

Psychodynamic Aspects of Uncertainty among Patients in Intensive and High-Acuity Care: A Conceptual Analysis

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ABSTRACT

Background: Patients receiving intensive or high-acuity care often face sudden, life-threatening medical crises that can cause profound psychological distress. However, uncertainty in critical care is commonly discussed in terms of limited information or difficulties in understanding a patient's condition. This perspective may overlook the deeper intrapsychic and emotional processes that arise when individuals confront acute medical trauma. This theoretical gap hinders the understanding of the emotional subjective dynamics of this specific category of patients.

Aims: This study conducted a systematic concept analysis to define and theoretically refine the psychodynamic dimensions of uncertainty among adult patients in critical and high-acuity care settings.

Methods: The literature search was initially conducted using a scoping-oriented approach and subsequently informed a concept analysis based on Walker and Avant's framework. Four database sources were represented in the search records: PubMed, MEDLINE via EBSCO, APA PsycArticles via ProQuest, and Scopus. This study looked at the aspects of Uncertainty that patients feel when they are in intensive and high-acuity care.

Results: This conceptual analysis found five attributes: 1) A constant feeling of danger to life; 2) Hidden ways the mind protects itself such as denial, dissociation and splitting; 3) A sense of how the body is changing; 4) A need for relationships to keep emotions in check; 5) The trouble making sense of events and keeping a story together. These attributes seem to come from causes, especially deep psychological upset, dependence on medical machines and Uncertainty about the outcome.

Conclusion: Uncertainty is more than a thought problem. It is a feeling that lives in the body in the mind and in relationships. It goes beyond mental models of Uncertainty. Paying attention to hidden defensive processes and the role of relationships in emotional regulation provides a broader view of how patients cope with critical illness. This perspective may inform caring practices and interventions that support patients' emotional recovery after intensive care.

Keywords: *Uncertainty; Critical care; Defense mechanisms; Psychological stress; Concept analysis.*

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1. Introduction

When a person is suddenly confronted with a serious illness and admitted to an intensive care unit, the experience can be overwhelming. The ICU environment, with its machines, sedation and confusing moments can make patients feel disconnected from their own bodies and, from their sense of self. Memories may become fragmented or unclear. The future can seem uncertain or frightening. This experience can shake a person's identity and their ability to plan for life after the hospital. After leaving the hospital many ICU survivors continue to struggle with anxiety, depression or post-traumatic stress. These psychological challenges can last for months or even years affecting their quality of life long after the physical recovery is complete (Cypress, 2016; Rabiee et al., 2016). Research suggests that approximately 20% of adult ICU survivors experience clinically significant symptoms of post-traumatic distress during the first year after hospitalization. Low mood and depression are also common concerns (Rabiee et al., 2016; Righy et al., 2019). Although the outcomes attracted attention in care, research still don't know much about patients feel and react to sudden serious threats while they are in the hospital.

Uncertainty in healthcare has mostly been studied using thinking-based models Mishel's Uncertainty in Illness Theory. In that view uncertainty happens when patients can't make sense of what's going on with their health because the information's missing, confusing or hard to understand. This idea has worked well for long-term illnesses. Care outside the hospital. In intensive care and other high-stress settings, where people are facing life-threatening situations this way of thinking may not be enough. Patients often can't think clearly because they are in physical pain on machines like ventilators or not fully awake. These conditions make it hard to reflect or reason. In moments uncertainty isn't just about not understanding facts. It can also be an emotional reaction to danger, something that happens deep inside even without being fully aware of it. Thinking rationally might not be possible for a while. So looking at these experiences through a lens might help explain parts of uncertainty that the usual thinking-based models miss.

Another way to understand uncertainty especially at the unconscious and relational levels, is through a psychodynamic perspective. This approach examines how individuals use defense mechanisms, relate to others, and manage early, preverbal emotional experiences when facing danger (Sharpless, 2019). Modern psychodynamic theories also say that extreme threats can push people back to older ways of coping—like splitting, denial or projective identification. These defenses can help people deal with anxiety but they can also get in the way of talking making decisions or joining in therapy while in critical care (Luyten et al., 2017). In practice ideas, like containment and holding describe how doctors, nurses and other care team members can help patients by being present and emotionally attuned. With this kind of relationship painful experiences can be easier to think about and process of being acted out or pushed away through detachment (Abrahams & Rohleder, 2021). Intensive care settings make this very difficult. Time limits, the heavy use of medical equipment and few chances, for long personal interactions can leave patients more exposed to broken, backward or split reactions (Polnay et al., 2025). Psychodynamic practitioners who work with ICU survivors say that transference, countertransference and the hidden meaning of actions can help explain how uncertainty becomes deeply personal. For some ICU survivors uncertainty may appear as fears of being left behind body harm or being destroyed (Sayde, 2023).

Research in critical care populations has largely documented psychological symptoms and their prevalence. Less attention has been paid to the intrapsychic processes through patients experience and manage uncertainty during critical illness (Rabiee et al., 2016; Righy et al., 2019). This leaves an important gap in understanding how perceived bodily threats and relational support shape patients' experiences of uncertainty during critical illness, particularly when emotional responses and psychological defenses are not fully accessible to conscious awareness.

