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Catherine Sideris

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From post-traumatic stress disorder to absolute dependence in an intensive care unit: reflections on a clinical account

Tina Sideris[1,2]

[1]Clinical Psychologist Private Practice Wits Donald Gordon Medical Centre, Johannesburg, South Africa
[2]Research Associate WISER, University of the Witwatersrand, Johannesburg, South Africa

Correspondence to
Dr Tina Sideris, Clinical Psychologist, Wits University Donald Gordon Medical Centre, Parktown 2193, South Africa; tinanded@icon.co.za, tinanded@icon.co.za

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ABSTRACT

This paper tells the story of one man's experience of terrifying hallucinations and nightmares in an intensive care unit (ICU), drawing attention to the reality that intensive care treatment induces emotional suffering severe enough to be identified as post-traumatic stress disorder (PTSD). A body of international research, confirmed by South African studies, links life-saving critical care to symptoms which qualify for secondary psychiatric diagnosis including of post-traumatic stress. Risk factors include pre-ICU comorbid psychopathology. Early on in the clinical encounter with the patient in this paper it emerged that he bore the scars of another trauma. He had been a soldier. Recounting the terror he experienced when he was being weaned off mechanical ventilation evoked memories of his military history. Paradoxically, these shifted the focus away from the symptoms of PTSD, to make the helplessness and dependency of ICU patients more visible. This patient's clinical account and patient experiences in other studies reveal the relational vulnerability of ICU patients. In as much as experiences of ICU treatment can be terrifying, the non-response of carers distresses patients. This interplay of wounding and care provides a starting point from which to explore how we account for the neglect of relational care that is a recurring theme in medical contexts, without blaming the carers. These questions find resonance in a South African novel to which the paper refers. A novel about war and trauma movingly portrays the internal conflict of the central character, a nurse and her quest not to care, as a defence against vulnerability. In these ways writing about the relational vulnerability of patients opened up questions about the social and institutional context of carer vulnerability.

INTRODUCTION

At the launch of the University of Free State's research project, 'Wounds of History', the interests of the project in trauma, healing and trauma narratives were located in a novel titled *Kamphoer, The Camp Whore* in its English translation.[1] During the Anglo Boer War, a British soldier rapes Susan Nell, the central character in this book. Years later as a nurse in England working with World War I shell-shocked soldiers she comes to face her rapist, now a patient. Wondering what she would do, the author describes a poignant scene, where having taken the patient to the countryside, she takes his hand and brings it to the scar his attack had left. In his introduction to the launch, author Francois Smith highlights the ambivalence in that gesture.

> What was happening in that scene, as far as I can say now with hindsight, is that it was ambivalent, it was a mixture of abhorrence and intimacy. And maybe that approach to a scar is still meaningful today.[1]

Reflecting on the physicality of the image, chair of the research project, and trauma expert, Gobodo-Madikizela points to the desire that victims have for recognition of their pain; not only in words, but in the wish for the other to experience the pain, 'touch it, feel it'.[1] In this way she identifies the embodiment of trauma, the physiological and corporeal register of overwhelming events.

Why introduce a paper on intensive care treatment, with reflections on this scene out of a book on a survivor of rape nursing traumatised World War I solders?

This paper tells the story of one man's experience of terrifying hallucinations and nightmares in an intensive care unit (ICU). Constructed in clinical encounters, his story draws attention to the perplexing reality that intensive care induces emotional suffering severe enough to be identified as post-traumatic stress disorder (PTSD). Early on in the encounter with this patient, it emerged that in addition to his terminal illness he bore the scars of a different trauma. He had been a soldier, a reminder that violence and conflict remain close to the surface in South Africa. Apart from this convergence of medical context, the themes of war, trauma and trauma stories, it is the complex interplay of wounding and care in the novel *The Camp Whore*[2] that resonates with this paper.

Paradoxically, the meeting of this patient's combat history and medical technology unfolded to raise questions about ICU-induced PTSD. On recounting his terrifying experiences in ICU, he recollected an experience of callous indifference when he was a soldier that left him distraught. Surprisingly, the experience did not involve the shocking scenes of violence and injury that we have come to expect of military memories. Instead, he recounted being rendered helpless in the face of danger to an intimate other. The contextual and relational dimensions of his ICU distress, and this historical association, raised questions about whether the category PTSD is sufficient to conceptualise what happens in the ICU. At this level then, the trauma evoked in *The Camp Whore* serves as a counterpoint to the narrative of PTSD in the literature on ICU. Indeed the question arises whether trauma, but more particularly PTSD, has come to be too easily applied to all manner of suffering.

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The scene referred to by Francois Smith in his opening reflections highlights our vulnerability to each other. Wounding and care coincide at the intimate borders of our bodies and relationships. Trauma of human origin transgresses personal boundaries, and healing requires intimate acts of care.[1] In as much as experiences in ICU can be terrifying, the perceived non-response of carers distresses patients. By shifting the focus away from the diagnosis of PTSD, the relational vulnerability of patients becomes more visible. But, it is our shared human dependency that provides a starting point from which to think about what happens when needs are not met, and how we account for the non-response.

