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# Psychosocial care for hospitalized young survivors after the terror attack on Utøya Island: A qualitative study of the survivors' experiences

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ABSTRACT

*Objective:* The objective of the study was to explore hospitalized youths' experiences with psychosocial care in the hospital after the shooting on Utøya Island, Norway, in 2011.
*Methods:* 17 hospitalized youths were interviewed face-to-face 30–31 months after the attack. The interviews were analysed using interpretative phenomenological analysis (IPA). The initial reading and coding of the interviews was carried out inductively. To explore the emphasis placed on everyday conversation and ordinary interaction detected during the initial reading, the text was re-read while bearing in mind concepts from the research field of sociology concerning the therapeutic potential in commonplace conversations and situations.
*Results:* The youths highlighted the need for health care workers to embrace essential aspects of their past, present and future. Therefore, three overarching categories emerged related to 1) Remembering the past, 2) Dealing with the present and 3) Preparing for the future. For each temporal category, two related subcategories were identified: Past:*Engaging in the trauma narrative; Understanding the trauma reminders*; Present: *Bringing back normalcy; Being there*; Future: *Supporting confidence; Instilling trust*.
*Conclusions:* For the youths in the current study, talking with the hospital staff about their traumatic experiences was mostly perceived as positive and linked to various helpful outcomes. In addition to engaging in the trauma narrative, the staff needed to comprehend and address how the traumatic experiences and the hospitalization resulted in the survivors' extended fear and changed appraisals about the world and themselves. Having the time to stay physically and mentally close to the youths and engage in everyday interaction was crucial in rebuilding their sense of safety and bringing back normalcy. The hospital staff played a significant role in strengthening the survivors' confidence in own capabilities and trust in others. The different professionals in the hospital contributed to various aspects of psychosocial care, and both trauma-focused interventions and commonplace conversations and actions were emphasized as important and meaningful approaches.



## Introduction

Terror attacks are violent and traumatic events constituting major threats to survivors' health. Severe psychological distress is common, and many also experience physical harm and may require hospitalization [1–3]. Physically injured survivors exhibit particularly high levels of distress [4,5]. The hospital setting may also be psychologically demanding due to clinical procedures such as surgery or having needles or scans [6].

Severe early psychological distress has been found to predict the development of later posttraumatic stress symptoms (PTSS) and disability in both paediatric and adult samples after traumatic injury [7,8]. Therefore, adequate support in the early phase is important and may help prevent the development of

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PTSS. However, there is a lack of evidence concerning the effects of early interventions. Based on theoretical models and empirical findings from related research fields, Hobfoll and colleagues published a consensus document describing five essential elements for promoting psychosocial health and functioning in the early phase after mass traumas: rebuilding a psychological sense of safety, calming emotions and bodily arousal, enhancing a sense of self-efficacy, i.e. the sense of control over positive outcomes in life, promoting social connectedness and instilling hope for the future [9]. To promote trauma-informed psychosocial care after mass traumas in general, as well as in specific settings such as hospitals, guidelines for clinical practice have been developed [10–12]. Such guidelines are designed as practical strategies aimed at supporting the work of first responders and staff, and their main focus is to reduce initial fear and promote adaptive functioning and coping over time. Despite the widespread recognition of Hobfoll's principles and the use of guidelines in trauma-informed care, the underlying research evidence is limited [11,13]. For both adult and paediatric samples of survivors with traumatic injuries, there is a lack of knowledge about the impact of early interventions [7,8]. There is also a need for research that can broaden our understanding of patients' needs and provide knowledge about specific settings for care [14].

For hospitalized survivors of traumatic events, the early aftermath is particularly demanding. Complex challenges related to psychosocial needs and care may arise as a result of the traumatic event, injuries and the hospital stay itself. It has been argued that assessing the effect of specific interventions is not sufficient to address this broad spectrum of challenges [15]. One way to bring the field forward is to qualitatively explore survivors' perspectives on their own experiences [16,17]. A few studies on survivors' hospital experiences have been published, and issues such as processing the traumatic experiences, supporting the sense of safety and rebuilding a sense of normalcy have been elaborated on [18–21]. To our knowledge, no studies have investigated survivors' experiences with psychosocial care in hospital after terror attacks.

