CALM: WITHIN THE STORM.
COPING WITH STRESS AND BUILDING RESILIENCY DURING THE COVID PANDEMIC

Dr Timothy Lau,
President of the Medical Staff, Royal Ottawa Mental Health Centre.
Distinguished Teacher, Faculty of Medicine, University of Ottawa
Associate Professor of Psychiatry
A STORY

- Louise is 41 year old mother of 3 (2,8,17).
- Fulltime teacher, John worked as a consultant for the federal government.
- In March of 2020
- Mother in LTC
- Mother had COVID
- Louise struggled. School reopened Fall 2020
- Life started to seem normal
- Lockdowns began again
STORM
NOT ALL IN THE SAME BOAT
You can't calm the storm... so stop trying. What you can do is calm yourself. The storm will pass.
You can't calm the storm... so stop trying. What you can do is calm yourself. The storm will pass.

STOIC and Eastern perspective

ataraxia or tranquility

Freedom from distress or worry even in the face of a storm

“We suffer not from the events in our lives but from our judgement about them.”

— Epictetus
Feeling Anxious or Overwhelmed?
Try this approach:

C.A.L.M.

01 Cognitive

Step back and take a moment to assess the situation. Instead of taking an emotional approach, use a cognitive approach. Think it through. What are the facts? What are your priorities? Respond rationally, don’t react.

02 Awareness

Be aware of how you’re coping and accept that some things are out of your control. Take your own temperature. What do your mental health vitals say (sleep, tension, irritability, appetite, hope, sense of humour)? Consider asking a trusted friend, family member, colleague, or mental health professional for their perspective.

03 Lean

Lean into the positive. Think about the things for which you are thankful and cultivate gratitude on a daily basis. Look for the hidden advantage of your situation and learn to focus on the benefits.

04 Make things better.

Reframe the way you think, the way you live (exercise, sleep, play), and the way you connect with others. Rather than comparing yourself to others, focus on your own growth and progress. Meditation, mindfulness, or exercise can bring positive changes in your life! Finding a reason to do what you are doing, whether through mindfulness or spirituality, can make your life meaningful and more valued. Take the time to find an approach that works best for you.

Be C.A.L.M.

The next time you feel anxious or overwhelmed, Dr. Tim Lau, a psychiatrist at The Royal, recommends a C.A.L.M. approach. This can help us put things into perspective so that we can see the whole picture and cultivate a hopeful, constructive and meaningful attitude towards living life to the fullest.
Calm
Step 1: Cortical / Cognitive
Cortex vs. limbic system vs BRAINSTEM

Neocortex: REASON
Limbic system: EMOTIONS
Reptilian complex: INSTINCTS
ANXIETY

Perceived danger

Perceived abilities

\[
\text{Delta} = \text{Overwhelming anxiety}
\]
ANXIETY

Perceived danger

Increase abilities

Delta = *Less* overwhelming anxiety
ANXIETY

Overcome IRRATIONAL fear

Increase abilities

Delta = LESS overwhelming anxiety
“I’VE LIVED A TERRIBLE LIFE, MOST OF WHICH NEVER HAPPENED”
MARK TWAIN
Invisible Enemy

1

2

3
Invisible
ENEMY 1
Case fatality rate of the ongoing COVID-19 pandemic

The Case Fatality Rate (CFR) is the ratio between confirmed deaths and confirmed cases. During an outbreak of a pandemic the CFR is a poor measure of the mortality risk of the disease. We explain this in detail at OurWorldInData.org/Coronavirus

Source: Johns Hopkins University CSSE COVID-19 Data – Last updated 24 January, 09:02 (London time)
Cumulative confirmed COVID-19 deaths

Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.

Cases overview

Ontario
- Total cases: 257K (+2,363)
- Recovered: -
- Deaths: 5,764 (+40)

Canada
- Total cases: 747K
- Recovered: 664K
- Deaths: 19,067

Worldwide
- Total cases: 99M (+801K)
- Recovered: 54.6M (+15,846)
- Deaths: 2.13M

Source: Johns Hopkins University CSSE COVID-19 Data – Last updated 24 January, 09:02 (London time)
COVID-19 looks a lot closer to the season flu than to previous coronavirus outbreaks

- **COVID-19**
  - Fatal cases: 3.4%
- **Seasonal flu**
  - Fatal cases: 0.1%
- **SARS**
  - Fatal cases: 10%
- **MERS**
  - Fatal cases: 34%

*COVID-19, SARS, and MERS data are global and total to date. Seasonal flu data are U.S., for the 2018-2019 season.*

Chart: Elijah Wolfson for TIME • Source: CDC and WHO • Created with Datawrapper
4 UNIQUE PROBLEMS

1. **Asymptomatic / Paucisymptomatic Carriage**
2. **Variable Rate of Transmission**
3. **High Attack Rate, Means Health Care System Can Be Overwhelmed**
4. **Mutations**
GUIDED MISSILES
Invisible ENEMY 2: Fear, anxiety, depression
MENTAL HEALTH

- Since the spring of 2020, increased depressive and anxious symptoms.
Americans' Mental Health Ratings Sink to New Low

BY MEGAN BRENNAN

Gallup Poll in Nov Health and Healthcare survey
Mental health declined
Americans' Mental Health Ratings Sink to New Low

BY MEGAN BREHAN

WORSE FOR WOMEN. Better for those that attended religious services once a week.

Americans' Rating of Their Mental Health as Excellent, by Demographic Groups. 2019 vs. 2020

<table>
<thead>
<tr>
<th>Category</th>
<th>2019</th>
<th>2020</th>
<th>Change</th>
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<tr>
<td><strong>Gender</strong></td>
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<tr>
<td>Male</td>
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<td>41</td>
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<tr>
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<td>41</td>
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<td>Independent</td>
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<td>32</td>
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<td>Democrat</td>
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<td><strong>Religious service attendance</strong></td>
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<td>Weekly</td>
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<tr>
<td>Nearly weekly/monthly</td>
<td>47</td>
<td>35</td>
<td>-10</td>
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<tr>
<td>Seldom/never</td>
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<td>29</td>
<td>-13</td>
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<td><strong>Race</strong></td>
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<td>35</td>
<td>-10</td>
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<tr>
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<td>-8</td>
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<tr>
<td>Not married</td>
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<td>28</td>
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<td>-8</td>
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<tr>
<td>50-64</td>
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<td><strong>Household income group</strong></td>
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<tr>
<td>Under $40,000</td>
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<td>43</td>
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<tr>
<td>$100,000 or more</td>
<td>57</td>
<td>45</td>
<td>-12</td>
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</tbody>
</table>

GALLUP
Psychological Distress and Loneliness Reported by US Adults in 2018 and April 2020

Emma E. McGinty, PhD1, Rachel Presskreiser, MS1; Hahrie Han, PhD1; et al

Running Head: MENTAL HEALTH DURING COVID-19

Emerging new psychiatric symptoms and the worsening of pre-existing mental disorders during the COVID-19 pandemic: A Canadian multi-site study.

