The Patient’s Experience With Critical Illness

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objectives

Based on the content in this chapter, the reader should be able to:

- Explore relationships among stress, response to illness, and anxiety.
- Construct nursing interventions to assist patients in their adaptation to critical illness.
- Compare and contrast techniques that the patient and family can learn in an effort to manage stress and anxiety.
- Discuss alternatives to the use of physical restraint in the intensive care unit.
- Describe the phases of loss and specific nursing interventions for each phase.
- Develop nursing interventions that foster the ability of patients to draw strength from their personal spirituality.
- Develop strategies to care for patients and their families at the end of life.
The patient’s experience in an intensive care unit (ICU) has lasting meaning for the patient and his or her family members and significant others. Although actual painful memories are blurred by drugs and the mind’s need to forget, attitudes that are highly charged with feelings about the nature of the experience survive. These attitudes shape the person’s beliefs about nurses, physicians, health care, and the vulnerability of life itself.

This chapter describes specific measures that nurses use to support patients and their families through the stress of crisis and adaptation to illness, death, or a return to health. An understanding and appreciation of the intricate relationships among mind, body, spirit, and the healing process will help the critical care nurse provide emotional support to the patient and family. It is the caring and emotional support given by the nurse that will be remembered and valued.

PERCEPTION OF CRITICAL ILLNESS

Admission to a critical care unit (CCU) may signal a threat to the life and well-being of the patient who is admitted. Critical care nurses perceive the unit as a place where fragile lives are vigilantly scrutinized, cared for, and preserved. Patients and their families, however, frequently perceive admission to critical care as a sign of impending death, based on their own past experiences or the experiences of others. Understanding what critical care means to patients may help nurses care for their patients. However, effective communication with critically ill patients is often challenging and frustrating. Barriers to communication may relate to the patients’ physiological status; the existence of endotracheal tubes, which inhibit verbal communication; medications; or other conditions that alter cognitive function.

Patients’ Experiences

A number of authors have sought to study and describe patients’ experiences related to their ICU stay. In a review of 26 studies, Stein-Parbury and McKinley noted that between 30% to 100% of patients studied could recall all or part of their stay in the ICU. Although many of the patients recalled feelings that were negative, they also recalled neutral and positive experiences. Negative experiences were related to fear, anxiety, sleep disturbance, cognitive impairment, and pain or discomfort. Positive experiences were related to feelings of being safe and secure. Often, these positive feelings were attributed to the care provided by nurses. The need to feel safe and the need for information were predominant themes in qualitative research studies conducted by Hupcey and colleagues. Nurses’ technical competence and effective interpersonal skills were cited by patients as promoting their sense of security and trust.

STRESS

Stress has been defined as a situation that exists when an organism is faced with any stimulus that causes a disequilibrium between psychological and physiological functioning. All hormone levels can be altered by stress. Extreme levels of stress damage human tissue and may interfere with adaptive responses. If adaptive behaviors are effective, energy is freed and may be directed toward healing. If adaptive behaviors fail or are ineffective, however, the tension state is increased, as is the demand for energy. Therefore, the original stress of illness looms larger (Fig. 2-1). Hans Selye first described the stress syndrome and the general adaptation syndrome in the 1930s.

Response to Stress

The characteristic problems of adapting to limitations enforced by illness can be understood by exploring the relationship between the physical and the sociopsychological response to the illness. There is an observable lag between the physical onset of illness and its emotional acknowledgment—that is, the patient experiences illness and disability physically before acknowledging them fully on an emotional level. Denial is an example of this lag. Likewise, after physical health has been stabilized, the patient still experiences concerns and fears related to acute illness. At this point, the patient is likely to resist independence.
and be reluctant to cooperate with increased expectations for activity and self-care. Preparation for return to health, acknowledgment of concerns about increased activity, and the reassurance of watchful eyes help alleviate anxiety as the patient progresses.

If different responses of patients to illness could be plotted on a graph, they would show both common and unique points, just as electrocardiograms (ECGs) from different people show common characteristics and individual differences. The time and congruence between physical and sociopsychological responses vary, but the stages occur predictably. Like the electrical events of the heart, response to illness, both adaptive and maladaptive, can be anticipated. The nurse has several responsibilities:

- Anticipate, assess, and monitor the response to illness.
- Recognize and support effective behaviors.
- Minimize and redirect ineffective behaviors.

**ANXIETY**

**Causes of Anxiety**

Any stress that threatens one’s sense of wholeness, containment, security, and control causes anxiety. Illness is one such stress. A common cause of anxiety is a sense of isolation. Rarely is one lonelier than when in the midst of a socializing crowd of strangers. In such a situation, people attempt to include themselves, remove themselves, or emotionally distance themselves. The sick person surrounded by active and busy people is in a similar situation but with few resources available to reduce the sense of isolation. Hospital staff who ignore the presence of a patient, regardless of the patient’s alertness, contribute to the patient’s sense of isolation. Including the patient in conversations about treatment and providing a reassuring touch at frightening moments can reduce this sense of isolation.

Serious illness and the fear of dying also separate the patient from his or her family. The immediate development of dependent and intimate relationships with strangers is required. The reassuring cliche, “You’ll be all right,” often meant to comfort, only reinforces the patient’s sense of distance. It shuts off the expression of fears and questions about what is to come next. The efficiency and activity that surround the patient increase the sense of separateness.

Another category of anxiety-provoking stimuli includes those that threaten the individual’s security. Admission to the ICU dramatically confirms for the family and patient that their security on all levels is being severely threatened.

After the patient is admitted to the unit, the initial insecurity undoubtedly concerns life itself. Later, questions regarding such issues as length of hospitalization, return to work, financial implications, well-being of the family, and permanent limitations arise. The patient’s insecurity continues and needs to be sensitively considered.

Anxiety occurs when a person experiences the following:

- Threat of helplessness
- Loss of control
- Sense of loss of function and self-esteem
- Failure of former defenses
- Sense of isolation
- Fear of dying

**Responses to Anxiety**

**PHYSIOLOGICAL RESPONSES**

The physiological responses of rapid pulse rate, increased blood pressure, increased respirations, dilated pupils, dry mouth, and peripheral vasoconstriction may go undetected in a seemingly cool, calm, self-contained patient. These autonomic responses to anxiety are frequently the most reliable index of the degree of anxiety when behavioral and verbal responses are not congruent with the circumstances.