In this study, theoretical refinement does not mean adding terminology or creating a separate classification without a clear explanatory purpose. Rather the approach focuses on connecting known ideas from psychodynamic theory with current models of illness uncertainty. Three key areas stand out in this effort: defense mechanisms, the symbolic meaning of physical illness and relational containment. When these ideas are looked at together with cognitive factors, they may help explain why uncertainty, during serious illness doesn't always come down to a lack of information or trouble understanding medical details. The overall framework aims to guide care that addresses not just what patients need to know but also how they feel and what emotional challenges they may be facing.

2. Methods

This study utilized concept analysis following the eight-step method outlined by Walker and Avant (Walker & Avant, 2019). This methodological approach was chosen because of the conceptual ambiguity and inconsistent operationalization of psychodynamic uncertainty within intensive and high-acuity care settings. Following Walker and Avant's method the analysis aimed to clarify the concept by finding attributes, models and opposite examples origins, outcomes and real-world references (Tang et al., 2024; Walker & Avant, 2019). Carrying out these steps in order helped set limits for psychodynamic uncertainty set it apart from usual cognitive models and laid a base, for future clinical evaluation.

Search strategy

The literature search was conducted on 24 November 2025. Four database sources were represented in the search records: PubMed, MEDLINE via EBSCO, APA PsycArticles via ProQuest, and Scopus. The initial search yielded 170 records, comprising 38 from PubMed, 4 from MEDLINE via EBSCO, 85 from APA PsycArticles via ProQuest, and 43 from Scopus. The search focused on three groups of concepts: uncertainty, intensive or high-acuity care, and psychodynamic processes. The search terms included "uncertainty," "intensive care," "critical illness," "high-acuity care," "psychodynamic," "defense mechanisms," "unconscious," and "containment." The database-specific search strings, Boolean operators, and applied filters are documented in Supplementary File 1.

Operational definitions

Psychodynamic uncertainty is a concept that suggests when someone is very sick they feel unsure not about what's wrong with them or what will happen next but also about their feelings, how they see their body, their inner thoughts and the need for help from others. The idea comes from studies, about how people deal with uncertainty and stress in situations. The proposed attributes represent an interpretive synthesis of the selected sources rather than universally established clinical manifestations. Findings that concern family caregivers are set apart from findings that concern patients. The analysis does not claim that it can be directly applied to oncology treatment or to renal replacement therapy because the sources kept in the revised table do not give enough evidence, for those specific settings.

Criteria for inclusion and exclusion

Literature selection was guided by the objectives of Walker and Avant's concept analysis and the distinct functions of empirical and conceptual sources. Empirical studies were eligible if they talked about the experiences of adults who were 18 years old or older. These studies had to take place in care units or in settings that were clearly described and had high levels of urgency. The studies had to look at things like uncertainty, distress feeling physically weak, communication or feeling, in control. English-language books or articles that were scholarly were also eligible if they had a theory or clinical analysis that helped understand psychodynamic uncertainty. Completed reviews and summaries of research were considered as extra sources if they gave useful information or helped explain what happens in adult critical care.

Studies focusing exclusively on pediatric or neonatal populations, parents or caregivers without identifiable findings concerning adult patients, and clinicians' decision-making or attitudes without a direct conceptual contribution to psychodynamic uncertainty were excluded. Review protocols that did not include completed findings or publications not related to the clarification of uncertainty in intensive or high-acuity care were also excluded. When sources included both family perspectives these were clearly separated and not treated as the same thing. The analysis made a distinction, between empirical findings and theoretical interpretations throughout the synthesis.

Data extraction, selection, and conceptual synthesis

On 24 November 2025, carried out the database search. This search produced 170 records. These records came from four database sources: PubMed (n = 38) MEDLINE via EBSCO (n = 4) APA PsycArticles via ProQuest (n = 85)

and Scopus (n = 43). After removing three records 167 records remained for initial screening. Of those 167 records 153 records did not move forward to assessment. The screening log listed 59 records that were not clearly related to care or critical illness 29 records that did not clearly address psychodynamic processes or psychological uncertainty and 25 records that focused on pediatric populations. The remaining 40 records lacked metadata in the exported records and could not be evaluated using abstract information alone. Because the abstract was missing those 40 records were treated as lacking information for assessment, at the initial screening stage rather than being excluded for conceptual reasons. The primary database-screening process and the separate supplementary-source pathway are presented in Figure 1.