Rebecca Robillard*, PhD1,2; Alexander R. Daros, PhD3; Jennifer L. Phillips, PhD1,4; Meggan Porteous, BA1,2; Mysa Saad, MSc1; Marie-Helene Pennestrri, PhD5,6; Tetyana Kendzerska, MD7; Jodi D. Edwards, PhD4; Elizaveta Solomonova, PhD9; Raj Bhatla, MD4,10; Roger Godbout, PhD4; Zachary Kaminsky, PhD1; Addo Boafo, MD11; Lena C. Quilty, PhD11,12

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Figure 1. Changes in Positive Screening for Anxiety and Depression in people without a psychiatric history

Percentage of all respondents without a psychiatric history (n= 2,562) who endorsed clinically significant anxiety symptoms on the GAD-7 (Generalized Anxiety Disorder Scale; Panel A) and depressive symptoms on the QIDS-SR16 (Quick Inventory of Depressive Symptomatology-Self Report, short version; Panel B) before the outbreak (striped bars) and since the start of the outbreak (full bars).
U.S. Census Bureau-assessed prevalence of anxiety and depressive symptoms in 2019 and during the 2020 COVID-19 pandemic

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Email: jeantwenge@gmail.com

CDC: went from 1-2x/yr sampling to 2x per month during the pandemic N=336K.

TABLE 1 Symptoms of anxiety disorder,

<table>
<thead>
<tr>
<th>April</th>
<th>RR, 2019 versus April</th>
</tr>
</thead>
<tbody>
<tr>
<td>23–May 2019</td>
<td>4, 2020</td>
</tr>
<tr>
<td>23–May 2020</td>
<td></td>
</tr>
</tbody>
</table>

| Anxiety | 8.2% | 30.8% | 3.76 (3.57, 3.96) |
| Depression | 6.6% | 23.5% | 3.56 (3.36, 3.77) |
| One or both | 11.0% | 35.9% | 3.26 (3.12, 3.41) |

Note: Numbers in parentheses are 95% CIs for https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7405486/pdf/DA-9999-na.pdf.
Teens in Quarantine survey of 1,523 U.S. teens during May–July 2020, asking about their mental health, family time, sleep, technology use. Compared our 2020 teens’ responses in the national Monitoring the Future survey.

Figure 1. Teens’ Mental Health, 2018 vs. 2020, school in session and summer break

- 2018 in School
- 2020 Quarantined School
- 2020 Quarantined Summer

Source: Monitoring the Future; Teens in Quarantine

Institute for Family Studies/Wheatley Institution

Figure 2. Percent of U.S. Teens Depressed during Pandemic Quarantine, by regularity of seven or more hours sleep

Source: Teens in Quarantine

Institute for Family Studies/Wheatley Institution

COGNITION

- ADOLESCENCE
  - OVERALL WAS NOT WORSE, BEFORE AND AFTER
  - FAMILY CONNECTIONS MITIGATED SOME OF THE NEGATIVE EFFECTS
- IMPORTANCE OF BASIC NEEDS
Resilience and the Role of Depressed and Anxious Mood in the Relationship Between Perceived Social Isolation and Perceived Sleep Quality During the COVID-19 Pandemic

Arwa Ben Salah1,2, Briana N. DeAngelis2, Mustafa al’Absi2

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Abstract

Background The aim of the study was to examine the mediating role of depressed and anxious mood in the relationship between perceived social isolation and perceived sleep quality during the COVID-19 pandemic. We also aimed to investigate the moderating role of psychological resilience in this mediation.

Methods A cross-sectional study of adults (18+ years old) was conducted using an online, multi-language, international survey between March 31 and May 15, 2020. Simple and moderated mediation analyses were performed using the PROCESS macro for SPSS, with perceived social isolation as an independent variable, change in perceived sleep quality (during vs. before the COVID-19 pandemic) as a dependent variable, depressed and anxious mood (Patient Health Questionnaire-4, PHQ-4) as a mediator, and resilience (Brief Resilience Scale, BRS) as a moderator.

Results A convenience sample of 3816 participants (2692=female) from 94 countries (47.4% USA) met criteria for inclusion in the analyses. Results showed that depressed and anxious mood mediated the relationship between perceived social isolation and change in perceived sleep quality. This mediation was moderated by resilience; the indirect effect of perceived social isolation on change in perceived sleep quality through depressed and anxious mood decreased as the level of resilience increased (index of moderated mediation = 0.008, SE = 0.003, 95%CI [0.001; 0.014]).

Conclusions The study findings indicate benefits of psychological resilience in buffering negative effects of perceived isolation, suggesting potential benefits of developing targeted strategies to enhance resilience during times of significant crises.