In this paper, we seek to better understand how hospital professionals can respond to the acute psychosocial needs of severely traumatized survivors by interviewing hospitalized youths exposed to the 2011 mass shooting attack at Utøya Island in Norway. At Utøya, a man disguised as a police officer attacked the Norwegian Labour Youth's summer camp. Heavily armed, he pursued and targeted the 564 youths for about one and a half hours before he was arrested. A total of 69 people were killed, and 32 survivors were hospitalized due to physical injuries [22]. In the hospital, the youths were met by nurses and physicians who were specialized in the treatment and care of severely injured patients. Due to the extreme nature of the incident, the regular staff was assisted by psychosocial health care workers such as psychologists, psychiatrists, psychiatric nurses and social workers. Their main task was to provide information, strengthen the youths' sense of safety and help with the stabilisation of affects, in addition to supporting relatives and supervising the regular health personnel [23].

### *Aim of the study*

The aim of this study was to gain more knowledge of how physically injured survivors experience psychosocial care in the hospital after traumatic events. Specifically, we aimed to gain a broader understanding of what may help severely injured survivors after a major mass trauma through the examination of survivors' experiences with hospital care after the shooting attack on Utøya Island.

## Methods

The data is derived from an open cohort study conducted to explore the experiences and reactions of survivors and their parents after the shooting attack on Utøya Island 2011 [1]. Quantitative and qualitative data were collected at three time-points; T1, T2 and T3 (4–5, 14–15 and 30–31 months after the attack, respectively). In the current study, we analysed qualitative data from interviews with hospitalized injured survivors conducted at T3. All participants had been discharged from the hospital by this time-point.

### *Recruitment and participants*

The 27 hospitalized youths who participated in either the first or the second wave of the Utøya study were invited to participate at T3. A total of 17 agreed to be interviewed; the mean age at the time of the attack was 19 years (standard deviation = 2) and 77% were female. Sixteen of the 17 participants allowed access to their hospital records; thirteen were treated for severe bullet wounds, mainly located in the truncus, two were also treated for bullet wounds causing mild traumatic brain injuries, and three were treated for fractures. The mean injury severity score (ISS) was 18 (standard deviation = 11). ISS is a clinical score of injury severity ranging from 1 to 75. Major trauma is commonly defined by an ISS score over 15 [24].

### *Interviews*

A semi-structured interview guide was developed and contained the following main topics:

1) The youths' experiences with psychosocial help and support from different kinds of health care workers in the hospital (nurses, physicians, psychologists, psychiatrists or others): eliciting descriptions of how the help impacted them during and after hospitalization.
2) The youths' views on possible improvements in early psychosocial hospital care for traumatized survivors.

A group of three psychologists and one psychiatrist (the first author) trained at interviewing traumatized youths conducted the interviews.

### *Ethics*

The study was based on the written consent of all participants aged 16 years or older and from the parents of individuals younger than 16 years of age. The face-to-face interviews took place in the participants' homes. When a need for further health services was discovered, the interviewers facilitated contact with the appropriate resources. Ethical approval was gained from the Regional Committees for Medical and Health Research Ethics.

### *Analyses*

The interviews were audiotaped and transcribed verbatim and imported into NVivo 11 for coding. The length of the interviews varied from 5 to 37 min.

Since we were interested in the youths' own perspectives on their experiences in the hospital setting, interpretative phenomenological analysis (IPA) was used [25,26]. IPA consists of three core features. Firstly, it is phenomenological; it is intended to explore peoples' experiences, in particular, significant events in which the everyday flow of life is altered. Secondly, IPA is interpretative; the researcher tries to make sense of how the participant makes sense

of his/her life (double hermeneutics). Thirdly, IPA is ideographic; it analyses in detail the case at hand and how a particular subject is making sense of his/her situation. In the analysis, the researcher first "stays close" to the data and the participants' accounts, and then "steps back" and interprets these accounts.

The initial analysis of the interviews was informed by the authors' clinical experience working with traumatized youths and by knowledge from the trauma research field. During the analytic process, the youths' emphasis on everyday conversation and seemingly ordinary actions, such as being hugged or washed, caught our attention. To inform the further analysis and increase the possibility of interpretations pushing the field forward from what is already known, we introduced perspectives from adjacent fields of research. In a sociological study conducted at a treatment centre for drug abusers, researchers investigated the therapeutic potential of the commonplace and informal interaction between staff and clients such as conversations about common every-day issues and joining for a smoke outside [27][1]. Their findings show how such seemingly ordinary interactions may be therapeutic and contribute to healing by strengthening feelings of identity, normalcy and belonging. This research represented a conceptual framework that enabled us to identify when and how apparently trivial, superficial and common situations and conversations seemed to constitute powerful moments in the youths' progress towards normalization and health.