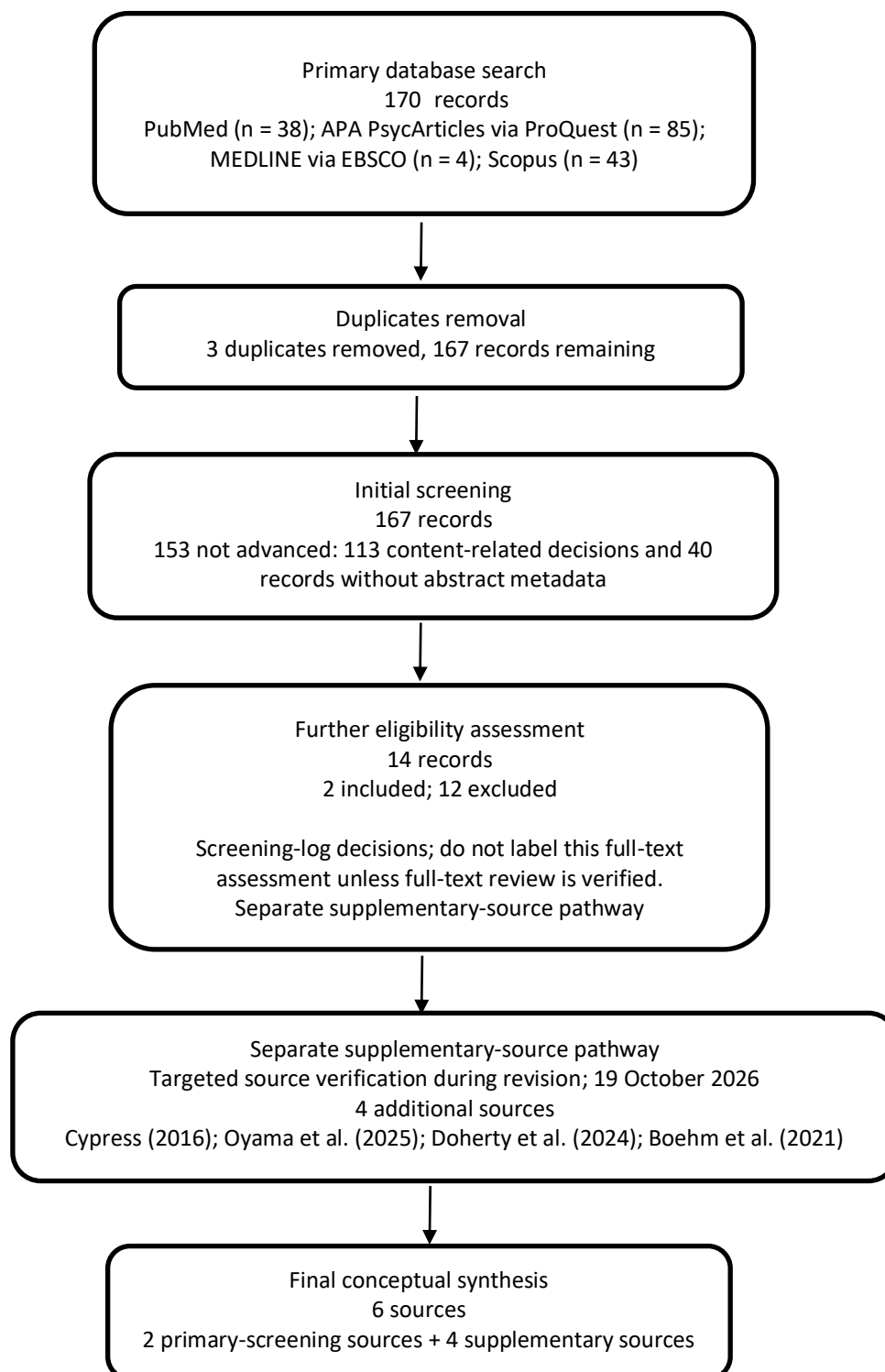


Figure 1. Literature search, screening, and conceptual selection flowchart

Fourteen records were retained for further eligibility assessment. According to the available screening log, two records were included and 12 were excluded. The two included records were Cerone (2019), which discusses a brief psychodynamic and person-centered approach to anticipatory loss in acute care, and Hurwitz (2022), which provides a psychoanalytic discussion of air hunger. The 12 excluded records were not considered sufficiently relevant to the specified critical-care context on the basis of the information recorded during screening. The available screening log did not document any records being reinstated from the excluded set through manual re-screening. Accordingly, no claim is made that previously excluded records were recovered through such a process. Four additional sources were considered separately from the database-screening results: Cypress (2016) Oyama et al. (2025) Doherty et al. (2024). Boehm et al. (2021). These four sources were not counted among the 170 records retrieved in the search and were not treated as records recovered through manual re-screening.

The four supplementary sources were retained for their distinct contributions to the conceptual synthesis. Cypress (2016) addresses uncertainty among critically ill patients in the ICU; Oyama et al. (2025) report adult ICU patients' experiences of discomfort, uncertainty, communication, and control; Doherty et al. (2024) discuss suffering, communication, and palliative care in the ICU; and Boehm et al. (2021) synthesize patient and family experiences of delirium-related distress. Family perspectives were used as contextual evidence and were not treated as interchangeable with adult patients' own reports. The six sources presented in Table 1 therefore comprise two sources included through the primary database-screening process and four supplementary sources considered separately for the concept analysis.

The conceptual synthesis followed Walker and Avant's framework. Relevant textual passages were extracted and organized to identify recurring patterns associated with psychodynamic aspects of uncertainty. Defining attributes were examined through comparative analysis, while antecedents and consequences were identified by examining the conditions preceding and the proposed attributes (Table 2). Empirical findings were distinguished from theoretical and clinically oriented interpretations. The relationship between uncertainty-related cognitive processes and proposed psychodynamic mechanisms was examined interpretively, rather than treating the selected sources as direct empirical confirmation of unconscious processes (Tang et al., 2024).