**SOCIOPSYCHOLOGICAL RESPONSES**

Behavioral responses indicative of anxiety are often family-based and culturally learned. They vary from quiet composure in the face of disaster to panic in the presence of an innocuous insect. Such extremes of control and panic use valuable energy. If this energy is not directed toward eliminating or adapting to the stressor, it only perpetuates the discomfort of the tension state. The goal of nursing care is always to promote physiological and emotional equilibrium.

**Patterns of Adaptation**

Figure 2-2 demonstrates one pattern of adapting to various stages of illness. During stress, the patient regresses in an attempt to conserve energy. During times of acute exacerbation or heightened expectations, or during any significant change, the initial response is regression to an earlier emotional position of safety. Weaning from a respirator, removal of monitor leads, increased activity, and reduction in medication often trigger anxiety and regression. This regression may even include a retreat into increased dependency, depression, and anger. At such times, the patient may find comfort in regressing to a state that has already been mastered. Behavior at this time may seem peculiar or irrational to the nurse. The regression is usually temporary and brief and can be used to identify the cause of anxiety. Nurses may become disappointed, anxious, or angry with the patient’s regression and may want to retreat. It is more helpful, however, to acknowledge that regression is inevitable and to support the patient.

**Figure 2-2** One pattern of adapting to various stages of illness. The darkly shaded areas represent transition into and out of illness and show the disparity between actual health and the person’s perception of his or her health. During transition to illness, there is denial. During the acceptance phase, physical and mental well-being are congruent. During the convalescence phase, an emotional lag exists between physical and emotional well-being.
with interventions appropriate to earlier stages. The nurse helps the patient understand what is happening by explaining the emotional lag phenomenon.

**NURSING ASSESSMENT**

Often it is not possible for the nurse simply to remove the stimuli that cause anxiety. In these circumstances, the nurse must assess the effectiveness of the patient’s behaviors and either support them, help the patient modify them, or teach new behaviors. Frequently, levels of anxiety are so high that the anxious state becomes the stimulus that demands additional coping responses. After assessing coping behaviors for effectiveness, the nurse has several choices:

- Support the behaviors.
- Help the patient modify behaviors.
- Teach new behavior.

Coping behaviors may be directed either toward eliminating the stress of illness or toward eliminating the anxiety state itself. The nurse must evaluate each behavior as to whether it helps restore a steady state. Behaviors that promote movement toward a steady state can then be supported and encouraged. The nurse may also need to help the patient modify or find substitutes for behaviors that are disruptive or threatening to homeostasis. At times, the nurse must introduce new behaviors to facilitate equilibrium and promote health.

Examples of nursing diagnoses associated with critical illness and injury can be seen in Box 2-1.

**NURSING INTERVENTIONS**

Whenever possible, stress must be reduced or eliminated for critically ill patients. If this can be accomplished, the problem is quickly resolved, and the patient is returned to a state of equilibrium. Usually, however, the stress is not eliminated so easily because many other stressors are introduced by attempts to remedy the original problem. If adaptive behaviors are effective, anxiety is reduced, and energy is directed toward rest and healing. A number of nursing interventions may be used to reduce anxiety and promote adaptation in critically ill patients. Often a combination of interventions is used.

**Creating a Healing Environment**

Florence Nightingale is considered the founder of modern nursing. She often wrote about the nurse’s role in creating an environment to allow healing to occur. She emphasized holism in nursing—that is, caring for the whole person. In today’s technological age, critical care nurses are challenged to create an environment of healing. These environments must allow critically ill patients to have their psychological needs as well as physical needs met. Manipulating the milieu may involve timing interventions to allow adequate sleep and rest, providing pain-relieving medication, playing music, or teaching deep-breathing exercises.

**Fostering Trust**

Almost every nurse in critical care can relate stories of special bonds that formed with individual patients and families. They can describe special situations where a trusting relationship developed and they made a difference in the patient’s recovery or even dignified death. In contrast, patients have related to us, through research, that when they mistrust their caregivers, they are more anxious and more vigilant of staff behaviors, and lack the feeling of safety and security. Our goal, then, is to display a confident, caring attitude, demonstrate technical competence, and develop effective communication techniques that will foster the development of a trusting relationship.

**Providing Information**

Besides the need to feel safe, critically ill patients identify the need for information as having a high priority. This need to know involves all aspects of the patients’ care. They need to know what is happening at the moment. They also need to know what will happen to them, how they are doing, and what they can expect. Many patients also need frequent explanations of what happened to them. These explanations reorient them, sort out sequences of events, and help them distinguish real events from dreams or hallucinations. Anxiety can be greatly relieved with simple explanations. Consider the patient, for example, who was being weaned from the ventilator who just needed reassurance that if he did not breathe, the machine would do it for him. Families, too, have identified the need for information as a high priority. This is followed closely by the need to have hope. Most families identify physicians as the primary source for information. It is important for nurses to be mindful of patient confidentiality issues when speaking to family members. Nurses should have the patient’s permission before giving confidential medical information to family members. If that is not possible because of the patient’s condition, a family spokesperson should be identified as the person who may receive confidential information. This information should be recorded in the patient’s medical record.

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**box 2-1 Examples of Nursing Diagnoses and Collaborative Problems for the Patient With Critical Illness or Injury**

- Anticipatory Grieving
- Anxiety
- Body Image Disturbance
- Impaired Verbal Communication
- Ineffective Denial
- Fear
- Risk for Loneliness
- Powerlessness
- Self-Esteem Disturbance
- Spiritual Distress
- Potential for Enhanced Spiritual Well-Being
Allowing Control

Nursing measures that reinforce a sense of control help increase the patient’s autonomy and reduce the overpowering sense of a loss of control. The nurse can help the patient to feel more control over his or her environment by:

- Providing order and predictability in routines
- Using anticipatory guidance
- Allowing the patient to make choices whenever possible
- Involving the patient in decision-making
- Providing information and explanation for procedures

Providing order and predictability allows the patient to anticipate and prepare for what is to follow. Perhaps it creates only a mirage of control, but anticipatory guidance keeps the patient from being caught off-guard and allows the mustering of coping mechanisms.