Two of the authors (the fourth and the last) were involved in planning the psychosocial care in the hospital after the Utøya 2011 attack. The first author worked as a psychiatrist in the hospital during the same period, and carried out some aspects of the psychosocial care for one of the 17 participants in this study. This was helpful in the planning of the study and the analysis because these authors knew the context the youths were reporting from. However, this could also create biased interpretations of the interviews. Inspired by the Consensual Qualitative Research model [29], a research team was therefore organized in order to enhance validity and counteract group thinking and researcher bias. Two of the five team members (the first and third authors) formed the primary analytic team. Consensus on themes was obtained after repeated rounds of independent reading, sharing of notes and discussion, then re-reading and re-discussing the interviews. The second author also read all interviews independently and acted as a discussant in the analyses. The last two group members (the fourth and last authors) then examined the team's analyses to check for consistency and soundness case by case and across cases after reading all interviews.

## Results

While care is provided to assist with the here and now, the youths highlighted the need for health care workers to embrace essential aspects of their past, present and future. Therefore, the analyses resulted in three overarching categories underpinning temporality within the descriptions of psychosocial care. We coded and labelled six subordinate categories related to the overarching categories: [1] Remembering the past: *Engaging in the trauma narrative, Understanding the trauma reminders* [2] Dealing with the present: *Bringing back normalcy, Being there* [3] Preparing for the future: *Supporting confidence, Instilling trust.*

In the presentation of results, each overarching category is given with its subordinate categories and selected quotes. The categories are formed in line with methodological recommendations for IPA requiring at least three participants contributing to each category. To ensure confidentiality, names, ages and places are concealed. To further reduce traceability, we use the pronouns *she* or *her* for all quotes regardless of gender.

### *Remembering the past*

The youths were admitted to the hospital immediately after the attack. Although they were safe in the hospital, their traumatic experiences were still vivid. Memories from the attack, trauma-related thoughts and fear were still in the foreground and played a role in how they perceived their needs and the care they received.

### *Engaging in the trauma narrative*

Several youths emphasized the staff's role in helping them talk about what had happened. They explained how talking through the trauma contributed to meaning-making and acceptance of their experience. One girl explained:

> And we often went through the whole story, I told my story several times, to work through it. ( . . . ) I think it was really helpful ( . . . ) and eventually it helped me to obtain a kind of understanding.

Another girl highlighted how talking helped her realize she was safe:

> I think maybe it helped me, not to forget it, but to understand that what happened a few hours ago will not happen within the next hour. ( . . . ) I became more aware that it happened a few hours ago, it's over now. It will not happen again ( . . . ) I wasn't afraid that it would happen again, sort of. She assured me that it was over, and that I didn't need to be afraid anymore. I think that really helped.

When asked about the impact of retelling what had happened, this youth said that she felt unsure of whether the attack was actually over, and, therefore, if she could feel safe. The health care worker was able to discover this and to assist her by listening to her story and related fears. Further, as the youth below explained, failing to seize this opportunity could hinder important corrections and the mending of misconceptions:

> No one talked to me about new facts that could have made the world appear safer. For one month I thought there were five terrorists because no one told me that they knew there was only one, no one talked to me about what advances had been made in the investigation. In my head, there was only bang, bang, bang. And that was my last experience. I was certain that there were ten people shooting because there were so many shots, and it was a long time before I found out how it had really been.

Notably, none of the youths described talking through the traumatic experiences as stressful. However, one survivor did not want to share her experiences fearing the staff's disbelief, and the administration of sedative medication seemed to contribute to this fear:

> After a while I said that I have seen at least ten dead people, and there are for sure many more, I would guess almost eighty, thinking of all those I saw getting randomly shot and all those I saw dead. And then I remember very well that they shot that kind of thing into my cannula, that kind of sedative medication, and I thought "they don't believe me anyway, they will believe I am totally crazy if I speak now and tell about what I have seen, so it's better to keep quiet."

By talking to health care providers, the youths could avoid sharing some of the horrible details with those close to them, thereby protecting them from further suffering:

[1] The paper presents results from a doctoral study written in Norwegian language [28]. Skatvedt A. Alminnelighetens potensial. En sosiologisk studie av følelser, identitiet og terapeutisk endring: University of Oslo; 2008.

