



How can we work in a psychologically informed way in critical care?

Dr Anna Turner - Consultant Clinical Psychologist in NUH Critical Care &

Dr Rachel Attfield - Lead Clinical Psychologist in Kings Mill Hospital Critical Care

AIMS



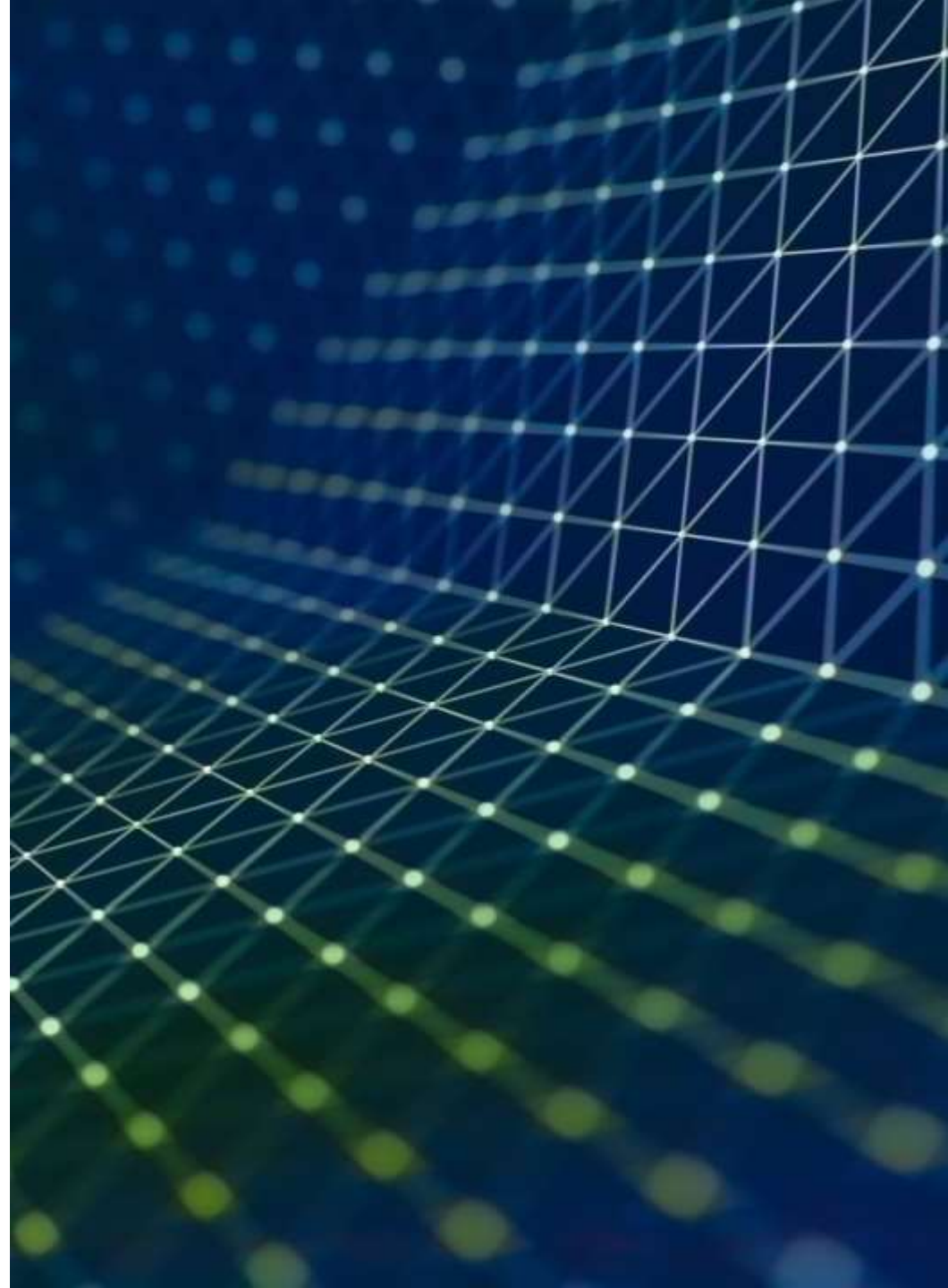
PSYCHOLOGISTS
WORKING IN CRITICAL
CARE



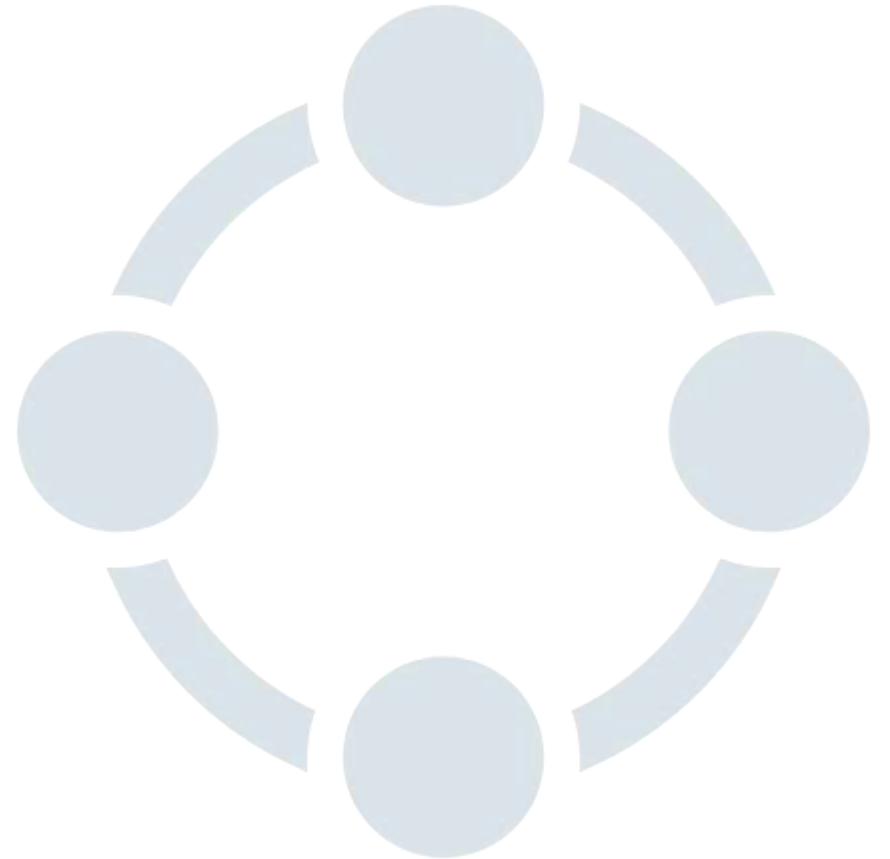
HOW CAN
PSYCHOLOGICAL
CONCEPTS RELATE TO
OUR WORK IN
CRITICAL CARE



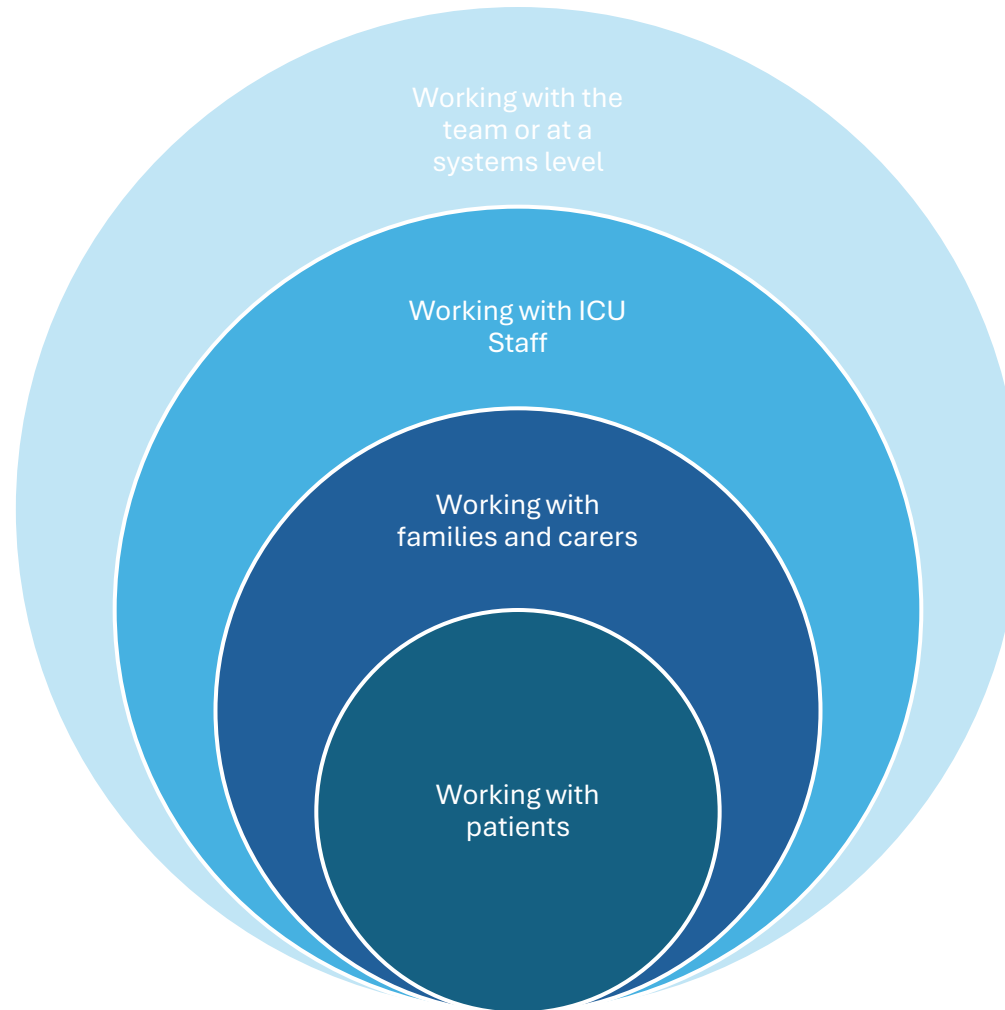
INTERACTIVE –
PLEASE JOIN IN!