Allowing small choices when the patient is willing and ready increases the patient’s feeling of control over the environment. Would the patient prefer to lie on his or her right or left side? In which arm should the intravenous (IV) line be placed? What height is preferred for the head of the bed? Does the patient want to cough now or in 20 minutes after pain medication? Any decisions that afford the patient a certain amount of control and predictability are important. These small choices may also help the patient accept lack of control during procedures that involve little choice.

Cultural Sensitivity

Interventions for individual patients must be contextually based and culturally sensitive. Transcultural nursing refers to a formal area of study and practice that focuses on providing care that is compatible with the cultural beliefs, values, and lifestyles of individuals. A cultural assessment includes the patient’s usual response to illness as well as his or her cultural norms, beliefs, and world views. Because individual responses and values may vary within the same culture, the patient should be recognized as an individual within the cultural context. Exploring the meaning of the critical event with the patient, family members, and significant others may give clues to the patient’s perception of what is happening. In addition, the nurse may ask if there is a particular ethnic or religious group with which the patient identifies and if there is anything the nurses may do to provide care that is sensitive to individual values or norms while the patient is hospitalized. Awareness and acceptance are the heart of cultural competence.

Presencing and Reassurance

Presence, or just “being there,” can in itself be a meaningful strategy for alleviating distress or anxiety in the critically ill patient. Presencing is the therapeutic use of self, adopting a caring attitude, and paying attention to an individual’s needs. This presence implies more than just a physical presence, however. It means giving one’s full attention to the person, focusing on the person, and practicing active listening. When a nurse uses presence, the focus is not on a task or outside thoughts. Energy and attention are directed at the patient and his or her needs or feelings. Snyder and colleagues describe a higher level of presence called transcendent presence, which conveys an energy exchange between the nurse and the patient that has a spiritual quality. Quinn describes the concept of intentionality in the development of the use of self as healer. This means one makes a conscious effort to use all of one’s capacity, including eyes, voice, energy, and touch, in a more intentionally healing way. Reassurance can be provided to the patient in the form of presencing and caring touch. Reassurance can also be verbal. Verbal reassurance can be effective for patients if it provides realistic encouragement or clarifies misconceptions. Verbal reassurance is not valuable, however, if it prevents a patient from expressing his or her emotions or stifles the need for further dialogue. Reassurance is intended to reduce fear and anxiety and evoke a calmer, more passive response. It is best directed at patients expressing unrealistic or exaggerated fears.

Cognitive Techniques

Techniques that have evolved from cognitive theories of learning may help anxious patients and their families. They can be initiated by the patient and do not depend on complex insight or understanding of one’s own psychological makeup. They can also be used to reduce anxiety in a way that avoids probing into the patient’s personal life. Furthermore, the patient’s friends and family members can be taught these techniques to help them and the patient reduce tension.

INTERNAL DIALOGUE

Highly anxious people are most likely giving themselves messages that increase or perpetuate their anxiety. These messages are conveyed in one’s continuously running “self-talk,” or internal dialogue. The patient in the ICU may be silently saying things such as, “I can’t stand it in here. I’ve got to get out.” Another unexpressed thought might be, “I can’t handle this pain.” By asking the patient to share aloud what is going on in this internal dialogue, the nurse can bring to awareness the messages that are distracting the patient from rest and relaxation. Substitute messages should be suggested to the patient. It is important to ask the patient to substitute rather than delete messages because the internal dialogue is continuously operating and will not turn off, even if the patient wills it to do so. Therefore, asking the patient to substitute constructive, reassuring comments is more likely to help the patient significantly reduce his or her tension level. Comments such as, “I’ll handle this pain just one minute at a time” or “I’ve been in tough spots before, and I am capable of making it through this one!” will automatically reduce anxiety and help the patient shape coping behaviors accordingly. Any message that enhances the patient’s confidence, sense of control, and hope and puts him or her in a positive, active role, rather than the passive role of victim, will increase the patient’s sense of coping and well-being.

The nurse helps the patient develop self-dialogue messages that increase:

- Confidence
- Sense of control
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Guided Imagery and Relaxation Training

These are two useful techniques that can be taught to the patient to help reduce tension. The nurse can encourage the patient to imagine either being in a very pleasant place or taking part in a very pleasant experience. The patient should be instructed to focus and linger on the sensations that are experienced. For example, asking the patient, “What colors do you see?” “What sounds are present?” “How does the air smell?” “How does your skin feel?” “Is there a breeze in the air?” helps increase the intensity of the fantasy and thereby promote relaxation through mental escape.

Guided imagery also can be used to help reduce unpleasant feelings of depression, anxiety, and hostility. Patients who must relearn life-sustaining tasks, such as walking and feeding themselves, can use imagery to prepare mentally to meet the challenge successfully. In these instances, patients should be taught to visualize themselves moving through the task and successfully completing it. If this method seems trivial or silly to the patients, they can be reminded that this method demands concentration and skill and is commonly used by athletes to improve their performance and to prepare themselves mentally before an important event. Guided imagery is a way of purposefully diverting or focusing the patients’ thoughts and has been shown to empower patients, improving their satisfaction and well-being.

The nurse can also use techniques that induce deep muscle relaxation to help the patient decrease anxiety. Deep muscle relaxation may reduce or eliminate the use of tranquilizing and sedating drugs. In progressive relaxation, the patient is first directed to find as comfortable a position as possible and then to take several deep breaths and let them out slowly. Next, the patient is asked to clench a fist or curl toes as tightly as possible, to hold the position for a few seconds, then to let go while focusing on the sensations of the releasing muscles. The patient should practice this technique, beginning with the toes and moving upward through other parts of the body—the feet, calves, thighs, abdomen, chest, and so on. This procedure is done slowly while the patient gives nonverbal signals (e.g., lifting a finger) to indicate when each new muscle mass has reached a state of relaxation. Extra time and attention should be given to the back, shoulders, neck, scalp, and forehead, because many people experience physical tension in these areas.

