

# The EMDR Recent Traumatic Episode Protocol With an Intensive Care Survivor: A Case Study

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The intensive care survivor population is increasing. Critical illness can lead to long term psychological distress for a significant proportion of intensive care survivors. This situation has been brought into even starker focus with the impact of COVID-19. Critical illness can lead to long term psychological distress for a significant proportion of intensive care survivors. Risk factors for post-intensive care psychological distress include delirium experiences. This single case study describes the therapeutic process and utility of the Recent-Traumatic Episode Protocol (R-TEP), an eye movement desensitization and reprocessing (EMDR) therapy protocol for early intervention, with an ICU survivor where therapy was conducted remotely. The treatment provision is unusual in terms of the use of the R-TEP protocol and therapy not being in person. Treatment response was assessed using three standardized measures pre-treatment, post-treatment and at 4-month follow-up, and through qualitative feedback. The advantages of the R-TEP structure are discussed and the need for further research with the ICU survivor population considered.

**Keywords:** early EMDR intervention; intensive care; posttraumatic stress disorder; PTSD; recent trauma; clinical practice

The impact of intensive care unit (ICU) survivorship on individuals, families, society, and healthcare providers is increasing as the number of people surviving critical illness grows (National Institute for Health and Care Excellence [NICE], 2009). Psychological morbidity contributes to poor quality of life post-ICU (da Costa et al., 2019); therefore, healthcare providers play a vital role in supporting post-ICU adaption (Tingey et al., 2020).

## PTSD in ICU Survivors

Approximately a quarter of ICU survivors develop symptoms of posttraumatic stress disorder (PTSD) and, given the dramatic increase in ICU admissions as a consequence of the COVID-19 pandemic, clinicians in many settings are likely to see a rise in post-ICU PTSD cases (Murray et al., 2020). Critical-care experiences can include fear of dying, of ICU equipment, of suffocating, and of the future (Wade, 2012). The very nature of critical illness results in traumatic experiences while unable to move or communicate. Risk

factors for developing post-ICU PTSD include type and duration of sedation; previous history of anxiety or depression; delirium; and emotional stress (Wade et al., 2013). There is limited evidence that psychologically-informed interventions while in intensive care prevents the development of ICU-related PTSD (Wade et al., 2019), although there is some evidence that ICU diaries are helpful (Kredentser et al., 2018).

Delirium is a significant factor in critical illness, occurring in 80% of ICU patients (NICE, 2010). Delirium is a fundamental risk factor for post-ICU psychological distress. ICU hallucinations are experienced on a sensory level, are complex, and can last several days, reflecting a similar process to experiences during psychosis (Wade et al., 2014). For ICU survivors, there is often a dual experience of poor recall of actual memories of intensive care, alongside the occurrence of delirium, with patients generally more traumatized by delusions than by real events, as evidenced by 88% of critical care survivors with PTSD experiencing delirium-related flashbacks (Wade et al., 2014).

Post-ICU PTSD can present with unique features, such as re-experiencing symptoms focused on threats of recurrence and avoidance of health care, which serve to establish a maladaptive cycle, placing both physical and psychological symptoms at risk of increase (Jackson et al., 2014). An individual's ICU experience is often an extended exposure to a life-threatening situation and, for many, critical illness amounts to a lifetime diagnosis (Cuthbertson et al., 2010) with a significant impact on quality of life (Van den Boogaard et al., 2021). In the United Kingdom (UK), NICE (2009) recognizes that, alongside an unclear picture of the longer-term impact of critical illness, there is no standardized format for post-ICU follow-up and evidence in relation to ICU follow-up is a high research priority (Reay et al., 2014). Additionally, in a summary of the research and evidence base for the treatment of post-ICU PTSD, Murray et al. (2020) recognize that published research focuses on the prevention of PTSD and there is an absence of clinical guidelines on delivering trauma-focused therapy with the ICU survivor population.

