Post-Immediate Emotional Management of the Announcement of Bad News in the Hospital : Case of a Family Treated by an Emergency Psychological Intervention in EMDR Therapy in a Referral Hospital in Sub-Saharan Africa

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SUMMARY

Context

The announcement of bad news is an art that often eludes doctors, despite its decisive impact on the acceptance of a diagnosis and adherence to care. When this announcement is poorly made, it can be traumatic and induce significant emotional crises in both the patient and their caregivers, which can manifest immediately or in the long term. The objective of this work is to present the impact of a psychological emergency intervention tool in managing acute emotional crises.

Methods

We conducted an interventional study with a family who experienced traumatic distress following the failure of their mother's cataract surgery. Our convenience sample consisted of 4 participants. We administered standardized tests for immediate and post-intervention assessments. The intervention included individual therapy for the mother and group therapy for the children, incorporating various therapeutic techniques from Eye Movement Desensitization and Reprocessing (EMDR) therapy.

Results

The therapy sessions yielded positive outcomes, significantly reducing symptoms in family members. Participants reported feelings of relief, calmness, and clarity following the sessions. They felt more equipped to cope with the situation and had acquired effective tools for managing their emotions. Furthermore, the therapy facilitated improved communication within the family unit. A comparison of immediate and post-intervention assessment scores revealed a clinically significant decrease in symptoms of acute stress, post-traumatic stress, and anxiety.

Conclusion

This work underscores the crucial role of psychological support in crisis situations. The psychologist's intervention, utilizing a range of therapeutic techniques, was instrumental in helping the family navigate a challenging experience and restore emotional equilibrium.

Keywords: anxiety, acute stress disorder, cataract surgery, emergency psychological intervention, EMDR therapy.

INTRODUCTION

Difficult medical announcements, such as a serious diagnosis or poor prognosis, pose a significant challenge for patients and their families. These crisis moments can trigger intense emotional shock, characterized by distress, anxiety, anger, sadness, denial, and feelings of loss of control and helplessness.

In the field of health psychology, extensive research has emphasized the importance of empathetic and appropriate communication during these difficult announcements. Studies have consistently shown that inadequate communication can have negative effects on patients' emotional well-being, treatment adherence, and ability to cope with the disease.

The pioneering work of Kübler-Ross (1969) described the stages of grief and the process of coping with illness, highlighting the importance of acknowledging patients' emotional reactions and providing suitable psychological support. Although her model has undergone criticism and refinement, it remains foundational in understanding patient needs.

More recent research has focused on the communication skills of healthcare professionals and their impact on the patient-doctor relationship. This has led to the development of tools and training protocols aimed at enhancing physicians' ability to communicate difficult information with empathy, sensitivity, and respect (Baile et al., 2000; Street et al., 2009). Patient-centered communication, which addresses the emotional and informational needs of patients and their families, has been associated with improved psychological well-being and patient satisfaction (Epstein & Street, 2011).

Furthermore, studies have demonstrated that early psychological intervention following a difficult medical announcement can mitigate symptoms of post-traumatic stress disorder and foster resilience (Meichenbaum, 2017). One therapeutic approach that has shown promise in managing recent traumatic events is Eye Movement Desensitization and Reprocessing (EMDR) therapy. Developed by Francine Shapiro, EMDR is a psychotherapeutic approach that aims to reprocess traumatic memories using bilateral stimulation (Shapiro, 2018). Research has indicated that EMDR can effectively reduce symptoms of post-traumatic stress, even in cases of recent trauma (Jarero, Artigas, & Luber, 2011).

In light of these findings, the objective of this article is to evaluate the effectiveness of EMDR therapy in the context of delivering unfavorable medical news, integrating recent data on its efficacy in managing recent traumatic events.

METHODOLOGY

Setting, population and type of study.

Our study was conducted at the Liaison Psychology Unit of the Laquintinie Hospital in Douala, involving a family who had recently received distressing news. Given the circumstances, our sample was selected for convenience. We employed an interventional study design, which spanned a period of one month.

