Case study on psychological first aid on Italian COVID-Hospital

Simona Abate[1], Giulia Lausi[2], Emanuela Mari[2], Anna Maria Giannini[2], Jessica Burrai[2]

[1] Health Department , Sant'Andrea University Hospital, Rome, Italy; [2] Department of Psychology, Sapienza University of Rome, Rome, Italy

SUMMARY

Coronavirus disease had an enormous impact on public health by affecting millions of people who have either fallen ill or died as a result of this disease. The pandemic resulted in several short- and long-term psychological effects, while restrictive measures adopted resulted in challenges in terms of support and counselling meetings, demonstrating the need to move to a digital health care system. In this context, the Psychological First Aid Service at Sant'Andrea, a service for COVID-19 patients and their loved ones, was set up in the Lazio region (Italy). The service provides two free telephone interviews, and if necessary, people are directed to other free support services in the region. In this article, we report a case study of two brothers who contacted the service during the second pandemic wave in Italy. The case has been discussed according to the recent literature, taking the practical and operational aspects of psychological first aid into account.

Key words: coronavirus, telemedicine, psychological support, telepsychotherapy, clinical psychology

Introduction

Since late 2019, coronavirus disease 2019 (i.e., COVID-19) has spread extremely rapidly around the world, and on 11 March 2020, the World Health Organisation [1] (WHO) declared a pandemic status. COVID-19 has affected daily life and slowed down the global economy; it also had an enormous impact on public health by affecting millions of people who have either fallen ill or been killed as a result of this disease. The most common symptoms are fever, cold, cough, bone pain and respiratory problems, which eventually lead to pneumonia. As a "new" viral disease that affected humans for the first time, vaccines were not yet available when it began to spread; therefore, the entire prevention system was based on extensive precautions, such as strict hygiene protocols (e.g., regular hand washing, avoidance of face-to-face interaction, etc.), social and interpersonal distancing, the use of face masks, and so on [2]. The pandemic resulted in several psychological effects (e.g., increases in anxiety, stress, obsessive compulsive disorder symptoms, insomnia) [3] in the general population across age groups [4-6] and different family and working conditions [6-8]. These effects were observed both in the short term and in the long term, and according to Inchausti et al. [9], it was possible to identify at least three main groups at risk of psychological distress during and after the COVID-19 pandemic: (1) health care workers who experience a higher frequency of exposure to the virus [10]; (2) individuals who, as a result of the pandemic, have been exposed to potentially traumatic events such as the loss of a loved one, threats to their health, or their ability to work [8,11,12]; and (3) people with pre-existing diagnosed psychiatric disorders, especially severe or complex ones [13,14].

COVID-19 surprised the entire healthcare system and, in Italy, severely weakened it by turning hospitals into the only place to treat the virus in a very short amount of time. During the acute phase of the pandemic (early 2020), a concrete strategy was needed: creating COVID hospitals. COVID hospitals are healthcare facilities needed to deal with emergency situations, such as COVID-19, isolating patients and assisting them. These facilities were needed in order to dedicate only a few structures to managing COVID-19 and to guarantee the use of the other hospitals – which was necessary to provide health security for the population and to respond to new infections, avoiding the spread of the virus to all healthcare facilities. Later, given the higher number of infected patients, most Italian hospitals were converted to COVID hospitals.

In addition to the impact on hospital and physical health care, the rapid spread of COVID-19 has put a strain on the provision of mental health services, negatively affecting the capacity, responsiveness and availability of public and private health care systems worldwide [15,16]; it has also become clear that there is a need for a digital (TeleMedicine) rather than conventional healthcare system, which guarantees continuity of care and quality of care in synergy with the services provided in the presence of the patient [17]: the use of a digital psychological intervention that addressed problems that may occur due to the pandemic was crucial. Zhang et al. [18] suggested that any intervention during the period of the COVID-19 pandemic should focus on providing rapid adaptation skills and on psychological first aid (PFA). In the pandemic context where face-to-face meetings are extremely limited, increasing access to psychological therapies through technologically informed approaches (telepsychotherapy) presents an opportunity to adapt to the provision of mental health services remotely while supporting patient choice regarding the modalities and flexibility of its provision [19]. During the COVID-19 pandemic, few studies were conducted on hospitalised patients; as noted by Cheng et al. [20], there were additional difficulties compared to a classic application of PFA after a disaster. First, there was a significant difference in the number of mental health professionals and the high demand among hospitalized patients. Second, patients' psychological symptoms changed rapidly, requiring interventions that adapted to these evolving demands at an early stage. Furthermore, the environment of the COVID hospital had an impact on the effectiveness of psychological interventions, and the emergency itself limited the application of face-to-face interventions; a potential solution to these problems was online psychological intervention.

