

# PTSD after intensive care: A guide for therapists

## Background

The COVID-19 pandemic has led to vastly increased admissions into intensive care units (ICU). Around one in four ICU patients develop PTSD symptoms after the admission. Other disorders, including depression and various anxiety disorders are also common.

This guide aims to provide information for therapists working with patients who have developed PTSD after an ICU admission, or a similar medical environment.

## Post-ICU PTSD

Various risk factors in ICUs lead to higher rates of PTSD than other medical settings. Besides being critically unwell, patients are exposed an environment of constant noise, light, pain, medical checks, sleep disruption, partial consciousness, reduced ability to communicate and high levels of medication. This places patients at risk of delirium, sometimes including terrifying hallucinations. It also disrupts memory processing, increasing risk of PTSD.

Trauma memories from ICU may relate to:

- Experiences where the patient believed they were about to die
- Moments when the patient learnt bad news, such as realising they had COVID-19
- ‘Flashforwards’ or images of something terrible happening which subsequently become re-experienced as if they are memories
- Invasive (and sometimes painful) medical procedures
- Seeing or learning about other people on the ward dying or acting in a frightening way
- Hallucinations caused by delirium
- A combination of the above. For example, patients may have memories of a medical procedure, which they believed at the time was the nurse trying to kill them.

## Treatment considerations

Cognitive Therapy for PTSD (CT-PTSD) is a trauma-focused cognitive behavioural therapy recommended by the National Institute for Health and Care Excellence (NICE, 2018). It is an effective treatment for people with PTSD following ICU.

For therapists who have already had core training in CBT, further information on how to effectively deliver CT-PTSD, including demonstration videos, can be accessed free of charge on the OXCADAT resources website: [www.oxcadatresources.com](http://www.oxcadatresources.com).

**When treating PTSD following trauma experiences in ICU, use the same elements of CT-PTSD as you would following other types of trauma.**

Here are some additional areas to include:

- *Psychoeducation and normalisation*: In addition to psychoeducation about PTSD, include normalising information about post-ICU PTSD and delirium (if relevant). This is important because patients may have beliefs about their experiences such as ‘I’m going mad’ (especially in the case of delirium) and ‘I should be over this by now’. Include the fact that PTSD after ICU is common (20-30%), delirium during ICU admissions is

extremely common (60-80%), is caused by the strong medications, is temporary, and not a sign of severe mental illness). Arranging to speak to ICU staff, surveys, and patient forums (e.g. [www.icusteps.org](http://www.icusteps.org)) can also be a helpful ways of normalising experiences.

- *Reclaiming your life:* Where significant physical changes and/or lifestyle changes have occurred, emphasise 'rebuilding your life', as a return to some previous activities may not be possible in the same way. You may need to pace and adapt work with your patient to accommodate pain or disability.
- *Addressing the trauma memory:* Where trauma memories are very fragmented, it can be helpful to construct a timeline of the person's stay in ICU, using information from medical records, ICU diaries (which are in use in some units) and recollections from family or friends. Writing a narrative of the memories which are recalled, together with the information from the timeline, helps access hotspots and their threatening meanings. You can use imaginal reliving with updating information to update one hotspot at a time, and also include updates in the narrative in a different colour or font. Updating can be also achieved by asking the client to read out the narrative (or read out to them if they prefer), especially if the client is prone to dissociation or was delirious, by slowly reading out the hotspot and updating information, holding both in mind together.
- *Addressing appraisals of the consequences of the trauma:* For post-ICU PTSD, common themes include: anxiety about health ('I might get ill again'), survivor guilt ('why did I survive and not others?'), permanent change ('I'll never get my old self back'), and beliefs about the delirium experience ('I can't trust my mind').
- *Working on triggers:* Using the 'Then vs Now' technique to discriminate triggers is an important element of treatment in CT-PTSD. As well as visual triggers, look out for triggers which are smells, tastes, sounds and bodily sensations. People may also be triggered by seeing their scars, and by attending medical appointments. Online images, sounds and videos can be used to practise 'Then vs Now' in therapy sessions.
- *Site visits:* ICUs may be able to facilitate site visits, if you contact them first. Returning to the ICU is particularly helpful if delirium occurred, to look for updating information (e.g. the nurses are trying to help people, not harm them), and for clues to understand where hallucinations originated (often real elements of the environment are incorporated into hallucinations). If you cannot return in person, or as a step before a visit, try using video tours of ICUs, such as the one on the Chelsea and Westminster hospital website.
- *Address maintaining behaviours/cognitive strategies:* Including over-protecting others, checking behaviours, ruminating, avoiding looking at or touching scars and so on.

*Be aware that your therapy environment may be triggering for post-ICU patients, especially if you work in a hospital. Teach your patient to use 'Then vs Now' early on, and be prepared to alter aspects of your physical environment to make the patient more comfortable. Offer video or phone sessions for patients who cannot attend appointments in person, especially if they have ongoing health problems or disability. If you are working remotely, encourage patients to keep reminders of the here and now nearby during sessions.*

## PTSD in families of patients and ICU staff

PTSD, as well as other mental health problems such as depression, is also common amongst family members of patients, and the staff who treated them. **Again, CT-PTSD can be used to treat PTSD in these people and is effective.** Common themes include grief, guilt and anger.