PSYCHOLOGICAL ACTIVITIES IN THE INTENSIVE CARE UNIT

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Ospedale A. Manzoni – Lecco

Ma io, sempre estraneo, sempre penetrando
il più intimo essere della mia vita,
vado dentro di me cercando l'ombra.
(Fernando Pessoa)

SUMMARY

The Intensive Care Unit is an area of treatment with high emotive and ethic impact both due to the uncertainty of the therapeutic outcome, as well as the intensive relational involvement, intrinsic to the doctor-nurses and worker-patient interactions. Following this premise, a psychologist started to operate within the team, which revealed three very important features that have been the key explanations of the positive results of the treatment. 1) The 'caring group' becomes the core of the therapeutic work and its breakdown leads to sufferance, conflicts and burn-out. 2) The comprehension of the patient's needs, who perceives his life threatened because his body does not work properly. 3) The help to the family, who is under a constant threat to loose a dear relative.

INTRODUCTION

The psychological work in the Intensive Care Unit is still in its developmental phase, and as its practise is limited, it has not been investigated and even less described.

This short introduction will be used to outline what has been already proposed, to select the most important aspects and suggest the main steps to reach a final picture in which to improve the emotional knowledge in the intensive care unit. The objective of this intervention aims at the person overall, and is not only about the physical aspects but also represents the approach to the psychological features, attention and sensibility about the relational and communicative factors. Therefore, the work is structured as a three-level game between the sick person, his family and the health staff.

1. -Methods and Materials

1.1 - THE THREE LEVELS

1.a - The sick person

Since the first studies it has emerged that, during the stay in an intensive care unit, the most common physiological disorders that the patients can develop are anxiety, forms of depression and delirium, with an incidence estimated between 14% and 72% [1], [2]. Some of the factors that contribute to the rising of these psychological disorders include the need of adaptation to the new situation, the existing personality, the effect that the environment has on the patient's sleep and the type of interaction between patients and the health staff. Moreover, *Rodrìguez et al.* [3] have demonstrated that twelve months after patients are discharged from the ICU, the patients have more health problems, are more depressed, depend on other people and have reduced sexual activity in comparison with other members of the same community.

Different studies show that, until patients are in the intensive care unit, some of them develop an acute state of confusion, known as the ICU syndrome [4] [5]. This syndrome develops as a psychological reaction to the strong anguish of delirium [6]. The increasing critical factors include the extreme instability and vulnerability often perceived as internal extended tension [7].

A loving relationship is an element that can decrease anguish: in fact, caring and affectionate relatives and friends have a positive effect on patients [7] [8]. The attitude of the health staff towards the patients is also a variable that can affect their precarious state: a calm and relaxed approach could decrease fear and tension; on the contrary, anxious and restless behaviour could scare patients [7].

Finally, it has been noted that if the psychological problems of the patients are not approached, the patients' period of confinement in the intensive care unit tends to increase [9]; it is therefore important to make sure that the patient can shorten his stay in the intensive care unit, firstly to improve its long-term psychological state of mind and secondly to reduce the costs of treatment.

1.b – The relatives

Some studies show that the time spent by a patient in the intensive care unit influences relatives about some aspects of personality, family relationship and perception of fear of death.

The relatives could feel fear, emotional shock, scepticism, lack of hope, guilty, persecution anxiety, confusion, etc. [11] [12]; it is true that these forms of reaction only rarely become mental disorders [13]. However, in complicated circumstances (i.e. severe mental and physical consequences due to paraplegia, tetraplegia, amputation, or death), relatives could develop mental symptom similar to post-traumatic stress disorder, various depressive syndromes, phobias and other minor syndromes [10].

Intensive emotional reactions on behalf of the relatives increases the risk of unhealthy behaviour such as inadequate sleep, deficiency of physical exercise and a poor diet [10]. Moreover, they could suffer from cardiovascular diseases [14], ignore their own needs [15], develop a greater use of psycotropic drugs and lower self-esteem [16].

Other authors have also conducted studies about the difficulty to express anger or feelings connected to the aggressive sphere [17]. Finally, it is proved that more than 2/3 of relatives who visit the patients in the ICU feel anxiety [18], whilst more than 50% of relatives show depressive symptoms [13].

