Phased Approach for Supporting the Mental Health of Healthcare Workers and Others Affected by the COVID-19 Pandemic (PAC)

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The current COVID-19 pandemic is unprecedented in reach around the world and the extended nature of this invisible threat. No one is left without impact whether it is direct such as exposure to infection or infection risks or changes in or loss of employment or indirect through impact on loved ones and communities. Much of the world has experienced an extended and uncertain time period of quarantine and/or social distancing restrictions that have substantially interfered with usual work and social routines, cultural and religious customs, work and leisure activities, and the availability of services. Many are predicting that the mental health fall out will be grim as well. We agree that the mental health impact will be significant, but we also feel confident that for most people this will be a significant stressor that they cope with in real time and even if highly distressed acutely, will eventually naturally recover and move on to a new normal and satisfying life. The mental health response should be measured and not overly emphasize a belief and expectation of an epidemic of unmanageable long-term negative mental health impacts. Instead, while planning to address mental health needs that will arise, we should also project hope and have confidence that for most people this will be distressing but they will recover with time. Data from the field of trauma and bereavement suggest that most people will ultimately be resilient even in the face of severe challenges. Nonetheless, finding ways to help people cope acutely and to assure those in need of higher levels of mental health intervention can access it are critically important goals. While the evidence base for prevention intervention is less clear about optimal approaches, there are nonetheless many helpful strategies that may help reduce both short- and long- term distress, and their targets are guided by relevant clinical and research lessons learned over many years.

Key to any mental health response to the current pandemic or other extended potentially highly distressing and/or traumatic events is a response that simultaneously considers both timing (referred to as phase) and associated distress and/or functional impairment (referred to as level). As defined below, the framework includes three phases (initial, post, and longer-term) and three levels (system level, self-directed level, and mental health supported brief intervention).

Phased Approach

This program of phased interventions and resources is intended to assist health systems and programs impacted by the pandemic to plan for how to address current mental health issues arising as well as to prepare and plan for the continued needs of their communities, patients, and staff. In addition, many of the resources presented may be used by healthcare professionals and others on the front lines of care, as well as anyone being significantly impacted by COVID-19 as they see fit. This unprecedented pandemic presents an ongoing stressor with elevated risk of COVID-19 infection to healthcare and other essential frontline workers and their families as a result of their service. The nature of the current situation combines much that is new and ever changing as the virus moves across populations and as our governments and social structures work to address the many impacts of this pandemic. While this specific pandemic is larger than previous pandemics and has resulted in more deaths than 9/11, there is much that the mental health field knows from military, disaster settings, and other types of trauma exposures that can help guide how we support our health professionals working in this extremely stressful environment. Investments in efforts to support mental health and provide indicated prevention and intervention may decrease long-term risk for negative mental health outcomes for healthcare workers and other staff on the frontlines of the pandemic. This proposed phased approach is intended to help guide efficient allocation of mental health resources to those most in need of assistance at the time that they need it at the level that they need it (e.g., self-directed versus brief intervention with

some support versus traditional treatment sessions with a provider). Appropriate allocation of expert mental health resources can assist the system in providing evidence based clinical care to those who need it.

The **initial phase** includes the period of time while we are dealing with the ongoing stressor, such as the current COVID-19 pandemic. This phase would end at the point that the initial risk and impact has ended or reduced to a "new normal" or lower level of risk. The **post phase** covers the initial responses in the period after the acute exposure to risk and loss is complete and the next three months when expectations are that people impacted will be having various levels of emotional reactions and response. The **long-term phase** covers from three months after the individual's experience of impact and loss is over and into the future. For this pandemic, the phases will overlap for individuals depending on their roles and specific impacting traumatic exposures (traumatic loss of significant others, exposure to death at work, etc.). In addition, Further, grief responses generally occur on a longer timeline with current iterations of prolonged or complicated grief utilizing a 6 or 12 month minimum for diagnosis to account for broad individual, cultural and religious variability in usual acute grief and its evolution to more integrated forms of grief.

Within each phase, there are different levels of response. The **System Supported Level** focuses on recommendations for leadership and organizations to put in place for those in the relevant phase. The **Self-Directed Level** includes resources that individuals can work with on their own. These self-directed interventions are intended to be used based on either self-assessment of need or as an initial intervention for those with mild to moderate distress and/or functional impairment without imminent risk to self or others. Finally, the **mental health supported brief intervention level** includes brief interventions provided with entry through primary care or mental health providers for those with a higher level of need or for whom self-directed approaches are not possible and/or effective.

Often people forget what worked for them in the past when confronted with stress. We recommend that healthcare workers make sure they are taking breaks to recharge even when demand is high and stay connected to others such as using virtual communication options. Increasing a sense of community and/or individual social support efforts can be helpful, as well as providing access to structured opportunities for sanctioned self-care and accessible ways to enhance mindfulness, exercise, sleep, or relaxation strategies. We urge care not to over-pathologize a "normal" response to this extremely abnormal pandemic situation as pathology, inability to cope, or acute stress disorder. Key to these levels when in the initial or post phases remains a general focus on not pathologizing these responses as natural recovery remains the most common long-term outcome, even for those highly distressed acutely.

Some people may report emotional responses (such as upsetting intrusive memories or depressed mood) at a level that interferes with their ability to perform their daily tasks. This may occur due to preexisting mental health issues that have worsened or may be due to specific new and highly distressing experiences such as a traumatic death or other traumatic experiences. If their reactions are persistently highly distressing and/or interfering with functioning, the self-directed or mental health supported brief intervention level of assistance may be warranted. For those with preexisting mental health conditions that were under treatment and worsen, however, it is also important to assure they have access to prior care such as needed medications. Similarly, anyone with acute suicidal ideation with a plan or behaviors should be referred to an emergency room or call 911.

Systems and individuals engaging in mental health response are encouraged to:

1) Ensure basic needs for food, sleep, and lodging are met. For healthcare providers and staff this means management of risk of personal and family COVID-19 infection such as PPE.
2) Find creative ways to safely enhance social connection and support.
3) Provide ongoing support for people as they would like- not a single shot.
4) Encourage people to use what positive coping strategies have worked for them in the past that they can draw on again such as talking with friends and/or family, exercise, yoga, prayer, etc. and monitor or possibly reduce unhelpful coping such as the use of alcohol or other harmful strategies.
5) Create opportunities for people as they are interested and able to talk about difficult experiences. This can be helpful to process them, but avoid compelling people to tell their stories, especially in groups. Let them share as they are ready and willing- be ready to listen but don't force the story.
6) Avoid group debriefing where everyone is forced to share and listen to details of death or traumatic events in their stories together. This has shown iatrogenic effects in some studies of trauma and PTSD. Other types of group support efforts, however, can be helpful to provide opportunity to build community, emotional support, psychoeducation and reminders about resources (even if virtual).
7) Provide information about accessible mental health resources for those who may need them.

Maslow's hierarchy of needs suggests that now is the time to make sure basic needs are cared for. Later is the time to work on what may be left in the aftermath. People undergoing stress most often do not need our help. They need support from family and community for basic needs, safety, and emotional support.

