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LETTER TO THE EDITOR

# Use of mirrors in the critically ill patient admitted to the Intensive Care Unit, do they have a place?☆

## Uso del espejo en el paciente crítico ingresado en la Unidad de Cuidados Intensivos, ¿tiene cabida?

### Dear Editor,

A characteristic of Departments of Intensive Care Medicine that have a post-intensive care syndrome follow-up program is the testimony of the evaluated patients, with the documentation of phrases such as: ''It was as if it weren't me'', ''I thought I was living a series in which they were interacting with me''; or ''I was like an actor in a film, in which a woman congratulated me on my way of acting''.

Survivors of critical illness often suffer cognitive and psychiatric problems.[1] Depersonalization and derealization episodes such as those described can entail behavioral changes in the acute phase, that can be interpreted as delirium and/or leave psychological sequelae.

Many variables can contribute to these phenomena. The structuring of most Intensive Care Units (ICUs) allows many patients to be visualized simultaneously, but limits the visual field of the patients to the ''control area''. The patients do not perceive what is happening around them, and this contributes to the sensation of being controlled, as *Foucault* would say, enhancing the feeling of invisible omniscience associated with derealization. Monitoring, usually not visible to the patient and involving acoustic alarms, implies continued and frequent displacement of the healthcare staff inside and outside the visual range of the patient, which can favor depersonalization. Likewise, the lack of familiarity with the environment, communication difficulties and loneliness can activate feelings of sequestration and prejudice that in turn result in fear and loss of control and autonomy.

Thanks to *Wallon* and *Lacan*, we know that mirrors are involved in human development, favoring self-perception capacity by facilitating the integration of one's own body image. On examining the therapeutic utilities of mirrors, we find that they have been employed in the patient rehabilitation setting to improve motor function following stroke, with moderate evidence in favor of their use.[2] Mirrors have been postulated as a supporting tool in neurological evaluations,[3] and their effects have been studied in a sample of critically ill surgical patients, with no conclusive results regarding the reduction of delirium, though with the documentation of a lesser incidence of traumatic memories.[4] A qualitative study in the ICU concluded that the use of mirrors could improve patient self-perception.[5] No robust studies are available on the short and long-term psychological-psychiatric implications of the use of mirrors in critical patients.

Considering the above, we hypothesize that the use of mirrors in the ICU could contribute to avoiding the above-mentioned phenomena. However, we would like to open debate on their applicability: What would be the right moment for introducing mirrors? Who should apply them and to what patients? Is patient autonomy respected? Would it be an act of beneficence for all critical patients? In the case of burn or facial trauma patients, when would the principle of non-maleficence be considered? Would consent be required, or could a legal representative provide consent?

We feel that mirrors may have a place in application to certain critical patients. However, there are not enough studies on their applicability in the ICU, where their implantation could give rise to ethical considerations.

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## Conflicts of interest

The authors declare that they have no conflicts of interest.

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