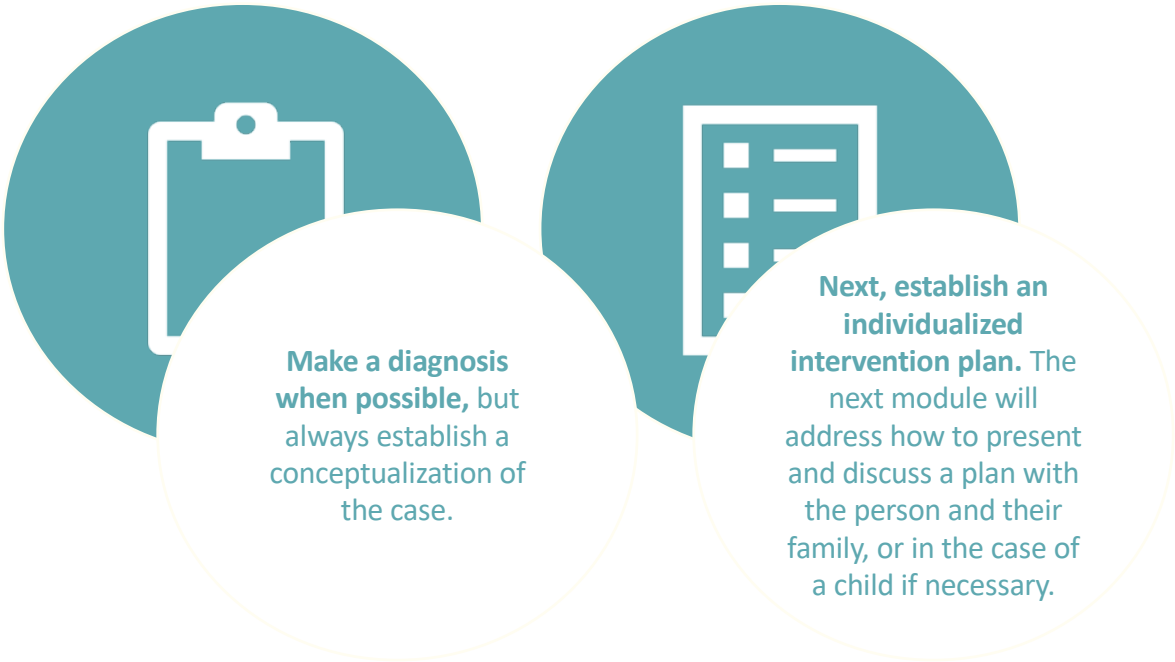
Include social support structures as well as personal and community resilience factors.

Exploring solutions

Seek to fill the gaps in the person's current psychosocial resources. For example, refer them to food kits, facilitate access to testing or to a doctor, help them access survival resources.

MODULE 2: EVALUATING AND DEFINING AN INTERVENTION PLAN

5 ESTABLISH



Make a diagnosis when possible, but always establish a conceptualization of the case.

Next, establish an individualized intervention plan. The next module will address how to present and discuss a plan with the person and their family, or in the case of a child if necessary.

MODULE 2: EVALUATING AND DEFINING AN INTERVENTION PLAN

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

IDENTIFY THE PROBLEM	SOCIODEMOGRAPHIC AND CONTEXTUAL DATA	LIVED EXPERIENCE
▪ Get to know the person's current situation by asking what motivated them to seek psychological care.	▪ Assess the physiological needs of the individual and their family (food, housing, health care, etc.). ▪ Assess psychological needs (e.g., resilience, depression, etc.). ▪ Assess the person's social needs (e.g., death of family members or friends). ▪ Identify the influence of the individual's culture on his/her resources, norms, roles, and attitudes (e.g., bereavement practices, religious practices, willingness to seek help, etc.).	▪ Assess the traumas experienced by the individual and their family (including loss of human lives, injuries, bereavement, psychological and social harm). ▪ Assess the individual's perceptions of EVD, including its cause and perceived consequences, etc. ▪ Identify the role of culture in interpreting the experience and in the perceptions of current symptoms;

MODULE 2: EVALUATING AND DEFINING AN INTERVENTION PLAN

DESCRIPTION OF THE TOOLS TO BE USED

Attached are recommended questionnaires to assess the person's experience with EVD, Covid-19 or others, the person's current state of mental health and more. You will also find a brief description of each measure and its utility, instructions for its use, cultural appropriateness, and steps for interpreting the data obtained.

MODULE 3

PRACTICING PSYCHOEDUCATION

MODULE 3: PRACTICING PSYCHOEDUCATION

SUMMARY OF OBJECTIVES AND ACTIVITIES

OBJECTIVES	GUIDELINES	RECOMMENDED TOOLS
○ Recognize the various determinants of the disorder. ○ Normalize symptoms. ○ Explain the case conceptualization, including the diagnosis, if applicable. ○ Explain the intervention plan and how it will achieve the established objectives. ○ Describe the role of each of the parties in the implementation of the intervention plan. ○ Give Hope.	○ Describe the role of the psychologist, the client/patient (parents, in the case of a child), and the intervention. ○ Normalize the symptoms of mental health problems presented in relation to the illness. ○ Take the opportunity to learn more about the client's symptoms. ○ Discuss the factors that are contributing to the mental health problems. ○ Explain the client's thoughts, feelings, symptoms and behaviours in relation to the case conceptualization. ○ Discuss the client's skills. ○ Discuss therapeutic techniques. ○ Clarify treatment objectives. ○ Present the structure and components of the treatment. ○ Introduce the idea of practitioner/client collaboration.	○ Handouts on psychoeducation of disorders ○ Examples of analogies (alarm...)

MODULE 3: PRACTICING PSYCHOEDUCATION

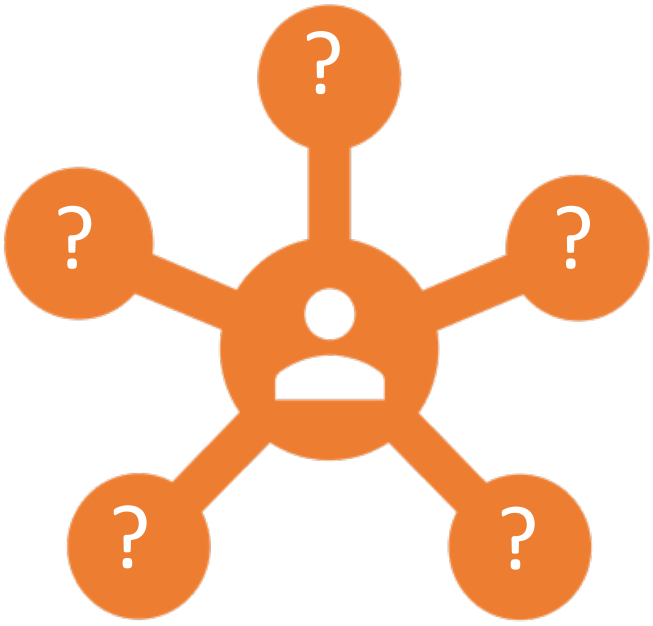
DEFINITIONS

Psychoeducation: The purpose of psychoeducation is to equip clients with knowledge about causes, symptoms, their development and possible treatments. In the case of children, psychoeducation provides parents with the necessary information to understand the causes, symptoms, and factors that maintain them and gives them tools to better help them during treatment. Psychoeducation also aims to give hope to the client (and their family) by providing a better understanding of the problem.

MODULE 3: PRACTICING PSYCHOEDUCATION

MODULE 3: PRACTICING PSYCHOEDUCATION

1 RECOGNIZE



Help the person identify and recognize the various factors that predispose, contribute to, trigger, and maintain the elements related to the disorder or problem they are facing, as well as the individual, family, social, and cultural protective factors.

MODULE 3: PRACTICING PSYCHOEDUCATION

2 NORMALIZE

Normalize the symptoms of mental health problems by explaining to the person that many people at one time or another experience some of these symptoms. Also normalize symptoms in the context of EVD or Covid-19 specifically.

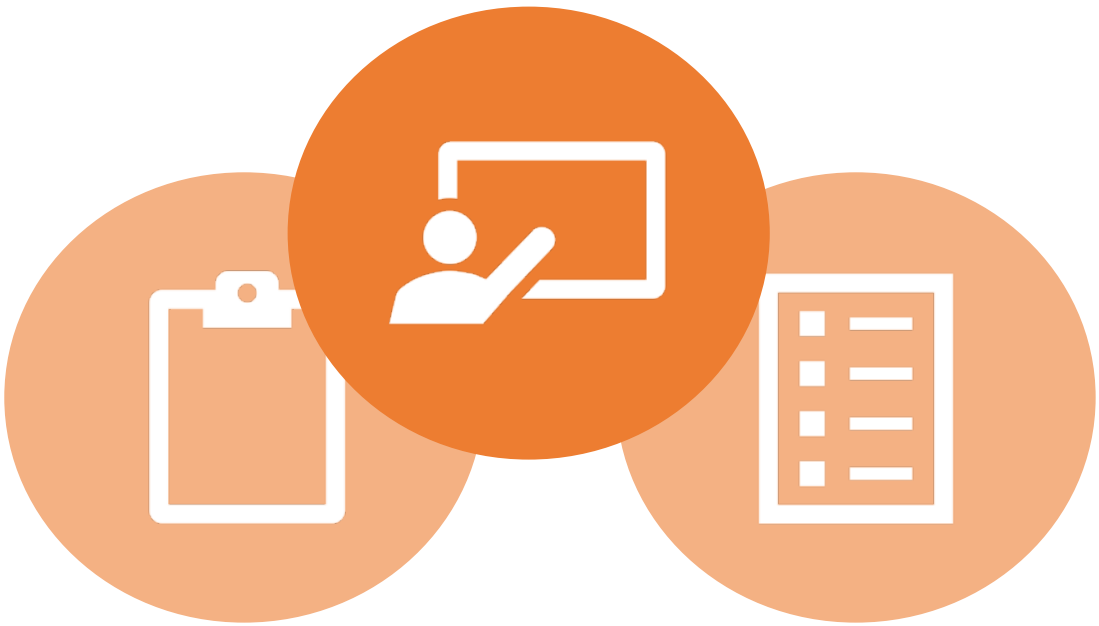
Be sure to indicate that many of the symptoms the person is experiencing are treatable.

In order to meet this objective, the psychologist must give him/herself the opportunity to learn more about the person's symptoms, listen to the person's concerns and worries, and take the time to answer the person's questions.

MODULE 3: PRACTICING PSYCHOEDUCATION

3 EXPLAIN

During the psychoeducation session, it is important to first take a moment to explain the case conceptualization and then, the diagnosis, followed by the treatment plan. Before explaining, consider putting the treatment plan into context by clarifying its objectives. Afterwards, present the structure and components of the treatment. Discuss the therapy techniques that will be used, the skills of the person that will be practiced, and the social supports and resources that will be mobilized.



MODULE 3: PRACTICING PSYCHOEDUCATION

4 DESCRIBE

Describe the role of each party in the implementation of the treatment plan. This includes the role of the psychologist, the role of the person receiving treatment, the role of their family and other social supports, and the role of parents or caregivers when the person receiving treatment is a child.

MODULE 3: PRACTICING PSYCHOEDUCATION

5 GIVE HOPE

An important goal of this module is to give hope to the person through explanations and by making room for questions. By listening carefully, answering the person's questions, and explaining that the symptoms experienced can be improved, you can alleviate the person's fears and concerns. It is always important to give patients or clients hope. This will help them hold on to life!

MODULE 3: PRACTICING PSYCHOEDUCATION

! REMEMBER:

1. Only a physician may prescribe

2. If necessary, do not hesitate to hold two sessions of psychoeducation.

3. As treatment progresses, time should be set aside to continue to explain to the client the difficulties they experience and the course of the treatment plan.

4. Psychoeducation must be adapted to the age, level of education, and to other sociodemographic characteristics.

5. Psychoeducation must be adapted to cultural factors.

6. Give practical tools to the client, exercises to be completed at home.

MODULE 3: PRACTICING PSYCHOEDUCATION

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

DESCRIBE ROLES	NORMALIZE SYMPTOMS	ADDRESS DETERMINING FACTORS	OBJECTIVES AND COMPONENTS OF THE TREATMENT PLAN
▪ Describe the role of the psychologist, the parents, and the intervention.	▪ Normalize the symptoms of mental health problems in everyday context as well as in the context of the epidemic. ▪ Take the time to learn more about the person's symptoms through observations, active listening, and by asking questions.	▪ Discuss the factors (including biological factors) that contribute to the person's mental health problems. In the context of EVD or COVID-19, biological factors can be very important. ▪ Discuss factors that specifically work towards the maintenance of the symptoms of the disorder.	▪ Explain the case conceptualization, including the diagnosis, if applicable. ▪ Clearly state the objectives of the treatment. ▪ Present the structure and components of the treatment. ▪ Discuss the therapy techniques that will be used. ▪ Discuss the person's existing skills that will be practiced. ▪ Introduce the concept of practitioner/client collaboration.

MODULE 3: PRACTICING PSYCHOEDUCATION

DESCRIPTION OF TOOLS TO BE USED

Handouts: In the appendix you will find printable handouts that can be used as a guide during psychoeducation. You will find handouts for some disorders that are likely to be prevalent. Use them as a guide when you are conducting psychoeducation with someone with a disorder not included in the examples. These checklists are intended to help you tailor psychoeducation to the disorders and co-morbidities experienced by the person. You can also write to us at vtrac@uottawa.ca, in case you find certain disorders for which there are no handouts. We will work on developing these handouts.

Analogies: You may sometimes find it helpful to use analogies to illustrate more concretely the person's symptoms, the causes of those symptoms, and the treatment process. You will find some examples of analogies in the appendices.

MODULE 3: PRACTICING PSYCHOEDUCATION

DO'S AND DON'TS IN PSYCHOEDUCATION

DO'S	DONT'S
▪ Ask questions ▪ Use language that is consistent with the client's language ▪ Ensure that explanations make sense ▪ Be alert to questions ▪ Encourage experimentation	▪ Preach ▪ Use professional jargon ▪ Argue or intimidate ▪ Minimize client's questioning ▪ Seek false or premature compliance

MODULE 4

LIVING AND WORKING THROUGH BEREAVEMENT

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

SUMMARY OF OBJECTIVES AND ACTIVITIES

OBJECTIVES	GUIDELINES	RECOMMENDED TOOLS
○ Assess grief and related level of distress; ○ Investigate the individual's interpersonal history (first family relationships, other losses, relationship with the deceased, story behind the death, etc.); ○ Psychoeducation; ○ Establish grief-related objectives; ○ Acknowledging, managing, and accepting the loss; ○ Adjusting to the new life.	1. Understanding and accepting grief 2. Managing emotional pain 3. Envisioning the future 4. Strengthening existing relationships 5. Telling the story of the loved one's death 6. Living with the reminders 7. Connecting to memories	○ Structured questionnaires : Traumatic Grief Inventory (A) ○ Grief Monitoring Journal ○ Emotions Worksheet ○ Imaginal Revisiting ○ Situational Revisiting ○ Reminder of the loved one ○ Imaginal conversation ○ Handouts

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

DEFINITIONS

* Not everyone will have experienced a loss related to EVD or COVID-19. Therefore, this module may not be relevant to some of the clients. *

Grief: The natural emotional response to a significant loss, particularly the death of a loved one. The period of mourning as well as the presentation of grief varies culturally.

Accute grief: Normal symptoms experienced in the months following the loss. Symptoms can be intense and may include: shock, distress, sadness, lack of appetite, sleep disturbances, and trouble concentrating. Symptoms slowly improve over time.

Complicated grief: Grieving symptoms that sometimes last for years without ever seeming to diminish. The loss continues to feel unreal and unmanageable; feeling constant guilt about returning to a normal life without the loved one.

* Possible comorbid conditions : MDD, PTSD, Substance Abuse

Integrated grief: Adjusting to the loss and an evolved relationship with the loved one. The individual envisions a future without the loved one. The individual regains a sense of meaning in life and allows him/herself to experience positive feelings such as happiness in the absence of the loved one.

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

1 MODULE OBJECTIVES

The main objective of this module is to assess grief and the related level of distress.

Symptoms of grief that are persistent, prolonged, and interfere with functioning in the following contexts:

- Personal
- Family
- Social
- Educational
- Professional
- Other

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

1 MODULE OBJECTIVES

The role of the mental health worker is also to guide the individual through the 7 stages of grief:

1 . Shock: A short phase that marks a rupture during which a person does not feel any salient emotions.

2. Denial: Refusal to believe the information; causes internal and external debate.

3 . Anger: A revolt against oneself and others resulting from the realization that the person cannot go back in time. Anger can lead to behaviours that the person does not understand, its level of intensity varies from person to person.

4. Sadness: A state of hopelessness.

5. The Upward Turn : Abandoning the fight against the facts of the new reality. May be accompanied by feelings of helplessness or rejection.

6. Acceptance: Acceptance of loss and gradual return of hope.

7. Reconstruction: A progressive reconstruction of self where the person learns to better know themself and their personal resources in order to prepare their return to their commitments within society.

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

2 INVESTIGATE INTERPERSONAL HISTORY

Investigate the individual's interpersonal history (first family relationships, other losses, relationship with the deceased, story behind the death, etc.);

Encourage the individual to talk to you about his/her relationship with the deceased (the individual may not be ready, respect this).	• What type of relationship did he/she have with the deceased? • Be sure to ask the name of the lost loved one and try, as much as possible, to refer to the deceased by name. This allows for more personal support.
Encourage the person to recount the events surrounding the death	• What details of the death of the loved one are known to the grieving individual? How did the individual learn about the death? Where was the individual when they heard the news? Who was with him/her? What were his/her first reactions after learning of the death? Etc.
Assess the person's well-being since the death	• In what way does the person feel affected by the death of their loved one? How has the person's day to day life changed?
Assess the individual's social support	• Does the individual have a social network that can provide support during the grieving period? • Identify potential sources of support (e.g., parish members, family members, friends, etc.).

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

3 PSYCHOEDUCATION

- Carry out psychoeducation according to the needs of the individual. For example, define normal grief and complicated grief.

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

4 ESTABLISH GRIEF-RELATED OBJECTIVES

- Help the individual set personal grief-related objectives and plan to follow up in future sessions.

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

5 ACCEPTANCE, ADAPTATION, AND RECONSTRUCTION

Recognizing, managing, and accepting loss

- Offer the individual a compassionate approach and active listening so that they can navigate the stages of grief in a safe and trustworthy way.
- Normalize the time it may take before the individual acknowledges the loss as real.
- Normalize the distress and suffering that may accompany the recognition of loss.