Plans for mental health response in the coming months should focus on providing social support and helping people to feel in control of things they can control while focusing professional mental health resources on those who need it most. This resource offers some ideas about how to integrate a phased approach to helping support those on the front lines or anyone being significantly emotionally challenged by the COVID-19 pandemic.

Initial Phase

System Supported Level 1

Target Population. This first level targets all healthcare and any other frontline workers in settings with heightened risk of COVID-19 infection, such as patient care settings, as well as others impacted by COVID-19. Level 1 content includes basic information that can be made widely available to people prior to the start of a shift and throughout their work with COVID-19 patients. This section touches on some examples and resources currently available at no cost to support front line workers.

Initial Phase System Supported Level

This framework is evidence informed and based on what the field has learned through prevention research. The Initial Phase System Supported Level targets what organizations can do to support front

line healthcare workers and staff working in the COVID-19 pandemic with the goal of enhancing support of decreasing negative mental health outcomes.

Recent research provides direction on how to meet the needs of healthcare workers as they manage this **ongoing stressor**. Following a listening session with healthcare workers, Shanafelt and colleagues (Shanafelt, Ripp, & Trockel, 2020) collated responses and presented a useful framework for organizational response to 5 requests from healthcare workers in the current pandemic. This framework is a very helpful way of approaching this first level of need, and has been described and expanded on below based on this article.

1) "Hear me"

To the degree possible, organizations and leaders need to listen to and act on the local expert perspectives and experiences of the frontline staff. This means making sure that communication channels are open and diverse methods of communication of concerns are available (leadership listening sessions, email, leaders visiting impacted groups, etc.). Local listening is key as the specific needs of an organization will change with time and institutional resources as well as institutional history. For instance, organizations that have been understaffed prior to the pandemic may have additional needs for support.

2) "Protect me"

This request focuses on staff safety. The organization needs to reduce the risk of infection for healthcare workers and the risk of them transmitting the infection to others in their lives. Such efforts should include access to proper protective equipment (PPE) and procedures to reduce transmission to family members, as well as access to quick and reliable testing when required. For those working directly with patients with the highest risk of infection (e.g. respiratory procedures, ICU, ER), consideration of alternate living arrangements or access to scrubs, shower and change facilities prior to returning home is critical. Regular daily or frequent updates from a trusted source with accurate information about status of the unit and resources for protection of staff supports this request.

3) "Prepare me"

This request requires the organization to provide necessary training. Two primary targets of preparation are:

A) **Training**: Healthcare workers are being asked to provide care outside of their normal roles in high tempo critical situations. Ensuring brief but effective training for skills required is critical to the comfort and success of the providers and their response following exposures to stressful incidents outside their usual work experience. The perception of control and support during stress is a robust predictor of positive outcomes for providers (Dinenberg, McCaslin, Bates, & Cohen, 2014; Gros et al., 2016; Hancock & Bryant, 2018). The more providers are supported to feel they are practicing within their competence and/or sufficiently supervised in areas outside their scope of practice, the better the provider and patient outcomes will be. For instance, many frontline workers who have not worn Personal Protective Equipment (PPE) previously and need rapid access to fit testing when appropriate (i.e. N95 masks) and training in safe use and handling of PPE to decrease infection risk. In addition, for those who may have anxiety and fear

reactions to the experience of high activation of stressful situations while their breathing is restricted in the face mask. This may even result in panic attacks for some providers. A collaborative group from NYU, University of Chicago and Emory University School of Medicine created a mask and PPE self-directed desensitization program for providers or others who need to wear masks to prevent and normalize potential difficulties (Tips for Getting Comfortable in your PPE).

B) **Confidence in timely communication of important evolving information**: Clear and consistent communication about the ever changing environment, and novel challenges for front line staff and providers including briefings about frequent changes to anticipated hospital service needs, patient care practices, safety procedures, training and supervision resources, and rapidly evolving medical knowledge about the virus and its optimal management.

4) "Support me"

This request includes providing support that recognizes the human limitations of healthcare workers and acknowledges their efforts while also providing resources and protections to reduce negative outcomes, such as exhaustion. This includes providing for:

A) **Physical needs** such as breaks, sleep, and food, as well as support for individual needs recognizing they are part of a family and community system that may be requiring their efforts as well. This may include assistance with or special arrangements to support elder or childcare needs, safe transportation home, lodging for those who reside with others at high risk of infection, and so forth.

B) **Emotional needs** must be recognized and supported as well. The organization and those providing emotional support such as employee assistance programs, wellness programs or mental health support teams can provide messages and mental health resources directed to providers that support wellness and enhance coping such as those that:

1. Promote **calming** and **presence** for providers at work, including reminders to
    i. Breathe - stopping to focus on breathing in and out even for just a minute can reduce stress and calm the mind.
    ii. Take breaks to recharge even when providers want to continue when demand is high.
    iii. Break big problems into steps or pieces.
2. Assist providers to engage in **helpful coping** and **review coping resources,** including reminders that:
    i. When confronted with extreme stress, people often forget what has worked for them in the past. Recalling and utilizing these strategies is a first line of defense.
    ii. Talking with friends, exercise, yoga, prayer, etc. can help
    iii. Monitoring or possibly reducing unhelpful coping such as the use of alcohol or other harmful strategies.
    iv. Safely exercise, walk or spend time outdoors if possible every day.
3. Encourage providers to practice self-compassion, including reminders that
    i. Having emotional reactions is normal. Give themselves room to react. Do **not over-pathologize** a "normal" response to this very abnormal pandemic situation as pathology.

   ii. Encourage providers to accept their reactions and emotions and talk with people they trust about them.
   iii. Encourage providers to recognize they are human and having a human response to a scary and stressful situation. Providers don't need to be robots, nor is that healthy.
4. Promote a sense of **Self** and **Collective Efficacy**, including reminders to
   i. Celebrate small and large accomplishments together (end of shift, end of week, etc.).
   ii. Encourage providers to give themselves and their colleagues compliments and recognition of their hard work whenever possible.
5. Promote **Connectedness** across front line units and healthcare organizations as a whole including
   i. Reminders that social support improves outcomes.
   ii. Create creative safe spaces/time for people to interact and share information, even if virtually.
6. Promote **Hope** with accurate statements that help with longer term perspectives such as
   i. We will make it through together.
   ii. This will pass at some point.
7. Encourage **acceptance and being present with** current experiences as each person is willing and able, respecting individual differences. Encourage providers to talk to people about the successes and difficulties of each day, as well as condone a need to take a break and put it aside as well.

