



An Insight review on the agony amongst the family of Intensive Care Unit patients

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I. Introduction

When a loved one is hospitalised in the intensive care unit, it is a time of crisis for everyone involved. Negative effects on family members and potential damage to the family unit might result when one member suffers from acute or chronic sickness (Davidson, 2009). When one member of the family goes through a difficult time, the rest of the family rallies around them to help them through it. As a result, the whole family experiences psychological and emotional disruption. A member of the family is defined as "a person who belongs to a (certain) family; a (near) relative" (Oxford, 2017). They are more concerned about the patient's welfare since they are family members, especially in cases of terminal illness that necessitate surrogate decision-making and may result in the loss of a loved one. Anyone of any age, gender, or diagnosed condition can contract this potentially fatal severe illness (Baker, 2015). Several million people worldwide lose their lives each year as a direct result of serious illness (Adhikari et al., 2010). Between 10 and 15 percent of ICU admissions end in death (Jensen et al., 2011). Family members of patients in the intensive care unit sometimes feel helpless and disorganised as a result of their loved one's severe sickness, which can lead to stress, sadness, and even post-traumatic stress disorder (Chang et al., 2018). This is especially true in the intensive care unit (ICU), which has been called "the most stressful setting in any hospital" by the World Health Organization (WHO, 2004). Because of the imminent danger of death or disability, as well as the unknown nature of the patient's illness and prognosis, they view the hospital as an aggressive and menacing space. Patients in the intensive care unit (ICU) typically need round-the-clock care and close observation due to their condition, which is not possible on the regular wards. As a result, the intensity of the situation in the intensive care unit (ICU) can cause an array of emotional responses in the patient's loved ones, including disbelief, rage, guilt, denial, and melancholy (Wong et al., 2015). A person's psychological or mental health is measured by how effectively they are able to handle the stresses of daily life. If a person is unable to deal with the pressures they encounter in daily life, they may suffer emotionally. Rnanicmt (2014) identifies ways in which family members' lives can be impacted, such as through shifts in family duties and responsibilities, financial worries, and disruptions to routines, and he suggests that healthcare providers make an effort to comprehend the range of emotions experienced by family members during critical care. Family members of ICU patients frequently suffer from melancholy, worry, and stress (Frivold et al., 2015).

Critical Care Family Requirements Inventory (CCFNI) by Nancy Molter (1979) is a commonly used questionnaire to determine the psychosocial needs of families of ICU patients, as discovered by reviewing the existing literature. Proper and holistic care for the patient and their family requires an in-depth understanding of, and attention to, the needs of the family members involved. Information on visiting hours, open lines of communication, patient safety, reassurance, and a customized timetable for family members are all vital nurse interventions. Family members will be happier, have less stress, be in a better mental place to help out their loved one in the ICU, and see greater results as a result (Gundo et al., 2014; Min et al., 2018).

Research synthesis known as a scoping review is meant to "map the literature on a given issue or study area and offer an opportunity to identify significant concepts, voids in the research, and forms and evidence sources to educate on practise, policymaking, and research" (Daudt et al., 2013). This scoping review attempts to synthesise research about the frequency, causes, symptoms, and consequences of psychological distress among loved ones of intensive care unit (ICU) patients. This research fills in some of the gaps in the current literature and paints a realistic picture of the difficulty experienced by relatives when a loved one is brought to the intensive care unit.

II. Methods

This scoping review was built using the methodology described by Arksey and O'Malley (2005). For this scoping review, formulating the research question came first, followed by the search for applicable research. Then, we used the scoping review's inclusion and exclusion criteria to pick the best research to include. Fourth, charts were made of the studies' information based on their authors, participants, places of research, publication years, aims, methods, and findings. After that, we used the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist to compile, summarise, and report our findings (Tricco et al., 2018).

This literature study seeks to answer the following question: What's really known from the published studies about the psychological discomfort among the family and friends of ICU patients?