So, how do we account for the neglect of relational care that is a recurring theme in medical settings? What happens in the relationship between nurse and patient that suggests a failure to be moved by the suffering of another? If personal and social histories elaborate patients' experience of illness and treatment, then it is important to reflect on how personal and social histories might affect nurses and their practices of care. And what mixture of moral conflict and abhorrence might be evoked by the intimacy that caregiving requires.

The Camp Whore[2] movingly portrays Susan Nell's internal conflict, between caring nurse and vengeful aggressor, and her quest not to care, as a defence against vulnerability. Reflections on the account in this paper, and on patient experiences in other studies, provide food for thought. Decontextualising care, and the carer, can lead to unhelpful blaming. So in the writing of this paper, thinking about the patient's vulnerability, opened up questions about the social and institutional context of carers' vulnerability.

While narrative theorists ask what drives us to tell particular stories, a psychologist might ask, what is of interest about this case? It is important to note that the account presented in this paper is not a case study. As a clinical account, it is one among a range of possible stories about patient vulnerability and ICU-induced distress. An unexpected association provided the stimulus for raising questions about PTSD in ICU. However, the paper neither repudiates nor disaffirms the use of PTSD in the critical care, and biomedical contexts more generally. More inclined towards what Viney *et al*[3] propose, the paper encourages reflexive practice. That the complexity of human suffering exceeds the interpretive capacity of any one discipline, and any single concept, is implicit in this paper.

An assemblage of prevailing narratives and personal interests exerted a push to write this account.[4] The patient and his family cast the terrifying experiences he had in ICU in terms of PTSD. He encouraged this writing about his experience because he felt that all patients in ICU should receive psychological support. For him, the connection between motivating for psychological support to ICU patients and writing by a professional was implicit. For a psychologist with an academic and clinical background in war trauma, this patient's history of combat-related distress sparked concern. Writing provided an opportunity to reflect on how personal histories and medical technologies meet to complicate the distress of critical illness and ICU treatment. Finally, the thread of helplessness in his distressing experiences pointed to a concept through which to explore a long-standing interest in relational care and its neglect in medical settings.

The first clinical encounter

'I see you've done research on trauma in situations of war', said Mr G, as he entered my room. His wife entered with him. Immediately after he spoke, she said, 'Our son is also a psychologist.'

Had he taken a special interest in my research because his son was a psychologist, I wondered, or had something transpired in his life? Mr G was consulting me to discuss his medical condition and treatment. He had been diagnosed with end-stage liver disease and informed that, without organ transplantation, death was certain. Psychological consultation is one element of the multidisciplinary series of investigations that precede being placed on a waiting list for transplant. I made a mental note to ask whether he had experienced combat-related trauma since the physical and emotional challenges he was facing could well open old wounds.

Four months past his 59th birthday, Mr G looked surprisingly well in spite of his condition. He was a tall man, dressed in casual blue jeans and a checked shirt—simple, uncluttered clothing. With no hint of grey in his hair and smooth skin, he looked somewhat younger than his years. His skin and eyes did not have a yellow tinge, the symptoms of jaundice that often accompany liver failure. He was composed and communicated clearly. He was well oriented to his environment: he knew the time, date, month and year, and where he was.

Despite this apparent wellness, the suffering he endured became clear when, pointing to his abdomen, he complained, 'I hate the ascites. I'm so uncomfortable. It's difficult to breathe.'

It was easy to understand why he complained of discomfort. His belly was large and distended, the flesh stretched tight across it.

> There's not much pain, but I'm bloated. And I feel so tired and weak. I've had several litres of fluid tapped, but it just builds up after a few weeks. And what bothers me is sitting, not knowing what to do, waiting.

The accumulation of fluid in his abdominal cavity was no longer responding to diuretics. Symptomatic of advanced liver disease, the ascites had brought on a hernia, a common complication. Fortunately, he had no infections. Extracting the fluid via an abdominal tap provided temporary relief. But rapidly recurring ascites was beginning to feel relentless. Mr G was at high risk of progressive deterioration while he waited for a suitable organ. As his body broke down, the discomfort would continue unabated.

After we had discussed the background to his referral, biographical details and life circumstances, the question of previous experience of adversity, severe stress or trauma came up. His interest in my research on trauma in situations of war was telling. He said he had been in the military. Instead of relating incidents or experiences, he described his behaviour and emotional state after completing service.

> I was aggressive, impulsive, short-tempered and withdrawn; too many war stories. What was that all about?

He was not asking a question. It seemed more of a comment on the senselessness of the time he had spent in the military. Without pausing, he moved straight on, to talk about his last admission to an ICU.