Shanafelt, et al, 2020

https://jamanetwork.com/journals/jama/fullarticle/2764380

Initial Phase

System Supported Resources

Leadership and Supervisor Management of Death and Dying During the Pandemic

The Center for the Study of Traumatic Stress at Uniformed Health Services University has developed a series of extremely useful brief handouts directed at supporting institutions, leaders, and healthcare workers exposed to deaths, building on lessons learned from disaster work. These are included below as well as information sheets helpful to patients and families:

1. Guidance for leaders in communication about losses and community grief: https://www.cstsonline.org/assets/media/documents/CSTS_FS_Grief_Leadership_During_COVID19.pdf
2. Stress management for leaders and supervisors in mortuary and death care: https://www.cstsonline.org/assets/media/documents/CSTS_FS_Stress%20Management_for_Leaders_and_Supervisors_of_Mortuary_and_Death_Care_Operations_during_the_COVID19_Pandemic.pdf

3. Guidance about family notification after a COVID-19 death: https://www.cstsonline.org/assets/media/documents/CSTS_FS_Notifying_Families_After_COVID19_Death.pdf

The American Psychiatric Association Committee on Psychiatric Dimensions of Disaster Workgroup on COVID-19 has also developed a helpful resource for the management of exposure to death and dying in the workplace. The link below will download the most recent version:

https://www.psychiatry.org/File%20Library/Psychiatrists/APA-Guidance-Death-Dying-in-Workplace.pdf

Initial Phase

Self-Directed Level

Target Population. Initial Phase Self-Directed Level targets any healthcare workers who would like self-directed preparation and support during their work as they continue to care for or provide services for COVID-19 patients or those who are having initial responses with low to moderate distress and/or interference in function but without imminent risk of harm to self or others. Content continues to focus on prevention of negative mental health outcomes but includes some specific direction on managing difficult emotional experiences workers (or impacted others) may be encountering.

Initial Phase Self-Directed Level Considerations

For those healthcare workers and staff who are interested, Self-Directed Resources provide brief guidance to support mental health and wellness for use as they are working in the COVID-19 pandemic. The burgeoning number of these can be somewhat overwhelming to wade through. Organizations' wellness and mental health support teams can highlight those they see most helpful in an organized privately accessible fashion. For example, self-help resources can be personalized and selected by organizations based on the local reported needs of the providers and the organizational resources and goals. A central easily accessible repository of easy to find, available vetted self-help resources should be developed with its location disseminated regularly, such as a website or email distribution with links. In addition to specific targeted self-guided online approaches, resources may include webinars or trainings developed through the employee assistance program, wellness teams, or other groups such as the department of psychiatry, consult liaison mental health providers, and/or social work teams supporting front line medical providers and staff.

Those involved in mental health support should develop pathways to support referral of those with greatest distress/risk/symptoms interfering with functioning to the appropriate level of intervention needed to allow them to return to baseline function. Local resources and indications to access them must be made widely known/available to decrease stigma and other barriers to access. Specific local crisis contact numbers should be communicated as part of this phase of support. If significant risk to self or others is a concern or substance abuse to the point that there is concern for safety is identified, a higher level of assessment and referral is needed and Level Four would be indicated.

Initial Phase

Self-Directed Level Content and Recommended Resources

A. Health and Mental Health Wellness Self-management Resources

COVID Coach app: One highly organized easy to use free resource for first line self-care strategies to promote health and wellness include a recently released app, COVID Coach, developed by the US Department of Veterans Affairs to support anyone (military connected or civilian) who is impacted by the COVID pandemic (https://apps.apple.com/us/app/covid-coach/id1504705038). This app like many in the Coach series provides brief, simple, well categorized self-guided strategies to promote health and wellness, as well as information and links to other resources within it. The sections are organized as Manage Stress (e.g., Mood Check, Learn [individual and family wellness including infection prevention], and Resources. Within each section are a wealth of brief, simple tools supporting many evidence informed approaches to stress, sleep, mood and anxiety management and wellness.

B. Specific Self-Help Resources to Address Identified Challenges During the Pandemic

Some additional select approaches below are based on common areas of concern in healthcare workers and staff battling the COVID pandemic on the front lines. The modules listed below are examples of nationally available resources that can be used given the specific needs of the current COVID-19 pandemic but does not represent an exhaustive list. Specific organizations can consider if they want to vet, refine, or enhance access to these resources or make a broader list available for those impacted to review and use as they see fit. In addition, the system may decide to integrate efficient access to higher level of care with a mental health professional at this stage or hold that for the next phase. If the system chooses to include local crisis or mental health resources, the resources chosen should include how to privately contact that system.

Face Mask and PPE Related Anxiety

For those people who have significant acute anxiety reactions when wearing a face mask or PPE, the same resources previously provided for general face mask information has additional information on how to reduce that anxiety reaction through self-directed exposure.

> https://adaa.org/sites/default/files/Tips%20for%20Getting%20Comfortable%20in%20Your%20Mask%20and%20with%20PPE_UChicago%20Medicine%2C%20NYU%2C%20Emory%20.pdf

Insomnia and Sleep Disturbances

Recognize that in times of extreme stress, the body may have a hard time turning off. This will be especially difficult if alcohol, caffeine, or other substances have been used to try and regulate activation or if the provider is outside of a normal wake/sleep cycle. Providing reminders about principles of sleep hygiene can be a helpful resource and many versions are widely available as brief handouts (see below links).

Core principles when integrating psychoeducation into local resources include making sleep a priority with regular sleep wake times when possible within work schedules, attending to transition to sleep routines and stimuli that promote wakefulness, limiting alcohol and caffeine at night, and exercising when possible but for most people just not prior to bedtime. Further, for those awake in bed trying to

sleep for 20 minutes without success, sleep experts suggest getting up and engaging in a low arousal and low light activity, such as reading a book (not on a screen but a physical book). If sleep hygiene self-help is insufficient, referral to a mental health or sleep professional may be warranted. A COVID-19 specific handout developed by the Center for the Study of Traumatic Stress is an especially timely resource, and the COVID Coach app that was developed by the VA National Center for PTSD provides an introduction to sleep hygiene.

Harvard Sleep Handout

http://healthysleep.med.harvard.edu/healthy/getting/overcoming/tips

Center for the Study of Traumatic Stress, COVID and Sleep Handout

https://www.cstsonline.org/assets/media/documents/CSTS_FS_Fight_COVID19_w_Better_Sleep_Health.pdf

Sleep Health During COVID, Center for the Study of Traumatic Stress, Uniformed Services University

https://www.cstsonline.org/assets/media/documents/CSTS_FS_Fight_COVID19_w_Better_Sleep_Health.pdf

General Coping and Distress

The following resources include general resources to help people impacted to consider positive coping, reduce unhelpful coping, and address low to moderate levels of distress. The resources include various single page informational pieces as well as COVID Coach that includes very comprehensive self-assessment and self-directed interventions for many different ways that people may be experiencing difficulty.

