I nearly died..
I should feel grateful..
Why can't I remember?

Psychology on ICU

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Objectives for today

- To think together about the ICU environment, the patient experience and common responses
- Outline the role of Clinical Psychology across the pathway
- Share my experiences of ICU follow-up and bring to life with patient stories
- Signpost to available guidance and suggested service specifications

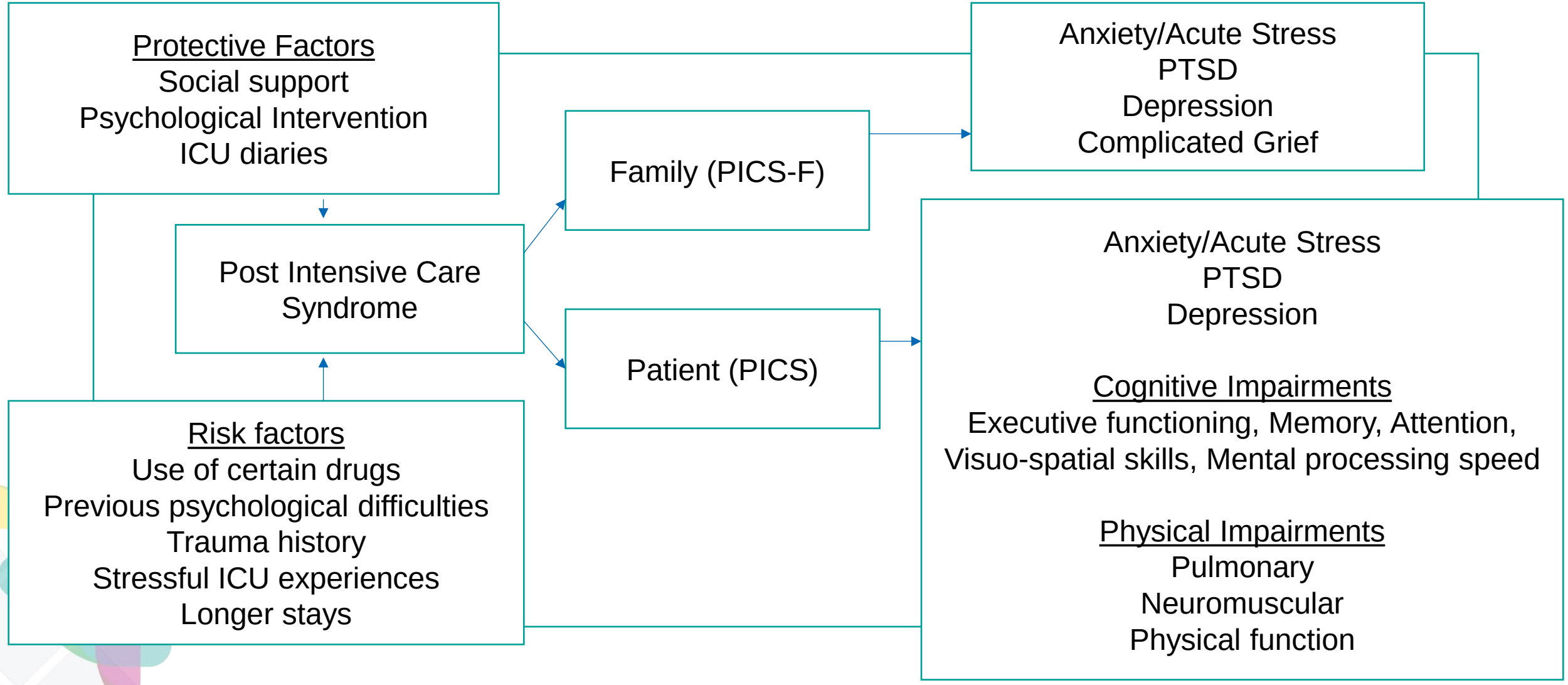
Critical illness

- Involves single or multiple organ failure
- Requires intensive monitoring, mechanical and medicinal support in a critical care unit
- Can be a medical emergency
- Can occur after major trauma
- Can occur after planned major or emergency surgery
- Can be a complication of many long term conditions

Context

- NICE Guidance (CG38) and Quality Standard (QS158) set out the need for psychological assessment and intervention across the critical care rehab pathway
- NHS 5 Year Forward calls for greater integration of physical and psychological services
- Mental Health 5 Year Forward calls for improved access to psychological support services for people with long-term physical health services (including PICS)
- Guidelines for Provision of Intensive Care Services v2.1 (2021)