Once a state of relaxation is achieved, the nurse can suggest that the patient fantasize or sleep as deeply as the patient chooses. The patient must be allowed to select and control the depth of relaxation and sleep, especially if the fear of death is prominent in the patient’s mind. A moderately dark room and a soft voice facilitate relaxation. Asking the patient to relax is frequently nonproductive compared with directing him to release a muscle mass actively, let go of tension, or imagine tension draining through the body and sinking deeply into the mattress. Again, the patient is assisted to take an active rather than passive role by the nurse’s careful use of language.

Deep Breathing

When acutely anxious, the patient’s breathing patterns may change, and the patient may hold his or her breath. This could be physically and psychologically detrimental. Teaching diaphragmatic breathing, also called abdominal breathing, to the patient may be useful as both a distraction and a coping mechanism. Diaphragmatic breathing can be taught easily and quickly to the preoperative patient or to a patient experiencing acute fear or anxiety. The patient may be asked to place a hand on the abdomen, inhale deeply through the nose, hold briefly, and exhale through pursed lips. The goal is to have the patient push out his own hand to demonstrate the deep breath. The nurse may demonstrate the technique and perform it along with the patient, until the patient is comfortable with the technique and is in control. The mechanically ventilated patient may be able to modify this technique by concentrating on breathing and on pushing out the hand. Mechanically ventilated patients experiencing severe agitation may not be able to respond to this technique.

Music Therapy

Music therapy has been used in the critical care environment as a strategy to reduce anxiety, provide distraction, and promote relaxation, rest, and sleep. The patient is provided with a choice of specially recorded audiotapes and a set of headphones. Usually, music sessions are 20 to 90 minutes long, once or twice daily. Music selections may vary by individual taste, but the most commonly used
selections have a tempo of 60 to 70 beats, a simple, direct musical rhythm, and a low-pitched sound with primarily a string composition. Most patients prefer music that is familiar to them.

Humor
A good belly laugh produces positive physiological and psychological effects. Laughter can increase the level of endorphins, the body’s natural pain relievers, which are released into the bloodstream. Laughter can relieve tension and anxiety and relax muscles. The use of humor by nurses in critical care can help reduce procedural anxiety or provide distraction. Once again, the humor must be compatible with the context in which it is offered and with the individual’s cultural perspective. Many nurses report using humor cautiously after they have established a rapport with the individual. Nurses also report that they are able to take cues from the patient and visitors regarding the appropriate use of humor. Patients have reported that nurses who have a good sense of humor are more approachable and easier to talk with. In an effort to incorporate the positive effects of humor into health care settings, some institutions have developed humor resource rooms or mobile humor carts. These provide patients with a variety of lighthearted reading materials, videotapes, and audiocassettes. Also included on the cart may be games, puzzles, and magic tricks. Some nurses have created their own portable therapeutic humor kits. Use of humor by patients may help them reframe their anxiety and channel their energy toward feeling better. Appropriate use of humor can relieve stress among critical care nurses who work in complex, challenging environments with significant economic pressures.

Massage and Therapeutic Touch
Massage is the purposeful stroking and kneading of muscles with the goal of providing comfort and promoting relaxation. Nurses have traditionally used effleurage for back rubs for patient comfort. Effleurage uses slow, rhythmic strokes from distal to proximal areas of long muscles such as the back or extremities. Consistent, firm yet flexible hand pressure is applied with all parts of the hand to conform to body contours. Lotion may be used to decrease friction and add moisture. Massage has been effective at reducing anxiety and promoting relaxation. Patient selection is an important consideration when electing massage as a therapeutic intervention. Patients who are hemodynamically unstable, for example, would not be appropriate candidates. In addition, nurses require additional training in massage therapy to effectively incorporate more advanced massage techniques such as petrissage or pressure points into plans of care for critically ill patients.

Therapeutic touch is a set of techniques where the practitioner’s hands move over a patient in a systematic way to rebalance the patient’s energy fields. An important component of therapeutic touch is compassionate intent on part of the healer. Therapeutic touch as a complementary therapy has been used successfully in acute care settings to decrease anxiety and promote a sense of well-being. It is a foundational technique of healing touch. Healing touch involves a number of full-body and localized techniques to balance energy fields and promote healing. Implementation of healing touch therapy involves a formal educational program for healers, and its potential benefits are under active investigation.

Meridian Therapy
Complementary and alternative medicine (CAM) is a phrase used to describe an array of nontraditional healing approaches. Meridian therapy refers to therapies that involve an acupoint, such as acupuncture, acupressure, and the activation of specific sites with electrical stimulation and low-intensity laser. Meridian therapy originates from traditional Chinese medicine. Meridians are complex energy pathways that integrate into intricate patterns. These pathways contain sensitive energy points that are amenable to stimulation to relieve blockages that affect various physiological functions. Research has demonstrated the effectiveness of meridian therapy for pain relief, postoperative nausea, and other functions. Currently, research is underway to validate acupoint sites. Meridian therapy should be performed only by professionals with specialized training.

Animal-Assisted Therapy
The human–animal bond has been well documented. Pet ownership has been linked to higher levels of self-esteem and physical health. Pet therapy (or, more broadly, animal-assisted therapy) has had measurable benefits for school children and residents of nursing homes. More recently, this concept has been introduced to the acute and critical care settings with positive results. In one California hospital, a formal program exists in which volunteer owner–dog teams visit patients in the hospital on a variety of units. In a small pilot study, Cole and Gawlinski described patients’ delight in having fish aquariums placed in their rooms while they were awaiting heart transplantation.

RERAINTS IN CRITICAL CARE

Physical Restraints
Historically, physical restraints have been used for patients in critical care to prevent potentially serious disruptions in patient care through accidental dislodgment of endotracheal tubes or life-saving IV lines and other invasive therapies. Other reasons that have been cited for use of restraints include the prevention of falls, behavior management, and avoidance of liability suits due to patient injury. However, research related to restraint use, especially in the elderly, has demonstrated that these reasons, although well-intentioned, often are not valid. Patients who are restrained have been shown to have more serious injuries secondary to falls as they “fight” the device that limits their freedom. In addition, there are reportedly a greater number of lawsuits related to improper restraint use than to injuries sustained when restraints were not used. Critically ill, intubated
patients have been known to self-extubate despite the use of soft wrist restraints.21, 23–24, 27

The forced immobilization that results from restraining a patient can prolong a patient’s hospitalization by contributing to skin alterations, loss of muscle tone, impaired circulation, nerve damage, and pneumonia.25,28 Restraints have been implicated in accelerating patients’ levels of agitation, resulting in injuries such as fractures or strangulation.