3. Results

Uses of the Concept of Psychodynamic Uncertainty

The idea of uncertainty has been looked at nursing and healthcare; seeing things based on where to look. Mishel created the Mishel Uncertainty in Illness Scale to measure how uncertain patients feel about their symptoms, diagnosis, treatment, relationships with caregivers and plans for the future (Mishel, 1988). These studies show that uncertainty in healthcare isn't about not having enough information. It's more complex than that. The word psychodynamic comes from a kind of thinking. According to the American Psychological Association psychodynamics is about how our thoughts, feelings, motivations and drives interact. The ones we're not fully aware of. In theory defense mechanisms are unconscious ways people react to protect themselves from anxiety caused by inner conflicts or outside threats. In this concept analysis psychodynamic aspects of uncertainty mean a new way of thinking about how people experience uncertainty during illness. Not as a lack of information but also as something tied to unconscious defenses what the body's changes might symbolize, needs in relationships and problems in making sense of what's happening. This idea builds on what's known but it's not a standard or official diagnosis. The five key features found in this analysis are: threat, possible unconscious defensive processes, symbolic meanings tied to physical changes, relational containment and trouble making meaning or telling a clear story about the illness. Studies, on experiences show uncertainty, discomfort trouble communicating and feeling out of control. Those studies alone don't prove that people are using unconscious defense mechanisms.

Defining Attributes of Psychodynamic Uncertainty

The essential characteristics of psychodynamic aspects of uncertainty are the foundational traits that consistently manifest in environments of intensive and high-acuity care, distinguishing this concept from cognitive or informational uncertainty. Understanding the conceptual account of the phenomenon of psychodynamic uncertainty requires a detailed investigation with the following characteristics, as shown in Table 2.

Table 1. Conceptual sources in analyzing the Psychodynamic Aspects of Uncertainty in Intensive and High-Acuity Care

No	Conceptual Role	Care Context	Focus of Study	Relevance to Psychodynamic Aspects of Uncertainty
1	Core conceptual anchor	Acute. Palliative care environments that deal with serious illness; not a study that is only for the ICU.	Psychodynamic and person-centered methods for dealing with expected loss in acute care situations.	Offers a way to understand the emotions people feel when they are very sick including not knowing what will happen next having both hope and the idea of losing someone at the same time and the value of good relationships, between patients and the people caring for them. The examples given show how things are done in life not how psychodynamic uncertainty is proven in ICU patients (Cerone, 2019).
2	Core conceptual anchor	Psychoanalytic discussion; not an empirical study of a defined ICU patient cohort	Psychic Transformations: Air Hunger; psychoanalytic perspectives on air hunger and subjective experience	Provides an interpretive perspective on the possible psychological significance of air hunger and bodily threat. It is used as a theoretical source and not as direct empirical evidence of psychodynamic uncertainty in ICU patients or patients undergoing renal replacement therapy (Hurwitz, 2022).
3	Supporting conceptual source	Intensive Care Unit (ICU); patients, family members, and nurses involved in critical illness	Uncertainty during critical illness, examined in relation to Mishel's Theory of Uncertainty in Illness	Explores uncertainty in the ICU and provides context for patients' and families' experiences of not knowing what will happen, whether the illness is progressing, or whether the patient will survive. It supports the illness-uncertainty component of the analysis but does not directly establish unconscious psychodynamic mechanisms (Cypress, 2016).
4	Supporting conceptual source	ICU; critically ill adult patients in a university hospital in Japan	Adult patients' experiences of discomfort and comfort, including overlapping uncertainties, communication difficulties, and perceived control	Provide accounts of uncertainty, physical discomfort, mental discomfort, communication difficulties and patients control, over aspects of care. These findings inform the basis of the concept; unconscious defenses and other specifically psychodynamic processes were not directly examined (Oyama et al., 2025).
5	Supporting conceptual source	ICU patients, families and people who make decisions on their behalf.	Chances for early and special palliative care in the ICU	It looks at deep emotional pain typical symptoms talking with patients help, for people who make decisions for others and moving between different levels of care. It puts pain and support in the ICU into context. Does not clearly show how the mind works in these situations (Doherty et al., 2024).
6	Supporting conceptual source	ICU patients and family members experience delirium-related distress.	ICU patients and family members describe delirium-related distress and find factors that might relieve that distress	The study pulls together the experiences of ICU patients and family members about delirium. It helps to talk about psychological distress and the way relationships are affected. It does not directly study uncertainty as a separate construct (Boehm et al., 2021).

Source: Developed by the authors based on the reviewed literature

Persistent existential threat associated with life-threatening illness

Uncertainty psychodynamics involve a constant feeling of death, of being out there but nothing there, of not being safe, and of no safe sense of future. This uncertainty is more than just the unpredictability of clinical outcomes, it's a radical confrontation that faces death and the risk that core understandings of the self and life will come to an unexpected end.

Activation of unconscious defensive mechanisms

A major component of the psychodynamic phenomenon of uncertainty is the activation of defensive strategies as a way to deal with threatening, overwhelming physiological and existential situations. When emotional demands exceed patients' capacity for conscious regulation, defenses such as denial, dissociation, splitting, projection, and isolation of affect are brought into use to handle the ensuing unbearable anxiety and fear.

Symbolic experience of bodily disruption and threat

Psychodynamic uncertainty entails perceiving the body as a locus of symbolic and psychological threat. The body is not safe anymore because of treatments that go deep inside depending too much on machines and feeling really bad because of sudden symptoms. Because of this the body's normal functions start to look like signs of being trapped not being able to help oneself breaking apart and being destroyed.