Post Intensive Care Syndrome (PICS)



Prevalence

- Around half of patients on ICU experience acute stress including unusual experiences such as hallucinations and delusions (Parker et al 2015)
- Psychological morbidity including PTSD, anxiety and depression affects up to half patients (Wade et al 2015)
- Anxiety 25-46% and Depression 29% (Nikayin et al 2016)
- Roughly a quarter of people self report symptoms of PTSD 1-6mnths from admission and 22% at 7mnths (Parker, et al 2015)
- 50% of patients have mental impairment after ICU discharge

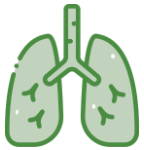
Family members

- 33% of family members have symptoms of PTSD 90 days after discharge
- 70% of family members experience symptoms of anxiety after discharge
- 50% of bereaved family members experience symptoms of depression
- Symptoms of depression and anxiety decrease over time but are still higher than normal 6 months after discharge

(taken from Critical Illness Roadmap by Lee Cutler Consultant Nurse at Doncaster and Bassetlaw Teaching Hospitals)

ICU Environment

Medical interventions
Medical interventions might be frightening, uncomfortable, painful, or all three.



Mechanical ventilation
Being fitted with a breathing tube means that you cannot communicate, can leave you feeling powerless, and puts you at greater risk of becoming delirious.

Hallucinations, unusual beliefs, and dreams
Patients in critical care often have frightening experiences of feeling persecuted, such as seeing things which are not real. These are your mind's attempts at making sense of what is happening to you.

Awareness of your life being in danger
Your 'threat system' being active leads to normal feelings of fear or terror.

Delirium
Delirium is a severe state of confusion. People with delirium cannot think clearly, have difficulty understanding what is going on around them, and may see or hear things that are not there.

Sleep deprivation
Sleep deprivation is a leading cause of distressing psychological symptoms.

Sedation affecting consciousness
It is disorienting to drift in and out of consciousness. Sedative medication can lead to delirium.

Healthcare staff wearing PPE equipment
We are programmed to find kind faces reassuring. A combination of feeling semi-conscious and seeing masked faces can contribute to paranoia.

Restraint
Patients in ICU are very occasionally restrained with safety mitts or soft bandages in order to prevent them from removing tubes or equipment. It can leave you feeling powerless and out of control.

Isolation
Lack of contact with your loved ones can leave you feeling alone and isolated.

Prolonged duration
Some traumatic experiences are over in minutes, but your stay in intensive care might last days or weeks, giving you a bigger 'dose' of trauma.

Environmental factors, such as lighting or the noise of machines
This can leave you feeling disoriented or unable to sleep.

Psychology Tools Critical Care and PTSD, 2021

On the unit

- Screening for delirium and Acute Stress using validated tools to ensure support is put in place early
- IPAT
- Psychoeducation
- Those screened as at risk of developing issues offered interventions
- Psychological assessment to form part of discharge plan

Supporting MDT

- Problem solving with MDT and direct intervention to address psychological factors that can inhibit ability to engage in rehab
- Formulation for each patient to gain shared understanding
- Advise support strategies to prevent and reduce delirium
- Training for staff on communication with delirious or distressed patients
- Interventions on step-down wards
- Follow-up clinics to screen for ongoing difficulties and provision of evidence based therapies

Supporting Friends and Family

- Safe space to explore the impact of having a loved one on ICU
- Provision of psychological first aid to reduce psychological trauma experienced and reduce demands on medical teams
- Provision of psychoeducation about why their loved ones might be acting as they are

Supporting staff

Staff wellbeing essential for optimal patient care

Workplace stress and burnout associated with poorer clinical outcomes, higher error, infection and mortality rates