Adaptating to a new life and rebuilding one's self

- Guide the individual towards the integration of grief, so that they can once again envision their life without their loved one and resume their daily activities.

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

1. UNDERSTANDING AND ACCEPTING GRIEF	2. MANAGING EMOTIONAL PAIN
▪ Carry out psychoeducation in an interactive manner by encouraging the individual to ask questions during information sessions. ▪ Explain the grieving and coping model/process. ▪ Normalize grief (and thus, the symptoms of grief), explain why people grieve the loss of a loved one, and give hope that effective treatment exists. ▪ Depending on the needs of the individual, the clinician may be able to discuss the variability of grieving symptoms from one person to another; what is involved in coping with loss; the factors that may aggravate grief and hinder the healing process; define the types of grief and the treatment plan being considered. It is important to note that a diagnosis and a treatment plan can bring relief and hope to the bereaved person. ▪ When necessary, explain the symptoms that the person is experiencing using his or her beliefs.	▪ Encourage the individual to recognize that grief is a natural response to their loss. ▪ Encourage the individual to monitor the progress of their grief and the emotional pain associated with the grieving period. ▪ For example, see the tool 'Grief Monitoring Journal'.

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

3. ENVISIONING THE FUTURE	4. STRENGTHENING EXISTING RELATIONSHIPS
▪ Introduce the idea of a promising future even in the absence of a loved one. Have the individual imagine that their grief has reached a manageable level; What does the individual want for themself? The individual must then formulate a plan to achieve these goals. Set aside a few minutes in future sessions to discuss this plan. ▪ Some individuals, especially those with complicated grief, may find it difficult to complete this exercise. In such cases, the clinician could either ask the individual what he/she would want if the deceased was still alive or ask the individual to set goals in an important area of their life, for example, seeking to take better care of their health, learning how to manage their finances, taking a walk in the park, etc.	▪ Encourage the individual to discuss existing interpersonal relationships and to identify at least one person who can serve as a confidant. ▪ When the individual feels ready, encourage him/her to become involved in social activities again. ▪ During the sessions, keep in mind the concept of strengthening social bonds and use opportunities, as they arise, for the individual to identify people who can help them, who they can share with, and who can encourage them to make the most out of themself. ▪ For example, for widowers, this could mean looking for a new partner.

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

5. TELLING THE STORY OF THE LOVED ONE'S DEATH	6. LIVING WITH THE REMINDERS
▪ Although telling the story of the death of the deceased is a tool to facilitate accepting the reality of loss, there may come a time when it is no longer culturally acceptable to continue talking about the deceased in social context. As a result, the individual experiencing complicated grief may feel isolated and feel a lack of social support. It is then useful to invite the individual to tell the story of their loss several times over the course of several sessions (see as an example, the tool "Imaginal Revisiting"). ▪ The purpose of loss re-experiencing exercises is to help the individual come to terms with the painful reality. By reliving the story of the loss repeatedly, the individual will eventually be able to revisit the loss with fewer avoidance mechanisms, emotional reactivity, and a greater sense of coherence.	▪ For many, avoiding reminders of their loved one is a fair solution for managing emotional pain, however, this coping mechanism can result in several constraints in the individual's daily life. Moreover, when treating the symptoms of complicated grief the emphasis must be placed on accepting grief as a normal process rather than trying to avoid it. ▪ For some, simple words of encouragement may be enough to expose them to elements that evoke a reminder of their loved one. For others, "situational revisiting" can be useful. ▪ For some, the first encounters will evoke positive memories in addition to the emotional pain of the loss. It is possible at this point that the individual may remember the benefits he/she has gained from the experience, thus facilitating the next exposure.

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

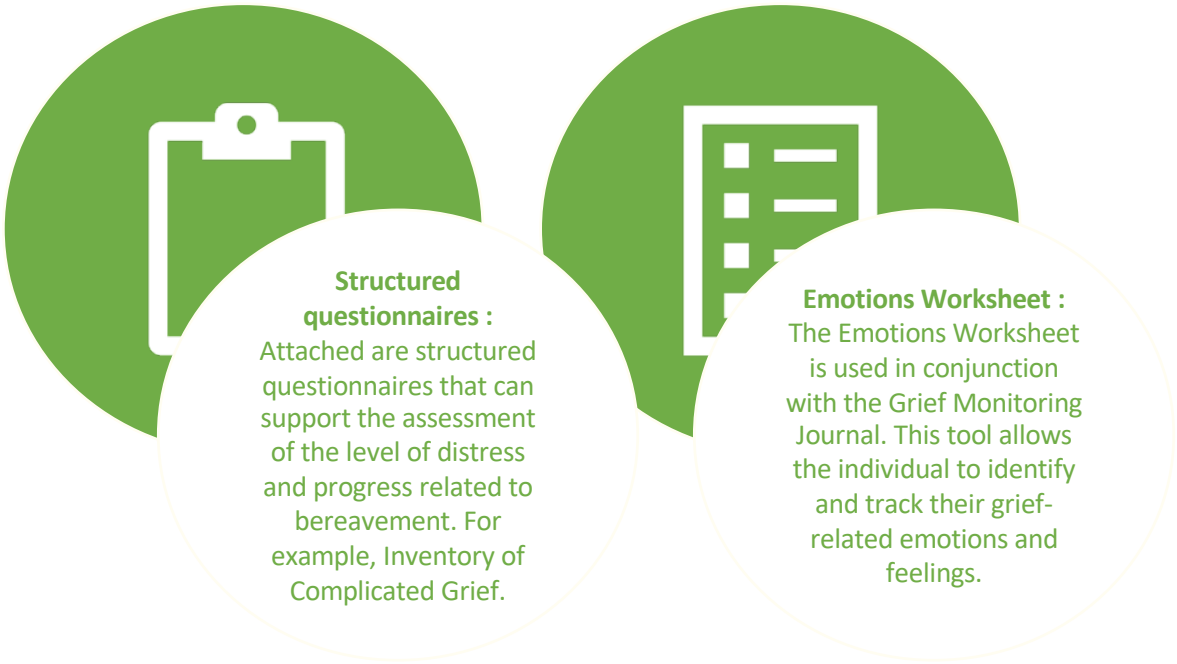
DESCRIPTION OF ACTIVITIES TO BE COMPLETED

7. CONNECTING TO MEMORIES

- Help the person understand that their relationship with their loved one is not over; it continues, although it has changed.
- Discuss the importance of memories in relationships.
- Memories have an important place in our relationships with people when they are alive.
- Memories help create a rich representation of our loved ones and they live on once they are gone.
- Help the individual feel a deep connection to their loved one through memories. For example, using the activity “Reminder of the loved one”.

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

DESCRIPTION OF TOOLS TO BE USED



Structured questionnaires : Attached are structured questionnaires that can support the assessment of the level of distress and progress related to bereavement. For example, Inventory of Complicated Grief.

Emotions Worksheet : The Emotions Worksheet is used in conjunction with the Grief Monitoring Journal. This tool allows the individual to identify and track their grief-related emotions and feelings.

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

DESCRIPTION OF TOOLS TO BE USED

Grief Monitoring Journal:

The journal is used to keep track of triggers, as well as less painful and more painful situations in order to identify recurring patterns that reinforce the symptoms of grief. In this exercise, the individual takes 5 minutes at the end of each day to identify a time in their day when grief was at its highest intensity, giving it a score from 1 to 10, and taking note of the events that were taking place at that time. The same exercise is repeated to identify the time of day when grief was at its lowest intensity. Finally, the individual gives a score for the overall level of grief experienced during the day. At the next session, invite the individual to discuss the days on which he/she felt the most and least intense grief over the past week (or according to the frequency of the clinical sessions).

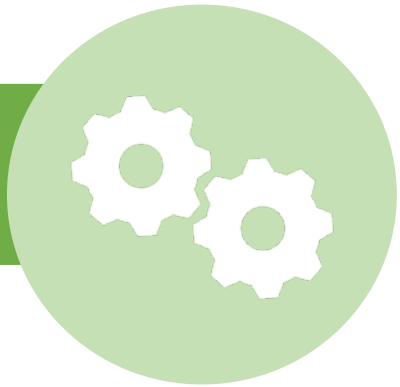
Imaginal Revisiting:

In this exercise, the client takes a few minutes to describe, on a recording device, the moment when he/she became aware of the death of his/her loved one. Following this, the client describes to the psychologist what he/she observed while telling the story. The individual is encouraged to select a reward that he/she will self-administer after each listening of the recording. The individual is encouraged to listen to the recording every day until the psychologist and the individual determine that it is no longer necessary.

The purpose of the exercise is to help the client accept the loss by treating it on an emotional level and integrating this emotional treatment with rational knowledge of the death of the loved one. The debriefing following the recording encourages the client to reflect on the past from a present-day perspective.

MODULE 4: LIVING AND WORKING THROUGH BEREAVEMENT

DESCRIPTION OF TOOLS TO BE USED



Situational Revisiting:
The client identifies activities or places previously avoided because they evoke a reminder of their loved one. The client is encouraged to engage in a situational revisiting the activity every single day.

Reminder of the loved one:
In this exercise, the individual is encouraged to recall positive and less positive memories and aspects of their loved one. It may be helpful for the client to bring photos or other souvenirs of their loved one with him/her.

Imaginal Conversation:
In this exercise, the client imagines that their loved one has just died but has the ability to speak. The client then engages in an imaginary conversation, where the individual plays both the role of him/herself and the role of the loved one.

Handouts:
Attached you will find printable handouts that can be used as a guide during psychoeducation on grief and persistent complicated grief.

MODULE 5

PRACTICING RELAXATION

MODULE 5: PRACTICING RELAXATION

SUMMARY OF OBJECTIVES AND ACTIVITIES

OBJECTIVES	GUIDELINES	RECOMMENDED TOOLS
1. Assess current relaxation practices 2. Educate 3. Master techniques	✓ Ask the person to describe the relaxation techniques he/she currently uses. ✓ Describe the importance of relaxation. ✓ Describe relaxation techniques and give examples. ✓ Provide psychoeducation that is developmentally and culturally appropriate. ✓ Help the individual master the use of relaxation tools and through these exercises, help the individual recognize and manage his/her symptoms of stress.	

MODULE 5: PRACTICING RELAXATION

DEFINITIONS

Relaxation:

Aims of relaxation

- ✓ Achieve relaxation of body and mind;
- ✓ Create awareness of our ability to move from a state of tension/distress to a state of relaxation.

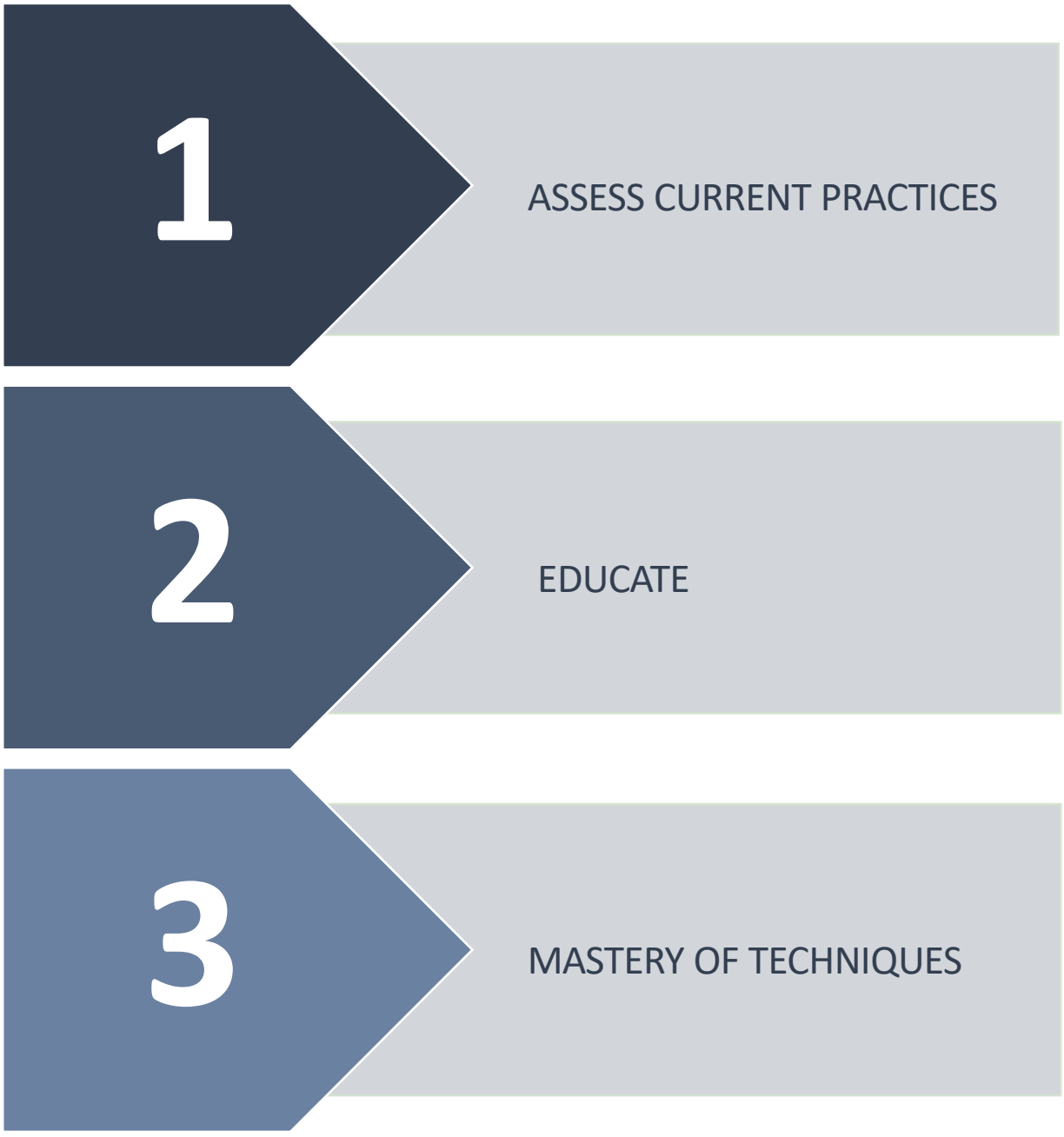
Relaxation techniques

- ✓ Breathing;
- ✓ Progressive muscle relaxation;
- ✓ Mindfulness (e.g., guided imagery).
    - ✓ These techniques are different from distractions such as watching television or videos on the Internet.
    - ✓ A description of these techniques and exercise examples can be found in Module 5 and in the appendices.
- ✓ Muscle relaxation and breathing exercises are bodily techniques designed to induce rest for both body and mind. These exercises are performed in a state of wakefulness and the individual can repeat them at various times of the day.

Impacts of relaxation

- ✓ Physiological impacts: deactivates physiological tension/nervousness/alertness.
    - ✓ Breathing only through the mouth activates the fight/flight/freeze reaction, e.g., running away.
- ✓ Psychological impacts: Triggers take you back to the past; mindfulness takes you back to the present.
- ✓ Relaxation techniques and breathing exercises can be helpful in responding to both the anxiety and the fear of a person sick with Ebola or COVID-19, the healed, family members, but also frontline health professionals.

MODULE 5: PRACTICING RELAXATION



MODULE 5: PRACTICING RELAXATION

1 ASSESS CURRENT PRACTICES

Ask the person to describe the relaxation techniques he/she currently uses.

MODULE 5: PRACTICING RELAXATION

2 EDUCATE

- ✓ Describe the importance of relaxation.
- ✓ Describe relaxation techniques and give examples.
- ✓ Provide psychoeducation that is developmentally and culturally appropriate for the individual.

MODULE 5: PRACTICING RELAXATION

3 MASTERY OF TECHNIQUES

Help the individual master the use of relaxation tools and through these exercises, help the individual recognize and manage his/her symptoms of stress.

MODULE 5: PRACTICING RELAXATION

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

EVALUATING CURRENT RELAXATION PRACTICES

- Ask the person to describe the relaxation techniques he/she currently uses.
- It is important to consider the relaxation strategies typically used, with regards to their culture, by the person and/or their family members in order to manage stress.
- Knowledge of shared cultural values can help you identify the relaxation strategies that will be most helpful to the person. You will find in the appendices a list of relaxation techniques adapted to various cultural groups.

MODULE 5: PRACTICING RELAXATION

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

EDUCATION: EFFECTS OF STRESS RESPONSE

- Explain the response to stress according to the cultural or ethnic group. For example, in individuals belonging to certain Asian, African-American, and Hispanic ethnic groups, symptoms of stress often appear in the form of physical complaints (e.g., headaches, stomach aches, nausea, non-descript pain).

- Make a direct link explaining that by relaxing one's body, an individual can reduce these unpleasant physical symptoms.

MODULE 5: PRACTICING RELAXATION

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

EDUCATION: RELAXATION TECHNIQUES			
Technique 1 : Breathing	*Technique 2: Progressive muscle relaxation*	*Technique 3: Mindfulness*	*Alternative methods of relaxation*
▪ Explain the response to stress according to the cultural or ethnic group. For example, in individuals belonging to certain Asian, African-American, and Hispanic ethnic groups, symptoms of stress often appear in the form of physical complaints (e.g., headaches, stomach aches, nausea, non-descript pain). ▪ Make a direct link explaining that by relaxing one's body, an individual can reduce these unpleasant physical symptoms.	▪ In general, progressive muscle relaxation involves tensing the muscles of the body and relaxing them, one muscle group at a time. It is often recommended to start with the muscles of the toes and progress upward to the muscles of the face. Please refer to the tools section for detailed exercises.	▪ Mindfulness consists of focusing on the present, where we accept it as it is, without judgment, that is, the thoughts that go through our heads, the stimuli in our environment, and the physical and emotional sensations felt.	▪ Alternative methods of relaxation can include meditation, yoga, visual imagery, etc. In sum, any exercise that can lead the person to recognize their stress symptoms and reduce their physiological activation without adopting avoidance behaviors.

MODULE 5: PRACTICING RELAXATION

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

INTERVENTION WITH CHILDREN: ADAPTATION TO THE CHILD'S DEVELOPMENTAL STAGE AND CULTURE

Use creativity when introducing relaxation techniques to children. Ask the child to help you modify the technique to make it more relevant to him/her. In addition, the exercises should be adapted to the child's culture or spirituality, if relevant.

For visual imagery, it is important that visualization exercises use scenes that are familiar and soothing to the person. For example, for recently bereaved children, visualization may include a scene of the loved one.

In addition, the relevance of the exercises should take into account the developmental stage of the child. For example, children 5 years of age and younger rarely have the sustained attention span required for progressive muscle relaxation. Instead, try drawing with the child, which may be a better activity.

