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PSYCHOLOGICAL CARE TO PATIENTS ON INVASIVE MECHANICAL VENTILATION: EXPERIENCE REPORT IN THE COVID-19 PANDEMIC

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Abstract: The experience report aimed to discuss psychological care for ICU patients who are on invasive mechanical ventilation (IMV) during 2020. The psychologist performed care for patients and their families, as well as interventions in conjunction with other professional categories aimed at comprehensive care for patients. Communication by video call or voice call was also used as a psychological intervention, seeking to provide a form of presence of family members to the patient and acting to welcome the emotional reactions that hospitalization and family interaction caused. After such experiences, it can be seen how psychological action, working in an interprofessional way, helped to minimize anxiogenic agents and the anguish resulting from the use of IMV, favoring a successful weaning. Finally, the need for further studies that deepen and expand the interventional psychological strategies with patients admitted to the ICU who are on IMV is highlighted.
Keywords: Mechanical ventilation. Psychology. Intensive Care Units.

INTRODUCTION

This study was configured as an experience report, coming from the experiences of a resident psychologist in the Intensive Care Unit (ICU) sector of a general hospital of the public health network in the state of Pernambuco. Thus, it aimed to report the experiences of psychological care to ICU patients who are on Invasive Mechanical Ventilation (IMV).

The patient admitted to the ICU is subjected to several stressors, such as: bed restriction, constant noise and lighting, invasive procedures, in addition to social withdrawal. Such factors cause a series of emotional repercussions, influencing the way in which their clinical evolution will occur. Interprofessional action in this context can help to minimize such emotional mobilizations, enhancing the patient's investment and coping in their treatment and rehabilitation process. With regard to IMV, whether performed by tracheostomy or oro/nasotracheal intubation, as a result of this procedure, the patient is unable to speak, which exacerbates all the suffering mentioned above, and may even interfere with the patient's recovery. Thus, in order to act aiming at the patient's biopsychosocial health and thus be able to intervene in their psychic condition, the Psychology professional must find other forms of communication through non-verbal language, aiming to enable the expression of the patient's feelings that found in VMI (ARRUDA, 2019).

Due to the scarcity of scientific production on psychological care in these cases, this and other successful research and reports on this topic are essential, so that they can contribute to the theoretical-technical training of intensive care professionals, as well as to enhance their interventions and practices. interprofessional. In addition, this research also becomes relevant for Psychology as a science and professional, as well as for the scope of public health, considering the current pandemic context of COVID-19 and the need to think about new professional practices that can enhance care. and the health care of the user who is in the public health service.

METHODOLOGY

The experience of psychological care took place during the year 2020, with the main focus on patients who were on IMV. The hospital consists of three ICUs, which have a structure that is always air-conditioned and lit, and has its own multidisciplinary team that monitors the clinical evolution of patients hospitalized in this sector. Before the pandemic, family visits took place daily in the afternoon, with the entry of one family member at a time. At the end of each visit, the professionals

communicated with the family of each patient, reporting their clinical condition, thus allowing the family to be aware of the patient's evolution on a daily basis. Psychology participated in family visits, in order to offer emotional support to those involved, as well as to gather more information about the patient's family and psychic dynamics. It is observed how this interaction of the family-patient-team triad favors the minimization of the subjects' psychic suffering and the strengthening of trust between the triad, even enhancing the patient's recovery.

However, with the occurrence of the Covid-19 pandemic and the government recommendation to reduce the movement of people and agglomerations, it was decided to restrict visits in all sectors of the hospital, so that patients admitted to the ICUs were prevented from having contact with their families, intensifying their psychological suffering and influencing their treatment and recovery. In addition, one of the three ICUs was separated to receive only patients diagnosed with the new corona virus, being more isolated from the other two.

The resident psychologist is part of the multiprofessional team of the ICU, performing consultations through consultation and active search for patients and families, and acting to minimize the suffering resulting from the hospitalization process, as well as mediating communication between the triad. The psychologist worked in the three ICUs, caring for patients who were on IMV with or without COVID-19, but who were in a similar emotional context of isolation from family members and discomforts caused by ventilatory support.