Mentimeter: What
do psychologists
do?



Psychologists in critical care



Psychology vs Psychiatry in an acute hospital setting

Psychology

- Support patients with psychological difficulties related to their physical health
- Create formulations to help understand factors contributing to a person's psychological difficulties and what may be keeping them going
- Do not diagnose mental health conditions but their assessments may contribute to an MDT approach leading to diagnosing a mental health or developmental condition
- Do not prescribe medication

Psychiatry

- Psychiatrists are medical doctors who specialise in mental health in child & adolescent, working age or older adults
- Work with individuals who are suicidal, or who have been admitted due to self harm or who are demonstrating signs of severe and enduring mental health problems such as psychosis, bipolar disorder
- Diagnose mental health conditions, advise on, and prescribe medications for mental health difficulties whilst an inpatient
- Link with community services such as local mental health teams

What does psychologically informed mean?

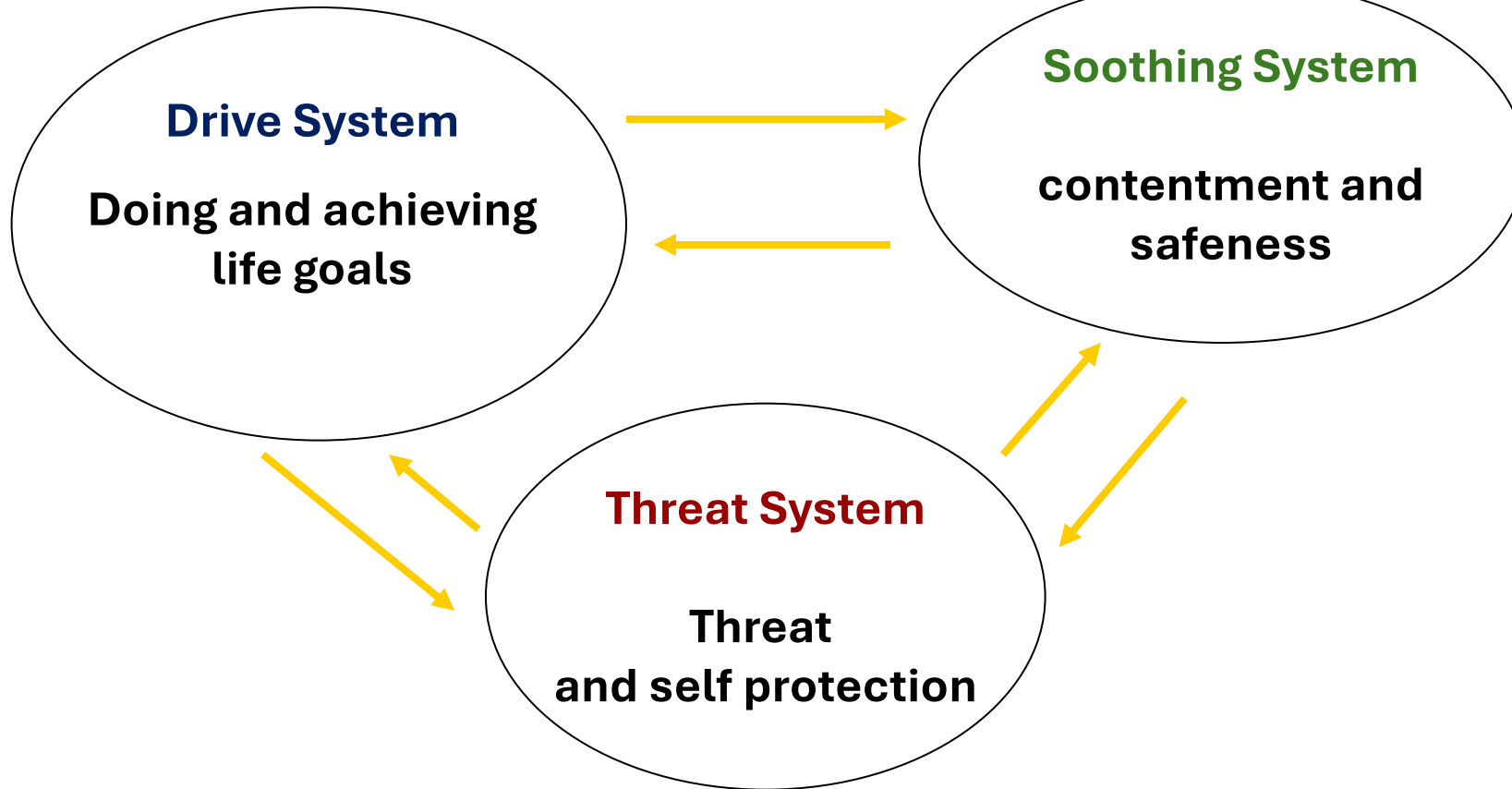
Understanding the psychological needs of patients, families and the critical care team