You are limited only by your creativity

Every child reacts differently to relaxation training, and preferred methods vary widely. For example, some children will not find muscle relaxation useful, no matter how interesting you make the instructions. However, every child can benefit from learning relaxation. So be creative. We've found that using a variety of relaxation techniques, from dance to creative arts, can be effective in helping children relax. Use your imagination and work with the child to find what works best in each case.

MODULE 5: PRACTICING RELAXATION

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

INTERVENTION WITH CHILDREN: RELAXATION TECHNIQUES

Technique 1 : Breathing

Explaining the rationale

Take the time to explain to the child the importance of these breathing techniques and how they differ from their everyday breathing. The basic reasoning is that breathing will slowly help control their level of tension and distress.

Demonstrating a good positioning of the body

You and the child should be sitting comfortably in chairs with your feet on the floor and your arms by your side. Place one hand on your stomach, under the rib cage, and the other hand on your chest.

Showing proper breathing technique

You should practice a little ahead of time to make sure you demonstrate the technique effectively, so that the hand on your chest remains relatively still while the hand on your stomach rises and falls with your breaths. Don't forget to congratulate the client for a good practice of the technique. Once the child has tried it with a few breaths, ask him or her to slow down the exhalations. This can be done by counting, or simply by focusing on a slow exhalation.

MODULE 5: PRACTICING RELAXATION

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

INTERVENTION WITH CHILDREN: RELAXATION TECHNIQUES

Technique 1: Breathing (continued)

Introducing the word "relax"

Once the child seems to have mastered the slow exhalation, ask them to choose a word to say in their head while they exhale. Good examples are "calm" or "relax". Ask the child to try to only think about breathing and that word. When other thoughts come to mind, the child should try to imagine them floating away.

Ask the child to demonstrate

When the child is ready, he/she will be able to "test" his/her control of the technique. Some children may enjoy lying on the floor with a small toy or paper cup on their stomach (please note that other children may find it uncomfortable to lie on the floor in a room with an adult - use good judgment for your clients. With each breath, the object should move up and down. Don't forget to praise successful attempts.

Controlled breathing may be an inappropriate technique

If, after several attempts, the child simply cannot perform the stomach breathing technique correctly, ask them to focus on slowing down the exhalation and pronouncing the relaxation word without getting too distracted by the stomach and chest movement.

MODULE 5: PRACTICING RELAXATION

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

INTERVENTION WITH CHILDREN: RELAXATION TECHNIQUES

Technique 2: Progressive muscle relaxation

Teaching muscle relaxation to a child

Explain to the child that when people's muscles are not relaxed, we can feel tense, sore or nervous. By relaxing them, we feel calmer and more in control.

Putting the child at ease

Do your best to create a relaxing environment in your office. Make sure the child is in a comfortable position. This will depend on the relaxation technique you use, but generally, for progressive muscle relaxation, the best body position is to lie down or to sit comfortably on a chair.

Demonstrating technique and inducing relaxation

The demonstration will vary depending on the type of relaxation chosen. For younger children, it is often best to do a demonstration of progressive muscle relaxation over the whole body before having the child copy it. For older children, demonstrating the technique for each muscle group and having the child repeat each action works well.

MODULE 5: PRACTICING RELAXATION

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

INTERVENTION WITH CHILDREN: RELAXATION TECHNIQUES

Technique 3: Mindfulness

Mindfulness and meditation strategies can be used to help children relax and can be especially helpful for older children and adolescents. Mindfulness works by helping people focus their attention on the present moment, without judgment, by accepting thoughts, feelings, and sensations. Similar practices such as yoga and prayer can also be useful ways to help adolescents refocus their minds on the present moment. Guided imagery involves working with clients to identify an image or place where they feel safe, calm, and relaxed.

MODULE 5: PRACTICING RELAXATION

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

INTERVENTION WITH ADOLESCENTS: ADAPTING TO THE INDIVIDUAL

Individuals in this age group can generally master breathing techniques, progressive muscle relaxation, and mindfulness and meditation techniques. However, mastery does not guarantee that they will like or use them! Adolescents tend to express a desire to use their own preferred relaxation strategies that they have developed. There is no problem integrating these activities into the relaxation toolkit, as long as you are reasonably sure that they result in a decrease in physiological arousal, not just a simple distraction. Take, for example, an adolescent who likes to listen to violent and aggressive music to "calm down". If this type of music distracts and irritates the adolescent, it is probably not a good idea to use it as part of a relaxation plan.

MODULE 5: PRACTICING RELAXATION

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

INTERVENTION WITH ADOLESCENTS: EDUCATION

How are relaxation exercises useful?

Explain to the adolescent that relaxation is an important strategy for coping with stress, but sometimes it is easier to be told to relax or "loosen up" than to do so. Once we are activated by something, it takes a while for our bodies to return to a neutral state and feel comfortable. The following information can be used to explain to teens the usefulness of relaxation exercises.

The exercises teach us to identify the symptoms of stress in our bodies. You will learn to stretch and relax various parts of your body that often respond to stress with increased physical tension. In doing so, you will learn to recognize when you are stressed and where in your body the stress is affecting you, and also to recognize the sense of relaxation you want to achieve in order to bring your body back to a less agitated state. Then you will learn that you have control over the stress in your body. You have the power to transform a state of tension into a state of relaxation. You will learn how to get into a relaxed state through relaxation exercises that last about 20 minutes. Since it is not always practical to stop a stressful activity and take 20 minutes to relax, you will also learn strategies that you can use "on the spot" to help you reach a state of relaxation instantly. These strategies include using deep breathing, checking the level of tension throughout your body and relaxing the parts of your body that are stressed, as well as using visualization scenes that give you a sense of calm and peace. Finally, relaxation allows us to think more clearly about problems. You will learn how to use a state of relaxation to help you reflect on uncomfortable situations in order to find solutions.

MODULE 5: PRACTICING RELAXATION

DESCRIPTION OF TOOLS TO BE USED

Breathing :

1st breathing technique: connect with your breath to reset it

Inhale an exaggerated quantity.
When the lungs are full, take one more breath.
Breathe out and relax your muscles.
Release the tension.
Repeat 2-3 times.

2nd technique: counting during breathing exercise

I will count 1, 2, 3, 4, 5 when you inhale…And 5, 4, 3, 2, 1 when you exhale.
After you have exhaled and before you inhale again, I will also count 5 seconds.

3rd technique: Record the sensations

Right hand on the belly/stomach, left hand on the heart.
Follow the rhythm of your breathing and the body movements associated with each breath.
Feel your belly resting on your right hand, then your chest on your left hand.
Feel your shoulders and their movements while breathing.
Pay attention to your nose and the feeling of inhaling.
Start noticing the air entering your nose... how cold it is.
Start noticing the air coming out and how warm it is.

MODULE 5: PRACTICING RELAXATION

DESCRIPTION OF TOOLS TO BE USED

Breathing :

4th technique: Breathing 4-7-8

Andrew Weil, a specialist in alternative medicine, drew inspiration from the principles of yoga to develop his technique. Here's how it works:

1. You can do this exercise in any position, but you can sit down, keep your back straight and your feet on the ground. Then, touch your palate with the tip of your tongue, just behind the upper incisors. And hold this position during the exercise.
2. Breathe out all the air from your lungs through your mouth. You are now ready to experiment with 4-7-8.
3. Close your mouth and breathe in quietly through your nose, counting (in your head) to 4.
4. Hold your breath by counting to 7.
5. Breathe out loudly through your mouth while counting to 8.
6. Repeat this 4-7-8 breathing technique three times.

5th technique: Wim Hof Breathing Technique

Take a quick deep breath in through your nose and quickly exhale through your mouth.
Repeat 30 times without pausing between each repetition.
After 30 repetitions, take a deep breath in, out and hold for 60 seconds.
Repeat this cycle 3 times.

MODULE 5: PRACTICING RELAXATION

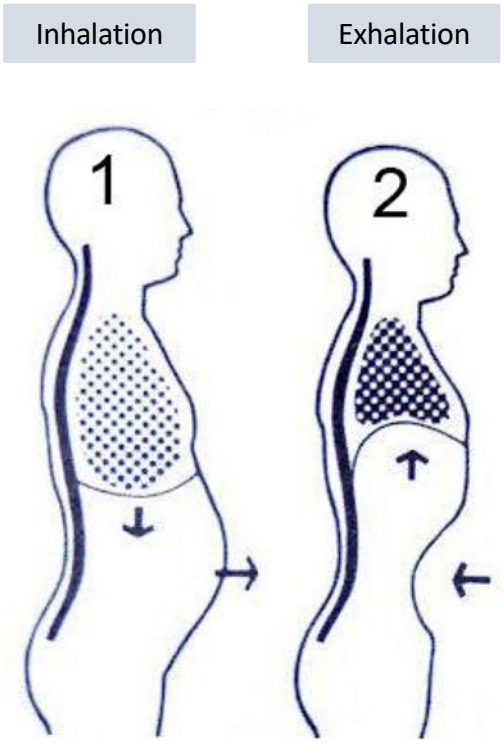
DESCRIPTION OF TOOLS TO BE USED

Breathing:

6th technique: diaphragmatic breathing

1. Lie on the floor and inhale through your nose.
2. Put both hands on your belly/stomach and breathe from the belly/stomach.
3. Place one hand on your belly and one hand on your chest and breathe in through your belly and then through your diaphragm.

Feel your belly go up during the inhale and down during the exhale.
Feel your diaphragm expand during the inhale and contract during the exhale.



MODULE 5: PRACTICING RELAXATION

DESCRIPTION OF TOOLS TO BE USED

Progressive muscle relaxation :

In general, progressive muscle relaxation involves tensing the muscles of the body and relaxing them, one muscle group at a time. It is often recommended to start with the muscles of the toes and progress upward to the muscles of the face. Please refer to the tools section for detailed exercises.

Mindfulness/Grounding :

Grounding technique 5-4-3-2-1
This method is simply called 5-4-3-2-1 and involves all 5 senses, as is the case in mindfulness exercises.

5. Sight: look around and identify 5 things that are part of the surroundings.

4. Hearing: Identify 4 things that you can hear.

3. Touch: 3 things you can feel - a ring on a finger or both feet in your shoes, for example.

2. Smell: 2 different smells .

1. Taste: 1 taste in particular, such as the smooth texture of the teeth on the tongue or a sip of water.

Variation: Instead of naming something you can taste, you can name something for which you are grateful for today.

Do it again and again, whenever you want! For example, when we are lost in our thoughts, on public transit, while taking a break, going to the bathroom, before going to bed, etc.

Guided imagery (audio)
https://students.dartmouth.edu/wellness-center/wellness-mindfulness/relaxation-downloads

MODULE 5: PRACTICING RELAXATION

DESCRIPTION OF TOOLS TO BE USED

Mindfulness/Grounding:

Other gounding method

1. Find a comfortable sitting position. Your back should be straight, and your body relaxed.
2. Close your eyes and take ten slow, deep, full breaths. Each time you exhale, imagine that you are breathing out all your worries and concerns.
3. Continue to breathe deeply and concentrate on how your feet feel. Just see if you can feel the sensations in the soles of your feet. Do this before moving on to the next step.
4. Now see if you can feel the sensations in your hands. Can you feel the tingling in your palms? Do this before proceeding to the next step.
5. Continue to breathe deeply. Continue to feel the sensations in your hands and feet. Do this for ten slow breaths.
6. Now see if you can feel the sensations throughout your body. Let your consciousness cover your whole body at once. Feel yourself breathe. Feel your buttocks on the floor (or the chair). Do it for ten more breaths.
7. Continue for at least 5 minutes.

May also include: hearing, taste, smell, and other sensory elements.

MODULE 6

WORKING ON EMOTIONAL REGULATION

MODULE 6: WORKING ON EMOTIONAL REGULATION

SUMMARY OF OBJECTIVES AND ACTIVITIES

OBJECTIVES	GUIDELINES	RECOMMENDED TOOLS
➢ Teach the basics of the Cognitive Triangle to the client. ➢ Assist the client in identifying signals that generate a traumatic reminder. Help the client reduce the intensity of their feelings before they progress into negative behaviours. ➢ Provide tools for emotional regulation.	➢ Psychoeducation ➢ Recognize signals and reminders of trauma ➢ Recognize the signs of distress / emotional dysregulation	➢ Scale of 1 to 10 ➢ Daily journal

MODULE 6: WORKING ON EMOTIONAL REGULATION

DEFINITIONS

Emotional regulation skills in trauma-focused cognitive behavioural therapy (TF-CBT): During TF-CBT, the individual learns to identify and recognize trauma reminders as well as the sequence of negative feelings and behaviours that follow, and to apply emotional regulation skills, such as discussing their frustrations rather than expressing their frustrations through problematic behaviours.

Thoughts : Thoughts are ideas, images, opinions and/or what the individual says to themselves in their head. Thoughts may emerge suddenly or may be actively generated by the individual through a process.

Feelings : Cn emotional state or reaction.

Actions : The things we do, how we act, that is, our behaviours.

MODULE 6: WORKING ON EMOTIONAL REGULATION

1. TEACH THE CLIENT THE BASICS OF THE COGNITIVE TRIANGLE

2. HELP THE CLIENT IDENTIFY THE SIGNALS THAT GENERATE A TRAUMATIC REMINDER

3. HELP THE CLIENT REDUCE THE INTENSITY OF THEIR FEELINGS BEFORE THEY PROGRESS INTO NEGATIVE BEHAVIOURS

4. PROVIDE TOOLS FOR EMOTIONAL REGULATION

MODULE 6: WORKING ON EMOTIONAL REGULATION

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

PSYCHOEDUCATION

- Describe the thoughts, the feelings, and the behaviours and how they are related (see "The Cognitive Triangle" and "The Impact of Traumatic Cues on Feelings and Behaviours" in the appendices).
    - It can be useful to learn with children through activities (see an example of an activity in the appendix "Children : Thought, Feeling, and Action Identification Game“).

- Explain that when you are experiencing overwhelming feelings, there are ways to reduce the intensity of those feelings.
    - Describe the scale of 1 to 10 (see "Description of Tools to Be Used").
    - For children, the traffic light analogy can be used along with the scale of 1 to 10 (see "Description of Tools to Be Used").

- Explore techniques to reduce the intensity of negative feelings experienced.
    - What are some things you can do to go from a 10 to a 1 or 2?
        - A child might prefer to answer with drawings.
    - What are some things you can tell yourself to make yourself feel better?
        - Ask the individual to make a list that he/she can keep.
    - For young children, see the appendices for a checklist that can be helpful to parents.

MODULE 6: WORKING ON EMOTIONAL REGULATION

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

RECOGNIZING TRAUMA SIGNALS AND REMINDERS	RECOGNIZING SIGNS OF DISTRESS / EMOTIONAL DYSREGULATION
	▪ Ask the client for examples of thoughts and associated feelings that he/she may be having ▪ Ask the client to keep a journal of his/her feelings between sessions (see "Description of Tools to Be Used") ▪ For parents, see the appendix entitled "Parents: Recognizing Signs of Distress / Emotional Dysregulation in Children"

MODULE 6: WORKING ON EMOTIONAL REGULATION

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

INTERRUPTING ESCALATION USING TRAUMA-FOCUSED CBT - FEELING IDENTIFICATION SKILLS

- ***Recognizing and learning :***
  - Ask questions about the feelings and emotions you observe in the individual. For example, “You seem very sad when you talk about this. What is going on inside you at this time?”

- ***Validating feelings :***
  - Normalize the client’s feelings with affirmations, such as “Of course you feel a lot of sadness. I would also be sad if something like this happened to my own family.”
  - However, avoid comments that imply that you know exactly how the person feels, such as “I know how you feel”. Instead, use words that reflect your empathy, but don't pretend to be in the other person's shoes, for example “I can only imagine how sad you must be feeling”.

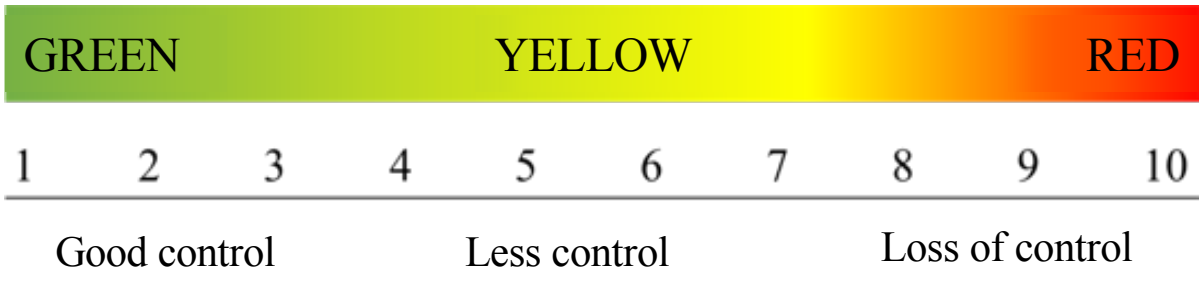
- In the case of a child, the parents are involved at every stage to help the child eventually recognize his/her feelings and validate them. If the child denies the feelings identified and suggested by the adult, the adult should ask the child to clarify the feelings he/she is experiencing.

MODULE 6: WORKING ON EMOTIONAL REGULATION

DESCRIPTION OF TOOLS TO BE USED

Scale of 1 to 10

The stronger an individual's emotional reaction, the more uncontrollable their behaviour becomes, and the less able they are to listen, to reason, to think clearly or to use their coping skills. If behaviour problems are rated on a scale of 1 to 10, with 1 = perfect control of the behaviour and 10 = behaviour completely out of control, the intervention tools are most effective when emotional and behavioural responses are at 4-5, not 8-9 on the scale. In the case of children, the traffic light analogy can be used, where green (1-3) is "safe", yellow (4-7) is "warning - slow down", and red (8-10) is "danger - STOP! ". Do not use this analogy if the child's city or town does not have traffic lights. Find examples that are meaningful to the child. The idea is that the individual must learn to brake when the problem is between 4 and 7 (yellow) on the scale. When the problem is somewhere between 8 and 10 (red), it is too late and problem behaviours tend to occur.