> In 2009 I had variceal bleeding. I lost consciousness. They diagnosed me as having a panic attack. After being discharged, I had post-traumatic stress reactions. I took tranquilisers but stopped after a few months.

Once again Mr G gave the bare minimum of information and revealed little emotion. Minimising the gravity of events, and the anxiety they evoke, is not an unusual way of protecting our

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psychological integrity. Some months after the initial consultation, he reflected on his anxiety in ICU.

> Probably normal as I was busy bleeding out. I was rattled by the haemorrhage. But I was very upset a few days later when I found out that I had liver cirrhosis.

Yet, his internal bleeding must have been terrifying. Liver scarring reduced the blood flow through his liver. As more blood flowed through the vessels in the oesophagus, stomach and rectum, these vessels became enlarged—varices. He haemorrhaged when the varices ruptured.

Mrs G had remained quiet since mentioning their son was a psychologist. At this point she intervened. A tall, slender woman, she calmly described intense anxiety in her husband during his admission to ICU. Without changing her expression, she said he had hallucinated. Her composure did not mask the traces of deep concern in her voice, as she questioned how he would cope with ICU treatment at the time of an organ transplant.

ICU-induced PTSD

The visible, usually dramatic symptoms of organ failure, the agonising experience of collapsing of physiological functions and the portent of death render critical illness stressful, and for some emotionally overwhelming. However, it was evident that Mr and Mrs G were concerned about, and associated the treatment in intensive care with traumatic stress. This is not as strange as it might seem. A growing body of research links life-saving critical care treatment to symptoms of post-traumatic stress.[5–8] In her literature review, Trubshaw refers to the call for a disease-specific assessment tool, in which ICU admission is the disease (p. 14). Stayt reviewed studies showing that the majority of patients found the ICU experience 'terrifying' (p. 44).[9]

South African research confirms the findings that ICU treatment leaves patients with symptoms, which qualify for secondary psychiatric diagnosis.[10 11] Hatchett administered structured interviews to patients who, between them, had an average stay of 3 days in the ICU of an academic hospital. Of the 98 people who participated in the study, 58% had symptoms of anxiety and depression severe enough to indicate clinical disorder; 32% presented with PTSD.[11]

Treatment in ICU includes the drugs administered; the use of drips; mechanical monitoring of heart rate, blood pressure and oxygen saturation; mechanical ventilation and hands-on medical interventions. A systematic review of literature concludes that factual memories of ICU, even unpleasant, are protective 'against the anxiety caused by retention of unreal memories and the disruption in visual and auditory processing by sedative drugs' (Trubshaw, p. 22).[7] She reiterates that the recall of delusional memories is a factor in the development of PTSD.[7]

On the basis of data collected, other researchers make a strong argument that the delusions and hallucinations induced by pharmacological treatment, sepsis and physical illness are the cause of trauma.[6 12] In their study, Wade *et al* found that the patients were more traumatised by frightening delusions and hallucinations than by real events.[12] Di Martini *et al* went so far as to argue for the extension of the criteria for the diagnosis of PTSD to include psychically induced experiences during a life-threatening medical illness (p. 436).[6]

Parker and colleagues conducted a meta-analysis and systematic review of literature on data from >3400 patients. They synthesised the data on patient-specific and ICU-related risks factors for PTSD, health-related quality of life in those with PTSD and the effectiveness of treatment and interventions.[8] They found that one in five patients experience clinically important PTSD symptoms in the 12 months post-ICU and these patients have worse health-related quality of life. They note three variables associated with PTSD in ICU survivors, the use of benzodiazepines, pre-ICU comorbid psychopathology and early memories of ICU frightening experiences. Diagnosis, severity of illness and length of stay in ICU were not consistently associated with PTSD.[8]

Commenting on the review, Davydow pointed out the variability of methods used to ascertain post-ICU PTSD as a limitation to reaching a definitive understanding of risks for PTSD in critical illness survivors.[5] Nevertheless, he noted that the review by Parker *et al* confirms that PTSD symptoms are 'alarmingly' common with negative effects on quality of life and increased costs to healthcare (p. 1152). He called for ongoing research, which should include assessment of the efficacy of interventions to reduce psychiatric morbidity.[5]

PTSD is neither a natural nor an uncontested category. A reading of the periodic changes in the diagnostic criteria reveals the social making of a psychiatric diagnosis. Since 1980, when PTSD was first listed in the third revision of the American Psychiatric Association's Diagnostic and Statistical Manual for Mental Disorders (DSM-III),[13] the criteria have been fully revised three times.

With a view to getting federal government support, psychiatrists, social workers and veteran activists urged DSM compilers to recognise the effects of the Vietnam War. Specialists working with adult survivors of sexual and domestic violence and child abuse, as well as holocaust scholars, joined the veteran activists in the move to have psychological responses to extreme experiences recognised as a psychiatric disorder. In 1980, the DSM listed the stressor criterion as 'the person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone.'[13] For Vietnam Veterans, and for those working on violence against women, PTSD served an important political purpose.