Physical restraints include any device that is used to restrict the patient’s mobility and normal access to his or her body. These may include limb restraints, mittens with ties, vests or waist restraints, geriatric chairs, and siderails. Siderails are considered a restraint if used to limit the ability of the patient to get out of bed rather than to help him or her get up.26

Standards on restraint use are published and monitored by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration). A summary of these standards is given in Box 2-2. These standards may be viewed on the respective agency’s website. Many hospitals have revised their policies, procedures, and documentation of the use of restraints to comply with the most recent revision of these standards, effective January 2001.

**Chemical Restraint**

Chemical restraint refers to pharmacological agents that are given to patients as discipline or to limit disruptive behavior. Medications that have been used for behavior control include, but are not limited to, psychotropic drugs such as haloperidol, sedative agents such as benzodiazepines (e.g., lorazepam, midazolam), or the anticholinergic antihistamine, diphenhydramine.29 This definition does not apply to medications that are given to treat a medical condition.29 The use of sedative, analgesic, and anxiolytic medications is an important adjunct in the care of the critically ill patient. Documentation of the use of these medications should include the indication for the drug and the patient’s response.

Delirium is a common phenomenon in the ICU and may be related to sleep disturbance, the person’s underlying medical condition, the unfamiliar environment, medication side effects, or a combination of these factors. Elderly patients are especially vulnerable. Delirium is a reversible cognitive disturbance associated with confusion, inappropriate behavior, decreased attention span, short-term memory impairment, and altered perceptions.10 Dementia, however, is generally considered to be a progressive disease associated with mild to severe cognitive impairment.

Care must be taken to provide adequate comfort for patients experiencing life-threatening illnesses and a variety of noxious interventions. It is desirable to use the least amount of medication as feasible to achieve the goals of patient care because all medications have potential side effects and adverse reactions. Patients must be continually assessed for adequacy of comfort. Behaviors that seem to indicate pain may actually indicate a change in the patient’s physiological status. Agitation, for example, may be a sign of hypoxemia. Caution must be exercised when using as-needed (PRN) medications to reduce pain and promote comfort. Without consistency in assessment, goal setting, and administration, PRN dosing may inadvertently lead to overmedication or undermedication in the critically ill patient. In addition, these medications can have rebound effects if abruptly withdrawn. Weaning a patient from analgesic or sedative medication may be as important as weaning a patient from a mechanical ventilator. Many CCUs incorporate assessment tools for patient comfort on their daily flow sheets.30

**Alternatives to Restraints**

What, then, is the well-meaning nurse to do when a patient is experiencing confusion or delirium and is pulling at his or her lifesaving devices and tubes? Remember that physical restraint is the last resort, to be used only when the patient is a danger to himself or others and when other methods have failed. Restraints may actually potentiate the dangerous behavior. Rather, the nurse should attempt to identify what the patient is feeling or experiencing. What is the meaning behind the behavior? Is he cold? Does she itch? Is the person in pain? Does the person know where he or she is and why he or she is there? Sometimes addressing the patient’s needs or concerns and reorienting the patient is all that is needed to calm him or her. Other interventions may include modifying the patient’s environment,
loss can be described in the following four phases:

- **Shock and disbelief**
- **Development of awareness**
- **Restitution**
- **Resolution**

Each phase involves characteristic and predictable behaviors that fluctuate among the various phases in a unpredictable way. Through recognition and assessment of the behaviors and an understanding of their underlying dynamics, the nurse can plan interventions to support the healing process.

**Shock and Disbelief**

In the first stage of response to loss, patients demonstrate behaviors characteristic of denial. They fail to comprehend and experience the rational meaning and emotional impact of the diagnosis. Because the diagnosis has no emotional meaning, patients often fail to cooperate with precautionary measures. For example, patients may attempt to get out of bed against the physician’s advice, or they may deviate from the prescribed diet and assert, “I am here for a rest!”

Denial may go so far as to allow patients to project difficulties onto what is perceived as ill-functioning equipment, mistaken laboratory reports, or, more likely, the sheer incompetence of physicians and nurses.

When such blatant denial occurs, it is apparent that the problem is so anxiety provoking to the patient that it cannot be handled by the more sophisticated mental mechanisms of rational problem solving. The stressor is temporarily obliterated. This phase of denial may be the period during which the patient’s resources, briefly blocked by the shock, can be regrouped for the battle ahead. Therefore, stripping away denial may render the patient helpless. Furthermore, although denial has its obvious hazards, it has been associated with higher rates of survival after myocardial infarctions.

**NURSING INTERVENTIONS**

The principle of intervention consists not of stripping away the defense of denial but of supporting the patient and acknowledging the situation through nursing care.

The nurse recognizes and accepts the patient’s illness by watching the monitor or changing the dressings. In these ways, the nurse communicates acceptance of the patient through tone of voice, facial expression, and touch. The nurse must reflect statements of denial back to the patient in a way that allows the patient to hear them—and eventually to examine their incongruity and apply reality. For example, the nurse may say something such as, “In some ways you believe that having a heart attack will be helpful to you?” The nurse can also acknowledge the patient’s difficulty in accepting restrictions by making comments such as, “It seems hard for you to stay in bed.”

By verbalizing what the patient is expressing, the nurse gently confronts behavior but does not cause anxiety and anger by reprimanding and judging. In this phase, the
nurse supports denial by allowing for it but does not perpetuate it. Instead, the nurse acknowledges, accepts, and reflects the patient’s new circumstance.

