Psychological reactions in family members of patients hospitalised in intensive care units

Natalia Jezierska, Bartosz Borkowski, Wojciech Gaszyński

Chair of Anaesthesiology and Intensive Therapy, Medical University in Łódź, Poland

Abstract

The environment of the intensive care unit (ICU) is burdensome to a patient and the patient’s family. There is a higher risk of depression, anxiety and stress-related disorders in the ICU patients’ family members. In relatives of critically ill patients, the cluster of adverse psychological reactions, such as: anxiety, acute stress disorder, posttraumatic stress disorder, depression and complicated grief, is called post-intensive care syndrome — family (PICS-F). These complications may affect the relatives’ ability to perform the role of a caregiver and it can also hinder their daily functioning. Apart from negative psychological consequences experienced after a loved one’s stay in the ICU, there are also some positive changes observed in patient’s relatives called posttraumatic growth. In this review, the psychological repercussions in the ICU patient’s family and the means to prevent their undesirable responses are discussed.

Key words: intensive care unit, patient’s family, post-intensive care syndrome, family; posttraumatic stress disorder, family; posttraumatic growth, family

The intensive care unit* (ICU) is an environment inducing mental strain among conscious patients and their families. Family members of patients treated in ICUs are at higher risk of developing depressive, anxiety- and stress-related disorders. After the patient’s death, an estimated one in three bereaved family members meets the criteria of at least one of the following psychiatric disorders: depression, anxiety or complicated grief [1]. Relatives of ICU patients are also at risk of developing acute stress syndrome and posttraumatic stress disorder (PTSD) [2].

In 2010, the Society of Critical Care Medicine suggested its own term for this form of reaction in family members: ‘post-intensive care syndrome-family’ (PICS-F) [3]. This paper presents information about psychological reactions in family members of ICU patients and preventive approaches to psychiatric disorders likely to develop. We consider the needs of families and the possibilities of their fulfilment under ICU conditions.

PSYCHOLOGICAL REACTIONS IN FAMILY MEMBERS OF ICU PATIENTS

In recent years, researchers have become increasingly interested in the mental functioning of family members of ICU patients worldwide. Literature reports have demonstrated an increased risk of depressive and/or anxiety disorders as well as stress-related conditions within several months following a relative’s stay in ICU, irrespective of whether the hospitalised patient is a newborn, a child or an adult. These adverse psychological effects can persist for several years after the patient’s discharge, which is likely to affect later involvement of family members in the patient’s care [3]. Moreover, caregivers have been demonstrated to have an increased risk of depression, disturbed lifestyle and reduced employment one year after the patient’s discharge from the ICU [4].

The trauma experienced when someone’s health, life or mental integrity is endangered can lead to adverse consequences, particularly in the psychological sphere of life. The health- and life-threatening conditions of our close relatives hospitalised in ICUs can be associated with re-experiencing trauma through recurrent pictures, reflections, dreams (intrusions), avoidance of trauma-related conversations, behaviours or thoughts and excessive excitement. Such symptoms present for less than a month are suggestive of acute stress syndrome. If re-experiencing of trauma and
associated symptoms persist beyond one month, it is likely to be PTSD [2]. After the patient’s discharge from ICU, carers face numerous challenges regarding proper care, further treatment and rehabilitation of the affected, which in the long-term perspective modifies their mood and can result in its substantial deterioration. On the other hand, sudden death, or death preceded by slow departure, can induce a complicated grief reaction in which symptoms of grief persist beyond one year after death. These symptoms include thoughts, feelings and behaviours reflecting excessive or distracted focusing on the circumstances or consequences of death [4].

The risk of PTSD in family members of adult patients discharged from ICUs is estimated to be 33–49%, whereas the risk of depression ranges from 6% to 26%, depending on the study timing. The estimated risk of PTSD in families whose relative died in ICU is 14–56%; the risk of depressive disorders is 18–42%, including severe depressive disorders whose incidence is 27%. Moreover, approximately 12–16% of parents of children hospitalised in paediatric ICUs are affected by depressive disorders at least four months after admission. The risk of PTSD in this group is estimated to be about 13–35% [3].

**RISK FACTORS OF PICS-F**

The development of PICS-F in family members of ICU patients is favoured by earlier persistent anxiety and/or dejection as well as a history of anxiety, depression or severe mental disease [5]. Impaired mental functioning due to a relative’s stay in ICU is more common among women [6, 7] and younger family members [8]. The mental strain is higher in spouses. An additional risk factor is being a single parent [1]. The patient’s age [9] and education of individual family members are also of importance [10]. One of the major variables inducing adverse psychic consequences is increased level of stress [11]. Numerous studies have indicated that the patient’s death during ICU stay, high risk of death, and the presence of relatives at death [12] substantially increase the level of stress experienced by family members. A sudden, unexpected disease [13] or a disease the patient has been battling against for less than five years which require ICU admission, are similarly stressogenic events. Moreover, the co-existence of additional stressors, e.g. another hospitalisation, can increase the risk of negative psychological reactions in a patient’s relatives [1].