National Center for PTSD – Managing Healthcare Workers' Stress Associated with the COVID-19 Virus Outbreak

https://www.ptsd.va.gov/covid/COVID19ManagingStressHCW032020.pdf

National Center for PTSD – Managing Healthcare Workers' Stress Associated with the COVID-19 Virus Outbreak (en espanol)

https://www.ptsd.va.gov/spanish/COVID_healthcare_workers_sp.asp

COVID MH responders, Harvard University

https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2555/2020/03/HSPH-COVID-19-mental-health-tips-3-11-20_kk.pdf

SAMSHA Disaster Workers Preventing and Managing Stress
https://store.samhsa.gov/product/Preventing-and-Managing-Stress/SMA14-4873

COVID Coach

https://www.ptsd.va.gov/appvid/mobile/index.asp

Managing Personal Losses due to COVID-19

Loss of a loved one is one of the most intensely distressing yet universal life experiences. There is no single way to grieve, and most people will manage to cope with the pain of loss over time without any intervention. However, the circumstances related to COVID-19 have understandably impacted many commonly supportive community, religious and cultural traditions, as well as a chance to say goodbye due to social distancing, quarantines and rules about visitors. Finding creative ways to enhance social support, even if virtually, and allow the bereaved space to come to terms with the permanence of the loss and begin to envision even in small ways a positive future are ways to support bereaved individuals. Psychoeducation about normal grief and loss, the broad range of responses to loss, ways grief can become stuck and not progress over time, and when to seek help is also reassuring. Ultimately, allowing space for the bereaved to talk about the loss and their response to it while listening empathically is most important. This can help the bereaved accept the permanence of the loss and their intense emotions, while supporting them to allow for the normal waxing and waning of grief with less survivor guilt as they move to a place where they can begin to imagine a life without the deceased.

The Columbia Center for Complicated Grief has both general as well as COVID specific resources including a psychoeducational handout about acute and prolonged grief, and when to seek help:

https://complicatedgrief.columbia.edu/wp-content/uploads/2020/04/Managing-Bereavement-Around-COVID-19-HSPH.pdf

Initial Phase

Mental Health Supported Brief Intervention

In the initial phase, referral to mental health should be used cautiously as emotional reactions and distress are normative for this phase. Such referral would occur: 1) if the individual requests and desires this for support, or 2) for risk to self or others or exacerbation of preexisting mental health issues. If required, suggested content for assessment and intervention presented on Post Phase Mental Health Supported Intervention (below) would be warranted.

Post Phase

System Supported Level

The **post phase** covers the initial responses in the period after the acute exposure to risk and loss is complete and the next three months when expectations are that people impacted will be having various levels of emotional reactions and response. The **System Supported Level** covers the recommendations for leadership and organizations to put in place for those in the relevant phase.

Post Phase System Supported Level content would continue the resources and follow the recommendations from the Initial Phase System Supported Level. In addition, Post Phase System

Supported Resources would include access to more formal Employee Assistance Resources with providers who are trained in how to approach COVID-19 related distress.

Post Phase

Self-Directed Level

The **post phase** covers the initial responses in the period after the acute exposure to risk and loss is complete and approximately the next three months when expectations are that people impacted will be having various levels of emotional reactions and response. The **Self-Directed Level** includes resources that individuals can work with on their own. These self-directed interventions are intended to be used based on either self-assessment of need or as an initial intervention for those with some functional impairment without imminent risk to self or others. These are also resources that can be made available for those on waitlists such as for non-urgent referrals for individual therapy should available mental health providers have access limitations. For those healthcare workers who are interested and those who may experience significant distress and/or mild to moderate impairment due to emotional reactions to experiences during the pandemic, the Self-Directed Phase is designed to provide guidance for them to approach their experiences in a therapeutic way. This approach is designed to allow for additional self -directed intervention for specific needs as well as emotional processing of the memories and their thoughts about the experiences and the meaning of those experiences in their lives.

Post Phase

Self-Directed Level

Target Population. Post Phase, Self-Directed Level targets any healthcare workers who would like to have a supported way to approach their experiences as well as healthcare workers who are reporting early signs of difficulty, such as not being able to stop thinking about experiences, intense emotional reactions when they think about their experiences, etc. Mental health support teams should also develop means to support referral of those with the greatest distress/risk/symptoms at a level significantly interfering with functioning, with the appropriate level of intervention provided to allow them to return to baseline functioning. Local resources and indications to access them must be made widely known/available to decrease barriers to access. Quick access to trained local mental health support, especially if that support is knowledgeable about the self-directed interventions provided by the organization would be ideal and is strongly encouraged as an organizational resource. If risk to self or others is a concern or substance abuse to the point that there is concern for safety is identified, a higher level of assessment and referral is needed, and the Mental Health Supported Level would be indicated. Anyone with acute suicidal thinking with a plan or suicidal behaviors should also be provided access to emergency services or directed to call 911.

Post Phase

Self-Directed Level Resources

Making meaning of the difficult days

This is a self-directed version of the Prolonged Exposure for Primary Care written exposure protocol that has shown efficacy in military service members to reduce PTSD symptoms when provided within the primary care environment with an embedded mental health provider as support (Cigrang et al., 2017).

This modified version for COVID-19 healthcare workers and other impacted was created to provide an option for healthcare workers who want to approach difficult memories on their own. Appendix A: Self-Directed Exposure.

COVID Coach

COVID Coach is an evidence informed free app available from the VA National Center for PTSD that includes self-directed coping and mindfulness resources as well as self-assessment and connections to additional mental health resources if necessary.

https://www.ptsd.va.gov/appvid/mobile/index.asp

Post Phase

Mental Health Supported Brief Intervention Level

As mentioned previously, the **post phase** covers the initial responses in the period after the acute exposure to risk and loss is complete and the next approximately three months when expectations are that people impacted will be having various levels of emotional reactions and response. The **mental health supported brief intervention level** includes brief interventions provided with entry through primary care or mental health providers. The goal of this phase is to deliver evidenced based or evidenced informed cognitive behavior therapy (CBT) for patients with symptoms of anxiety or depression and functional impairment. Timing and engagement in this phase is likely protracted with some coming for assistance soon and others not requesting care for even years following the end of the pandemic.

Post Phase

Mental Health Supported Brief Intervention Level

Target Population. For those healthcare workers who request contact with a mental health professional as well as those reporting stress, anxiety, or depression associated with significant distress, functional impairment or signs of risk to self or others. This intervention is for those with an identified mental health need and may occur through contact with mental health in primary care or specialty mental health settings. For efficient use of system mental health resources, we suggest the use of brief embedded primary care mental health where that is available. Treatment plans in embedded primary care will focus on the established brief model for the identified issues presenting in the presenting individual. For PTSD, this may include Prolonged Exposure for Primary Care (Cigrang et al, 2017). For depression, cognitive behavioral Therapy for Depression (CBT-D; https://www.mirecc.va.gov/visn16/docs/therapists_guide_to_brief_cbtmanual.pdf). For those who do not respond to the primary care based interventions, referral to specialty mental health would be provided. Preference for providers with training in first line trauma-focused psychotherapy would be preferred though guidance below is provided for those systems that may not have enough providers with training. Offering expert consultation and accessible training resources are other ways to support clinicians with less experience.

Post Phase

Mental Health Supported Brief Intervention Level Content

Whether care is provided in PC or Specialty Mental Health, below are key areas of focus for initial interactions.

1. **Assess** –Duration of assessment will depend on setting (i.e., primary care versus specialty mental health) of the appointment (30 to 90 minutes).