Since then, debate about what constitutes a traumatic event is ongoing. Revisions leading to the DSM-IV and the DSM-IV R specified traumatic events that involved physical harm to self, or harm to others. Violent physical assaults included torture, kidnap and mugging. Natural or man-made disasters included floods, earthquakes and bombings. Transport accidents and exposure to war were also specified. DSM-IV added a subjective component to the stressor criterion, specifying that individuals had to respond to the event with intense fear, helplessness or horror.[14]

In 2013, 33 years after the DSM-III, the latest revision, DSM-5, once again redefined trauma. The traumatic stressor is defined as exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence. Indirect exposure is defined as learning about the violent or accidental death or perpetration of sexual violence to a loved one.[15] Exposure through electronic media, radio and television is excluded. DSM-5 eliminates the subjective response on the basis of the argument that in the DSM-IV-R the subjective response focused on fear to the exclusion of other possible emotional responses, such as shame. Clearly, the specificity of the stressor is not easily resolved. Indeed, there is some debate about whether much weight should be given to external stressors.

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Postoperative clinical encounter: mechanical ventilation, terrifying nightmares and hallucinations

Mrs G's concerns about the risks to her husband's mental state at the time of organ transplantation were well founded. About 6 months after our first clinical meeting, he received an organ. His transplant surgery was relatively uneventful and he was recovering well. After surgery he was cared for in ICU. From there he moved to the High Care Unit, and once considered stable enough, he was transferred to a general ward. This constitutes the pathway to recovery, the general ward being the last stop before discharge. Shortly after his transfer to the general ward, Mrs G phoned to request a consultation for her husband. Once again, her calm and composed manner was striking, as she explained that he was showing signs of post-traumatic stress.

Mr G was alone in a single-bed, T-shaped room, on the far end of the ward, tucked away from the nurses' station. His room was quiet, almost silent compared with the din and bustle of ICU and the High Care ward. The window in the horizontal wall let in the warm light of a summer day. He sat on a chair in front of the window, still dressed in the pale blue hospital gown. Free of drips, pipes and machines, he looked well. He nodded politely to my greeting, but was distant and detached. Unlike our previous encounter, there was barely any emotional connection. If anything, he seemed irritated. His response to the concern expressed about his mental state was consistent with his tendency to minimise.

> Your wife phoned to say she was worried about you. She asked me to come and see you.' I pulled up a chair and sat opposite him.
> I'm a bit emotional.

I nodded, but remained silent. Working with patients at the bedside can be challenging for psychologists and psychotherapists. Hospital wards are impersonal and lacking in privacy. Steel beds, drip stands, wall-mounted oxygen outlets, grey epoxy food trays, latex examination gloves and surgical masks clearly define the place as biomedical. This is in stark contrast to the psychologist's private consulting room, a familiar therapeutic space, with rules that are applied within its boundaries, to provide a sense of purpose and safety.

In the hospital, families, doctors, nurses or other professionals make the referral, leaving the patient's choice an open question. If there has been previous contact with patients, this has usually been for assessment rather than to establish a psychotherapy contract, as was the case with Mr G. Generally, the hospital patient is going through or has lived through extreme pain and suffering, which does not easily find expression in language, the currency of the psychotherapies. The pull to fix things, to make better, or to reassure, can be very strong. Of course, this defence against professional helplessness only leaves patients feeling misunderstood. Caring about, and for, requires us to honour the awfulness.

Sometimes the most important thing we can offer is our presence.[16] I have sat in stillness with a patient, who, after emerging from massive surgery, regressed to a preverbal state and was mute. Every now and again a reminder that I was there elicited a tear or a glance of recognition. In several meetings, we sat together in silence until she recovered her speech.

I sat quietly with Mr G for a few minutes after his terse admission of being emotional. From what his wife had told me it was evident that Mr G had referred to distressing events in ICU. I recalled what he had told me about his previous ICU admission when he was haemorrhaging. It was important to find a way to allow him to talk about his recent ICU experience.

Structured questions can be a way to approach sensitive material before moving into the intimacy that a discussion can involve. It seemed appropriate to use the Intensive Care Psychological Assessment Tool, made up of 10 questions asking patients about their stay in ICU. There are three response choices: A, no; B, yes a bit; C, yes a lot. The compilers who tested this questionnaire on a large population, to validate it for detection of acute stress, and to predict risk for future psychological distress, determined that a score of >7 was significant.[12]

According to the criteria used in this assessment tool, Mr G scored well above the cut-off point for significance. After going through the questions, we sat in silence again for a few moments.

Then, sitting very still in his chair, Mr G's face softened and tears welled up in his eyes. Slowly, he started describing the experience of being weaned off the mechanical ventilator.

> After the op, I had lots of hallucinations, horrible dreams, they stopped the pain medication. I was very grateful to be out of the op and in the ICU.