Very few papers address therapeutic interventions for ICU-related PTSD. Recently Murray et al. (2020) offered an outline of how cognitive therapy techniques can be applied. Two previously published papers describe the application of EMDR therapy. In a pilot study (Hulme, 2018), after a mean of five sessions of EMDR therapy, ten ICU survivors showed significant improvement, with the mean score on the Impact of Events Scale—Revised (Weiss & Marmar, 1997) reducing from 62 to 16. Sarah Wake (an ICU survivor and a doctor) and Deborah Kitchener (an independent psychotherapist) published an article in the *British Medical Journal* describing their experience of delirium-related PTSD and treatment using EMDR therapy (Wake & Kitchener, 2013).

## EMDR Therapy

EMDR therapy is an evidence-based psychotherapy recommended as a treatment for PTSD by the World Health Organization (WHO, 2013), the International Society for Traumatic Stress Studies (Bisson et al., 2019), and NICE (2018). The theoretical underpinnings of EMDR therapy posit that the brain's information processing system can be disrupted by situations involving high levels of emotional disturbance, which leads to blocked or incomplete processing, resulting in information being stored with the sensations, emotions and beliefs present at the time (Shapiro, 2017).

Therapy with EMDR therefore involves eliciting specific targets to represent the traumatic event and

using bilateral stimulation (eye movements, taps or tones) to bring together cognitive, emotional, and sensory aspects of the traumatic memory (NICE, 2018), stimulating the innate processing system, and facilitating integration into adaptive memory networks (Shapiro, 1989, 2017). Many ICU survivors have very few coherent time-referenced memories of critical illness, combined with often having memories of physical sensations and experiences of intense emotional responses; therefore, EMDR therapy's capacity to focus on the emotional and sensory aspects of traumatic experiences, alongside cognitive appraisals, makes it an ecologically valid intervention for post-ICU PTSD.

EMDR is an eight-phase treatment method including: history taking, preparation, assessment, desensitization, installation, body scan, closure, and re-evaluation. Post-ICU PTSD is often focused on delirium-related experiences. PTSD can also present as affect without recollection, whereby re-experiencing can be of an intense emotion or physical reaction from traumatic experiences without recalling the event itself (Ehlers & Clark, 2000; Murray et al., 2020). Many ICU survivors attempt to logically work out which of their memories are real and which are not, and to understand their emotional and physical reactions to ICU traumatic experiences, of which they have little or no memory. This process is often very unhelpful. EMDR works with the emotional brain, linking in thoughts, sensory perceptions and physical sensation (Ecker et al., 2012); therefore, it is a good fit as a therapeutic intervention for ICU survivors whose emotions, cognitions and physical sensations related to traumatic memories are often present in a very disconnected form.

EMDR therapy has been successfully used in medical settings, including oncology (Capezzani et al., 2013; Farretta & Borsato, 2016), cardiology (Arabia et al., 2011), multiple sclerosis services (Wallis & De Vries, 2020), and with chronic pain (Tesarz et al., 2019). Medical experiences can often be a significant life event and traumatic in nature. The author of this paper is an accredited EMDR Consultant and Practitioner with 11 years' experience of offering EMDR therapy and 4 years' experience of working in critical care, delivering regular EMDR therapy in this context. The author attended training facilitated by Elan Shapiro on the EMDR Recent Traumatic Episode Protocol (R-TEP; Shapiro & Laub, 2008; Shapiro, 2012) in 2018. The author's clinical experience is that ICU survivors often return to EMDR therapy sessions, with a different target each session.

## EMDR R-TEP Protocol

EMDR R-TEP is an early EMDR intervention for the treatment of recent traumatic events, facilitating processing on perceptual, experiential, and meaning levels, incorporating containment and allowing for the fragmented nature of recent trauma memories (Shapiro & Laub, 2008, 2014). The effectiveness of EMDR R-TEP has been documented with a range of different situations (Shapiro & Laub, 2015; Shapiro et al., 2018; Tofani and Wheeler, 2011). Gil-Jardiné et al.'s (2018) research indicates that the R-TEP is a feasible intervention, and potentially effective physically and psychologically, in the context of a hospital Emergency Room. The application of the EMDR R-TEP protocol in the treatment of post-ICU PTSD is novel.