For these reasons, a PFA service for direct and indirect victims of COVID-19 was developed by Sant'Andrea University Hospital in Rome to give patients the opportunity to benefit from remote specialist psychological support. Considering national measures adopted to prevent COVID-19 infection, this allowed victims to (1) receive psychological support without leaving their homes and (2) when necessary, give them the opportunity to continue psychological support for many sessions. The PFA protocol is intended to facilitate victims' contact with their support network, whether affective, family, social, or working. Indeed, adequate social support allows the victim to talk about themselves, to elaborate a coherent reconstruction of what happened, to express the emotions experienced, and to perceive the sympathy and solidarity around them.

Through the exemplification of a clinical case, we aimed to represent this remote PFA model in favour of indirect victims of COVID.

Main characteristics and procedure

Some structures of the Lazio Regional Health Service have activated a PFA service for the distress caused by the pandemic, including the Sant'Andrea University Hospital in Rome. The Psychological First Aid Service at Sant'Andrea (PFA-SA) was set up on 15 March 2020 with the activation of a dedicated telephone number and is reserved for COVID-19 patients and their loved ones. From 15 March 2020 to 15 May 2021, a total of 140 patients were admitted to the PFA-SA, 62 of whom were women and 78 men, with 50% in the 35-45 age group. The PFA is provided in the time slot from 8.00 am to 8.00 pm.

The theoretical model on which PFA-SA is based is that of McCabe et al. [21], which is an empirically-based model that consists of the following steps: 1. Initial contact (relationship establishment and stabilisation); 2. Brief assessment and triage; 3. Intervention; 4. Triage; 5. Referral, liaison, and support from a medical specialist; 6. Awareness and self-care.

Based on the theoretical model of McCabe et al. [21], it was also possible to integrate the PFA-SA protocol with more recent models specifically used in telepsychotherapy [22,23] to build an intervention model aimed at providing effective coping tools during periods of disruption, threat to one's life and the lives of loved ones.

The PFA-SA consists of two telephone contacts to draw up and guide the activation of the territorial network according to individual needs.

First contact

The patient calls the telephone number found on the reference portals of the Lazio Region service network mapping.

The PFA-SA is responded to by a trained psychologist who limits the victim's hyperarousal reactions through

emotional containment techniques (stabilisation, normalisation, and anchoring). The aim of the intervention is to reduce the present state of crisis and to restore the subject's level of pre-critical functioning in the shortest possible amount of time. Stabilisation is focused on the "here-and-now" [24] and has the aim of establishing safety in the areas of physical, cognitive-behavioural, interpersonal, and social functioning, as advocated by Herman [25]. Normalisation means the victim's understanding that their symptoms are "normal" in response to the traumatic event (legitimation of experienced symptoms [26,27]). Anchoring refers to the use of the technique of grounding, a particular type of coping strategy designed to immediately connect the person with the present moment, and which can be usefully applied in cases of misperception, confusion, and disorientation [28]. Grounding is a body-mind technique that comes from Lowen's [29] bioenergetics and allows one to recover resources by focusing on a relaxation experience that combines breathing with imagination. It is one of the rapid techniques recommended in emergency response and can be practised in any circumstance.

The psychologist uses psychoeducation, an evidence-based technique initially designed for patients, both with psychological disorders (e.g., schizophrenia, depression, eating disorders) and physical illnesses, and for their relatives as well [30,31]. Psychoeducation consists of helping the patient understand how their exposure to the situation may impact their functioning (e.g., causes and effects of anger) and emotional validation (e.g., anger is a normal reaction to stressful conditions) to facilitate emotional containment and acceptance. Psychoeducation therefore provides information on how this impact can be reduced and what strategies can be implemented to cope with such experiences [32] and has proven to be an effective approach in reducing the negative effects of trauma [32,33].