I think it was most useful just to talk about it and to tell what had happened. Because the more times I got to talk about it, the easier it was for me to accept. ( . . . ) And that I didn't have to tell my mom about it ten times, that she maybe heard about it only eight times (laughter) instead. Because it wasn't that easy for her to listen in the same way as for the psychologist who could endure listening. In that way, the nurses were really ok, you could tell them the most terrible things and it didn't bother them.

However, for these disclosures to be helpful, several youths emphasized that the staff had to have time to listen to their stories and be compassionate:

The other nurses and doctors also asked what had happened, but they didn't have the time to listen to me ( . . . ) while she had the time to listen, and she asked, if I told her something, "yes, and what happened then?" that she appeared interested in what I said, and that she showed me, in a way, that she cared.

The staff's emotional capacity to handle the horrific details of what had happened was also important:

But then we came to (place) and there was some kind of miserable mental health care worker entering the room and looking at me, as if I were a "psycho-case." ( . . . ) She tried talking with me, but she felt so bad about what had happened ( . . . ) it was almost a burden having her there ( . . . ) and then I told her a little bit of what had happened, and she thought it was so horrible. I felt she came because she was curious.

The mental health care worker's expression of horror made this youth feel like she was abnormal, a feeling that seemed to make her uncomfortable, thereby disturbing the development of a potentially therapeutic relationship.

*Understanding the trauma reminders*

Many youths described how certain situations within the hospital environment triggered fearful thoughts and emotions by reminding them of experiences from the terror attack. Unsurprisingly, therefore, the youths were concerned by how these reminders and moments of fear were understood and met by the staff:

I wasn't sure if I could feel safe anywhere, but they were really good at making me feel safe in the hospital. And when we had a thunderstorm, for instance, that they would immediately run over to me explaining that it was nothing but thunder. They explained and made sure that I wouldn't be scared and they listened to what I had to say.

This youth appreciated the active engagement of the nurses. Being listened to and receiving normalising explanations of the reminders and how they may trigger responses made many youths feel safe and understood. However, the contextualisation and normalisation of such responses needs to be done with sensitivity:

I remember one nurse that was supposed to help me, and I was afraid of sounds all the time, and then she said, "just think that if no one else is afraid, then there is nothing to be afraid of." In my head that wasn't logical at all, because that was exactly what had happened the last time that had happened, so for me it was like, "are you a complete idiot? That is why I got into this! No one was afraid and then all of a sudden and out of the blue I was shot." ( . . . ) maybe if they had asked me properly, like, why do you think this is dangerous? Then I would have explained, then they could have provided a logical explanation for why it couldn't be like that.

Here, being told that she should not be afraid because no one else was afraid appeared illogical and unhelpful, as only hours before she had experienced a sudden disaster in a peaceful environment. She seemed provoked by the nurse's lack of understanding and her response that did not align with what the youth considered helpful.

What constitutes a trauma reminder may not be apparent, again underscoring the need for staff to know about the particular experiences of their patients. The following quote demonstrates how a combination of traumatic experiences and threatening hospital procedures may trigger comprehensive fear, and it illustrates how detrimental a lack of knowledge and understanding of the nature of trauma reminders may be:

And when, in addition, I thought that everyone wearing a uniform was a fake person, then it became like that for all information, I thought it was all a lie for a very, very long time ( . . . ) in the beginning I was operated on almost every second day, and there was very little information on what they would do, and then I thought that every time I was sedated they would kill me because they weren't real ( . . . ). One time I was going into a MR machine for examination, I got all . . . and then it is written in my medical records that I got some kind of attack or flashback or something, because then I shouted things like "I know that you are going to kill me", or something like that. And then they sort of forced me into the machine.

*Dealing with the present*

The youths not only talked about how their trauma experiences needed to be addressed and understood, but also about being cared for in ways that helped them overcome and cope with current needs. In these descriptions, they emphasized aspects of care that are potentially relevant to all patients. However, although these needs may be construed as commonplace, their meaning needs to be interpreted within the context of traumatization.

*Bringing back normalcy*

Several youths emphasized the importance of everyday conversation as they seemed to contribute to a sense of normalcy. The content of these conversations reminded them of times free of threat, demonstrating to the youths that the world was still the same as it was before the horrific event:

I just thought it was really, really useful that they talked about other things, that made me understand that the world still had some parts that were the same as before ( . . . ). Because I woke up and thought that the world was different, that the world was totally cruel. I didn't recognize my own world or any people in it. So it really helped ( . . . ) the first time she just talked about a television series that she had been watching or something, and then I sort of remembered that there were still television series, that one could still laugh at them, that they were still part of the world.