In the case of patients in the COVID-19 ICU, professionals were constantly instructed to clarify as soon as patients arrived at the sector why they were transferred there, since many were even unaware of the diagnosis itself, being scared by the professionals' attire. and the devices that were placed on them. Thus, an awareness-raising work was carried out with the team in order to favor a greater reception of patients and greater clarification regarding their health status and the need for attire. Such issues were emergency points in psychological care for patients with COVID-19, in addition to the feeling of helplessness and loneliness caused by the family's distance and the fear of their diagnosis and prognosis, which is often exacerbated by being the patient's first hospital admission, making the environment strange and threatening for him.

Due to the difficulty of verbal communication of patients on IMV without sedation, alternatives were sought for interventions through non-verbal language. Thus, the meanings produced by looks, gestures, lip reading and writing were used so that they could guide psychological care and enable communication between the triad. Instruments containing images and words were also applied so that the patient could indicate the feeling(s) he was experiencing at that moment, as well as possible needs, from physiological to emotional ones, such as talking to the family or knowing its diagnosis and/or prognosis. In addition to patient care, psychological support was also provided to their family members who, while before the pandemic, were carried out physically, in a reserved room or even in the corridors outside the ICU, with the restrictions on visits, it began to occur through telephone calls.

As a way of trying to make possible a return to the family members about the patient's clinical condition, the hospital separated some doctors who would be responsible for giving news about the patient's health status, thus providing the family members with two telephone contacts that they could call to have access to such information.

This organization was carried out during the beginning of the pandemic in March / 2020, remaining so until the end of the year, even with the difficulties experienced in this process.

During psychological consultations with family members, intense psychic suffering was observed due to the impossibility of seeing their relatives hospitalized, one of the most common complaints being the difficulty of having news about the patient's health status through such telephone contacts. Thus, it was evidenced that in most attempts, the calls were not answered, or when they did, the professionals read the chart, which was often concise and with little information that could clarify to the family how the patient was, allowing an increase considerable in its anxiety and suffering. Thus, such issues were emergency points in psychological care, seeking to mediate the channel of communication between the triad, offering emotional support to family members and enabling greater coping in this difficult and painful period for those involved.

Concerning the concerns and complaints observed in the patients during this period, they were mainly: the discomfort and pain caused by organic-psychic pathologies or even by the failure to properly change the position; and extra-hospital concerns, such as work or a relative, even bringing a feeling of abandonment due to the impossibility of seeing their family members. The psychologist performed sensory-perceptive stimulation in order to favor the orientation of the patient, since the ICU environment can favor the occurrence of mental confusion in patients, requiring prophylactic interventions, and when the beginnings of such symptoms are detected, intervene aiming at minimization and even extinction. of such confusion, when it is purely of an environmental and psychic nature, requiring a multidisciplinary assessment to investigate the origin of such disorientation.

In addition, psychological care was also provided to patients with a focus on their hospitalization and illness, considering the unique needs of each case, as well as interventions in conjunction with other professional categories, seeking to provide comfort and biopsychosocial well-being. Regarding the discomfort caused by IMV, the psychologist intervened mainly with Physiotherapy in patients who were agitated with the use of ventilatory support. Psychological care was provided using non-verbal forms of communication to express their anguish (such as gestures, lip reading, etc). At the same time, Physiotherapy helped in monitoring IMV, as well as in lip reading, as it was easier to understand due to the constant stay in the ICU. In addition, interventions were also carried out together with the medical, nursing and social service team. Such interprofessional actions demonstrated the possibilities of a joint intervention of different knowledge aiming at the integral assistance to the patient's health.

The suspension of visits triggered the search for new forms of presence of family members for patients, without physical contact. The solution found was through the underused technological resources in the hospital environment. One of the strategies was the visit to the virtual bed, a program of the government of Pernambuco created to enable contact between hospitalized patients with Covid-19 and their families through videoconferencing. This program was implemented through Technical Note No. 22/2020 - GAB/SEAS (BRAZIL, 2020). This and other strategies created from the pandemic demonstrated the various therapeutic possibilities that technology can offer.