EMDR R-TEP allows for the processing of the disturbing fragments of a traumatic experience using an adapted version of the standard EMDR eight-phase process (Shapiro & Laub, 2008, 2014). EMDR R-TEP works with the concept of a traumatic episode, an ongoing trauma continuum running from the original incident up until today. The episode narrative involves telling the story out loud with continuous bilateral stimulation (BLS), a process which serves to ground and contain affect, and begin integration. The traumatic episode is comprised of multiple targets referred to as points of disturbance (PODs). PODs are identified by asking the person to scan the trauma episode non-sequentially, without talking, with BLS, and to stop when they find something disturbing to them now (Google scan; Shapiro & Laub, 2014). For each POD, the therapist works with the individual to identify the target image, the negative cognition (NC), positive cognition (PC), the validity of the positive cognition (VOC) on a scale of 1–7, emotion, level of distress rated on the Subjective Units of Distress Scale (SUDS) from 0 to 10, and body location. Focused reprocessing is then undertaken using either EMD (a narrow focus, limiting the range of associations to the POD) or EMDr (working with the associative span of the adaptive information processing system related to the current traumatic episode). EMDr tends to be the main processing strategy, and if something comes up, which is not related to the traumatic episode, the person is asked to refocus by returning to target. Once the SUDS rating is reduced to an ecologically valid level, the PC is installed, but there is no body scan at this point. The “Google scan” is repeated until no more PODs are found. The episode SUDS rating is checked, and further processing completed if necessary, before

moving to installation of the episode PC, followed by the body scan.

Following training in the use of EMDR R-TEP the author introduced its use into the ICU follow-up clinic. The structure of the protocol offered the capacity to contain targets shifting between sessions through the use of the “Google scan.” As a consequence of the impact of the COVID-19 pandemic, many services were switched to being delivered remotely, including EMDR therapy conducted as part of ICU follow-up. The aim of this case study is to describe the use of EMDR therapy and specifically the EMDR R-TEP protocol delivered online, as a relatively early intervention for post-ICU PTSD, to explore its feasibility and relevance.

## Method

### Design

There are currently no published articles describing the use of EMDR R-TEP for post-ICU PTSD, either in person or remotely. A single case study can provide a hypothesis on the utility of the EMDR R-TEP protocol for ICU-related PTSD and, by so doing, can suggest the need for further research, inform clinical practice and contribute to an in-depth understanding of the individual experience (Grey, 2011). Information is provided to contextualise the intervention described.

### Case Description

This is a retrospective case study; therefore, there are no multiple baseline measurements. In the current climate and with the related increase in the ICU survivor population, it appeared important to share the experience with other EMDR practitioners. Helen (which is a pseudonym name) has provided informed consent, including reviewing the paper. The context for this work is an ICU in the southwest of Britain. Brief psychometrically validated screening questionnaires are used to establish which ICU survivors may benefit from psychological support (Tingey et al., 2020). Screening questionnaires are sent 3 months post-discharge to all the unit's ICU survivors with an ICU admission of 4 days or more (NICE, 2009, 2017). The questionnaires include the Post-Traumatic Stress Syndrome 14-Questions Inventory (PTSS-14) (Twigg et al., 2008), the Generalised Anxiety Disorder-7 Questionnaire (GAD-7) (Spitzer et al., 2006), the Patient Health Questionnaire (PHQ-9) (Kroenke et al., 2001) and the EQ-5D (EuroQol Group, 1990; 2001).

The PTSS-14 is a validated measure to screen for acute PTSD after ICU discharge with a threshold of 45 indicating clinically significant distress (Twiggs et al., 2008). Different trauma-related screening questionnaires have been trialled, but the resultant drop in response rate suggests the PTSS-14 has ecological validity for ICU survivors. Additionally, a PTSS-14 score of over 49 has been found to correlate with delirium duration (Bashar et al., 2018).