   Assess what the presenting problem is. Allow freedom in telling you what happened. Listen empathically. Express condolences if someone died. Don't pathologize if normal/expected response to overwhelming circumstances.

   Assess for pre-existing or exacerbating conditions.

   Assess for psychiatric medication use and/or recent discontinuation

   Assess what usually helps/healthy coping (exercise, social support)

   Assess unhealthy coping (alcohol, drugs, isolation, anger)

   Assess what patient reported needs and treatment goals – just someone to listen, duration, or treatment

2. **Treatment plan**

If in a primary care setting with embedded mental health, follow the clinic process for intervention and brief primary care based intervention. If in specialty mental health and diagnostic criteria for an Axis I or II disorder are not present, establish a time-limited treatment plan that addresses the patient's needs. This will likely focus on active listening and coaching to engage in healthy coping behaviors and acceptance. This can include:

-Acceptance of Not knowing
-Making the decision to trust there is something on the other side
-Discussion of growth that comes when we lean into the unknown
-Concept that Not knowing is like an empty bowl and an empty bowl is useful

If patient DOES meet criteria for an Axis I disorder, including an adjustment disorder, complete a psychosocial history as per usual practice to determine targets for treatment. Unified protocol provides a concise model for application of cognitive behavior therapy (CBT) principles (Barlow et al., 2017) with some available worksheets modified specifically for COVID-19 response UP-COVID Materials (modified by Rachel Ammirati, PhD, Clair Cassiello-Robbins, PhD, & M. Zachary Rosenthal, PhD).

If the patient appears "haunted" by something that happened, even if they do not meet full criteria for PTSD, start with:

*Tell the story of what happened ("exposure"). Allow them to start at the beginning and go through what happened in detail, describing what they were feeling, thinking, and experiencing. Have them record on their smart phone so they can listen to it in between sessions. Therapist should respond appropriately, for example, if someone died, can simply say, "I'm sorry," or if the patient had to make a difficult perhaps life-and-death decision, could say, "I'm sorry you were in that position." (adapted from (Foa, Rothbaum, Hembree, & Rauch, 2019; Rothbaum et al., 2012)).

If the patient is amenable, may be useful to have them repeat it, maybe more than once. Very often the first repetition is quick, the 2nd repetition takes longer and includes more detail and more distress, and the 3rd repetition is where they can see the first signs of distress decreasing.

After the recounting, engage in processing.

Processing Imaginal Exposure

A. General processing of the exercise: "How was that for you? Did anything change from repetition to repetition?" Point out what you want them to notice.

B. "Processing Lite:" Elicit themes that they need to work on to move forward from the event. "What themes stood out for you? What was the most difficult part of the event for you? What are any unhelpful thoughts you noticed?" Please refer to Table 1 for suggestions.

C. Write down helpful things the patient can say to her/himself during the coming week on homework sheet. Offer suggestions for things they can be saying to themselves if they can't come up with phrases on their own.

D. If the patient doesn't process new information presented by the therapist, identify it as an important theme to return to in future sessions. "This seems like an area where you're feeling stuck right now and that will be important for us to come back to later."

Identify Behavioral Exposure(s) to be done in the coming week

A. Help the patient identify something s/he may wish to avoid that is a safe place/thing to do, or that they normally do, because it reminds them of the event/trauma, or because they are now afraid or want to avoid thinking about it. Best if they identify the exposure. You can offer suggestions if necessary.

B. If the patient cannot identify a specific task, assign a general exposure task that elicits some aspect of the event (e.g., watching the news).

C. Explain what constitutes a therapeutic exposure (Stay in the situation long enough or do it repeatedly for anxiety to decrease). If they leave before their anxiety decreases, they will reinforce the fear, so it's important that they stay long enough to NOT do that.

D. Record behavioral task(s) on homework sheet (Table 2).

Explain Normal Reactions to Event and Identify Self-Care Tasks for the Week

A. Prepare the patient for/normalize reactions they may have due to undergoing an event like this (feeling emotionally raw/numb/tearful, tired, disconnected from others, angry, sad, difficulty sleeping).
B. Tell him/her the most important thing is to take care of him/herself, to give themselves a break for the next few days as much as possible and when possible.

C. Help the patient identify self-care tasks and record on the homework sheet (e.g., exercising, taking a hot bath, fixing a favorite meal, talking to a supportive friend or family member).

Breathing Retraining (see Table 3)

Please refer to Table 4 for notes on processing and Table 5 for suggestions of what to say and what not to say to a trauma survivor.

Bereavement Due to Death and Dying

If bereavement is the reason the patient presents for care, the American Psychiatric Association has provided workgroup guidance for how mental health providers can help people address personal losses due to COVID-19 related death on their COVID Resource page. The link below will download the most recent version of the guidance:

https://www.psychiatry.org/File%20Library/Psychiatrists/APA-Guidance-Death-Dying-Personal-Bereavement.pdf

Long-Term Phase

All Levels

Long-term phase covers from approximately three months after the individual's experience of impact and loss is over and into the future. The long-term phase will continue all the same levels as the Post phase but will focus more closely over time on those with identified functional impairment over time. We include it as a separate phase given the importance of noting that a significant minority of impacted people will continue to have mental health distress over time. Further, grief responses generally occur on a longer timeline with current iterations of prolonged or complicated grief utilizing a 6 or 12 month minimum for diagnosis to account for broad individual, cultural and religious variability in usual acute grief and its evolution to more integrated forms of grief. For this pandemic, the phases will overlap for individuals depending on their roles and specific impacting traumatic exposures (traumatic loss of significant others, exposure to death at work, etc.). Over time, resources tailored to these needs will need to addressed in the mental health system through expanded training and access to providers.

References

Barlow, D. H., Farchione, T. J., Bullis, J. R., Gallagher, M. W., Murray-Latin, H., Sauer-Zavala, S., . . . Cassiello-Robbins, C. (2017). The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders Compared With Diagnosis-Specific Protocols for Anxiety Disorders: A Randomized Clinical Trial. *JAMA Psychiatry, 74*(9), 875-884. doi:10.1001/jamapsychiatry.2017.2164

Cigrang, J. A., Rauch, S. A., Mintz, J., Brundige, A. R., Mitchell, J. A., Najera, E., . . . Peterson, A. L. (2017). Moving effective treatment for posttraumatic stress disorder to primary care: A randomized controlled trial with active duty military. *Fam Syst Health, 35*(4), 450-462. doi:10.1037/fsh0000315

Dinenberg, R. E., McCaslin, S. E., Bates, M. N., & Cohen, B. E. (2014). Social support may protect against development of posttraumatic stress disorder: findings from the Heart and Soul Study. *Am J Health Promot, 28*(5), 294-297. doi:10.4278/ajhp.121023-QUAN-511

Foa, E. B., Rothbaum, A. O., Hembree, E. A., & Rauch, S. A. M. (2019). *Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences, 2nd Edition*: Oxford University Press.