When the patient is in denial, the nurse demonstrates acceptance in several ways:

- Tone of voice
- Congruent facial expression
- Use of touch
- Use of reflection of inaccurate statements
- Avoiding joking with patient about serious issues

Development of Awareness

In this second stage of grief, the patient’s behavior is characteristically associated with anger and guilt. The anger may be expressed overtly and may be directed at the staff for oversights, tardiness, and minor insensitivities. In this phase, the ugliness of reality has made its impact. Displacement of the anger onto others helps soften the impact of reality on the patient. The expression of anger gives the patient a sense of power in a seemingly helpless state. A demanding manner and a whining tone often characterize this stage and represent the patient’s primitive attempts to regain the control that appears to have been lost. However, such behavior often alienates the nurse and other personnel. The patient who does not demand or whine has probably withdrawn into depression because of anger directed toward self rather than toward others. This patient will demonstrate verbal and motor retardation, will likely have difficulty sleeping, and may prefer to be left alone.

During this phase, the nurse is likely to hear irrational expressions of guilt. Patients seek to answer the question, “Why me?” They attempt to isolate their human imperfections and attribute the cause of the malady to themselves or their past behavior. Patients and their families may look for a person or object to blame.

Guilt feelings concerning one’s own illness are difficult to understand unless one examines the basic dynamic of guilt. Guilt arises when there is a decrease in the feeling of self-worth or when the self-concept has been violated. In this light, the nurse can understand that what is behind an expression of guilt is a negatively altered self-concept. Blame therefore becomes nothing more than projection of the unbearable feeling of guilt.

NURSING INTERVENTIONS

During the patient’s development of awareness, nursing intervention must be directed toward supporting the patient’s basic sense of self-worth and allowing and encouraging the direct expression of anger. Nursing measures that support a patient’s sense of self-worth are numerous and include calling the patient by name; introducing strangers, particularly if they are to examine the patient; talking to, rather than about, the patient; and, most important, providing for and respecting the patient’s need for privacy and modesty. The nurse needs to guard against verbal and nonverbal expressions of pity. It is more constructive and productive to empathize with the patient’s specific and temporary feelings of anger, sadness, and guilt rather than with a condition.

The nurse can create an outlet for anger by listening and by refraining from defending the physician, the hospital, or his or her own actions. A nondefensive, accepting attitude will decrease the patient’s sense of guilt, and the expression of anger will avert some of the depression. Later, when the patient apologizes for an irrational outburst, the nurse can interpret the patient’s need to make this kind of verbalization as a necessary step toward rehabilitation and health.

Restitution

In this stage, the griever puts aside anger and resistance and begins to cope constructively with the loss. The patient tries new behaviors that are consistent with the new limitations. The emotional level is one of sadness, and time spent crying is useful. As the patient adapts to a new image, considerable time is spent going over significant memories relevant to the loss. Behaviors in this stage include the verbalization of fears regarding the future. Often these go unexpressed and undetected because they are unbearable for the family to hear. Furthermore, after severe trauma, which may have resulted in scarring or removal of a body part or loss of sensation, patients may question their sexual adequacy. They worry about the future response of their mates to their changed bodies. The patient probably also questions a new role in the family. Most likely, the patient has a variety of concerns that are specific to his or her lifestyle. Therefore, in the mourning process, such manifestations as reminiscing, crying, questioning, expressing fears, and trying out new behaviors help the patient modify the old self-concept and begin working with and experiencing a revised concept.

NURSING INTERVENTIONS

During restitution, nursing care should again be supportive so that adaptation can occur. Listening to the patient for lengthy periods of time is necessary. If the patient is able to verbalize fears and questions about the future, he or she will be better able to define the anxiety and solve new problems. Furthermore, hearing oneself talk about fears helps put a person into a more rational perspective. The patient may require privacy, acceptance, and encouragement to cry so that respite from sadness can be found.

During this stage, the nurse may have the patient consider meeting someone who has successfully adapted to similar trauma. This measure provides the patient with a role model as a new identity is assumed, which often occurs after the crisis period. Many support groups of recovering people with all types of illnesses and injuries will send someone to support and be a role model for patients and families.

The patient, with appropriate support from the nurse, begins to identify and acknowledge changes arising from the adaptation to illness. Relationships can and do change. Friends may respond differently to the patient who has suffered a permanent disability, causing the patient to believe that the attitudes and feelings of others have changed as a result of the injury or illness.

During this time, the family has also been going through a similar process. They too have experienced shock, disbelief, anger, and sadness. After they are ready to try to solve their problems, their energies are directed toward wondering how the changes in the patient will affect their
Resolution

Resolution is the stage of identity change. At first patients may overidentify themselves as invalids. They may discriminate against their bodies. Another method patients may use is to detach themselves emotionally from the source of trauma (e.g., a stoma, prosthesis, scar, or paralyzed limb) by naming it and referring to it in a simultaneously alienated and affectionate way. Patients are sensitive to the ways in which health care workers respond to their bodies. A patient may make negative remarks to test the acceptance of the nurse. Chiding or telling the patient that many others share the problem will be less helpful than acknowledging feelings and indicating acceptance by continuing to care for, and talk with, the patient.

As time passes and the patient adapts, the sting of the endured hurt abates, and the patient moves toward an identification as a person who has certain limitations due to illness rather than as a “cripple” or an “invalid.” The patient no longer uses a defect as the basis of identity. As the resolution is reached, patients are able to depend on others, if necessary, and should not need to push beyond their endurance or to overcompensate for an inadequacy or limitation. Often, the patient reflects on the crisis as a time of growth or maturation. Such a patient achieves a sense of pride at accomplishing the difficult adaptation and is able to look back realistically on successes and disappointments without discomfort. At this time, the patient may find it useful and gratifying to help others by serving as a role model for people in the stage of restitution who are experiencing their own identity crises.

Unfortunately, the critical care nurse is rarely in a position to observe the successful outcome of resolution. However, it is useful to know the process in order to work with and communicate an attitude of hope, especially when the patient is most self-disparaging.

NURSING INTERVENTIONS

The goal of nursing care during the resolution stage is to help the patient attach a sense of self-esteem to a rectified identity. Nursing intervention centers on helping the patient find the degree of dependence that is needed and can be accepted. The nurse must accept and recognize with the patient that periods of vacillation between independence and dependence will occur. The nurse should encourage a positive emotional response to a new state of modified dependence. Certainly the nurse can support and reinforce the patient’s growing sense of pride in rehabilitation. For nurses who have had the experience of successfully working through the process with one person, the challenge is to stand back and allow the patient to move away from them.