Keywords Anxiety · Depression · Resilience · Sleep · Social isolation · COVID-19

Cross sectional, international survey. N=3800, PHQ4, Brief Resilience Scale, Perceived sleep quality

| Table 2 Descriptions of the dependent, independent, mediator, and moderator variables |
|---------------------------------|-----|-----|-----|-----|
| Perceived social isolation | 3814 | 2.2 | 1.7 | 0–5 |
| Depressed and anxious mood (PHQ-4) | 3809 | 4.4 | 3.4 | 0–12 |
| Perceived sleep quality before the spread of SARS-CoV-2 | 3816 | 2.0 | 0.8 | 0–3 |
| Perceived sleep quality in the time since SARS-CoV-2 began spreading | 3816 | 1.5 | 0.9 | 0–3 |
| Change in perceived sleep quality | 3816 | –0.4 | 1.0 | –3 to +3 |
| Resilience (BRS) | 3792 | 3.4 | 0.8 | 1–5 |

For PHQ-4 and BRS, existing translations of validated measures were used when available

n number of respondents, SD standard deviation, Range observed range in the sample

a PHQ-4 4-item Patient Health Questionnaire (41)
b SARS-CoV-2 severe acute respiratory syndrome coronavirus 2
c Change in perceived sleep quality perceived sleep quality since the spread of the virus minus perceived sleep quality before the spread of the virus, BRS Brief Resilience Scale (26)

| Table 3 Pearson’s correlations between perceived social isolation, depressed and anxious mood, perceived sleep quality, and resilience |
|---------------------------------|-----|-----|-----|-----|-----|-----|
| (1) | (2) | (3) | (4) | (5) | (6) |
| Perceived social isolation | | | 0.31** | –0.15** (n = 3814) | –0.20** (n = 7900) | –0.03 (n = 3814) | –0.17** (n = 3814) |
| Depressed and anxious mood (PHQ-4) | | | | | | |
| Change in perceived sleep quality | | | | | | |
| Resilience (BRS) | | | | | | |
| 1 | | | | | |

a PHQ-4 4-item Patient Health Questionnaire (41)
b Change in perceived sleep quality perceived sleep quality since the spread of the virus minus perceived sleep quality before the spread of the virus
b BRS Brief Resilience Scale (26)
**p < 0.001
Fig. 2 Simple mediation model: Indirect effect of perceived social isolation on change in perceived sleep quality through depressed and anxious mood during the COVID-19 pandemic (n = 3807). PHQ-4 4-item Patient Health Questionnaire (41); *** p < 0.0001; 95% CI (confidence interval) obtained using bootstrap method.
The psychological and mental impact of coronavirus disease 2019 (COVID-19) on medical staff and general public – A systematic review and meta-analysis

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¹ Department of Anesthesiology, The 960th Hospital of the Joint Logistic Support Force of the People’s Liberation Army of China, Jinlin, 130011 China
² Department of Psychology, 960th Army Hospital, Jinlin, 134001 China
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Article info

Abstract

The coronavirus disease 2019 (COVID-19) pandemic has caused enormous psychological impact worldwide. We conducted a systematic review and meta-analysis on the psychological and mental impact of COVID-19 among healthcare workers, the general population, and patients with higher COVID-19 risk published between 1 Nov 2019 to 25 May 2020. We conducted literature research using Embase, PubMed, Google scholar and WHO COVID-19 database. Among the initial search of 2907 studies, 62 studies with 162,629 participants from 17 countries were included in the review. The pooled prevalence of anxiety and depression was 33% (95% confidence interval: 29%-35%) and 14% (95% confidence interval: 9%-19%), respectively. The prevalence of anxiety and depression was the highest among patients with pre-existing conditions and COVID-19 infection (56% [39%-73%] and 55% [48%-62%]), and it was similar between healthcare workers and the general public. Studies from China, Italy, Turkey, Spain and Iran reported higher-than-pooled prevalence among healthcare workers and the general public. Common risk factors included being women, being nurses, having lower socioeconomic status, having high risks of contracting COVID-19, and social isolation. Protective factors included having sufficient medical resources, up-to-date and accurate information, and taking precautionary measures. In conclusion, psychological interventions targeting high-risk populations with heavy psychological distress are in urgent need.

1. Introduction

The coronavirus disease 2019 (COVID-19) outbreak is posing a serious public health threat worldwide. According to the World Health Organization (WHO), as of 1 June 2020, 6,040,609 confirmed cases and 370,657 deaths have been reported globally (World Health Organization, 2020). A recent large-scale study has shown that multi-faceted public health interventions are temporarily associated with improved control of COVID-19 pandemic (Yin et al., 2020). However, in addition to the physical health, the potential psychological and mental health impact by the COVID-19 pandemic should also be taken seriously. Although previous research has suggested that the mental impact of a major disaster had a wider and longer effect on people compared to physical injuries, mental health suffers far fewer personnel for planning and resources (Allanegg et al., 2019).

Studies conducted on the psychological impact of previous infectious outbreaks, such as the severe acute respiratory syndrome (SARS) that is similar to the COVID-19 pandemic, have found heavy psychological burdens among healthcare workers and the general public such as anxiety, depression, panic attacks, or psychotic symptoms (Maunder et al., 2003; Xiang et al., 2020). Healthcare workers who were quarantined, worked in SARS units, or had family or friends infected with SARS, had commonly more anxiety, depression, frustration, fear, and post-traumatic stress than those who had no such experience (Xiang et al., 2020; Wu et al., 2009). Similarly, many published studies have assessed the psychological impact of COVID-19 and have also found high levels of psychological distress (Lai et al., 2020; Zhang et al., 2020; Zhu et al., 2020; Chen et al., 2020; Li et al., 2020; Li et al., 2020; Du et al., 2020; Wang et al., 2020; Zhang et al., 2020; Cao et al., 2020; Tan et al., 2020; Chen et al., 2020; Coronado et al., 2020; Zhang et al., 2020; Guiryo et al., 2020; Wang et al., 2020; Li et al., 2020; Huang and Zhao, 2020; Lei et al., 2020; Ahmed et al., 2020;
N=163k, 17 countries

Prevalence of depression and anxiety were worse after the pandemic, in different countries, for the public and for patients.
The mental health impact of the COVID-19 pandemic on people with and without depressive anxiety, or obsessive-compulsive disorders: a longitudinal study of three Dutch case-control cohorts

Koan Yu-Fan, Almei A. Kik, Marjke Eikendouw, Rick Van der Horst, Fred de Wijk, Rob A. Lutsu, DiDi Rheeder, Patricia van Oppen, Enki Giltay*, Benda A*†‡†§\*\*\*  
Summary
The impact of the COVID-19 pandemic on mental health in people with pre-existing mental health disorders is unclear. In three psychiatry case-control cohorts, we compared the perceived mental health impact and coping and changes in depressive symptoms, anxiety, worry, and loneliness before and during the COVID-19 pandemic between people with and without lifetime depressive, anxiety, or obsessive-compulsive disorders.