If the relatives are facilitated to express sad feelings, their anxiety decreases and their ability to face difficult situations beyond common experience increases [19]. As *Price* argues [8], it is important that the health staff identifies the families that are very upset so they can assist them with additional support.

1.c – The health care professionals

In the literature there are many approaches to the role of doctors and nurses; indeed, daily, these latter actors are subject to emotional tensions, which can favour the onset of psychological difficulties, as well as the burn-out syndrome. This syndrome appears to manifest itself through the loss of interest and through a decrease of working efficiency, leading the doctor or the nurse to

work with emotional detachment, instead of establishing a relationship with the patient. Moreover, they develop somatic, psychological and/or behavioural symptoms, most frequently tiredness, irritability, headache, maladjustment and affective and cognitive disinvestment of objects [20].

An emotional impasse is caused by the lack of autonomy during professional work, overwork, organisational limits [21] [22], communication with patients and their relatives, inadequate resources and shortage of caregivers, conflicts of role and exposure to the family's and the patient's sufferings [23].

These factors all have an impact on the environment where decisions must be made quickly and have a life-or-death impact; this is an environment where uncertainty of prognosis, uncertainty about medical decision making and uncertainty about the length of a disease are ever present [24].

Therefore, these health care professionals face high risk activities, that is to say they always face the real as well as metaphorical meaning of "death" [25].

For these reasons, it becomes vital to understand the psychological needs of caregivers and complaints of family. The administrators couldn't ignore more and more greater need. The presence of psychologist in Intensive Care is our answered.

1.2. THE STAFF

In the light of these events we can understand the requests for psychological intervention on behalf of the medical staff, and in particular, by the nursing unit, by the CPR unit, as well as the more common request by family members. These requests must be taken into serious account by the administration because they represent the emergence of a persisting need, which can no longer be marginalised. As a result to these requests, the Department of Mental Health, through the Simple Functional Structure of Psychology, assigned a psychologist specialised in psychotherapy to the CPR and to the anaesthetic department, so that she could also fulfil her compulsory period as an intern. The basic idea advocated by the coordinator of the Simple Functional Structure of Psychology, who will take on the role of supervisor, was that every intern of the psychotherapy school must present in its curriculum a deep understanding of the contact with the limits of suffering.

The leit motif of this decision, born out of the personal experience of the 5 years spent as a nurse in the emergency room as part of the university curriculum, shows that the observer becomes a participant of the oscillatory experience between life and death, both from the physical and from the mental point of view, bringing us closer to the intense anguish of separation and loss. This further reveals all the individual and group dynamics that are normally well controlled, but that in the edge of life situation explode with such evidence and violence which we don't encounter in other situations. Hence, there could be no better place for an intern to come face to face with this reality and be under supervision.

The psychological unit is composed of one psychologist and a supervisor who is also psychologist; the psychologist, previously trained in the fields of clinical dialogue, diagnosis and observatory methodology, has been in training in a psychodynamic school of psychotherapy; furthermore she also began her work in CPR already having a year of experience from the Hygiene Mental Centre (in Lombardy called CPS, Psycho-Social Centre), where she carried out individual and supervised psychotherapies, also with an observing therapeutic group.

The supervisor is a psychoanalyst from the International Psychoanalyst Association with broad international experience (Clinical and Programme Associate at the London Tavistock Clinic for two years and Visiting Research Fellow at the University of Adelaide for one year) and has a long experience working in hospital, especially in the psychiatric department. The psychologist is actively present in the CPR 14hours a week plus two weekly hours of supervision. The supervisor, apart from the two hours of supervision, also devotes two extra hours on a fortnightly basis for the mixed group supervision, similar to the Bailnt style, which includes doctors, nurses and the psychologist.

The psychologist spent the first two months in the CPR as a simple observer, following the guidelines of the supervisor, inspired by the techniques of the Infant Observation as well as his experience with therapeutic groups. After these two months the real work began and was rooted in the analysis and discussion of the relational reality and the CPR's management.

2 – Building caring group: first steps

The first step was to organize a meeting with psychologists in order to understand the doctors and nurses needs. Standing in a circle, caregivers spoke freely about themselves, whilst the psychologist only intervened to clarify and to keep the discussion to the point in agreement with Bion's ideals of *Esperienze nei gruppi* [26].

