

## ORIGINAL RESEARCH

# The Role of OH Cards in Psychological Interventions for Children With Fractures

Yuna Jiang, MM; Xiaokang Zhou, MM; Liuqing Yang, MM; Hongxia Zhang, MM;  
Qiujing Chen, MM; Jing Feng, MM; Haimin Wu, MM; Lina Fang, MM;  
Meina Zheng, MM; Ye Li, MM; Juan Zhang, MM; Yan Yan, MM

### ABSTRACT

**Context** • Fractures are traumatic events, with psychological effects that can have a negative impact on children hospitalized with fractures. They can seriously affect children's physical rehabilitation and quality of life and even produce psychological disorders. The OH card is a metaphorical card that allows access to an individual's inner world and can have a positive effect in psychotherapy.

**Objective** • The study intended to investigate the use of OH Cards during psychological interventions with children with fractures and to provide a methodological reference for the use of OH Cards in therapy.

**Design** • The research team performed a randomized controlled study.

**Setting** • The study took place in the Department of Trauma Surgery at Children's Hospital of Hebei Province in Shijiazhuang, China.

**Participants** • Participants were 74 children with fractures who had been admitted to the hospital between September 2020 and November 2021.

**Intervention** • The research team randomly divided participants into two groups using a random number table: (1) 37 in the intervention group, who received a conventional nursing intervention and also an OH-card intervention, and (2) 37 in the control group, who received conventional nursing interventions only.

**Outcome Measures** • At baseline and postintervention, the research team: (1) measured the participants' posttraumatic growth scores, using the children's version of the Post-Traumatic Growth Inventory (PTGI);

(2) assessed their coping styles, using the Medical Coping Modes Questionnaire (MCMQ); (3) determined the existence of any stress disorders, using the Child Stress Disorder Checklist (CSDC); (4) evaluated their mental statuses using the Depression Self-Rating Scale (DSRSC) and the Screen for Child Anxiety-related Emotional Disorders (SCARED); and (5) measured participants' Fracture Knowledge Questionnaire scores.

**Results** • At baseline, no significant differences existed between the groups for any outcome measure at baseline. Postintervention, the intervention group's scores: (1) on the PTGI, were significantly higher for mental change, appreciate life, individual force, new possibilities and personal relation than those of the control group; (2) on the MCMQ, were significantly higher for facing and significantly lower for avoidance and yield than those of the control group; (3) on the CSDC, were significantly lower for trauma incidents and acute response than the control group did; (4) on the DSRSC were significantly lower and on SCARED were significantly higher than those of the control group; and (5) on the Fracture Knowledge Questionnaire were significantly higher than those of the control group.

**Conclusions** • OH Cards can increase the posttraumatic growth scores of children with fractures, improve their coping styles, reduce stress disorders, decrease depression and improve their psychological state, increase their knowledge about fractures, and promote their recovery. (*Altern Ther Health Med.* 2023;29(6):198-203).

Yuna Jiang, MM; Xiaokang Zhou, MM; Liuqing Yang, MM; Hongxia Zhang, MM; Qiujing Chen, MM; Jing Feng, MM; Haimin Wu, MM; Lina Fang, MM; Meina Zheng, MM; Ye Li, MM; Juan Zhang, MM; Yan Yan, MM; Department of Trauma Surgery, Children's Hospital of Hebei Province, Shijiazhuang, China.

Corresponding author: Xiaokang Zhou, MM  
E-mail: 421680743@qq.com

Children are a high-risk group for fractures, with approximately 2.5%-6.25% of children worldwide suffering from fractures each year, of which 28.1%-67.8% are school-age children.<sup>1</sup> Children's fractures are common in extremities such as the humerus and femur and less common in the thoracolumbar spine.<sup>2,3</sup>