Impacts on absenteeism, presenteeism and staff retention

- 30% report burn out
- 13% prevalence of PTSD
- High exposure to moral injury

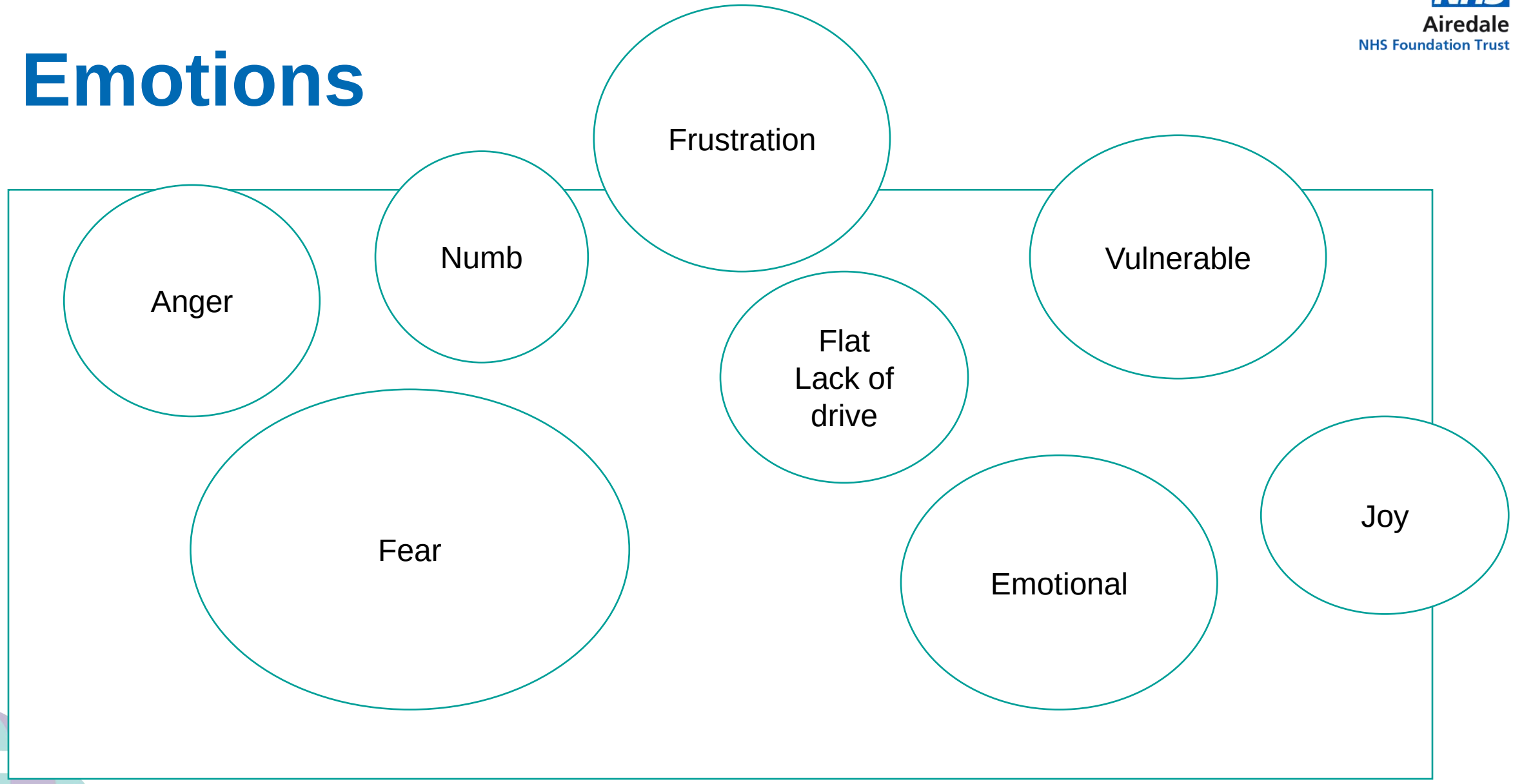
Supporting staff

- Psychological help to process the emotional burden of the work
- Individual and group opportunities to facilitate story telling
- Enable new skills in self care and enhanced care for patients
- Advise leaders on systemic issues that might impact on staff well-being

Follow-up clinic

- All patients with 48hr+ stay on ICU
- Approximately 3 – 6 months from discharge
- Screened with PHQ-9, GAD-7 and PTSS-14
- Run by ICU Consultant, Clinical Psychologist and an ICU Nurse
- Monthly
- Covid Follow-up Clinics – larger MDT including Dietician and Physio

Emotions


Frustration
Anger
Numb
Vulnerable
Flat
Lack of
drive
Fear
Emotional
Joy

Cognitions

I nearly died

Staff are trying to kill or torture me

I'm weak

I was abandoned onto the ward

I'm losing my mind

Why can't I remember?