Intervention tools

EMDR (Eye Movement Desensitization and Reprocessing) is a psychotherapeutic approach recognized for its effectiveness in treating disorders related to traumatic experiences. It was developed by Francine Shapiro in

the 1980s and aims to address psychological conditions such as post-traumatic stress disorder (PTSD), anxiety, depression, phobias, and other trauma-related issues.This therapy is based on the Adaptive Information Processing (AIP) model, which organizes treatment across three timeframes: past, present, and future. EMDR is carried out in eight structured phases (history taking, preparation, evaluation, desensitization, installation, body scan, closure and reevaluation).

While individual EMDR is the most common form, group adaptations have been developed and studied over the past several years. EMDR was originally developed by Shapiro (1989) to stimulate brain regions involved in the processing of traumatic memories and emotions. The therapy promotes emotional release and the integration of difficult experiences through alternating bilateral stimulation (ABS) (Shapiro, 2018). These techniques can be particularly valuable in emergency situations, where individuals may be overwhelmed by intense emotions and distressing memories.

We used the Group Traumatic Episode Protocol (G-TEP), a desensitization and reprocessing protocol adapted for groups of individuals who have experienced the same traumatic event. Based on the Recent Traumatic Episode Protocol (R-TEP)—an individual protocol designed for recent traumatic experiences—Elan Shapiro developed the Group Protocol for Traumatic Episodes (G-TEP) as an adaptation of EMDR for group settings. Although applied in groups, this protocol strives to preserve the effectiveness of the individual R-TEP format. It is a simplified version of the EMDR R-TEP, designed for use with adults, adolescents, or children in group contexts. G-TEP can be used to treat recent traumatic experiences or disturbing events with lasting effects, (Shapiro, 2012), such as those encountered by refugees. The protocol maintains the eight phases of the original EMDR model and incorporates a specific worksheet that places particular emphasis on safety and emotional containment.

Procedure for the psychological care of the family

Our work followed a four-step procedure. After explaining the purpose and implications of the intervention to the participants, we obtained verbal informed consent for the use of their data in scientific research. All information was collected and analyzed in strict accordance with medical confidentiality and ethical guidelines. The intervention was conducted by two therapists trained in EMDR therapy.

Initial assessment : The psychologist meets with the family to assess the situation, understand the needs of each individual, and identify available resources. Standardized assessment tools are used prior to the intervention, including the STAI Forms Y-A and Y-B to evaluate levels of state (situational) and trait anxiety, and the PCL-5 to assess symptoms of acute and post-traumatic stress disorder. Additionally, the Subjective Units of Disturbance (SUD) scale is used as a clinical tool to measure the intensity of emotional disturbance related to the traumatic experience.

Individual therapy for the mother : The mother is seen individually to address her emotional experience, specific difficulties, and personal needs.

Group therapy for children : Children participate in group therapy to desensitize their experiences and develop effective coping strategies.

Follow-up and reassessment : The psychologist provides regular follow-up to assess progress, adjust interventions, and offer ongoing support to the family. The same scales were re-administered at the end of the session and one month after the procedure.

Presentation of the Situation

In the context of a delicate and sudden announcement following an unfavorable post-surgical outcome, the ophthalmic surgeon requested the psychologist to manage the emotional crisis of a family to whom she had just announced the failure of their mother’s surgery.

Indeed, two months ago, Mrs. Y, a 75-year-old widow of six months and mother of five children, underwent surgery on her left eye to treat an advanced cataract. The family was reassured by the therapeutic process,

which promised a generally positive prognosis. However, their hopes were shattered when the specialist informed them that the eye would never regain vision due to rare complications that occurred during and after the operation. At the time of this devastating announcement, the widowed mother was accompanied by three of her children, all of whom were deeply affected by the news.

On-site, the psychologist's interview with the specialist helped clarify the situation. The patient had undergone surgery two months earlier, which had gone somewhat well. The lens, essential for vision, needed to be replaced in this eye, but the available replacement lens was not suitable for her case. The chosen solution was to close the eye, allow it to heal, and then insert the substitute lens later. However, the eye remained watery, and the healing process was delayed and incomplete. The patient regularly returned for dressing changes and follow-up appointments while awaiting the second surgery. Impatient and anxious, with many questions about the treatment's duration and receiving little reassurance, the patient's reaction to the latest update was catastrophic. This led to outbursts of anger from the family and panic among the healthcare providers.