Dependence on relational containment for affect regulation

Another salient feature is the greater reliance on the relational environment for emotional regulation. In the arena of intensive, high-acuity health care, those experiencing the treatment may exhibit diminished internal (self) regulatory skills and require their emotional stability from relational containment provided by health care providers. It is contained in the emotional attunement, in the presence and in the empathic communication.

Disruption of meaning-making and narrative coherence

Psychodynamic uncertainty refers to problems in the processes of meaning-making: patients experience difficulties when trying to call up bodily threats and emotional experiences as healing or meaningful stories within their personal frameworks. This disintegration of the continuity of the story weakens the ability of patients to symbolize the experiences they have; it also increases their uncertainty and carries on after the initial throes of the illness.

Model Case

An adult patient was admitted to the ICU because of respiratory failure and needed mechanical ventilation. The patient often said that they were scared of dying and worried that life after discharge would be very different. This shows a threat. When the doctor talked about the patient getting worse the patient sometimes tried to make the problem seem small or stopped talking. These reactions might be defensive, cannot be sure because only see the behavior. The patient said that the ventilator and each bodily feeling felt strange and hard to fit with the person they used to be. This shows how the body can have meaning when something changes. When a nurse stayed with the patient listened to the patient's worry. Spoke in a calm way the patient could talk more about what was happening. This shows how relational containment can help. With this help the patient had trouble putting together the hospital stay bodily experiences and uncertain future into one clear story. This shows a break in meaning making and narrative coherence. This case shows all five attributes that were suggested. The idea that the patient is using defensive processes is only a guess. More assessment is needed to say for sure not from isolated behavior (Walker & Avant, 2019).

Borderline Case

An adult patient with chronic obstructive pulmonary disease was admitted to the ICU with a sudden worsening and needed non-invasive respiratory support. The patient was scared that they would get worse asked nurses for reassurance times and said that the breathlessness made the body feel unfamiliar. These signs show threat, bodily estrangement and a need for relational help. However the patient could still describe the experience in a way understood how breathing problems were linked to anxiety and answered to explanations and comfort. The available information does not establish unconscious defensive processes or persistent disruption of meaning-making. This is a borderline case because it contains some, but not all, of the defining attributes proposed for psychodynamic aspects of uncertainty (Walker & Avant, 2019).

Table 2. Antecedents, Defining Attributes, and Consequences of Psychodynamic Aspects of Uncertainty

Antecedents	Defining Attributes	Consequences
Life-threatening illness; awareness of death	Ongoing threat to existence; future uncertainty	Mental distress about existence; anxiety
Physiological instability; reliance on medical devices	Potential hidden defense reactions such as denial, dissociation, splitting and withdrawal	Broken memories; story gaps
Prognostic ambiguity; changing paths	Bodily threat, as a symbol; loss of control	Heightened alertness; emotional numbness; symptoms linked to Post-Intensive Care Syndrome (PICS)
Clinical factors requiring differential assessment: sedation, delirium, pain, and impaired coping resource	Relational containment dependence; disrupted meaning-making	Dependence on reassurance; trust/communication disruption

Source: Developed by the authors based on Walker and Avant's Concept Analysis Method and the reviewed literature

Related Case

An adult patient has been brought into the ICU because of pneumonia and feels worried about an uncertain prognosis. The patient keeps asking the team about the diagnosis the treatment plan and how likely a recovery is. The patient speaks clearly understands why the worry exists and feels calmer after the team gives information and reassurance. This case shows illness-related uncertainty and emotional distress. It does not give clear proof of unconscious defensive processes, symbolic distancing from the body or a breakdown, in narrative coherence. It is therefore a related case rather than a model case because it shares uncertainty and distress without demonstrating the defining combination of attributes proposed in this analysis (Mishel, 1988; Walker & Avant, 2019)

Contrary Case

The hospital stay is for a planned, brief and complex procedure – the patient has a thorough understanding of the situation and is confident in the outcomes. The patient has some worries now and then. The patient is able to control the feelings and take part in making choices without needing the doctors or nurses to help with emotional support. The sensations a person feels during treatment are perceived as short-lived and manageable as opposed to something threatening or indicating that he or she is collapsing spiritually. The patient continues to have a coherent personal narrative and incorporating the hospitalization without any disruption in a patient's life, and also a good sense of identity and a future forward perspective. No indications of unconscious defence mechanisms, existential threats, or ones that interfere with meaning-making processes. It is not a case of uncertainty because it does not show any of the characteristics of psychodynamic uncertainty.

Conceptual Boundaries and Differentiation from Related Concepts

To establish boundaries psychodynamic uncertainty must be separated in clinical practice from general anxiety, existential distress and cognitive uncertainty. While general anxiety appears as conscious emotional excitement in response to daily stress, psychodynamic uncertainty works through unconscious defense mechanisms (denial, dissociation, splitting) that happen when serious physical trauma threatens the body. Unlike distress, which focuses on conscious thinking about meaning, death and personal purpose psychodynamic uncertainty involves deep early feelings of fear where the ability to think and talk about things is stopped or avoided. Cognitive uncertainty (as described by Mishel) is about not having information where patients try to get more details to build ideas; on the other hand, psychodynamic uncertainty is about inner and relationship problems where more facts do not help because the thinking part of the brain is not working properly.

