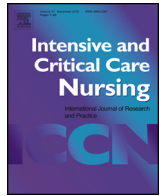




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Original article

Impact of prior ICU experience on ICU patient family members' psychological distress: A descriptive study

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ABSTRACT

Objective: To determine if current levels of anxiety, depression and acute stress disorder symptoms differ significantly among family members of intensive-care-unit patients depending upon previous intensive-care experience.

Research design: This study used a prospective, descriptive study design.

Setting: Family members (N = 127) from patients admitted within a 72-hour timeframe to the medical, surgical, cardiac and neurological intensive care units were recruited from waiting rooms at a medium-sized community hospital in the Southeastern United States.

Main outcome measures: Participants completed the Hospital Anxiety and Depression Scale, the Impact of Events Scale-Revised, the Acute Stress Disorder Scale and a demographic questionnaire.

Results: A multivariate analysis revealed that family members of intensive-care-unit patients with a prior intensive-care experience within the past two years (n = 56) were significantly more likely to report anxiety, depression and acute stress symptoms, $\Lambda = 0.92$, $F [4,122] = 2.70$, $p = 0.034$, partial $\eta^2 = 0.08$, observed power = 0.74.

Conclusion: Results of this study show that family members' psychological distress is higher with previous familial or personal intensive-care experience. Nurses need to assess for psychological distress in ICU family members and identify those who could benefit from additional support services provided in collaboration with multidisciplinary support professionals.

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Implications for Clinical Practice

- ICU nurses who are aware that family members' previous experience in ICU may contribute to increased anxiety, depression and acute stress disorder symptoms in a subsequent admission may choose to approach these family members with greater sensitivity and awareness of their psychological wellbeing during the hospital stay.
- ICU nurses need to be aware that the experience of anxiety, depression and acute stress disorder symptoms are not limited to first degree relatives and should extend support to all family members, especially if it is not their first ICU experience.
- ICU nurses need to collaborate with families and support professionals, such as counselors or chaplains, to address their psychosocial needs during admission and after patient discharge from the ICU.
- Family members of ICU patients may have difficulty comprehending information while in the ICU, hence the need for follow up, especially if it is not their first ICU experience.

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Introduction

Psychological distress including anxiety, depression and stress in family members of intensive-care-unit (ICU) patients is a well-documented phenomenon across a wide variety of countries including, but not limited to, Brazil, Italy, China, Greece, France, Sweden, the United Kingdom and the United States (Chiang et al., 2016; Davidson et al., 2012; Fumis et al., 2015; Jones et al., 2012; Konstanti et al., 2016; Mistraletti et al., 2016; Pochard et al., 2001). Family members may show psychological distress when trying to comprehend simple concepts (Rutherford and von Wenckstern, 2016) such as that of time. For example, in one clinical instance experienced by the first author, a family was repeatedly unable to grasp the concept of time regarding when the end of a nurse's shift occurred; yet, this same family was asked to make crucial life or death decisions. This clinical example embodies what is now known from scientific advances in neurobiology, which demonstrates that humans under stress have a reduced recall capacity and recognition performance (Schwabe et al., 2012).

A family member's ICU admission is a stressful event, which was confirmed via saliva cortisol levels by Turner-Cobb et al. (2016); however, for some family members, the stress experienced exceeds the expected acute stress reaction and may actually lead to the development of post-traumatic stress disorder (PTSD) (Sundararajan et al., 2014). The overstimulating influence of technology present in the ICU environment was identified as a contributing factor to psychological distress in family members of an ICU patient (Fumis and Deheinzelin, 2009). Researchers have conceptualised this persistent psychological distress experienced by family members of ICU patients as *Postintensive Care Syndrome–Family (PICS-F; Davidson et al., 2012)*.

Despite the acknowledgment that PICS-F may occur for up to four years after an ICU experience, no known research has investigated whether previous ICU experience contributes to the symptoms of anxiety, depression and stress experienced by families of an ICU patient. This particular lack of literature is intriguing when considered with the recommendation from 1996 by Jamerson et al. (1996) for nurses to assess family members' prior experiences with ICUs as part of the ICU-education process for the family members. The purpose of this study was to determine if levels of anxiety, depression and acute stress disorder symptoms differ significantly among family members of ICU patients depending upon previous ICU experience. For the purposes of this study, previous ICU experience is defined as an ICU encounter within the previous two years, with no limitations on who was the patient in the previous ICU experience(s).

Methods

Research question

The aim of this study was to answer the following research question: Do levels of anxiety, depression, and acute stress disorder symptoms differ significantly among family members of ICU patients, depending upon previous ICU experience?

Design and setting

This study used a prospective, descriptive study design. Family members of ICU patients were recruited from waiting areas in medical, surgical-trauma, cardiac and neurological ICUs in a single, medium-sized community medical center in a mid-sized Southeastern United States urban area with a total of 45 ICU beds.

Participants

A convenience sample of participants was recruited from the four ICUs via study-recruitment flyers posted prominently around the waiting areas. The study recruitment flyer indicated that family members in the waiting rooms and family members of patients admitted within the past 72 hours to the ICU were eligible to participate. Sample size was determined using G*Power for a MANOVA with two independent groups, four response variables, a small effect size of 0.10, significance level of 0.05, and power of 0.80. This resulted in a needed sample size of 126 participants. In addition to active recruitment through the posted study flyers, snowball sampling was encouraged. Additional participant characteristics are presented in Table 1.

Inclusion and exclusion criteria

Inclusion criteria were:

- Having a family member admitted to the ICU as an ICU-status patient within the past 72 hours;
- Ability to read and write in English;
- Presently being 19 years of age or older
- Having physically visited the patient since the patient's admission to the ICU.

Exclusion criteria:

- Cognitively-impaired family members were excluded from the study, determined by nursing judgement.
- Four family-member participants per patient were already enrolled.

Ethical approval

The institutional review board (IRB) of the participating university and hospital facility granted an expedited review approval, reference numbers 453564-2 and S-1009. Participants completed a written consent form after communicating interest in participating to ICU staff.

Data collection

Data were collected from June 2013 through September 2014. See Fig. 1 for recruitment process. Family members who communicated interest to ICU staff about participating received paper copies of the consent form, the demographic questionnaire, the Hospital Anxiety and Depression Scale (HADS) (Zigmond and Snaith, 1983), the Acute Stress Disorder Scale (ASDS) (Bryant et al., 2000) and the Impact of Events Scale – Revised (IES-R) (Weiss and Marmar, 1997) to complete at the time of enrollment. Initially, only 17 participants from approximately 400 identified family members were enrolled in the study. Recruitment increased after a \$10 financial incentive was introduced. The incentive was disbursed upon return of the study materials.

Measures

Hospital anxiety and depression scale

The HADS was developed for screening purposes only to assess anxiety and depression in a general hospital setting but is not used to make a diagnosis of a psychiatric disorder (Zigmond and Snaith, 1983). The HADS consists of a total of 14 items culminating in two subscales, one for anxiety and one for depression; each subscale is comprised of seven items (Zigmond and Snaith, 1983). The HADS is a self-report measure using a four-point Likert-type scale in which

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