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Research Article

Covid-19 and Psychotherapy: Family Therapy and EMDR

Espinosa-Gil Rosa Maria[1]* and Monteagudo Santamaria Maria[2]

[1]FEA Clinical Psychology, Rehabilitation Service, Hospital Clínico Universitario Virgen de la Arrixaca, Murcia, Spain

[2]FEA Rehabilitation, Head of the Physical Medicine and Rehabilitation Service, Rehabilitation Service, Hospital Clínico Universitario Virgen de la Arrixaca, Murcia, Spain

***Corresponding Author:** Espinosa-Gil Rosa María, FEA Clinical Psychology, Rehabilitation Service, Hospital Clínico Universitario Virgen de la Arrixaca, Murcia, Spain

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Abstract:

The beginning of the pandemic in Spain, generated in the population, helplessness and uncertainty. The first to be infected were exposed to great fear.

Sample: Familia who suffered since March 2020 the COVID infection of 4 of the 5 members, being the father who was admitted to the ICU. The patient was admitted to the ICU for about 55 days in isolation and with significant severity.

Instruments: BDI II (depression), STAI (anxiety), EGS (post-traumatic stress).

Method: Initial interview and data collection Systemic family therapy and integrative group treatment with EMDR) (Eye movements desensitization and reprocessing (EMDR-IGTP) Jarero y Artigas,2016).

Results: At the beginning, the patient and his wife had symptoms compatible with post-traumatic stress disorder along with dissociative symptoms. Along with depressive disorder. We started the systemic family therapy sessions and applied 3 sessions of the EMDR-IGTP protocol of Jarero and Artigas, 2016 on PTSD for continuous trauma together. The results obtained have been very promising, because the symptomatology both depressive, the symptoms of post-traumatic stress and the dissociative, has been significantly reduced in the two members of the family.

Keywords: Covid; Family; Post-Traumatic Stress; Family Therapy; EMDR; Psychotherapy

Introduction

The American Society for Critical Care (SCCM) defined Post ICU Syndrome (PICS) as "New or worsening of physical, mental, or cognitive health problems related to critical illness that persist upon discharge from the hospital in the survivor." In addition, he linked PICS to the family member or caregivers (PICS-F) because as a result of the critical illness they can develop complications in their mental health [1]. The researchers recommend the intervention of rehabilitation clinicians (doctors and mental health specialists) together with therapists from the service to coordinate and cope with post-ICU syndrome. Regarding the care of families once the patient has survived the disease, it is necessary to review their emotional states and not tomonitor the normal emotional reactions of the relatives, being necessary to establish clear and consensual criteria with all the professionals involved to determine if intervening is more beneficial than not doing so [2,3].

Alteration in the activities of daily living, in instrumental activities. This disability, like making the purchase, occurred in 70% of

ICU survivors who required ventilation for more than 48 hours, and these disabilities are correlated with the patient's age [4].

The hospitalization of a loved one, and more specifically in a critical care unit generates modifications in perceptions, thoughts and feelings, even disturbing consciousness such as Post-ICU Syndrome (PicS), which affects the hospitalized critical patient, and Post Intensive Care Syndrome-Family (PICS-F), which affects the relatives of admitted patients and was created by the Society of Medicine Criticism [5,6].

In the case of an invisible disease, the alarms go off and generate depressive processes, reactive to so much insecurity and intense emotional processes where sometimes specialized human resources are needed to accompany both the patient who has suffered an infectious disease of which information on its way of proceeding is still unknown, and the high mortality, and the transmission of information (through the media) generate anguish and probably phobic-anxious processes.

There are studies on family members who have to make decisions in intensive care and have a higher level of anxiety, and a higher prevalence of post-ICU syndrome [7].

The National Institute for Health and Care Excellence NICE (2018) [8] guidelines advocate active monitoring during the first month after exposure to potential trauma before intervening. If the person shows psychopathological signs after that time, it would be advisable to consult with specialized professionals.

To conclude and following the recommendations of the Spanish Society of Rehabilitation and Physical Medicine (2020) rehabilitation should be considered as a continuum of care with an early preventive approach over time and a follow-up to discharge from the ICU and the hospital, which ensures a comprehensive outpatient follow-up, including multidisciplinary post-ICU consultations [9].

A recent study investigated ptSD symptoms according to severity and medical needs required after Covid-19, in 13,049 patients, finding that those who needed hospitalization, admission and respiratory support, (effect size 0.454d.e., P less 0.001) intrusive images were the most prominent symptom. The authors highlight the importance of being evaluated by mental health specialists [10].

Focusing specifically on the beginnings of the Covid-19 pandemic, studies focused on psychological effects are beginning to proliferate. This is how we found the study carried out in the US where high levels of anxiety and depression have been reported in people infected with COVID-19 [11]. Based on 62,354 people diagnosed with COVID, a greater association between psychiatric diagnosis and having suffered from COVID was observed. The probability of receiving a psychiatric diagnosis is 18% higher among post-COVID patients between 14 and 90 days post-COVID. This means that there is a higher incidence of COVID in people who had not previously had any psychiatric diagnosis.