Antecedents of Psychodynamic Aspects of Uncertainty

The psychodynamic, clinical, and experiential precursors are interrelated (Table 2) and cause psychodynamic uncertainty. Probably most important is a sudden experience of a danger to life disease, which challenges this basic assumption of safety and continuity (Major et al., 2019; Zhang, 2017). There is further high physiological

instability, which, combined with a significant reliance on advanced technology (such as mechanical ventilation), detaches patients from their own bodies and leads to a significant loss of agency (Oyama et al., 2025).

Beyond this, fluctuating clinical courses generate significant uncertainty about prognosis, leading to the inability to establish patients' cognitive or affective rules during the transition (Major et al., 2019). Additional contributing antecedents include depleted coping resources stemming from pain, delirium, or heavy sedation.

Consequences of Psychodynamic Aspects of Uncertainty

This impact of 'Psychodynamic uncertainty' is experienced in both acute and longer-term recovery pathways (Table 2). Acute consequences that have been documented include mental upset, constant alertness that lasts even after the body has steadied and a stronger need for outside emotional help. Long-term consequences involve memories, stories that no longer flow smoothly and mental health problems that match Post-Intensive Care Syndrome (PICS).

Empirical Referents

In this concept analysis, empirical referents are considered in relation to the patient experiences and clinical phenomena described in the literature summarized in Table 1. The reviewed sources provide different forms of support: empirical accounts describe illness-related uncertainty, physical and psychological discomfort, and experiences of connection and control, whereas conceptual and clinical sources inform the interpretation of these experiences. These forms of evidence should be distinguished when identifying potential empirical referents for psychodynamic uncertainty (see Table 3).

Table 3. Empirical Phenomena Relevant to the Proposed Concept of Psychodynamic Uncertainty

Phenomenon or contribution	Source in Table 1	Relevance to psychodynamic uncertainty
Uncertainty about what will happen and how illness will. Whether survival is possible.	Cypress (2016)	Empirical evidence shows uncertainty related to illness; it does not prove that unconscious psychodynamic forces are at play.
Overlapping. Trouble controlling physical pain.	Oyama et al. (2025)	Shows psychological experiences during critical illness; No prove that body experiences have symbolic meaning.
Connection with others, relief of pain and thirst through care and chances to make personal choices	Oyama et al. (2025)	Evidence shows connection, comfort, and a feeling of control; it does not directly prove psychodynamic containment.
Loss and therapeutic relationships	Cerone (2019)	Interpretation is based on clinical cases; it does not provide direct evidence from ICU patients.
Psychoanalytic interpretation of air hunger. Subjective bodily feeling	Hurwitz (2022)	This is a view; it does not give direct evidence of psychodynamic uncertainty in ICU patients.
Suffering, communication, palliative care and delirium-related distress	Doherty et al. (2024); Boehm et al. (2021)	It gives context for suffering and distress; it does not prove that psychodynamic uncertainty is a separate idea

Cypress (2016) described uncertainty among critically ill patients in terms of not knowing what would happen, whether their condition was progressing, and whether they would survive. These patient stories show that there is uncertainty about how illness will progress and what the outcomes will be in the care unit. They do not prove that this uncertainty comes from unconscious psychodynamic processes.

Oyama et al. (2025) found that adult intensive care patients face uncertainties at the same time. The patients also have trouble managing pain. Must endure mental and situational challenges. The study highlights things that bring comfort, such as feeling connected, to people who are receiving care that eases pain and thirst and having chances to make personal choices. These findings give evidence for the bodily, psychological, relational and perceived-control aspects discussed in this analysis. The other sources listed in Table 1 help clarify the findings. They should not be taken as proof of the proposed idea. Cerone (2019) shares stories about anticipatory loss and therapeutic relationships. Hurwitz (2022) offers a view on air hunger and the subjective bodily experience. Doherty et al. (2024) describe suffering and palliative care in the ICU, while Boehm et al. (2021) combine family views on delirium-related distress. These works add depth to the theoretical discussion yet the evidence in Table 1

does not confirm specific unconscious defense mechanisms or validate psychodynamic uncertainty as a separate construct.

Thus the literature that is currently backed by evidence points to patients reporting uncertainty, about illness progression and outcomes experiencing psychological discomfort during critical illness and feeling connection, relief and personal choice. The ideas of defensive processes, symbolic meanings given to bodily experiences and broken narrative coherence remain theoretical psychodynamic explanations. More research is needed to see if these attributes can be reliably identified and set apart from clinical phenomena.

4. Discussion

Uncertainty during illness can come from not knowing enough about what's wrong being in a strange place with unfamiliar machines and routines, not being sure what will happen next and worrying about recovery. Studies with adult patients in the ICU show they often feel unsure about their surroundings, their body and their future. They also feel uncomfortable because they can't easily speak up or make choices about their care (Cyress, 2016; Oyama et al., 2025). These findings help to understand that uncertainty isn't about missing information. It's shaped by the whole experience of being in intensive care. From a point of view this uncertainty might shake a person's sense of safety and control. Ideas like unconscious defenses or threats to identity are interpretations. Not direct results from the studies. Patients may still feel uncertain if they can't understand their illness can't predict what comes next or don't know how to make sense of the environment. Adult patients have said uncertainty often goes hand in hand with pain trouble speaking their needs and little control over daily care (Cyress, 2016; Oyama et al., 2025). This supports the idea that uncertainty's a common part of being in intensive care.