This meeting revealed:

- the concern over the emotional suffering of patients and their relatives; the difficulty to be related to in-patients (i.e. spinal cord injury or attempted suicide) and their relatives; the general questions concerning the health of their loved ones ("how long could they remain in a coma?"; "could the quality of life be the same as before?"; "is he suffering?"; etc.). These questions are not only asked to understand the clinical state, but also to be reassured about their anxiety, as patients and relatives impel on caregivers their condition of powerlessness and anxiety. Furthermore, it is important to note that the communication with relatives is more difficult in the first hours of admission because the prognosis is still unknown;
- the problem to control anxiety and aguish as well as to modulate emotions regarding the patients. In this way it is possible to maintain efficiency and treatment. Caregivers are always faced with pain, anguish, death, therapeutic powerlessness. Therefore, the objective is to decrease the psychological suffering of both the patient and the caregiver, in order to help both to manage the emotional and psychological difficulties connected with serious pathology. Nowadays, it is known that loneliness, negligence, pain, anguish, if not rightly treated, affect the broader medical picture, the adaptation to a disease and the therapeutic compliance. Therefore the aim is to offer psychological support to families to accustom them with the idea of possible death, or the time of convalescence, rehabilitation and management of the patient.

In the beginning, the psychologists only observed with the aim of understanding the organization of the unit and to develop the best way to structure their own work in an environment different from the usual, where the classical setting is based on the “external” the internal “internal” approaches.

The former concerns the place of talk (i.e. confidential, pleasant and quiet room); the time (usually not more than 45/50 minutes), appointments at agreed time and place. The request must be made by the patient.

The latter concerns the capacity of psychologist to be empathic, intuitive, capable of grasping the point of view of the other person, but simultaneously without mingling, forcing or curbing the freedom of expression.

3 – The program of intervention

After a month of personal and group meeting as well as constant observation, we agreed on the methodology of intervention with the operators of the CPR, which included:

1. support talks with the inpatients
2. support talks with the relatives
3. evaluation of the inpatient condition with the medical staff
4. talks with the medical staff
5. training meetings

The spatial-temporal organization of this work took place near the inpatients during the free moments from medical checks and possibly in moments of intimacy. The talks with the relatives took place near the inpatient during visiting hours or in the adjacent room where the talks with the staff also take place. For the group reunions we had to book a conference room; these meeting take place at 14,15 to favour those who had done nightly shifts or had just finished their shifts and to establish distance with those currently working.

The following sections will analyse each points of intervention.

3.a – Support talks with in-patients

The in-patient can share with a psychologist his experiences, his affections and his worries. The relationship should reflect specific moments that the patient is going through. Obviously, it is not possible to talk with all the in-patients, because the majority of them are in coma, pharmacological coma or suffer from high fever.

Therefore, this new setting forces the psychologist to revise his internal outlines, because the approach, the mode of listening and the mode of intervention are different compared to usual. Outlines are structures of knowledge, that allow to attribute meaning to what we see, which wouldn't be possible without a grid where we can insert all the events with a temporal, logical or causal order. The main difficulties are not only due to the physical conditions of patients, who can hardly speak – as they are usually intubed or tracheostomized -, but to their general condition which forces them to withdraw, speak little and be indifferent.

The work of a psychologist is to understand if this attitude is caused more by physical pain or by depression. In the second case, the silence is a signal to keep on dealing with them. Patients need to be listened, to be able to express their own fears, their worries, their anxiety; they need to tell their life experiences to maintain their identity, which has been distorted by the disease and by the cure that violates their own privacy.

The objective of the talks is to facilitate the knowledge of news, to contain anxiety, to identify and support internal or cognitive personal resources, to restore mental functions (thought, reflection, creative imagination) altered by the trauma or by the disease.

3.b - Support talks with relatives

Intervention is not classical psychotherapy. The aim is not to reorganize personality, but to "accompany" relatives as auxiliary Ego, or to intervene in order to maintain the same levels of awareness. So, they are helped to recognise, to understand the current realty and pain, to use the family strength and social entourage in the best possible way (i.e. the leader, number of member and good support).

The objects of the talks are actual life experiences, even if the general theme is more close to the concept of incoming difficulties. Many relatives need to know how to behave with children or old persons, to feel reassured over the attitude to patient and to be supported.