The primary objective of the psychologist's intervention was to provide psychological support to the family, helping them cope with this difficult situation. The goal was to alleviate their emotional distress, assist them in understanding and managing their emotions, and promote a healthy coping process that would enable them to consider alternative solutions.

Immediate management

Following the interview with the specialist, the psychologist has the family concerned brought together to allow better communication, understanding and digestion of this news. See what needs to be done and explore possible possibilities. We set up a container and did the 4-7-8 breathing exercise to create more grounding and stability. The situation was normalized, emotions stabilized and an appointment was made for 48 hours to better manage the thoughts and emotions around this event for a more objective decision-making.

The immediate post-intervention 48 hours later

The family was seen by the psychologist 48 hours after the announcement for both curative and preventive therapy. Since they all experienced the same event—though their individual perceptions, reactions, and backgrounds differed—the therapist chose group therapy for the children and individual therapy for the mother. This approach aimed to optimize the intervention while making efficient use of limited resources and time.

For this session, two therapists were involved: a primary therapist who led the session and a co-therapist who helped contain emotions throughout. Upon arrival, the framework was established, and the family was divided into two groups—the mother on one side and the children on the other. The mother, as the primary victim, was seen first, followed by the children as secondary victims. The intervention lasted approximately an hour and a half for the mother and three hours for the children.

First part: intervention with the mother

Story: her late husband had been successfully operated on for cataracts a few years earlier in the same hospital. This gave him confidence for this operation. She is devastated when she is told that it will no longer be seen in this light. She would have preferred to lose another part of her body than her eyes. His third born died a few years ago in unexpected conditions in the hospital.

Positive memory: she describes herself with her grandsons in a joyful atmosphere. We install a positive resource from this memory before starting the R-PET.

Conduct R-TEP:

It all starts with a preparation phase and then the narration phase of the event by applying bilateral alternating stimulations (SBA) tactile (tappings on the knees). With this phase, we have identified a point of disruption.

The most difficult moment at the moment: "I can't see and I don't even have a lens in my eye". She doesn't know her current situation, especially since the right eye is not in very good condition. A level of disturbances evaluated at 10/10

The shrink invites her to focus on everything the doctor said, what she feels, what happened during this time, let it go and the therapist gives her the SBAs. After a series of stimulation, one pauses, takes a deep breath and specifies if there are any changes.

Ms. Y: Can't describe how she feels at the first break

The shrink: continue with what's here now (SBA)

Mrs. Y: I feel a little peace, my head is down, I feel calm at the 2nd break

The shrink: keep going with it (SBA)

3rd break I'm stalled, nothing particular

Mrs. Y: I think back to Tuesday, it passes despite what the doctor did, I just feel tired

The shrink: Closing her eyes, thinking about Tuesday, reviewing the event, what does she notice?

Mrs. Y: Feels warmth in her eyes,

The shrink: Focus on it and let your brain manage it (SBA)

Mrs. Y: The heat advances in my head, the tingling from my shoulders to my feet, my ears are blocked.

The shrink: keep going with this + SBA

Mrs. Y: Freshness, her body is still coming back.

The shrink: keep going with this + SBA

Mrs. Y: Feels calm and relaxed

The shrink: anchoring in the present (turning your head in both directions of the room and observing. What is she listening to? Feeling your body on the chair, your feet on the floor.

Mrs. Y: I feel in good shape.

The shrink: Psychoeducation on therapy, noting the changes and circumstances that could occur. Question? Uneasiness?

Mrs. Y: Yes, do you know an ophthalmologist? Because I must not give up.

The shrink: Yes, the next session you will have information that will allow you to consider other possibilities. Positive reinforcement.

At the end she is really relieved and says thank you several times. The therapist makes her wait and takes the secondary victims (her children).

Part Two: Intervention with Children

Briefing_: We are sitting in a circle. This session aims to prevent the various emotional complications that can occur following this type of event. To allow a mental digestion of everything that has happened. The group is

made up of three adults: the eldest of the siblings who is a 56-year-old woman, the second who is a 51-year-old man and the fourth who is a 39-year-old woman.