Although controlled, the emotion in his voice was intense and it moved me.

> Then I was feeling someone is killing me. I was feeling the whole country is experiencing pain. I was fighting the ventilator. I thought I was dying forty times. It's like somebody is strangling you, a sensation of suffocating. I wanted to say stop, pull the tube out. I was grateful to be in ICU.

Mechanical ventilation is a life support system that uses a machine to help individuals breathe. This treatment is used when people are unable to breathe, well enough on their own due to injury of the brain or spinal cord, severe physical weakness, respiratory failure or metabolic instability. The endotracheal tube attached to the mechanical ventilator that controls inhalation and exhalation is inserted through the mouth into the larynx—the voice box. This means that, if you are mechanically ventilated, you cannot speak.

For her doctoral research, Samuelson interviewed 250 patients 5 days after and then 2 month after discharge from ICU, to investigate their perceptions of endotracheal tube-related discomfort.[17] General discomfort and inability to speak were the most stressful and remembered events in her patient population. Forty-one per cent of the patients she interviewed remembered being extubated or being weaned off mechanical ventilation.[17]

Weaning was explained to me in layperson's terms in the following way (Hatchett, M 2017). Discontinuation, or what is generally called weaning off mechanical ventilation, involves two processes. There is a complex assessment of the body's stability, including blood pressure, neuromuscular strength, and cardiac and lung function. At the same time, the patient's capacity to resume breathing is tested. Patients may be immediately shifted from ventilated support to spontaneous breathing. In other cases, weaning can take days, during which there is gradual, and on and off, withdrawal of support.

The number of breaths per minute controlled by the ventilator is reduced so that the patient can take over breathing. At the same time, chemical agents that support sedation are reduced. In the rare cases in which agents have been used to induce muscular paralysis, these are stopped. During this process, it can happen that ventilator and patient breaths are not synchronised. As a result, patient and ventilator fight for breath, sometimes taking a breath at the same time. When this happens the patient, unable to breathe, experiences sensations of choking, sweating and fear, the same feelings that are associated with panic.

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It is not possible to fully access the subjective experience of another. Under normal conditions, we engage in common worlds and share languages, which allow us to, more or less easily, understand each other. Extraordinary experiences exceed familiar interpretations. This does not mean there is no resonance. Whether we apprehend the other's experience via analogy, projection, introjection, empathy or non-verbal affect-laden communication is the subject of complex theoretical debate.[18] Some find common ground in the role that bodily sensations play in this process of attunement.[19]

As Mr G recounted his nightmares, sensory hallucinations and the experience of strangulation, a palpable sense of dread emerged in the space between us. I felt a tightening of the muscles across my chest and back.

'The dreams were horrible', Mr G continued. 'I dream I'm getting a clot, and it's getting bigger and bigger and it's going to pop. Dreaming, I woke up in pain and I wondered why everyone isn't reacting, they must all be feeling the pain. I was in the right place. But I was not being told what is going on. Just tell me what is going on. Just tell me what is going on.'

Chemical agents used to optimise ventilation, reduce anxiety and manage pain are known to cause bizarre dreams, hallucinations and disturbances of thought. Persecutory dreams are commonly reported. In a study of critically ill patients in the ICU of a Johannesburg academic hospital, Bokaba reports that patients dream of staff kidnapping them and trying to kill them.[10] These themes, being kidnapped, being chased and of someone trying to kill one, are reported in literature that quotes dreams of patients from various geographical locations.

The psychodynamic significance of the dreams of delirious ICU patients is not extensively researched. However, the nightmares and hallucinations are neither arbitrary nor meaningless ravings. In his research on dreams after traumatic events, Hartmann[20] argues that dream imagery contextualises emotions. Dreams of being chased to be killed, contextualise emotions of fear and terror. Equally, the dreams in ICU reflect elements of the environment. For example, patients dream of the bed as a coffin. Sounds take on meaning, for example, 'the slamming of a metal cabinet door became a gunshot' (Andrews).[21]

In some cases, the dreams seem to represent the struggle that illness involves. For example, Bokabo recounts the dream of a patient, 'walking on air to a faraway destination that they never reached, and they felt very tired, as if they were really walking' (Bokabo, p. 52).[10] After major surgery, a patient who had been a construction worker before he went into liver failure recounted the disturbing dream that he was repeatedly being forced to do hard labour, despite protesting that he was too weak and sore.

After spending up to 3 hours a day at the bedside of a delirious patient, Sacks, well known for popularising the neurological case study, says he began to see how:

> … fact and fantasy were admixed in the hieroglyphic form of his delirium, how he was reliving and at times hallucinating the events and passions of a long and varied life. (Sacks, p. 181)[22]

It is evident that the dreams and hallucinations that occur in ICU are accompanied by overwhelming affect, and shock the capacity to make sense. Mr G listened quietly as I acknowledged the horror of his dreams and hallucinations, and tried to provide him with a sense of emotional safety by contextualising his experiences. Giving him information about the feelings he might expect and outlining strategies for seeking help seemed to comfort him.