For this youth, returning to the idea of the world as a safe place was crucial in the process of regaining a sense of safety. She almost seemed trapped by the memories of her traumatic experience and by the unfamiliar hospital context, and she needed to somehow break free and reconnect to a positive view of the world. Talking about and even laughing at ordinary things, such as a television series, represented a reconnecting link which provided implicit information that the world was still intact and safe.

Everyday conversations could also be a way of coping with intrusive thoughts, providing some acute relief:

Then I just had to lie there, so it was nice just to talk with someone, about anything. I had some conversations about porridge, I remember. So that was nice ( . . . ) just to make the

time pass and my thoughts stop spinning around Utøya and in a more normal setting, even if the setting you're in is abnormal.

Ordinary conversation was also linked to other features promoting positive feelings and wellbeing:

Well, there were some female nurses there that, just talking to me and talking to my family, and joking around with (name) and making her laugh and that kind of thing. Just that did that a lot.

The significance of humour and laughter needs to be understood in the context of the extreme situation encompassing comprehensive damage and tragedy. Seeing those close to her laughing again seemed to comfort her as laughter signalized optimism and positivity and represented the world as it used to be and could be again.

*Being there*

As presented above, many of the youths focused on aspects of care related to verbal communication, including how their traumatic experiences were received and responded to and the significance of ordinary conversation. Importantly, however, the descriptions also contained opinions on the presence of staff without reference to what was said.

For these young survivors, the feeling of being unsafe was not easily overcome, and their descriptions underpinned the importance of the more or less continuous presence of others:

She made sure that there was always someone with me, so if she, for example, had to go to the restroom, she asked another nurse if she could stay with me, and she kind of asked my aunt if it was ok that she left, and I felt that she was really responsible, or made sure . . . I kind of felt that she looked after me.

The nurses played a significant role in strengthening the feeling of safety. This was related to their availability and flexibility when interacting with youths with continuous and fluctuating emotional states and needs. Further, some survivors described more in-depth aspects of non-verbal care:

. . . and I woke up after the surgery, I woke up just laughing and laughing. My mom wasn't there, but I felt as if there were a lot of mothers there, because they were kind of with food and all that . . . and I remember one of them washing my feet, because I had been running in mud and stuff like that, my nails were all dirty, and they were, it was just so cosy and lovely that right there I don't think that I thought that much about what I had gone through. They just made us, at least me, feel very safe and good.

This youth highlighted the importance of explicit acts of compassion and touch in strengthening her sense of safety. The nurses were described as motherly figures, reminding us that mechanisms of human attachment are activated and essential in stressful situations.

To feel others' suffering to some degree, and to be able to express that empathy, is essential to the provision of compassionate help. Some youths elaborated on how the health care workers expressed their feelings:

In any case, I wasn't able to answer, and what they asked about kind of felt so trivial anyway, and even if I tried to answer, I couldn't do it. So what I felt was really liberating, that really helped, was when that nurse who stayed with me started crying herself ( . . . ) and then she just laid down beside me and just hugged me, and then I started crying. ( . . . ) She kind of stood right next to my bed, and then she laid her upper body against me and held me and cried herself. And then I thought that this is one of those few people that understand. So I felt a bit safer, I felt less alone.

It may be that such deeply human and "ordinary" compassionate acts such as crying and hugging, although not common in interactions between health care workers and their patients, represented an indispensable key to acknowledging and addressing the youth's state of immense fear and sadness in this situation.

However, as described below, compassion may also result in emotional expressions affecting victims negatively:

I think that the more sensational things are, the more one needs things to be normal. At least I would have needed that people behaved normally. That the staff behaved normally ( . . . ) that I didn't have to feel that I had gone through the worst, worst, worst all the time.

This youth seemed to ask for expressions of "normalcy" so that she could liberate herself from the restrictive identity of being a victim of the worst thing that could ever happen.

*Preparing for the future*

As presented above, the continuous role of the traumatic event, the prolonged sense of fear and experiences with how these issues were addressed were central topics for the youths. In addition, they discussed how the staff contributed to strengthening their confidence and hope for the future. The hospital stay was implicitly depicted not only as an arena for processing actual and ongoing psychological issues, but also as a "greenhouse" which could provide the opportunity to prepare for the future under beneficial conditions.

