Psychological/Cognitive issues in ICU patients

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Background

- *Psychological factors* have been found to influence a variety of *physical illnesses*.

- When *psychiatric disorders* are present along with general medical conditions, they may increase the likelihood of adverse events, length of stay, and cost; they also may negatively impact on outcomes and increase morbidity and mortality.

- Medical treatment in an ICU always means exposure to a critical medical incident with associated *physical and emotional trauma*. 
Psychological factors affecting medical conditions (1/2)

• Psychological factors may present a risk for medical disease, or they may magnify and/or adversely affect a medical condition.

• Biological and molecular reactions to stressors in the sympathetic nervous system, the pituitary-adrenocortical axis, and the immune system.
Psychological factors affecting medical conditions (2/2)

- A meta-analyses of more than 300 empirical articles suggests that psychological stressors may be associated with suppression of both cellular and humoral measures (Segestrom & Miller, 2004).

- The expanded diagnostic category *psychological factors affecting medical condition* in the DSM-IV-TR (APA, 2000) includes the identification of psychological factors that interfere with medical treatment, pose health risks, or cause stress-related pathophysiological changes.
Diagnostic criteria for psychological factors affecting medical conditions (DSM-IV-TR)

A. A general medical condition (coded on axis III) is present.

B. Psychological factors adversely affect the general medical condition in one of the following ways:

1. The factors have influenced the course of the general medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the general medical condition.

2. The factors interfere with the treatment of the general medical condition.

3. The factors constitute additional health risks for the individual.

4. Stress-related physiological responses precipitate or exacerbate symptoms of the general medical condition.
Psychological factors affecting general medical conditions

- Mental disorder
  *(e.g. major depressive disorder)*
- Psychological symptoms
  *(e.g. depressive symptoms)*
- Personality traits or coping style
  *(e.g. pathological denial for the need for surgery; hostile, pressured behavior)*
- Maladaptive health behaviors
  *(e.g. overeating, lack of exercise, unsafe sex)*
- Stress related physiological response
  *(e.g. stress-related hypertension or arrhythmia)*
- Other unspecified psychological factors
  *(e.g. interpersonal, cultural, religious factors)*
Psychological responses to serious medical conditions (1/2)

- **The degree of stress is dependent upon the person’s perception of the illness.**

- Peoples questions can be many and varied when they find themselves faced with a serious medical problem:
  - Will I suffer pain?
  - How will I cope?
  - Will I be disfigured?
  - Will I be able to function as a wife or husband, parent, and member of society?
  - Am I going to die?
  - Will I have long-term disability?
  - How will this affect my life?
  - Will I be able to continue to work?
  - Will I be able to continue to work?
  - Will I be able to continue to work?
  - Will I suffer pain?
  - Will I retain a reasonable quality of life?
Psychological responses to serious medical conditions (2/2)

• The psychological impact of medical illness can be severe and can account for a higher rate of disruption in functional ability than just the medical illness alone would indicate (Varcarolis & Halter, 2010).

• Most common psychological responses to physical illness:
  - Depression
  - Anxiety
  - Substance use
  - Grief and loss
  - Denial
  - Fear of dependency
  - Hopelessness
  - Anger
Common problems after ICU and hospital discharge

• Physical problems:
  - Muscle weakness
  - Breathlessness
  - Sexual dysfunction

• Psychosocial problems:
  - Delirium
  - Anxiety
  - Depression
  - PTSD
  - Helplessness
  - Frustration
  - Uncertainty
  - Hallucinations
  - Delusional memories
  - Dehumanization
  - Nightmares
  - Sleeplessness
Illness-as-lived

• Frank (1995) reacts on the objectivity of data by differentiating between disease and illness.

“Objective talk about disease is always medical talk. When a person becomes a patient and learns to talk disease talk, her body is spoken as a place that is elsewhere, a ‘site’ where the disease is happening. If disease talk measures the body, illness talk tells of fear and frustration of being inside a body that is breaking down. In illness-talk there is no such thing as the body, only my body as I experience it. What is happening to me? Not it, but me.”
Listening to the voiceless patient

- **Written-choice conversational strategy** (Garrett & Beukelman, 1995; Garrett & Huth, 2002)
- **Partner-assisted scanning technique** (Garrett et al, 2007)
- **Augmentative and alternative communication (AAC) devices**

### Written-choice conversational strategy

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### Partner-assisted scanning technique

![Partner-assisted scanning technique](image)

### AAC devices

![Augmentative and alternative communication devices](image)
Informational needs (1/2)

• During the acute phase of critical illness, informational needs include:
  - *Nature of illness/treatments*
  - *Prognosis*
  - *Impact of treatment*
  - *Potential complications*
  - *Expected care needs after hospitalization*
Informational needs (2/2)

- Patients and families also report fragmentation of care associated with transfers between the ICU and the general ward and between acute care and the community.