Gros, D. F., Flanagan, J. C., Korte, K. J., Mills, A. C., Brady, K. T., & Back, S. E. (2016). Relations among social support, PTSD symptoms, and substance use in veterans. *Psychology of addictive behaviors : journal of the Society of Psychologists in Addictive Behaviors, 30*(7), 764-770. doi:10.1037/adb0000205

Hancock, L., & Bryant, R. A. (2018). Perceived control and avoidance in posttraumatic stress. *European Journal of Psychotraumatology, 9*(1), 1468708-1468708. doi:10.1080/20008198.2018.1468708

Rothbaum, B. O., Kearns, M. C., Price, M., Malcoun, E., Davis, M., Ressler, K. J., . . . Houry, D. (2012). Early intervention may prevent the development of posttraumatic stress disorder: a randomized pilot civilian study with modified prolonged exposure. *Biol Psychiatry, 72*(11), 957-963. doi:10.1016/j.biopsych.2012.06.002

Shanafelt, T., Ripp, J., & Trockel, M. (2020). Understanding and Addressing Sources of Anxiety Among Health Care Professionals During the COVID-19 Pandemic. *Jama*. doi:10.1001/jama.2020.5893

Table 1. Suggestions for Processing

(1) Challenge unhelpful/unrealistic cognitions and ask the patient how they want/need to be thinking about this to move forward from the event. (2) Themes to watch for: Shame, Blame/Guilt, Anger, Safety/Fear (3) If they had to make difficult decisions, especially if it turned out badly for someone, acknowledge the "damned-if-you-do-damned-if-you-don't" nature of the decision. Ask questions that will allow them to take a wider perspective such as: -"What do you wish you had decided?" -"Why didn't you make that decision?" -"What was the information you had at the time?" -"What did you learn later?" -What do you think someone else would have decided?" -"Why would they have made that decision?" -"Describe the context" -"What would you advise a junior colleague/daughter/son/sister/brother if they had been in this exact same situation?" -"What did you learn from this situation?" -"What do you want to do differently in the future?" -"Do you want to be the kind of person who can make life or death decisions and not feel the weight?"

Note: Adapted from Rothbaum, Kearns, Price, Malcoun, Davis, Ressler, Lang, & Houry (2012).

Table 2. Homework Form.

Homework

1. Practice remembering the event daily using the tape, in a safe place, by yourself.

2. Practice breathing exercise twice daily, with or without the tape.

3. Things to TELL MYSELF:

_____

_____

_____

4. Things to DO:

_____

_____

_____

5. Ways I am going to take care of myself this week:

_____

_____

_____

Table 3. Breathing Retraining Instructions.

Important, before you begin, ask if the patient has asthma and adjust exercise as Needed (if asthmatic, have them pause after the inhale, not after the exhale)
A. Tell the patient that you will now teach him/her a breathing exercise that they can use to help cope with overwhelming negative feelings. This can also be helpful if the patient is having difficulty sleeping.
B. Record on patient's phone.
C. Provide instructions (normal breath in through the nose, breathe out while saying "calm" silently to themselves, pause for four counts, repeat). Tell the patient you will guide them through 15 breaths, fading out as you go.
D. Guide the patient through 15 repetitions, fading out as you go. Use fingers to keep track.
E. Ask the patient how the experience was for him/her
F. Remind them that their breath is something that is always with them that can be accessed for soothing. The goal is to not rely on the recording but they can use the recording until they learn how to do it without.
G. Show the patient that the homework sheet asks them to practice the breathing exercise twice daily. A good time to practice this exercise is before bedtime, since people often have difficulty sleeping after experiencing an event like this.

Note: Adapted from Foa, Hembree, Rothbaum, & Rauch (2019).

Table 4. Notes on Processing.

Processing involves the therapist following the patient as she considers how this event impacts her thoughts about herself and the world, at the time of the event and now. This includes placing the traumatic event(s) in memory, or in context of time and space where the event occurred. For COVID-19, this is an extraordinary context that must be taken into account. Taking into account the context of the trauma/event is usually an important part of processing, particularly if there is moral injury. . Processing is not Socratic questioning as would occur in cognitive therapy with direct challenge of unhelpful thoughts. In PE, processing uses reflective listening and clarification as the therapist and the patient examine together the patient's unhelpful thoughts, consistently comparing what the patient may have thought previously to what she is thinking now after having approached the memory and reminders in recounting what happened. The emphasis is on perspective- making, incorporating the "new" information that resulted from imaginal revisiting, and strengthening the differentiation between then and now. During the processing discussion, look for opportunities to normalize the patient's feelings, thoughts, and behavior in the context of what happened and trauma and PTSD, and help the patient understand and accept her reactions and symptoms. Always help the patient elaborate on these important shifts in perspective by asking questions; refrain from telling her how she should think or feel. Reflective statements are an excellent way to clarify changes in meaning with the patient during processing. Such statements may include "I heard you say that you knew that patient was going to die with or without the ventilator. Tell me

more about that," or "You did not do anything? Tell me again what you did when you saw your colleague displayed signs of COVID-19." Often in processing, elements of the trauma context emerge— that the patient has not fully attended to or recognized— that impacted how the trauma occurred or the patient's reactions during and after the trauma.

Other statements that are important to address during processing are the patient's expressions of unrealistic or excessively negative views of herself, other people, the world, and her ability to cope with the trauma and its aftermath. Explore these "themes" that emerge during exposure.

Note: Adapted from Foa, Hembree, Rothbaum, & Rauch, 2019 PE manual.

Table 5. What To Say and What Not to Say to a Trauma Survivor.

What should you NOT say:	**What you should ALWAYS say:**
"Oh my G-d, you almost died"	"I'm sorry this happened to you."
From WENK (change words if use:	"I'm sorry you were put in this position."
"You must be mistaken."	"I'm sorry you had to make that awful decision."
"It can't have happened that way."	"I believe you."
"You were wrong."	"I want to help in any way I can."
"Why didn't you leave?"	"It wasn't your fault."
"Why didn't you tell someone?"	"I am proud of you."
"You're lucky to be alive."	"This doesn't change how I feel about you."
"Adults know best."	"Anyone in that situation would have done what you did."
"He's so nice – he couldn't have done that to you."	"I can't imagine being in that situation."
"It was your fault."	"Whatever you did, you did the right thing because you are here to tell about it."
"I can't look at you the same way."	"I want to help but you may have to let me know how."
"I can't touch you now."	"You are a good person; this doesn't change that."
"You knew this would happen."	"Even people who others see as nice can do bad things."
"This is war – what did you expect?"	"You did what you had to do to survive."
"Did you kill anyone?"	"I'm glad you survived."
"It doesn't sound that bad."	
"It couldn't have been that bad or you would have left."	
"Why didn't you scream?"	
"Why didn't you run away?"	

"Why didn't you fight?" "Why did you let him do that to you?" "I wouldn't have let him do that to me." "You're a wimp." "You have to toughen up." "What are you so upset about?" "What does it matter? He was the enemy." "Get over it."	"This doesn't change what I think of you."

