

A BRIEF INTERVENTION MODEL FOR TRAUMATIC EVENTS

Mali HARZANU-LETI¹, Jonathan GEZ²,
Mair NADAV³, Barbara REICHER⁴, Vasile CHIRIȚĂ⁵

Abstract:

Acute stress reaction is a response to an event related to a severe threat to a person's body integrity or to those close to him. In the past decade, the Israeli population has been exposed to terror and war-related incidents, and as a result, acute stress reactions have become commonplace. Often, emergency rooms and primary clinics have had to deal with situations of multiple victims. Aside from a physical response, these victims are also in need of an initial psychological intervention as "anxiety victims". In this article, we will propose a model of tools and principles for primary intervention for this population of patients. These principles don't require extensive skills or training and are available for immediate and simple use. The acronym OSBD was chosen to indicate the principles of O – orientation, S – safety, B – body, D – dialogue. These principles will be developed in the article and we hope will constitute a useful and available tool for those professionals who meet with victims in emergency rooms or immediately after their release from community medical frameworks.

Keywords: acute stress reaction, model of intervention, tools, principles

Introduction

Anxiety, stress and trauma: As a result of the increase in terrorist acts perpetrated toward civilian populations, the term "anxiety victim" has been coined. This term relates to those people who react to an event (missiles, terrorist attack, natural disaster, accidents) in a powerful way, with a clear-cut physical or emotional expression. Generally, these victims are referred to emergency rooms of general hospitals and during times of war, to special centers geared to treat them in an immediate fashion. Later, they may continue treatment with family physicians and mental health centers.

The ICD-10 defines "anxiety victims" as suffering from an acute stress reaction (ASR). This definition relates to an unusual physical and / or psychological reaction. The source of the stress can be a shocking traumatic incident, related to a severe threat to a person's security or body integrity or of those close to him. The symptoms can be expressed in an emotional-functional, behavioral, and

¹ M.S.W., Ph. D, Psychiatric Dept., Soroka University Medical Center and Faculty of Health Sciences, Beersheba, Israel

² M.D., Ph.D., Trauma Clinic, Psychiatric Dept., Soroka University Medical Center, Ahva Academic College, Beersheba, Israel

³ M.A., M.D., Psychiatric Dept., Soroka University Medical Center, Beersheba, Israel

⁴ M.S.W., M.D., Private Practice, Beersheba, Israel

⁵ M.D., Ph. D., Professor, Dept. of Psychiatry, University of Medicine and Pharmacy "Gr. T. Popa" Iași, Romania; Senior Psychiatrist, Clinical Psychiatric Hospital "Socola" Iași, Romania; Member of Romanian Academy of Medical Science

cognitive fashion. Typically, they include an initial stage of “shock”, with some level of diminished consciousness and limited attention span with difficulty in receiving and comprehending stimuli as well as disorientation. In addition, there can be further withdrawal from the milieu (even to the point of a dissociative freeze), or excitation and over-activity.

Autonomous signs of extreme anxiety (tachychardia, sweating, redness) can be very common. There can be partial or full amnesia of the episode. The extent of the response can range from a number of minutes to several days. However, in most cases, the recovery is spontaneous (2). There can be cases where the reaction reaches the level of an acute stress disorder and even a post-traumatic stress disorder as defined in the DSM-IV (3). Additional factors in defining an event as traumatic are its unexpectedness, its incredible nature, its uncontrollability or its unpredictability.

Early Intervention: In light of the various debilitating responses to trauma, and the potential for a more serious disorder to develop in the future, it is important to make early interventions for anxiety victims.

Over the years, several methods of early intervention have been proposed, the most well-known and best-researched of which is debriefing. This early intervention consists of an intensive session where different people who were exposed to the traumatic incident take part. During the session, there is a discussion of the various elements of the trauma so that each participant can develop for himself a fuller understanding of what happened as well as insight into his own responses. At present, the efficacy of this debriefing intervention is being called into question by quite a few research studies which also raise questions about possible damage being done.

At any event, it is clear that the initial goals of any immediate intervention after a traumatic event are to ease the victim's suffering: reduce tension, enable functioning, prevent the development of a negative self image, maintain satisfactory interpersonal relations, and prevent post-traumatic stress disorder. Furthermore, clinical experience has shown how important it is to offer an initial intervention for anyone experiencing a traumatic incident. While not everyone shows signs of immediate distress or dysfunction during the incident, PTSD can develop later. Up-to-date findings support the contribution of primary psychological intervention to prevent negative long-term impact of trauma.