The PHQ-9 is a nine-item, self-report scale used for diagnosing depression, assessing symptoms and functional impairment, as well as monitoring treatment. A score of 11 or above is a score within the clinical range. The GAD-7 is a seven-item, self-report, assessment tool validated for assessing anxiety disorders. A score 8 or above indicates clinically significant anxiety symptoms. The EQ-5D-5L is a five-item, self-report measure of health-related quality of life. Five items are rated on a five-point scale, from no problems to extreme problem; e.g., 11111 indicates no problems on any of the five dimensions. It includes an EQ Visual Analogue scale (EQ VAS) on which the person records their self-rated health on a scale with endpoints of 100 “the best health you can imagine” and 0 “the worst health you can imagine.”

From 2014 to 2020, the unit sent out between 336 and 413 questionnaires a year, with response rates between 35.9% and 48.6%. Across the timeframe, 30.6%–50.4% of the returned questionnaires scored in the clinically significant range for PTSD, anxiety, or depression. Since 2019, the questionnaires include an option to attend an ICU multi-disciplinary team (MDT) follow-up clinic.

Helen returned the screening questionnaires and her scores were 55 on the PTSS-14 (above threshold), 6 on the GAD-7 (mild anxiety), 16 on the PHQ-9 (moderately severe depression), and 11313 60 on the EQ-5D-5L. When the screening questionnaires were returned, Helen had opted to attend the ICU MDT follow-up clinic. However, the follow-up clinic was suspended for a period of time due to the impact of COVID-19 on ICU staffing and resources. The unit’s critical care psychology service is commissioned to work with ICU survivors post-discharge and it was agreed that an outpatient focus would be maintained throughout the challenges and changes associated with the pandemic. Helen’s questionnaire scores were above the thresholds, indicating clinical significance in terms of symptom severity and frequency; therefore, she was offered a psychology assessment appointment while remaining on the waiting list for the ICU MDT follow-up clinic.

Helen’s initial appointment occurred at a time when the systems being set up for online work in the

National Health Service (NHS) were not effective, particularly in rural areas with reduced internet bandwidth. The initial assessment appointment was therefore completed on the telephone just before Helen’s 60th birthday, 5 months after her discharge from ICU. Helen is a widow, living on her own, and she works in a school. In the UK, at the beginning of the COVID-19 pandemic and for about a year afterwards, people considered to be clinically extremely vulnerable and at very high risk of severe illness from COVID-19 were asked to “shield” which meant not leaving their homes and minimising all face-to-face contact. At the time of the assessment, Helen was signed off work, shielding, and uncertain about returning to work.

ICU discharge paperwork indicated that Helen was taken to hospital following a 10-day history of vomiting and diarrhea, and admitted straight into the intensive care unit, where she remained for 5 days, followed by a further 6 days in hospital. Helen has a previous history of type II diabetes, asthma, colorectal cancer, and coeliac disease. During the initial assessment, Helen explained that 10 years previously, she had several tumors removed from her colon, which resulted in having a stoma fitted for 4 months. Following the cancer diagnosis, Helen undertook private therapy, which she found helpful. Helen had also previously experienced a ruptured appendix and consequentially found it difficult to be in hospital. Additionally, she reported having been prescribed antidepressant medication for many years.

Critical care psychology assessment processes explore the lived narrative of critical illness, the related impact on mood, and provide psychoeducation if appropriate. Helen spoke of the context of her critical illness. Three months prior to her ICU admission, Helen unexpectedly lost her mother and 2 months later, her husband died suddenly. Helen explained that prior to being admitted to ICU, she had been ill for several days, had seen her general practitioner (GP; medical doctor), but was reluctant to attend hospital, until her neighbor insisted on calling an ambulance. Helen remembered being surprised when she was admitted to ICU. She remembered being very cold, being surrounded by people, dialysis, struggling to eat, and pain. Helen described “being emotional” and sleeping a lot following discharge home. Helen felt her mood had probably decreased further in the time since she completed the screening questionnaires due to re-triggering from frequently seeing ICU environments on television reports related to COVID-19. Helen reported experiencing a range of flashbacks. She explained that her GP had increased the dose of antidepressant. In summary, Helen presented with



symptoms of psychological distress related to her period of critical illness, and had appropriate support networks in place; therefore, we agreed to proceed with EMDR therapy.

