

How telling stories helps patients to recover psychologically after intensive care

Time in intensive care can lead to post traumatic stress and other problems. While telling stories can help psychological recovery, some patients need support in this

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ABSTRACT Williams SL (2010) How telling stories helps patients to recover psychologically after intensive care. *Nursing Times*; 106: 5, 20-23.

Background Studies have shown both the risk of post traumatic stress following intensive care unit treatment, and the helpfulness of telling trauma stories for psychological recovery.

Aim This article is based on recent doctoral research exploring the impact of unexpected life threatening events after admission to hospital.

Method The original research used a qualitative design blending discourse, narrative and phenomenological approaches, guided by sensitivity to participants' evolving work of pulling stories together. Patients chosen from ICU discharge summaries showing a critical life threatening event after admission gave unstructured interviews soon after discharge from hospital and a year later.

Results This article focuses on one particular finding, showing that critical illness can make it difficult for patients to construct personal stories of their experience. Limited evidence suggested overcoming those difficulties meant they had an improved sense of wellbeing a year after discharge.

Discussion Stories are an essential way in which humans make sense of their experience, which is crucial both for responding appropriately and for personal wellbeing following traumatic life events. Therefore, difficulties in "storying" significant experience can have a negative impact on wellbeing.

Conclusion Some patients need help piecing together stories of their critical illness experience.

INTRODUCTION

After intensive care treatment, patients sometimes suffer from post traumatic stress (for example, Sukantarat et al, 2007; Cuthbertson et al, 2004; Jones et al, 2001).

The issues arising from the psychological effects of critical illness can be both immediate and long term (Pattison and Dolan, 2009).

Turning traumatic events into stories is considered crucial to recovering psychologically from overwhelming life experience (Meichenbaum, 2006; Tuval-Mashiach et al, 2004; Herman, 1994).

However, until recent research explored the impact of unexpected life threatening events after admission to hospital (Williams, 2008), the role of story construction in resolving traumatic memories after ICU had not been investigated.

HOW ARE PERSONAL STORIES NORMALLY USED?

Before reviewing findings from the original doctoral study, some background information on how people use personal stories and their benefits helps clarify the significance of those findings.

We all use stories to make sense of our experience of both the external world and our internal world of thoughts and feelings. This organic process helps us respond appropriately to the environment, which can be crucial for survival.

"Storying" our experience (the process of constructing and telling the story) is so automatic that we usually only become aware of the process when something gets in the way.

When an experience is personally significant, difficulties with storying can be extremely distressing.

PRACTICE POINTS

- Understanding the function of story processing could give ICU follow up clinics and nursing staff a clearer sense of their potential contribution to critically ill patients' psychological recovery.
- Practice development initiatives could enhance nursing communication. Since story construction is central to people's core identity processes, these findings would also be relevant to person centred nursing objectives.

Pulling together a story

Stories are not just handed to us, even though they often seem to come automatically. Our brains have to select and order significant information from an ocean of sensory information (Kelly, 1963) before the meaning of an experience can be understood.

Experiential information is organised by linking internal and external events into an increasingly clear and personally meaningful story. Stories can have coherence on a number of dimensions (McAdams, 2006;

Androutsopoulou et al, 2004; Habermas and Bluck, 2000), such as those listed in Box 1.

Using stories

Once stories are coherent, tellers can use them to achieve various social goals, such as gaining understanding, respect or sympathy, or even making a moral point (Mishler, 2004; Harvey et al, 2000; Baumeister, 1994).

Eventually, a transformational turning point can be worked into the story, potentially even changing the plot completely (Meichenbaum, 2006) from, for instance, a tragic story of events beyond one's control to an epic story of true grit. Through this transformation, people can move on from the original experience of helpless passivity to become more active survivors.

Storying experience helps people cope with powerful emotions after trauma, and also has health benefits when coping with more general forms of stress (Tuval-Mashiach et al, 2004; Smyth and Pennebaker, 1999).

Processing past experience through storying can help people contemplate a future that moves away from that past.

It can also make personal communication more meaningful. For instance, relatives and friends can be kept in touch with identities

that change through experiences, both bridging relationships and enabling others to offer appropriate comfort.

All this helps storytellers manage life more effectively.

Because this story process is cumulative, each step towards transformation and integration depends on completing the previous task (Salvatore et al, 2004). If the event related information is not gathered, it is impossible to construct an adequate story.

If the emotions are not integrated into a coherent personal account, then the personal meaning of the event cannot be adequately grasped and embraced within the wider life story (McAdams, 2006; Neimeyer et al, 2006). This also means help with stories must respect patients' level of event awareness at the time of any intervention, because, for instance, lack of emotional integration can mean they have yet to overcome obstacles to comprehending the event, such as feeling terror.