The Intervention model: The following intervention model was developed on the basis of our experience in the psychiatric department of Soroka Hospital (Beer Sheba, Israel). We found that due to the sudden and unexpected nature of stress situations, the treatment often takes place under less than optimal conditions and it is critical that the treatment provider should have simple and easily accessible tools. The following intervention technics can also be useful for family physicians in primary clinics.

The intervention model goes by the acronym of OSBD to aid in easy recall. Each letter stands for one of the four principles on which the primary intervention is predicated:

O – Orientation, S – Security, B – Body, D – Dialogue

Orientation: Information is provided to the victim such as where he is, who is speaking to him, and his present situation. Additionally, Informative questions are asked such as the patient's name, address, profession, where he/she came from, what happened, when, etc. If the anxiety victim is not able to speak, the therapist speaks to him. After experiencing a trauma incident, many victims experience disorientation and it is important to redirect them in order to maintain a sense of life continuity and a feeling of knowledge about oneself and where one is. In this way, the event will not become fragmented, autonomous, and irrelevant.

Security: The patient is presented with a clear message that he is in a safe and protected place, outside of the range of danger, and that the staff is ready and prepared to take care of him. For example, after a rocket has fallen, people arriving at the emergency room can continuously look up, in search of windows, feeling they are not yet safe. It is essential to relate directly to the need for a protected space and to evacuate dangerous areas. In a safe place, the victim can move from survivor mode to more organized behavior.

The sense of security is augmented, among other things, by making contact with family members. When possible, it is helpful for a family member to be present and display physical contact (holding hands, embracing). In a situation of extreme insecurity, a person needs to feel basic security which can be provided best by someone trusted and with whom he has experienced daily security. Therefore, it is important to locate such an individual in the initial hours.

Body: Our experience has shown us that grounding activities like teaching breathing exercises, encouraging motility and the movement of limbs, and supportive walking with the victim until he is able to do so independently are critical. Body control facilitates general control.

Often, treatment staff try to contain a victim by letting him stay in bed, in a wheel chair, or otherwise preventing him from moving around. We have found that it is much more therapeutic to propose and even demand returning the victim to a point where he can “stand on his own two feet”. The faster the body returns to a functional balance, the more easily we can eliminate the potential for a regression which is liable to empower the traumatic incident as a central and generalized event that can be stored in the body over time.

At this stage, the anxiety victim will be given something to drink and eat.

Dialogue: After easing the physical symptoms as much as possible, there should be a brief dialogue with the victim about the incident, legitimizing his reaction and explaining why he reacted that way. It is especially important to use this dialogue to plan together with him the next few hours: where to go, how he will arrive home, what he will do at home, which supportive figure will be with him. In this way, the victim's return to his regular milieu is mediated. Furthermore, information is supplied as to the possibility of unusual responses like insomnia or emotional reactions and to stress that these are normal reactions to exposure to an unusual happening. Finally, the victim is assured that if a need arises later, he can return for help.

3 Clinical Examples:

1st example:

A young man aged 23, an only child, who worked in a store, was brought to the emergency room by ambulance accompanied by a female colleague. He was carried to the emotional aid area of the hospital on a stretcher, wailing loud and unclear sounds, with loud chopped breathing. One half hour before his arrival, a Grad missile fell near him. He heard the missile fall but did not actually see it. The young man appeared in a dissociative state, and did not react to our talking to him.

The therapist called him by name, introduced herself, told him calmly and confidently where he was, promising him that it was a safe place.

The therapist asked the colleague accompanying the victim to hold his hand and described to the victim that B, his co-worker, is nearby him and that they spoke with his mother who is on her way there. After this, the victim was briefly told what happened to him and how he arrived at the hospital. Throughout this procedure, he continued to weep and did not react to the conversation. The therapist asked that the young man look at her directly while reiterating who and where he is. Gradually he ceased weeping, and glanced for short periods at the therapist. When he had begun to calm down, his mother arrived and she was also requested to hold his hand. The mother and the co-worker helped him sit up in bed, even though at first he refused. The therapist demonstrated breathing exercises, after which she oriented the victim in time, place, and environment. After 20 minutes, the young man began to visually focus and respond to people and questions. At this stage, he collaborated in getting up and began to walk. He was anxious and didn't believe he could do this. However, with encouragement and physical support, he began to walk independently. When he returned to his bed, he was given a glass of water. At first, he was helped to hold the glass, eventually holding it himself, even while claiming he wasn't thirsty. He was again requested to breathe and think of a place he likes to be in (“safe place”).

