PTSD, EMDR & ICU PILOT

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What is PTSD?

- Post-traumatic stress disorder.
- Exposed to actual or threatened death, serious injury or sexual violence.
- The exposure can be direct, witnessed or indirect, e.g. by hearing of a relative or close friend who has experienced the trauma.
- Symptoms for less than 4 weeks post-trauma: “watchful waiting”.
- Symptoms for more than 4 weeks, consider PTSD diagnosis.

Symptoms

- Intrusive thoughts or memories.
- Nightmares related to the traumatic event.
- Flashbacks, feeling like the event is happening again.
- Avoiding thoughts, feelings, people or situations connected to the traumatic event.
- Negative thoughts or beliefs about one's self or the world.
- Distorted sense of blame for one's self or others, related to the event ('survivor guilt').
- Hypervigilance.
- Being easily startled.

What is EMDR?

- Eye movement desensitisation & reprocessing therapy.
- WHO (2013) and NICE (CG26, 2005) recommendation for PTSD, along with trauma-focused CBT.
- 7/10 RCTs have indicated that EMDR is more rapid or otherwise superior to trauma-focused CBT.
- Originally used with veterans.

How Does it Work?

- Based on Adaptive Information Processing (AIP) model: information processing system that assimilates new experiences into already existing memory networks.
- These networks are the basis of perception, attitudes & behaviour.
- Perceptions of current situations are automatically linked with associated and existing memory networks. This metabolizes, digests and allows us to make sense of new experiences.
- Problems arise when an experience is inadequately processed.
- Distressing incident becomes frozen in time, in its own neural network and unable to connect with other memory networks that hold adaptive information.

- Memory is encoded in its original distressing form with the original perceptions.
- This memory can continue to be triggered by reminders of the original trauma.
- Past events retain their power because they’re not assimilated into adaptive memory networks.
- Leads to inappropriate and unhelpful emotional, cognitive, behavioural and physical symptoms.
- In EMDR, changes are made via processing of memories.

Mechanisms of EMDR

- Alternating bilateral stimulation via left-right eye movements or taps.
- Evokes brain state similar to REM sleep:
  - “Sleep on it”
  - Restorative
  - Mops up the days residues
- 8 phase protocol.

ITU Pilot

- PTSD affects between 8% to 27% of ICU patients (Wade et al, 2013), compared to 6% to 8% of the general population (APA, 2013; Pietrzak et al, 2011).
- Pilot ran from 1st June 2016 to 31st May 2017.
- Each EMDR session lasts 90-120 mins. Therefore able to see 3 to 4 patients at a time.
- Screened via Impact of Event Scale (IES)
  - 22 questions, 0 – 4 Likert scale
  - 24-32: PTSD is a clinical concern. Those with scores this high who do not have full PTSD will have partial PTSD or at least some of the symptoms.
  - 33+: This represents the best cut-off for a probable diagnosis of PTSD.

- One of our psychiatrists visited ITU each week for TLC / psycho-education to patients and staff support.
- Letter to all patients who’ve been in ITU 1 month post-discharge, explaining symptoms of PTSD and asking them to either see GP to do IES or contact me.
- Letter to GP along with IES to screen.
- If self-referral, I’ll email IES.

9 Month Overview

- 817 letters to patients/GPs. So would have expected between 65 & 220 responses based on the evidence
- 29 responses:
  - 14 met criteria for PTSD based on their IES-R score
  - 8 failed to return IES-R
  - 5 did not meet criteria for a diagnosis of PTSD
  - 2 with PTSD diagnosis unable to attend BRI weekly so advised IAPT
- Therefore 14 patients invited into therapy
- 3 dropped out after 1-2 sessions and 1 decided not to proceed at all
- 10 completed treatment:
  - Mean IES score went from 62 to 16
  - Mean BDI score went from 25 to 9
  - Mean number of treatment sessions = 5

Considerations

- Good outcomes, but based on the evidence, we would have expected to hear from 65-220 patients!
- Was returning to the scene of their trauma an obstacle?
- Future initiatives should look at how participation in such studies could be increased, e.g. offer therapy on a different site than where the ICU is located, possibly in patients' homes.

References

- Hulme, T. (2018). Using eye movement therapy to reduce trauma after intensive care. **Nursing Times. 114** (3), pp18-21.

- Hulme, T. (2018). Eye movement desensitisation and reprocessing therapy for medically unexplained symptoms: a case study. **Mental Health Nursing. 38** (1), pp10-13.

Thank you.

Questions?