Embedding trauma-informed, compassionate care into everyday practice

Not just what we do, but how we do it

Drive, excite, vitality

Content, safe, connect



Anger, anxiety, disgust

In Threat

- Fight, flight, freeze, fawn
- Better safe than sorry approach
- Negativity bias



In Drive

- Motivates us to meet our needs and pursue life goals
- Associated with dopamine
- How do we help activate our patients drive system?



Soothing system

- Balances the threat and drive system
- Associated with oxytocin and endorphins
- Feel calm, safe and connected



Task: How can we help
move patients from
threat to soothing, even
in short interactions?





Task: How might patients, families, and staff live in different circles on critical care?

How the circles show up in Critical Care



Patients: Often stuck in threat (pain, fear, confusion)



Families: Mix of threat (grief, fear of future) and drive (seeking info)



Staff: Predominantly drive (task focused, get things done), risk of tipping into threat (overwhelm)



Soothing system can get neglected

Co-regulation



When we show up as calm and regulated in our nervous system, it helps others to return to a state of emotional and physiological balance



Our patients cannot often regulate themselves because of pain, distress, disorientation/confusion, or due to real or perceived threat

We become their external regulators not just through medical care, but through our presence, tone of voice, body language and behaviour

There are many factors that can impact on this because of mirror neurons...

Key messages...



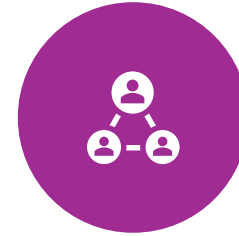
THREAT-BASED RESPONSES
ARE COMMON AND
UNDERSTANDABLE IN ICU



UNDERSTANDING WHAT IS
DRIVING BEHAVIOUR AND
REFRAMING THIS CAN
ENCOURAGE COMPASSION
AT STRESSFUL TIMES FOR
PATIENTS AND STAFF



SMALL RELATIONAL
INTERVENTION CAN
ACTIVATE SOOTHING
SYSTEMS AND SUPPORT
RECOVERY



THE MODEL CAN HELP STAFF
STAY REGULATED,
REFLECTIVE AND LESS
REACTIVE



THIS IS WHAT
PSYCHOLOGICALLY
INFORMED CARE CAN LOOK
LIKE IN ACTION: NOT JUST
WHAT WE DO, BUT HOW WE
DO IT – WITH AWARENESS OF
EMOTION, SAFETY, AND
CONNECTION, SMALL
PRACTICAL REGULATION
SKILLS CAN RIPPLE
THROUGH TEAM CULTURE

Three things you
could apply to your
clinical practice...



Any
questions?