Session plan:

n evaluation is made to take the flow temperature,

Preparation for the course of the therapy

A re-evaluate at the end to take the temperature of the end,

Update on the evolution of mom, what happened in the session and the rest,

CONCLUSION

Session schedule (G-TEP)

The evaluation is done, the STAI Y-A & B plus PCL-5 tests are filled in 20 minutes by the two oldest and in 30 by the youngest.

Towards the end of the information of their PCL-5 and while waiting for the end of the testing of the youngest, we take stock of the mother's session, in order to give them confidence and reassure them.

They all have bitterness towards the doctor: "she cannot and will not escape them" they say. Anger could be seen on the face of the eldest; in the man, arms crossed and firmness in his words in a rather calm style.

Start of therapy:

We start with a preparation and stabilization phase with the mindfulness, breathing and safe place exercises. The work material is given to each person (a format, containing boxes A, B, C & D and a pencil)

The shrink: "To be there in the present, the here and now, to take the time to look around you and notice 3 things you haven't seen yet since you've been here, 2 things you can hear and one thing you can feel. Deep breathing; then breathing in 4, 7, 8; then slow breathing. Producing saliva in the mouth and spreading it on all sides. Let the light of your imagination think lead you to a quiet and safe place. Give each other a butterfly hug. »

During this exercise, where they seemed a little disinterested at first, they gradually got involved. At the end, they feel relaxed and drained respectively.

The Psy invites them to share their place on: for the eldest, it's a countryside with greenery and bird calls. For the youngest, she prefers not to share and for the man it's her room. After this stabilization phase, we enter the desensitization and reprocessing phase.

The shrink invites them to take a few minutes to rewatch the day on Tuesday when the event took place. Without sharing what marked them negatively. On box A, everyone must write down what represents the most difficult moment (it can be a sentence, a word, an image, a representation, etc.) At the bottom of this box, specify the level of disturbance from 0 to 10 and do the self-tappings on the knees (SBA)

The most difficult noted for the oldest is "mommy's supervision", for a level of disturbance of 7/10. For the man, see his mother in tears, 2/10. The youngest, draws a cross sprinkled with anger on the vertical and hope on the horizontal, 1/10. The youngest sways her feet more and more, her eyes shine.

Each person taps on the thighs focusing on what they have noted.

The shrink: take a break, Breathing, resumption of SBA

We observe a lot of resistance in the youngest, agitation as well as slight tremors and difficulty in mobilizing. We're going to help her by tapping her shoulders and encouraging her to stay strong and keep going.

After a moment of calm,

The shrink: On box B, note what is currently worrying and the intensity.

For the eldest, what worried her at that moment was the announcement of the disaster and the doctor's silence after his scandal, at an intensity of 8/10. The man wonders what will happen next, at an intensity of 3/10. The youngest is scared and angry at 7/10.

The shrink: Concentrate on it, do tappings, breathing, resumption.

The older one also weakens and can no longer type quickly, abreaction (crying fit) too while the younger one recovers a little and manages to do them a little faster. Our assistance then turns to the largest.

The shrink: take a break and take a deep breath, and continue the SBAs

After a moment of lull,

The shrink: On box C, just give the intensity of our current disturbance.

For the largest, 8/10; man 0/10; the youngest 9/10. The shrink: focus on that and keep going

The shrink: take a break and take a deep breath, and continue the SBAs

The shrink: Feel your body, look around, move your toes, identify three blue colors, two pinks and one red. What we hear, beyond what we hear from the surrounding noises. Thinking about our safe place, giving each other another butterfly hug, breathing, stretching.

The shrink: How much do you rate your level of disturbance now on a scale of ten?

The largest one answers 1/10, the man answers 0/10 and the smallest 1/10

The shrink: We have arrived at the end of this session, you have done an excellent job on yourself, what we have done can come back to you, if you have things that come back to you, it's normal, write them down and next time we discuss them. Do you have any concerns or reactions before separating? We had very spontaneous reactions, the youngest laughs, doesn't fold her arms anymore, says it feels good; The man exclaims, saying, "It's like sports," and the older one is released. Everyone leaves the session with a big smile.

Sharing of experiences of the session:

The man: "You feel like it's the game at the beginning, but in the end you realize that you're right here, cut off from everything, working."

The greatest: "I was able to get some disarray out. »

The youngest: "I feel clear, with inner peace, some grey areas have been classified."