Methods Between April 1 and May 15, 2020, online questionnaires were distributed among the Netherlands Study of Depression and Anxiety: Netherlands Study of Depression in Older Persons, and Netherlands Obsessive Compulsive Disorder Association cohorts, including people with (n=1181) and without (n=336) depressive, anxiety, or obsessive-compulsive disorders. The questionnaire contained questions on perceived mental health impact, fear of COVID-19, coping, and four validated scales assessing depressive symptoms, anxiety, worry, and loneliness used in previous waves during 2006–16. Number and chronicity of disorders were based on diagnoses in previous waves. Linear regression and mixed models were done.

Findings The number and chronicity of disorders showed a positive graded dose–response relation, with greater perceived impact on mental health, fear, and power coping. Although people with depressive, anxiety, or obsessive-compulsive disorders scored higher on all four symptom scales than did individuals without these mental health disorders, both before and during the COVID-19 pandemic, they did not report a greater increase in symptoms during the pandemic. In fact, people without depressive anxiety, or obsessive-compulsive disorders showed a greater increase in symptoms during the COVID-19 pandemic, whereas individuals with the greatest burden on their mental health tended to show a slight symptom decrease.

Interpretation People with depressive anxiety, or obsessive-compulsive disorders are experiencing a detrimental impact on their mental health from the COVID-19 pandemic, which requires closer monitoring in clinical practice. Yet, the COVID-19 pandemic does not seem to have further increased symptom severity compared with their previous wave.

Lancet Psychiatry (2021); 8: 230–36  
Published Online December 8, 2020  
https://doi.org/10.1016/S2215-0366(20)30333-9  
Outlook at the future

Lancet Psychiatry Feb 2021  
n=1181 + 336 = 1317.  
mental health impact, fear of COVID19, Coping  
Higher with more disorders

Scales for depression, anxiety, worry and loneliness

Future uncertainty, concern has been growing about the mental health sequelae of the COVID-19 crisis. Most psychosocial stressors, a rise in psychological distress in April, 2020 compared with in 2013–15 has been reported.

<table>
<thead>
<tr>
<th>Number of disorders in previous waves</th>
<th>n</th>
<th>Crude mean (SE)</th>
<th>Adjusted standardised score (mean [SE])</th>
<th>Adjusted p value</th>
<th>p value for trend</th>
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<tbody>
<tr>
<td>0 disorders</td>
<td>325</td>
<td>2.12 (0.65)</td>
<td>0 (ref)</td>
<td>0.0001</td>
<td>p = 0.0001</td>
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<tr>
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<td>2.81 (0.71)</td>
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<td>5 or 6 disorders</td>
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<td>0.80 (0.06)</td>
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<td>Fear of COVID-19</td>
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<td>3.00 (0.59)</td>
<td>0 (ref)</td>
<td>0.007</td>
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<tr>
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<td>272</td>
<td>3.10 (0.72)</td>
<td>0.09 (0.06)</td>
<td>-</td>
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<tr>
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<td>3.24 (0.73)</td>
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<td>5 or 6 disorders</td>
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<td>-</td>
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<td>Positive coping</td>
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<td>328</td>
<td>3.90 (0.49)</td>
<td>0 (ref)</td>
<td>0.0001</td>
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<tr>
<td>1 disorder</td>
<td>272</td>
<td>3.86 (0.53)</td>
<td>-0.05 (0.05)</td>
<td>0.32</td>
<td>-</td>
</tr>
<tr>
<td>2 disorders</td>
<td>253</td>
<td>3.74 (0.55)</td>
<td>-0.17 (0.05)</td>
<td>-</td>
<td>-0.0007</td>
</tr>
<tr>
<td>3 disorders</td>
<td>227</td>
<td>3.63 (0.58)</td>
<td>-0.28 (0.05)</td>
<td>-</td>
<td>-0.0001</td>
</tr>
<tr>
<td>4 disorders</td>
<td>196</td>
<td>3.56 (0.65)</td>
<td>-0.34 (0.05)</td>
<td>-</td>
<td>-0.0001</td>
</tr>
<tr>
<td>5 or 6 disorders</td>
<td>206</td>
<td>3.40 (0.71)</td>
<td>-0.48 (0.05)</td>
<td>-</td>
<td>-0.0001</td>
</tr>
</tbody>
</table>

Figure 3: COVID-19-specific dimensions in severity and chronicity of depressive anxiety, or obsessive-compulsive disorders

Severity is the number of lifetime disorders. Chronicity is the percentage of previous waves with current disorders. The crude means refer to the mean score in each dimension by mental health disorder status. To create the forest plot, each COVID-19-specific dimension score was standardised. The adjusted standardised score was derived from linear regression, adjusted for age, gender, education, living situation, and date of response.
SUICIDES

Did they increase?

https://www.bmj.com/content/bmj/371/bmj.m4352.full.pdf
Projected increases in suicide in Canada as a consequence of COVID-19

Roger S. McIntyre\textsuperscript{a,b,c,d,e,*}, Yena Lee\textsuperscript{a,b}

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\textbf{A B S T R A C T}

Macroeconomic indicators, notably unemployment, are significant moderators of suicide. We projected the number of excess suicides in Canada as a consequence of the impact of COVID-19 on unemployment. Annual suicide mortality (2000-2018) and unemployment (2000-2019) data were derived from Statistics Canada. Time-trend regression models were used to evaluate and predict the number of excess suicides in 2020 and 2021 for two possible projection scenarios following the COVID-19 pandemic: 1) an increase in unemployment of 1.6\% in 2020, 1.2\% in 2021, or 2) an increase in unemployment of 10.7\% in 2020, 8.9\% in 2021. A percentage point increase in unemployment was associated with a 1.0\% increase in suicide between 2000 and 2018. In the first scenario, the rise in unemployment rates resulted in a projected total of 418 excess suicides in 2020-2021 (suicide rate per 100,000: 11.6 in 2020). In the second scenario, the projected suicide rates per 100,000 increased to 14.0 in 2020 and 13.6 in 2021, resulting in 2114 excess suicides in 2020-2021. These results indicate that suicide prevention in the context of COVID-19-related unemployment is a critical priority. Furthermore, timely access to mental healthcare, financial provisions and social/labour support programs, as well as optimal treatment for mental disorders is urgently needed.
Fig. 1. We conducted a time-trend regression analysis of suicide and unemployment rates between 2000 and 2018 in Canada. Suicide mortality in 2019 was predicted using the 2019 unemployment rate of 5.7%. Suicide mortality in 2020 and 2021 were projected for three scenarios of change in unemployment rates: no change (i.e., 5.9% in 2020 and 6.0% in 2021 as published in the 2019 Federal Budget), moderate increase (i.e., 7.5% in 2020, 7.2% in 2021), and extreme increase (i.e., 16.6% in 2020, 14.9% in 2021).
Real-time suicide mortality data from police reports in Queensland, Australia, during the COVID-19 pandemic: an interrupted time-series analysis

Stuart Leslie, Kairi Kõlves, David Corrigan, Ellis Arensman, Diego de Leo

Summary
Background Deaths by suicide can increase during infectious disease outbreaks. This study analysed suspected suicide rates in 2020 relative to 2015–19 to assess any early effects of the COVID-19 pandemic in Queensland, Australia.