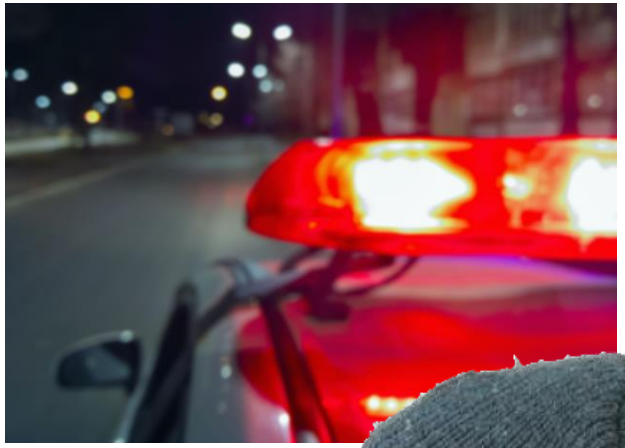
I didn't know I was ill

I can't trust medical professionals

I should feel grateful

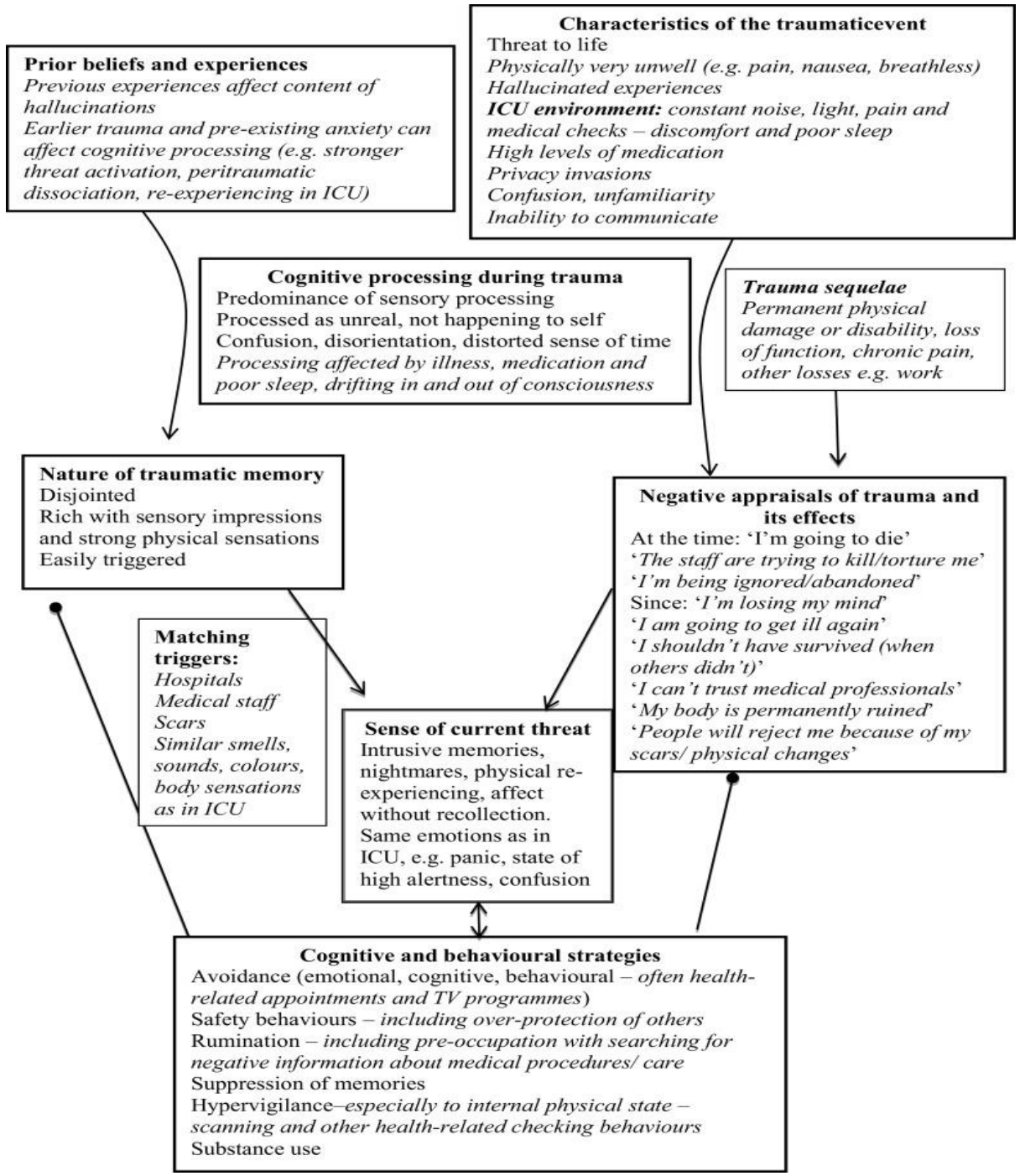
My body is ruined

People will reject me



Making sense

- Depression, Anxiety, Anger, Confidence, Motivation
- **Sense of current threat** intrusive memories, nightmares, physical re-experiencing, affect without recollection, same emotions as when in ICU panic, state of high alert, confusion
- Triggers – Hospitals, medical staff, scars, smells, sounds, bodily sensations from ICU
- Behaviours – Avoidance (emotional, cognitive, behavioural), safety behaviours, rumination (including preoccupation with searching for negative information about procedures etc), suppression of memories, Hypervigilance including internal scanning, substance use


Characteristics of the traumaticevent
Threat to life
Physically very unwell (e.g. pain, nausea, breathless)
Hallucinated experiences
ICU environment: constant noise, light, pain and medical checks – discomfort and poor sleep
High levels of medication
Privacy invasions
Confusion, unfamiliarity
Inability to communicate
Prior beliefs and experiences
Previous experiences affect content of hallucinations
Earlier trauma and pre-existing anxiety can affect cognitive processing (e.g. stronger threat activation, peritraumatic dissociation, re-experiencing in ICU)
Cognitive processing during trauma
Predominance of sensory processing
Processed as unreal, not happening to self