Note: Adapted from Rothbaum, B. O. & Rauch, S.A.M. (under contract). Trauma: What Everyone Needs to Know. New York. Oxford University Press. Expected publication June, 2020.

Appendix A. Self-Directed Exposure Protocol

Making Meaning of Difficult Experiences:

Self-Directed Memory Processing Developed for Response to the COVID-19 Pandemic

Version Date: April 29 2020

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Who is this for?

Making Meaning of Difficult Experiences is intended as a self-help strategy for people who have experienced difficult and potentially traumatic experiences as a result of the COVID-19 pandemic that are haunting them. These experiences may take many forms including caring for those who are dying in acute respiratory failure, exposure to death and dying with associated fear of becoming infected with risk of dying due to potential exposure to the virus, sudden unexpected loss of loved ones and/or other intensely distressing experiences that are persistently troubling. This tool is not a treatment for PTSD and if you feel that you are suffering from PTSD or another mental health issue, referral to a mental health professional for effective treatment should be pursued. This tool **IS** intended as a self-help strategy in the aftermath of tough experiences for an individual who wants to work through those experiences on their own. In addition, if working through it on your own feels like too much to handle, then please reach out to your local mental health resources. Depending on your area this may include an employee assistance program through your employer, your primary care physician (PCP) or local mental health providers/clinics. If you have health insurance, you can contact them for referrals or resources. If you feel imminently unsafe, you can contact the national crisis line at 1-800-273-8255 or go to your nearest emergency room or dial 911.

Confronting Highly Distressing/Traumatic/Uncomfortable Memories: Memory Exposure

The current COVID-19 pandemic is unprecedented in its reach around the world and the extended duration of this invisible threat. The combination of rapid, serious illness and high fatality of COVID-19, combined with our limited supplies and knowledge about how to prevent or treat it has resulted in both changes to the reassurances of usual routines and social connections, as well as high levels of anxiety and distress nearly universally. No one is left without impact whether it is direct impact on personal health or employment or indirect impact through availability of services and impact on loved ones. Many are calling the siren that the mental health fallout will be grim as well. While the mental health impact will likely be significant, we can also feel confident that for most people this will be a significant event that they manage to cope with in real time. Most people will eventually naturally move on and settle into a new normal and satisfying life. Initial intense emotional responses should not be seen as necessarily problematic. Instead, hope and an expectation of recovery are the norm. Finding ways to retain or enhance social support and perceived control, despite these unusual times of quarantines and social isolation, can help us all get through this. While planning to address mental health needs that will arise, we should project hope and have confidence that for most people they will recover with time. This program is developed with that idea in mind. It is a tool for people to use **as they see fit and if/when they think they need it**. It can be shared or not shared as each individual would like with significant people in their life. We suggest that the memory exposure **should be repeated** and not done just once as it is through repetition that distress decreases and new meaning often becomes most clear. At its best, we believe this tool may help people think through their experiences in a way that allows them to find meaning and move on with less distress. Some people do this naturally on their own through journaling or other forms of autobiographical writing. This tool offers a structured targeted way to do this. However, tempting it may be to do so, this tool **should not be used in a group** format as previous research suggests compelling the sharing of traumatic details in a group may have harmful impact.

As you may have experienced, doing things to avoid thinking about potentially traumatic memories may make sense in the short-run, and may sometimes be a necessary strategy for focusing on the task at hand, especially when faced with a need to function during a crisis. However, it is important to come back to thinking about or talking about these upsetting

memories when the time is right to process them. If you continue to avoid in the long run it can prevent you from:

- learning these memories are not dangerous,
- finding new meaning or ways of looking at these events,
- learning you can handle the discomfort that your memories may cause,
- seeing that the discomfort you experience decreases the more you confront these memories, and
- being able to put your uncomfortable memories into your life story.

Until now, your potentially traumatic or uncomfortable memories likely have been like a messy closet. Whenever something reminds you of those distressing memories, the door of the closet falls open and the most upsetting parts of your memories pop out and dump on the floor. You may start to look at the stuff that fell out, but then feel overwhelmed and slam the closet door closed. Then, the next time something reminds you, the closet opens again and the whole process starts over, leaving you feeling out of control. If we respond to these kinds of memories by slamming the door to push them out of our mind, we are never really able to see how the intense parts fit with the rest of the story. If you can't even think about it, then you can't possibly think about it differently. When you are able to get the full story of these memories, you can discover what this memory means and does not mean for you. You are able to find a place for it in your life story, and you can put it away as finished business. This does not mean that you will not think about those potentially traumatic or uncomfortable memories sometimes, but that when you do think about it, it does not bring up all of the strong emotions. You can feel in control even when you think about these memories.

These exercises are designed to help you gain comfort with highly distressing, traumatic or uncomfortable memories so that you can learn to control them rather than let the memories control you. Confronting the memories is like cleaning out the closet. Instead of shoving things in and slamming the door shut, you can organize the memories just as you would organize a messy closet. You can figure out what goes where and why, and maybe what can be thrown away. By going through each memory from beginning to end with repetition, you can see how it all fits together. Also, the more you go over the memories, the emotions that are connected to them will get less intense and more manageable.

Memory exposure is one way to confront your potentially traumatic or uncomfortable memories. You will be asked to write your memory in the present tense. That means as though it is happening right now. When you do this, try to include as many details as you can so that you really feel like you can see, hear, smell, touch, and taste what was happening at the time of the incident. You also want to be sure to include descriptions of what you remember doing and thinking as well as emotions you remember feeling. Read the tips for memory exposure in the box below.

While this is not a treatment, we do recommend that you invest time in doing the exposures if you decide it may be helpful. This means each time you do it to stay with the exposure exercise for at least 30 minutes and then commit to repeating the exposure at least 2 times or until your distress associated with the memory is reduced. We suggest you write out the memory exercise once per week. Before beginning the memory exposure exercise, set aside a **30-minute period** where you can focus on memory exposure without distraction. To help you do this, go into a room where no one will interrupt you, turn off the ringer on the phone, and turn the television/radio off. Sit in a comfortable chair. **Do not** do this exercise right before you want to go to sleep because this may make it harder to fall asleep or lead to nightmares.

Before you start writing the distressing memory, write down the date. Then, circle the number on the BEFORE scale that best shows how upset you are while thinking about writing the memory on the worksheet. Also, notice what time you began to write the memory exposure.

Now, in the space provided write down your most upsetting memory that you currently think about the most. If you do not feel ready to work on the most upsetting memory, pick a different one that you have been thinking about repeatedly within the past two (2) weeks. Begin writing about the memory wherever you believe things started to go awry. This might be the moment when you first felt that something was not right or the first moments when you felt that you were in danger. Do not worry if there are things that you do not remember or parts that are unclear. Write down whatever you remember. Write enough to fill the page and feel free to write more on the back of the sheet or on another sheet if you need it. When you get to the point that you feel like the memory is done, record what time you have finished writing. Also, circle the number on the AFTER scale that best shows how upset you are when you have finished writing the memory. Finally, circle the number on the HIGHEST scale that

shows the maximum level of distress you had while writing the story. Finally, write how much time it took you to write the memory in the total time space. When you have finished writing the story, read over what you wrote several times for the remainder of 30 minutes. We suggest reading through it at least 3 times, even if you have gone over 30 minutes. And don't just read it, but picture it and fully engage in the memory as you read it. Then consider the processing questions on the second sheet and write your responses.