*Supporting confidence*

Several descriptions concerned the staff's role in strengthening the youths' confidence through explicit acknowledgement and encouragement:

I got it in writing that I was resourceful. I want to frame that paper.

For this young survivor who had been physically and psychologically worn down, being told that she was still capable and "up and about" seemed to have a strong symbolic power which had a significant impact on a young mind under intense reorganization. This youth took us deeper into her perspectives on encouragement:

I didn't feel capable in that situation, because my body didn't function, so I needed help with everything all the time, and I couldn't even go to the toilet myself, and everything people said to me was positive, about how brave I was, or things that had to do with the attack. And then I remember that what really helped was that she (a nurse) was very good at telling me almost every day something that was good about myself, for instance, that he said, "you are very good at understanding other people, you are good at seeing other people", or "you are good at . . . ." Yes, such things that had to do with ME that maybe made me maintain some self-worth, that wasn't tied to, kind of, surviving.

After such a dramatic event, attention was naturally drawn to the most striking aspects of the attack scenes and how some youths managed to survive. This youth reminded us, however, of the importance of the everyday "real" her, who she was before the attack and who she still wanted to be.

In addition to general acknowledgment, positive, albeit demanding, support in focusing on more specific goals and tasks seemed important in establishing confidence and belief in control over one's own life:

I was injured, but at the same time an individual they had to listen to and for whom they did everything they could to save. I

felt that in comparison to family and friends dropping by and who were more like “poor you,” they were more kind of “ok, we will work this out” and “you have to do this and that” and they were a little more strict and “now you’ve got to get up and exercise”.

. . . and the environment was really positive, even if things were like shit, there was a lot of focus on what I had to do and what kind of things I could manage and . . . like completely normal things.

Confidence does not rely solely on others’ statements and behaviours. Some descriptions elaborated on how the survivors’ agency may have strengthened belief in their own capabilities:

I started writing a blog, partly because I was so tired of all the questions, and it took a lot of energy to answer every single time, for example answering their questions about what happened or that kind of thing. So then I found out that it was better to just write a text like I did and so people could read that, and I didn’t have to answer every single question all the time. That was actually quite useful. And for me, it was convenient, even if I was criticized (by a doctor), that I couldn’t write about my injuries and so on. And that was why we were at odds, because I was over sixteen years old, so it’s my decision if I want to make public my own medical history, as long as I don’t kind of pull other people into it. But it worked out really well for me, yes to protect myself.

This youth seemed to relate the decision of establishing a blog in spite of objections from staff to being grown-up and a feeling of taking control of her own life. To grasp the symbolic power of such actions in this situation, it is important to recognize that they were not seen as conventional, neither by the survivors nor the staff, meaning that they were not acceptable in the hospital setting. Carrying out these ordinary unordinary actions may have contributed to this youth gaining a sense of herself as a person who could stand up for own needs and being capable of doing what was good for her.

*Instilling trust*

Being pursued and shot at by another person affected the youths’ capacity to trust others. Given its crucial role in social life after discharge from hospital, the regaining of trust was naturally a concern:

That it was a good experience for me staying in the hospital, made it less threatening to leave it ( . . . ). That they kind of cared, and helped me to understand that other people also care. That it wasn’t dangerous or unsafe to stay in the hospital, made it less scary to go to another hospital, or to go to a shopping centre, or to go to a place with people.

For this youth, the hospital was a place where she could start rebuilding her capacity to trust others. Although the hospital represented a particular world, different from everyday life in many aspects, experiences in this setting were transferrable to life outside the hospital. The hospital appeared to function as a microenvironment encompassing both the clinical and the commonplace, and although they were strangers, the health care workers contributed to mending the youths’ shattered inner representations of other human beings.

In addition to rebuilding general trust in the world outside the hospital, re-establishing trusting relationships through interaction with staff was emphasized:

And it was helpful as it was the first place I said things aloud. And at the same time having to trust people, because that was something I’ve had some problems with. But in that situation you didn’t have a choice, you just had to trust the people around you, and maybe that made it easier for me to trust people again afterwards.

Some were also concerned with the significance of being put in contact with specific groups of professionals. Positive early contact with health care workers addressing psychosocial issues may have facilitated access to later help or treatment:

It was the first time I had talked to a psychologist, and I had a good feeling about psychologists afterwards when I got out of the hospital.