Most of meetings are “not structured” as usual “external setting” and occur on-site, i.e. near the bed. The psychologist, on instruction of the medical staff, often goes to the more delicate relatives, instead of waiting for their request.

When it seems necessary, the psychologist proposes a talk in a room (sometime fixed at a special hour and on a special day or immediately) to recreate the classical setting to contain anguish, anxiety, fear; otherwise the person continues to feel abandoned. In some cases, instead, relatives ask to talk with the psychologist. These different ways of intervention depend from the context, where bewilderment and dismay is hard.

Finally, the psychologist follows relatives also when they must decide if to donate organs or not, and after having accompanied doctors during the communication of cerebral death. An inadequate, or even missed, preparation to decide on the donation of organs procurement can facilitate the onset of psychological reactions of refusal, sense of guilty and catastrophic imaginations, both in caregivers and in relatives. These feelings influence firstly emotional availability and secondly, emotional reaction .

The methods of intervention on behalf the psychologist are very flexible because these problems are complex. For example, the relatives of children or of tetraplegics or of very restless patients could remain in the unit. If death is predictable, relatives are informed and, if they want it, they are invited to be near the dying person.

The dead body is left in a room not near to the others for some hours and relatives can sit bedside if they want. In these moments, the psychologist and all others caregivers are present to assist the relatives in a delicate manner, respecting the emotional privacy of death.

Sometimes, health staff puts pressure on the psychologist to assist relatives after death, the transfer or discharge of patients; this is due both to the fantasy of Almighty of group or difficulty of separation and consciousness to lost made work. This suggests the idea of abandonment, but it is necessary for a good cooperation and to contain the fantasy of Almighty.

Usually, when patients are discharged, you give them information about rehabilitation centre, psycho-social centre and so on.

Unfortunately, the psychologist, at the moment, is only present in the intensive care unit one day a week. Hence, the solution would be to create a framework of networking among three psychologists which would be called alternatively in cases of emergencies.

3.c – Assessment of in-patient with doctors and nurses

This moment allows to establish the personal and familiar situation of the patient, and it is used by a psychologist to ponder over the most appropriate type of intervention. This phase belongs to the diagnostic – therapeutic process and it's the starting point to treat illness and family relations.

One of most important purpose is that patient feels that all the group cares about him. The patient only places his trust completely in the caregivers if he perceives to be close to the group: he understands that the group talks about him, thinks of him, and that he is very important to them.

3.d - Support talks with caregivers

The psychologist helps caregivers to understand the need to stand by a patient in moments of difficulty and to elaborate, if needed, problems and/or conflicts that can arise during the relationship with him/her. In each relationship, in fact, you determinate an against-transference situation. Sometimes anyone who is close to another person feels emotions because the patient is feeling them and makes the caregiver feel his emotions. Other times these feelings rise due to our own behaviour and personality. It is important that caregivers know how to recognize these feelings so that they don't overwhelm patients with their own reactions.

Therefore the purposes of these talks can be summarised as follows:

1. to offer a space of communication and conversation, in particular between doctors and nurses;

2. to create a moment of elaboration of powerful thematic (therapeutic appropriateness, limitation of treatment, dignity of death, palliative treatments and so on);
3. to build a “three-dimensional” team, where each staff has assigned duties based on their recognised specializations.

3.e – training meetings

During these meetings, at the beginning fortnightly and then monthly due to the ,other training necessities, the following was analysed:

- clinical cases, to improve the understanding of the relationship with the patient, to learn more appropriate ways of communication and to elaborate not expressed fantasies and experiences of the patient;
- crisis situations, where health staff takes an experience that was incomprehensible, source of anguish or of particular states of mind – expulsion, refusal, disinterest, anger, hostility – showed in front of the patient and consequent sense of guilt.

This type of formative listening facilitates the contact with the own internal world in order to pay more attention to the own distressing experiences, learning to manage them better.

We noticed that these meetings centralize more functions:

1. to put the team on a new and unusual prospect: from hierarchical to group organization.
2. to reorganize daily activities according to what is seen and thus pluralize the vision of one owns work. Points of view could be different when you observe people.
3. to acquire a degree of tolerance through new points of view.
4. to favour a complex reconstruction of events so that all professionals are involved in decisional processes.