Because fractures are traumatic events, they usually have a negative impact on the patient's mind and body.<sup>4,5</sup> A fracture is a sudden and unexpected source of somatic stress

in daily life, instantly causing damage to somatosensory and motor functions, and at the same time, causing serious harm to children's psychology.<sup>6</sup> Those psychological effects can result in posttraumatic stress disorder (PTSD), mainly manifested as recurrent traumatic experiences and recurrent nightmares with traumatic content, posttraumatic fear, anxiety, sadness, depression, loneliness, and helplessness.<sup>6</sup>

If the posttraumatic stress reaction is too strong or lasts for more than one month, it can have a negative impact on children hospitalized with fractures and can seriously affect their physical rehabilitation and quality of life, and even produce psychological disorders.<sup>7</sup>

Depending on the extent of the injury, a physician may treat a child's fracture by bracing or surgery, but whatever the treatment, it will require the child's cooperation. The core symptom of PTSD is empirical avoidance, and one of the main diagnostic criteria is the child's attempt to avoid or flee from the traumatic event.<sup>8</sup> The more individuals who experience traumatic events avoid recalling the traumatic event afterward, the higher their risks of developing PTSD.<sup>9</sup> Therefore, conventional care through psychological interventions alone is often ineffective.

Assessment of posttraumatic growth and coping strategies are two methods of evaluating the effects of a traumatic event.

### Posttraumatic Growth

Posttraumatic growth refers to the positive psychological changes that occur as patients cope with severe life stress, and it's an evolving process. The patient's characteristics, the level of support he or she receives, and the degree of self-exposure have an impact in generating growth. The traumatic event threatens the patient's cognitive structures, and these threats cause new schemata, goals, and assumptions to emerge as the cognitive structures undergo various cognitive processes.<sup>10,11</sup> Yilmaz G et al confirmed that effective nursing interventions can promote patients' posttraumatic growth.<sup>12</sup>

### Coping Styles

Coping styles, also known as coping strategies, are behaviors measures that individuals adopt when managing stress and that they take to alleviate psychological stress.<sup>13</sup> Coping is a changeable behavior and usually changes as the context changes.

The categories of coping styles include such behaviors as giving in, confronting, avoiding, changing, and seeking help.<sup>14</sup> Positive coping can reduce an individual's negative emotions and thus maintain psychological well-being.

As time passes or the context changes, individuals' coping styles can change accordingly, and the interaction between coping styles and emotions influences the strength of an individual's stress response. Kasi et al suggested that some patients cope in a positive way and that they do everything they can to recover as quickly as possible, while those with the opposite view believe that adaptation is the priority at the moment.<sup>15</sup> Because of the physical and

psychological distress that sudden fractures cause, the stress and damage aren't limited to the moment of onset, and the psychological condition of worrying about the prognosis of the disease and anxiety and depression can persist.

Guiding patients to adopt positive ways of coping with their illness has been a common effort. Tu et al and Nogalski et al carried out studies on coping styles for patients with cancer and for chronic and traumatic diseases and found that positive coping style could promote psychological healing.<sup>16,17</sup>

### OH Cards

The German humanistic psychologist Moritz Egetmeyer and the Mexican artist Ely Raman developed the OH Cards, and they have been translated into 24 languages and used in more than 50 countries.<sup>18,19</sup> The OH Cards are subliminal projection cards, a system of free-association, consisting of 176 cards in two groups.<sup>20</sup> Of those 176 cards, 88 are picture cards containing watercolor patterns from all aspects of people's lives, and 88 are word cards with words that these watercolor patterns use as a background.

With the help of different combinations of patterns and words, the cards can stimulate patients' creativity and imagination; promote their cognition; enhance their self-awareness; help them to explore the subconscious; and allow them to investigate their true psyches, as distinguished from their own thoughts. They can help discover individuals' blind spots, thus allowing them to find ways to resolve confusion and to discover their potentials.

In the process of describing the cards, the patients are more likely to drop their defenses and impediments and open up and follow a caregiver's guidance to explore deeper within themselves while also accepting and supporting their peers.<sup>21</sup>

OH Cards are thought to be an intervention that can heal trauma,<sup>18</sup> but no studies of psychological interventions with OH cards in children are available. That is due to the openness of the OH cards, which allow different children to project different subconscious thoughts from the cards, and they are an appropriate tool for using in posttraumatic psychological interventions for hospitalized children.