Overall, the youths seemed to view the hospital as an arena where trust could be regained and strengthened. Just being in close and positive contact with the staff seemed to release and strengthen the capacity to trust others again.

## Discussion

The surroundings in which survivors spend the early aftermath after traumas vary, and different settings involve different premises for the provision of psychosocial care. It is crucial to understand specific aspects of the different settings and take into account victims’ experiences when developing psychosocial care. After being brought to safety, most survivors of the Utøya attack returned to their homes and the people closest to them. For the youths in our study, the first hours, days and weeks were spent in a hospital. Shortly after being rescued from the island, these youths found themselves in an unfamiliar clinical environment, closely and continuously surrounded by professional health care workers providing a wide range of care and clinical treatments. Some aspects of psychosocial care seemed to benefit from the characteristics of the hospital setting, while others were challenged.

Earlier research suggests that going through major traumas may change how victims perceive the world [30,31]. The current study demonstrated how the unfamiliar and clinical hospital environment represented an additional challenge to the youths’ perceptions of their surroundings. Firstly, procedures and equipment activated severe fear, even those that did not constitute obvious trauma reminders. Their unfamiliar nature, evoking the traumatic experiences of being bodily invaded and attacked, turned them into powerful triggers of distress. Hypervigilance is often seen after traumas and is defined as part of the clinical diagnosis of posttraumatic stress disorder [32]. Our study contributes to current knowledge by illustrating how hypervigilance after trauma may interplay with the hospital context inducing aggravated fear. The staff that understood this and acknowledged the origin of these exaggerated fears, and were sensitive in their efforts to contextualize and normalize reactions, were described as important in the youths’ healing processes. Secondly, the youths emphasized that their beliefs about the world as a safe place and other people as trustworthy were shattered. Their beliefs were not only challenged by the horrific and intentional violence, but also by waking up in an unfamiliar clinical environment, surrounded by strangers. Hobfoll connects the restoration of shattered beliefs to the strengthening of the feeling of safety and the rebuilding of hope [9]. Accordingly, the youths were explicit about the need to adjust their beliefs to feel safe. Interestingly, laughing or talking about well-known television series or food was emphasized as helpful in recognizing that the world was still safe, and ordinary interaction with the staff seemed to contribute to rebuilding trust in others. The role of interactions which simply focus on ordinary human togetherness and conversation in reinforcing the perception of the world as normal and trustworthy may seem obvious. Nevertheless, this aspect of care is poorly addressed in trauma research. In developing psychosocial care after traumas, the perspective of the “potential

of the commonplace" [27] may be helpful in contributing to normalcy and healing. Our findings indicate that approaching traumatized survivors with both clinical and everyday conversation can help them process a range of changed perceptions about the world and their surroundings.

Further, descriptions of the importance of being acknowledged and supported in feeling capable, made us aware of how the youths' perceptions of themselves were challenged. Accordingly, research has indicated that a weakened sense of control over, and belief in, positive outcomes in life, described by Hobfoll as self-efficacy, is often seen after traumas [9,11,18]. In our study, emphasis was put on being acknowledged as a valuable person independent of one's behaviour in the face of the traumatic event, that is, value connected to the ordinary self. The need for validation and being seen as 'normal' both by health professionals and by survivors themselves is also highlighted in earlier studies [17,21]. Research on patient culture in acute care hospitals has argued that patients seek *ordinariness* as their condition is *not ordinary* and as their future membership in the world of the ordinary is at stake [33].[2] Along the same line of reasoning, Skatvedt claims that in the process of reaching normalcy, the commonplace interactions between staff and clients may serve as powerful labelling situations which allow for the creation of new identities unconnected to deviance and degraded selves [27]. For the youths in our study, as trauma survivors in addition to being severely injured and hospitalized, reconnecting their self-perception to the ordinary seemed to be of fundamental importance in the acute aftermath of the trauma.

Due to the comprehensive system of care, being hospitalized implied that each youth was closely and more or less continuously surrounded by others. Being socially connected is obviously fundamental in regaining health after trauma as it enables support such as understanding and acceptance from others in addition to support in the sharing of traumatic experiences and normalization of reactions [9,11]. The findings in our study highlighted the perceived presence of such support within the hospital setting and contribute to an extended understanding of its impact after a deeply traumatic experience. In addition, the youths emphasized the link between being close to the staff and the rebuilding of their sense of safety. This finding was supported in another study of injury survivors' experiences in an emergency department, where the importance of having someone close was repeatedly stressed and linked to coping with feelings of loneliness and fear [19]. In spite of being an environment at times described as busy [18] and with the potential to induce aggravated anxiety, it seems that the hospital with its close social structures aimed at providing support and care, may also contribute substantially to the trauma survivors' sense of safety.

