ORIGINAL ARTICLE

Stress and Coping Strategies among the Caregivers of the Patients Admitted in Critical Care Units in Tertiary Hospital

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Abstract

Introduction: The number of patients with higher severity of illness admitted to critical care units has increased in recent years. Family members of the patients suffer physiological, emotional, and psychological changes in addition to financial and organizational losses. Those who struggle with efficient coping may experience interpersonal difficulties and struggle to find solutions to those issues. The aim of this study was to explore the stress and coping strategies among the caregivers of the patients admitted in critical care units.

Methods: A purposive phenomenological study involving eight caregivers from Intensive Care Unit and High Dependency Unit was conducted, using in-depth interview. Data was collected between August to September 2024. Ethical clearance was obtained from the Institutional Review Committee (Reference number: NAPFH-008/2024). The interviews were audio-recorded, transcribed verbatim, translated in English and analysed using thematic analysis.

Results: Out of eight participants, ten themes were identified. These include: a) Lack of information and communication; b) Emotional response to ICU and HDU admission; c) Role strain and physical exhaustion; d)Financial strain; e) Experience of the Critical Care Unit (CCU); f) Seeking Social Support; g) Emotional Regulation and Acceptance; h) Coping Mechanisms; i) Communication and Trust in Healthcare Providers; and j) Maintaining Physical Health.

Conclusions: The study found that family members experienced stress in their role as caregivers. People's perception of stress had a big impact on the caregiving duties they carry out. The findings showed that coping strategies were implied according to the stress perceived by the family members as caregivers.

Keywords: *caregivers; coping; phenomenology; stress.*

Introduction

The number of patients with a higher severity of illness admitted to Intensive Care Unit (ICU) has increased in recent years.[1] In a retrospective observational study that included all critically ill adult patients (≥18 years old) admitted to 17 ICUs in Nepal between September 2019 and September 2022, 18603 unique admissions were found.[2] For family members, receiving an admission to a critical care unit is an extremely difficult and stressful event.[3] Critical illness generally leads to millions of

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fatalities annually.[4] According to a study, a critically ill patient's admission to the ICU is seen as a crisis not just for the patient but also for the patient's family.[5] A study revealed that patient's unforeseen emergency hospitalization frequently puts family members in a distressing scenario because of their lack of familiarity with the hospital setting, the difficulty of the treatment plan, and the uncertainty surrounding the patient's prognosis and recovery.[6] It is estimated that the family may experience shock, guilt, denial, rage, helplessness, and sadness as a result of their patient being in the ICU.[7] For patients and their families, this situation can pose serious pressures, necessitating the development of coping strategies to handle such difficulties. [2]

The subjective experience of caregivers is not as widely documented as their outcomes. It is essential to learn the coping mechanisms and stressors of family members of critically ill patients in order to improve patient-family interactions, increase support, and provide focused interventions that lessen stress and encourage healthy coping during critical care hospitalization.

This study aimed to explore the stress and coping strategies among the caregivers of patients admitted in critical care units via a phenomenological approach.

Methods

This phenomenological study was conducted among the caregivers of patients admitted in ICU and HDU. Ethical clearance was obtained from the Institutional Review Committee (Reference number: NAPFH-008/2024). Data was collected by first researcher from August-September 2024 using purposive sampling method with eight participants reaching saturation. Semi-structured, in person, audio-recorded individual interviews were conducted in quite counseling rooms to explore and understand the participants' experiences. To ensure sensitivity, open ended exploratory questions were used, cultural and contextual appropriateness was considered and probing was done as necessary. To ensure specificity the questions were aligned with objectives, subject experts were consulted to review the tool and thorough literature review was done, clear wordings were used, and field notes, observations of non-verbal cues and patient dynamics were documented. The inclusion criteria were: being a first degree relative of the patient, must be living in the same household, must be above eighteen years of age and be present in patient counselling. Those having language barriers were excluded from the study.

Introduction was done at the start of the interview, the purpose of the study was explained, and both verbal and written consent was obtained before proceeding. The duration of each interview ranged from 25 to 45 minutes. Data was analysed using thematic analysis by Braun & Clarke. At first familiarization with the data was done. The collected data were transcribed and then translated in English language by a third person not involved in the research, to avoid bias. Subsequently, the words and phrases that stood out were underlined, initiating the codes. Repeated reading of the interview transcript was done. Following that, the data was coded. Then all of the data was organized into groups identified by the codes. After that created codes were reviewed to identify the patterns and the themes were developed. The themes made were checked to asses if it is relevant to the research objective or not. Using a back-and-forth methodology that involved assessment, comparison, and inquiry, the researcher repeatedly went over the themes. This process was done manually with the assistance of co-author. The findings were then returned to participants for checking.