Reviewing the existing literature, the impact of trauma is cumulative [12]. The risk of PTSD and comorbid disorders (anxiety, depression) increases with the number of exposures [13].

As for the integrative group treatment (EMDR-IGTP) *Eye movements desensitization and reprocessing*- integrative group treatment, has been used in different parts of the world both with children and adults, after natural disasters or caused by human action. This treatment combines the 8 phases of standard EMDR treatment with a group model [14].

This treatment is based on Shapiro's Adaptive State Information Processing System (SPIA) model [15]. Within the SPIA model, the continuous experience of trauma over a period of three or more months is conceptualized, during which there is no post-trauma safety window for memory consolidation [16]. In the authors' words, the continuum of prolonged adverse experiences creates a cumulative memory network of trauma exposure [17].

Receiving a Covid diagnosis implies a phase of isolation, fear of the future, fear of death. Separation of family members (in this family the patient was admitted to ICU 60 days) and the wife also with Covid at home. Daily calls, feelings of guilt, intra- and extra-family stigmatization, especially at the beginning of the pandemic (March 2020), generates an accumulation and continuous stress.

Sample

Conjugal system of a family where the husband was admitted to intensive care for COVID 19 and the wife with the same disease isolated at home.

Family (Patient and wife).

Critical care patient

The 72-year-old patient was admitted to hospital with dyspnea and fever, with an oxygen saturation of 84%. And on the x-ray bilateral infiltrates appeared. With a diagnosis of respiratory failure secondary to bilateral bronchopneumonia due to SARS-COV-2, he was admitted to the ICU, subsequently developing acute respiratory distress syndrome.

During his stay in the ICU, he remains sedated and connected to mechanical ventilation, which required other prone positioning, on two occasions. The stay in the ICU lasted for 55 days developing polyneuromyopathy of the critical patient.

Wife isolated at home

A 70-year-old woman, a rural dwelling, her work by profession, dedicating herself mainly to the care of the countryside with her husband and her animals.

The family was initially evaluated after an average of 60 days in the ICU. The main value of these data is because they were among the first families affected at the beginning of the pandemic (March 2020).

Instruments

- **Beck Depression Inventory-II [18]:** According to Sanz, García-Vera, Espinosa, Fortún and Vázquez (2005), the Spanish version has excellent internal consistency (α = .89). This instrument evaluates the severity of depressive symptoms in adolescents and adults through 21 multiple-answer questions.
- **State-Trait Anxiety Inventory [19]:** The inventory, composed of 40 items, 20 for each subscale, assesses the level of anxiety and the person's predisposition to respond to stress. Cronbach's lfa of .94 for anxiety-status (STAI-E) and .90 for anxiety-trait dimension (STAI-R).
    - **Anxiety as a state (A/E):** evaluates a transient emotional state, characterized by subjective, consciously perceived feelings of attention and apprehension and by hyperactivity of the autonomic nervous system.
    - **Anxiety as a trait (A/R):** indicates an anxious, relatively stable propensity that characterizes individuals with a tendency to perceive situations as threatening.
- DSM-5 Post-Traumatic Stress Disorder **Revised Symptom Severity Scale (EGS-R)** [20].
- It is a heteroapplied scale that is structured in a Likert format from 0 to 3 according to the frequency and intensity of the symptoms. It consists of 21 items in correspondence with the diagnostic criteria of the DSM-5. (Re-experimentation, cognitive and/or behavioural avoidance, negative cognitive and mood disturbances and increased psychophysiological activation and reactivity).

The range of the global scale ranges from 0 to 63 points. Four items have been added to evaluate in a complementary way the presence of dissociative symptoms due to the importance given to these symptoms in the DSM-5 and six items to assess the degree of affectation or dysfunction related to the traumatic event.

Procedure

After initial evaluation, systemic family therapy sessions were scheduled. The first two sessions revealed a great resistance on the part of the children (two of them also affected by the disease) and a tendency to minimize the symptoms. Because the main patient (verbalized that he did need psychological help and the wife's affability for psychological intervention), we resumed the following sessions only with the marital subsystem).

- **Session 3:** The symptoms of post-traumatic stress persisted in the 3rd session, setting the following.
- **objectives:** Apply the continued PTSD-IGTP protocol [21] (3 sessions).

We explained the Adaptive Information Processing System and proceeded to the establishment of the safe place through the Butterfly Embrace that as established by the authors (it is not a technique to favor the self-regulation of the affections", but the desensitization is a by-product of the reprocessing of the disturbing material, using the Butterfly Embrace as a method of self-administration of bilateral stimulation, during EMDR therapy, in group or individual format [22].

In the next two sessions with a difference of 15 days we applied the protocol itself for continuous trauma (Figures 1,2 and Table 1).