If necessary, a second contact was arranged with the patient, agreeing with him when to perform the second intervention.

Second contact

The aim of the interventions is to normalise affective reactions and, in accordance with the patient's condition, promote personal coping strengths related to caring behaviours. Particular attention is given to the subjective distressing experience resulting from the emotions felt by the pandemic situation. The aims are shared and, if necessary, the local psychosocial network is activated. In fact, if there is a need to continue psychological support (as in step 5 of McCabe and colleagues [21]), the patient is referred to free psychological support provided locally (e.g., ANIACARES, developed several years ago to support road victims and later expanded to support COVID victims) [34,35].

A case study

In December 2020, during the second pandemic wave in Italy (November 2020 - March 2021), the PFA-SA service was contacted by two brothers, S. and V., aged 18 and 20, respectively.

The first request was addressed to obtain information about the functioning of the service and the justification of psychological support needed. During this first contact, the characteristics of the PFA-SA service were described; therefore, contact was established with the two brothers, a welcoming activity took place, and the events that led to the perception of frustration, distress and emergency-oriented thoughts (the reason for calling) were explored. The main objective of this early stage was reassurance, containment of distress, emotional support, and assurance of confidentiality.

The breaking event occurred a few hours before the request, i.e., the two brothers living with their parents learned about the molecular swab positivity of their parents, who had been suffering from mild symptoms in the previous days. The brothers, in agreement with their parents, decided to move away from their house of residence to settle in a second home, especially because of the vulnerability of V. who, being affected by an oncological disease, was more fragile and immune-compromised in the case of a contagion.

An exploratory phase began concerning experienced emotions and experienced reactions. Regarding the experienced emotions, anxiety of separation from the parents affected by COVID emerged, distress for a potential contagion of the more fragile subject, and intense distress of the sibling and caregiver, who did not perceive himself as able to cope with the family situation. Regarding the experienced reactions, at the beginning a total emotional absorption from the event was experienced, with loss of awareness of the surrounding environment. The siblings described feeling estranged from the home where they went and were unable to unpack, feeling frozen. S. complained of insomnia and intrusive dreams several days before the swab results. Both showed depressed mood, sadness, anger, guilt, and shame. Hypervigilance, increased sensitivity to potential threats and an amplified state of alarm prevailed in S.

During the interview, the prevailing anxieties of the two brothers resided in forced estrangement from their parents, who, both being positive for COVID-19, remained in a different house, with symptomatology that could be managed from home. The brothers' main request was to obtain information on how to psychologically support their parents from a distance and to discuss the usefulness of their choice in emotional terms. They were both reassured about the choice they made and were encouraged to work on settling in the chosen home;

also, they were made aware of their own thoughts and feelings. The psychologist who intervenes conducted psychoeducation and normalisation of the emotions felt by the two brothers; in particular, they were guided in the recognition and verbalisation of their emotions. They were given practical indications with respect to managing separation anxiety from the parents, suggesting the use of video calls with them. Separate interviews were also held with each of them, and S.'s intense anxieties were collected, while V. employed functional coping strategies, both problem- and emotion-oriented. A new telephone appointment was agreed upon after 2 days.

After the 2 days had passed, the two brothers reported feeling more serene, above all reassured by the result of their molecular swab, in which both were negative, and by the general stable condition of the parents, who did not seem to developed a worsening of their symptoms. A separate interview was held with each of them.

V., who suffers from oncological pathology, appeared to be the reference point for his brother S. and reported that he was very worried about his brother's depressive reaction; although V. was already followed up by a psychologist specialising in psycho-oncology at the hospital division where he is treated, he had not yet contacted her because he also wanted to give a listening space to his brother and therefore to have access to a new service dedicated to the family. At this stage, the psychologist reinforced V. to take note of his own effective abilities to cope with the present situation. Additionally, V. was encouraged to contact the psycho-oncologist, and he was reassured that S. would be directed to a psychological service in the territory (ANIACARES).