When children choose picture and word cards that represent PTSD and then internalize the meaning of the cards, they are using the picture and word cards to project their most troubling source of PTSD at that moment.

### Current Study

At present, the treatment for children with fractures in China is mostly focused on promoting the recovery of somatic functions but ignores interventions for PTSD, which isn't conducive to the recovery of those functions and is likely to have adverse effects on their psychology. Therefore, it's important to help children with fractures to recover their physical functions, and at the same time, to alleviate their PTSD and improve their psychological statuses.

However, only a few scholars have reported on the effectiveness of OH Cards in individual counseling and stress

management for children. The current research team hypothesizes that the psychological projections that the OH Cards cause may have a therapeutic effect on postfracture psychology.

The current study intended to investigate the use of OH Cards during psychological interventions for children with fractures and to provide a methodological reference for the use of OH Cards in therapy.

## METHODS

### Participants

The research team performed a randomized controlled study, which took place in the Department of Trauma Surgery at Children's Hospital of Hebei Province in Shijiazhuang, China. Potential participants were children with fractures who had been admitted to the hospital between September 2020 and November 2021.

The study included potential participants if they: (1) were aged 6 to 12 years; (2) met the diagnostic criteria for limb fractures, as confirmed by symptoms, X-ray, and/or computerized tomography (CT); (3) were scheduled to undergo emergency surgery at the hospital, which the same surgical team performed; (4) had reading comprehension and no communication difficulties; and (5) were all in the custody of their immediate families.

The study excluded potential participants if they: (1) had a previous psychiatric history; (2) recently had been taking antipsychotic medications; (3) had a history of surgery within the 6 months prior to the study; (4) were critically ill and unable to receive intervention; (5) had visual, hearing, cognitive, or intellectual impairment; or (6) had multiple fractures.

The study's protocols met the relevant requirements of the Declaration of Helsinki.<sup>22</sup> All participants sign written informed consents and ethics committee of our hospital approve the study protocols.

### Procedures

**Groups.** The research team randomly divided participants into two groups using a random number table: (1) the intervention group, who received a conventional nursing intervention and also an OH Card intervention, and (2) the control group who received a conventional nursing intervention only.

**OH Cards intervention team.** The team included: (1) one deputy chief nurse, a pediatric clinical nurse; (2) four nurses-in-charge, all pediatric clinical nurses; (3) three pediatric nurse leaders; and (4) one professional, child-emotional-intelligence trainer and national level-3 psychological counselor. The team gave professional guidance.

**Psychological state assessment.** At baseline, a psychological counselor used one-to-one interviews to gain an in-depth understanding of the children's psychological and behavioral manifestations related to stress disorders. These included such behaviors such as: (1) avoidance of topics related to the occurrence of a fracture, (2) nightmares

related to the occurrence of a fracture, (3) requests to parents to accompany them to sleep, (4) reduced sleep quality, (5) mood disorders, (6) reduced attention span, (7) reduced learning, and (8) abnormal behavior.

Members of the OH Cards intervention team obtained general information about each child's age and degree of illness, analyzed his or her psychological and stress state, and provided a basis for the implementation of the OH Cards.

**Intervention.** All the members of the intervention team were young mothers and were familiar with the content of the OH Cards, which consist of 88 word cards reflecting character interactions and emotional reactions and 88 picture cards covering various life situations. The nurse could use them individually or in combination.

**Outcome Measures.** At baseline and postintervention, the research team: (1) measured the participants' posttraumatic growth scores, using the children's version of the Post-Traumatic Growth Inventory (PTGI)<sup>23</sup>; (2) assessed their coping styles, using the Medical Coping Modes Questionnaire (MCMQ)<sup>24</sup>; (3) determined the existence of any stress disorders, using the Child Stress Disorder Checklist (CSDC)<sup>25</sup>; (4) evaluated their mental statuses using the Depression Self-Rating Scale (DSRSC)<sup>26</sup> and the Screen for Child Anxiety-related Emotional Disorders (SCARED)<sup>27</sup>; and (5) measured participants' Fracture Knowledge Questionnaire scores.