After some minutes of silence, he went on to reflect on previous adverse life experiences. He talked briefly about the death of his father, to whom he was very close. Before long, his reflection settled on an experience when he was a young man, serving in a military unit far from home.

'I received a radio message to say my wife was critically ill.' Choked with emotion, he paused to gather himself. 'The commandant wouldn't let me go home. For three days, I couldn't sleep or eat.' He related the fear that she might die, the feeling of utter helplessness and his panic.

He, and I, was surprised at the sediment that his experience in ICU had unsettled. He did not talk about scenes of violence, nor of nightmares and flashbacks of combat. Terrifying sensory hallucinations, and feelings of dying in ICU, had awakened a dormant memory of the fear and panic he had experienced on hearing about the threatened death of his wife. And anger at the commandant's refusal, which rendered him helpless, impotent. He commented that he had forgotten about this event, and until now, had never spoken to anyone about it.

Remembering, forgetting and unforgetting are the subject of controversy in traumatic stress and PTSD literature, with amnesia and implicit memory at the centre of contestation. That traumatic events are not integrated into explicit memory systems is a theme that has come to be definitive of post-traumatic stress.

Accordingly, there is an argument that the experience, dissociated, denied or encoded in implicit memory, is not accessible to conscious recollection, but remains in the memory of the lived body.[19 23] Studies on traumatic stress that focus on memory propose two memory systems, one verbally accessible and one situationally accessible. The idea is that situationally accessible memories are evoked when situations induce intense emotional arousal, similar to that experienced during previous traumatic events. Even though they accept the notion of psycho-physiological reactivity, critics, on the other hand, question that there can be bodily memory, without explicit memory.[24]

In a paper addressed to nurse anaesthetists, Wofford, Herzberg and Vacchianno point out the risks of perioperative morbidity in surgical patients who have a previous diagnosis of PTSD. They draw on the theory of situationally accessible memories, to show that events during and after surgery can induce reactions that have roots in previous traumatic experience.[25]

> A young woman who developed PTSD as a result of sexual and physical assault during a civil conflict in her home country, developed acute agitation immediately after emerging from anaesthesia. The patient became physically violent towards staff and had to be physically and chemically restrained. The patient later reported that, during the episode, she had re-experienced her prior abuse. She attacked staff members because she thought they were her original perpetrators. (Wofford, Herzberg and Vacchianno, p. 468)[25]

Could it be that Mr G's physical helplessness in ICU had evoked the emotional arousal associated with the exercise of authority that had left him feeling helpless in the face of the threatened death of his wife?

Is PTSD sufficient to capture the particularity of the ICU experience?

We—patient, family and psychotherapist—cast Mr G's suffering in terms of PTSD. This is consistent with his subjective experience and with a body of literature that identifies ICU-induced PTSD. However, close reflection on Mr G's experience during weaning, and the memories it evoked, generates questions about whether PTSD, in particular the stressor criterion of the DSM-5,

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captures the particularity of the ICU experience. Conversely, as others have asked, does the use of trauma to refer to all suffering strip it of specific meaning?[26]

In her examination of standardised PTSD treatment manuals, Lord points out that 'trauma' and PTSD are increasingly applied to all experiences, individual and social, that involve suffering.[26] To an increasing extent, media accounts of the mental state of soldiers returning from wars in Iran and Afghanistan reflect that PTSD has become a 'catchall' for any experience including sadness, regret and even moral conflict. According to Lord, interest in trauma appears to arise around war, industrialisation, developments in new technologies and major social upheavals.[26] In the ICU, a modern medical environment with ever-changing technologies, PTSD is a culturally accessible idiom of patient distress, familiar to patients and medical professionals.

Are the experiences of rape, combat or assault with the intention to kill, or the massive destruction of persons and personal worlds in war, commensurable with the experience of terrifying persecutory hallucinations? In her narrative, Brison argues that what trauma survivors have in common is the experience of utter helplessness in the face of life-threatening violence of human origin.[27] She points out that overwhelming, life-threatening experiences not of human origin affect the survivors' sense of self differently, typically not leaving a sense of betrayal or inability to trust.

In ICU, the origin of the threat is elusive. The distressing experiences occur in a context where the aim is to provide care, and the intention is life saving. It is interesting that, even during the time that he was having terrifying nightmares and hallucinations, Mr G was, in some moments, relieved to be in ICU. This echoes Stayt's finding that patients experience technology as a series of paradoxical relationships, alienating yet reassuring.[9] Indeed, Mr G assumed the possibility of help when, in his mind, he cried out, 'Just tell me what is going on.'

To repeat, where the traumatic event is of human origin, the stressor criterion in PTSD implies intention to do harm. The intention of ICU treatment is for the good, leaving the door open for caring relationships.