It's possible that uncertainty continues when patients move between care settings but that's not something the cited studies actually tested. Need research to see how uncertainty changes as patients recover and shift from one level of care to another. The studies on adult ICU patients point to three things: uncertainty, physical and mental discomfort and trouble communicating or making decisions during care (Cyress, 2016; Oyama et al., 2025). These findings show uncertainty isn't about not having medical facts. It's also tied to what the body feels and how dependent a person becomes on others. The idea that these experiences break up a person's sense of meaning, body image or identity is an interpretation. It's not something that came directly from reports. It's a theory that needs more research.

The analysis takes an approach than Mishel's Uncertainty in Illness Theory. Mishel's model focuses on uncertainty. When patients can't understand illness events because information is missing, unclear or unpredictable (Mishel, 1988). This analysis doesn't say psychodynamic uncertainty is separate from that. Instead it adds that during illness uncertainty can also come from feeling threatened in the body emotional reactions, needing relationships and struggling to make sense of the illness. These psychodynamic parts are not proven by the studies reviewed. The analysis suggests two ways to think about uncertainty. One is more psychological. When people don't have information or when events have many possible meanings. The other is more psychodynamic. When uncertainty is unconscious tied to thoughts and relationships and shows up as activated defenses when the body is under threat and the mind can't process it clearly. The proposed features. Like defenses, symbolic breakup of the body and dependence on relationships to feel safe. Are different from Mishel's cognitive model. They're about emotional and relational experiences. Mishel's model assumes people can still think clearly and process information. In acute illness thinking and awareness are often reduced. In these high-stress environments psychodynamic uncertainty explains the instinctive distress that happens when the mind can't make sense of what's going on (Abdelbaky & Eldelpshany, 2024; Boehm et al., 2021; Lange et al., 2022).

When the body is under stress patients may feel fear, uncertainty, helplessness and can't speak up. Qualitative research shows adults in the ICU often face overlapping uncertainties, physical and mental pain and feel powerless over their care. These experiences fit with a view. Especially around feeling unsafe out of control or overly dependent. Ideas like denial, dissociation or regression should be seen as possible theories not confirmed facts. Unless studies directly looked at them. So this analysis offers a way to interpret these experiences, not a claim that all these mechanisms are proven in ICU patients. How healthcare workers interact with patients can shape how uncertainty and discomfort they feel. Adult ICU patients say they feel better when staff explain what's

happening listen to their worries and respond to their needs. They feel worse when care goes on without them being able to speak up or choose (Oyama et al., 2025). This shows how important clear communication, responsiveness and letting patients have a say in their care are. The idea of containment. Where relationships help hold the patient's emotional state. Is a psychodynamic concept that fits here. But the Oyama et al. Study didn't actually measure containment as a process. Physical threats in the ICU aren't about breathing or machines. They can cause deep fears of being destroyed feeling broken apart and losing control over the body (Vrettou et al., 2022; Worsham et al., 2021). Adult ICU patients have reported pain, mental distress and a loss of control (Oyama et al., 2025). In this analysis bodily experiences might also carry symbolic meaning.

Understanding what patients say about being critically ill can help healthcare workers spot uncertainty, discomfort communication problems and unmet needs. Evidence shows that explaining what's happening listening to concerns responding to pain and involving patients in decisions help (Oyama et al., 2025). These actions can help patients feel more in control and part of their care.

Implications for Clinical Practice

This concept analysis matters for how to talk to and care for patients in high-acuity settings. Adult ICU patients report not knowing what's going on, struggling to say they're in pain, and having control over parts of their care. They also say they feel better when staff explains things, responds to their needs and honor their choices (Oyama et al., 2025). Clinicians should check how well patients understand, give information suited to how they can communicate, manage emotional discomfort, and involve them in decisions when possible. Psychodynamic ideas like containment, defensive reactions or broken meaning-making can offer extra ways to think about patient experiences. More research to see if these concepts can be used in practice. Direct attention, to what patients are actually feeling and needing. Dynamic uncertainty can be thought of as a process in which the unconscious defenses respond to the threat posed by the body, that is slowed down, or contained, by the relationship, and, depending on the events, can either become "stuck" or "changed", either by decomposition, or by reconstruction through meaning making. If any element of this process is affected, whether it be a potentially life-threatening body threat that is not contained or the failure of or the presence of a narrative being integrated, the resulting existential distress and psychological residues stay with the individual for the long term, such as post-intensive care syndrome (PICS) (Ronflé et al., 2025; Yang et al., 2025)

Distinction from Delirium and Sedation Effects

A challenge when trying to understand psychodynamic uncertainty in intensive care is that certain behaviors, like pulling away emotionally or having broken memories, are not clear signs of unconscious defenses. These same signs can show up with delirium, sedation, pain or other medical issues that affect how alert a patient is, how well they can talk or how much they remember. Therefore, these observations cannot independently establish the presence of psychodynamic defenses. The distinction proposed in this concept analysis is conceptual rather than a validated clinical diagnostic distinction. Delirium-related distress, as discussed in the reviewed literature, provides an important clinical context for understanding patients' experiences in the ICU (Boehm et al., 2021). However, the reviewed sources do not establish criteria for differentiating delirium-related changes from unconscious defensive processes. Likewise, the clinical and conceptual sources listed in Table 1 do not prove that sedation-associated changes or pain-related responses represent defenses.