### Interventions

After children had passed a risk period and their conditions had stabilized, the intervention team carried out the OH Cards intervention, with a guardian accompanying the child. The children randomly selected three sets of picture cards and word cards, the content of which was intentionally related to such topics as facing frustration, self-awareness, knowledge about fractures, and positive cooperation. The intervention team asked the children to design a complete story for the three sets of picture and word cards that started with an "I".

While the children designed the story, the nursing staff guided them to make the story about how they had overcome the fracture's limitations despite setbacks and cooperated with the treatment, so that they could immerse themselves in the story and imagine that they were the main characters.

In addition, the intervention team selected seven word cards and one picture card and asked the children to make a connection between the picture card and the other cards and to choose the word card that they thought was most appropriate. The intervention team formed groups of children who chose the same word and picture cards, which allowed the children to feel that they were among like-minded people and increased the cohesiveness of the small group and set an example of cooperation in treatment.

At the same time, the intervention team divided children into groups of three, and each group designed a psychodrama based on the content of the relevant OH Cards, about the impact of the fracture on them. Each child underwent a one-

**Table 1.** Participants' Demographic and Clinical Characteristics at Baseline

Characteristics	Intervention Group n = 37 n (%) Mean ± SD	Control Group n = 37 n (%) Mean ± SD	$\chi^2/t$	P value
Gender			0.056	.814
Male	21 (56.76)	22 (59.46)		
Female	16 (43.24)	15 (40.54)		
Age, y			-0.247	.806
Years	9.01 ± 1.23	9.08 ± 1.21		
Range	6-12	6-12		
Time From Injury to Hospital Admission, h	3.65 ± 1.01	3.61 ± 1.03	0.169	.866
Mode of Injury			0.057	.812
Car accident	15 (40.54)	14 (37.84)		
Fall	22 (59.46)	23 (62.16)		
Site of Fracture			0.294	.588
Upper limb	27 (72.97)	29 (78.38)		
Lower limb	10 (27.03)	8 (21.62)		
Part			0.054	.816
Left side	19 (51.35)	20 (54.05)		
Right side	18 (48.65)	17 (45.95)		
Fracture Pattern			0.218	.896
Traffic accident	9 (24.32)	8 (21.62)		
Heavy object striking	3 (8.11)	4 (10.81)		
Fall	25 (67.57)	25 (67.57)		
Surgical Procedure			0.247	.619
Incisional reduction	3 (8.11)	2 (5.41)		
Closed repositioning	34 (91.89)	35 (94.59)		

time OH Card conversation, and the whole process lasted about 2 hours.

After grasping the children's psychological characteristics, the nursing staff gave targeted psychological interventions to help the children transform their negative psychology into normal psychology while informing the children's guardians that they should adopt more kind and amiable attitudes to communicate with the children.

These processes helped to correct the any wrong perceptions that the children had and to change behaviors to reduce the stress that the fracture had caused. The psychological interventions included pain care, dietary care, exercise care, rehabilitation training, and education of the children's parents.

## Outcome Measures

**Posttraumatic growth score.** The children's version of the PTGI has 21 items in five dimensions: (1) mental changes, (2) appreciate life, (3) individual force, (4) new possibilities, and (5) personal relation.<sup>23</sup> Scoring uses a scale of 0-5, with higher scores indicating better posttraumatic growth.

**Coping style.** The MCMQ scale consists of three dimensions representing three coping styles: Facing, avoidance, and Yield.<sup>24</sup>

**Stress disorders.** The CSDC is a 36-item scale that includes: (1) trauma incidents—one item, (2) acute response—5 items, and (3) recent reactions—30 items.<sup>25</sup> Each are rated on a 0-2 scale, with a possible total score of

0-72. The higher the score, the more pronounced the symptoms of stress.