## Case Conceptualization

Formulation in EMDR therapy identifies the relationship between target memories and current symptoms, establishing a timeline of events, linking symptoms and targets (De Jongh et al., 2010). In practice, the assessment process serves to establish the link between current symptoms of psychological distress and critical illness experiences. Helen's formulation recognized that her distress incorporated a series of relatively recent inter-related events, including critical illness and delirium. Interestingly, it was also recognized during the ICU follow-up clinic, as part of the ICU consultant's intervention, that the two recent traumatic bereavements probably contributed to Helen's ill health deteriorating to the point of becoming critically ill. The R-TEP protocol provides a constructive structure to integrate formulation and intervention. The identification of a traumatic episode and the scan to identify the related points of disturbance to be processed mean that target selection of traumatic experiences is based on what currently feels disturbing.

## Course of Treatment

**Assessment Session.** Treatment really began during the assessment session. Phase one and phase two of the R-TEP were completed, establishing readiness, previous functioning, prior trauma history, assessing risk, and ensuring appropriate safety and containment through Helen's response to calming exercises.

**Session One.** The first decision was whether to go ahead with therapy on the telephone. NHS services were generally prohibited from using freely available functional online platforms, necessitating a lot of adjustment in delivering therapy at a time of great stress and working to understand how to maintain safe and effective therapy in a strange, limited medium. The EMDR Association UK was extremely helpful in this respect, providing easily accessible information and webinars on the process of working remotely. Phase 3 of EMDR R-TEP extends assessment using the traumatic episode. Clinical practice has been to ask the individual when they feel the traumatic episode started; Helen decided it started when her mother fell. The next stage of protocol is to ask the individual to speak through the episode narrative. In the case of working on the telephone, tapping is the only realistic

BLS option. There is a challenge inherent in tapping (to set the speed), while listening to another person tap, with all communication limited to a phone line. The situation required a very clear explanation of the process and active listening skills. Helen spoke through the traumatic episode with continuous tapping.

The next stage of the R-TEP protocol is for the person to scan through the traumatic episode to identify POD, a process which is completed without talking. Clinical practice has underlined the importance of explaining that this section is completed without speaking. Helen completed a scan of the trauma episode and identified the first POD as finding her husband deceased.

The R-TEP protocol indicates that for every POD, it is advisable to perform a standard EMDR phase 3 assessment, i.e., to identify a target image representing the worst aspect, the negative cognition (NC), positive cognition (PC), validity of the positive cognition (VOC), level of distress rated on the subjective units of distress scale (SUDS) from 0 to 10, and body location. Helen identified a target image of seeing her husband and the blood, an NC of "I should have done something, I am alone," a PC of "I could not have done anything," a VOC rating of 4, emotion of guilt and fear, a SUDS rating of 10, and body sensation of an ache everywhere. During reprocessing, Helen became audibly distressed but continued the procedure. At the end of the session, Helen provided feedback that she was surprised by not being as upset when talking about what happened as she thought she might be and by the recognition that the physical ache she experienced was a representation of her emotional distress. Phase seven is closure of each session. A container and calm place exercise were used for closure as the reprocessing was incomplete.

**ICU MDT Follow-Up Clinic.** Between the first and second therapy sessions, Helen attended the re-started ICU MDT follow-up clinic. The design of the clinic reflects the need to bring together the medical and lived narratives and to update memory (Clarke et al., 2020; Solomon, 2016). Ordinarily critical care psychology is part of the follow-up clinic, but on this occasion, the multi-disciplinary follow-up clinic ran with only the ICU consultant and ICU nurse specialist for those individuals who had already attended a separate psychology assessment during the clinic's suspension.

**Session Two.** From this session onwards, therapy was completed using an online platform which enabled us to see, as well as speak, to each other. Helen described the MDT follow-up clinic as helpful. She reported that the image of the first POD had faded.