Methods We analysed data from the inter-Queensland Suicide Register (iQSR), a state-wide real-time suicide surveillance system, using an interrupted time-series design. The data source for the iQSR is the Form 1 police report of a death to a coroner. Two QSR staff independently classified the probability of a death by suicide as possible, probable, or beyond reasonable doubt. The analysis included the probable or beyond reasonable doubt categories as suspected suicides. The primary outcome was the monthly suspected suicide rate. We applied Poisson and negative binomial regressions to assess whether Queensland’s Public Health Emergency Declaration on Jan 29, 2020, affected suspected suicides from Feb 1 to Aug 31, 2020. Secondary outcomes included absolute or relative changes in police-reported motives of recent unemployment, financial problems, domestic violence, and relationship breakdown.

Findings 3793 suspected suicides were recorded with an unadjusted monthly rate of 14.85 deaths per 100 000 people (from Jan 1, 2015, to Jan 31, 2020) before the declaration, and 443 suspected suicides were recorded with an unadjusted monthly rate of 14.07 deaths per 100 000 people (Feb 1, 2020, onwards) after the declaration. An interrupted time-series Poisson regression model unadjusted (rate ratio [RR] 0.94, 95% CI 0.82–1.06) and adjusted for overdispersion, seasonality, and pre-exposure trends (RR 1.02, 95% CI 0.93–1.12) indicated no evidence of a change in suspected suicide rates. We found no absolute or relative increases in the motives for suspected suicides, including recent unemployment, financial problems, relationship breakdown, or domestic violence from February to August, 2020, compared with the pre-exposure period.

Interpretation There does not yet appear to be an overall change in the suspected suicide rate in the 7 months since Queensland declared a public health emergency. Despite this, COVID-19 has contributed to some suspected suicides in Queensland. Ongoing community spread and increasing death rates of COVID-19, and its impact on national economies and mental health, reinforces the need for governments to maintain the monitoring and reporting of suicide mortality in real time.

Funding None.

https://www.thelancet.com/action/showPdfPii/s2215-0366%2820%2930435-1
Stay at home advisory did not lead to a rise in suicides in Massachusetts

Many believe that shelter-in-place or stay-at-home policies might cause an increase in so-called deaths of despair. While increases in psychiatric stressors during the COVID-19 pandemic are anticipated, whether suicide rates changed during stay-at-home periods has not been described.

This was an observational cohort study that assembled suicide death data for persons aged 10 years or older from the Massachusetts Department of Health Registry of Vital Records and Statistics from January 2015 through May 2020. Using autoregressive integrated moving average (ARIMA) and seasonal ARIMA to analyze suicide deaths in Massachusetts, we compared the observed number of suicide deaths in Massachusetts during the stay-at-home period (March through May, 2020) in Massachusetts to the projected number of expected deaths. To be conservative, we also accounted for the deaths still pending final cause determination

The incident rate for suicide deaths in Massachusetts was 0.67 per 100,000 person-month (95% CI 0.56-0.79) versus 0.81 per 100,000 person-month (95% CI 0.69-0.94) during the 2019 corresponding period (incident rate ratio of 0.83; 95% CI 0.66-1.03). The addition of the 57 deaths pending cause determination occurring from March through May 2020 and the 33 cases still pending determination from the 2019 corresponding period did not change these findings.

The observed number of suicide deaths during the stay-at-home period did not deviate from ARIMA projected expectations using either preliminary data or an alternate scenario in which deaths pending investigation (exceeding the average remaining number of deaths still pending investigation which occurred during the corresponding 2015-2019 period) were ascribed to suicide. Decedent age and sex demographics were unchanged during the pandemic period compared to 2015-2019.

The stable rates of suicide deaths during the stay-at-home advisory in Massachusetts parallel findings following ecological disasters. As the pandemic persists, uncertainty about its scope and economic impact may increase. However, our data are reassuring that an increase in suicide deaths in Massachusetts during the stay-at-home advisory period did not occur.
Increase in suicide following an initial decline during the COVID-19 pandemic in Japan

Takanao Tanaka1 and Shohei Okamoto2

There is increasing concern that the coronavirus disease 2019 (COVID-19) pandemic could harm psychological health and exacerbate suicide risk. Here, based on month-level records of suicides covering the entire Japanese population in 1,848 administrative units, we assessed whether suicide mortality changed during the pandemic. Using difference-in-difference estimation, we found that monthly suicide rates declined by 14% during the first 5 months of the pandemic (February to June 2020). This could be due to a number of complex reasons, including the government’s generous subsidies, reduced working hours and school closure. By contrast, monthly suicide rates increased by 16% during the second wave (July to October 2020), with a larger increase among females (37%) and children and adolescents (49%). Although adverse impacts of the COVID-19 pandemic may remain in the long term, its modifiers (such as government subsidies) may not be sustained. Thus, effective suicide prevention—particularly among vulnerable populations—should be an important public health consideration.
Fig. 2 | The effects of COVID-19 pandemic on suicide across gender and age groups using DID and event-study approaches. a, Results of the DID and the event study using all pooled samples. b, c, Results of comparing suicide rates among males (b) and females (c). d–f, Results for different age groups: below 20 years (d), 20–69 years (e) and ≥70 years (f). Lines represent point estimates before the pandemic (grey), during the first outbreak of COVID-19 (blue) and during the second outbreak (red), with shaded areas showing the first and second outbreaks, respectively. Full results are presented in city-by-month fixed effects and are weighted by the population. Standard errors (lower and upper 95% CI) are given. The separated observations are extracted and aggregated at prefectural level.