Therefore, unconscious defense mechanisms should not be inferred from withdrawal, denial-like statements, changes in behavior or gaps, in memory. These observations may be considered within an interpretation only after competing clinical explanations have been examined and sufficient contextual evidence has been gathered. When a patient's level of awareness, communication, or recall is substantially affected, the presence of a specific unconscious defense should remain undetermined rather than being assumed. This distinction limits what can currently say about the construct. The literature looked at shows that uncertainty, physical and psychological discomfort, relational experiences and distress linked to delirium're all important in critical care.. It doesn't prove a way to tell apart psychodynamic uncertainty from delirium or from the effects of medicine. Future studies need to test if the proposed psychodynamic features can be clearly identified and separated from these possible explanations, in real clinical settings.

Strengths and Limitations

This concept analysis has limitations. First the concept analysis was based on six anchor sources, which narrows the breadth of evidence that informs the proposed concept. Second the concept analysis leaned heavily on book-based sources. While these sources help build a picture they do not give the same empirical weight as primary studies that report patients' experiences in intensive care. Therefore the attributes and relationships that are proposed should be seen as a synthesis not as an empirically validated model. Third the concept analysis was limited to English-language publications so studies published in languages might have been left out. Fourth no formal quality appraisal was carried out.

The sources were chosen for their relevance to the concept analysis but their methodological quality was not checked with a standard appraisal tool. Because of this the strength of the conclusions must be read with caution. Fifth, manual selection and interpretation of sources can bring in subjectivity when trying to separate empirical findings from theoretical ideas and spotting possible psychodynamic attributes. Consequently the conceptual relationships that the concept analysis proposes should be seen as interpretive and provisional not as definitive. Finally the cultural contexts shown in the literature that was reviewed may not fully reflect experiences in other Asian intensive care settings. Family presence, family participation, in decisions coping and culturally shaped expressions of distress can change how patients feel and talk about uncertainty. Because these contextual factors were not studied in a way the proposed concept cannot be fully generalized to all cultural settings.

These limitations show that more research is needed with an more culturally diverse evidence base. Future studies should add empirical work evaluate methodological quality when possible and look at how family relationships, spiritual coping and cultural norms influence how critically ill patients feel uncertainty.

5. Conclusion

This concept analysis proposes aspects of uncertainty. This perspective helps to understand uncertainty among ill patients beyond just the cognitive and informational parts. The study identified five defining attributes: existential threat, possible unconscious defensive processes, symbolic meanings attached to bodily disruption, reliance on relational containment for affect regulation and disruption of meaning-making and narrative coherence. The literature shows evidence for illness-related uncertainty, physical discomfort, psychological discomfort and for the experience of relational connection and perceived control. The unconscious and symbolic processes that suggest are still theoretical ideas not yet proven as real traits of critically ill patients. Therefore, this concept offers a preliminary framework for future study, not a finished clinical tool or assessment. Recommend that future research tests the validity of these attributes and checks whether they are distinct from clinical phenomena, such, as delirium and the effects of sedation.

Recommendations

The findings of this concept analysis point to important areas for future research and clinical work. First empirical studies are needed to look closely at the defining features of psychodynamic aspects of uncertainty in critically ill patients. Research should clearly separate what patients actually say about their experiences, like uncertainty tied to their illness, physical and emotional discomfort connections with others and how control they feel from theoretical ideas that involve unconscious defenses, symbolic meanings of the body and broken storytelling. Assessment tools should be built only after these features have been tested through data, should not assume the concept is already proven without evidence.

Second, future studies should investigate whether the proposed attributes can be distinguished from other clinical phenomena that may affect patients' awareness, communication, behavior, and recall, including delirium, sedation-related effects, and pain. Studies should also examine whether the proposed concept contributes explanatory value beyond existing understandings of illness-related uncertainty and psychological distress. Longitudinal research may help clarify whether, and how, these experiences relate to psychological outcomes during recovery after critical illness. Such relationships should be tested empirically rather than assumed from the present conceptual analysis.

Third, further research should examine the relevance of psychodynamic aspects of uncertainty across different cultural and clinical settings, must pay attention to how family involvement, spiritual coping communication practices and culturally shaped expressions of distress shape patients' experiences of uncertainty. Studies in Indonesian and other Asian intensive care units can show whether these proposed attributes work in cultural settings or if they need to be tweaked.

In clinical work this new framework can act as a temporary lens to look at patients' experiences of uncertainty and to notice their need for communication, emotional support and participation in care. It is meant to add to, not replace, the clinical assessments and patient-centred care that already use, must not jump to conclusions, about defense mechanisms from a single action and should not assume that psychodynamic treatments will make care better until have checked that they are feasible, safe and truly effective.

Conflict of Interest

There is no conflict of interest. Nothing to disclose.

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