- "Timing it Right" (TIR) framework

- In 2009*, the National Institute for Health and Clinical Excellence developed a consensus statement to address the care of patients following a period of critical illness.

Key characteristics of survivors’ needs and experiences by phase of recovery

1. CRITICAL ILLNESS EVENT AND ICU CARE
   - Need for information concerning diagnosis, prognosis, and illness event.

2. PERIOD OF STABILIZATION ON THE GENERAL WARD
   - Medical progress made since ICU discharge and the treatments and medications needed to ensure ongoing recovery.
   - Difficulty with transition to the ward

3. PREPARATION FOR RETURN TO COMMUNITY LIVING
   - Long-term sequelae
   - Discharge planning and information concerning community resources

4. FIRST FEW MONTHS OF HOME ADJUSTMENT
   - How to adapt to living at home
   - Rehabilitation and psychological counseling
   - Community-based care

5. LONG-TERM ADJUSTMENT TO COMMUNITY LIVING
   - Managing the long term consequences
   - Secondary Prevention
   - Ongoing clinical management

PTSD in ICU patients

• Awareness and experiences while sedated are usually vague, but can often lead to PTSD.
• 35% of the ICU patients had PTSD.
• 62% of the survivors who developed PTSD still had symptoms two years after discharge.
• 50% of the same group was taking psychiatric medications.

(Needham et al, 2013)
PTSD and complicated grief in family members (1/2)

- Family members of patients in ICU are at risk for mental health morbidity both during and after the ICU stay (70% anxiety, 35% depression; Pochard et al, 2005).
- After patient discharge or death, family members develop PTSD related to the ICU experience and bereaved family members are at risk for complicated grief.
- **Within 1 year of their relative’s death, 34% met criteria for at least one psychiatric illness and 5% had complicated grief disorder** (Siegel et al, 2008).
PTSD and complicated grief in family members (2/2)

- Both oral and written advance directives decreased family members’ risk of PTSD (Tiden et al, 2001).

- Family members who were more involved in decisions were more likely to have PTSD symptoms 3 months later (Azoulay et al, 2005).

- PTSD was not more common in bereaved than non bereaved participants, and neither PTSD nor complicated grief was associated with decision – making role preference or with anxiety or depression during the patient’s ICU stay (Anderson et al, 2008).

- Those who preferred to play a passive role in decision-making about their relative’s care were at greater risk for both depression and anxiety (Anderson et al, 2009).
Secondary traumatic stress/compassion fatigue in health care professionals

- STS/CF has been associated with higher rates of physical illness, greater use of sick leave, higher turnover, lower morale, lower productivity and poor professional judgments such as mis-diagnosis, poor treatment planning or abuse of patients that may lead to patient care errors.

- The majority of ICU nurses are at the high level risk for STS/CF (57.9%) and burnout (56.1%) and the low level of potential for compassion satisfaction (61.5%).

(Mangoulia et al, 2011)
Recommendations to increase the multidisciplinary team’s sensitivity towards sedated or unconscious patients (1/2)

✓ Consider the possibility that the patient can hear all conversations in the room, although absorption of information may be distorted.

✓ The patient needs reassurance, compassion and care.

✓ Explain medical and other procedures to the patient.

✓ Keep the patient informed about everyday realities like the time of day and what the weather is like outside.

✓ Touch the patient in a comforting way.

✓ Talk to the patient continuously in a comforting and reassuring way.
Recommendations to increase the multidisciplinary team’s sensitivity towards sedated or unconscious patients (2/2)

✓ Provide spiritual support to the patient and constantly communicate hopeful messages to the patient.

✓ Inspiring music in the background may reduce common sounds in the ICU, enhance relaxation, alleviate pain and promote rehabilitation.

✓ Ask the family to take photos of the patient while in ICU—it can help the person to feel more “included” in their own trauma and experiences once they have recovered.
Illness and trauma are challenges that involve the individual as a totality.

The overarching aim is to increase insight into the thoughts, feelings and bio-psychosocial needs of the patient receiving treatment in ICU.

Little is known about the psychosocial dynamics of a patient who recovers from critical illness and the psychosocial impact of the ICU experiences have not been fully investigated.

Further research on this topic is necessary to improve ICU treatment, not only on a physical level, but with emphasis on the psychosocial and spiritual needs of the patient.
Key points to consider (2/2)

- Narratives of illness can help with the physical, mental and spiritual healing of the patient.
- There is a need to develop a wider range of interventions to improve symptom control, communication, and support in ways appropriate both for patients who may recover, and for those who deteriorate or die.
- It is critical that we better understand the risk factors for PTSD and complicated grief in family members.
Thank you very much for your attention!