Phase 8 of the R-TEP protocol is re-evaluation at the start of each session using the scan process. Helen completed a scan of the traumatic episode and identified the next POD as her mother's death, with a NC of "I am an orphan, have to make my own decisions and have no one for support," a PC of "I am stronger than I think, can do things for myself and make my own decisions," emotions of loneliness and fear, SUDS of 5 and the body location in her head. Desensitization used the EMDr strategy, limiting associations to the current traumatic episode. Following reprocessing, the SUDS rating came down to 0 and the VOC rating went up to 7. Phases 2–5 were repeated to identify and reprocess remaining PODS. The next POD returned to Helen's husband, with the NC "I could have done more and it's not fair," PC "I cannot change it; I could not do anything, and I can move on," and an emotion of guilt. Helen described a feeling of working hard in the session. The container and calm place exercise were used for closure.

**Session Three.** Helen reported finding the therapy helpful, that she had stopped having nightmares and the images were fading. A scan of the traumatic episode was completed, and the next POD returned to her husband, with a NC of "I did not know how ill he was," PC of "he did his own thing" and emotion of guilt. This POD was fully processed with the SUDS rating down to 0 and the VOC up to 7. We then returned to a traumatic episode scan and the next POD was Helen's own illness with a NC of "I did not realise how ill I was" and a PC of "I can listen to my own body." During reprocessing, Helen noticed that it was a combination of events that will not happen again. At the end of the session, there was a decision point about whether a strong closure was needed. The collaborative decision was not to complete a container and calm place exercise. Helen felt she would benefit from sitting with what had come up during the session without closing it down.

**Session Four.** The session began with a scan of the traumatic episode. The identified POD was Helen's husband's body being taken away, with a NC of "He has gone, and I have a mess to sort out," a PC of "I did it" and emotions of horror and disbelief. The SUDS rating level dropped to 2, which felt ecologically valid. During the installation phase, Helen noticed that "I am actually quite tough, even though I cry." The VOC went up to 7. A calm place exercise closed the session.

**Session Five.** As usual, this session began with a scan of the traumatic episode, which runs up until today. Helen identified a POD of a sense of a fear related to "disappearing down a dark hole." As this

was something which had not actually happened but was related to a future fear, it was processed very much like a flashforward. The target image was turning into a quivering wreck, with a NC of "I will start to think I can't go on," PC of "I am strong, can get over it and move on," emotion of despair, SUDS rating of 8/9, and a body location of all over the body. Helen reflected that it felt like the same feeling she had when worrying about getting ill again and it processed well. At this point, it felt as if a lot of the past, present, and future had been reprocessed. After some discussion and with reflection on Helen's forthcoming return to work, we agreed to a 2-month break in therapy, with the understanding that if things became difficult in the meantime, Helen could get in touch.

**Session Six.** By the time we met for this session, Helen had returned to work. She reported that work left her feeling tired and, at times, overwhelmed by panic. The scan identified a POD of a dream, with a target image of "waking up hearing myself trying to scream," a NC of "I am not at peace," PC of "I can sleep and wake up refreshed," a sense of tiredness in her head, with a SUDS rating of 6. Helen noticed a connection to being critically ill and delirium experiences of monsters, recognising that "they were trying to help me." Helen said, "I understand where they come from now and I can let myself sleep." It was collaboratively agreed that the session did not require closure exercises.

**Session Seven.** The session followed the usual pattern of beginning with a scan of the traumatic episode. Helen identified a POD of a recent dream with a target image of her mother's eyes while hearing her mother shouting at her, NC of "I am in trouble" and a PC of "I can let it go." The POD was fully processed with SUDS dropping from 5 to 0 and a VOC of 7.

**Session Eight.** Helen reported distress related to a recent incident at school, which left her experiencing several recurring dreams. Following the traumatic episode scan, Helen identified a POD from the dream, with a target image of herself hiding, a NC of "I will get it wrong, and people will judge me," PC of "people respect me," a sense of discomfort in her stomach, with SUDS of 6. During reprocessing, Helen noticed the thought that "I need a cape to protect myself from other people's stuff" (which became a resource). We agreed on the between-session task of going into avoided places and acting "as if I am confident."