Results

A total of eight participants completed the interviews, with the average age of 46.75 ± 8.99 years. Out of 8, 4(50%) were male, 1(12.50%) attained higher level education, 6(75%) were from rural area, 7(87.50%) were Hindu, 4(50%) were Chhetri, 5(62.50%) were married and 1(12.50%) was widow, 4(50%) was nuclear family, 3(37.50%) each of the caregivers were wife and son, 5(62.50%) worked as full-time during admission and 7(87.50%) had 1-20 visits before interview.

10 themes and 26 subthemes were developed to describe the findings.

Theme 1: Lack of Information and Communication

Sub-theme 1.1: Inadequate Explanation of the Patient's Condition

The participant stated that she hasn't been explained in detail about her husband's condition and that he has been shifted from ward to HDU, which aided to the increase in stress level of the caregiver.

Participant 1(P1): "*I was informed that my husband had a spinal fracture and was initially admitted to the ward. However, after a few days, an abscess developed near the anal area, accompanied by pus and a persistent fever lasting over 10 days. The doctors noted that his haemoglobin levels were low and recommended a blood transfusion. Then, he had an allergic reaction during the transfusion. Then he was transferred to the HDU. I haven't received a detailed explanation about his condition and the underlying illness. I feel like I haven't been fully informed about the main issue.*"

Sub-theme 1.2: Uncertainty and confusion about diagnosis and prognosis

Families of patients wanted medical experts to provide them with concise, accurate, and current information regarding the patient's condition. Here, participant 2 and 4 were confused about what is happening to their patient, and what will the prognosis of their illness be. They were concerned about the worsening condition of their loved ones and whether they will survive this illness or not. Also the patient's actual cause of illness was unknown to the participant 8.

P2: "*I don't know what's happening inside (sobbing). In my thought when he was taken from airport to hospital, his words weren't clear but he would communicate by writing. If he was treated well that time he would have been better by now. The condition is worsening now.*"

P4: "*I have confused thinking thoughts, what type of illness is this? Will my husband survive from this? Will any other illness affect him again? What might be the solution of all this?*"

P8: "*There was blood over pillows and bed. He was vomiting blood. He had alcohol intake that day. We have to say what has happened truthfully. After that he was brought to emergency ward and doctor said, he can't be treated here, he has to be admitted to ICU and then we shifted him here. In emergency ward, they said this might has happened due to hypertension as well. They said the actual reason can only be explained after an endoscopy. After endoscopy they stated, there was a wound in the stomach (gastric ulcer).*"

Sub-theme 1.3: Unclear Expectations Regarding Hospital Transfers

Transfer of patient from one to another ward created confusion. Participant 1 thought that she and her husband were being transferred to some other hospital or some other place as she wasn't aware of the availability of different level of care at the same institution. She stated that she was completely lost and alone.

P1: "*I thought we were going somewhere else. I was all alone and had never been to this hospital before. I was completely lost. When I imagined it, I thought he was being transferred to some another place. They said there will be more equipment for monitoring, so I thought it was some different place.*"

Theme 2: Emotional response to ICU and HDU admission

Sub-theme 2.1: Fear of Patient's Death

Family members feared of patient's mortality. Family members frequently feared the worse and assumed the patient wouldn't make it.

P1: "*I was afraid when the patient was transferred to HDU. I thought the patient might not survive..., that's why he is being transferred here. There were machines all around, and I felt my patient wouldn't survive. I felt that. I thought I might not take the patient back alive home; the main reason for which I was here might not be fulfilled. I used to cry sitting outside, I cried a lot.*"

P4: "*I have fears like there is no treatment to this illness and that is the only difficulty i felt, I am feeling helpless without him.... We haven't stayed separately even for a single day for all these years and now it's been so long i am away from him......*"

P7: "*I knew about the unit but I was scared as the doctor already said there are 50- 50 chances and we have to take risk and then only he will start the treatment. On top of that he would be kept in ventilator so I was nervous. I had fears because keeping patient in ICU means patient is critical and keeping in ventilator meant patient may no longer live. He is also a cancer patient so there is fear because cancer signifies death so we were afraid. There is concern that something terrible could occur.*"

Sub-theme 2.2: Anxiety and Emotional distress:

Four family members experienced tremendous feelings of anxiety, worry, and despair such as crying, restlessness, insomnia, and helplessness. Because of the uncertainty and high stakes involved in the patient's health, anxiety and emotional discomfort were typical in the context of critical care.

