Surviving ICU and the need for psychotherapeutic support

With Laura Barnett

Jenna:
Hello and welcome to our UKCP podcast recorded under COVID-19 restrictions. Current safety measures mean that both psychotherapists and clients are adapting to new online circumstances. Being placed on ventilated support in hospital is one of the most extreme experiences a person can face. In this episode, our CEO Sarah Niblock talks to UKCP psychotherapist Laura Barnett to find out how time in intensive care can affect us. Laura goes on to discuss the sense of mortality ICU can trigger for both patients and their loved ones, and the importance of therapeutic work in alleviating distress.

Sarah:
Laura, thank you for agreeing to be interviewed for this podcast. To create some context to our conversation about COVID-19, could you please describe your career history for listeners?

Laura:
Okay, yes, I trained as an existential therapist, and I still greatly value the dialogue between philosophy and therapeutic practice, both in my personal life and in my professional work, and it has an important place there. And it also underpins the two books that I've edited and the one I'm working on at the moment. In the 1990s, I set up a cancer counselling service at my local hospital in Croydon, and that's how I first came across patients who'd been in intensive care. I can still vividly picture the moment when I came across ITU syndrome, as it was then called, and of the fate of people who have been in intensive care.

Sarah:
I was so interested to see, I mean we're speaking because you've drafted information on your website, specifically to help COVID patients and loved ones make sense of their experience if they do unfortunately end up being in the intensive care unit. Was it your past experience that prompted you to create this resource?

Laura:
Yes, I'm very passionate about this client group. It's been a Cinderella client group for far too long. I mean if you just compare the number of cancer counselling services in hospitals across the country, and you know, with great justification, they're there, to that of a post intensive care counselling service. When I started mine, it was the first routine service of its kind. And there's very little if anything, written by psychotherapists for psychotherapists.In recent years as being the really important resource of the charity ICU Steps, that has a website. But as far as I could see, there was nothing on helping a therapist to work therapeutically with the content of intensive care, vivid dreams and hallucinations, which I believe to be crucial.

Sarah:
And never more so than now. We're recording this as we're entering into a second wave of Coronavirus. You know, I've read your web-materials, and they are absolutely fascinating and very accessible.

And you begin by acknowledging that being on a ventilator is one of the most extreme experiences someone can face. What typically are patient's memories of that experience when they recover?

Laura:
Well, it's one of the most extreme experiences a person can face, not so much because of the actual memories it gives, but simply because without ventilation, the patient would most likely die. And that's what makes it really extreme.

Sarah:
So what practical, physical factors about being in an intensive care unit tend to loom large in people's recollections that require the intervention and support of a psychotherapeutic professional such as yourself?

Laura:
First must remember that patients are likely to be drifting in and out of consciousness. So, they often don't havewhat you could call mental memories, you know, it's more a felt sense. ICU is often experienced as an alien space. So, it is a felt sense of, if not a memory, of being wired up, unable to move, being unable to speak, and sometimes not realising that this is only temporary. And I've known patients who were in intensive care for weeks before realising that they would be able to speak again one day, so that's terrifying. A lot of invasive interventions such as intubation, extubation. In many hospitals intensive care units, there is no daylight. There may be even constant artificial light, I believe in recent years that has changed. Mechanical noises and machines make noises, the peddle bins make noises, night and day. There's often no visible clock, it's very difficult to gauge a sense of time and people might come around and have no idea whether it's the middle of the night, the middle of the day. There's the one-to-one nursing and the dependency on that one nurse, which can be the most wonderful thing, and the most terrifying one, when they get transformed in a paranoid dream. The sense of other people dying around them. And then of course, visitors, or of course, a lack of any. That's one of the most dramatic things of COVID patients.

Sarah:
You've described a situation that sounds incredibly vulnerable, we are reliant on others for our survival. I've read so many interviews with people who have survived COVID and have been put into comas and they each seem to recall vivid dreams and hallucinations, which may even continue once they have left hospital. Can you tell us more about that? And perhaps why that might happen?

Laura:
I think the why of it is not really our problem as psychotherapists, it's not the question we need to ask ourselves. It's one for clinicians and one that some psychologists have engaged with. But to answer your question, I think nobody knows exactly why there are those dreams, but certainly some medications have got hallucinogenic effects, and they're trying to cut down on those medications. There's something to do about oxygen levels also. And, personally, and that is, my question about this, is when I think of the strength that some of those dreams clearly generate. I mean, you have patients who are really sick, pulling out wires, punching nurses, I wonder how much of the vividness of the dreaming is due to the activation of the sympathetic nervous system and the fight-or-flight response? So that is my question. I find that an interesting oneto which I don't have an answer, obviously.

Sarah:
Do patients or clients or service users who survived an intensive care unit spell? Do they remember these dreams?