III. Results

Prevalence of psychological distress

This scoping review focused primarily on studies that examined the frequency with which relatives of intensive care unit (ICU) patients experienced emotional distress. Among 350 relatives of university ICU patients, 94.2 percent developed anxiety or sadness, according to research by elik et al. (2016). About half of the family members (57%) had moderate to severe traumatic stress, about 80% (n = 59) had borderline signs of anxiety, and about 70% (n = 51) had borderline symptoms of depression, according to a study conducted by McAdam et al. (2010) at a large university hospital on the West Coast of the United States. Research conducted by Garrouste-Orgeas et al. (2010) in the medical-surgical intensive care unit at Saint Joseph Hospital in Paris, France, found that the prevalence of anxiety and depressive symptoms were 58.5% and 26.2%, respectively. Consistent with the research by Garrouste-Orgeas et al., Kao et al. (2016) used structural equation modelling (SEM) analysis to evaluate the prevalence of symptoms of anxiety and depression among the family members of intensive care unit (ICU) patients in southern Taiwan (2010). Belayachi et al. (2014) observed that 39.5 percent of relatives of intensive care unit patients (n = 120) experienced both anxiety and depression, while 59.2 percent of relatives (n = 180) experienced either anxiety or sadness. Among the 304 loved ones of ICU patients at Morocco's Western-North University Hospital, researchers found a high prevalence of anxiety (55.6%; n = 169) and depression (41.1%; n = 125). In contrast to past studies, however, only 6.6% of family and friends of ICU patients at Massachusetts General Hospital reported depressed symptoms and only 15% experienced anxiety (Hwang et al., 2014). There was a correlation between the length of time a patient spent in the ICU and their level of psychological discomfort. Recent years have seen analytical efforts directed at pinpointing the peak of the anxiety level, and those findings indicate that the third day of a patient's hospitalisation is when a sizable number of family members suffer a high level of cardiac anxiety (Konstanti et al., 2016). Hwang et al. (2014) also reported that the stress levels of families who detected their loved ones in the ICU were almost identical between short-stay (20.7%; CI = 10.4) and long-stay (8.3%; CI = 7.8) patients (p = .1). This suggests that the length of an ICU patient's admission had only a minimal impact on the loved ones' emotional distress. The prevalence of depressive symptoms was 8.6% (CI = 7.2) among the relatives of short-stay patients and 4.2% (CI = 5.7) among the families of those with a longer hospital stay (p = .45), indicating a tendency similar to that seen with anxiety symptoms. Consistent with previous studies, this one suggests that the patients' loved ones are at risk for PTSD and borderline anxiety and depression up to three months following the intensive care unit stay (Garrouste-Orgeas et al., 2012; McAdam et al., 2010). However, Bolosi et al. (2018) found that depression gradually increased over the course of the first week, and that anxiety levels varied with the patient's health status. Variables such as age, education, relationship closeness, and APACHE II score were tracked as well as their effects on participants' anxiety levels. There was no statistically significant difference in anxiety between the two time periods, however the percentage of people experiencing depressive symptoms rose dramatically from 38% on day 1 to 58.3% on day 2. (day 7). After 90 days after a patient's admission to the ICU, however, Matt et al. (2017) found that family members suffered prolonged post-traumatic stress (p = .014) and anxiety (p = .019). This review of the research highlights the necessity for early psychological treatment to prevent suffering from becoming more severe by family members of patients admitted to the intensive care unit (ICU).

Factors contributing to psychological distress

Among the most tense places in a hospital is the intensive care unit. Because of the unknowns surrounding the patient's condition, treatment options, and prognosis, families that have a beloved one hospitalized to the ICU typically struggle to cope emotionally (Frivold et al., 2015). This article examines the role that the patient's environment, the family's socioeconomic status and structure, the patient's history in the intensive care unit (ICU), and the patient's severity play in the family's emotional suffering. This scoping review analysed six studies that looked at how different demographic characteristics, such as age, gender, marital status, and income, were associated with the experiences of loved ones of intensive care unit (ICU) patients (Bailey et al., 2010; Belayachi et al., 2014; Kanmani et al., 2019; Konstanti et al., 2016; Kose et al., 2016; McAdam et al.,