Any significant failure to complete stories can mean that thoughts or feelings from the experience may return unbidden in the form of intrusive visual or emotional memories, which are hallmarks of post traumatic stress (Herman, 1994; Horowitz, 1987). Patients may need to tell stories repeatedly to achieve both multidimensional coherence and shared understanding with relatives and friends (Harvey et al, 1990).

METHOD

This research was carried out in a regional intensive care unit with full ethical approval. Participants selected from ICU discharge summaries gave informed consent before being interviewed in a place of their choice, with follow up interviews carried out a year later. All interviews were unstructured and explored participants' experiences of the critical incident and its aftermath.

Data was analysed by coding three uses of language (that is, language rich in discourse, discursive narrative and phenomenological narrative) and applying appropriate forms of analysis, with sensitivity to the constructive process of storytelling.

RESULTS AND DISCUSSION

Problems with storying

ICU patients experienced difficulties with their ability to construct stories of their critical illness. Because people care about putting significant life experiences into stories, and critical illness experiences are inherently significant, patients were distressed about these difficulties with storying their illness.

BOX 1. DIMENSIONS OF COHERENCE IN STORIES

- Temporal coherence: the story hangs together chronologically with a unified timeline (Ricoeur, 1991), creating order out of chaotic fragments of experience, which contributes to a sense of personal peace.
- Emotional and cognitive coherence: the story blends the storyteller's feelings with information about events, helping them understand and cope with event related emotions.
- Thematic coherence: the story links current experience to knowledge about similar kinds of experience, contributing to a growing understanding and personal wisdom about life.
- Autobiographical coherence: the story weaves the event into a wider life story so the person's sense of self can absorb and grow with the experience. This also reconstructs and stabilises that sense of self in the wake of experience which may have shattered identity processes.
- Causal coherence: the story makes sense either of why events turned out the way they did, or why the cause is uncertain.

The first hurdle: an information gap

To begin with, a lack of consciousness, whether total or partial, meant that the flow of sensory information to the brain was not only interrupted but also difficult to order.

Patients were keen to collect the facts of what happened when they were critically ill. This had nothing to do with patient rights, but rather a need to know information that was first and foremost their own personal information, even if they might be the last to hear about it.

This information gathering marked the crucial beginnings of story formation. One patient said:

"The thirst for knowledge is there, if you know what I mean, because it's happened to you."

Essentially, patients need to reclaim ownership of a momentous event in their life by knowing what happened. Another said:

"It's hard to believe that it's happened. And everybody else is talking about it and it's as if I wasn't there, but I suppose I wasn't really."

Not knowing was like being an outsider in this patient's own life. Constructing her story helped her not only to gather the facts when she was ready for them, but also to believe it actually happened. This helped her overcome the shock that such a catastrophic event could suddenly have left a healthy 26 year old semi-conscious for three weeks after admission to hospital just to give birth.

She could never have absorbed that reality if she had not acquired the information about what happened first.

That information in part helped to fill a memory gap (Griffiths and Jones, 2000)

about what occurred during her period of unconsciousness.

However, patients' lack of memory is not the only information gap. Even when friends, family or patient diaries contribute to personal information, people need medical information (Wessen, 1997) to grapple with the esoteric facts about their particular condition and treatment.

This research highlighted a lack of reliable and timely help for patients with both kinds of information.

Struggles to organise the story

Patients struggled to mesh their own memories with facts provided by staff. In the process of telling stories repeatedly, delusional memories could eventually be reinterpreted and storied as delusional, but only after acknowledging them as real – however delusional – parts of their story (Williams, 2008). This was just one of the ways in which patients found it hard to unify the many strands of their experience.

Different strands of time: the sense of disorientation, typical of intensive care experience, was helped by blending private timeless memories with information about what was happening in real time during the illness. This blending helped patients to give their story temporal coherence. Patients who had had periods of unconsciousness found it hard to order stories in relation to time. This can be disconcerting since this kind of coherence helps people feel oriented in relation to the rest of the world (Ricoeur, 1991). Also, we expect to feel oriented in time, since by the age of three most people can tell stories with some temporal coherence (Habermas and Bluck, 2000). Temporal coherence not only facilitates storytellers' connection with the outside world but also helps listeners connect personally with stories.

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Different explanations of cause: after accounting for what happened, patients needed to explain why events occurred; the more clearly storytellers can account for why events occurred, the more causal coherence their story has. This matters, as the better patients could understand why an event occurred, the more prepared they were to take responsibility for their healthcare again.

Struggles to make sense of new experience
Sudden illness meant that patients were not prepared for what happened, which can mean they lack an adequate conceptual framework for making sense of those experiences (Janoff-Bulman, 1989).

The number and complexity of new experiences for patients are compounded by all the objects and staff whose functions are often a mystery. The medical technology of an ICU can be, at the very least, an overwhelming experience, particularly if people's faculties are impaired.