Confusion, disorientation, distorted sense of time
Processing affected by illness, medication and poor sleep, drifting in and out of consciousness
Trauma sequelae
Permanent physical damage or disability, loss of function, chronic pain, other losses e.g. work
Nature of traumatic memory
Disjointed
Rich with sensory impressions and strong physical sensations
Easily triggered
Negative appraisals of trauma and its effects
At the time: 'I'm going to die'
'The staff are trying to kill/torture me'
'I'm being ignored/abandoned'
Since: 'I'm losing my mind'
'I am going to get ill again'
'I shouldn't have survived (when others didn't)'
'I can't trust medical professionals'
'My body is permanently ruined'
'People will reject me because of my scars/ physical changes'
Matching triggers:
Hospitals
Medical staff
Scars
Similar smells, sounds, colours, body sensations as in ICU
Sense of current threat
Intrusive memories, nightmares, physical re-experiencing, affect without recollection.
Same emotions as in ICU, e.g. panic, state of high alertness, confusion
Cognitive and behavioural strategies
Avoidance (emotional, cognitive, behavioural – often health-related appointments and TV programmes)
Safety behaviours – including over-protection of others
Rumination – including pre-occupation with searching for negative information about medical procedures/ care
Suppression of memories
Hypervigilance–especially to internal physical state – scanning and other health-related checking behaviours
Substance use