After this round of interventions, he was requested to get up and walk around. This time he asked to visit the bathroom and smoke a cigarette. He was accompanied by the therapist. Upon returning, he sat in a chair and a brief dialogue ensued regarding his functioning in the near future, the following day, when he will return to work, who he wants to speak with, etc. He was told that it is

possible he might feel similar things again, but this will most likely pass. And, in the event he would want further help, he can return.

After 45 minutes of intervention and an additional 20 minutes of rest, the young man left the hospital in a calm and recovered state, accompanied by his mother.

2nd example:

A 48 year old divorced housewife, mother of 4 children – 3 of whom are married, the 4th aged 14 living with her. The woman was home alone during an air-raid preceding the falling of a Grad missile in BeerSheva. While she was running to the shelter, the missile fell some distance from her. However, she was under the impression that it fell very close to her house. The woman was found by her daughter 30 minutes later. She was still in the shelter, in a freeze mode and unable to move due to fear. She was brought by ambulance to the hospital and in a wheel chair to the emergency room. She requested to lie in bed. The therapist coaxed her into a chair. After several minutes, she was asked to walk, supported by two therapists. The woman fell down and complained she felt faint. The therapists spoke confidently that she is supported by them and therefore there is no fear of her falling down. They asked her to look forward and begin walking. They continued walking for a several minutes and only afterwards, let her sit down. Breathing exercises were demonstrated as well as the “safe place” technic. Physical safety was provided with the help of an older daughter who had in the meantime arrived. The woman drank some water. Up until now she had not spoken. At this point, she began to talk, asking about the event and the therapists spoke to her about what happened. Eventually, she told the staff about her intense anxiety due to her son taking part in a large army maneuver. Her anxiety reached intolerable proportions when she heard the air-raid siren, without any connection to where the missile fell or the outcome.

Together with her daughter, the release of this woman was planned. She complained of insomnia and was given Phenergan. This woman was advised to come for further help in the mental health clinic. In the interim, the staff had several phone calls with her to help her calm down.

3rd example:

A 40 year old woman, married with children, was driving on her own to the kindergarten where she worked when an air-raid siren went off signaling that a rocket will befalling. She stopped at the side of the road, but remained in her car despite security recommendations to exit one's vehicle. The rocket fell in view of her and she could actually see pieces of metal dispersing. The only thing she was capable of doing was to call her husband who brought her into the emergency room.

She was brought into the hospital on a wheel chair, immobile, unable to respond physically or verbally. Her husband, who is a career soldier, had to return to his unit. We discovered retrospectively, that this actually increased the patient's anxiety.

The therapist approached the woman, speaking in a soft and pleasant voice. He made efforts to orient her as to where she was, time, and explanations about the people around her. He assured her that the place there are in is safe. While the woman did not respond, her eye contact indicated that she was listening to the therapist. The therapist repeated his words several times, gently touching the woman's arm after verbalizing his intention to do so. Later, he brought the woman a glass of water and helped her drink it. He gradually placed the glass in her hand, encouraging her to drink on her own. She did so while the therapist repeated his previous message while adding several simple questions.

The woman did not respond to the questions, so after several minutes the therapist directed her to breathe deeply together with him. She drank autonomously and the therapist repeated questions like: where the woman lives, where she works, her name, the names of her children, etc.

The woman began answering hesitantly, although she gradually began to respond in a more spontaneous fashion. While talking to her, the therapist asked that she write down the names of her children, their ages, and where they are studying. The woman was surprised, but collaborated with the request.

This act of grounding marked a major change. Following it, she asked, of her own volition, to sit on a chair and, later, to walk over and get herself another glass of water and cookie. When she returned, she requested to call her eldest daughter and husband.