Nearness to death was a new experience for most patients, which made it difficult for them to adequately story their experience.

There is a significant difference between contemplating the meaning of death from afar (either in the abstract or in relation to someone else) and confronting its stark reality personally (Bush, 2002). Death anxiety is a common response to sudden life threatening events (Lifton and Olson, 1976). The total loss of physical control intrinsic to critical illness is intensified by the global existential loss of control in a near death encounter (Arndt and Solomon, 2003).

At the same time, though often disguised by a deceptively calm exterior, the power and quality of emotions were new to patients (van der Kolk, 1996). An emotion such as terror is more powerful and also quite distinct from fear, just as rage is more powerful but also quite different from anger. Also, a number of different feelings were experienced simultaneously, all at a time of physical weakness when patients were less able to manage the complexity of emotions.

This multidimensional newness can overwhelm cognitive/emotional regulatory systems, resulting in numbness and shock. The experience of shock can itself be new, leaving people much less able to pull a unified story together, since emotions are not cognitively accessible for integration into stories. People can therefore experience powerful emotions on one level while not being aware of them (Lane and Schwartz, 1987), leaving them feeling helpless and powerless over those feelings. This can feed

BOX 2. SPECIFIC RISK FACTORS

A diminished sense of self-efficacy (Bandura and Locke, 2003) made it less likely that patients would tackle the obstacles to story construction.

Relatives and friends sometimes resisted patient attempts to gain information (Lepore et al, 1996), perhaps concerned about making the distress worse. As a result crucial social support (Brewin et al, 2000) was compromised along with the story process.

One patient told her husband: "Whenever I start to ask you questions and you, you answer me them, but you would say don't dwell on it; but it's stuff I need to ask, but then I do, I just carry on" (Williams, 2008).

Avoidant reactions inherent in post traumatic stress can create yet more barriers to constructing illness experience stories.

spiralling emotional reactions to the global loss of control, encompassing both internal and external life worlds.

Box 2 outlines risk factors for difficulties or obstacles in storying.

Some benefits of a coherent story

Clarity of understanding of experience had crucial benefits for recovery.

First, authoring – that is, assuming the authority to construct their own – coherent narratives of critical illness experience helped patients begin to regain control of their lives (Baumeister, 1994) and then manage personal healthcare again after discharge. This personal control also made it possible for people to reconstruct life after a major event if their former way of life was no longer viable.

Telling coherent stories also diminished the sense of isolation left by the intensely individualised illness experience (Guay et al, 2006).

Even more importantly, constructing coherent stories helped patients regain a sense of wellbeing by providing a framework for transforming their experience into a personally meaningful and beneficial event (Meichenbaum, 2006; Joseph and Linley, 2005; Tuval-Mashiach et al, 2004; Calhoun and Tedeschi, 2001). One patient said:

"When something bad happens to you, you draw strength from it, you know. Once you recover, you know, that gives you strength to recover so... it made you stronger. So there's a good thing there. Right? And it makes you more careful, wiser, you know? So there's another good thing."

This patient's story was the most coherent on all five dimensions listed in Box 1, as well as the most clearly transformed from a distressing life experience to a beneficial life event. This person was also most able to focus on the future, and the most capable of thinking realistically about the life changes necessitated by the critical illness.

CONCLUSION

This study extends previous research showing the benefits of transformed personal trauma stories for personal wellbeing to the critical care setting. It suggests the pivotal role of storytelling for psychological recovery after ICU treatment. However, as this exploratory research used a small sample, future studies are needed to substantiate these findings. ●

This article is based on a study originally published in *Nursing in Critical Care* (Williams, 2009).

REFERENCES

- Androutsopoulou A et al (2004) Forming criteria for assessing the coherence of clients' lifeworlds: a narrative study. *Journal of Family Therapy*; 26: 384-406.
- Arndt J, Solomon S (2003) The control of death and the death of control: the effects of mortality salience, neuroticism, and worldview threat on the desire for control. *Journal of Research in Personality*; 37: 2, 1-22.
- Bandura A, Locke EA (2003) Negative self-efficacy and goal effects revisited. *Journal of Applied Psychology*; 88: 1, 87-99.
- Baumeister RF (1994) How stories make sense of personal experiences: motives that shape autobiographical narratives. *Personality and Social Psychology Bulletin*; 20: 6, 676-690.
- Brewin et al CR (2000) Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology*; 68: 5, 748-766.
- Bush NE (2002) Afterward: making meaning after frightening near-death experiences. *Journal of Near-Death Studies*; 21: 2, 99-133.
- Calhoun LG, Tedeschi RG (2001) Posttraumatic growth: the positive lessons of loss. In: Neimeyer RA (ed) *Meaning Reconstruction and the Experience of Loss*. Washington, DC: American Psychological Association.
- Cuthbertson BH et al (2004) Post-traumatic stress disorder after critical illness requiring general intensive care. *Intensive Care Medicine*; 30: 450-455.
- Griffiths RD, Jones C (2000) Filling the intensive care memory gap? *Intensive Care Medicine*; 27: 344-346.
- Guay S et al (2006) Exploring the links between posttraumatic stress disorder and social support processes and potential research avenues. *Journal of Traumatic Stress*; 19: 3, 327-338.
- Habermas T, Bluck S (2000) Getting a life: the

emergence of the life story in adolescence. *Psychological Bulletin*; 119: 31-50.