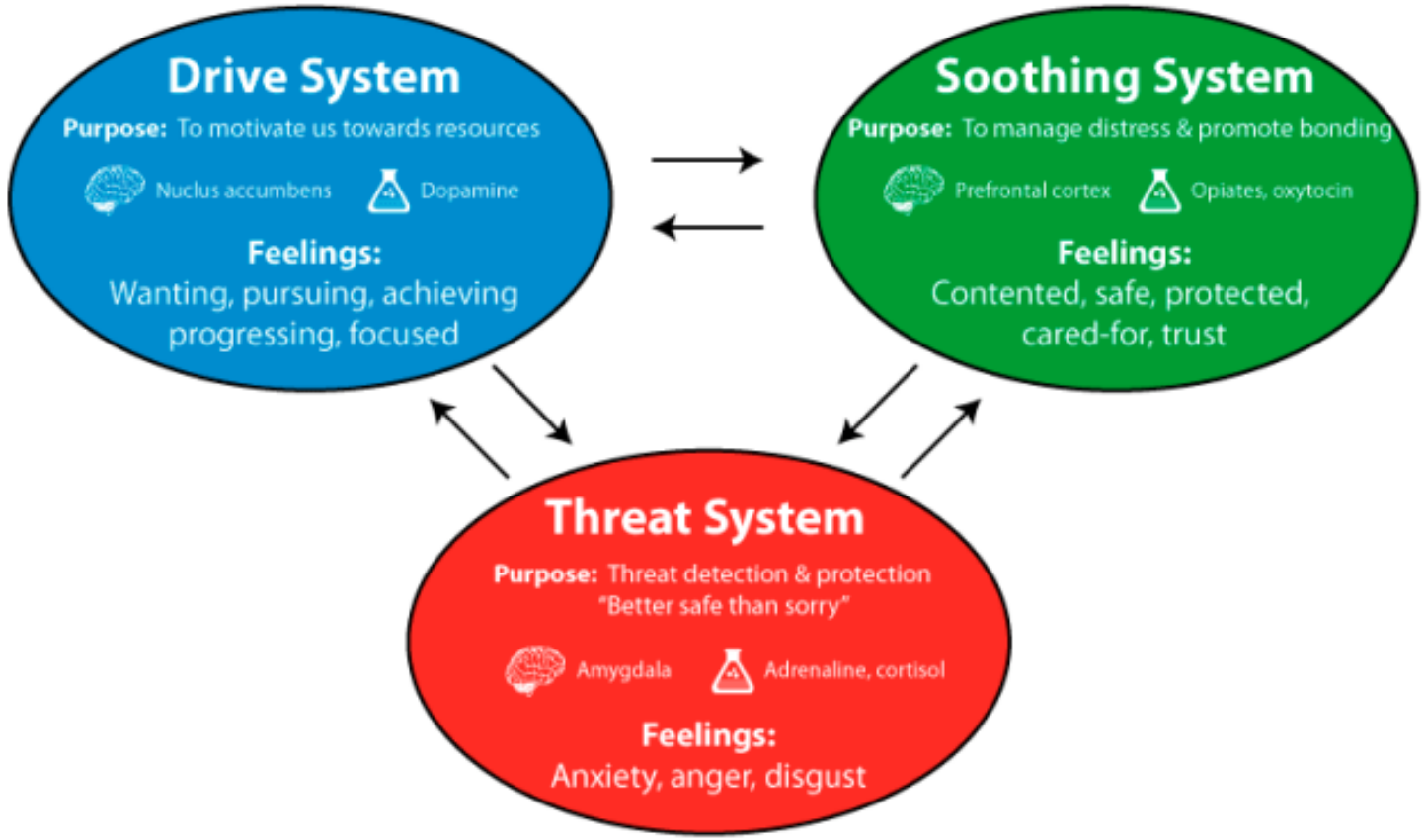
Interventions

- Acknowledge, validate and make sense of strong emotions with a trauma lens
- Psychoeducation around PTSD and ICU
- Can’t stop the triggers but can gain control over responses and reduce the impact and length of flashback
- Grounding and relaxation techniques
- Time-line and patient diary