Then as previously mentioned read the memory for 30 minutes each day until your distress is reduced. Before you start to read it, circle the number on the BEFORE scale that best shows how upset you are thinking about reading the memory. When you are reading it really try to see the image of the memory as clearly as you can. Let yourself feel the emotions that you felt at the time of the incident. This may be difficult, but the more you allow yourself to experience the memory, the more you can begin to take control back from the memory. As people read their memories, they may notice details that they think are important to add or change. This is a normal part of processing of a memory. When you read your memory, make any necessary changes you believe are necessary. Write in the margins or over the top. If you really feel it is needed, pull out a new sheet and rewrite the memory. Add details to your story as they occur to you. Expand on your answers to the questions. When you get to the end of memory, circle the number on the AFTER scale to show how upset you are after reading the memory. Circle a number on the HIGHEST scale to show the maximum level of distress you had while reading the story. Also, write down the time it took you to read the memory in the total time space Plan to spend about 30 minutes per day on this activity until you see your discomfort rating peak below 5 on the discomfort scale.

As you continue to do the memory exposure exercise, you will learn:

- these memories are not dangerous,
- you can handle the discomfort your memories may cause,
- your discomfort decreases the more you confront these memories, and
- your uncomfortable or potentially traumatic memories can fit into your life story.

Before you begin the exposure, plan for a positive activity that you can do to reward yourself after approaching the memory. This does not need to be a huge activity but having something you enjoy even briefly can help you to move on to reengaging with your life after focusing on your memory. For people who may tend to isolate or withdraw when under stress, it may be especially important for this activity to involve contact with others. It can be a simple phone call or if it is safe in your community it may be a brief visit or walk with a friend or family member. For others this might be exercise or yoga or even prayer. Choose something that requires your brain to attend to the activity. Consider choosing activities that have helped you feel good or relax even when stressed in the past. After you finish the memory exercise and recording, engage in your positive activity for about 30 minutes. This way you have a time when you are approaching the memory and then a time when you end that activity and go back to what you need to do today.

Memory Exposure Tips

1) **DO NOT** do this exercise right before you want to go to sleep.

2) **STAY WITH YOUR ANXIETY/EMOTION** throughout the exercise. Do not try to reduce it and do not stop in the middle of the exposure.

3) Include **DETAILS** of what you saw, heard, touched, smelled, and tasted at the time of the trauma.

4) Include what you thought, emotions you felt, and things you did at the time of the trauma.

5) **DO NOT AVOID** letting yourself experience the memory.

6) **REPEAT** the memory exposure for **AT LEAST 30 minutes 3 times per week or until your peak discomfort rating is below 5**.

7) If you feel overwhelmed take a break and if needed contact your local mental health provider, _____, to talk about your exercise.

8) If you feel that you want to hurt yourself or someone else call the National Suicide Prevention Hotline at 1-800-273-8255 or go to your nearest emergency room.

Memory Exposure Exercise

Date of Exercise: _____

Use the following scale to rate your DISCOMFORT:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Completely Relaxed	**Mostly Relaxed**	**Noticeably Upset**	**Very Upset**	**Most Upset Ever**

Rate your discomfort **BEFORE** completing the memory exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Write your difficult memory below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How long did it take you to complete the exercise: _____

Rate your discomfort **AFTER** completing the writing exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate the **HIGHEST** level of discomfort you experienced during the writing exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Processing Questions

1) Why do you think this event happened to you?

_____

_____

_____

2) What caused it to happen?

_____

_____

_____

3) How has this event changed what you think about yourself?

_____

_____

_____

4) How has this event changed how you think about others?

_____

_____

_____

5) How has this event changed how you think about the world?

_____

_____

_____

6) What new, different, or important information did you notice when you wrote and reviewed your memory today?

_____

_____

_____

_____

7) What would you tell your friend/daughter/son/sister/brother if this had happened to them?

_____

_____

_____

_____

Memory Exposure Daily Reading Exercise

Use the following scale to rate your discomfort:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Completely Relaxed	**Mostly Relaxed**	**Noticeably Upset**	**Very Upset**	**Most Upset Ever**

Date of Exercise:_____(Day 1) How much time did you spend on the exercise: _____

Rate your discomfort **BEFORE** completing the memory exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate your discomfort **AFTER** completing the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate the **HIGHEST** level of discomfort you experienced during thereading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Date of Exercise:_____(Day 2) How much time did you spend on the exercise: _____

Rate your discomfort **BEFORE** completing the memory exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate your discomfort **AFTER** completing the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate the **HIGHEST** level of discomfort you experienced during the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Date of Exercise:_____(Day 3) How much time did you spend on the exercise: _____

Rate your discomfort **BEFORE** completing the memory exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate your discomfort **AFTER** completing the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate the **HIGHEST** level of discomfort you experienced during the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Memory Exposure Daily Reading Exercise

Use the following scale to rate your discomfort:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Completely Relaxed	**Mostly Relaxed**	**Noticeably Upset**	**Very Upset**	**Most Upset Ever**

Date of Exercise:_____(Day 4) How much time did you spend on the exercise: _____

Rate your discomfort **BEFORE** completing the memory exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate your discomfort **AFTER** completing the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate the **HIGHEST** level of discomfort you experienced during the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Date of Exercise:_____(Day 5) How much time did you spend on the exercise: _____

Rate your discomfort **BEFORE** completing the memory exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate your discomfort **AFTER** completing the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate the **HIGHEST** level of discomfort you experienced during the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Date of Exercise:_____(Day 6) How much time did you spend on the exercise: _____

Rate your discomfort **BEFORE** completing the memory exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate your discomfort **AFTER** completing the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate the **HIGHEST** level of discomfort you experienced during the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Memory Exposure Daily Reading Exercise

Use the following scale to rate your discomfort:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Completely Relaxed	**Mostly Relaxed**	**Noticeably Upset**	**Very Upset**	**Most Upset Ever**

Date of Exercise:_____(Day 7) How much time did you spend on the exercise: _____

Rate your discomfort **BEFORE** completing the memory exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate your discomfort **AFTER** completing the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate the **HIGHEST** level of discomfort you experienced during the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Date of Exercise:_____ How much time did you spend on the exercise: _____

Rate your discomfort **BEFORE** completing the memory exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate your discomfort **AFTER** completing the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate the **HIGHEST** level of discomfort you experienced during the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Date of Exercise:_____ How much time did you spend on the exercise: _____

Rate your discomfort **BEFORE** completing the memory exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate your discomfort **AFTER** completing the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10

Rate the **HIGHEST** level of discomfort you experienced during the reading exercise:

0---------1---------2---------3----------4----------5----------6----------7----------8----------9----------10