Table 1: Summary of the intervention

G-TEP	R-TEP
1st general session (immediate)	**2nd session with the single mother (48 hours later)**
Normalization of feelings	Reassessment of general condition
Psycho-trauma education	Reminder of self-stabilization exercises
Introduction to Breathing 4-7-8	Narrative with SBA

Installing a container	Disturbance Assessment (SUD) and Cognition
Setting up a safe place	Complete desensitization of the traumatic episode
Closure of the session	Closure with psychoeducation

TESTING RESULTS

The results of the psychometric assessment show a significant level of distress of varying intensity among the participants. We note a high situational anxiety in all participants and a moderate level of anxiety in the S1 subject and a high level of anxiety in the mother with the presence of a state of acute stress in 3 participants (see Table 1).

Then, we note Table 1: Distribution according to tests and participants the presence of the 4 criteria of acute stress state as described in the DSM-5 in 3 participants (see Table 2).

In contrast, immediate post-intervention assessment shows a significant decrease in symptoms as we can observe in Table 3 with the level of disturbance (SUD) and the level of anxiety state (STAI Y-A).

Finally, the control evaluation done one month after the intervention allows us to observe a constant and clinically significant improvement as described in Table 4.

Table 2: Initial Assessment Outcome

	S1	S2	S3	Mother
STAI Y-A	62	36	48	67
STAI Y-B	46	36	36	56
PCL-5	53	9	31	60
SOUTH	7	2	1	9

Table 3: Symptom Distribution of Acute Stress Disorder

	S1	S2	S3	Mother
Intrusion	4	0	1	4
Avoidance	1	2	1	2
Cognitive and mood symptoms	4	0	1	4
Awakening and reactivity	3	0	0	3

Table 4: Post-immediate reassessment

	Pre	Post-immediate	Pre	Post-immediate
	STAI Y-A		SOUTH	
S1	62	31	7	1
S2	36	22	2	0
S3	46	32	1	1
Mother	67	43	9	1

Table 5: Follow-up reassessment one month after the intervention.

	STAI Y-A		STAI Y-B		PCL-5		SOUTH	
	Pretest	Posttest	Pretest	Posttest	Pretest	Posttest	Pretest	Posttest
S1	62	28	46	34	53	7	7	0
S2	36	20	36	27	9	2	2	0
S3	46	25	36	22	31	9	1	0
Mother	67	35	56	38	60	15	9	1