An interview was held with S., who appeared worried about the persistence of insomnia, a lack of appetite and generalised anxiety. S. wanted to deepen the emotional theme of the family context and reported that he has always grown up surrounded by a constant threat of emotional loss and anxiety of death (the theme of separation anxiety thus appears to be recurrent in the S's life, independent of COVID, but aggravated by it), he reported that his brother V. fell ill as a child and that he has always feared losing him, and in particular he has always seen his parents anguished and suffering because of V.'s illness.

Thus, there was a re-actualisation of the anxiety of death (re-actualisation of S.'s death anxiety is related to her brother's prior oncology pathology exacerbated by the COVID situation and the increased risk that COVID may be nefarious to her brother), the perception of loneliness and the sense of impotence felt towards V. and, in addition, the fear of not being able to be a support for his brother in case of illness.

From this call, the need for a recommendation to a support service in the territory emerges, as S.'s emotional and affective fragility emerged, triggered by his parents' contagion. They were contacted by the service again after a week (follow-up) to monitor the state of psychological well-being of the two brothers, and whether they had followed the indications from the PFA-SA psychologist, both of whom had; in fact, V. reactivated the support pathway with the psycho-oncologist, and S. made an online appointment with one of the ANIACARES psychotherapists. They felt serene about everyone's stable state of health and were waiting for the parents to be negative so they could meet again and come back home.

Conclusions

The COVID-19 pandemic has proven to be a major challenge for mental health services, highlighting the need to implement resources for psychological support and services, as well as resources for the diagnosis and treatment of psychopathologies.

The possibility of providing not only face-to-face but also online interventions will play a key role in the case of future emergencies that require exclusively or predominantly online assistance, providing support to those who require it; this also highlights another advantage of online psychological interventions, i.e., its flexibility.

The PFA-SA is a psychological first aid protocol specifically formulated and adapted to intervene and provide psychological support to direct and indirect victims of COVID-19. The strength of the project is to support victims during the earliest stages of the traumatic experience, offering the possibility of support in a remote mode, as well as offering victims who show additional support needs the possibility of being referred to other territorial projects or specialists. The benefits of the spread of PFA-SA, as well as similar programs, are several: to limit the impact of emotional distress of victims, which in turn could limit the onset of psychopathologies related to the traumatic event; to promote compliance with medical treatment and facilitate the recovery processes; to lighten the workload of hospital staff (doctors and nurses) and rescue personnel who could focus on their tasks, "delegating" the support and psychological support that victims need to specialists.

The development of PFA services delivered through audio and/or video calls, combined with psychoeducational material, may be a fundamental contribution in identifying mental health problems that could go unrecognised during crisis situations, such as COVID-19 [36].

As highlighted by Cheng et al. [20], the effectiveness of PFA by remote modality may be hampered by a potential difficulty in understanding the patient's stress symptoms and general condition compared to traditional methods. Moreover, online communication could interfere with the process of establishing trust and a therapeutic al-

liance between the psychologist and the user, which is essential for the intervention to be effective. However, the results of a recent review [29] showed that there is no significant difference in interactional characteristics between telephone and face-to-face therapies, including regarding therapeutic alliance, communication, empathy, attention or participation. Irvine and colleagues [37] aimed to emphasize that these interventions need to be flexible to adapt to the characteristics of the emergency and take the availability of personnel into account [20]. In addition, governmental and financial support for these initiatives, as well as the presence of volunteers and experts in the organisation of these services, appear to be of fundamental importance [37].

Ethical consideration
The Institutional Review Board of Department of Psychology, University of Rome "Sapienza" (protocol number 2414/2019) approved the procedures.

Conflict of interest
The Authors declare no conflict of interest.

Author contributions
The Authors contribuited equally to the work.

References

1. World Health Organization. WHO Director-General's opening remarks at the media briefing on COVID-19, 11 March 2020 (https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020 (accessed in July 2021).