**Psychological state.** Psychological state is an important indicator that reflects the level of health. The DSRSC score of  $\geq 13$  indicating depression.<sup>26</sup>

**Fracture knowledge questionnaire.** The research team created this questionnaire, which consists of 10 items. The questionnaire includes key points, such as observation of a child's fracture, the correct position to be taken, and functional exercises. The higher the score, the better the child's bone knowledge.

## Statistical Analysis

The research team analyzed the data using the SPSS 20.0 statistical software (Chicago, Illinois, USA). The team: (1) expressed measurement data as means  $\pm$  standard deviations (SDs) and compared the groups using the *t* test and (2) expressed counting data as a number (N) and percentage (%) and used the chi-square  $\chi^2$  test to compare the groups.  $P < .05$  indicated that the difference was statistically significant.

## RESULTS

### Participants

The study included and analyzed the data of 74 children, 37 in the intervention group and 37 in the control group (Table 1). The intervention group included 21 males and 16 females, and their ages ranged from 6 to 12 years old, with a mean age of  $9.01 \pm 1.23$  years. The control group included 22 males and 15 females, and their ages ranged from 6 to 12 years, with a mean age of  $9.08 \pm 1.21$  years. No significant differences existed between the groups at baseline ( $P > .05$ ).

### Posttraumatic Growth

At baseline, no significant differences existed between the groups in the scores on the PTGI (Figure 1). Postintervention, the intervention group had significantly higher scores in mental changes ( $P < .001$ ) appreciate life ( $P < .001$ ), individual force ( $P < .001$ ), new possibilities ( $P < .05$ ), and personal relation ( $P < .01$ ) than the control group did.

### Coping Styles

At baseline, no significant differences existed between the facing, avoidance, and yield scores of the groups ( $P > .05$ ). Postintervention, the intervention group's mean facing score ( $P < .001$ ) was significantly higher and its avoidance and yield scores were significantly lower (both  $P < .001$ ) than those of the control group.

### Stress Disorders

Figure 3 shows that no significant differences existed at baseline between the groups in the scores for trauma incidents, acute response, or recent reactions ( $P > .05$ ). Postintervention, the intervention group's scores for trauma incidents and acute response were significantly lower than



those of the control group (both  $P < .001$ ). Although no significant difference existed between groups postintervention in the scores for recent reaction, those scores decreased postintervention for both groups.

### Psychological State

Figure 4 shows that no significant differences existed between the groups at baseline in the DSRSC and SCARED scores ( $P > .05$ ). Postintervention, the intervention group's DSRSC were significantly lower ( $P < .001$ ) and SCARED scores were significantly higher than those of the control group ( $P < .001$ ).

### Fracture Knowledge

Figure 5 shows that the intervention group's scores were significantly higher postintervention than those of the control group on the fracture knowledge questionnaire ( $P < .001$ ).

## DISCUSSION

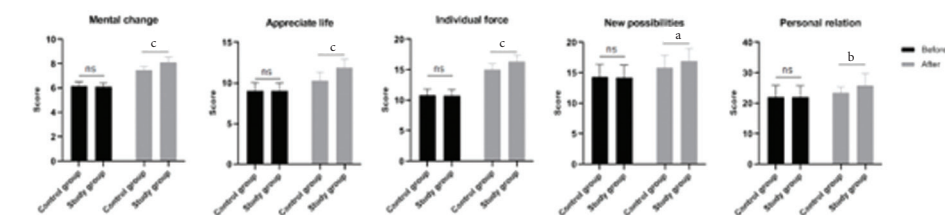
Wang et al. found that the OH card intervention could significantly improve the positive coping scores of nurses.<sup>28</sup> The current study found that the intervention group scored significantly higher than the control group in mental change, appreciate life, individual force, new possibilities, and personal relation, suggesting that OH Cards can improve the scores on the PTGI and promote postinjury growth in children with fractures. This may be due to the fact that the OH Cards can help the children to face difficulties better and to regain confidence, thus generating positive feelings and psychological growth.