5. to help to build an indispensable store of knowledge and psychological instruments, allowing to face and manage the relational problems in the right manner and to improve the quality of life.
6. to develop the same language to share and compare with colleagues who experienced an event together. Everyone would like to possess "breviary of good behaviour" to be sure of their own attitude with the patient. As you know, interpersonal relationships can not be learned in a theoretical way, but must be experienced by living and speaking to allow professional and human growth.

These meetings with doctors, nurses and psychologist of the unit, which take place fortnightly and have a duration of one hour and thirty minutes, are chaired by the coordinating psychologist (who is not part of the group). His job is to stimulate and facilitate interactive and thoughtful dynamics. The working group does not have a closed number. This flexibility allows all professionals to participate in relation to their turns in the intensive care unit.

The participants are invited to tell others what they feel and perceive and to keep in their mind the colleagues' reports, information as well as experiences, and their emotions, what has been or not been shared. All themes are discussed and elaborated again and new reflections are slowly assimilated, time allowing. We think this is the right way to change and to upgrade our understanding of reality.

From the beginning of the second year, we decided to analyse both a clinical case and a crisis situation from a psychological point of view on a monthly basis. We have done this because we perceived the need of a continuous understanding of what is occurring; following this perception we have decided to discuss fortnightly the clinical cases also from the medical point of view. During this meeting, everyone working inside the ward will participate to the discussion including the psychologists, a task that allows us to integrate the three agents of change: technique, relationship and organization.

4 – The results: Data

After a pilot study of nine months during which we have been interested in collecting data, the psychologist started to write on a clinical charts all of his activities and interventions, with the aim of making explicit and operative the three-dimensional working of the team. To write on clinical charts is not only an informative operation but it also acts as a confrontation document, as proof of health performance and as a legal act which binds the psychologist with the other members of the team and certifies his technical and scientific responsibility. As a results, it is possible to read the psychological activities during the last five months, when the psychologist worked inside the ward for a period of 160 hours and conducted 180 interviews with 48 patients and their families, of a duration of approximately 45minustes, sometimes more, sometimes less. Most of the interviews were made with family members, rather than with patients or the medical staff.

These data show a piece of reality in a unit where emergency is the priority, but the urgency of psychological help is also very important, that is the appearance at a specific moment of a need such as a traumatic loss. Sometime the psychologist works both with patients and the family, sometimes only with the patient, sometimes only with families. In some cases the psychologist operates only with the employees. These data allow us to define a simple and highly comprehensible operative trend. However, due to the lack of coherence of the interventions we have not made any statistical speculation, even though the typologies of interventions appear to be hiding interesting data; for example, the presence in the CPR of a child with reserved prognosis as a result of an accident, entailed a high number of interviews with the medical staff. However, the analysis of all the different typologies of intervention requires a long interpretative investigation.

These few data allow us to describe a different form of reality in a unit where medical emergency is the priority, but where there is also a psychological emergency, i.e. the emergence of a need, such as death or the loss of integral mobility of the inpatient, the traumatic loss of a intimate link for the relatives, experiences of impotence and the anguish of similarity (“if he were my son”) on behalf of the medical staff. Even though the concept of

psychological emergency is widely diffused, the idea of having a psychologist on site to help dealing with a traumatic event is also quickly becoming popular.

Therefore, these interventions belong to 2 categories, those temporally and spatially close to the event –maximum 12hours after - and those carried out later to the event. In the latter case the psychologist has time to prepare himself and understand what has happened; he has also time to come closer to the medical staff and maybe even make them carry out the elaborative intervention of emotional state to understand the meaning of anguish and the forms of defence being used.

The interventions spatially and temporally close to the event have a high emotional impact, as they are part of the traumatic event itself; interventions become an integral part of the event and the psychologist's role as a neutral observer vanishes and is replaced with the active role of being a participant of the event itself. The psychologist's sharing of the pain and the anguish becomes one of the most significant aspects of our experience, valued also by the relatives and by the inpatient itself, and often also by the medical staff, demonstrated through the high coordinating capacity of the modalities of emotional interaction.