Larger rise for females
Larger rise for those under 20
The pandemic appears to have a cumulative effect
1. Risk lower at first
2. Then worse for women
3. Worse for the elderly
4. Worse after the second school closure
Heterogeneous effect of pandemic, students not affected as much with some improvement at first school closure.
INVISIBLE ENEMY
THE STORM

THE PANDEMIC CHALLENGE: PSYCHOLOGICAL

- LONELINESS,
- ISOLATION,
- VULNERABLE LOVED ONES
- EDUCATION: CHILDCARE/HOMESCHOOLING
- SUICIDES

- BOREDOM-LEISURE, TRAVEL, SCHEDULES CHANGED
- UNCERTAINTY AND FEAR
- MARGINALIZATION
  - SPECIAL POPULATIONS, THE ELDERLY, SHUT-INS, HOMELESS, PRISON

- PSYCHOLOGICAL DISORDERS INCLUDING SUBSTANCE ABUSE
- ECONOMIC IMPACT (VARIABLE) — LOST JOBS, FOOD SCARCITY FOR SOME
- DOMESTIC ABUSE AND INTIMATE PARTNER VIOLENCE
• Those are the facts.

• Stress doesn’t come from the facts but the meaning we give to the facts.
Calm

Step 2: Awareness
MENTAL HEALTH VITALS

- SLEEP, TENSION, IRRITABILITY, APPETITE, HOPE, SENSE OF HUMOUR?
TAKE YOUR OWN TEMPERATURE: ARE YOU?

- Calm, Relaxed, Content
- Worried, Irritable, Sad
- Fear, Shame, Humiliation, Hopelessness
- Terror, Numbness, Despair, Anger

https://www.cma.ca/physician-wellness-hub/resource-centre
“She felt guilty, useless, ashamed of herself,” explained her sister, “she couldn’t bear the guilt of being home while her overwhelmed colleagues continued to work. “It’s a lot of pressure,”
“Awareness is the greatest agent for change.”

-Eckhart Tolle
ACCEPT WHAT IS.
LET GO OF WHAT WAS.
TAKE CONTROL OF YOUR RESPONSE AND WHAT WILL BE
Our circumstances don’t define us. Our choices do.

AWARENESS

• We often do not choose our circumstances
• We make conscious choices
• Respond and not react
AWARENESS

• **Bosco:** **Kidnapped.**

  • **How he found Freedom in a 6x9 cell**

  • **He realized what he could change and what couldn’t.**

  • **He took control of his life**
DISCOVER YOUR FREEDOM

• “EVERYTHING CAN BE TAKEN FROM A MAN BUT ONE THING: THE LAST OF THE HUMAN FREEDOMS—TO CHOOSE ONE’S ATTITUDE IN ANY GIVEN SET OF CIRCUMSTANCES, TO CHOOSE ONE’S OWN WAY.”

• — VIKTOR E. FRANKL, MAN'S SEARCH FOR MEANING
MAN’S SEARCH FOR MEANING

• “A WHY CAN BEAR ALMOST ANY HOW”

• VICTOR FRANKL QUOTING NIETZSCHE
Association Between Life Purpose and Mortality Among US Adults Older Than 50 Years

Aliya Alimujang, MPH; Ashley Wiensch, MPH; Jonathan Boss, MS; Nancy L. Fleischer, PhD, MPH; Alison M. Mondul, PhD, MPH; Karen McLean, MD, PhD; Bhramar Mukherjee, PhD; Celeste Leigh Pearce, PhD, MPH

Abstract

IMPORTANCE A growing body of literature suggests that having a strong sense of purpose in life leads to improvements in both physical and mental health and enhances overall quality of life. There are interventions available to influence life purpose; thus, understanding the association of life purpose with mortality is critical.

OBJECTIVE To evaluate whether an association exists between life purpose and all-cause or cause-specific mortality among older adults in the United States.

DESIGN, SETTING, AND PARTICIPANTS The Health and Retirement Study (HRS) is a national cohort study of US adults older than 50 years. Adults between the ages of 51 to 61 were enrolled in the HRS, and their spouses or partners were enrolled regardless of age. Initially, individuals born between 1931 and 1941 were enrolled starting in 1992, but subsequent cohort enrichment was carried out. The present prospective cohort study sample was drawn from 8419 HRS participants who were older than 50 years and who had filled out a psychological questionnaire during the HRS 2006 interview period. Of these, 1142 nonresponders with incomplete life purpose data, 163 respondents with missing sample weights, 81 participants lost to follow-up, 1 participant with an incorrect survival time, and 47 participants with missing information on covariates were excluded. The final sample for analysis was 6985 individuals. Data analyses were conducted between June 5, 2018, and April 22, 2019.

Key Points

Question Does an association exist between life purpose and all-cause or cause-specific mortality among people older than 50 years participating in the US Health and Retirement Study?

Findings This cohort study of 6985 adults showed that life purpose was significantly associated with all-cause mortality.

Meaning Life purpose is a modifiable risk factor and as such the role of interventions to improve life purpose should be evaluated for health outcomes, including mortality.
MEANING CAN BE A **MATTER OF LIFE AND DEATH**
Purpose in Life and Hospitalization for Ambulatory Care-Sensitive Conditions in Old Age

Robert S. Wilson, PhD, Ana W. Capuano, PhD, Bryan D. James, PhD, Priscilla Amofa, BA, Zoe Arvanitakis, MD, Raj Shah, MD, David A. Bennett, MD, and Patricia A. Boyle, PhD
Rush Alzheimer’s Disease Center (all authors) and Departments of Neurological Sciences (RSW, AWC, ZA, DAB), Behavioral Sciences (RSW, PAB), Internal Medicine (BDJ), and Family Practice (RCS), Rush University Medical Center, Chicago, IL USA

Abstract

Objective—To test the hypothesis that higher level of purpose in life is associated with lower subsequent odds of hospitalization.

Design—Longitudinal cohort study.

Setting—Participants' residences in the Chicago metropolitan area.

Participants—A total of 805 older persons who completed uniform annual clinical evaluations.

Measurements—Participants annually completed a standard self-report measure of purpose in life, a component of well-being. Hospitalization data were obtained from Part A Medicare claims records. Based on previous research, ICD-9 codes were used to identify ambulatory care-sensitive conditions (ACSCs) for which hospitalization is potentially preventable. The relation of purpose (baseline and follow-up) to hospitalization was assessed in proportional odds mixed models.