2010). While four of the included studies in this meta-analysis (Bailey et al., 2010; Belayachi et al., 2014; Konstanti et al., 2016; McAdam et al., 2010) found that female caregivers were more prone to psychological distress than male caregivers, Kanmani et al. (2019) found the opposite to be true. Belayachi's (2014) study was the first to our knowledge to employ the Arabic translation of the Hospital Anxiety and Depression Symptoms (HADS) scale to measure emotional distress among relatives of intensive care unit (ICU) patients. Women were shown to be more vulnerable to experiencing psychological discomfort than men (OR = 3.04, 95% CI = 1.62-5.70, $p = .01$). According to this analysis, a patient's age had a substantial impact on their family member's levels of worry.

Spouses had a higher rate of anxiety and despair than any other family member admitted to the ICU (Konstanti et al., 2016; Kose et al., 2016). Bailey et al. (2010) found that the average caregiver's financial burden was 6.28 2.36, which was substantially greater than the reference value for working individuals ($t = 3.511$, $p .001$). (Kanmani et al., 2019). When it comes to providing medical attention, the Intensive Care Unit (ICU) is the place to go. Wong et al. (2015) looked into how families interacted with medical professionals, the facility as a whole, the patients themselves, and other families. They discovered that families' attempts to learn more about their loved ones were met with unhelpful interactions and poor communication from the staff. When patients are admitted to the intensive care unit, Belayachi et al. (2014) found that respondents' stress levels were higher if they had to share a room with other family members and if they were not updated on the patient's condition frequently enough.

Family members' emotional discomfort is exacerbated by the short visitation hours. Multiple research have linked low satisfaction ratings to restricted visiting hours, which in turn is linked to relatives with higher HADS scores. In addition to a decrease in the prevalence of anxiety and sadness, substantial levels of pleasure were also observed among family members who were able to visit their loved ones in the ICU during regular visiting hours. The patients and their loved ones were less stressed and were more satisfied overall when visiting hours could be adjusted to better suit their schedules (Askari et al., 2012; Belayachi et al., 2014; Fumis, Ranzani, Faria et al., 2015; Fumis, Ranzani, Martins et al., 2015).

Previous family members of ICU patients report increased psychological distress. Family members of intensive care unit (ICU) patients who had been admitted within the previous two years ($n = 56$) were significantly more likely to report anxiety, depression, and acute stress symptoms, $\beta = 0.92$, $F [4122] = 2.70$, $p = .034$, $\text{partial } \eta^2 = 0.08$, observed power = 0.74, according to research by Lewis and Taylor (2017).

Symptoms and impact of psychological distress

Members of the family of patients in the intensive care unit commonly suffer from minor worry, moderate to extreme sleep disruption, and exhaustion. Studies have shown that family members in the early stages of an intensive care unit hospitalisation suffer from poor sleep quality and exhaustion due to the stress of the situation (elik et al., 2016; Chang et al., 2018; Day et al., 2013; Kao et al., 2016). A higher incidence of insomnia symptoms, anxiety, and sadness was also seen in the families of intensive care unit (ICU) patients, as was the case in the studies by Fumis, Ranzani, Faria et al. (2015) and Fumis, Ranzani, Martins et al. (2015). Eighty percent of family members experienced physical and emotional symptoms during an ICU stay, including fatigue, sadness, and fear. The highlighting important of psychological distress during an ICU stay were identified as fear, hallucinations, and incapability to communicate (Dziadzko et al., 2017); emotions of helplessness and uncertainty (Matt et al., 2017). (McAdam et al., 2010). Having an open line of communication between loved ones and ICU nurses can aid in the early diagnosis of psychological distress signals, allowing for the provision of both in-house and external care, both of which can have a beneficial effect on the family's experience in the ICU as a whole (Huffines et al., 2013). According to a study by Kao et al. (2016), patients who had access to more information reported less instances of insomnia, depression, and anxiety (Dziadzko et al., 2017). Thus, methods such as assessing family responsibilities and family members' psychological symptoms might lessen the symptom and effect of psychological distress if they are implemented early.