2. Haleem A, Javaid M, Vaishya, R. Effects of COVID 19 pandemic in daily life. Curr. Med. Res. Pract 2020;10:78-79. https://doi.org/10.1016/j.cmrp.2020.03.011

3. Rogers JP, Chesney E, Oliver D, et al. Psychiatric and neuropsychiatric presentations associated with severe coronavirus infections: a systematic review and meta-analysis with comparison to the COVID-19 pandemic. Lancet Psychiatry 2020;7:611-627. https://doi.org/10.1016/S2215-0366(20)30203-0

4. Burrai J, Barchielli B, Cricenti C, et al. Older adolescents who did or did not experience COVID-19 symptoms: associations with mental health, risk perception and social connection. Int J Environ Res Public Health 2021;18:5006. https://doi.org/10.3390/ijerph18095006

5. Biondi S, Casale S, Burrai J, et al. Personality and lockdown: a study on italian undergraduates during the COVID-19 pandemic. Front Psychiatry 2021;12:818. https://doi.org/10.3389/fpsyt.2021.622366

6. Pietrabissa G, Simpson SG. Psychological consequences of social isolation during COVID-19 outbreak. Front Psychology 2020;11:2201. https://doi.org/10.3389/fpsyg.2020.02201

7. Mari E, Fraschetti A, Lausi G, et al. Forced cohabitation during coronavirus lockdown in Italy: a study on coping, stress and emotions among different family patterns. J Clin Med 2020;9:3906. https://doi.org/10.3390/jcm9123906

8. Mari E, Lausi G, Fraschetti A, et al. Teaching during the pandemic: a comparison in psychological wellbeing among smart working professions. Sustainability 2021;13:4850. https://doi.org/10.3390/su13094850

9. Inchausti F, García Poveda NV, Prado Abril J, et al. La psicología clínica ante la pandemia COVID-19 en España. Clin Salud 2020;31:105-107. https://dx.doi.org/10.5093/clysa2020a11

10. Shreffler J, Petrey J, Huecker M. The impact of COVID-19 on healthcare worker wellness: a scoping review. West J Emerg Med 2020;21:1059. https://10.5811/westjem.2020.7.48684

11. Zhai Y, Du X. Loss and grief amidst COVID-19: a path to adaptation and resilience. Brain Behav Immun 2020;87:80-81. https://10.1016/j.bbi.2020.04.053

12. Xiao S, Luo D, Xiao Y. Survivors of COVID-19 are at high risk of posttraumatic stress disorder. Global Health Res Pol 2020;5:1-3. https://doi.org/10.1186/s41256-020-00155-2

13. Burrai J, Roma P, Barchielli B, et al. Psychological and emotional impact of patients living in psychiatric treatment communities during COVID-19 lockdown in Italy. J Clin Med 2020;9:3787. https://doi.org/10.3390/jcm9113787

14. Cordellieri P, Barchielli B, Masci V, et al. Psychological health status of psychiatric patients living in treatment communities before and during the covid-19 lockdown: a brief report. Int J Environ Res Public Health 2021;18:3567. https://doi.org/10.3390/ijerph18073567

15. Emanuel EJ, Persad G, Upshur R, et al. Fair allocation of scarce medical resources in the time of COVID-19. N Engl J Med 2020;382:2049-2055. https://doi.org//10.1056/NEJMsb2005114

16. Legido-Quigley H, Mateos-García JT, Campos VR, et al. The resilience of the Spanish health system against the COVID-19 pandemic. Lancet Public Health 2020;5:e251-e252. http:// dx.doi.org/10.1016/S2468-2667(20)30060-8

17. Burrai F, Gambella M, Scarpa A. L'erogazione di prestazioni sanitarie in telemedicina. G Clin Nefrol Dial 2021;33:3-6. https://doi.org/10.33393/gcnd.2021.2226

18. Zhang J, Wu W, Zhao X, et al. Recommended psychological crisis intervention response to the 2019 novel coronavirus pneumonia outbreak in China: a model of West China Hospital. Precis Clin Med 2020;3:3-8. https://doi.org/10.1093/pcmedi/pbaa006

19. Inchausti F, MacBeth A, Hasson-Ohayon I, et al. Telepsychotherapy in the age of COVID-19: a commentary. J Psychother Integr 2020;30:394-405. http://dx.doi.org/10.1037/int0000222