Results—During a mean of 4.5 years of observation, there was a total of 2,043 hospitalizations (442 with a primary ACSC diagnosis, 1,322 with a secondary ACSC diagnosis, 279 with no ACSCs). In initial analyses, higher purpose at baseline and follow-up were each associated with lower odds of more hospitalizations involving ACSCs but not hospitalizations for non-ACSCs. Results were comparable when those with low cognitive function at baseline were excluded. Adjustment for chronic medical conditions and socioeconomic status reduced but did not eliminate the association of purpose with hospitalizations involving ACSCs.

Conclusions—In old age, higher level of purpose in life is associated with lower odds of hospitalization for ambulatory care-sensitive conditions.

Purpose in Life Is Associated With Mortality Among Community-Dwelling Older Persons

Patricia A. Boyle, PhD, Lisa L. Barnes, PhD, Aron S. Buchman, MD, and David A. Bennett, MD
Rush Alzheimer’s Disease Center (P.A.B., L.L.B., A.S.B., D.A.B.), and the Departments of
Behavioral Sciences (P.A.B., L.L.B.) and Neurological Sciences (L.L.B., A.S.B., D.A.B.), Rush
University Medical Center, Chicago, Illinois.

Abstract

Objective—To assess the association between purpose in life as an important determinant of health outcomes and mortality in community-dwelling elderly persons.

Methods—We used data from 1238 older persons without dementia from two longitudinal cohort studies (Rush Memory and Aging Project and Minority Aging Research Study) with baseline evaluations of purpose in life and up to 5 years of follow-up to test the hypothesis that greater purpose in life is associated with a reduced risk of mortality among community-dwelling older persons.

Results—The mean ± standard deviation score on the purpose in life measure at baseline was 3.7 ± 0.5 (range = 2–5), with higher scores indicating greater purpose in life. During the 5-year follow-up (mean = 2.7 years), 151 of 1238 persons (12.2%) died. In a proportional hazards model adjusted for age, sex, education, and race, a higher level of purpose in life was associated with a substantially reduced risk of mortality (hazard ratio = 0.60, 95% Confidence Interval = 0.42, 0.87). Thus, the hazard rate for a person with a high score on the purpose in life measure (score = 4.2, 90th percentile) was about 57% of the hazard rate of a person with a low score (score = 3.1, 10th percentile). The association of purpose in life with mortality did not differ among men and women or Whites and Blacks. Further, the finding persisted after the addition of terms for several potential confounders, including depressive symptoms, disability, neuroticism, the number of chronic medical conditions, and income.

Conclusion—Greater purpose in life is associated with a reduced risk of all-cause mortality among community-dwelling older persons.

Figure 1.
Cumulative hazard of mortality for participants with high versus low purpose in life.
Meaning in Life and Self-Control
Buffer Stress in Times of COVID-19: Moderating and Mediating Effects With Regard to Mental Distress

Tatjana Schnell 1,2* and Henning Krampe 2

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Background: As evidenced by several studies, mental distress increased substantially during the COVID-19 pandemic. In this period, citizens were asked to exercise a high degree of self-control with regard to personal and social hygiene behavior. At the same time, we witnessed an increase of prosocial acts and shared creative expressions, which are known to serve as sources of meaning. Meaning in life and self-control are acknowledged psychological resources. Especially in times of crisis, meaning in life has been shown to be a crucial factor for resilience and coping. However, threatening and stressful situations can also jeopardize existential security and trigger crises of meaning. The present study aimed to document levels of acute COVID-19 stress and general mental distress in Germany and Austria during the lockdown and in the weeks thereafter. In order to identify potential risk factors related to demographics and living conditions, their associations with COVID-19 stress were analyzed exploratively. The primary objective of the study, however, was to investigate the buffering effect of two psychological resources—meaningfulness and self-control—with regard to the relation between acute COVID-19 stress and general mental distress. Finally, a potential aggravation of mental distress due to the occurrence of crises of meaning was examined.

Method: A cross-sectional survey was conducted online during lockdown (survey group 1) and the subsequent weeks characterized by eased restrictions (survey group 2). A total of N = 1,538 German-speaking participants completed a questionnaire battery including a novel measure of acute COVID-19 stress, meaningfulness and crisis of meaning (CoMeS), self-control (SCS-KD), and a screening of general mental distress, measured by core symptoms of depression and anxiety (PHQ-4). In a first step, associations between living conditions, demographics, and COVID-19 stress were explored. Second, a moderation and a mediation model were tested. Meaningfulness, a measure of presence of meaning in life, as well as self-control were proposed to serve as buffers in a time of crisis, thus moderating the relation between acute COVID-19 stress and general mental distress (double moderation). Crises of meaning, operationalizing an experienced lack of meaning in...
AWARENESS. TRANSFORM YOUR LIFE BY BEING AWARE OF YOUR CHOICES AND WHY

WHY...A TRANSFORMATION
What is the meaning of all of the sacrifices we are making?

Survival of the **non-fittest**.

- **Who are we fighting for?**
- **Especially for the vulnerable, the elderly, the sick, the disabled**
People don’t value what they don’t fight for.

TONY ROBBINS
Life’s beauty is inseparable from its fragility

SUSAN DAVIS, Harvard Trained Psychologist, TED talk
PART OF THE BEAUTY AND PRECIOUSNESS OF LIFE IS ITS FRAGILITY.
Discomfort is the price of admission to a meaningful life.

SUSAN DAVIS, Harvard Trained Psychologist, TED talk
STEP 3: LEARN TO LEAN INTO THE POSITIVE.

- Think about the things for which you are thankful and cultivate gratitude on a daily basis. Look for the hidden advantage of your situation and learn to focus on the benefits.
• "You may encounter many defeats, but you must not be defeated. In fact, it may be necessary to encounter the defeats, so you can **know who you are**, what **you can rise from**, how you can still come out of it." —Maya Angelou
Refuse to be defined by tragedy or circumstance.
• 1-5 WAYS THINGS COULD BE WORSE NOW

• 2- LOOK FOR HIDDEN ADVANTAGE OF YOUR SITUATION

• 3- PERSPECTIVE. COMPARE PROGRESS TO YOURSELF

Lindsey Roy TED Talk
https://www.youtube.com/watch?v=lUw8z7laPu
3 SECRETS OF RESILIENT PEOPLE

- ACCEPTANCE
- FOCUS-BENEFIT FINDING
- HELPING OR HURTING

Lucy Hone, TED Talk
https://www.youtube.com/watch?v=NWH8N-BvhAw
“Don’t lose what you have because of what you have lost.”