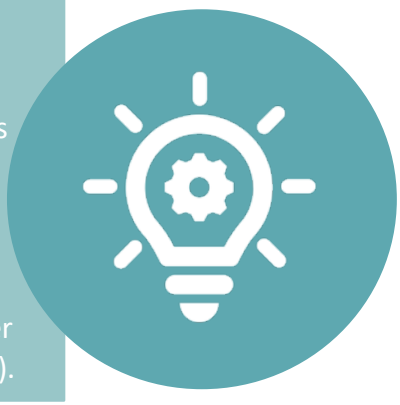


MODULE 6: WORKING ON EMOTIONAL REGULATION

DESCRIPTION OF TOOLS TO BE USED

Daily journal

The journal is used to practice identifying the traumatic triggers as well as the thoughts, feelings, and behaviours of the individual.
During this exercise, the individual first identifies a thought that he/she had during the day. Then the individual identifies the event that preceded the thought, as well as the feelings and behaviours that accompanied the thought. Ideally, the individual produces a few journal entries between each session. This tool can help the individual to eventually recognize his/her patterns and habits that result from his/her traumatic reminders (see appendix “Daily Journal Template").



MODULE 7

RECOUNTING THE TRAUMA NARRATIVE

MODULE 7: RECOUNTING THE TRAUMA NARRATIVE

SUMMARY OF OBJECTIVES AND ACTIVITIES

OBJECTIVES	GUIDELINES	RECOMMENDED TOOLS
➢ Explain to the individual that it can help to share traumatic experiences with someone they trust. ➢ Identify another trusted person with whom they can share their traumatic experiences. ➢ Help the individual explore and acknowledge feelings felt while sharing their trauma experiences.	1. Explain to the individual that it can help to share traumatic experiences with someone they trust. 2. Explain to the client that they are in control of the details related to sharing their trauma experiences. 3. Identify the feelings experienced by the individual when sharing. 4. Address specific questions and feelings related to trauma experiences. 5. Identify the individual's trauma reminders. 6. Identify another trusted person with whom the individual could share their traumatic narrative.	➢ N/A

MODULE 7: RECOUNTING THE TRAUMA NARRATIVE

1. DISCUSS THE SHARING OF TRAUMATIC EXPERIENCES
2. IDENTIFY A TRUSTED PERSON
3. HELP THE INDIVIDUAL EXPLORE AND RECOGNIZE THEIR FEELINGS

MODULE 7: RECOUNTING THE TRAUMA NARRATIVE

1 RECOUNTING THEIR TRAUMA AND MAKING IT THEIR OWN

SOME FINDINGS

- People who have experienced trauma tend to use avoidance as a strategy to forget the event and the emotions, affects, and negative feelings associated with it.
- Certain elements and places that are reminders of the trauma experienced cannot be avoided (e.g., ETC or the hospital where the person was treated).
- Studies have shown that avoidance can be harmful and often makes the trauma more painful.

THE ROLE OF THE MENTAL HEALTH PROFESSIONAL

- Help the client who has survived an infectious disease outbreak (e.g., Ebola, COVID-19, etc.), a bereaved family member or a health care professional, progressively remember the trauma experienced by providing them with a safe environment.
- Help the client move toward progressive exposure to traumatic experiences that cause a loss of emotional power and desensitization to the disease.
- Remember that sharing traumatic experiences surrounding the disease can be emotionally intense and can cause feelings of shame, anxiety, and embarrassment. Therefore, offering active listening, empathy, and asking open-ended questions or making reflections without pointing or judging are necessary.
- If your client explains their experiences with the disease well, there's no point in interrupting them. If you see that they are deviating from their story, go back over an aspect of the story, ask them for details, this will allow them to come back to it.
- The therapist must themself avoid avoidance and fear of exploring certain aspects of the trauma. However, if you think that something that the client has not discussed could potentially hurt them, you can wait until they are more willing to share this aspect of their experience with the disease.
- Don't be afraid to repeat the exercise. Yes, it seems repetitive, but that is exactly the purpose of this exposure process.

MODULE 7: RECOUNTING THE TRAUMA NARRATIVE

1 RECOUNTING THEIR TRAUMA AND MAKING IT THEIR OWN

TRAUMA NARRATION

- The trauma narrative is a psychological technique that allows survivors of epidemic-related trauma to make sense of their experiences by gradually exposing themselves to the painful memories associated with them.
- In this module, we present the trauma narrative technique. It allows the client to recount the various traumas surrounding the disease and the emotions related to them. It allows them to confront the most painful memories by telling their trauma narrative, and to overcome them by building assisted resilience.
- The narration of the trauma is normally done in written form to allow the client to write their story, express their emotions, their thoughts, their affects, and their feelings related to Ebola virus disease, COVID-19 or other diseases, before and during the session.
- Always adapt to the client's culture, traditions, and literacy level. If you think they will be unable to write their story, do not embarrass them. Instead, plan otherwise so that they can tell you their story orally or even record themselves.

OBJECTIVES

Telling their story in a safe setting allows the client to:

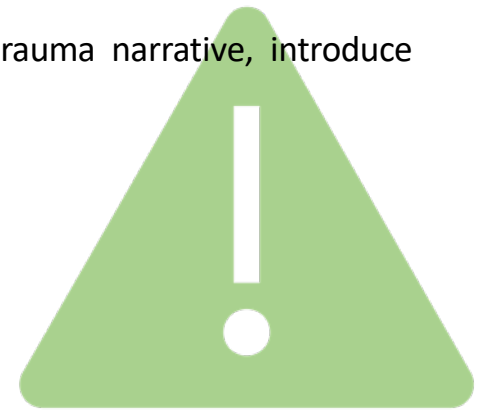
1) Take ownership of their trauma narrative
2) Identify erroneous thoughts related to the triggering of emotions (e.g., fear, sadness)
3) Understand their entire trauma narrative so as to avoid reminders of the trauma
4) Progressively become desensitized

MODULE 7: RECOUNTING THE TRAUMA NARRATIVE

1 RECOUNTING THEIR TRAUMA AND MAKING IT THEIR OWN

IMPORTANT

- It is important to begin this stage after psychoeducation and when the client has learnt appropriate coping mechanisms.
- Since epidemic situations often result in multiple and complicated traumas, the client may have experienced multiple traumas. Therefore, allow the client to go through each event in the order that suits them.
- Invite the client to reread their trauma narrative in therapy (even if it is repetitive) until they are desensitized to these experiences related to their own infection, to that of their family, or their work with patients in the case of a health professional.
- When the client is comfortable with their trauma narrative, introduce cognitive coping tools.



MODULE 7: RECOUNTING THE TRAUMA NARRATIVE

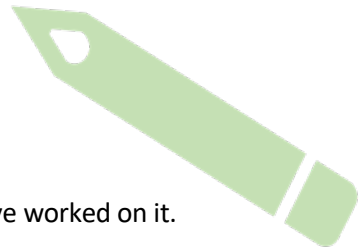
1 RECOUNTING THEIR TRAUMA AND MAKING IT THEIR OWN

THE RULES

- Invite the client to write their trauma narrative either before or during a therapy session.

Give the folowing instructions:

- Write at your own speed (the trauma narrative can be written in one sitting or over several days).
- You can start by describing the event (the facts: who, what, when, where, how) and then link your emotions to them (insist on the fact that the client needs to relate their emotions to the facts. For some clients, this will not be easy, so you may want to schedule a time to do this during a session).
- The length of the text is for you to decide (there is no fixed number of words or pages to be respected).
- Your memories surface slowly or suddenly.
- Take time to understand your feelings related to the traumatic events.
- Don't push your emotions away.
- Everything you write is for you .
- It's normal to not feel well while writing.
- You can keep what you've written for as long as you like or dispose of it after we've worked on it.
- You can reread your story once in a while or never read it again after we've worked on it.
- Remember that what you're describing is in the past, give a conclusion to your story.



MODULE 7: RECOUNTING THE TRAUMA NARRATIVE

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

1. EXPLAIN TO THE INDIVIDUAL THAT IT CAN HELP TO SHARE TRAUMATIC EXPERIENCES WITH SOMEONE THEY TRUST	2. EXPLAIN TO THE CLIENT THAT HE/SHE IS IN CONTROL OF THE DETAILS RELATED TO THE SHARING OF HIS/HER TRAUMATIC EXPERIENCES
▪ Although it may seem difficult to talk about traumatic experiences, it is sometimes an important step that can help the individual recognize trauma reminders and deal with the painful feelings and thoughts that follow. ▪ The individual may feel more comfortable sharing his/her traumatic story with a trusted objective person, such as a therapist. ▪ Later, the therapist can help the individual identify another trusted person with whom he/she can share his/her traumatic experiences.	▪ The individual has control over when he/she chooses to share. ▪ The individual has control over how he/she chooses to share. o Provide the individual with examples of how he/she can tell his/her trauma narrative. ▪ When sharing, it is important that the therapist follows the pace of the individual. The client may choose to stop while sharing their trauma narrative if they find it too difficult to relive the events. In such situations, the therapist's role is to help the individual recognize the feelings they are experiencing in that moment. In addition, the therapist can help the individual remember emotional regulation tools.

MODULE 7: RECOUNTING THE TRAUMA NARRATIVE

DESCRIPTION OF ACTIVITIES TO BE COMPLETED (*continued*)

3. IDENTIFY THE FEELINGS EXPERIENCED BY THE INDIVIDUAL WHEN SHARING

- The therapist will help the individual explore and acknowledge the feelings they feel as they share their traumatic experiences. For example, by :
  - Providing examples of ways the individual can recount their trauma narrative (children may prefer writing, drawing, books, poetry, comic books, puppet shows, interview or radio style, etc.).
  - Encouraging the individual to share their feelings about recounting their trauma narrative.
    - With children and adolescents, it may be useful to ask them to describe their feelings in writing or drawings.
  - Encouraging the sharing of feelings when sharing;
    - Verify the intensity of the person's feelings at least three times: just before sharing, in the middle of the trauma narrative, and at the end, after sharing their trauma narrative.
    - Refer to the scale of 1 to 10 (see Module 5).
  - Encouraging the identification of key elements of the story.
    - For example, what is the title of his/her trauma narrative? What are the different "chapters" or key parts of their trauma narrative? Etc.

MODULE 7: RECOUNTING THE TRAUMA NARRATIVE

DESCRIPTION OF ACTIVITIES TO BE COMPLETED (*continued*)

4. ADDRESS SPECIFIC QUESTIONS AND FEELINGS RELATED TO THE TRAUMATIC EXPERIENCES	5. IDENTIFY THE INDIVIDUAL'S TRAUMA REMINDERS	6. IDENTIFY ANOTHER TRUSTWORTHY PERSON WITH WHOM TO SHARE

▪ Following the sharing of the traumatic narrative, the therapist and client together can select questions and/or feelings to discuss (see appendix entitled "Examples of Questions and Feelings to Discuss After Sharing the Narrative Story").
▪ Identify thoughts related to the questions and/or feelings and then explore the feelings and actions that result from them.
  ○ Together, the therapist and the client challenge thoughts that are inaccurate or unhelpful, examine evidence, and explore thoughts that are more accurate and more useful.
		▪ Is there anyone else with whom the individual would like to share their traumatic experiences?
		
		▪ Some examples of questions to ask the individual may include :
		  ○ How would you feel about sharing your traumatic experiences with this person one day?
		  ○ Are there any questions you would like to ask your trusted individual?

MODULE 8

SUPPORTING RESILIENCE

MODULE 8: SUPPORTING RESILIENCE

SUMMARY OF OBJECTIVES AND ACTIVITIES

OBJECTIVES	GUIDELINES	RECOMMENDED TOOLS
▪ Identify existing risk and protective factors ▪ Reduce risk factors ▪ Increase protective factors ▪ Increase trans-adversity protective factors	1. Assess natural resilience 2. Target factors in partnership 3. Co-conceive an individualized intervention 4. Establish, support, and facilitate access to resources	▪ Resilience scales ▪ Risk Factor Scale ▪ Protective Factor Scale ▪ Social network tables ▪ Projective methods

MODULE 8: SUPPORTING RESILIENCE

DEFINITIONS

Natural Resilience: Resilience is a process that allows an individual to cope with adversity (e.g., trauma, stress, etc.) and emerge from it without psychological problems and maintaining a level of functioning equal to or greater than that experienced prior to the adversity. The natural resilience process takes place without psychological intervention.

Assisted resilience: It is characterized by identifying and developing the potential of people at risk; identifying existing resources in the person's environment; and preparing for future adversity.

Trans-adversity protective factors: Trans-adversity protective factors are factors that serve as protection against several types of adversity. Examples of trans-adversity protective factors may include: having good self-esteem, using humour to relate to others, good social support, parental interest in the child's academic achievement, and good family dynamics.

Ecosystemic perspective: A change affecting one part of a whole will necessarily have an impact on the whole. In a context of resilience, protective factors and risk factors of an individual, family, social, and environmental nature will have an impact on each other and effect the overall level of resilience of the individual.

MODULE 8: SUPPORTING RESILIENCE

1. IDENTIFY EXISTING RISK AND PROTECTIVE FACTORS
2. REDUCE RISK FACTORS
3. INCREASE PROTECTIVE FACTORS AND TRANS-ADVERSITY PROTECTIVE FACTORS

The main objective of this module is to recognize the existing risk and protective factors of the individual to help them further develop their trans-adversity protective factors in order to decrease the effect of risk factors, increase the individual's potentiality, and better prepare the individual for future adversity.

MODULE 8: SUPPORTING RESILIENCE

DESCRIPTION OF ACTIVITIES TO BE COMPLETED

1. ASSESS NATURAL RESILIENCE	2. TARGET FACTORS IN PARTNERSHIP	3. CO-CONCEIVE AN INDIVIDUALIZED INTERVENTION	4. IMPLEMENT AND SUPPORT
▪ Assess, from an ecosystemIc perspective, natural resilience, i.e., existing risk and protective factors. ▪ Use tools such as resilience scales, risk and protective factor scales, social network tables, projective methods, etc., as needed.	▪ Once natural resilience has been assessed, choose, with the individual, the protective factors to be increased and the risk factors to be reduced. ▪ Together, target the modifiable risk factors that are most upsetting to the person. ▪ Target existing protective factors that can be increased. ▪ Work together to identify other protective factors that promote resilience.	▪ Together, conceive a resilience-focused ecosystemic intervention. ▪ The therapist and the individual must ensure that the intervention meets the client's needs and preferences. ▪ The intervention must be individualized and address all of the individual's life systems, i.e., individual, family, and environmental factors (e.g., school, professional sphere, health services, religious life, etc.).	▪ The implementation of the intervention must be applied by both the therapist and the individual. ▪ Once the resilience intervention is in place, the clinician should then monitor the individual's progress.

MODULE 8: SUPPORTING RESILIENCE

DESCRIPTION OF TOOLS TO BE USED

See appendices for examples of measurement tools used to assess resilience.

MODULE 9

TAKING CARE OF YOURSELF AND YOUR TEAM

MODULE 9: TAKING CARE OF YOURSELF AND YOUR TEAM

1. BURNOUT AND COMPASSION FATIGUE
2. VICARIOUS TRAUMA
3. SELF-MANAGE ANXIETY
4. COMPASSION
5. SELF-CARE
6. TAKE CARE OF YOUR TEAM

MODULE 9: TAKING CARE OF YOURSELF AND YOUR TEAM

DEFINITIONS

Compassion fatigue: A state of physical and emotional exhaustion resulting from an over-investment in suffering people. It leads to a decrease in empathic and compassionate abilities.

Distress: Distress is described as the subjective emotional reaction that everyone experiences in response to the many stresses, challenges, and demands of our lives. Distress is a normal part of life and everyone experiences it at some point. However, when distress is not well managed, it can eventually lead to a burnout. In cases of epidemics and crises, mental health professionals face a great deal of distress from patients, families, and colleagues that can reinforce feelings of helplessness and burnout.

Burnout: A state of physical and emotional exhaustion that can lead to a sense of lack of accomplishment and loss of identity.

Vicarious trauma: When treating people who have lived traumatic experiences, workers may also, themselves, be traumatized by the emotions and events shared by the client during therapy. Some refer to this as vicarious trauma. In cases of Ebola, COVID-19 or other diseases, mental health professionals may themselves be anxious and fearful of being infected or exposed to the death of patients, colleagues, and loved ones. These elements add to what they experience as vicarious trauma in dealing with patients and affected people and health care workers.

Self-compassion: Self-compassion consists in acting towards oneself in the same way as one would act towards others who are going through a difficult time or facing a failure. Instead of ignoring your pain and sorrow, it is about acknowledging it, recognizing that you are going through a difficult time and seeking to comfort yourself as you would others, for example, with the same attention, understanding, kindness and gentleness. Note that self-compassion should not be confused with self-pity, self-indulgence or self-esteem.

MODULE 9: TAKING CARE OF YOURSELF AND YOUR TEAM

1 BURNOUT AND COMPASSION FATIGUE

Burnout sources

- ✓ Unmanaged distress
- ✓ Work overload
- ✓ Lack of control and helplessness
- ✓ Lack of recognition and/or benefits
- ✓ Lack of social support
- ✓ Lack of work-life or work-family balance
- ✓ Lack of specificity in tasks/role description
- ✓ Unfairness
- ✓ Conflicts of values

Signs and symptoms of burnout

- ✓ Exhaustion, including emotional exhaustion
- ✓ Loss of empathy and compassion
- ✓ Decreased sense of accomplishment
- ✓ Cynicism
- ✓ Inefficiency
- ✓ Disengagement
- ✓ Increased stress
- ✓ Helplessness and/or hopelessness

See the appendices for a self-assessment tool for signs and symptoms of burnout

Compassion fatigue sources

- ✓ Indirect exposure, through speech, to the details of a traumatic event suffered by another person
- ✓ Increased levels of helplessness
- ✓ Feeling isolated from a support network

MODULE 9: TAKING CARE OF YOURSELF AND YOUR TEAM

2 VICARIOUS TRAUMA

Symptoms of vicarious trauma

- ✓ Intrusive thoughts and images related to information shared by the client
- ✓ Development of physiological symptoms (e.g., sweating)
- ✓ Development of somatic symptoms (e.g., persistent pain that interferes with functioning)
- ✓ Avoidance
- ✓ Disturbing emotions

The impact of vicarious trauma on practice

The development of vicarious trauma can disrupt the practice of the intervention. The mental health professional may have the following difficulties:

- ✓ Inability to think clearly and use their professional skills
- ✓ Psychological distress
- ✓ Development of psychological disorders

MODULE 9: TAKING CARE OF YOURSELF AND YOUR TEAM

3 SELF-MANAGE ANXIETY

Recognize that responding in epidemic situations is a source of anxiety...

- ✓ In epidemic situations, psychological intervention can consist of several specific aspects:
  - ✓ Location: intervening in the hospital room, in the patient's CUBE, in the family's home.
  - ✓ Frequency: The mental health professional may need to intervene at more sustained frequencies to address the anxiety, anguish, and despair of patients, families, and health professionals. In the case of the Ebola virus disease, for example, some psychologists have had to intervene three to four times on certain days to help patients.
  - ✓ Protect yourself: In some cases, mental health professionals intervene with protective clothing. This clothing can make you feel uncomfortable and can have a peculiar effect on human contact.
  - ✓ Dealing with the great physical suffering of patients and the death of some of them on a recurring basis.
  - ✓ It is also possible to deal with the infection and death of colleagues.