The variables mentioned above enhance the probability of negative mental consequences in family members of ICU patients. On the other hand, social support and attitudes of ICU personnel, particularly good communication, are factors reducing negative psychological consequences among family members [14]. Mothers of children treated in ICU examined during follow-up visits demonstrate fewer PTSD symptoms when they can talk about their experiences on admission to the unit [15]. The level of anxiety among family members of ICU patients before discharge to another ward was lower in individuals who experienced stronger social support [16]. The protective factor was also the feeling that they were provided with comprehensive information about the patient’s health [17] and that the attending physician was supportive [18]. Furthermore, study findings reveal the positive impact of family-personnel meetings focused on breaking bad news [19] and of brochures informing about the specifics of the grieving process [20].

**PREVENTION OF BURDENING MENTAL CONSEQUENCES IN FAMILY MEMBERS OF ICU PATIENTS**

Preventing negative effects of ICU stay in patients’ families assumes that the ICU personnel are equipped with appropriate knowledge about mental burden in family members, their needs and possibilities of their fulfilment during ICU hospitalisation. Families should have access to current information about the patient’s health provided by appropriate staff members in comprehensible language devoid of professional terminology [21, 22]. Considering the level of stress of family members and its effects on perceptive abilities, information should be delivered using various measures, e.g. oral, written or multimedia. A good strategy for family members interested in being involved in a patient’s care is to encourage them to participate in certain nursing procedures [3]. The involvement of the family in nursing care and in decision-making is essential. The lack of a patient’s living will is a source of potent stress for his or her family [23]. Family members of ICU patients differ in their declared readiness to influence treatment decisions. Therefore, the assessment of and respecting the extent of involvement in treatment and recovery preferred by family members is crucial for the prevention of enhanced negative stress and reduced satisfaction with care [10]. In the long-term perspective, emotional reactions of families are more positive when they perceive the attending physician to be comforting and the nurses to be more supportive [1].

An enormous role in reducing the negative psychological effects in family members of ICU patients is played by proper communication between ICU personnel and the family. Curtis et al. [24] suggested the VALUE model of communication should be followed during conversations between personnel and the families of ICU patients. The abbreviation VALUE stands for: V — value the involvement of family in discussion, A — acknowledge emotions of family members, L — listen, U — understand that the patient is a human being, and E — elicit questions from family members. Another form of prevention is the involvement of adult relatives in patient care. This involvement would
be manifested in carrying out some nursing procedures, such as filing nails, applying body and lip balsams, or passive exercises taught by the personnel. Such interventions require interactions of the family with the patient and ICU personnel and give the relatives the feeling of being needed in the ICU environment that does not favour relaxation. Moreover, they can help carers to get used to their role after leaving hospital [25, 26]. The inclusion of psychiatrists and psychologists in the unit activities helps the families to understand the mental condition of critically ill patients and ways to prevent PICS-F. However, since the patient’s relatives are not formally patients of the hospital, the provision of this kind of support is often hindered [3].

The support for families taking care of patients after discharge involves follow-up visits directed at a suitably structured way of communication and assessment of psychophysical capacities [27]. Considering the challenges that the relatives of patients discharged from ICU face, such visits are obviously beneficial. In Great Britain, nearly 30% of intensive care units organise follow-ups after a patient’s discharge [28]. The participants relate that groups of support and visits in outpatient clinics are helpful. However, there have been no studies measuring the effectiveness of this method and demonstrating its advantages for patients and their family members, which is most likely attributable to the lack of defined procedures and standards determining the scope of such visits, and consequently to the uncertainty as to the choice of interventions resulting in best outcomes [3]. On the other hand, there have been reports revealing a relationship between the use of preventive conversations with patients’ families enabling them to express their emotions, to experience support and reduce the feeling of guilt, and reduced risks of PTSD symptoms, depression or anxiety three months after the patient’s death [20].

Another strategy to reduce negative stress and anxiety among relatives of critically ill patients is the provision of information about the specificity of ICUs, most common procedures and possible psychophysical states of patients in the form of brochures received during the first contact with ICU personnel. Such brochures help relatives to better understand the situation of the patient, which reduces distress, increases satisfaction with the ICU work, and facilitates contact with the personnel, indirectly modifying the later reactions of families [29].

POSTTRAUMATIC GROWTH

In general, traumatic events result in negative emotions. However, in many individuals, such experiences can also lead to positive changes in functioning, called posttraumatic growth (PTG). The implemented changes, e.g. appreciation of interpersonal relationships, higher level of empathy or revision of the entire life, are based on preventive measures undertaken by an individual. Emotional distress and posttraumatic growth, independently, can be the co-existing consequence of traumatic experience [30]. A study of positive changes in parents of children hospitalised in ICU carried out four months after discharge demonstrated that PTG is an important phenomenon in this group. According to respondents, PTG developed more often due to moderate stress [31]. In the commentary to the study, Schieveld [32] explains that in cases of posttraumatic growth in parents of children hospitalised in paediatric intensive care units, low stress is not likely to give life a new meaning, whereas too high stress will leave no room for positive reactions.

Therefore, balanced stress and understanding of stress-related reactions experienced by patients’ families shown by ICU personnel are essential.

References:


Corresponding author:
Natalia Jezierska, MPsych
Chair of Anaesthesiology and Intensive Therapy, Medical University in Łódź
ul. Kopcińskiego 22, 90–153 Łódź, Poland
e-mail: natalia.jezierska1@wp.pl

Received: 9.04.2013
Accepted: 28.10.2013