Discussion and summary

Exposure to a traumatic event demands timely therapeutic intervention which will efficiently meet the needs of the survivors. There is a broad continuum of responses to stress which include various signs of distress, from the expected to the extreme of total dissociation. Sometimes the responses are short-lived, sometimes long term with a continuous impact. Some people do not react immediately with strong or unusual emotional responses, only later to develop an acute disorder. "Anxiety victims", while conceptualized as reacting normally to an abnormal situation, are of concern due to their potential to develop a posttraumatic disorder syndrome. In general, many people exposed to trauma are liable to conceive the world as dangerous, unsafe, and untrustworthy; they are liable to see themselves as unable to cope with life. If trauma survivors limit their daily routines and consistently refrain from talking about the trauma, including evading thoughts and conversations about what happened, then their negative beliefs are liable to become fixated and transform into chronic symptoms of PTSD.

After many years of experience in providing psychological aid after multi-victim traumas in the emergency room, as well as surveying the literature, we built a model of intervention which is efficient, clear and simple.

REFERENCES:

1. World Health Organisation (1992). International statistical classification of diseases and related health problems (10 ed.). Geneva, Switzerland. Author.
2. Shalev, A.Y. (1997). Treatment of prolonged stress disorder-learning from experience. *Journal of Traumatic Stress* 10: 415-423.
3. American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders (4 ed.). Washington, D.C. American Psychiatric Association.
4. Foa, E.B., Zinbarg, R., Rothbaum, B.O. (1992). Uncontrollability and unpredictability in post-traumatic stress disorder: an animal model. *Psychological Bulletin* 112: 218-238.
5. Harvey, A.G., Bryant, R.A. (1999). The relationship between acute stress disorder and post-traumatic stress disorder: a 2 year prospective evaluation. *Journal of Consulting and Clinical Psychology* 67(6): 958-988.
6. McKibben, J.B., Bresnick, M.G., Wiechman Askay, S.A., Fauerbach, J.A. (2008) Acute stress disorder and post-traumatic stress disorder: a prospective study of prevalence, course, and predictors in a sample with major burn injuries. *Journal of Burn Care & Research* 29(1): 22-36.
7. Raphael, B., Meldrum, L., McFarlane, A.C. (1995). Does debriefing after psychological trauma work? *British Medicine Journal* 310:1479-1480.
8. Mayou, R.A., Hobbs, M. (2000). Psychological debriefing for road accident victims: three year follow-up of a randomized controlled trial. *British Journal of Psychiatry* 176: 589-593.
9. Van Emmerik, A.A.P., Kamphuls, J.H., Hulsbosch, A.H. (2002). Single session debriefing after psychological trauma: a meta-analysis. *Lancet* 360: 766-771.
10. Shalev, A., Tuval-Meshiah, R. (1999). Early intervention and debriefing after traumatic events. *Conversations (Si-hot-in Hebrew)*. 13(3): 206-219.
11. Solomon, Z., Schwartzwald, L., Mikulincer, M. (1987). Reactions. *American Journal of Psychiatry*. 144: 448-454.
12. Shalev, A.Y., Schreiber, S., Galai, T. (1993). Early psychiatric responses to traumatic injury. *Journal of Traumatic Stress*. 6: 441-450.
13. Bisson, J.I., Shepherd, J.P., Joy, D., Probert, R., Newcombe, R.G. (2004). Early cognitive behavioral therapy for post-traumatic stress symptoms after physical injury. *British Journal of Psychiatry*. 184: 63-69.
14. Foa, E.B. (2006). Psychosocial therapy for post-traumatic stress disorder. *Journal of Clinical Psychiatry*. 67: 40-45.
15. Zommer, E., Bleich, A. (eds) (2005). Mental health in the shadow of terror: the Israeli experience (in Hebrew). Tel Aviv: Ramot.
16. Herman, J.D. (1992). Trauma and Recovery. Tel Aviv: Am Oved.
17. Friedman, M.J., Keane, T.M., Resick, P.A. (eds) (2007). Handbook of PTSD: Science and Practice. NY: Guilford Press.
18. Van der Kolk, B.A., McFarlane, A.C., Weisaeth, L. (eds). (1996). Traumatic Stress. NY: Guilford Press.
19. Braun, P., Greenberg, D., Dasberg, H., Lerer, B. (1990). Core symptoms of post-traumatic stress disorder unimproved by alprazolam treatment. *Journal of Clinical Psychiatry*. 51(6): 236-238.
20. Mellman, T.A., Bustamante, V., David, D., Fins, A.I. (2006). Hypnotic medication in the aftermath of trauma. *Journal of Clinical Psychiatry*. 63(12): 11833-1184.