The Role of Critical Care Psychology

Dr Becky Coles-Gale
HCPC Registered Clinical & Health Psychologist
East Sussex Healthcare NHS Trust Critical Care Service

Email: rebecca.coles-gale@nhs.net
1. Context: Why should psychology have a role in the ICU?
2. Our story – bringing psychology to critical care in ESHT
3. Psychology work on the ESHT ICU and 2 strategies for non-psychologists
4. Psychology work in ESHT ICU which requires a qualified therapist
5. Psychology work supporting ESHT ICU staff
Why should Psychology have a role in the ICU?
Policy: NICE Guidance Rehabilitation after Critical Illness

- Assessing for pre-existing psychological issues
- Psychological symptoms that have developed during ICU
- Screening for symptoms of PTSD
- This should be on the unit and before discharge home
Policy: Guidelines for the Provision of Intensive Care Units

- Provide psychological assessment on the unit and after transfer to the wards
- Provide psychological support to patients, families and staff
- Provide training to increase staff knowledge on psychological issues
- Play a role within MDT, ward rounds, consultation integrating psychologically minded care
- Play a full role in follow up care, through follow up clinic and outpatient psychological therapy clinic
Approximately 50% of critically ill patients suffer serious emotional distress – often characterised by anxiety, grief reactions, low mood & panic.

These emotions may relate to a fear of dying, invasive treatments such as ventilation, pain and discomfort, inability to communicate and terrifying hallucinatory delusions.

Up to two-thirds have unusual experiences such as hallucinations and delusions while in the unit.

The hallucinations and delusions experienced by patients in the ICU have been linked to delirium, medication for sedation, the critical illness itself, immobility, and sensory and sleep deprivation.
ESHT ICUs
Our ICU Psychology Story

• Originally ½ a day a week psychology provision into one of the two ESHT ICUs

• Pilot Project 6mths of funding for one day into each ESHT ICU:
  – Inpatient work
  – Outpatient work
  – Follow up clinic
  – ICU Steps
  – Staff Wellbeing
Outcome Data

• Inpatient Data (n=15)
  – Withdraw of treatment
  – Prior mental health difficulties
  – Mood disturbance
  – Life altering illness/ injuries
  – Delirium

• Follow-Up Clinic (n=38)
  – PAS-ICU data

<table>
<thead>
<tr>
<th>Psychological Issue</th>
<th>Mean Score Across the Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression Score (risk =&gt;4)</td>
<td>15</td>
</tr>
<tr>
<td>PTSD Score (risk = &gt;15)</td>
<td>29</td>
</tr>
</tbody>
</table>
Outcome Data

• **Outpatient Therapy Patient Data (n=18)**
  – QoL scores doubled
  – Anxiety and depression scores dropped from moderate to mild range
  – All return to work or found meaningful activity

• **Staff Data (n=34)**
  **Maslach Burnout Inventory**
  53% of respondents strongly identified with experiences of depersonalisation, which reflects a vulnerability to a loss of empathy, or compassion fatigue.
  **The Secondary Traumatic Stress Scale**
  47% of respondents scored over the clinical cut-off, indicating nearly half of the staff were experiencing symptoms of PTSD in relation to their work.

• **Used the outcome data from 6mths project for a business case to take to the hospital board...**
ESHT ICU Psychology Input Now

- One full-time permanent post:
  - Two days at Eastbourne
  - Two days at Hastings
  - One day Follow-Up Clinic at Bexhill/ Admin

- Covers:
  - Inpatient, outpatient and follow-up clinic work
  - Work with families/ relatives
  - Work with staff
  - Teaching
  - On-going service development work
Psychology in the Units
Two areas of work & strategies for non-psychologists

1. Delirium
2. Emotional distress
1. Delirium
THIS IS ME .... This information will help us get to know and care for you

My Name: What I prefer to be called

Hobbies & Preferences :
- Sports
- Programmes
- Music

The person who knows me best: My family/friends & people who are important to me: My Pet(s)

Important things about me... other interests:

Things that may worry or upset me:

I wear: (please tick)

Completed by:
Date:
Delirium Awareness for Families and Friends

Does your loved one seem more confused than normal?

What does delirium look like?

- Lack of concentration and getting distracted easily
- Not being able to respond to a question by getting stuck in thought or an opinion
- Poor recent memory
- Being disoriented to time and place
- Difficulty in comprehending speech, readings, and writings
- Hallucinations (seeing things that do not exist) although these will seem very real to the patient
- Delayed response and movement
- Significant changes in sleep and habits
- Rapid and unpredictable mood changes
- Feeling low in mood, despondent or euphoric without reason

These symptoms can fluctuate and often significantly improve as the person gets better

Did you know that patients in Intensive Care (ICU) can be more vulnerable to developing delirium?

This is due to a combination of:

- Being critically ill
- The medication they are being given
- The disruption to their normal sleep pattern
- Hearing unusual noises around them (bleeps and alarms)
- Being in an unusual environment (the clinical nature of ICU)
- Not being able to easily communicate

How you can help...