During the experience with patients on IMV hospitalized in the ICU, communication by video call or voice call was used as a psychotherapeutic intervention, seeking to provide a form of presence of these family members to the patient. When it was not possible to make the call due to the patient's clinical condition, or if the patient did not want synchronous communication due to his speech limitation, videos/audios recorded by family members were shown, with messages of encouragement, comfort and love. Such a strategy of recorded videos/audios was also performed in patients on IMV who were under some degree of sedation, with physiological and emotional reactions being perceived when hearing the voice of their loved one (increased heartbeat, eye opening, tears, etc.), demonstrating that there is awareness of what is happening around them. Letters prepared by the family were also read, with nicknames and phrases used among their members, and when pronouncing such expressions, the same reactions were perceived. After such stimuli, psychological consultations were carried out in order to offer emotional support to those involved, both patients and family members.

It is important to note that before carrying out such interventions, there was consent from both parties, respecting the patient's desire about whether and with whom he would like to communicate, and in what way, whether synchronous or asynchronous interaction. In the case of patients with some degree of sedation, interviews were carried out with the socio-affective network, aiming to understand the patient's relational dynamics and with whom he/she had greater bonds, in order to provide contact between the patient and this support figure, be it a member of your family (parents, children, siblings, grandparents, spouse, etc.) or of your social network (friends, neighbors, etc.). After weaning from ventilation and consequent adaptation to spontaneous breathing, some patients brought memories or even dreams about such interactions with family members in their speech during psychological care, remembering them and considering them as an emotional support for the moment they experienced. during ICU stay and the use of IMV.

The resources used throughout the psychological experience aimed at non-verbal communication were mainly: the use of signs and gestures, lip reading, touches; articulation with professionals from other categories in order to assist in effective communication with the patient; and in the case of literate patients, written communication tools can be used, aiming at expressing patients' feelings and communicating their desires. Such resources are essential for the expression of the patients' feelings, being able through them to intervene for the re-signification of the experienced moment. They can also function as mediation in the communication of the patient-team-family triad, enabling greater transparency and articulation between subjects.

In the case of unconscious patients, who could not find alternative forms of communication, we sought to bring to the team and family the importance of considering the subjectivity of patients, considering them as active subjects in hospitalization, even when they cannot speak for themselves. The same way, we sought to reflect on the importance of the family in the patient's hospitalization, including the socio-affective network in this process, clarifying them, even remotely, about the patient's clinical and emotional condition, the possible changes experienced during hospitalization. and on the procedures that the patient needs to perform, in this case, on IMV and even on the ventilatory weaning process. Psychoeducation work was also carried out with the team, bringing

about ways of humanizing care, especially regarding the importance of always identifying yourself before touching the patient and communicating the procedures they need to perform and what their purpose is, even if the patient cannot interact by being unconscious.

RESULTS AND DISCUSSIONS

One of the aspects related to the ICU is ventilatory support, which aims to relieve the work of the respiratory muscles. Mechanical ventilation can be classified as: invasive, which uses an oro/nasotracheal tube or tracheostomy, and non-invasive, using a mask as an interface between the patient and the artificial ventilator. Although mechanical ventilation is one of the main resources used in the treatment of critically ill patients in the ICU, it can cause several complications, making the patient's rapid return to spontaneous breathing essential. Due to this, ventilatory weaning is started after the reason that made the patient go to IMV has been resolved. Weaning is carried out through different stages and is considered successful when the patient maintains spontaneous ventilation for at least 48 hours (ARAÚJO; ASSIS; SCIAVICCO, 2019; ARRUDA, 2019; CARVALHO; TOUFEN JUNIOR; FRANCA, 2007; GOLDWASSER et al., 2007).

Patients who use IMV are commonly sedated, but there are also cases in which patients are awake or are already in the process of weaning and interrupting sedation daily. This process involves several physical aspects, such as pain, discomfort when breathing, feeling of suffocation and nausea, as well as emotional aspects, such as fear, anxiety and irritation (ARRUDA, 2019). By working on these issues in the interprofessional follow-up, it is possible to provide a better adaptation of the patient to IMV and in the process of weaning from ventilation, confirming what was observed during the practice in the ICU.

Depending on the complexity of COVID-19 and other pathologies that patients have acquired, they may remain in the ICU for a long time, which predisposes them to numerous complications related to immobility, causing even more psychological distress to the patient (FURTADO; et al, 2020). In this sense, psychological support, together with other categories, particularly Physiotherapy, provided emotional support and minimized anxiogenic factors, based on the identification of biopsychosocial discomforts and annoyances. It also made it possible to express concerns and anxieties beyond speech, providing greater psychic strengthening in the patient and, consequently, a better adaptation to spontaneous ventilation and a successful weaning from ventilation.