This is well illustrated by the experience of Nancy Andrews, an artist who writes a blog about her experience of delirium. She explains that despite continuing to hallucinate, she derived comfort from a change in her carer's behaviour.[21]

> While in ICU, I was fighting to get out of bed, convinced I was being unjustly imprisoned. The nurse on duty and the ICU 'sitter' (critical care bedside companion who monitors patients) were frustrated with me and I was feeling very angry and agitated. The 'sitter' started singing, and I was entranced. I was the snake and she was the snake charmer. My agitation immediately was reduced. I felt human warmth and attachment to her, a sense of caring and trust. I don't know what she was singing, but I suspect that it might have been a Haitian lullaby. (Andrews)[21]

Absolute dependence and helplessness in ICU

Neither does PTSD capture the helplessness and dependency that weave Mr G's harrowing experiences together. To varying degrees, illness impairs the capacity for independent self-care. Though intrinsic to physical incapacity, in ICU, dependency is also a consequence of exposure to medical technologies. For example, attachment to mechanical ventilation, whereby breathing is externally performed and controlled, is effectively a state of absolute dependence.[9]

Our dependency is rooted in biological helplessness. The degree of our dependency changes across the lifespan, and is determined by changing bodily, emotional and sociopolitical circumstances. Nevertheless, we continue to meet, and have our needs met in relationships. Winnicott, the paediatrician and child psychoanalyst, emphasised this in his postulation that there is no such thing as an infant without a mother. Similarly, we could say there is no such thing as a patient without a doctor, or a nurse.[28]

The infant and maternal care, together, form a unit. And herein lies our vulnerability. Winnicott described absolute dependence in this way:

> In this state the infant has no means of knowing about the maternal care, which is largely a matter of prophylaxis. He cannot gain control over what is well and what is badly done, but is only in a position to gain profit or to suffer disturbance. (Winnicott, p. 590)[28]

What is at stake then in the ICU, which has as its purpose the treatment of those whose existence is threatened? Staff response to patient need is a common theme in studies on patient experiences of ICU. A patient who had been on mechanical ventilation in Geire Hospital, in the Netherlands, explains:

> You know, it made me feel helpless, and powerless. It's hard to describe. You feel, what can I say, you feel hurt and you could easily start to cry. Yes and then I thought oh please let someone come; don't let a person who is so dependent wait so long. That is important, right? (Hofhuis, *et al*, p. 308)[29]

Another patient, quoted in the same article, points to the sense of security that communication provides.

> … And if the ventilation machine next to me stopped for a moment they told me about it. Or when they were trying something else out. You knew that they would explain what they were doing first. Yes, in my opinion you'd worry less about things. (Hofhuis *et al*, p. 308)[29]

Support nurtures a sense of safety. Patients in Hofhuis's study identify a continuum of support: receiving information about what is being done and what is going to be done; being treated as the centre of attention, as a whole person; and being treated with compassion.[29] Similarly, in their study, Lykkegaard and Delmar found that staff communication relieved patient feelings of being powerless.[30]

Psychiatrists Coulson and Almeida argue that, in addition to pharmacology, the key to management of acute delirium syndrome is the introduction of support and environmental management. These measures include clear and concise communication, regular verbal reminders of time and place, encouraging staff to identify themselves and their purpose, minimising noise, ensuring adequate lighting, reducing stimulation and encouraging competence.[31]

With a view to helping patients deal with fragmentary and frightening memories, ICUs in some European hospitals, including in Denmark, Sweden, Norway, Germany, Italy and Portugal, introduced patient diaries. Brief daily entries made by nursing staff are factual notes on patient status and the situation and context of treatment. In some places, the diaries include photographs.[32] The effectiveness of such diaries in reducing new onset PTSD among critical illness survivors was investigated in a randomised controlled study of 352 patients.[33] Jones *et al* found that the diaries reduced new onset PTSD. Patients with high levels of PTSD symptoms at 1 month post ICU benefited most from the diaries. In general, patients reported finding the text and photographs useful for understanding their illness and coming to terms with their experiences.[33]

South African authors Herbst and Drenth analysed the narrative account of an ICU patient who was sedated and unconscious,

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but recollected fragments of her experience and the activities around her. They recommend that staff explain medical procedures to the patient, talking continuously in a comforting and reassuring way; and that they be sensitive to the possibility that the patients can hear all conversations in the room.[34] Confirming a similar approach, Samuelson argues that providing information, facilitating communication and arranging for the presence of family at the time of weaning may be helpful in reducing endotracheal tube related distress.[17]

Some 6 months after discharge, Mr G recounted that, while he was on the ventilator, he heard a doctor talking about not being complacent. The doctor he heard was talking about the possibility of bleeding, and going back to theatre. Mr G experienced this as a direct address:

> Don't be complacent, you're not out of the woods, you could bleed and go back to theatre.

He recalled what he believed he heard with outrage at the insensitivity of the doctor. In the same meeting, he disclosed the feeling that I had abandoned him, because I did not show up to see him in ICU.