Compassion Focused Therapy

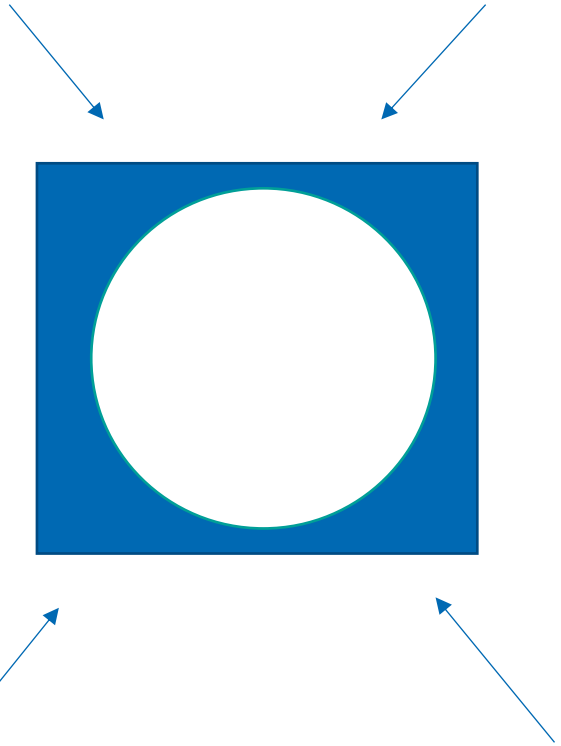
Emotional Regulation Systems

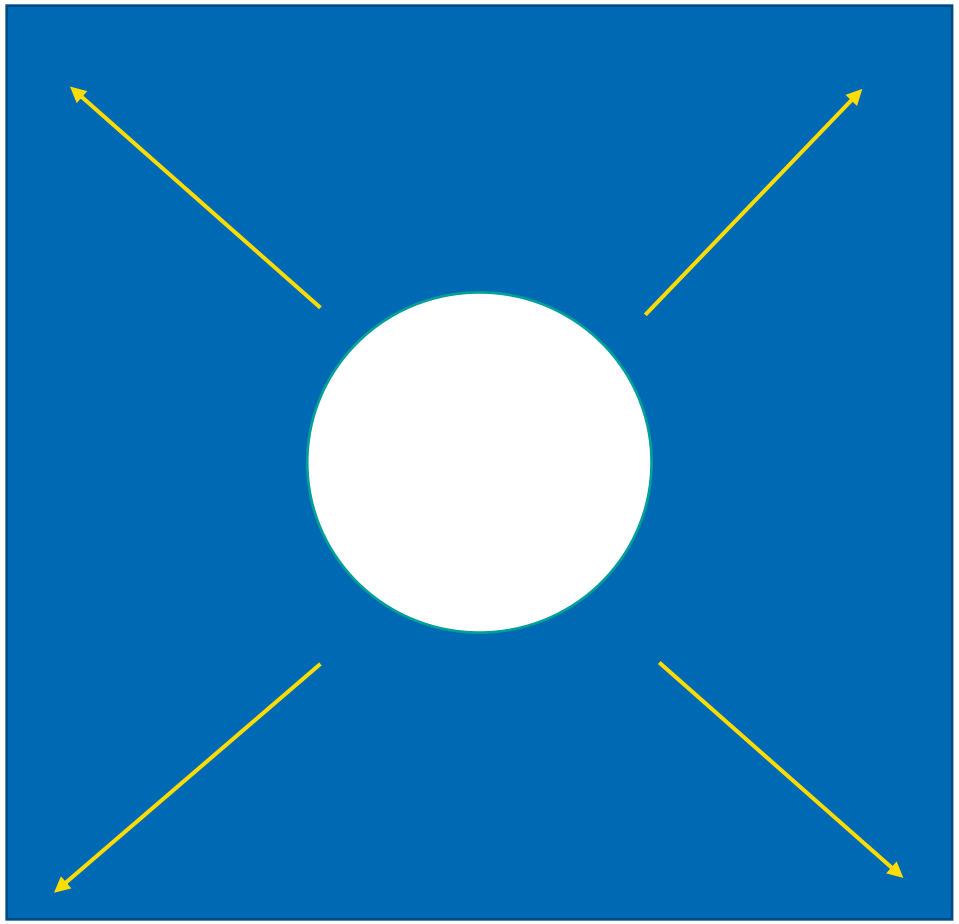
Paul Gilbert's evolutionary model proposes that human beings switch between three systems to manage their emotions.
Each system is associated with different brain regions and different brain chemistry.
Distress is caused by imbalance between the systems, often associated with under-development of the soothing system.



Adapted from: Gilbert, P. (ed) (2005). *Compassion: Conceptualisations, Research and Use in Psychotherapy*. Routledge.

Acceptance and Commitment Therapy





Challenges

- Limited and mixed evidence base
- DNA rate
- Capacity
- Time limited interventions

Feedback

- You have given me back hope...I honestly think I wouldn't be here without your help
- At last I feel like people care, understand and have listened
- It is still there (the anxiety) but I can control it better

Service developments – humanising ICU wrap arounds for the walls, improved discharge information, ICUsteps booklets and information sheets available in family room

Resources and References

Guidance and Service Specification - Integrated Practitioner Psychologists In Intensive Care Units. The British Psychological Society and Psychologists in Intensive Care Network (PINC) (2022)

Guidelines for the Provision of Intensive Care Services V.2 Faculty of Intensive Care Medicine and the Intensive Care Society (2022)

ICUSteps https://icusteps.org

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