MODULE 9: TAKING CARE OF YOURSELF AND YOUR TEAM

3 SELF-MANAGE ANXIETY

What to do to take care of yourself?

- ✓ Take the time to normalize your experiences (feelings, emotions, reactions, etc.) in these difficult times. Recognize that this is not a normal situation, but a crisis. It is perfectly normal to be anxious and afraid of being infected and worrying about your loved ones. However, anxiety can be both counterproductive and disabling in the provision of care. Therefore, what can be done?

    - ✓ Talk about it with colleagues: Making the decision to set up a weekly team meeting can help to discuss the emotions associated with work. In the case of a large team, a one-hour meeting every morning can also be a good initiative.

    - ✓ Take care of yourself: Take care to identify coping techniques that will be useful to you in general as well as in more difficult contexts and make use of them.
        - ✓ Your coping techniques may include relaxation or grounding (you can draw inspiration from the module on relaxation), emotional regulation and reflection (you can draw inspiration from the module on emotional regulation).

MODULE 9: TAKING CARE OF YOURSELF AND YOUR TEAM

4 COMPASSION

✓ Try to replace your self-judgments and criticisms with kindness.

✓ Recognize that you are not alone, that suffering and feelings of inadequacy in one's position are frequently experienced by many clinicians, especially in difficult situations or in times of crisis. Recognizing and normalizing this suffering can help you feel less alone and isolated.

✓ Look at your current situation in relation to the big picture. Use mindfulness techniques to observe and recognize your thoughts and feelings. Take the opportunity to review your successes and accomplishments and accept your sense of helplessness in the face of certain obstacles.

See the appendices for a self-compassion scale, and self-compassion exercises

MODULE 9: TAKING CARE OF YOURSELF AND YOUR TEAM

5 SELF-CARE

See appendices for self-assessment tools for adaptive and maladaptive coping strategies

Why?

- ✓ Avoid burnout, persistent distress, and compassion fatigue that can lead to self-doubt and self-blame
- ✓ Promote your psychological and physical well-being
- ✓ Maintain a balance between personal and professional life
- ✓ Help others adequately

For whom?

All mental health professionals

MODULE 9: TAKING CARE OF YOURSELF AND YOUR TEAM

5 SELF-CARE

WELLNESS ACTIVITIES

Work

- ✓ Take breaks during work
- ✓ Plan your schedule
- ✓ Set boundaries (e.g., saying no)
- ✓ External supervision (consult your colleagues about your work-related emotions or for advice)
- ✓ Stay informed (e.g., read academic journals)

Physical health

- ✓ Adequate sleep
- ✓ A balanced diet
- ✓ Physical activity

Mental health

- ✓ Socialize with family and friends
- ✓ Meditate or practice your religious beliefs
- ✓ Consult a therapist
- ✓ Artistic activities (e.g., painting, writing, drawing)
- ✓ Muscle relaxation
- ✓ Controlled breathing

Make a plan to practice self-care and follow the plan (e.g., take a walk every day, consult with colleagues once a week, call a friend on weekends). You can always modify your plan by self-assessing its effectiveness. Remember that it is important to take care of yourself in order to take care of others.

MODULE 9: TAKING CARE OF YOURSELF AND YOUR TEAM

6 TAKE CARE OF YOUR TEAM

An epidemic/pandemic has many consequences for the clinician's home and work environments. Two important elements are seldom addressed directly: ***fear*** and ***uncertainty*** that come from our relative ignorance.

Fear: An essential defence mechanism in the face of real danger, fear leads us to protect ourselves and those close to us. When it becomes too great, it produces paralysis. Sometimes, it is also denied or minimized, which leads to excessive risk taking.

Uncertainty: Uncertainty, combined with the vast limits of our knowledge, contradicts the myth of expertise and science. It puts clinicians and decision-makers in a difficult situation: they represent knowledge and must reassure the public, but they know that this knowledge is insufficient to ensure the safety of all.

Fear and feelings of uncertainty vary over time for each person and from person to person. These fluctuations are associated with a lot of tension and mutual blaming: some people are accused of taking too many risks, others of not taking enough, and we blame each other for failures.

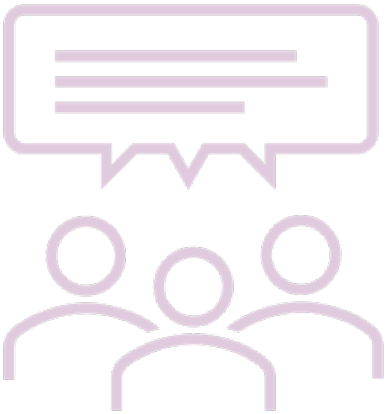
- ***Intra-family tensions*** are very common for clinicians: the family may make clinicians feel that they are putting themselves at risk and/or accuse them of endangering them. On the other hand, the clinician may feel that their family does not understand and support them.
- In teams, ***conflicts multiply***, reflecting different power relations, clinical administration, interdisciplinary, hierarchical, etc.: implicitly there is disagreement over the level of exposure to the hazard and responsibility for confusion and failure. This creates a climate of blame that erodes the protective role of the team.
    - Sometimes these conflicts escalate, and the associated anger and interpersonal tensions interfere with joint clinical work.

MODULE 9: TAKING CARE OF YOURSELF AND YOUR TEAM

6 TAKE CARE OF YOUR TEAM

WHAT TO DO?

- ✓ Have team meeting areas **to validate each other's fears**, in a supportive and non-judgmental atmosphere that can ease tensions: it is normal to be afraid for oneself and one's family, some people are more afraid than others and we must be indulgent in our differences.
- ✓ This validation makes it possible to, together, see what is possible for everyone, taking into account individual strengths and limitations, in a supportive and blame-free climate.
- ✓ When tensions emerge, it is important to be able to think about them rather than escalate them. A system of mediation by a third party can sometimes be useful to prevent anger from escalating and to negotiate solutions.
- ✓ This recognition of our fears and limitations is a necessary prerequisite for mobilizing collective courage and solidarity with those who need our help.



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APPENDICES

The Evaluation Scales

Ebola Virus Disease-Related Stigma Scale - ADULT

	Because of the Ebola Virus Disease:	**0 = Never**	**1 = Rarely**	**2 = Sometimes**	**3 = Often**	**4 = Always**				
A.	Someone insulted you by referring to the Ebola virus disease.					0	1	2	3	4
B.	People have been uncomfortable in your presence because of the Ebola virus disease.					0	1	2	3	4
C.	You have been rejected.					0	1	2	3	4
D.	Someone refused to shake your hand or greet you properly.					0	1	2	3	4
E.	You have been subjected to mockery or other attitudes of the like.					0	1	2	3	4
F.	Someone refused to speak to you.					0	1	2	3	4
G.	Someone has refused to sell you products.					0	1	2	3	4
H.	Someone refused to buy products from you.					0	1	2	3	4
I.	You lost your job or business.					0	1	2	3	4
J.	A company refused to hire you.					0	1	2	3	4
K.	A school refused to accept your children.					0	1	2	3	4
L.	Neighbours and other people have prevented you from returning to your home.					0	1	2	3	4
M.	The people in your neighborhood destroyed your home.					0	1	2	3	4
N.	After you returned, some of your family members refused to take you in their home.					0	1	2	3	4
O.	After your return, your spouse refused to let you come home.					0	1	2	3	4
P.	Your spouse has left you.					0	1	2	3	4
Q.	You feel like people are avoiding you.					0	1	2	3	4
R.	You feel like you are being rejected.					0	1	2	3	4
S.	You feel like people are afraid of you.					0	1	2	3	4
T.	You engage in avoidance behaviours such as staying home for fear of being stigmatized or rejected.					0	1	2	3	4

Note. This scale was developed in the context of research on Ebola Virus Disease but is easily adaptable to COVID-19 and other infectious diseases.

Reference:

Cénat, J. M., Rousseau, C., Derivois, D., Bukaka, J. & Birangui, J-P. (2018). Ebola virus disease-related stigma scale –Adulte Version. *Ottawa :* Vulnerability, Trauma, Resilience, & Culture Lab.

Ebola Virus Disease-Related Stigma Scale – CHILD/ADOLESCENT

Because of the Ebola Virus Disease:	**0 = Never**	**1 = Rarely**	**2 = Sometimes**	**3 = Often**	**4 = Always**
A. Someone insulted you by referring to the Ebola virus disease.	0	1	2	3	4
B. People have been uncomfortable in your presence because of the Ebola virus disease.	0	1	2	3	4
C. You have been rejected.	0	1	2	3	4
D. Someone refused to shake your hand or greet you properly.	0	1	2	3	4
E. You have been subjected to mockery or other attitudes of the like.	0	1	2	3	4
F. Someone refused to speak to you.	0	1	2	3	4
G. Someone has refused to sell you products.	0	1	2	3	4
H. Someone refused to buy products from you.	0	1	2	3	4
I. Your parents lost their job or business.	0	1	2	3	4
J. A company refused to hire your parents.	0	1	2	3	4
K. A school refused to accept you.	0	1	2	3	4
L. Neighbours and other people have prevented you from returning to your home.	0	1	2	3	4
M. The people in your neighborhood destroyed your parents' home.	0	1	2	3	4
N. Family members refused to take you in because of Ebola.	0	1	2	3	4
O. After your return, you're your parents refused to let you come back home.	0	1	2	3	4
P. You feel like people are avoiding you.	0	1	2	3	4
Q. You feel like you are being rejected.	0	1	2	3	4
R. You feel like people are afraid of you.	0	1	2	3	4
S. You have avoidant behaviours such as staying home for fear of being stigmatized or rejected.	0	1	2	3	4

Note. This scale was developed in the context of research on Ebola Virus Disease but is easily adaptable to COVID-19 and other infectious diseases.

Reference:

Cénat, J. M., Rousseau, C., Derivois, D., Bukaka, J. & Birangui, J-P. (2018). Ebola virus disease-related stigma scale – Child/Adolescent Version. *Ottawa :* Vulnerability, Trauma, Resilience, & Culture Lab.

Ebola Virus Disease Exposure Scale - ADULT

About Ebola virus disease:	**Oui**	**Non**
A. Have you been in a town or village where people have fallen ill with the Ebola virus?		
B. Have you been in a neighbourhood where people have gotten sick from the Ebola virus?		
C. Do you personally know people who have become ill with the Ebola virus?		
D. Have you been in contact with someone who is not related to you and who subsequently became ill with the Ebola virus?		
E. Did a friend get sick from the Ebola virus?		
F. Has a member of your family been sick with the Ebola virus?		
G. Has a family member living in the same house as you gotten sick with the Ebola virus disease?		
H. Did you treat a family member or friend who got sick with the Ebola virus?		
I. A friend died from the Ebola virus		
J. Did a member of your family die of the Ebola virus?		
K. Have you yourself been sick with the Ebola virus?		
L. Have you been hospitalized in an Ebola treatment centre?		
M. Have you attended funerals of people who died of the Ebola virus?		
N. Have you touched the bodies of people who died of Ebola virus disease?		
O. Were you part of a health care team?		
P. Were you part of a team managing the bodies of people who died from Ebola disease?		
Q. Did you become disabled as a result of Ebola disease?		

Note. This scale was developed in the context of research on Ebola Virus Disease but is easily adaptable to COVID-19 and other infectious diseases.

Reference:

Cénat, J. M., Rousseau, C., Derivois, D., Bukaka, J. & Birangui, J-P. (2018). Ebola virus disease exposure scale – Adult Version. *Ottawa :* Vulnerability, Trauma, Resilience, & Culture Lab.

Ebola Virus Disease Exposure Scale – CHILD/ADOLESCENT

About Ebola virus disease:	**Oui**	**Non**
A. Have you been in a town or village where people have fallen ill with the Ebola virus?		
B. Have you been in a neighbourhood where people have gotten sick from the Ebola virus?		
C. Do you personally know people who have become ill with the Ebola virus?		
D. Have you been in contact with someone who is not related to you and who subsequently became ill with the Ebola virus?		
E. Did a friend get sick from the Ebola virus?		
F. Has a member of your family been sick with the Ebola virus?		
G. Has a family member living in the same house as you gotten sick with the Ebola virus disease?		
H. Did you treat a family member or friend who got sick with the Ebola virus?		
I. A friend died from the Ebola virus		
J. Did a member of your family die of the Ebola virus?		
K. Have you yourself been sick with the Ebola virus?		
L. Have you been hospitalized in an Ebola treatment centre?		
M. Have you attended funerals of people who died of the Ebola virus?		
N. Have you touched the bodies of people who died of Ebola virus disease?		
O. Are you part of a health care team?		
P. Are you part of a team managing the bodies of people who died from Ebola disease?		
Q. Did you become disabled as a result of Ebola disease?		

Note. This scale was developed in the context of research on Ebola Virus Disease but is easily adaptable to COVID-19 and other infectious diseases.

Reference:

Cénat, J. M., Rousseau, C., Derivois, D., Bukaka, J. & Birangui, J-P. (2018). Ebola virus disease exposure scale – Child/Adolescent Version. *Ottawa :* Vulnerability, Trauma, Resilience, & Culture Lab.

Peritraumatic Distress Inventory (PDI)

INSTRUCTIONS : **Please rate the extent to which each item was experienced during the last Ebola virus disease epidemic and immediately after. If one of the statements does not apply to your experience of the epidemic, please check the box for "Not at all".**					
	Not at all true (0)	**Slightly true (1)**	**Somewhat true (2)**	**Very true (3)**	**Extremely true (4)**
A. I felt helpless to do more					
B. I felt sadness and grief					
C. I felt frustrated or angry I could not do more					
D. I felt afraid for my safety					
E. I felt guilt that more was not done					
F. I felt ashamed of my emotional reactions					
G. I felt worried about the safety of others					
H. I had the feeling was about to lose control of my emotions					
I. I had difficulty controlling my bowel and bladder					
J. I was horrified by what happened					
K. I had physical reactions like sweating, shaking, and pounding heart					
L. I felt I might pass out					
M. I thought I might die					

Each item has a score between 0 (Not at all true) and 4 (Extremely true) for a total score ranging from 0 to 52. The **average score** is obtained by dividing the total score of the items by the total number of items (i.e., 13).

Reference:

Brunet, A., Weiss, D. S., Metzler, T. J., Best, S. R., Neylan, T. C., Rogers, C., ... & Marmar, C. R. (2001). The Peritraumatic Distress Inventory: a proposed measure of PTSD criterion A2. American Journal of Psychiatry, 158(9), 1480-1485.

Kessler Psychological Distress Scale (K10)

In the past week, how often did you feel…	**None of the time** (1)	**A little of the time** (2)	**Some of the time** (3)	**Most of the time** (4)	**All the time** (5)
A. Tired out for no good reason.					
B. Nervous.					
C. So nervous that nothing good could calm you down.					
D. Hopeless.					
E. Restless or fidgity.					
F. So restless that you could not sit still.					
G. Depressed.					
H. That everything was an effort.					
I. So sad that nothing could cheer you up.					
J. Worthless.					

The score for each item ranges from 1 to 5 for a total score between 10 and 50. Interpretation is done by matching the total score to one of the categories below.

Total score:
Below 20 – likely **well**
20-24 – **minor** mental health problem likely
25-29 – **moderate** mental health problem likely
30 and up – **severe** mental health problem likely

Reference :

Kessler, R.C., Andrews, G., Colpe, .et al (2002) Short screening scales to monitor population prevalences and trends in non-specific psychological distress. Psychological Medicine, 32, 959-956.

Andrews, G., Slade, T (2001). Interpreting scores on the Kessler Psychological Distress Scale (k10). Australian and New Zealand Journal of Public Health, 25, 494-497.

Life Events Checklist (LEC 5)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: **(a)** it happened to you **personally**; **(b)** you **witnessed it** happen to someone else; **(c)** you **learned about it** happening to a close family member or close friend; **(d)** you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); **(e)** you're **not sure** if it fits; or **(f)** it **doesn't apply** to you. List only those events that involved life-threatening, serious injury or sexual violence.

Events	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	N/A
A. An attack	☐	☐	☐	☐	☐	☐
B. Natural disaster (for example, flood, hurricane, tornado, earthquake)	☐	☐	☐	☐	☐	☐
C. Fire or explosion	☐	☐	☐	☐	☐	☐
D. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)	☐	☐	☐	☐	☐	☐
E. Serious accident at work, home, or during recreational activity	☐	☐	☐	☐	☐	☐
F. Exposure to toxic substance (for example, dangerous chemicals, radiation)	☐	☐	☐	☐	☐	☐
G. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	☐	☐	☐	☐	☐	☐
H. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)	☐	☐	☐	☐	☐	☐
I. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	☐	☐	☐	☐	☐	☐
J. Other unwanted or uncomfortable sexual experience	☐	☐	☐	☐	☐	☐
K. Combat or exposure to a war-zone (in the military or as a civilian)	☐	☐	☐	☐	☐	☐
L. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)	☐	☐	☐	☐	☐	☐
M. Life-threatening illness or injury	☐	☐	☐	☐	☐	☐
N. Severe human suffering	☐	☐	☐	☐	☐	☐
O. Sudden violent death (for example, homicide, suicide)	☐	☐	☐	☐	☐	☐
P. Sudden accidental death	☐	☐	☐	☐	☐	☐
Q. Serious injury, harm, or death you caused to someone else	☐	☐	☐	☐	☐	☐
R. Any other very stressful event or experience, specify	☐	☐	☐	☐	☐	☐

References:

Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.G., Marx, B.P., & Keane, T.M. (2013). The Life Events Checklist for DSM-5 (LEC-5). Instrument available from the National Center for PTSD at www.ptsd.va.gov

Gray, M., Litz, B., Hsu, J., & Lombardo, T. (2004). Psychometric properties of the Life Events Checklist. (PDF) Assessment, 11, 330-341. doi: 10.1177/1073191104269954 PILOTS ID: 26825

PTSD Checklist (PCL-5)

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the **past month.**

In the last month, have you been affected by:	*0 Not at all*	*1 A little bit*	*2 Moderately*	*3 Quite a bit*	*4 Extremely*
A. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
B. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
C. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
D. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
E. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
F. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
G. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
H. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
I. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
J. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
K. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
L. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
M. Feeling distant or cut off from other people?	0	1	2	3	4
N. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
O. Irritable behaviour, angry outbursts, or acting aggressively?	0	1	2	3	4
P. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
Q. Being "super alert" or watchful or on guard?	0	1	2	3	4
R. Feeling jumpy or easily startled?	0	1	2	3	4
S. Having difficulty concentrating?	0	1	2	3	4
T. Trouble falling or staying asleep?	0	1	2	3	4

In general, a score of **2 (Moderately) or more** on an item indicates probable experience of this symptom of PTSD. Taking the DSM-5 into account, a score of **2 or more** on the following items indicates the **probable presence** of PTSD symptoms above the clinical threshold:

1 Category B item - questions **1-5**;
1 item from category C - questions **6-7**;
2 items from category D - questions **8-14**;
2 Category E items - questions **15-20**;

The **severity** of symptoms is determined by adding the score for each item to obtain a total score between 0 and 80. A score of **33 or higher** indicates the need for further assessment.