**Session Nine.** The R-TEP protocol requires that phases 2–5 are repeated to identify and process PODs arising until none are found. At the start of session nine, the scan of the traumatic episode was repeated,

and it was clear. The next stage is to check the episode SUDS rating before moving on to installation of the episode PC. Helen's episode SUDS rating was 0. Helen then identified an episode PC of "I am confident and can move forward," which was installed with a VOC of 7. Phase 6 is the body scan. Helen's body scan was clear, and she reported feeling relaxed. It was agreed that therapy could be concluded with an understanding that she could self-refer if anything re-occurred. At the last session, we discussed what Helen will take away with her from therapy, identified any warning signs which may indicate her mood might be slipping, and explored what Helen will remember if she notices any of these signs. This discussion was summarized in a letter to Helen. Helen's scores on the questionnaires at the completion of therapy were 21121 85 on the EQ-5D-5L, 0 on the GAD-7 and 1 on the PHQ-9.

**Follow-Up.** As part of an audit of critical care psychology, a letter and repeat questionnaires were sent out 4 months after Helen completed therapy. Helen's scores were 0 on the GAD-7, 2 on the PHQ-9, and 11121 80 on the EQ-5D-5L. Helen also sent an email containing qualitative feedback. Helen reported cutting down her antidepressant medication from 30mg to 10mg daily and a sense of the future looking good. Helen expressed a need to know that she can self-refer if experiencing any re-triggering in the future. A further 3 months later, following contact in relation to this case study, Helen reported that she had completely stopped all antidepressant medication. A month later (8 months after completing therapy), Helen was interviewed by a research assistant as part of a service evaluation of critical care psychology and these are some of the quotes from the transcription of the interview: "As I got further and further in, it was incredible"—"It saved me. I don't know how I can describe it"—"After all this therapy, you know, I just feel I can take on the world"—"I can now talk about every aspect of what had happened to me and I don't cry. And, for me, that's success."

## Discussion

An intensive care medical experience is both critical and intense; therefore, it can result in a significant impact on psychological wellbeing (Tingey et al., 2020), with high rates of psychological distress often being found at 3 months post-discharge (da Costa et al., 2019). In relation to long-term recovery, ICU-based rehabilitation alone is insufficient, so it is important to recognize, and then offer early treatment for, ICU-acquired psychological difficulties (Inoue et al., 2019). This case study illustrates the utility of the

EMDR R-TEP protocol with an ICU survivor experiencing psychological distress related to her period of critical illness. In the service described, ICU survivors are generally assessed and, if appropriate, offered psychological treatment relatively early in their community recovery process.

In writing this case study, it became apparent that the impact of COVID resulted in the bypassing of the usual collection of information from questionnaires. Standardly, a trauma measure, such as the IES-R or PCL5, is used as a pre- and post-measure, but this did not happen. Helen presented with symptoms indicative of psychological trauma, which can be conceived of as post-ICU PTSD, hence the selection of EMDR as an appropriate intervention. A proportion of ICU survivors seen by critical care psychology do not score above clinically significant level on psychometric measures, possibly reflecting the early nature of the intervention, and indicating that psychological distress exists on a continuum from normal reaction to adverse circumstances, to adjustment disorder, to PTSD. Clinical practice has shown that EMDR therapy utilising the R-TEP protocol is equally promising with the range of presentations evidenced in the patient population.

The critical care psychology service has kept an audit for four years. Figures indicate that some ICU survivors attend only one therapy session. It is understood that this occurs for several reasons. A percentage of patients report that in the time between attending the ICU MDT follow up-clinic and starting therapy, their psychological distress has resolved; for others, it is not the right time for therapy, as they have ongoing physical health issues requiring attendance at numerous medical appointments; for some, the reason is less clear. Figures from 2017 to 2021 indicate a large range of session numbers from 1 to 27, with an average between 4.25 and 7.75 each year. Interestingly, the person who attended 27 sessions had been in the ICU five years earlier; fewer sessions may have been required if an intervention had been offered sooner. Recovery rates in terms of a reduction in scoring in the clinically significant range on outcome measures are high. The service context is such that most people will receive EMDR therapy, and after 2018, it will have been using EMDR R-TEP, so the recovery rate and number of sessions indicate that Helen's experience is replicable.