1. Remind them that they are in hospital and staff are caring for them
2. Reassure them that they are safe
3. Ensure if they normally wear glasses, hearing aids or false teeth that these are with the person so they can be used when appropriate
4. Bring in small familiar objects from home, including photos of family, friends and pets.
5. Share with the staff the person’s hobbies and interests so we can talk with them about things that make sense on a personal level
6. Talk and read to the person when you are visiting, tell them what you’ve been doing... this can help orientate them
7. Ask staff if you can complete a ‘This is me’ form — this helps staff learn more about your loved one and what’s important to them so we can know them as a person as well as our patient
DELIRIUM

Know the signs and symptoms

They often fluctuate throughout the day, and there may be periods of no symptoms. Primary signs and symptoms include changes in:

- **Perceptions of the environment** such as:
  - Lack of concentration and getting distracted easily
  - Not being able to respond to a question by getting stuck in thought or an opinion

- **Thinking skills** such as:
  - Poor recent memory
  - Being disorientated to time and place
  - Difficulty in comprehending speech, readings, and writings

- **Behaviour** such as:
  - Hallucinations (seeing things that do not exist) although these will seem very real to the patient
  - Delayed response and movement
  - Significant changes in sleep and habits

- **Emotion** such as:
  - Rapid and unpredictable mood changes
  - Feeling low in mood, despondent or euphoric without reason

Know the signs and symptoms

They often fluctuate throughout the day, and there may be periods of no symptoms. Primary signs and symptoms include changes in:

- **Perceptions of the environment** such as:
  - Lack of concentration and getting distracted easily
  - Not being able to respond to a question by getting stuck in thought or an opinion

- **Thinking skills** such as:
  - Poor recent memory
  - Being disorientated to time and place
  - Difficulty in comprehending speech, readings, and writings

- **Behaviour** such as:
  - Hallucinations (seeing things that do not exist) although these will seem very real to the patient
  - Delayed response and movement
  - Significant changes in sleep and habits

- **Emotion** such as:
  - Rapid and unpredictable mood changes
  - Feeling low in mood, despondent or euphoric without reason
2. Emotional Distress

• One of the most important factors is that people *feel safe*

Questions:
• Ask how safe they feel
• Re-orientate ‘you are in hospital and you are safe’
• Ask if there is anything else we as a team can do to increase their sense of safety
Grounding Techniques:

- 3 senses
- visualisation of safe place
- Scent bottle
- Anchoring object
- Message board
Psychology Outpatient Work
Themes in the work

- PTSD – what brought a person into hospital/ hospital procedures/ surgery - anaesthesia awareness
- ICU-PTSD/ PICs – delirium and nightmares-related
- Loss and grief – loss of identity/ role/ purpose/ innocence/ facing mortality/ bereavement
- Emotional distress – lack of safety in the body/ in the world
- Body image – scars/ weight changes/ movement issues
Case Study

- 49yr old woman
- Married with 3 children
- COPD
- Referred when in HDU due to levels of distress
  - Episodes of Hypo- and Hyper Delirium
  - Nightmares
On the Unit Work

• ‘This is ME’ document completed

• Orientation board with photos of family, drawings from her son and affirming messages from staff

• Re-scripting nightmares – wrote reminder on orientation board and shared technique with staff
Outpatient Therapy Work

• Contact made through Follow-Up Clinic

• Asked to be seen by psychology again for support due to level of emotional distress
Assessment - symptoms

- Flashbacks to nightmares and intrusive imagery connected with delirious episodes
  “I was sucked into many dark underworlds each were like personal hells, each were unpredictable and relied on me begging for my life...”
- Hypervigilant
- Limited sleep
- Poor concentration
- Emotionally distressed
- Psychological Formulation: ICU-PTSD
Therapy Treatment Plan

- Psychoeducation about PTSD
- Psychoeducation about ICU-PTSD
- Discussed TF-CBT approach to treatment (one of the NICE guidance gold standard treatments for PTSD)

- And wasn’t having any of it...

“I’m not sure now if talking about it will do any good. I truly believe there are other worlds dimensions ECT. And being in a coma somehow brings you there. There's nothing that would change my mind on that. And its weird. People who experience it online say the same as me”
Six weeks later...

“Sorry to text...can I please get an appointment with you u again. Things just worse. Cant get back to who I was”
Re-Assessment

• I listened more to her narratives of having travelled to other worlds and dimensions whilst in a coma. This led me to explore her relationship to spirituality, faith and existentialism.

• While talking about her spiritual beliefs, she peppered the conversation with information about a very traumatic and chaotic upbringing and the figures that had played significant roles in her family that linked back to the spirit world.

• Importantly, she held strong beliefs about being able to communicate with the spirit world and this being a gift which several women in her family had also held.
Family story seemed complicated so we drew:
1. Genogram
2. Timeline of significant events
   – Traumatic childhood raised by grandparents
   – Reunited with mother age 13
   – Estranged from mother aged 14
   – Reunited with father age 19
   – Estranged from father aged 19

Strong theme that since a teenager she had held strong beliefs and connection with spirit world – used Ouija boards, mediums, tarot cards, measured electrical spirit activity to commune with people who had died.

- Psychological Formulation: A strong narrative of her identity and purpose which themed being connected to the spirit world, this being a gift/skill but now causing a significant sense of vulnerability, isolation, and feeling fundamentally unsafe.
Therapy Treatment Plan No. 2

• Blended together grief work and narrative frameworks for an evidence-informed intervention

• Invited hospital chaplain to join a session and offer a her protective blessing

• In session time writing down each traumatic nightmare in detail and burn to send the experience back into the ether

• Reconnect her with the church through graded exposure

• Revisit ICU (potentially...)
The Role of Psychology and ICU Staff Support

"Well, John, in the past two years you've gone from being extremely depressed to being basically unhappy like the rest of us. My work here is done."
The Role of Psychology in Staff Support: What is possible...

- Individual sessions – work-related issues
- Debriefing – Critical Incident Stress Management model
- Being present on the Unit and offering guidance
- Teaching – in QIGs and quarterly training sessions offering frameworks to understand:
  - PTSD
  - Grief
  - Anxiety
  - Depression
- Articles in the ‘Oracle’ and ‘Psychology Corner’
- Clinical Supervision with Practice Educator