Reference:

Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The posttraumatic stress disorder checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. Journal of traumatic stress, 28(6), 489-498.

The Child PTSD Symptom Scale for DSM-5 (CPSS-V SR) - ENFANTS

These questions ask about how you feel about the upsetting thing you wrote down. Read each question carefully. Then circle the number (0-4) that best describes how often that problem has bothered you IN THE LAST MONTH.

0 = Not at all	1 = Once a week or less/a little	2 = 2 to 3 times a week/somewhat	3 = 4 to 5 times a week/a lot	4 = 6 or more times a week/almost always

A.	Having upsetting thoughts or pictures about it that came into your head when you didn't want them to	0	1	2	3	4
B.	Having bad dreams or nightmares	0	1	2	3	4
C.	Acting or feeling as if it was happening again (seeing or hearing something and feeling as if you are there again)	0	1	2	3	4
D.	Feeling upset when you remember what happened (for example, feeling scared, angry, sad, guilty, confused)	0	1	2	3	4
E.	Having feelings in your body when you remember what happened (for example, sweating, heart beating fast, stomach or head hurting)	0	1	2	3	4
F.	Trying not to think about it or have feelings about it	0	1	2	3	4
G.	Trying to stay away from anything that reminds you of what happened (for example, people, places, or conversations about it)	0	1	2	3	4
H.	Not being able to remember an important part of what happened	0	1	2	3	4
I.	Having bad thoughts about yourself, other people, or the world (for example, "I can't do anything right", "All people are bad", "The world is a scary place")	0	1	2	3	4
J.	Thinking that what happened is your fault (for example, "I should have known better", "I shouldn't have done that", "I deserved it")	0	1	2	3	4
K.	Having strong bad feelings (like fear, anger, guilt, or shame)	0	1	2	3	4
L.	Having much less interest in doing things you used to do	0	1	2	3	4
M.	Not feeling close to your friends or family or not wanting to be around them	0	1	2	3	4
N.	Trouble having good feelings (like happiness or love) or trouble having any feelings at all	0	1	2	3	4
O.	Getting angry easily (for example, yelling, hitting others, throwing things)	0	1	2	3	4
P.	Doing things that might hurt yourself (for example, taking drugs, drinking alcohol, running away, cutting yourself)	0	1	2	3	4
Q.	Being very careful or on the lookout for danger (for example, checking to see who is around you and what is around you)	0	1	2	3	4
R.	Being jumpy or easily scared (for example, when someone walks up behind you, when you hear a loud noise)	0	1	2	3	4
S.	Having trouble paying attention (for example, losing track of a story on TV, forgetting what you read, unable to pay attention in class)	0	1	2	3	4
T.	Having trouble falling or staying asleep	0	1	2	3	4
To what extent have these symptoms disrupted your daily life?						
U.	Praying	0	1	2	3	4
V.	Doing your chores	0	1	2	3	4
W.	Relationships with your friends	0	1	2	3	4
X.	Fun things you want to do	0	1	2	3	4
Y.	Schoolwork	0	1	2	3	4

Z. Relationships with your family	0	1	2	3	4
AA. Being happy with your life	0	1	2	3	4

A total score of **31 or more** on the first part of the questionnaire (items **A to T**) indicates a probable diagnosis of PTSD in the child and therefore requires further assessment.

Match the individual's total score to one of the categories below to determine the **severity** of symptoms:

0-10 – minimal
11-20 – mild
21-40 – moderate
41-60 – severe
61-80 – Very severe

The second part of the questionnaire (items **U to AA**) is used to determine the level of impact of symptoms on the individual's daily activities. The higher the score, the more severe the impact.

Reference:

Foa, E. B., Asnaani, A., Zang, Y., Capaldi, S., & Yeh, R. (2018). Psychometrics of the Child PTSD Symptom Scale for DSM-5 for trauma-exposed children and adolescents. *Journal of Clinical Child & Adolescent Psychology*, *47*(1), 38-46.

Depression (Beck Depression Inventory Short-Form)

Instructions: This questionnaire consists of 13 groups of statements. Please read each group of statements carefully. And then pick out the one statement in each group that best describes the way you have been feeling **during the past two weeks, including today**. Click on the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group.

A.	0	I do not feel sad
	1	I feel sad
	2	I am sad all the time and I can't snap out of it
	3	I am so sad and unhappy that I can't stand it
B.	0	I am not particularly discouraged about the future
	1	I feel discouraged about the future
	2	I feel I have nothing to look forward to
	3	I feel the future is hopeless and that things cannot improve
C.	0	I do not feel like a failure
	1	I feel I have failed more than the average person
	2	As I look back on my life, all I can see is a lot of failures
	3	I feel I am a complete failure as a person
D.	0	I get as much satisfaction out of things as I used to
	1	I don't enjoy things the way I used to
	2	I don't get real satisfaction out of anything anymore
	3	I am dissatisfied or bored with everything
E.	0	I don't feel particularly guilty
	1	I feel guilty a good part of the time
	2	I feel quite guilty most of the time
	3	I feel guilty all of the time
F.	0	I don't feel disappointed in myself
	1	I am disappointed in myself
	2	I am disgusted with myself
	3	I hate myself
G.	0	I don't have any thoughts of killing myself
	1	I have thoughts of killing myself, but I would not carry them out
	2	I would like to kill myself
	3	I would kill myself if I had the chance
H.	0	I have not lost interest in other people
	1	I am less interested in other people than I used to be
	2	I have lost most of my interest in other people
	3	I have lost all of my interest in other people
I.	0	I make decisions about as well as I ever could
	1	I put off making decisions more than I used to
	2	I have greater difficulty in making decisions more than I used to
	3	I can't make decisions at all anymore
J.	0	I don't feel that I look any worse than I used to

	1	I am worried that I am looking old or unattractive
	2	I feel there are permanent changes in my appearance that make me look unattractive
	3	I believe that I look ugly
K.	0	I can work about as well as before
	1	It takes an extra effort to get started at doing something
	2	I have to push myself very hard to do anything
	3	I can't do any work at all
L.	0	I don't get more tired than usual
	1	I get tired more easily than I used to
	2	I get tired from doing almost anything
	3	I am too tired to do anything
M.	0	My appetite is no worse than usual
	1	My appetite is not as good as it used to be
	2	My appetite is much worse now
	3	I have no appetite at all anymore

Add up the score for each item to obtain an overall score between 0 and 39. A higher score indicates a higher level of depression. The categories below will help you determine the severity of depression:

0-4 – none or minimal
5-7 – low
8-15 – moderate
16 or higher - severe

For children and adolescents, please refer to the **Children Depression Inventory**. This tool is protected by copyrights and mental health professionals are required to request permission in order to use it:
Kovacs, M. (1992). Children Depression Inventory CDI: Manual. New York: Multi-Health Systems.

Reference

Beck, A. T., & Beck, R. W. (1972). Screening depressed patients in family practice: A rapid technic. *Postgraduate medicine*, *52*(6), 81-85.
Kovacs M (1992) Children's Depression Inventory. New York: MultiHealth Systems.

Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom ***during the past month, including today***, by circling the number in the corresponding space in the column next to each symptom.

During the last 7 days, I was bothered by…	0 Not at all	1 Mildly, but it didn't bother me much	2 Moderately – it wasn't pleasant at times	3 Severely – it bothered me a lot
A. Numbness or tingling	0	1	2	3
B. Feeling hot	0	1	2	3
C. Wobbliness in legs	0	1	2	3
D. Unable to relax	0	1	2	3
E. Fear of worst happening	0	1	2	3
F. Dizzy or lightheaded	0	1	2	3
G. Heart pounding / racing	0	1	2	3
H. Unsteady	0	1	2	3
I. Terrified or afraid	0	1	2	3
J. Nervous	0	1	2	3
K. Feeling of choking	0	1	2	3
L. Hands trembling	0	1	2	3
M. Shaky / unsteady	0	1	2	3
N. Fear of losing control	0	1	2	3
O. Difficulty in breathing	0	1	2	3
P. Fear of dying	0	1	2	3
Q. Scared	0	1	2	3
R. Indigestion	0	1	2	3
S. Faint / lightheadedness	0	1	2	3
T. Face flushed	0	1	2	3
U. Hot / cold sweats	0	1	2	3

Add the score to each item to obtain an overall score between **0 and 63**. Then use the categories below to determine the level of anxiety:

0-7 – minimal
8-15 – low
16-25 – moderate
30-63 – severe

Reference:

Beck, A.T., Epstein, N., Brown, G., & Steer, R.A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. Journal of Consulting and Clinical Psychology, 56, 893-897.

Substance Use Scale

In the past 12 months, how many times have you consumed these products?	Not at all	Occasionally	About once a month	On weekends or once or twice a week	3 times a week or more, but not every day	Ever y day
1. Alcohol	☐	☐	☐	☐	☐	☐
2. Cannabis (pot, marijuana, weed, hachisch, huile, etc.)	☐	☐	☐	☐	☐	☐
3. Hemp						
4. Other drugs (ecstasy, amphetamines, speed, cocaine, acid, etc.)	☐	☐	☐	☐	☐	☐

Reference:

Landry, M., Tremblay, J., Guyon, L., Bergeron, J., & Brunelle, N. (2004). La Grille de dépistage de la consommation problématique d'alcool et de drogues chez les adolescents et les adolescentes (DEP-ADO): développement et qualités psychométriques. *Drogues, santé et société*, *3*(1), 20-37.

Suicidal Ideations and Behaviours

It may be hard to answer the following question. If you feel like you need help, we encourage you to talk to a mental health worker.

A. Have you ever <u>seriously</u> thought of committing suicide?

☐ No **If you answered no, you have completed this questionnaire.*

☐ Yes **If you answered Yes, please go to the next question.*

B. Have you ever attempted suicide?

☐ No

☐ Yes

C. How many times have you attempted suicide?

☐ Once

☐ More than once

Reference:

Statistics Canada. (2007). National Longitudinal Survey of Children and Youth (NLSCY): User's Handbook and Microdata Guide. Ottawa, Canada.

Quality of Life (WHOQOL-BREF)

The following questions express feelings about what you are currently experiencing. There is no right answer, it is above all personal.						
A.	How would you rate your quality of life?	Very poor □	Poor □	Neither poor nor good □	Good □	Very good □
B.	How satisfied are you with your health	Very dissatisfied □	Dissatisfied □	Neither satisfied nor dissatisfied □	Satisfied □	Very satisfied □
C.	To what extent do you feel that physical pain prevents you from doing what you need to do?	Not at all □	A little □	A moderate amount □	Very much □	An extreme amount □
D.	How much do you need any medical treatment to function in your daily life?	□	□	□	□	□
E.	How much do you enjoy life?	□	□	□	□	□
F.	To what extent do you feel your life to be meaningful?	□	□	□	□	□
G.	How well are you able to concentrate?	□	□	□	□	□
H.	How safe do you feel in your daily life?					
I.	How healthy is your physical environment?	□	□	□	□	□
J.	Do you have enough energy for everyday life?	Not at all □	A little □	Moderately □	Mostly □	Completely □
K.	Are you able to accept your bodily appearance?	□	□	□	□	□
L.	Have you enough money to meet your needs?	□	□	□	□	□
M.	How available to you is the information that you need in your day-to-day life?	□	□	□	□	□
N.	To what extent do you have the opportunity for leisure activities?	□	□	□	□	□
O.	How well are you able to get around?	Very poor □	Poor □	Neither poor nor good	Good □	Very good □

□

P.	How satisfied are you with your sleep?	Very dissatisfied □	Dissatisfied □	Neither satisfied nor dissatisfied □	Satisfied □	Very satisfied □
Q.	How satisfied are you with your ability to perform your daily living activities?	□	□	□	□	□
R.	How satisfied are you with your capacity for work?	□	□	□	□	□
S.	How satisfied are you with yourself?	□	□	□	□	□
T.	How satisfied are you with your personal relationships?	□	□	□	□	□
U.	How satisfied are you with your sex life?	□	□	□	□	□
V.	How satisfied are you with the support you get from your friends?	□	□	□	□	□
W.	How satisfied are you with the conditions of your living place?	□	□	□	□	□
X.	How satisfied are you with your access to health services?	□	□	□	□	□
Y.	How satisfied are you with your transport?	□	□	□	□	□
Z.	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	Never □	Seldom □	Quite often □	Very often □	Always □

Reference:

World Health Organization. (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychological medicine*, *28*(3), 551-558.

Social Support (Multidimensional Scale of Perceived Social Support)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement using the following scale: 							
There is a special person who is around when I am in need.	1	2	3	4	5	6	7
There is a special person with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
My family really tries to help me.	1	2	3	4	5	6	7
I get the emotional help and support I need from my family.	1	2	3	4	5	6	7
I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
My friends really try to help me.	1	2	3	4	5	6	7
I can count on my friends when things go wrong.	1	2	3	4	5	6	7
I can talk about my problems with my family.	1	2	3	4	5	6	7
I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
My family is willing to help me make decisions.	1	2	3	4	5	6	7
I can talk about my problems with my friends.	1	2	3	4	5	6	7

To obtain the total score on the scale, calculate the average of all item scores. To obtain the score on each of the 3 subscales (significant other, family, friends), calculate the average of the items belonging to each subscale (see below). A higher average indicates the presence of greater social support.

Significant other scale:
Q1 + Q2 + Q5 + Q 10

Family subscale:
Q3 +Q4 + Q8 + Q11

Friends subscale:
Q6 +Q7 +Q9 + Q12

Reference:

Zimet, G.D., Dahlem, N.W., Zimet, S.G. & Farley, G.K. (1988). The Multidimensional Scale of Perceived Social Support. Journal of Personality Assessment, 52, 30-41.

General Self-Efficacy

Please choose the answer that best describes you:	Not at all true	Hardly true	Moderately true	Exactly true
A. I can always manage to solve difficult problems if I try hard enough.				
B. If someone opposes me, I can find the means and ways to get what I want.				
C. It is easy for me to stick to my aims and accomplish my goals.				
D. I am confident that I could deal efficiently with unexpected events.				
E. Thanks to my resourcefulness, I know how to handle unforeseen situations.				
F. I can solve most problems if I invest the necessary effort.				
G. I can remain calm when facing difficulties because I can rely on my coping abilities.				
H. When I am confronted with a problem, I can usually find several solutions.				
I. If I am in trouble, I can usually think of a solution.				
J. I can usually handle whatever comes my way.				

Each item scores from **1** (Not at all true) to **4** (Exactly true) for a total score between **10 and 40**. A higher score indicates more self-efficacy.

Reference:

Schwarzer, R., & Jerusalem, M. (1995). Generalized Self-Efficacy scale. In J. Weinman, S. Wright, & M. Johnston, Measures in health psychology: A user's portfolio. Causal and control beliefs (pp. 35-37). Windsor, UK: NFER-NELSON.

Religious Coping Strategies (Brief-RCOPE)

Think about the last infectious epidemic/pandemic and the way you reacted to it. **Respond to the following items by checking the box that corresponds the best to the ways you have reacted in difficult situations. Answer honestly without worrying about what someone would have done in your place:**	Not at all	Once in a while	Often	A great deal
1. Looked for a stronger connection with God.				
2. Sought God's love and care.				
3. Sought help from God in letting go of my anger.				
4. Tried to put my plans into action together with God.				
5. Tried to see how God might be trying to strengthen me in this situation.				
6. Asked forgiveness for my sins.				
7. Focused on religion to stop worrying about my problems.				
8. Wondered whether God had abandoned me.				
9. Felt punished by God for my lack of devotion.				
10. Wondered what I did for God to punish me.				
11. Questioned God's love for me.				
12. Wondered whether my church had abandoned me.				
13. Decided the devil made this happen.				
14. Questioned the power of God.				

Each item has a score ranging from **1** (Not at all) to **4** (A great deal). Calculate the total score of the items on each of the **2 subscales** (see below). A higher score indicates a more frequent use of the type of coping strategy.

Positive religious coping strategies: **1-7**
Negative religious coping strategies: **8-14**

Reference:

Pargament, K. I. (1997). *The psychology of religion and coping: Theory, research, practice*. Guilford press. New York, USA.

Coping Strategies (Brief COPE)

Think about the last infectious epidemic/pandemic and the way you reacted to it. Answer the following items by checking the box that corresponds the best to the ways you have reacted in difficult situations. Answer honestly without worrying about what someone would have done in your place:	I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
1. I've been turning to work or other activities to take my mind off things.	1	2	3	4
2. I've been concentrating my efforts on doing something about the situation I'm in.	1	2	3	4
3. I've been saying to myself "this isn't real."	1	2	3	4
4. I've been using alcohol or other drugs to make myself feel better.	1	2	3	4
5. I've been getting emotional support from others.	1	2	3	4
6. I've been giving up trying to deal with it.	1	2	3	4
7. I've been taking action to try to make the situation better.	1	2	3	4
8. I've been refusing to believe that it has happened.	1	2	3	4
9. I've been saying things to let my unpleasant feelings escape.	1	2	3	4
10. I've been getting help and advice from other people.	1	2	3	4
11. I've been using alcohol or other drugs to help me get through it.	1	2	3	4
12. I've been trying to see it in a different light, to make it seem more positive.	1	2	3	4
13. I've been criticizing myself.	1	2	3	4
14. I've been trying to come up with a strategy about what to do.	1	2	3	4
15. I've been getting comfort and understanding from someone.	1	2	3	4
16. I've been giving up the attempt to cope.	1	2	3	4
17. I've been looking for something good in what is happening.	1	2	3	4
18. I've been making jokes about it.	1	2	3	4
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.	1	2	3	4
20. I've been accepting the reality of the fact that it has happened.	1	2	3	4
21. I've been expressing my negative feelings.	1	2	3	4
22. I've been trying to find comfort in my religion or spiritual beliefs.	1	2	3	4
23. I've been trying to get advice or help from other people about what to do.	1	2	3	4
24. I've been learning to live with it.	1	2	3	4
25. I've been thinking hard about what steps to take.	1	2	3	4
26. I've been blaming myself for things that happened.	1	2	3	4
27. I've been praying or meditating.	1	2	3	4
28. I've been making fun of the situation.	1	2	3	4

The measure includes **14** subscales assessing *adaptive* and *maladaptive* coping strategies. Calculate the total score for each subscale. A higher score indicates that the strategy is used more frequently. See below for items belonging to each subscale.