We continued with the systemic framework, to facilitate the rapprochement in the family and eliminate the stigma of contagion

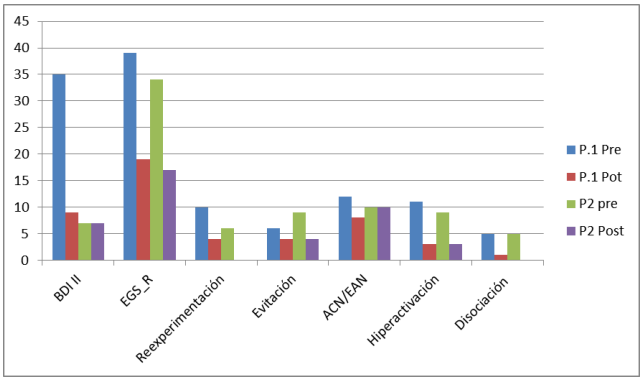

Table 1: Results obtained in the family at the beginning of psychotherapy and at the end of it. ACN/EAN: cognitive and/or mood disorders.

In re-experimentation and in post-treatment dissociation patient 2 (wife) scores 0, it is not recorded in the graph.

among its members (the wife felt rejected by certain family members).

Mainly we focus on a structural approach of systemic family therapy [23] where the different family subsystems (conjugal, parental and fraternal) will be located in the optimal place to guarantee their development and at the same time an adequate family differentiation that will facilitate the improvement of the family climate and the development of its members individually. Differentiation is related to the level at which each member of the family system can be emotionally independent of that system.

Results

After the initial evaluation according to protocol we found depressive symptoms in the patient and a diagnosis of post-traumatic stress in both the patient and the woman, as described in the literature on post UCI syndrome.

The patient scored significantly for PTSD, with the main symptoms being re-experimentation, hyperactivation, and cognitive and mood alterations. and had dissociative symptoms. The wife did not meet criteria for PTSD, although she presented two dissociative symptoms with maximum intensity) the total score was at limit 34.

The patient presented at the beginning of the treatment Depressive disorder measured with the BDI II without presenting autolytic ideation. Score of 35. At the end of the treatment the patient improved clinically being the 'score of 9.

No significant differences were obtained at the level of anxiety, both in trait and condition in the patient and in his wife.

The patient presented at the beginning of treatment post-traumatic stress disorder with symptoms of re-experimentation mainly, followed by hyperactivation and negative alterations in mood. The total score on the EGS scale is 39. Dissociative symptoms were present (2 symptoms at their maximum intensity in both spouses). At the end of the treatment, we found that the patient scored 19 in total on the scale and only retained 1 dissociative symptom with low intensity. A significant improvement of all symptoms of post-traumatic stress measured was observed.

As for the relative, he scored at the beginning 34 on the Scale of severity of PTSD symptoms, being avoidance, cognitive and mood alterations, along with hyperactivation, the most characteristic. He also presented 2 dissociative symptoms in maximum intensity, and after finishing the treatment the dissociation disappeared.

He maintained the same score in depressive and anxious symptoms, at the beginning and at the end of psychological treatment.

The end of the protocol is to present them with a vision of the future and to draw it. It can be observed that the most serious patient recovers his life as a hunter and that the wife returns to enjoy life in the field *"Relax in the field".*

The family managed to continue in their natural environment, preserving and carrying out their hobbies and normal activities of daily living, an aspect that is observed in the future vision of the applied EMDR-IGTP protocol.

Discussion

PTSD is a diagnostic entity that is usually present in patients who have been discharged in Specialized Intensive Units, being necessary its monitoring by Clinical Psychology, to favor the recovery of the patient and the family who have suffered the so-called Post UCI syndrome, which has been extensively investigated for more than a decade.

If we add the state of helplessness, isolation and lack of response that we still have about the virus, mental health will suffer even more than the literature has already described about the Post UCI syndrome.

The Rehabilitation Service must pick up the patient in the process, welcome the patient and his family to provide them with therapies appropriate to what the Post ICU syndrome, and the post covid can leave with disabling diseases, and with severe isolation due to the characteristics of the beginning of the pandemic.

We cannot generalize the results due to the low sample size and that we are still at the beginning of the treatment, however it is advisable to apply the protocol in cases where there is continuous trauma. Another drawback that we emphasize is that specific training is needed both in systemic therapy, as in EMDR and more specifically in the Integrative Group Treatment Protocol and that being a public environment a clinical psychologist is needed for its implementation. Fortunately, all these circumstances occurred, and we have found very promising data to alleviate the suffering of patients and families in post-covid syndrome.

Conclusions

Systemic family therapy in the hospital environment offers benefits and generates satisfaction and improvement of coping with the disease.

EMDR-IGTP, for continued post-traumatic stress, applied to both family members, is a therapy that can help when ptSD symptoms and specifically dissociative symptoms appear, in patients who have suffered from COVID 19 disease and their families.

A multidisciplinary work is needed and from the Rehabilitation Service to favor the follow-up of patients and their families who have suffered considerably from Postcovid syndrome.

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