Lucy Hone, TED Talk
https://www.youtube.com/watch?v=NWH8N-BvhAw
WHAT ARE YOU GRATEFUL FOR?
ON THE **PLUS** SIDE

- Gas is cheap
- Spending less
- More flexibility in working from home
- Less travel time
- Children are spending more time with their families
- Parents are home taking care of their children and getting to know them
- Fast food often replaced by home cooked meals
- Hectic schedules stopped
- World is quieter
ON THE **PLUS** SIDE

- **People are conscious about hygiene and health**
- **Money seems less important now**
- **Designer clothing is pointless**
- **Health care providers, Emergency Response teams, Supply Chain workers, and Cleaners are being praised rather than celebrities**
- **Technology is providing opportunities for connection and medical care more efficiently.**
- **We have more time to smell the roses and look up at the stars.**
What will be the effect of us, taking this forced pause on the extras in life?
Busy-ness can be an obstacle to improvement.

Improve the things that are most important in your life.

Actually not things but people.

An opportunity to strengthen relationships.
CALM

STEP 4: MOVE FORWARD, MAKE THINGS BETTER. IMPROVE
GET STRONGER
DON’T COMPARE YOURSELF TO OTHERS.
COMPARE YOURSELF TO YOURSELF.
THE IMPORTANCE OF PROGRESS
COGNITIVE BEHAVIOURAL THERAPY.

- THINK BETTER
- LIVE BETTER
- THEN FEEL BETTER
INTERPERSONAL THERAPY.
IPT

• CONNECT

Comprehensive Guide to Interpersonal Psychotherapy

Myrna M. Weissman
John C. Markowitz
Gerald L. Klerman
DIALECTICAL BEHAVIOURAL THERAPY. DBT

- Change
  - Emotion Regulation
  - Interpersonal Effectiveness
- Acceptance
  - Mindfulness
  - Distress Tolerance

Self-Management
Help people KNOW and GET what they want

MOTIVATIONAL THERAPY

FIVE PRINCIPLES OF MOTIVATIONAL INTERVIEWING

- Express empathy for the client
- Develop discrepancy between the client's goals and values and their current behavior, particularly regarding substance use
- Avoid argumentation and direct confrontation
- Roll with client resistance, instead of fighting it
- Support the client's self-efficacy, or their belief that they can change
Apply problem solving orientation
DEVELOP problem solving skills

Challenges vs Obstacles
"A comfort zone is a beautiful place, but nothing ever grows there."
LIFE DOES NOT GET EASIER, YOU JUST GET STRONGER.

@successpictures

Me now
The old me
CHOOSE **HOPE**. BE CONSTRUCTIVE. CHOSE **LIFE**
THINK ABOUT OTHER PEOPLE
FIRST DO NO HARM
FOLLOW YOUR CONSCIENCE
HOW DO WE **LIFT** OURSELVES AND EACH OTHER **UP**?

- **CONSTRUCTIVE**
  - **Exercise**
  - **Downtime**
    - **Recharge**
  - **Meditate/Pray/Contemplate**
  - **Play** — who says it is just for kids
  - **Humour**
Beneficial effect of laughter therapy on physiological and psychological function in elders

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Present address
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Abstract
Aim: In the present study we investigated the effect of laughter therapy on physiological and psychological function in older people.

Design: An open-label trial.

Methods: Seventeen older people who regularly attended an elderly day care centre were recruited. Stand-up comedy as laughter therapy was performed once a week for 4 weeks. Parameters of physiological and psychological function were evaluated before and after laughter therapy.

Results: Laughter therapy intervention resulted in a significant reduction in systolic blood pressure and heart rate, accompanied by a significant increase in plasma concentration of serotonin and a significant decrease in salivary concentration of chromogranin A. Questionnaire surveys of SF-8, GDS-15, and Vitality Index demonstrated alleviation of depression and improvement of sociability and activity in older people. Laughter therapy could be expected to become a practical treatment to improve quality of life of older people in an elderly day care center.

Keywords
blood pressure, geriatric depression scale (GDS), laughter therapy, quality of life (QOL), serotonin, SF-8

FIGURE 1
(a) BP before and after intervention. (N = 17). (b) HR before and after intervention. (N = 17). (c) Percent change in plasma serotonin concentration after four performances of laughter therapy (N = 16). (d) Concentration of salivary CgA before and after laughter therapy (N = 16). (e) Correlation of percent change in plasma serotonin concentration with percent change in plasma NK activity (N = 16). Values are expressed as mean ± SEM. * p < 0.05 versus Pre. Pre, the day before the first laughter therapy. Post, the day after the last laughter therapy.
FIND A WAY TO LAUGH AND PLAY

“JOKES CONNECT US, THEY EMBRACE US….WHEN YOU MAKE SOMEONE LAUGH YOU ARE NOT JUST BEING FUNNY, YOU ARE INDUCERS OF HOPE, EMBRACERS OF STRANGERS, ERADICATORS OF HOPELESSNESS, YOU ARE PHYSICIANS AND PEACEMAKERS”

McCarten TED talk
HUSKY, COLLIE, BEAGLE ...  
AFGHAN, POODLE, PUG ...  
YORKIE, SHIH TZU, CORGI.

YOUR HINDSIGHT IS 20/20.
Evidence that stress can make you stupid
JULIE NOLKE:
EXPLAINING THE PANDEMIC TO MY PAST SELF: PARTS 1-4

•HTTPS://WWW.YOUTUBE.COM/WATCH
  v=Ms7capx4Gb8
HUMOUR

• Humour obliges us to have an open mind, and obliges empathy
• Humour always forgives.
• Laughter connects us

McCarten TED talk
BE THERE FOR ONE ANOTHER

Friendships,
Peer supports,
Counselors,
In sharing in this hardship together, we can learn to be kinder, braver, and more resilient.
EACH DAY WE ARE CLOSER TO THE END OF THIS PANDEMIC
The End