It is important to consider both how EMDR R-TEP might be used with the ICU survivor population and what mechanisms might underpin its utility. Within the R-TEP structure, the traumatic episode narrative puts together a timeline of events. On completion of the narrative, many individuals reflect that it is the



first time they have talked through everything that has happened. Clinical experience is that this process often integrates with the input from the ICU MDT follow-up clinic, where an ICU consultant talks through the medical narrative, and which is often the first time an ICU survivor is fully aware of what happened when they were unconscious. During follow-up therapy sessions, individuals regularly reference information they have learned from the discussion about their medical narrative and this information is often included in reprocessing. Additionally, at the MDT clinic, ICU survivors meet members of the team who cared for them and review their current recovery process. This information is also often integrated into reprocessing in terms of making sense of what happened in the past and updating expectations in the present in connection with recovery processes.

In EMDR R-TEP, the traumatic episode narrative is followed by selection of a target based on what feels disturbing now, thereby maintaining a person-centered current trauma focus. This process appears to support the identification of targets with the strongest impact on current quality of life (De Jongh et al., 2010). The use of the scan allows a dynamic selection of targets relating to past events, current triggers, and future templates, based on what feels disturbing now. The different PODs can cover different domains. EMDR R-TEP therefore offers a responsive method of target selection and has the advantage of containing reprocessing to critical care-related experiences unless there is an identified and agreed need to broaden reprocessing to standard EMDR.

In session five, therapy integrated the use of reprocessing flashforward imagery. The rationale for the flashforward is that a person's focus may be on the future, but fears are experienced in the present, triggered by irrational thoughts with catastrophic content; therefore, the mental representation of the potential future catastrophe can be processed in the same way as past events (Logie & De Jongh, 2014). The use of the flashforward is supported in the context of ICU PTSD, which includes flashforward fear of it happening again (Jackson et al., 2014).

Fatigue and pain are regularly present in post-intensive care syndrome and have overlaps with psychological symptomology. Fatigue can be linked to depression or worry, and to lack of sleep. Pain and fatigue can be directly targeted with EMDR reprocessing. In session six, the use of EMDR R-TEP brought up tiredness, which was successfully processed. Many

ICU survivors report sleep-related problems and clinical experience is that EMDR therapy is often highly effective in enabling ICU survivors to feel safe enough to sleep. EMDR also allows the integration of physical and psychological aspects of critical illness, facilitating a re-evaluation of the present meaning of an experience (De Jongh et al., 2010). When Helen processed her recurring dream, there appeared to be echoes of delirium experiences of seeing monsters, with a re-evaluation of "they are trying to help me." Clinical experience is that ICU survivors will rarely initially speak about their delirium experiences, so it can be important to ask specific questions to help normalize potential ICU experiences and to open up discussion (Tingey et al., 2020).

EMDR R-TEP is considered an early intervention for recent events, which are often defined as having occurred within the last 3 months. However, clinical experience shows that EMDR R-TEP provides a helpful structure long after the initial 3 months. Additionally, as the traumatic episode spans up until today, it has the advantage of incorporating the longer-term consequences of being critically ill. The importance of easy access back to the service if a person experiences re-triggering is worth noting. Knowing the support is there helps maintain change and easy access means any potential problems can be dealt with efficiently and effectively.

The therapy described in this case study was conducted on a remote basis. Since the lockdown, many services switched online, with remote EMDR therapy proving effective (McGowan, et al., 2021). The use of technology can potentially increase the availability and efficacy of psychological treatment (Holmes et al., 2018). Moving services online had the additional consequences that ICU survivors do not need to attend the hospital, which is often a barrier to accessing services, and that access to the service is no longer being limited to those who live geographically close to the hospital.

This case study is a step in illustrating the potential benefits of an EMDR early intervention in facilitating broader recovery and adaptation to an often changed sense of self as a result of critical illness. EMDR and TF-CBT are effective interventions (Mavranouzouli et al., 2020a), with EMDR the most cost-effective (Mavranouzouli et al., 2020b). Given the longer-term impact of critical illness, there is a strong case for an effective early intervention to be provided for all ICU survivors who may benefit.



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