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FELLOWS-IN-TRAINING & EARLY CAREER PAGE

The Challenge of Identifying and Addressing Psychological Comorbidities

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"I was seriously contemplating giving up," the patient explained, sitting on the examination bed in the clinic. She had severe cardiomyopathy and was describing her recent stay in the intensive care unit (ICU). "I was more depressed than I have ever been. It would have been really helpful to have a psychologist or psychiatrist to speak with." Still volume-overloaded, she paused to catch her breath. "Why couldn't the doctors address my mental health needs?"

Her experience in the ICU led her to identify a blatant gap in care. Why was it that her physicians only addressed her physical ailments, while neglecting the psychological ailments that compounded her suffering? The consequences of such illnesses are anything but abstract. In patients like her, depression carries a mortality risk (1).

Even without antecedent depression, critical illness can affect mental health. ICU admissions carry a high risk of developing mood disorders, with 66% of patients acquiring ≥1 type of psychological symptom (2). Cardiology patients exemplify this problem. Among myocardial infarction (MI) patients in the cardiac intensive care unit, there is a high incidence of depression and other mood disorders (3,4). The risk of developing psychological comorbidities in the ICU is only the beginning of the problem, as quality of life for these patients significantly decreases after MI (5). The patient was right. Addressing only physical ailments in the ICU while neglecting psychological disease is delivering suboptimal care.

The field of pediatrics offers a different approach to emotional health during illness. Many children's hospitals utilize a program called Child Life. Child Life specialists focus on helping children and their families cope with illness. The American Academy of Pediatrics highlights the 3 main roles of Child Life services: "1) providing play experiences; 2) presenting developmentally appropriate information about events and procedures; and 3) establishing therapeutic relationships with children and parents to support family involvement in each child's care" (6). Working in a hospital with an active Child Life program, one sees how children and their parents thrive when their emotional needs are addressed. What could be better than a 3-year-old staying calm during a procedure because he is playing an electronic game of Go-Fish with the Child Life therapist? Or consider the 7-year-old with leukemia, painting with an art therapist while receiving chemotherapy. These programs do not simply allow children and families to have more enjoyable stays in the hospital; they may actually lead to improvements in health outcomes (6,7).

Just like their pediatric counterparts, ill adults—including those with heart disease—experience emotional distress as a result of their physical ailments. For a patient with mental illness, the symptoms can compound medical disease, creating a downward spiral. When heart failure patients have depressive symptoms, they are more likely to experience deterioration in their clinical status (8,9). The combination of physical and mental ailments requires a nuanced approach to healing.

One possible strategy to address this issue is to integrate a psychiatrist or psychologist into the cardiovascular clinical team. Although not yet implemented in cardiology to the authors' knowledge, incorporating mental health professionals has made a positive impact in the general ICU setting. A group at Careggi Florence University Hospital in Italy incorporated meaningful interventions with mental health providers into their critical care practice. Their

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patients experienced decreased levels of psychological symptoms and improved quality of life (10). Another study from the Brigham and Women's Hospital revealed a trend toward a decreased ICU stay and hospital length of stay when a psychiatrist rounded with the medical intensive care unit team (11).

A dually trained cardiologist-psychiatrist might seem like an odd profession, even to an internist-pediatrician training in cardiology. But during a conversation at the European Society of Cardiology conference this past August, one cardiologist-psychiatrist boasted "the ability to heal the entire patient." He relayed stories of how cardiologists often missed or skipped over signs of serious mental health conditions, exacerbating patients' suffering. In his experience, the skills he gained from his psychiatry training proved essential in the cardiology wards.

While planning for psychiatry residency may not be feasible for most of us, we must acknowledge that cardiology training often leaves us ill-equipped to recognize and address mental health conditions.

As the next generation of cardiologists, we can start by seeing each patient within a psychosocial context that includes family. The 2017 Family-Centered Care Guidelines, employed by critical care providers, highlight the importance of family-centered rounds, a multidisciplinary process that includes the patient and family in the decision-making process (12). Family-centered rounds improve communication between provider and family, improve patient and family satisfaction, and ultimately may lead to improvement in patient outcomes (13,14).

In adult cardiac intensive care units and telemetry wards, we must learn to address a patient's psychosocial needs by taking tips from Child Life programs and family-centered care practices. Interestingly, this model of care not only benefits patients, but may also benefit hospitals' bottom line. Child Life programs have been shown to reduce admission costs by reducing length of stay and decreasing the need for analgesics (6,7). Given the benefits offered by services like Child Life, adult hospitals should strive to mirror them by creating "adult life" services.

Our fellowship training should reinforce these practices. During cardiology training, fellows should receive instruction on how to recognize and understand the psychological effects of illness in their patients. In inpatient wards and heart failure clinics, fellows should be encouraged to utilize existing resources, like chaplain and social work services, and to seek formal psychiatric consultation for patients when appropriate. With time, the cardiology community will integrate a deeper, more nuanced psychosocial perspective into practice.

At the children's hospital a number of years ago, an 8-year-old girl with sickle cell disease came in with vaso-occlusive crisis. Like many patients in similar circumstances, she had difficulty getting her mind off the pain. At one point, she let slip that she liked the hip-hop artist JAY-Z. As she struggled that night with bony pain on a narcotic patient-controlled analgesia, the resident remembered the therapeutic role of music (15) and put on JAY-Z in the background. Even through the intense aching and stabbing brought on by her vaso-occlusive symptoms, a smile broke through. "This is my jam," she said.

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REFERENCES

1. Jiang W, Alexander J, Christopher E, et al. Relationship of depression to increased risk of mortality and rehospitalization in patients with congestive heart failure. Arch Intern Med 2001; 161:1849–56.

2. Huang M, Parker AM, Bienvenu OJ, et al. Psychiatric symptoms in acute respiratory distress syndrome survivors: a 1-year national multicenter study. Crit Care Med 2016;44:954–65.

3. Feng HP, Chien WC, Cheng WT, Chung CH, Cheng SM, Tzeng WC. Risk of anxiety and depressive disorders in patients with myocardial infarction: a nationwide population-based cohort study. Medicine (Baltimore) 2016;95: e4464.

4. Benyamini Y, Roziner I, Goldbourt U, Drory Y, Gerber Y. Israel Study Group on First Acute Myocardial Infarction. Depression and anxiety following myocardial infarction and their inverse associations with future health behaviors and quality of life. Ann Behav Med 2013;46: 310–21.

5. Lane D, Carroll D, Ring C, Beevers DG, Lip GY. Mortality and quality of life 12 months after myocardial infarction: effects of depression and anxiety. Psychosom Med 2001; 63:221–30.

6. American Academy of Pediatrics. Committee on Hospital Care. Child life services. Pediatrics 2000; 106:1156–9.

7. Wolfer J, Gaynard L, Goldberger J, Laidley LN, Thompson R. An experimental evaluation of a model child life program. Child Health Care 1988; 16:244–54.

8. Rumsfeld JS, Havranek E, Masoudi FA, et al. Depressive symptoms are the strongest predictors of short-term declines in health status in patients with heart failure. J Am Coll Cardiol 2003;42: 1811–7.

9. Nair N, Farmer C, Gongora E, Dehmer GJ. Commonality between depression and heart failure. Am J Cardiol 2012;109:768–72.

10. Peris A, Bonizzoli M, Iozzelli D, et al. Early intra-intensive care unit psychological intervention promotes recovery from post traumatic stress