IV. Discussion

The intensive care unit (ICU) is well recognised as one of the most stressful places in a hospital, and research has shown that loved ones of patients admitted to the ICU frequently exhibit signs of anxiety and despair, making them vulnerable to post-traumatic stress (Frivold et al., 2015). They'll have to modify their lifestyles to survive in this harsh new setting. The intensive care unit, as seen by the patient's loved ones, is a place where cutting-edge medical technology is used to treat the very sick. Family members' emotional distress, tension, and anxiety are amplified by the intensive care unit's (ICU) near-constant sounds from the machinery, bright lights, and lack of privacy, which are all signs that the patient's death is imminent (Jongerden et al., 2013). The patient's loved ones, who may not be familiar with the intensive care unit, will benefit from it if they take the time to familiarise themselves with it.

New families in the ICU can benefit from a thorough explanation of the hospital's systems, ward atmosphere, equipment, therapy, and protocols or guidelines offered by the healthcare professional (Chiang et al., 2017; Chien et al., 2006). It has been observed that 38% of family members prefer interactive tools for imparting educational information on the equipment and technique used on the patient, and that this number rises to 52% when the material is presented in a way that is relevant to the family (Smith & Custard, 2014).

Family members of patients in the intensive care unit (ICU) often experience high levels of psychological distress, and this review found that socio-demographic characteristics have a significant role in this. In addition, past research has shown that spouses and next of kin of ICU patients are more likely to feel symptoms of psychological distress than other family members because they are more likely to be involved in making decisions for their dear ones (Bond et al., 2016).

Williams (2015) claims that one of the detrimental effects of psychological discomfort is a decline in one's capacity to pay attention, concentrate, remember, and think clearly. Choi et al. (2014) observed that relatives of individuals who had suffered from stress and depression were more likely to exhibit stress-related behavioural or physiological changes, increasing their risk for future illness. Problems with behaviour include immobility, stifled communication, and an inability to cope with everyday challenges. Weissman et al. (2016) found that people who were experiencing severe psychological distress were more likely to suffer from chronic inflammatory lung disease, cardiovascular disease, and diabetes than those who did not. Prolonged stimulation of the stress response in critically ill individuals can cause immunosuppression, reduced tissue perfusion, tissue hypoxia, and other physiologic consequences that impede the healing process. The patient's prognosis suffers and the healthcare professional may face legal action if the patient's loved ones refuse to accept the inevitable (Buckley & Andrew, 2011). This scoping review identified a research need, proposing an intervention to ease family members' minds so they can better help their loved ones in the intensive care unit. Improvements in family satisfaction, patient duration of stay, and family members' emotional well-being can be achieved by preventative measures such as communication interventions that encourage family involvement in nursing (Sviri et al., 2019). According to Belayachi's (2014) research, people from all walks of life benefit most when instructional materials are presented in an honest and accessible manner.

ICU staff that work closely with families need education on how to spot signs of distress among family members and learn fundamentals of family support as soon as feasible (Lewis & Taylor, 2017).

V. Conclusion

Anxiety and depression are major concerns for loved ones of intensive care unit (ICU) patients, as this study shows. When nurses and family members of critically ill patients are facing challenging situations, it is especially important for nurses to have a mutual awareness and knowledge of the signs and consequences of psychological distress. Family members who may be at risk for stress and depression due to their loved one's illness can be identified and evaluated. As a result, ICU strategy efforts should centre on intervention and seek to mitigate contributing factors in order to lessen family members' emotional anguish. Anxiety can impair family members' capacity to get and process information, as well as their family's functioning, their coping abilities, and their ability to support the patient, therefore it's important to assess and intervene with them as soon as possible. More evidence is needed to show that family support coordinators, communication interventions, structured communication programmes, flexible and adaptable visiting hours, education knowledge to families via website, booklets, or leaflets, and a relaxed physical environment in the ICU can successfully reduce the psychological distress of patients' families.

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