In fact every traumatic event presents a series of unexpected reactions, because every person in these circumstances loses the capacity to restrain its own 'I', which acts as a reaction to the stimulus of the event in very different ways to its normal functioning. In these cases the psychologist work is a lot harder as he has to develop a strong capacity to manage the unexpected and has to express at its maximum levels its solid base of humanity, rational competence, emotional sensibility and the empathic capacity described by Winnicot. Furthermore, alongside the intervention of the traumatic event, the psychologist's works in the unit, and usually collaborates both with doctors and nurses to assess the mental and/or psychic state of the inpatient. This high-intensive knowledge allows the member of the staff to reflect over important aspects of the inpatient, focusing on aspects of his life, positive intentions, his potentials and so on, with the aim of enhancing the relationships between those who are taking care of him, his life and his internal state, i.e. a collection of fantasies which can become very important for the continuation of the healing process.

The relationship between the psychologist and the medical staff can occur at different stages, depending on the gravity of the pathologies, the requests for help and need of comprehension as highlighted by the inpatients needs and sometimes also by the communication with them.

Therefore, what we are trying to say is that in all of the 48 cases studied, the capacity of the psychologist to aggregate information and emotions, has clearly improved the capacity of expression and communication between the three integral actors of the therapeutic system: the inpatient, the relatives and the medical staff, generating a substantial emotional benefit for all. It is therefore possible to conclude that a three-dimensional operative system – the nurse who takes care of the body, the doctor who take care of the illness and the psychologist who takes care of the emotional state of the inpatient – facilitates the therapeutic perception and configuration of the inpatient as a person, i.e. as the subject and not as the object of the treatment.

5 – Conclusions

This work was not aimed at establishing a universally recognised behavioural model, nor to give indicative or definitive answers, but it has been useful to open a new field of exploration, where non-quantifiable aspects, such as psychology alongside the symbolic meanings that fuel it, has found space and reason to exist in a field so technologically advanced such as the Intensive Care Unit.

What we are trying to achieve is to understand which is the most appropriate course of action to employ with the patient and with the sickness which has disrupted his life-flow, so that we can firstly develop a flexible answer to the new questions posed by the existential reality, and secondly assure a personalised assistance centred around the needs of a specific patient and a specific family. Therefore nor the sickness, nor the patient are to be treated in an isolated way, but rather by taking a more general approach considering

them in a holistic manner, i.e. through emotional, relative, planning, social and operative/working means.

Thus, it is important that the patient, as well as his relatives, is consciously aware of the three-dimensional cure group, so that he is able to perceive the group as a whole, rather than only a doctor or some nurses, and the fact that they are taking care of him. The inpatient's perception of the sharing of information and decisions is in fact translated through a special mode of relationship with himself and with his illness so that he can experience the trust born out of the homogeneity of the team. Thanks to this intense perception the inpatient and his family find the positivenes to be welcomed in an environment that offers them feelings of security and reassurance. It is therefore required that the operators are able to create an "us" feeling within the team, yet still maintaining their own opinions and their own role, whilst continuing to confront each other. Furthermore, teamwork has the aim of promoting individual and collective capacities of growth, in order to experience how to achieve a progress "intended to spur the capacities of thought through transformations connected to different stages and modalities of collective psychological development" [26]. This is only possible if the doctors and the nurses are able to understand what has happened within them and within the group, in a situation which has generated confusion, anxiety, anger and pain; this is useful to build a new framework to help patients, as well as to feel more calm and relieved when confronted with particularly apprehensive situations. The building of the group, as well as the understanding of the interactions with the patient, his sickness and his entourage, have been the leitmotiv of the work conducted up to now. But what awaits us? An objective confrontation of what has really happened within the intensive care unit during the presence of the psychologist.

The topics that require a deepening, or actually a measurement, firstly relate to the acquisition of the meaning of the usage of symbolic language acting as a supplement for

the use of technological language, how this has been internalised and with which courses of actions it has been used, so as not to leave out how this approach to life, profoundly changes the way of thinking and living of the relationships of the operator.

Secondly, we will tackle the evaluation of the changes within the capacity of interaction between operator and operator, as well as between operator and patient; it is important to detect which variables have intervened and which ones have had a greater impact on the relative, emotional and perceptive change of the operator. In fact, the constant presence of a third operator modifies the structure of an organization; however, what is important is to know how this occurs and this is in summary the part of the work that now awaits us.