Psychological care for patients who are unable to speak, in this case due to the use of VMI, is a challenge for the field of Psychology, whose performance is mainly based on the field of speech. In view of this, it is essential that Psychology professionals have flexibility in their practice, since the technique focused solely on speaking and listening is not effective in these cases. Although the universe involving intensive care psychology has a lot of scenarios involving language limitations, there are few researches involving possibilities of interventions with this public, making it necessary to improve new psychological practices in the ICU sector, especially involving patients on IMV (ORTIZ; GIGUER; GRZYBOWSKI, 2016).

Ortiz, Giguer and Grzybowski (2016) also point out that because communication is a fundamental element for human life, its restriction ends up affecting not only the expression of patients' feelings and frustrations, but also their guarantee of

autonomy during hospitalization. Such limitations are frustrating for the patient, the family, and even for the health team, who face difficulties in articulating with the patient, and even in the practice of humanized care, because according to the authors, "the absence of speech brings new challenges for caring" (p. 45).

Such difficulties even raise the need to (re) think the practice of Psychology as an action based on verbal speech, since in the diversity involving the human being, there are also individuals who do not have such a form of communication, such as deaf or dumb, or even deafblind people. In view of this, it is inevitable to ask: how can Psychology include this diversity of patients, if it continues to be guided solely and exclusively by speech? Due to this, the need to seek different therapeutic forms that can encompass and represent different subjectivities and scenarios is essential.

During her experience with patients on IMV, the psychologist acted to welcome the emotional reactions that hospitalization and family interaction caused, having been observed, in patients who were in the process of weaning from ventilation, a decrease in anxiety and in other reactions. resulting from the hospitalization process, with greater relaxation and adaptation to ventilatory support being observed. As for the family, it was observed that with the psychological care, the mediation of communication between the triad, and the virtual interaction with the patient, there was a greater emotional strengthening during the patient's hospitalization, as well as a minimization of the families' suffering in the face of the distance imposed by health care due to the pandemic.

Considering the impersonality of the hospital environment, which reduces the patient to a disease and a bed, an action based on the humanization and singularization of care is essential. Being the Psychology professional capable of having an individualized look and listening to the patient's suffering, one of his roles is to mediate the relationship between patient and team, in order to highlight the idiosyncrasies and emotional functioning that can facilitate or hinder adherence to treatment and rehabilitation (VIEIRA; WAISCHUNNG, 2018). This way, it is essential to train the intensive care psychologist so that care practices can be implemented, contributing with their knowledge and interprofessional action to ICU patients on IMV.

However, studies show how incipient scientific production on this topic is, being even more emphasized in the field of Intensive Psychology (ARRUDA, 2019; CASTELO BRANCO; ARRUDA, 2020), which highlights the importance of having more discussions and empirical research on this topic.

It is necessary to seek care humanization strategies, as well as to integrate the family as part of this process, and to mediate communication between the patient-family-team triad to better favor the recovery of this patient and the guarantee and trust in the assistance provided (ARRUDA, 2019; WRZESINSKI; BENINCÁ; ZANETTINI, 2019). The strategies used in the ICU demonstrated the importance of the presence, albeit in new ways, of family members for the patient's biopsychosocial well-being. In this scenario, the psychologist provided the family with a space to express their feelings, fears and fantasies related to the patient's pathology, seeking to facilitate their communication with the team.

FINAL CONSIDERATIONS

This experience made it possible to learn about the possibilities of care for patients

unable to speak, but it raised some concerns. One of them is the need to (re)think ways of acting and intervention, since Psychology is intensively based on verbal language, being continuously a challenge and even an obstacle in the attendance when the professional is faced with circumstances in which this is not possible. form of communication. In addition, the possibility of creating care protocols for these patients is raised, seeking to emphasize the importance of psychological care in these ventilatory support procedures and the influence of the emotional aspect in this process.

Psychological action, working in an interprofessional way, can help to minimize anxiogenic agents and the anguish resulting from the use of IMV, favoring a successful weaning and reducing the possible complications of prolonged use of IMV. Finally, the need for other studies related to the theme is highlighted, seeking to deepen and expand the interventional psychological strategies with patients admitted to the ICU who are on IMV, as well as empirical research involving the influence of psychological care on weaning from ventilation.

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