Mr. Saunders, age 53, was admitted to the ICU conscious but unresponsive to verbal questioning. According to the accident report, a large truck had swerved out of control on an icy road, killing Mr. Saunders’ fiancée and injuring him. He had been hospitalized for observation and treatment of chest wounds and blood loss. Mr. Saunders’ leg was amputated above the left knee as a result of an injury incurred in Vietnam 30 years ago.

While trying to reach Mr. Saunders’ family, the nurse learned that his mother had died of cancer about 1 year ago and that 3 months later his father, suffering from depression, had killed himself. He had one sister who was flying in to see him.

The primary nursing problems were maintenance of ventilation and vital signs, pain control, and immobility. Mr. Saunders remained uncommunicative, although he was fearful. When he did talk, he expressed hopelessness and said he wanted to die. He asked, “Why me, God? What have I done to deserve this?” The Collaborative Care Guide in Box 2–4 focuses on addressing Mr. Saunders’ psychosocial problems.

SPIRITUALITY AND HEALING

Caring in nursing includes recognition and support of the spiritual nature of human beings. Spirituality refers to the realm of invisible and intangible factors that influence our thoughts and behaviors. This recognition not only includes religious beliefs, but goes beyond them. When people sense power and influence outside of time and physical existence, they are said to be experiencing the metaphysical aspects of spirituality.

Spirituality includes one’s system of beliefs and values. Intuition and knowledge from unknown sources and origins of unconditional love and belonging typically are viewed as spiritual power. A sense of universal connection, personal empowerment, and reverence for life also pertains to the existence of spirituality. These elements also may be viewed as benefits of spirituality. Spirituality includes the following:

- Religion
- Beliefs and values
- Intuition
- Knowledge from the unknown
- Unconditional love
- A sense of belonging
- A sense of connection with the universe
- Reverence for life
- Personal empowerment

Critical care patients and their families frequently pray for miraculous healing. Miracles of healing, when they are experienced by believers, can be viewed as normal healing
**OUTCOMES**

**Acknowledging Grief**  
Patient will:
- Verbally and nonverbally express his grief.
- Describe meaning these losses have for him.
- Share grief with another person with whom he is close.

**INTERVENTIONS**
- Ask patient about his feelings.
- Listen, reflect, and sit quietly with patient.
- Acknowledge patient’s reaction as a normal, expected response to multiple and severe loss.
- Acknowledge own feelings to self regarding loss and identify separateness from patient in order not to over-identify with patient and lose objectivity.
- Enlist other staff to act as resources for nurse and patient.
- Assess stage of grief related to death of parents, loss of leg, and Vietnam experience.
- Assess patient’s stage of grief in relationship to ability to make sound decisions (i.e., postdischarge psychiatric follow-up).
- Support denial, as needed to let patient move at own pace in perceiving degrees of loss.
- Consult psychosocial liaison nurse and spiritual counselor to assist in coping and facilitating appropriate grieving.
- Avoid the temptation to reduce pain with false reassurance.
- Acknowledge depth and breadth of loss.
- Offer hope by letting patient know that time will ease the degree of pain.
- Acknowledge that the patient has already demonstrated enormous personal strength by surviving the accident and his other losses.
- Provide hope that he will recover by talking about the future.
- Provide positive reinforcement for crying and grieving behaviors. (“Don’t apologize for your tears; it’s very important that you cry as much as you need to express your grief.”)
- Reframe the catastrophic event from a tragedy to the challenge of a lifetime.
- Allow patient as many choices as possible. Acknowledge soundness of choices.
- Question poor choices in a sensitive way (e.g., “You believe that giving up will somehow help you feel better about what has happened?”)
- Allow expression of irrational thoughts (e.g., “I must have done something very, very bad to deserve this.”).
- Reflect back statements emphasizing faulty logic (e.g., “You believe if you had been a better person, you could have controlled someone else’s driving and the weather?”).
- Teach patient about the stages of grieving and emphasize its necessity for health.
- Refer patient for mental health follow-up care and support.

**Overcoming the Sense of Powerlessness**  
Patient will:
- Demonstrate a sense of control over his own life by making sound decisions.
- Experience a decrease in feelings of guilt regarding the collision.

(continued)
events occurring in collapsed time. Nursing goals related to spirituality include the recognition and promotion of patients’ spiritual sources of strength. By allowing and supporting patients to share their beliefs about the universe without disagreement, nurses help patients recognize and draw on their own sources of spiritual courage. Recognition of the unique spiritual nature of each patient is thought to assist personal empowerment and healing.

Nurses who find their own spiritual values in religion must acknowledge and respect that nonreligious people may also be spiritual and experience spirituality as a life force. Regardless of personal views, the nurse is obligated to assess patients’ spiritual belief systems and assist them to recognize and draw on the values and beliefs already in existence for them.

Furthermore, critical illness may deepen or challenge existing spirituality. During these times, it may be useful for the nurse or family to call on a spiritual or religious leader, hospital chaplain, or pastoral care representative to help the patient make meaningful use of the critical illness experience.

CARE AT THE END OF LIFE

Over half of the two million patients who die annually in the United States will die in the hospital. Most of these patients are elderly. In CCUs, the mortality rate is high, with some estimates as high as 69%. Although the goal of critical care has traditionally been to preserve and restore life, nurses working in ICU will necessarily provide care to patients at the end of life.

Experiences with patients’ deaths in the CCU can be viewed on a continuum. There are times when death occurs suddenly and unexpectedly in the ICU, after aggressive resuscitative efforts have failed. Other times, death is expected, even anticipated. In such cases there may be a conscious movement that occurs over time in which treatment goals change from providing aggressive curative therapies to a comfort-focused plan of care. This comfort plan of care may involve withdrawing or withholding specific therapies.

Along this continuum of care, there is a multitude of complex issues and possible scenarios that patients and their families, physicians, and nurses must work through to optimize care of dying patients.

A Good Death

In a study of the experiences of intensive care nurses with end-of-life care, nurses described a “good” death as one where the patient was as pain free as possible and where dignity and comfort were maintained. Another important component was family involvement and satisfaction with care. In caring for patients at the end of life, nurses recognized their important role in communication and continuity of care. Congruence between the patient’s (or family’s) wishes for care and the level of care that is actually provided is also a determinant of a good death.