A specific characteristic of the hospital setting is the environment consisting of various professionals contributing to different aspects of care. Having the time to be emotionally and practically available, and thereby representing continuity of care, made the nurses essential in strengthening the youths' sense of safety. The mental health care workers seemed to be important in another emphasized aspect of care; addressing the youth's trauma experience and related thoughts and fears. Processing the trauma narrative is a main focus in effective treatment strategies for prolonged symptoms of posttraumatic stress and may be seen as useful by trauma survivors [35]. However, it is unclear to what degree trauma narrative processing needs to be implemented as an early intervention strategy among injured school-age children and youths [36,37]. Routine debriefing is not recommended, and the approach outlined in Psychological First Aid emphasizing the importance of not provoking additional distress, is considered best practice although sparsely informed by research [11–13]. Our study may contribute to the field illustrating how talking about what had happened mostly was perceived as positive, provided that the staff had time to listen and that the youths were met in ways which did not increase their anxiety and sense of otherness. Under these conditions, telling and talking was linked to various helpful outcomes such as; understanding what had happened and meaning-making, understanding trauma-reminders and their impact, discovering and altering unhelpful thoughts, as well as protecting loved ones from having to repeatedly listen to the horrifying story. These aspects are in accordance with findings in other studies on survivors and their parents after traumatic injury underlining the importance of meaning-making and protecting loved ones [17,20,38]. As also demonstrated in one of these studies, repeatedly having to share the trauma narrative for the purpose of informing the hospital staff was perceived as distressing [20]. Taken together with the findings in our study, this points to the importance of the context and the reasons for initiating conversations about trauma related issues emphasizing a sensitive approach where the needs of the victims are in focus.

As addressed above, professionalism influences which aspects of psychosocial care are utilised and how the care is carried out, and patients naturally have vivid expectations related to the various professional roles. Interestingly, Skatvedt claims that when a professional steps outside of what their client perceives as their stereotypical professional role, the symbolic power of what is said or done is strengthened [27]. In our study, this perspective helped us understand the way the nurses' authentic displays of emotion and ordinary care contributed to wellbeing and self-worth when combined with an understanding of the impact of trauma. Skatvedt claims that seemingly small acts may have the power to move people emotionally and communicate messages of identity and belonging, as was articulated by the youths in this study. We believe that the ordinary interactions within the clinical setting contributed to the youths' sense of participating and belonging in the world as normal people rather than just trauma survivors.

Ultimately, in line with earlier research, the nurses seemed to play a crucial role in providing helpful psychosocial care [19]. There was less emphasis on the work of mental health care workers and physicians, which was rather interesting due to the context of the extreme traumatic event and the physical injuries. We ask if the role of the commonplace may contribute to explaining the nurses' impact. Through displays of ordinary human togetherness, they demonstrated to the youths in this abnormal setting and moment in life, that the world was about to become safe again.

## Implications for practice

1) For trauma survivors in hospital settings, talking about the traumatic experiences may be helpful for various reasons. However, this is contingent on the staffs' availability and their emotional capacity to endure others' suffering and listen empathetically. Pertaining to this, support and supervision of staff should be a prioritized task.
2) Hospital staff needs to be trauma-informed and comprehend and engage in how exposure to trauma and hospitalization may result in extended fear and changed appraisals about the world and the survivors' perceptions of themselves.
3) Taking the time to stay physically and mentally close to trauma survivors in hospital settings needs to be acknowledged as crucial in promoting the sense of safety.
4) Commonplace interaction may need to be acknowledged as a powerful element of psychosocial care for trauma survivors in

[2] For a more thorough elaboration on the theme, we recommend Album's book written in Norwegian language [34]. Album D. Nære fremmede: pasientkulturen i sykehus: Tano; 1996.

hospitals. Everyday conversation and actions may be helpful in strengthening survivors' sense of safety in addition to helping them attain normalcy, i.e. normalise their appraisals about the world and themselves.

5) In hospitals, the various professionals may contribute with a broad range of psychosocial care approaches. Trauma-focused interventions and commonplace interaction may complement each other and together provide trauma survivors with a beneficial environment of care.

## Conflict of interest

No conflict of interest has been declared by any of the authors.

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