Laura:

Oh, yes. What I was going to add was, I believe that the principal question for us as psychotherapists is “how do we help patients understand the content of vivid dreams and hallucinations?”, which I think is of vital importance, and when I say vital, I mean, quite literally. And I think it's also a key for a sense of empowerment, and hence a tool against Post Traumatic Stress Disorder. These vivid dreams are commonly referred to as delusional memories, that's a sort of medical term for it, I think. But again, the question is not whether this is real or not, but what was the situation that was addressing the patient and how did they respond. And the situation is that patients on intensive care are between life and death. And the response is fighting or not fighting, or trying to resource oneself, which is a form of fighting. The first thing to say also about those dreams is that they are so vivid, it's impossible for patients often to distinguish between dream and reality. They feel totally real and often terrifying. So, on my website I offers sort of step-to-step approach for trying to make sense of the dreams and therationale for doing so. And I have one text for patients and one for therapists. And I mentioned the come under ten main themes, the two most common of which are trying to escape, and doctors and nurses are trying to kill me. When I first came across trauma therapy, I was sort of gobsmacked because it suddenly made sense of the work I was doing. Because in a traumatic event, the thinking part of the brain shuts down, and you're reacting from an instinctive fight, flight, or freeze or feign death, response. And when the body is triggered into remembering, for instance, seeing a ceiling and feeling spied upon, it goes straight into reliving the memory withjust the images and the emotions, it still doesn't make any sense of it. So, when you can help them make sense of their experience, and, what's more, feel empowered by it, then, that is one of the tools against Post Traumatic Stress Disorder.

Sarah:

Whereas the potential for Post Traumatic Stress Disorder, are there any COVID specific issues that arise for people who have emerged from ICU. I appreciate you're not working directly with those clients right now. But from your perspective, as a professional, I wonder whether you can identify any particular risks that need to be considered by practitioners when encountering such patients.

Laura:

Well, I think the tragedy of there not being any visitors and there's always been anecdotal evidence that intensive care patients who have no visitors at all, it affects their recovery. And so of course, now in a situation where this has been happening automatically. Then all the coming back to or coming from lockdown and self-isolation, the general uncertainty both in the country, I think it gives a very poor container at the moment for anxiety. I see that with clients in general, and in particular with my client’s children, and also the uncertainty around COVID. Will I get long COVID? Would there be other consequences?

Sarah:

What is it like for survivors and their families or loved ones when they return home after weeks in intensive care?

Laura:

Well, it is very difficult to generalise and we must remember that before discharge home, there's likely to have been discharged from intensive care to one or more wards. Each discharge may have been traumatic for various reasons, as indeed, is pre-admission to hospital and admission to intensive care. And we mustn't forget that we mustn't think it's just intensive care.

I think that a number of obsessively distressing questions will have already arisen on the ward and will continue at home like, well, you know, it's a survival. It's a survival from death, but it's a survival for what? What lies in the future? What happened? The sense of lost time, a sense of discontinuity, which is very characteristic of intensive care, because patients can find out what was done to them, because clinicians can tell them, their relatives can possibly tell them, but they don't know what they experienced, what they went through, nobody can tell them what they went through, except these weird dreams if they remember them. 'So, I was x and now suddenly am someone else.' This is very strange, then the why and the 'why me'. And that's where a therapist can help with the sort of not getting tangled in a sort of drama triangle of blaming, and, you know, victim, persecutor rescuer thing. Why me? Which is one of the big existential questions of why and for what purpose? I think home, coming home is obviously a relief - but not obviously if it's not - can be a relief. But also, the familiar may confront a person with what they can no longer do, whether it's temporarily or permanently. If they live alone, that's a difficult situation to manage. If they live with others, how have the dynamics of the relationship been altered? How much toll did it take on the family or the partner? How much are they allowed to be heard as well? For relatives, it's been an emotional roller coaster, and physically exhausting. I think it also depends on what the confrontation with mortality has triggered, both for the patient and for relatives. So, I think that's a lot going on there and a lot of work for therapists.

Sarah:

It's a lot of work for therapists. And I'm wondering if a loved one has tuned in to this podcast, I wondered whether you would have any words of advice or support for them in how to be with their relative.

Laura:

The most important thing is to try and be there and listen to their experience. Allow space for the difficult conversations if they're ready to have them. I've seen a number of patients who wanted to talk about the fact that they almost died, and you know, what if they were to die and relative say, 'oh, would you know, you will outlive us all' and whatever, even when it was someone who's very ill. There has to be space to speak and listen and accept each other's story.

Sarah

You have first-hand experience, and clearly you are a keen advocate for psychotherapy to be provided within the context of ICU support. I wondered whether in light of the pandemic, you have any message that you would like to relay to policymakers or parliamentarians or commissioners that might be listening to this.

Laura:

I think something should be offered and clearly some thought has been given to long-term COVID clinics. But I think that timely and routine offer of therapy just to reassure and normalise and psychoeducate, even one session can make a huge difference to a patient.

Sarah:

Thank you so much, Laura, for this. I wanted to just ask you for the name of your website, please.

Laura:

Yes, it's www.LauraBarnett.co.uk.

Sarah:

Thank you. And there's lots of incredibly useful, and as I say, accessible information there that will throw quite a lifeline to people who are experiencing this.

Jenna:

You've be listening to UKCP psychotherapist Laura Barnett, speaking to Sarah Niblock our CEO. If you're interestedin finding out more about the role of psychotherapy during the COVID-19 crisis, then why not check out one of our previous episodes? We are regularly updating our website with helpful guidance and resources, which you can find by visiting psychotherapy.org.uk. Till next time.