Self-distraction: **1, 19**
Active coping: **2, 7**
Denial: **3, 8**
Substance use: **4, 11**
Use of emotional support: **5, 15**
Use of instrumental support: **10, 23**
Behavioural disengagement: **6, 16**
Venting: **9, 21**
Positive reframing: **12, 17**
Planning: **14, 25**
Humor: **18, 28**
Acceptance: **20, 24**
Religion: **22, 27**
Self-blame: **13, 26**

Reference:

Carver, C. S. (1997). You want to measure coping but your protocol's too long: Consider the Brief COPE. *International Journal of Behavioural Medicine*, 4, 92-100.

Symptoms of Dissociation

Instructions: For each statement below, circle the answer that best describes how much each thing has happened to you in the past **SEVEN (7) DAYS.**

	Not at all	Once or Twice	Almost everyday	About once a day	More than once a day
1. I find myself staring into space and thinking of nothing.	0	1	2	3	4
2. People, objects, or the world around me seem strange or unreal.	0	1	2	3	4
3. I find that I did things that I do not remember doing.	0	1	2	3	4
4. When I am alone, I talk out loud to myself.	0	1	2	3	4
5. I feel as though I were looking at the world through a fog so that people and things seem far away or unclear.	0	1	2	3	4
6. I am able to ignore pain.	0	1	2	3	4
7. I act so differently from one situation to another that it is almost as if I were two different people.	0	1	2	3	4
8. I can do things very easily that would usually be hard for me.	0	1	2	3	4

Calculate the total score by adding the score to each item for a total between **0 and 32**. A higher score indicates more severe dissociative symptoms. Then calculate the mean score by dividing the total score by the number of items on the scale (i.e., **8**). The mean score allows you to interpret the average frequency of symptoms (refer to the 5-point scale, **0-Not at all** to **4-More than once a day**).

References:

DES-B (Dalenberg C, Carlson E, 2010) modified for DSM-5 by C. Dalenberg and E. Carlson.

Traumatic Grief Inventory Self-Report (TGI-SR)

Losing a loved one is accompanied by a variety of reactions with varying degrees of intensity. Please indicate on a scale of 0 to 4 the frequency at which you experience the following reactions.

0 = never or almost never; 1 = rarely; 2 = sometimes; 3 = frequently; 4 = always

	0 = never or almost never	**1 = rarely**	**2 = sometimes**	**3 = frequently**	**4 = always**
1. I had intrusive thoughts and imaged associated with his/her death					
2. I experienced intense emotional pain, sorrow, or pangs of grief					
3. I felt strong longing or yearning for the deceased					
4. I felt confusion about my role in life, or a diminished sense of identity					
5. I had trouble to accept the loss					
6. I avoided places, objects or thoughts reminding me of his/her death					
7. I found it difficult to trust others					
8. I felt bitter or angry about the loss					
9. I experienced difficulty to move on with my life (e.g., pursue friendships, activities)					
10. I felt numb over the loss					
11. I felt that life is meaningless or empty without the deceased					
12. I felt shocked or stunned by his/her death					
13. I noticed that my functioning (in my work, private life, and/or social life) was seriously impaired as a result of his/her death					
14. I had intrusive thoughts and images associated with the circumstances of his/her death					

15. I had difficulties with positive reminiscing about the deceased					
16. I had negative thoughts about myself in relation to the deceased or the death (e.g., self-blame)					
17. I experienced a desire to die in order to be with the deceased					
18. I felt alone or detached from other people					

Add the scores for each item to get a total out of **72**. A total score of **61 or higher** indicates that the individual may be experiencing, at the time of the evaluation, symptoms of complex grief that are above the clinical threshold.

Reference:

Paul A. Boelen & Geert E. Smid (2017) The Traumatic Grief Inventory SelfReport Version (TGI-SR): Introduction and Preliminary Psychometric Evaluation, Journal of Loss and Trauma, 22:3, 196-212, DOI: 10.1080/15325024.2017.1284488

Self-Compassion Scale (SCS)

For each statement, indicate how often you behave this way, using a scale of 1 to 5.

1	2	3	4	5
Almost never				**Almost always**

Item	Statements	Answer (1-5)
1.	I'm disapproving and judgmental about my own flaws and inadequacies	
2.	When I'm feeling down I tend to obsess and fixate on everything that's wrong.	
3.	When things are going badly for me, I see the difficulties as part of life that everyone goes through.	
4.	When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.	
5.	I try to be loving towards myself when I'm feeling emotional pain.	
6.	When I fail at something important to me I become consumed by feelings of inadequacy.	
7.	When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.	
8.	When times are really difficult, I tend to be tough on myself.	
9.	When something upsets me I try to keep my emotions in balance.	
10.	When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.	
11.	I'm intolerant and impatient towards those aspects of my personality I don't like.	
12.	When I'm going through a very hard time, I give myself the caring and tenderness I need.	
13.	When I'm feeling down, I tend to feel like most other people are probably happier than I am.	
14.	When something painful happens I try to take a balanced view of the situation.	
15.	I try to see my failings as part of the human condition.	
16.	When I see aspects of myself that I don't like, I get down on myself	
17.	When I fail at something important to me I try to keep things in perspective.	
18.	When I'm really struggling, I tend to feel like other people must be having an easier time of it.	
19.	I'm kind to myself when I'm experiencing suffering.	
20.	When something upsets me I get carried away with my feelings.	
21.	I can be a bit cold-hearted towards myself when I'm experiencing suffering.	

22.	When I'm feeling down I try to approach my feelings with curiosity and openness.	
23.	I'm tolerant of my own flaws and inadequacies.	
24.	When something painful happens I tend to blow the incident out of proportion.	
25.	When I fail at something that's important to me, I tend to feel alone in my failure.	
26.	I try to be understanding and patient towards those aspects of my personality I don't like.	

To calculate the score on the subscales, calculate the average score on each subscale. See below for the items belonging to each subscale.

To calculate the total score, first reverse score the items on the self-judgement, isolation, and over-identification subscales (i.e., **1=5, 2=4, 3=3, 4=2, 5=1**) and then calculate the total score.

Self-kindness: **5, 12, 19, 23, 26**
Self-judgement: **1, 8, 11, 16, 21**
Common humanity: **3, 7, 10, 15**
Isolation: **4, 13, 18, 25**
Mindfulness: **9, 14, 17, 22**
Over-identification: **2, 6, 20, 24**

Reference:

Neff, K. D. (2003). Development and validation of a scale to measure self-compassion. Self and Identity, 2, 223-250.

Resilience Scales

All resilience scales that have been validated in several cultures are protected by copyrights that do not allow us to share them. We particularly recommend two scales:

- The Resilience Scale by Wagnild & Young (1991) : https://www.resiliencecenter.com/products/resilience-scales-and-tools-for-research/the-original-resilience-scale/
- The Connor-Davidson Resilience Scale (CD-RISC) : http://www.connordavidson-resiliencescale.com/

The APA is offering the Cultural Formulation Interview (including the Informant Version) and the Supplementary Modules to the Core Cultural Formulation Interview for further research and clinical evaluation. They should be used in research and clinical settings as potentially useful tools to enhance clinical understanding and decision-making and not as the sole basis for making a clinical diagnosis. Additional information can be found in DSM-5 in the Section III chapter "Cultural Formulation." The APA requests that clinicians and researchers provide further data on the usefulness of these cultural formulation interviews at http://www.dsm5.org/Pages/Feedback-Form.aspx.

Cultural Formulation Interview (CFI)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE ***ITALICIZED.***
The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INDIVIDUAL:* I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about ***your*** experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

CULTURAL DEFINITION OF THE PROBLEM

CULTURAL DEFINITION OF THE PROBLEM

(Explanatory Model, Level of Functioning)

Elicit the individual's view of core problems and key concerns. *Focus on the individual's own way of understanding the problem.* *Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").*	1. What brings you here today? *IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would *you* describe your problem?
Ask how individual frames the problem for members of the social network.	2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
Focus on the aspects of the problem that matter most to the individual.	3. What troubles you most about your problem?

CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

CAUSES

(Explanatory Model, Social Network, Older Adults)

This question indicates the meaning of the condition for the individual, which may be relevant for clinical care. *Note that individuals may identify multiple causes, depending on the facet of the problem they are considering.*	4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]? *PROMPT FURTHER IF REQUIRED:* Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.
Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.	5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?

STRESSORS AND SUPPORTS

(Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help Seeking)

Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from co-workers, from participation in religion or spirituality).	6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?
Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.	7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?

ROLE OF CULTURAL IDENTITY

(Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents)

	Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By ***background*** or ***identity,*** I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.
Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.	8. For you, what are the most important aspects of your background or identity?
Elicit aspects of identity that make the problem better or worse. *Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).*	9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).	10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

SELF-COPING

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors)

Clarify self-coping for the problem.	11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?

PAST HELP SEEKING

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing). *Probe as needed (e.g., "What other sources of help have you used?").* *Clarify the individual's experience and regard for previous help.*	12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]? *PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:* What types of help or treatment were most useful? Not useful?

BARRIERS

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment. *Probe details as needed (e.g., "What got in the way?").*	13. Has anything prevented you from getting the help you need? *PROBE AS NEEDED:* For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?

CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

PREFERENCES

(Social Network, Caregivers, Religion and Spirituality, Older Adults, Coping and Help Seeking)

Clarify individual's current perceived needs and expectations of help, broadly defined. *Probe if individual lists only one source of help (e.g., "What other kinds of help would be useful to you at this time?").*	Now let's talk some more about the help you need. 14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?
Focus on the views of the social network regarding help seeking.	15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?

CLINICIAN-PATIENT RELATIONSHIP

(Clinician-Patient Relationship, Older Adults)

Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery. *Probe details as needed (e.g., "In what way?").* *Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.*	Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. 16. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

Handout Examples

Caregiver Psychoeducation: Depression

Objectives:

- to discuss purpose and process of sessions; including practice assignments, regular attendance, and end-of session caregiver briefings
- to explore the caregiver's understanding of why the child is in treatment and establish a framework of feeling better by learning there are things we can do to control our mood
- to introduce the general concept that we can control our feelings by (a) how we act and/or (b) how we think
- to discuss causes and "symptoms" of feeling good and bad for the child

Steps:

1.	**Normalize feelings of depression**	State that you will be talking about the child's depression today. Point out that everyone—children and caregivers—has a times when he or she feels bad, sad, gloomy, grouchy, etc. but that not everyone knows the things they need to do to stop feeling that way. Add that it's normal for a child to feel bad sometimes, but that we don't want to a child "get stuck" in the bad feelings.
2.	**Discuss factors contributing to depression**	Discuss factors (e.g., emotions, behaviour, cognitions, social systems, etc.) contributing to depression and how these factors work together to maintain the child's difficulties. You might examine how social fears are related to poor peer relations, negative self-thoughts, and social isolation, thereby maintaining depression.
3.	**Find out more about the child's feelings**	Next, you will want to get the caregiver's perspective on the child's negative feelings. Try to develop an individualized picture of the child's distinctive pattern of depression: • The triggers that provoke positive or sad feelings • The bodily response to such feelings (e.g., increased or decreased energy) • The outward appearance that accompanies the feelings (e.g., downcast eyes, slumping body) • The thoughts that go along with the feelings (e.g., "I'm no good" vs. "The world sucks") • The behavioural display involved (e.g., talkative and seeking others out vs. quiet and withdrawn)
4.	**Discuss skills**	Let the caregiver know that to change the child's moods, we might focus on some skills that involve • The ways he or she behaves • The ways he or she think about things, or • Both types of skills Draw a distinction between ways to cope that involve what we do and ways to cope by changing how we think.
5.	**Explain skill building concept**	Point out to the caregiver that much of the treatment for depression will involve teaching the child new skills that are designed to increase positive mood. Not every skill helps every child, but the idea is to give the child enough tools that he or she has many options to try when feeling sad or irritable.
6.	**Lay out structure and sequence of treatment**	Discuss how these skills will be learned through practice and rehearsal (e.g., role-playing, practicing new skills at home), and that regular attendance is very important because the child will need a chance to get feedback on his or her performance and to learn more than just one or two skills to feel better.
7.	**Clarify goals**	Make sure to get the caregiver's understanding of what is expected in treatment and to clarify what motivated bringing the child to treatment. Develop a plan for how the skills to be learned will be used as a strategy to achieve those goals.
8.	**Introduce the idea of monitoring**	Tell the caregiver that during new skill practice at home, he or she may need to write down or help the child write down some things about the task being practiced and the feelings the child experiences before and after practice. This is in order to find out what kinds of things are most reliable for increasing positive feelings.

Useful tips:

- Remember to praise often
- Remember to review often, by asking questions
- Brief any caregivers, teachers, or other adult figures who may be involved
- Simplify these steps if you have to
- This material can be covered in more than one session/meeting

Reference:

Chorpita, B. F., & Weisz, J. R. (2009). Modular approach to therapy for children with anxiety, depression, trauma, or conduct problems (MATCH-ADTC).

Examples of Analogies to Better Understand Mental Health Disorders

Anxiety:

Fire alarm: Anxiety is like a fire alarm. The fire alarm is used to signal the presence of a danger (a fire), so it is a good thing because it allows the individual to react in order to stay safe (leave the place where there could be a fire). However, an alarm that goes off repeatedly even when there is no danger (for example, when someone is using the oven) is annoying and can prevent the individual from having fun. A fire alarm that is defective will continue to sound until the batteries run out. Similarly, the individual's anxiety will not stop until the individual stops the avoidance behaviours and instead confronts the source of the anxiety.

Depression:

Sunglasses: Depression is comparable to wearing glasses covered with black paint. The information that the person receives from their environment passes through the lenses of their glasses and is perceived in a dark and negative way. The goal of the treatment is to help the individual assess their thoughts and scrape off this black paint in order to regain a clearer perspective. These painted glasses are also worn inside the individual and influence their feelings of fatigue, loneliness, apathy, pain, etc.

References:

Emmerson, C. (2016, February 11). My Anxiety Alarm Worksheet for Kids. Retrieved from https://counsellortoolkit.wordpress.com/2015/10/06/my-anxiety-alarm/

Killick, S., Curry, V., & Myles, P. (2016). The mighty metaphor: a collection of therapists' favourite metaphors and analogies. *The Cognitive Behaviour Therapist*, *9*.

Example of Emotion Worksheet

Identifying Difficult Moments

In this exercise, the individual identifies events that might be difficult in the absence of the loved one (e.g., anniversary of the death of the loved one, the individual's birthday, etc.), assesses the anticipated level of difficulty (1 = a little difficult; 10 = extremely difficult) and notes the reasons why each event might be difficult.

Event	Date	Rating (1-10)	Why?

Follow Up on the Level of Grief Across Various Activities

List the activities on your agenda and rate (on a scale of 1 to 10, 0 = not very intense and 10 = extremely intense) the intensity of grief, the level of positive emotions, and the level of negative emotions felt during each activity. Note the thoughts that arise during these activities.

Activity	Intensity of grief (1-10)	Positive emotions (1-10)	Negative emotions (1-10)	Thoughts

The Grieving Process

Grief: The natural emotional reaction resulting from a significant loss, especially the death of a loved one.

Everyone deals grief differently. Some people cry, laugh, worry about work, vomit or even feel numb. Some people recover quickly, while others take more time. Grief is a natural healing process, and there is no "right" way to go about it.

For some people, grief can become too painful. It can turn into something else entirely, such as depression or anxiety. At other times, grief can last too long and take over a person's life for years. This is called ***complicated grief***.

Key facts:

- The definition of "normal" grief varies widely, depending on culture, people and situations;
- Grief is a natural process and does not always require treatment;
- Complicated grief is treatable through psychotherapy.

Reference:

Therapist Aid LLC. (2016). Accédé via: TherapistAid.com

Progressive Muscle Relaxation: Steps to Follow

General procedure:

1. Inhale and tense up a muscle group (e.g., hands and forearms) for 5-10 seconds. Tense your muscles as tight as you can, but not so tight that you feel pain or cramping.
2. Exhale, and suddenly (not gradually) relax the muscles completely.
3. Relax for 10 to 20 seconds. Notice the difference between how the muscles feel when they are tense and when they are relaxed.
4. Work the next muscle group.
5. When you have completed all the muscle groups, take a moment to bring your attention back to the present moment, count backwards from 5 to 1 to bring your attention back to the present.

Note: Try to work muscle groups in order, for example, head to toe or toes to head.

Description of body parts and what to do:

Forehead: Frown.
Eyes: Close eyes as tightly as possible.
Mouth: Open mouth wide enough to stretch the muscles of your jaw.
Neck and shoulders: Raise shoulders up to your ears.
Chest: Tense your chest while taking a deep breath.
Belly/stomach: Suck in your belly/stomach.
Arms: Tense your biceps by pulling in your forearms to your shoulders.
Hands: Make fists.
Butt/hip: Squeeze your butt cheeks together.
Thighs: Tense them tightly.
Lower legs: Point toes towards the bottom while curling toes downwards.

Reference:

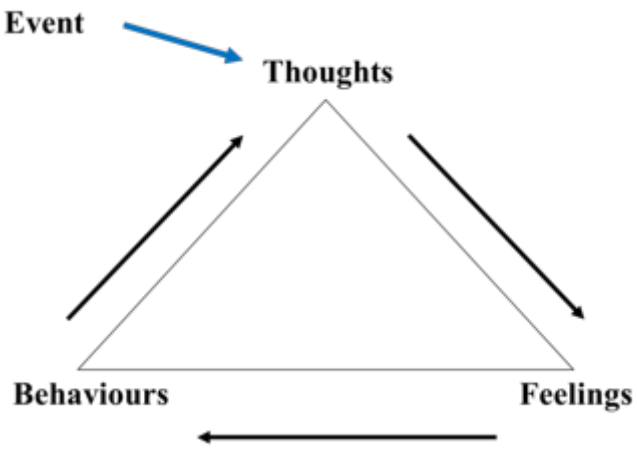
How to do Progressive Muscle Relaxation. (2019, April 17). Retrieved from https://www.anxietycanada.com/articles/how-to-do-progressive-muscle-relaxation/

Ambardekar, N. (2020, January 24). Progressive Muscle Relaxation (PMR) Technique for Stress & Insomnia. Retrieved from https://www.webmd.com/sleep-disorders/muscle-relaxation-for-stress-insomnia

Stress Management: Doing Progressive Muscle Relaxation. (2018, June 28). Retrieved from https://www.healthlinkbc.ca/health-topics/uz2225

Cognitive Triangle

Our thoughts affect our feelings and the way we act. When something happens, we think about it. These thoughts affect our feelings and our actions.