So it is that as relational beings we are vulnerable. Power is implicated in our dependence on an other to meet our needs, and, indeed in our meeting of the other's needs. In the context of ICU, patients are dependent on others for care, both of an advanced technological kind and care of a very basic nature—being fed, being cleaned and being turned—all of which evoke helplessness. There is always the risk of not being seen, not being helped. According to Lykkegaard and Delmar, 'The bodily changes and the powerlessness can cause death to be perceived as an easier alternative, or can lead to putting up with needs not being met' (Lykkegaard and Delmar, p. 7).[30]

For these reasons, how staff and patient relate is profound. Using the framework of intersubjective-systems theory, Stolorow emphasises that trauma is context dependent. By this he means that painful emotional experiences become enduringly traumatic when there is an absence of relationships, or connection with others, in which they can be held and integrated.[35]

There are, however, two dangers in this focus on helplessness, and the quality of staff and patient communication. The first is to judge helplessness as a problem.[36] The second is that, by casting the parties in binary terms—helpless patient-powerful nurse/carer—the carer stands to be blamed.

Winnicott's notion of absolute dependence provides a productive model for conceptualising helplessness in the ICU context.[28] Referring to Winnicott's ideas on existential helplessness, La Mothe makes the point that absolute dependence is only experienced as helplessness if the environment fails to meet the infant's need (p. 7).[37] In other words, the infant does not experience anxiety in relation to helplessness, where the good-enough parent meets the infant's needs. Helplessness not met, on the other hand, leaves the infant feeling that they must react to the environment, which is experienced as an impingement. According to Winnicott, good-enough parental adaptation not only allows a sense of continuity of being, but is a source of creativity.[28] The infant feels a sense of participation in having needs met. In this way, Winnicott allows for an ambivalent conceptualisation of helplessness, either a source of destructive intrusion or a source of creativity in human relatedness.

Similarly, drawing on Freud's reflections on the helpless infant, Philips emphasises Freud's argument that helplessness can be a source of moral motive.

> The first function of the scream is an attempt at evacuation, at discharge of stimuli, which can't work; but the secondary function is an appeal, a medium of communication or contact, between the 'helpless subject' and the person looking after her. It brings about an understanding with other people because it stimulates the other person to work out, to imagine, what it might be that the helpless subject is in need of. (Philips, pp. 134–135)[38]

These models provide us with a less disapproving view of helplessness. However, they do not resolve the danger of blaming the carer in the patient–carer unit. Winnicott was exceptional among the early psychoanalytic theorists in his emphasis on the environment, and in his move away from a purely intrapsychic focus. However, his writing tends to equate the environment to the mother/caregiver. While, from the perspective of the infant, the mother is the environment, a wider angle of vision takes in how motherhood is historically located, and that sociopolitical factors shape mothering.

Conclusion: from patient vulnerability to the carer's vulnerability

Similarly, focusing on the quality of staff communication in the ICU decontextualises the relationship between staff and patients. The question arises, how do we account for staff not communicating with patients? Feminist philosopher Drichel argues that vulnerability cast as the 'problem' requires protection, the shoring up of identity. Reframing vulnerability, she opens it up to reveal doubleness, 'wounding and caring' (Drichel, p. 10).[36] This opening up, Drichel points out, requires taking the risk of being affected, without being certain about the outcomes of caring.[36] If vulnerability is inherent to our relationships with each other, then how do we understand the vulnerability of carers, and the conditions under which they turn to defensive shutting down?

Caring is embedded in local institutional contexts, whose organisational hierarchies and practices are elaborated by wider sociopolitical values and economic priorities. To what extent these contexts and their practices encourage being receptive to, and being affected by the other, requires more detailed examination of specific instances. Equally, exploration of how increasingly complex medical technologies complicate caring-for may throw light on patient laments about the absence of hands-on-care and relational contact, without resorting to blame.

Reflecting on Mr G's passage out of mechanical ventilation has opened the patient experience to its complement, the carer's vulnerability. In as much as caring is embedded, carers are socially located and come to their roles with unique personal histories. Mr G's experiences remind us that the body, not purely biological, is also the locus of our experiences of self and world. What is inscribed on the bodies of carers, and how might their experience of self and world balance the scale of wounding and care? The experience of Susan Nell, the nurse in *The Camp Whore,* is instructive. In a hospital treating shell-shocked soldiers, she realises with shock when having to treat the man who abused her, that 'Nothing is ever completely over' (Smith, p. 126).[2]

Intermittent clinical encounters with Mr G continued when he consulted his physician. For, as Varela, the neuroscientist, wrote about his liver transplant: 'Transplantation is never in the past, then. It produces an inflexion that keeps an open reminder from the trace of the scar, altering my settledness, bringing up death's trace.'[39]

Mr G keeps an open reminder to vulnerability whose exposure he has embraced.

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