



Fight and Engage, or Suffer and Die?

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I'm the best at gettin' disappointed by my expectations

Try to read my mind it's always racing

—Rosie Darling, “Coping,” 2021

Coping with critical illness in the intensive care unit (ICU) can be a challenging experience for patients and their families and involves dealing with a range of physical, emotional, and psychological challenges that can be overwhelming. In particular, the loss of a sense of control that patients have over their medical care when they are unable to communicate or make decisions about their medical treatment may lead to feelings of helplessness or frustration, fear of death, and demoralization (1–4). Patients and their families can try to focus on positive aspects of the situation, such as the care and attention provided by medical staff, the potential for recovery, and the strength of their relationships. A good sense of humor and a positive attitude can also be helpful in reducing stress and promoting a sense of well-being (5). Social and emotional support from family members, friends, and medical staff can help patients and their families feel less alone and more connected to the world outside the ICU. Moreover, they could potentially modulate the negative effects of psychological distress on perceived quality of

life during their recovery after ICU discharge (6–8).

In this issue of *AnnalsATS*, Cox and coworkers (pp. 861–871) describe the feasibility and potential clinical impact of two different versions of a month-long self-guided mobile app-based coping-skills program called Blueprint compared with usual-care control (9). Blueprint is a self-guided symptom response smart adaptive coping-skills program with four themed weeks. It contains astonishing and novel presentations using audio, video, and text content. Cox and colleagues recruited patients with increased psychological distress symptoms just after discharge from adult ICUs and stepdown units in a large tertiary academic medical center. Patients were randomized to remotely use the Blueprint app with or without a therapist or receive usual care. Although this randomized controlled trial was not intended to test Blueprint's efficacy, the results show that this approach was feasible. Participating patients were motivated to complete the tasks, as shown by a high intervention adherence, and doing so tended to affect depression symptoms and quality of life. The authors are to be congratulated that they were able to perform this study during the coronavirus disease (COVID-19) pandemic outbreaks. The results indicate that it would be worthwhile to follow up on this first study with a larger prospective randomized controlled trial to provide more definitive evidence of the potential efficacy of the Blueprint app.

Although the reported results are interesting, several factors should be considered while interpreting the findings. First, one should particularly be aware of selection bias in the patients participating in this study. In addition, participants liked using the Blueprint app, and the population included had relatively good mental health, with 60% having no increased baseline distress. These factors may also explain why the study authors did not find a difference in results when a therapist was present versus absent. The authors correctly pointed out that ICU survivors frequently use maladaptive

coping strategies during their recovery process. It is therefore particularly interesting to consider the patients who were not willing to participate in the study. The authors mention that this was predominantly due to a reluctance to add another activity during a time when they already felt overwhelmed by the ongoing pandemic. It is also possible that the presence or absence of a spouse or close family member taking care of the patient could have played an important role. One might also argue that patients with less “fighting spirit” or “positivism” as coping skills would have been less likely to participate. These coping styles have previously been shown to be associated with ICU and hospital length of stay, and also with survival based on the Sickness Insight in Coping Questionnaire (10).

In view of the promising results that Cox and coworkers reported, we may consider a focus on the engagement of patients during their recovery trajectory. The obvious question then is: “How could we do that?” Also, should we start doing it during the ICU stay or focus on the recovery trajectory after ICU or hospital discharge? Trying to modify an individual's coping skills and, as such, expecting them to change their character traits is probably very hard, if not impossible, to attain during an ICU stay. Although Cox and colleagues' findings are promising, this may be a very difficult or almost impossible endeavor in a stressful environment in which patients and their family members are in “survival mode.” Indeed, nurses may consider changing the way they approach patients during daily ICU bedside care, particularly those with a prolonged ICU stay, to modify the patient's coping mechanisms in dealing with their long trajectory of ICU reconditioning (11). Besides being thoughtful and considerate in approaching patients, we also have to consider ways to engage our patients and their families to actively work on their recovery trajectory. This process is already important in the ICU, not only after discharge.

One way to try to improve the engagement of patients is the use of

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interactive video games with or without virtual reality goggles (12). Interactive video games may be a relatively novel, but valuable, tool for helping patients cope with critical illness in the ICU environment. They could theoretically provide a range of potential benefits, including reducing anxiety and stress, improving cognitive function, enhancing social interaction and communication, and providing a sense of control and empowerment (13). As such, they should be considered as an important part of the care plan for patients in the ICU. However, it is important to ensure that the games are appropriate for the patient's level of cognitive function and physical abilities and that they do not interfere with other medical interventions. Previous studies have shown that application of these games is feasible in the

ICU environment and that patients liked to use them (14–17).

Besides the start of engaging patients in their own rehabilitation process during an ICU stay, we also have to consider ways to continue those processes after ICU discharge. Recently, Haines and coworkers performed a qualitative study and described a framework of potential interventions in ICU survivors that could be useful in a particular case depending on individual needs and local setting (18). This study was part of the Society of Critical Care Medicine's THRIVE international collaborative sites (follow-up clinics and peer support groups). Haines and coworkers described domains of expectation management, rehabilitation for patients and caregivers, use of peer support groups and access to community-based supports after discharge, reconnecting with the ICU after

discharge, psychological support, education of issues of ICU survivorship for health professionals, and, most importantly, continuing support across the recovery trajectory. These domains could be used to improve the logistical structure and patient care in the ICU and also to improve outcomes after ICU discharge. Recovery from critical illness is hard work and a challenging and frequently demoralizing process. We have to improve and extend the toolbox we use to help patients and their family members win this challenge. If we do not fight with them, the patient might lose: not necessarily their life, but their autonomy and dignity and the quality of their life. ■

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