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ORIGINAL ARTICLE

The intensive care unit psychosocial care scale: Development and initial validation

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Intensive care unit;
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Summary The main objective of the current study was to construct a new self-report scale – ICU-PC Scale – to measure the psychosocial care (PC) of patients in Intensive Care Unit (ICU) and examine different psychometric issues in the development and initial validation of this scale. The findings indicate that the ICU-PC Scale has established high internal consistency. A three-factor structure – protection of human dignity and rights, transparency for decision making and care continuity and sustained patient, family orientation – has been identified with a substantial number of subjects ($N = 250$) in hospital settings. The three oblique factor solutions are found to be interrelated and interdependent with good indices of internal consistency and content validity. This new instrument is the first of its kind to measure the psychosocial care to be provided to patients in the ICU. The present findings indicate that the ICU-PC scale, with additional factor analytic research, could become an established and clinical tool.

Implications for Clinical Practice

- This new instrument – ICU-PC Scale – is the first of its kind to measure the psychosocial care to be provided to patients in the ICU.
- Though the scale has been developed with cardiac patients only, the extent of measurement has potential to be extended to any patients treated in ICU.

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- This instrument is designed for use with both men and women in clinical settings.
- Compared with other available instruments, this scale is brief, easy to understand, less time consuming and easy to administer and score.
- The scale has the potential to help the researchers and practitioners to quantify psychosocial care in clinical settings, especially in ICU.

Introduction

Psychosocial care in the context of intensive care units (ICU) in hospital settings refers to specific supportive interventions such as providing explanations, reassuring and raising faith and hope, cheering-up, strengthening patients' self-esteem, giving emotional warmth, offering empathetic listening, empathetic touch and spending extra time with patients (Frazier et al., 2002). Such interventions can work as a buffer against ICU trauma experienced by patients. ICU trauma refers to intense negative psychological states that impact well-being.

Psychosocial Care originates from the biopsychosocial model of health care, which in short is referred as 'patient centered care'. The Institute of Medicine (IOM, 2001) defined patient-centered care as 'care that respects and responds to the individual patient's preferences, needs and values, and ensures that clinical decision-making incorporates patients' values. In simple terms it refers to viewing and responding to illness through the patient's perspective (McWhinney, 1989), that calls for high quality communication (Hobbs, 2009) accompanied with appropriate intervention (Mead and Bower, 2000).

Psychosocial care, which is the crux of patient-centered care, is advocated in the context of treating cancer where the implied terminality of the disease gives rise to negative psychological consequences. In such cases there is a pressing need to effectively address the issue of emotional well-being of patients and members of their families (Andrykowski and Manne, 2006), management of pain (Gorin et al., 2012), fatigue (Kangas et al., 2008), loss of body image and isolation and distress (Holland et al., 2013).

A negative emotional state is closely associated with physical health status (Gallo and Matthews, 2003), heart problems (Kubzansky and Kawachi, 2000), and experience of pain intensity (Bair et al., 2008). This cannot be ignored as an isolated factor because several studies demonstrated its direct impact on health, illness, convalescence and prognosis (Rozanski et al., 1999).

A patient is admitted into ICU when s/he requires constant observation from the medical team — physician/doctor and nurse — either because the medical condition is serious or the patient is post major surgery. Several studies identified psychological repercussions of ICU stay, caused by a combination of physical pain, physical environment, isolation from family, apprehensions about the medical outcomes, dependency and loss of autonomy. Known as ICU trauma, they include intense adverse emotions such as fear, anxiety, agony, loneliness, bewilderment, depersonalisation, hopelessness and acute confusion (Lusk and Lash, 2005), feelings of purposelessness and loss of confidence (Granberg-Axell et al., 2001; Johansson and Fjellman-Wiklund, 2005; Johnson et al., 2006), dependency and vulnerability (Gjengedal, 1994; Samuelson, 2006; Almerud et al., 2008), powerlessness, frailty and vulnerability (Henriksen and Vetlesen, 2000) and feelings of insecurity (Samuelson, 2011). The ICU trauma manifests in many ways such as delirium, characterised by a high state of distress (Van Rompaey et al., 2008). Several studies have indicated that about 70% of patients admitted in ICU suffer from delirium (Fong et al., 2009; Miller, 2008; Pun et al., 2005) whereas in the case of post-operative cardiac surgery patients the percentage is 14.7% (Arenson et al., 2013).

Coronary artery bypass graft (CABG) surgery is associated with high levels of apprehension, anxiety, depression and psychological distress (Ebirim and Tobin, 2011; Powell and Johnston, 2007; Chaudhury et al., 2006), and cognitive impairment (Duits et al., 1997). Association of depression with poor recovery is also observed (Lopez et al., 2007; Murphy et al., 2008). Recent studies validate that post-traumatic stress disorder (PTSD) is prevalent in 14.7% of CABG patients (Dao et al., 2010). The symptoms of PTSD, including traumatic memories related to CABG surgery, are evident in up to 18% of 148 patients in a six-month follow-up study. The study, on stressful experiences in CABG patients, reveals that patients feel the ICU experience as hard (Gois et al., 2012). CABG patients are at a risk of anxiety and depression. It is found that 8% of CABG patients had major anxiety symptoms and 14% major depression symptoms (Murphy et al., 2008), and that depression continued for three years in 52% of patients, adversely impacting their well-being (Karlsson et al., 2008).

To minimise such inadvertent adverse impact of ICU trauma, the Accreditation Boards of Hospitals such as National Accreditation Boards of Hospitals (NABH), and Joint Commission International (JCI) have provided specific guidelines that integrate psychosocial care into patient care in ICUs. Indicating the mitigating effect of family support, Bergbom and Askwall (2000) found the presence of family as helpful in neutralising the psychological distress in ICU patients. However, in view of life risk condition, the focus of medical and para-medical staff gets concentrated on the biomedical needs of the patients resulting in psychosocial care taking a back seat (Hariharan and Chivukula, 2011). Hence, in view of the negative impact of ICU stay and the role of psychosocial care in minimising, if not mitigating the adverse impact of ICU stay, there is a dire need to standardise a scale that measures psychosocial care in ICU so as to quantify the psychosocial care in ICU practices. Such tools will go a long way in measuring the parameter and ensuring a holistic approach in ICU practices so as to counter ICU trauma.

Hence, the main objectives of the study were to — (i) construct a self-report scale to measure the psychosocial care of patients in ICU, (ii) assess its underlying structure and (iii) examine different psychometric issues in the development of this scale.

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