Harvey JH et al (1990) A social psychological model of account-making in response to severe stress. *Journal of Language and Social Psychology*; 9: 3, 191-207.

Harvey MR et al (2000) In the aftermath of sexual abuse: making and remaking meaning in narratives of trauma and recovery. *Narrative Inquiry*; 10: 2, 291-311.

Herman JL (1994) *Trauma and Recovery: From Domestic Abuse to Political Terror*. London: HarperCollins.

Horowitz M (1987) *Stress Response Syndromes*. New York: Jason Aronson.

Janoff-Bulman R (1989) Assumptive worlds and the stress of traumatic events: applications of the schema construct. *Social Cognition*; 7: 2, 113-136.

Jones C et al (2001) Memory, delusions, and the development of acute posttraumatic stress disorder-related symptoms after intensive care. *Critical Care Medicine*; 29: 3, 573-580.

Joseph S, Linley PA (2005) Positive adjustment to threatening events: an organismic valuing theory of growth through adversity. *Review of General Psychology*; 9: 3, 262-280.

Kelly GA (1963) *A Theory of Personality: The Psychology of Personal Constructs*. New York, NY: Norton.

Lane RD, Schwartz GE (1987) Levels of emotional awareness: a cognitive-developmental theory and its

application to psychopathology. *American Journal of Psychiatry*; 144: 2, 133-143.

Lepore SJ et al (1996) Social constraints, intrusive thoughts, and depressive symptoms among bereaved mothers. *Journal of Personality and Social Psychology*; 70: 2, 271-282.

Lifton RJ, Olson E (1976) The human meaning of total disaster. *Psychiatry*; 39: 1-18.

McAdams D (2006) The problem of narrative coherence. *Journal of Constructivist Psychology*; 19: 109-125.

Meichenbaum D (2006) Resilience and posttraumatic growth: a constructive narrative perspective. In: Calhoun L, Tedeschi R (eds) *Handbook of Posttraumatic Growth: Research and Practice*. Mahwah, NJ: Erlbaum and Associates.

Mishler EG (2004) Historians of the self: restoring lives, revising identities. *Research in Human Development*; 1: 1-2, 101-121.

Neimeyer RA et al (2006) Chaos to coherence: psychotherapeutic integration of traumatic loss. *Journal of Constructivist Psychology*; 19: 127-145.

Pattison N, Dolan S (2009) Exploring patients' experiences of a nurse-led follow-up service after critical care. *Nursing Times*; 105: 19, 16-19. tinyurl.com/effects-critical

Ricoeur P (1991) *Life in Quest of Narrative*. In: David Wood (ed) *On Paul Ricoeur: Narrative and Interpretation*. London: Routledge.

Salvatore G et al (2004) A model of narrative development:

implications for understanding psychopathology and guiding therapy. *Psychology and Psychotherapy: Theory, Research and Practice*; 77: 231-254.

Smyth JM, Pennebaker JW (1999) Sharing one's story: translating emotional experiences into words as a coping tool. In: Snyder CR (ed) *Coping: The Psychology of What Works*. Oxford: Oxford University Press.

Sukantarat K et al (2007) Physical and psychological sequelae of critical illness. *British Journal of Health Psychology*; 12: 65-74.

Tuval-Mashiach R et al (2004) Coping with trauma: narrative and cognitive perspectives. *Psychiatry*; 67: 3, 280-292.

van der Kolk BA (1996) The complexity of adaptation to trauma; self-regulation, stimulus discrimination and characterological development. In: van der Kolk BA et al (eds) *Traumatic Stress: The Effect of Overwhelming Experience on Mind, Body and Society*. New York, NY: The Guilford Press.

Wessen JS (1997) Meeting the informational, psychosocial and emotional needs of each ICU patient and family. *Intensive and Critical Care Nursing*; 13: 111-118.

Williams SL (2009) Recovering from the psychological impact of intensive care: how constructing a story helps. *Nursing in Critical Care*; 14: 6, 281-288.

Williams SL (2008) *Life After a Critical Incident in Hospital: an Exploration of Impact*. PhD thesis, University of Ulster, Jordanstown, UK.

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