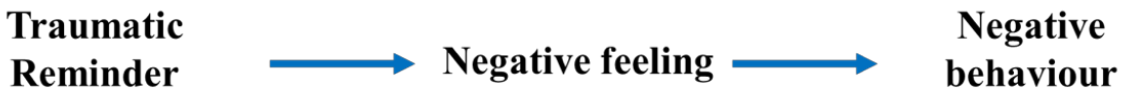


Consider your thoughts and how they make you act.

Reference:

Hendricks, A., Kliethermes, M., Cohen, J. A., Mannarino, A. P., & Deblinger, E. (n.d.). Dealing with Trauma: A TF-CBT Workbook for Teens. PDF. Repéré en mars 2020 via https://tfcbt.org/wp-content/uploads/2019/02/Revised-Dealing-with-Trauma-TF-CBTWorkbook-for-Teens-.pdf

Diagram of the Impact of Traumatic Reminders on Feelings and Behaviours



Reference:

Cohen, J. A., & Mannarino, A. P. (2013, September). Trauma-Focused Cognitive Therapy in Residential Treatment Facilities: An Implementation Manual. PDF. Repéré en janvier 2020, via https://tfcbt.org/wp-content/uploads/2018/05/RTF-Implementation-Manual-09-09-13-FINAL.pdf

Children: Thought, Feeling, and Action Identification Game

This game will teach you the difference between thoughts, feelings, and actions.

Put a **T** next to items that are **thoughts.**

Put a **F** next to items that are **feelings.**

Put an **A** next to items that are **actions.**

Happy	Singing
Running	She is mad at me
I am intelligent!	Eating
Hitting	Walking
Sad	Being excited
Playing	I will make it
Angry	Scared
I can do it!	Taking a deep breath
It's my fault	Hopping on one foot
Worried	Brave
Hiding	Talking to a friend
Crying	Safe

Reference:

Hendricks, A., Cohen, J. A., Mannarino, A. P., & Deblinger, E. (n.d.). Your Very Own TF-CBT Workbook. PDF. Repéré en mars 2020 via https://tfcbt.org/wp-content/uploads/2014/07/Your-Very-Own-TF-CBT-Workbook-Final.pdf

Parents: Recognizing Signs of Distress/Emotional Dysregulation in Children

Some elements to take into account to detect early signs:

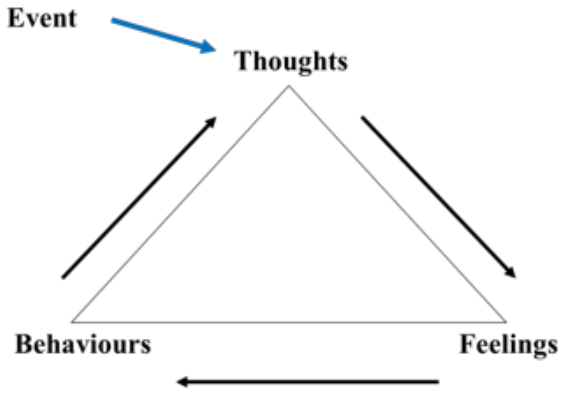
- Traumatic reminders that could trigger negative feelings and behaviours;
- Changes in facial expression or body language suggesting increased distress;
- Changes in verbal expression suggesting distress: increased volume, change in tone, increased irritability, increased arguing, etc.;
- Changes in the level of physical agitation, e.g., increased shaking of extremities, fidgeting, tapping of feet or fingers, etc.;
- Angry face, tight lips or fists, mumbling, eye rolling or squinted eyes;
- Requests for attention from authority figures and trampling when requests are not granted;
- Increase in silent behaviour, withdrawal, mood swings, appearing more disconnected, talking to oneself, appearing more confused, dissociative or psychotic than before;

Reference:

Cohen, J. A., & Mannarino, A. P. (2013, September). Trauma-Focused Cognitive Therapy in Residential Treatment Facilities: An Implementation Manual. PDF. Repéré en janvier 2020, via https://tfcbt.org/wp-content/uploads/2018/05/RTF-Implementation-Manual-09-09-13-FINAL.pdf

Daily Journal Template

Let's take a look at your thoughts and how they make you feel and act. List different events that happened today (or recently), the thoughts that accompanied them, how they made you feel, and what you did.



Events → Thoughts → Feelings → Behaviours

What happened	What I told myself	What I felt	What I did

Reference:

Hendricks, A., Kliethermes, M., Cohen, J. A., Mannarino, A. P., & Deblinger, E. (n.d.). Dealing with Trauma: A TF-CBT Workbook for Teens. PDF. Repéré en mars 2020 via https://tfcbt.org/wp-content/uploads/2019/02/Revised-Dealing-with-Trauma-TF-CBTWorkbook-for-Teens-.pdf

Parents: Helping the Child Reduce the Intensity of His/Her Feelings

Once the child has acknowledged his/her feelings, you have already begun defusing the situation. However, do not assume that the child will not behave in an out of control manner. At this stage, it is essential to help the child use his/her emotion regulation skills to "turn down the volume" of his/her feelings in order to avoid escalation. At this stage, you can:

Model the emotional regulation skills:
Continue keeping your voice calm. Speak slowly and softly, even if the child is shouting. Increasing the volume of your voice will not help him/her to calm down. Increasing the volume of your voice will only make him/her angrier and make the situation worse. Do not reprimand the child for swearing. This is a time to model emotional regulation, not to establish your authority.

Offer emotional regulation options:
Provide the child with emotional regulation options, for example, offer distraction options such as asking if he/she would like to play a game with you, go to a quiet place and talk with you, go for a walk, or if there is another emotion regulation skill in his/her repertoire that he/she would like to use. Your knowledge of the child in question, of his/her interests and moods, and your intuitive judgment of what will work best to defuse a given situation, are essential for positive outcomes.

Praise avoidance of escalation:
Once the child is able to respond calmly, praise him or her for avoiding further escalation. For example: *"Zane, you've done a great job keeping calm even though you're really angry. It's hard to do and I hope you're really proud of it".*

Reference:

Cohen, J. A., & Mannarino, A. P. (2013, September). Trauma-Focused Cognitive Therapy in Residential Treatment Facilities: An Implementation Manual. PDF. Repéré en janvier 2020, via https://tfcbt.org/wp-content/uploads/2018/05/RTF-Implementation-Manual-09-09-13-FINAL.pdf

Examples of Questions and Feelings to Discuss After Sharing the Narrative Story

Your thoughts related to your traumas affect your feelings and actions and can have an impact on other areas of your life. These thoughts can help you feel better faster or prevent you from feeling well. Let's look at some of your thoughts related to your traumas. You may have included some of your thoughts and feelings in your narrative story and you may want to talk about them with your therapist. Below is a list of questions and thoughts that people often have after a traumatic event. You and your therapist can choose which questions you will discuss, and you can add your own questions or thoughts at the end of the list. For each question, you can write down your answers or discuss them with your therapist. While identifying your thoughts related to your traumas, you and your therapist can also talk about feelings and behaviours related to the traumas. If any of these thoughts are false and/or unhelpful (you can review the evidence if you are unsure), you and your therapist can explore other thoughts that are more accurate and/or helpful to you. You can use these questions to create a tool that summarizes what has been learned in therapy.

1. Why did this happen to me?
2. Who is responsible for these traumas?
3. How will these traumas affect me in the future?
4. How have these traumas affected my family/my interpersonal relationships?
5. How have these traumas affected my safety and my ability to feel safe?
6. What has been the impact of these traumas on my ability to trust and/or connect with others?
7. Since the traumas, my worldview has changes in the following way:
8. Since the traumas, my view of myself has changes in the following ways:
9. Since I have been in therapy, I have learned the following things about myself:
10. Coming to therapy has helped me in the following ways:
11. If I had a friend who had experienced a similar trauma, I would give him/her the following advice:
12. If my friend thought it would be too difficult to talk about their trauma, I would tell them:
    a. _____
    b. _____
    c. _____

Reference:

Hendricks, A., Kliethermes, M., Cohen, J. A., Mannarino, A. P., & Deblinger, E. (n.d.). Dealing with Trauma: A TF-CBT Workbook for Teens. PDF. Repéré en mars 2020 via https://tfcbt.org/wp-content/uploads/2019/02/Revised-Dealing-with-Trauma-TF-CBTWorkbook-for-Teens-.pdf

Analogy of a Bad Song

Sometimes we think about something bad non-stop (like a song we don't like but is stick in our head). You can call this a ***bad song*** because it can make you feel really bad! But did you know that you have the power to stop that bad song? It's just a matter of noticing the bad song when it's playing in your head and pressing **STOP!** You can also say, "STOP! Go away bad song!" and then replace it with a happier song.

How does your ***bad song*** go? Describe your ***bad song*** in words or by drawing.

How does your ***happy song*** go? Describe your ***happy song*** in words or by drawing.

Let's try together! Sing your ***bad song*** in your head. When I say STOP, sing your ***happy song*** instead.

Reference:

Hendricks, A., Cohen, J. A., Mannarino, A. P., & Deblinger, E. (n.d.). Your Very Own TF-CBT Workbook. PDF. Repéré en mars 2020 via https://tfcbt.org/wp-content/uploads/2014/07/Your-Very-Own-TF-CBT-Workbook-Final.pdf

Examples of Cognitive Distortions

Sometimes we have thoughts that are not quite accurate and/or useful. Below you will find descriptions of different types of problematic thoughts. From the list, identify the problematic thoughts you have recently experienced, as well as how you felt and how you acted.

Filtering	Enhancing the negative details. The person dwells on the negative details and loses sight of the positive aspects. For example, "Nothing ever works out for me. ", "I'll never feel good again. »
"All or nothing thinking"	Thinking in a polarized, rigid and unbalanced way. For example, "I made a mistake, so my day is ruined.", "I got 90% on the exam. It's not 100%, so I suck. »
Overgeneralizing	Forming general conclusions following a single event. Expect an event to recur repeatedly because of what happened once. For example, "COVID-19 caused the death of my grandparents, it's only a matter of time before some virus causes the death of other loved ones.", "My mother became sick after being in contact with me. Wherever I go, death follows me. From now on I have to stay at home, even after the epidemic, to avoid the death of other relatives."
Jumping to conclusions	Making inferences about another person's thoughts and feelings. These inferences can take the form of ***mind reading***, that is, inferring the possible thoughts of a person and reacting as though they were true (for example, thinking, "She hates me." and behaving with discomfort in the presence of the person in question). These problematic thoughts can also take the form of ***prediction errors***, that is, taking for fact the expected outcome of an event (for example, thinking, "I will never meet someone who brings me as much joy as my late husband did" and behaving in a way that fulfills that prophecy).
Catastrophizing and minimizing	Magnifying the importance of an insignificant event to the point of perceiving it as a disaster or as intolerable (For example, thinking: "She must hate me, so I won't invite her to dinner anymore" when your friend notifies you at the last minute that she has to cancel your dinner plans). Conversely, reducing the importance of an accomplishment or other positive occurrence to something insignificant (for example, thinking, "It's nothing important" when you graduate from school).
Personalization	Believing that one is responsible for unfortunate events that are beyond one's control (e.g., thinking, "If I had been on time, the event wouldn't have been spoiled for everyone") or believing that what others say and do is directly related to oneself (e.g., thinking, "He doesn't leave his house anymore, probably because of something I said to him").
Blaming	Holding others responsible for one's own emotional pain (e.g., thinking, "If I live in darkness today, it's his fault") or holding oneself responsible for the emotions of others (e.g., thinking, "My child is suffering because of my failures as a parent").

False obligations	Having expectations about what one should do and what others should do without taking into account the facts of reality. Feeling angry, frustrated, resentful when people do not adhere to these rules dictating what should be done (e.g., thinking, "She should have been by my side when this event happened!") and feel guilty when rules are not followed by oneself (for example, thinking, "I should try to reconnect with my family members").
Labelling	Labelling oneself or others on the basis of one or two qualities without taking into account the context in which these qualities emerged. Reducing oneself or others to these situational qualities (e.g., thinking: "I screwed up, so I'm an idiot"; "He's a real jerk").
Emotional reasoning	Assuming that the emotions you feel correspond to reality (e.g., feeling nervous and scared in the presence of a new person and deciding that they are a "bad person," when in reality you know very little about them).

References:

10 distorsions cognitives qui entretiennent des émotions négatives. (2013, March 14). Retrieved from http://www.psychomedia.qc.ca/psychologie-cognitive/2013-03-14/distorsions-cognitives-liste-definitions

Beck, A. T. (1976). Cognitive therapies and emotional disorders. New York: New American Library.

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Grohol, J. M. (2019, June 24). 15 Common Cognitive Distortions. Retrieved from https://psychcentral.com/lib/15-common-cognitive-distortions/

Leahy, R.L. (2017). Cognitive Therapy Techniques, Second Edition: A Practitioner's Guide. New York: Guilford Press.

McKay, M. & Fanning, P. (2016). Self-Esteem: A Proven Program of Cognitive Techniques for Assessing, Improving, and Maintaining Your Self-Esteem. New York: New Harbinger Publications.

Examining the Evidence

When you are feeling sad, angry, or stressed, what thoughts or images come to mind? What do you say to yourself? Just because you have a thought does not mean that it is true or that you should continue to think that way. You can look at the evidence to see if 1) the thought is true and 2) the thought is useful. Practice below. First, write one thought that upsets you and then fill in the chart.

Upsetting thought:			
Proof that the thought is true	**Proof that the thought is false**	**Proof that the thought is useful to me**	**Proof that the thought is not useful to you**

Reflection :

What have you learned about your thought? If the evidence suggests that your thought may not be true and/or useful, can you identify a thought that would be more true/useful?

Reference:

Hendricks, A., Kliethermes, M., Cohen, J. A., Mannarino, A. P., & Deblinger, E. (n.d.). Dealing with Trauma: A TF-CBT Workbook for Teens. PDF. Repéré en mars 2020 via https://tfcbt.org/wp-content/uploads/2019/02/Revised-Dealing-with-Trauma-TF-CBTWorkbook-for-Teens-.pdf

Examining the Cognitive Distortions/Problematic Thoughts

This is an exercise to examine the impacts of your problematic thoughts. Refer to the *Examples of Cognitive Distortions* in the appendix to identify the types of problematic thoughts you have recently had. Fill out the chart below and discuss it with your therapist.

Thought	Type of problematic thought/cognitive distortion	Did you like the way the thought made you feel?	How did the situation evolve?	Can you imagine it going any other way?

Reference:

Hendricks, A., Cohen, J. A., Mannarino, A. P., & Deblinger, E. (n.d.). Your Very Own TF-CBT Workbook. PDF. Repéré en mars 2020 via https://tfcbt.org/wp-content/uploads/2014/07/Your-Very-Own-TF-CBT-Workbook-Final.pdf

Self-Assessment for Signs and Symptoms of Burnout

- ☐ I have disturbed sleep, eating, or concentration.
- ☐ I isolate myself from family, friends, and colleagues.
- ☐ I fail to take regularly scheduled breaks.
- ☐ I enjoy my work less than in the past.
- ☐ I find myself bored, disinterested, or easily irritated by clients.
- ☐ I have experienced recent life stressors such as illness, personal loss, relationship difficulties, financial problems, or legal trouble.
- ☐ I feel emotionally exhausted or drained after meeting with certain clients.
- ☐ I find myself thinking of being elsewhere when working with clients.
- ☐ I am self-medicating, overlooking personal needs, and overlooking my health.
- ☐ I find my work less rewarding and gratifying than in the past.
- ☐ I am feeling depressed, anxious, or agitated frequently.
- ☐ I am enjoying life less than in the past.
- ☐ I find myself experiencing repeated headaches and other physical complaints.
- ☐ I sit staring into space for hours and can't concentrate on my work.

Reference:

Barnett, J. (2014, December). Distress, burnout, self-care, and the promotion of wellness for psychotherapists and trainees: Issues, implications, and recommendations. [Web article]. Retrieved from: http://www.societyforpsychotherapy.org/distress-therapist-burnout-self-care-promotion-wellness-psychotherapists-trainees-issues-implications-recommendations

Self-Assessment for Adaptive Coping Behaviours

- ☐ I take regularly scheduled breaks.
- ☐ I take vacations periodically and don't bring work with me.
- ☐ I have friends, hobbies, and interests unrelated to work.
- ☐ I exercise regularly, have a healthy diet, and maintain and appropriate weight.
- ☐ I limit my work hours and caseload.
- ☐ I participate in peer support, clinical supervision, personal psychotherapy, and/or journaling as preventive strategies.
- ☐ I attend to my religious and spiritual side.
- ☐ I regularly participate in relaxing activities (e.g., meditation, yoga, reading, music).
- ☐ I regularly participate in activities that I enjoy and look forward to.

Reference:

Barnett, J. (2014, December). Distress, burnout, self-care, and the promotion of wellness for psychotherapists and trainees: Issues, implications, and recommendations. [Web article]. Retrieved from: http://www.societyforpsychotherapy.org/distress-therapist-burnout-self-care-promotion-wellness-psychotherapists-trainees-issues-implications-recommendations

Self-Assessment for Maladaptive Coping Strategies

- ☐ I self-medicate with alcohol, drugs (including over the counter and prescription), and food.
- ☐ I seek emotional support and nurturance from clients.
- ☐ I keep taking on more and try to just work my way through things.
- ☐ I try to squeeze more into the day, get more done, and measure success by how many tasks I complete and by how much I can accomplish in a day.
- ☐ I isolate, avoid colleagues, and minimize the significance of stresses in my life.
- ☐ I know that distress and impairment are for others and don't take seriously the warning signs I experience.
- ☐ I believe that everything will turn out fine just because I say so!

Reference:

Barnett, J. (2014, December). Distress, burnout, self-care, and the promotion of wellness for psychotherapists and trainees: Issues, implications, and recommendations. [Web article]. Retrieved from: http://www.societyforpsychotherapy.org/distress-therapist-burnout-self-care-promotion-wellness-psychotherapists-trainees-issues-implications-recommendations

Barnett, J. E. (2008). Impaired professionals: Distress, professional impairment, self-care, and psychological wellness. In M. Herson & A. M. Gross (Eds.), *Handbook of clinical psychology* (Volume One) (pp. 857-884). New York: John Wiley & sons.