20. Cheng W, Zhang F, Hua Y, et al. Development of a psychological first-aid model in inpatients with COVID-19 in Wuhan, China. Gen Psych 2020;33. https://10.1136/gpsych-2020-100292

21. McCabe OL, Everly Jr GS, Brown LM, et al. Psychological first aid: a consensus-derived, empirically supported, competency-based training model. Am J Public Health 2014;104:621-628. https://doi.org/10.2105/AJPH.2013.301219

[22] Rosen CS, Glassman LH, Morland LA. Telepsychotherapy during a pandemic: a traumatic stress perspective. J Psychother Integr 2020;30:174. https://doi.org/10.1037/int0000221

[23] Van Daele T, Karekla M, Kassianos AP, et al. Recommendations for policy and practice of telepsychotherapy and e-mental health in Europe and beyond. J Psychother Integr 2020;30:160. https://doi.org/10.1037/int0000218

[24] Ter Heide FJJ, Mooren T, Kleijn W, et al. EMDR versus stabilisation in traumatised asylum seekers and refugees: results of a pilot study. Eur J Psychotraumatol 2011;2:5881. https://doi.org/10.3402/ejpt.v2i0.5881

[25] Herman JL. Trauma and recovery. New York, NY: Basic Books 1992.

[26] Onofri A, Gattinara PC. L'intervento psicologico di gruppo con i richiedenti asilo traumatizzati. Uno studio preliminare sull'uso dell'EMDR in gruppo per favorire la resilienza. Psicobiettivo 2018. https://doi.org/10.3280/PSOB2018-002006

[27] Stige SH, Rosenvinge JH, Træen B. A meaningful struggle: trauma clients' experiences with an inclusive stabilization group approach. Psychother Res 2013;23:419-429. https://doi.org/10.1080/10503307.2013.778437

[28] Wheeler K. Psychotherapeutic strategies for healing trauma. Perspect Psychiatr Care 2007;43:132 141. https://doi.org/10.1111/j.1744-6163.2007.00122.x

[29] Lowen A. Bioenergética. Milano: Feltrinelli Editore 2013.

[30] Donker T, Griffiths KM, Cuijpers P, et al. Psychoeducation for depression, anxiety and psychological distress: a meta-analysis. BMC Med 2009;7:79. https://doi:10.1186/1741-7015-7-79

[31] Tomita T, Kudo S, Sugawara N, et al. Timing of psychoeducation for patients with depression who were treated with antidepressants: when should patients receive psychoeducation. Neuropsychiatr Dis Treat 2018;14:505-510. https://10.2147/NDT.S156797

[32] Whitworth JD The role of psychoeducation in trauma recovery: recommendations for content and delivery. J Evid Inf Soc Work 2016;13:442-451. https://doi:10.1080/23761407.2016.1166852

[33] Oflaz F, Hatipogˇlu S, Aydin H. Effectiveness of psychoeducation intervention on post-traumatic stress disorder and coping styles of earthquake survivors. J Clin Nurs 2008;17:677-687. https://10.1111/j.1365-2702.2007.02047.x

[34] Burrai J, Mari E, Couyoumdjian A, et al. Un modello di intervento psicologico per le vittime della strada: il progetto ANIACARES. Psicologia della salute 2020;1:147-160. https://10.3280/PDS2020-001011

[35] Couyoumdjian A, Cordellieri P, Burrai J, et al. ANIACARES: presentation of a case study on a model of early psychological intervention for road accidents victims. Psicoter Cogn Comport 2020;26. https://10.14605/PCC2622003

[36] Arenliu A, Uka F, Weine S. Building online and telephone psychological first aid services in a low resource setting during COVID-19: the case of Kosovo. Psychiatr Danub 2020;32:570-576. https://10.24869/psyd.2020.570

[37] Irvine A, Drew P, Bower P, et al. Are there interactional differences between telephone and face-to-face psychological therapy? A systematic review of comparative studies. J Affect Disord 2020;265:120-131. https://doi.org/10.1016/j.jad.2020.01.057