Barriers to Care

The landmark Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) revealed several shortcomings of care provided to seriously ill hospitalized patients. Specifically, family members of half of the patients who were conscious at the end of life reported that the patients’ last few days were spent in moderate to severe pain. In addition, most of the orders for “Do Not Resuscitate,” indicating a transition in the plan of care, were written in the last 2 days of life. Half of the over 4,000 patients in phase I of the study spent their last days of hospitalization in undesirable states—that is, comatose or in an ICU on a mechanical ventilator. In Phase II of the study, specific interventions were undertaken to improve the quality of care at the end of life. These interventions were targeted at enhancing opportunities for more patient–physician interaction, but were not successful in improving the desired outcomes. The authors propose greater individ-
ual and societal commitment to enhancing care of the dying, hospitalized patient. Communication about patient wishes, prognosis, goals, and treatment interventions remains a significant barrier to providing end-of-life care. Only about 10% of Americans have written advance directives. In patients who cannot communicate their wishes, we must rely on surrogates to help us identify patient values, beliefs, and past experiences or verbalizations that may provide clues to their wishes regarding invasive therapies or life support.

Other barriers create difficulties in providing adequate pain relief. Most nurses working in the ICU understand the principle of double effect. This principle acknowledges that providing comfort or pain medications to dying patients may have a side effect of hastening the time to death, but this is preferable to having a patient in pain or distress. In establishing a pain management plan, it is important to implement the plan consistently between nurses and between shifts. Pain consultants may be asked to evaluate the patient for further recommendations and management strategies. Pain may also be a symptom of emotional or spiritual distress. Interventions would therefore be directed at the etiology of the pain or distress and may be culturally based.

Nursing Interventions

**COMPASSION**

Most nurses recognize the importance of compassion and the development of a trusting relationship as key elements to providing quality care at the end of life. Benner describes death as a human passage where nurses can help patients and families by fostering leave-taking rituals and including the family in decision making and care. Nurses use all of their skills of presencing, caring touch, cultural sensitivity, and patient advocacy to demonstrate their compassion and support in the care of the dying.

**COMFORT**

Caring for the patient at the end of life in the ICU may be as demanding in terms of nursing time and energy as caring for the critically ill patient who is being aggressively managed. In general, attention is directed at comfort measures: positioning, skin and mouth care, pain and anxiety management, and addressing communication and spiritual needs. Campbell provides a useful manual on caring for the hospitalized patient who is near death. Practical information is provided on giving bad news to patients and families, administering to patients’ emotional needs, and forgoing life-sustaining therapy.

**COMMUNICATION**

Critical care nurses need to be involved in patient–family–physician discussions about treatment decisions and goals of care. At times, physicians will discuss treatment options, including a decision to withdraw or withhold therapy, away from the patient or unit. The nurse may be in a position to understand and interpret patient wishes based on his or her intense contact with the patient. The nurse may also be able to reiterate messages about prognosis and answer patient and family questions based on his or her involvement in the discussions. Consistent, congruent messages are important for maintaining patient and family trust and optimizing satisfaction with care.

Listening well is the cornerstone of effective communication. Although we want patients and families to have realistic expectations of care, we do not want to strip them of their hope. Involving spiritual consultants in the care of dying patients may be useful for patients and families struggling to come to terms with the patient’s impending death. Some patients do not want to talk about dying; to do so strips them of whatever hope they hold. Others deal with death in a symbolic way. They speak of “autumns” and “winters” and other subjects that symbolize endings. This is an effective way of terminating one’s life; no interpretation is necessary, and to do so would be inappropriate.

Communication is also expressed by the nurse’s attitude. Empathy and concern do not need to be expressed in a discouraging manner. Even dying people want to be cared for by a pleasant nurse. A good joke or a smile can be appreciated by a dying patient. Sensitivity to the patient’s mood and a sense of timing are useful in assessing a patient’s receptivity to lightheartedness.

**CONFLICT RESOLUTION/DEBRIEFING**

Despite our best intentions and efforts, conflicting emotions and perceptions may exist among patients, families, and caregivers regarding end-of-life care. Many institutions have established ethics committees or have ethical/palliative care experts available for consultation. These experts may be consulted proactively to help resolve a conflict or brought in to review a case for quality purposes. Debriefing after a death in the ICU rarely occurs, but may be a useful strategy for staff to support one another and identify areas for improving care.

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**clinical applicability challenges**

**Self-Challenge: Critical Thinking**

1. **You are the nurse caring for a patient who is scheduled for a cardiac catheterization in the morning. In report, you are told the patient has been “acting out all day—crying and very emotional.” Explore the possible meaning behind the patient’s behavior. Formulate an action plan, including additional data that may be needed.**

2. **You observe an elderly African-American woman clutching her Bible to her chest with her eyes tightly shut. She is moving her lips as if in animated prayer. Formulate a nursing plan to provide spiritual support for this patient.**

**Study Questions**

1. **Anxiety occurs when patients**
   - are occupied with internal dialogue.
   - are overly dependent on the nurse.
   - have a long-term recovery ahead.
   - perceive a threat to their well-being.

2. **The best way to help patients handle anxiety is to**
   - reassure them that they will receive the best possible care.
   - assist them to talk about their fears and concerns.
   - be direct and honest with them.
   - limit visitors’ time with them.
3. The nurse can help provide a sense of control in patients by
a. providing order and predictability.
b. offering as many choices as possible.
c. including them in decision making.
d. All of the above

4. Cognitive reappraisal is a technique that allows the patient to
a. identify the stressor and alter the response to it.
b. ignore a threatening stimulus.
c. use guided imagery and progressive muscle relaxation.
d. All of the above

5. A positive effect of laughter is
a. a psychological sense of well-being.
b. muscle relaxation.
c. reduced tension.
d. All of the above

6. Reassurance will not be valuable for the patient if it
a. calms excessive fears.
b. ceases expression of emotions.
c. decreases respiratory rate.
d. is combined with presenting.

7. Denial is a response that
a. is viewed as normal in the early phase of grieving.
b. helps the patient gather emotional resources to deal with problems ahead.
c. is a defense that should not be stripped away by the nurse.
d. All of the above

REFERENCES

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