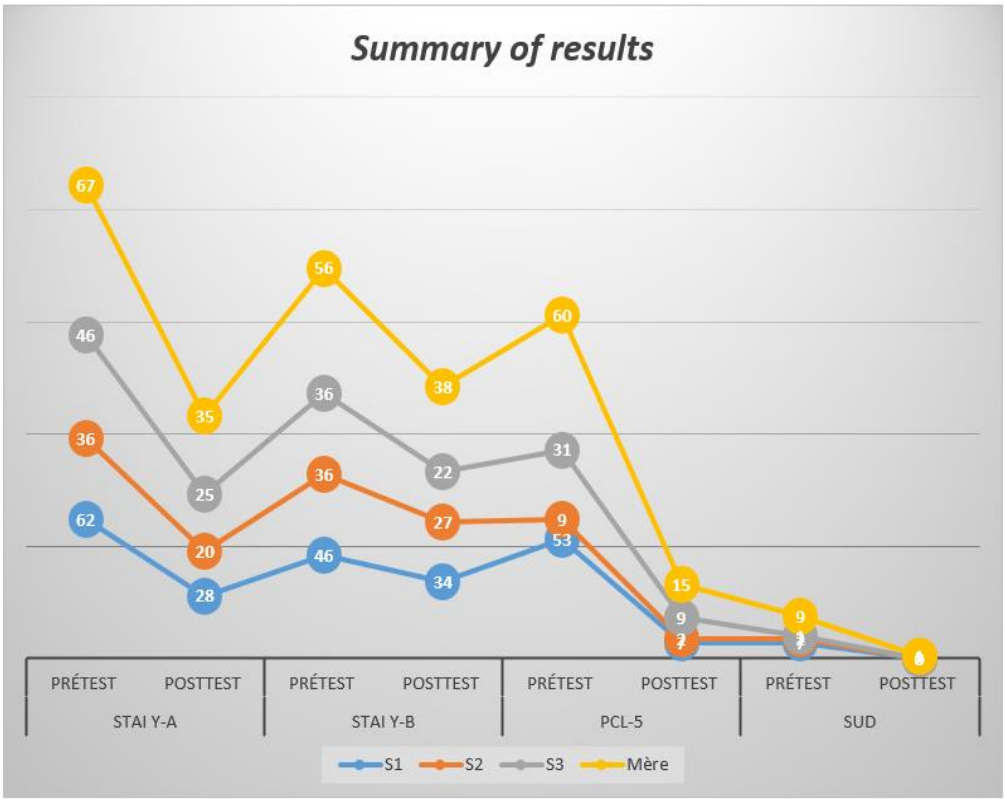

Figure 1: Summary of results

DISCUSSION

The announcement of an unfavorable diagnosis or prognosis represents a profound emotional shock for the patient and their loved ones. This case study vividly illustrates the distress and trauma experienced by a family following the sudden announcement of the loss of sight of one of their members, as detailed in Table 1. This experience underscores the emotional impact inherent in certain medical announcements, particularly when they involve the loss of a fundamental sensory function such as vision. Numerous studies (Kübler-Ross, 1969; Corr, 1993) have explored the stages of grief and adaptation to illness, emphasizing the importance of compassionate and gradual support during these difficult communications.

More recently, researchers such as Baile et al. (2000) have highlighted the significant impact of physicians' communication skills on patients' emotional well-being. They developed training protocols to improve physicians' ability to communicate difficult information with empathy and sensitivity. Street et al. (2009) also emphasized the importance of patient-centered communication, which takes into account the emotional and informational needs of the patient and family. A lack of tact or preparation on the part of healthcare professionals can exacerbate the trauma and hinder the coping process of the patient and their family. It is therefore crucial to think about existing protocols and training to help healthcare professionals improve communication during difficult announcements, taking into account the emotional and psychological needs of those affected.

In addition, the therapeutic method that we have developed is a protocol derived from EMDR, in particular protocols for the management of recent events in groups and individuals.

Breathing exercises help regulate stress and anxiety by acting on the autonomic nervous system (Brown & Gerbarg, 2005). They offer a simple and accessible way to find inner calm in the face of the emotional storm, especially useful in emergency situations where tension is at its peak.

On the other hand, several recent studies have explored the effectiveness of these techniques in addressing trauma and emotional difficulties, particularly in the management of medical-psychological emergencies. For example, research has demonstrated the value of EMDR in reducing symptoms of post-traumatic stress in

victims of traumatic events (Shapiro, 2017). Consistent with this, our findings show a significant decrease in acute stress symptoms following the intervention (see Table 2) and the absence of post-traumatic stress symptoms 30 days afterward (see Table 4). Additionally, studies have highlighted the effectiveness of mindfulness interventions, including breathing exercises, in reducing anxiety and enhancing emotional well-being (Baer, 2003).

Although the effectiveness of these techniques may vary depending on the individual and the context, their combination offers a flexible and personalized approach to accompany patients in their emotional journey in a medical-psychological emergency situation. Further research is needed to deepen our understanding of their mechanisms of action and optimize their application in this specific context. Moreover, the single-family nature of this work limits the possibility of generalization, but offers the possibility of multiplying clinical trials in similar contexts or adapting protocols as needed.

CONCLUSION

This article sheds light on the profound emotional impact that difficult medical announcements can have on individuals and their families. It emphasizes the importance of empathetic and appropriate communication by healthcare professionals, as well as the crucial role of psychological support in helping patients and families manage the emotions and stress associated with such news. However, this study has certain limitations, as it is primarily based on a single case report involving a family faced with the loss of a loved one's vision. Therefore, the findings may not be generalizable to other types of difficult medical announcements or to different family dynamics. Despite these limitations, the article offers valuable insights into the emotional consequences of distressing medical news and underscores the need for comprehensive, compassionate care for both patients and their families. It opens important avenues for improving healthcare communication and enhancing psychological support during moments of crisis. Future research with larger sample sizes and the inclusion of both experimental and control groups could provide a more robust understanding of the effectiveness of such interventions.

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