The current study also found that the intervention group's mean facing score was significantly higher and its avoidance and yield scores were significantly lower than those of the control group, suggesting that OH Cards can improve the coping styles of children with fractures and facilitate their psychological recovery. This may be due to the fact that the OH Cards can make the children more willing to actively face and treat the trauma brought about by the fracture, which can lead to a change from negative to positive psychology, thus improving the children's coping style.

The current study had some limitations. First, this intervention was a preliminary attempt to use the OH Cards for children with fractures, and it's unclear whether the experimental design objectively reflected the efficacy. Second, the sampling and implementation of the intervention was difficult due to the ages of the participants in the intervention group and to a need to respond to parental wishes, and the amount of data was not substantial.

Third, the duration of the intervention was relatively short, and it wasn't possible to follow the long-term posttraumatic growth of the children to understand the

**Figure 1.** Comparison of Posttraumatic Growth Scores Between the Intervention and Control Groups



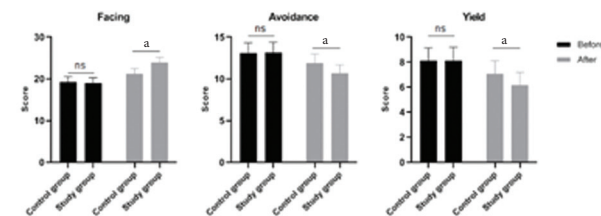
<sup>a</sup> $P < .05$

<sup>b</sup> $P < .01$

<sup>c</sup> $P < .001$

Note: Error bars, SEM; ns, not significant.

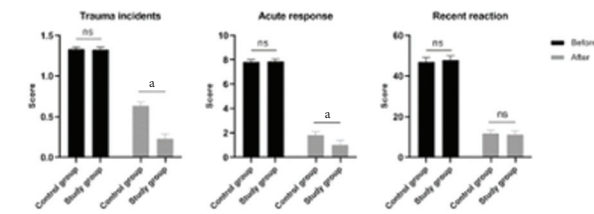
**Figure 2.** Comparison of Coping Styles Between the Intervention and Control Groups



<sup>a</sup> $P < .001$

Note: Error bars, SEM; ns, not significant.

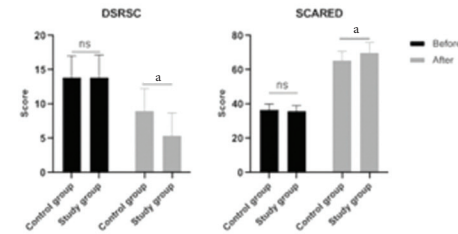
**Figure 3.** Comparison of Stress Disorders Between the Intervention and Control Groups



<sup>a</sup> $P < .001$

Note: Error bars, SEM; ns, not significant.

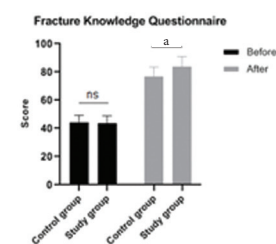
**Figure 4.** Comparison of the Children's Psychological States Between the Intervention and Control Groups



<sup>a</sup> $P < .001$

Note: DSRSC, Depression Self-Rating Scale; SCARED, Screen for Child Anxiety-related Emotional Disorders. Error bars, SEM; ns, not significant.

**Figure 5.** Comparison of Scores on the Fracture Knowledge Questionnaire Between the Intervention and Control Groups



$aP < .001$

Note: Error bars, SEM; ns, not significant.

dynamic psychological changes. The current research team plans to undertake similar studies in multiple centers, beyond the population of children with fractures. In addition, the team intends to extend the follow-up period in the intervention to determine the long-term effectiveness of the psychological treatment for children postintervention.

## CONCLUSIONS

OH Cards can increase the posttraumatic growth scores of children with fractures, improve their coping styles, reduce stress disorders, decrease depression and improve their psychological state, increase their knowledge about fractures, and promote their recovery.

## FUNDING

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