P1: "*I didn't eat for many days and I wasn't allowed to meet him frequently (about to cry)." I now understood how things work in this unit. Earlier I was stressed, way too stressed.*"

P2: "*I am in tension. I have lost hope. I have kept everything to myself. Neither crying nor screaming can help with the worries. The tension and sadness are here. If I were ill in front of him, that would be less painful. But he is lying in front of me, that's much more painful. What to do? (crying...)*"

P3: "*I was afraid. Ahhh .....I got frightened when they would mention about high care. I had fears like what would happen next. I felt something bad might happen to my father.*"

P8: "*The doctor has explained to perform tests related to tuberculosis and they also mentioned this might had happened because of smoking(crying....). He also has no one he could rely on except me (crying...). He had his mother and me but his mother died recently now he have only me as his support system...(crying...). My son and daughter in law are really good and supportive sometimes i consider myself lucky for having someone like them with me but partner's importance couldn't be explained in* *one's life. There's none like our partner for us in whole life (crying...). I am feeling strange; I am feeling like it will be difficult to live without my partner."*

Sub-theme 2.3: Guilt and Regret

Family members experienced severe emotional stress as a result of guilt and remorse about past occurrences. Their emotional load is increased by these regret and guilt sentiments, which increased stress and made it harder to deal with the present.

P1: "*This all happened because of the ego of my patient. We asked him a lot to quit his drinking habit, but he didn't listen. He used to fight a lot when asked upon to quit drinking. This all happened due to his drinking habit. If you let him know about I said of his drinking habit, he will fight with me and I would have to be the bad one here in front of his family members.*"

P8: "*Now, I feel he shouldn't be kept in ICU. He can be shifted to the ward, surrounded and looked after by family members. He can be consoled and be called out frequently. Maybe that will be good.*"

Sub-theme 2.4: Limited Visitation as a Source of Stress

Two of the family members felt upset and disheartened due to the limited access to their loved one in the ICU or HDU. The strict visitation rules hindered them from spending sufficient time with the patient, which diminished their ability to provide emotional support and stay closely connected during this crucial period.

P1: "*I am not permitted to visit the patient on a regular basis (crying...).*"

P3: "*Ahhh yes there were fears. I had fears like something might happen to her; we weren't allowed to go visit her frequently.*"

Theme 3: Role Strain and Physical Exhaustion

Sub-theme 3.1: Overburdened by Caregiving Tasks

Three caregivers stated they bore a heavy burden by the physical and emotional demands. The physical challenges of navigating a hospital setting caused stress and tiredness. The emotional and practical burden of juggling work obligations with caregiving responsibilities is reflected by Participant 7. The necessity to manage their employment responsibilities and be present for the patient overwhelmed the participant.

P1: "*His lower body isn't working, so it's hard to lift him. It's very difficult. He has urine and stool inconsistency, doesn't have a sensation. We are now in a hospital; there are people around to look after. I am all alone at home. How will I take care of him, how much of a duty will I do? (Long breath)*"

P3: "*Now we are facing difficulty because of distance like HDU is here medicine, pharmacies are far. We get tired while walking, that is the difficulty we are facing now, and this is the one. I felt HDU should be near to ICU the way it was previously.*"

P7: "*My mother and I are the only ones here; therefore it is obviously a challenging circumstance. I have to see everything. I need to handle the situation and see my work as well. I work fulltime, so it is difficult for me to manage my leave. I have to take of my patient and be present here. We have to be present here at all time because we don't know what will happen.*"

Sub-theme 3.2: Sacrifices in Personal Life

One participant reported that she needed to make compromises and adaptations in her personal life. Participant 1 believed that the responsibilities of caregiving had severely limited her personal independence and quality of life.

P1: "*He is in pain for whole life and my freedom and life is also gone now. The patient has urine and stool inconsistency along with being paralyzed, if only the patient was able to sense the stool and urine urgency, it would have been easy for me to some extent. Now, I can't go to other works leaving the patient behind. Everything happened because of his ego.*"

Theme 4: Financial strain

Sub-theme 4.1: Financial challenges

Three participants reported that managing financial obligations caused stress and difficulties, particularly when unforeseen costs occurred. The financial burden that came with providing care was especially high when family members were responsible for paying to everyday necessities like food, medicine, and medical attention.

P1: "*I quit my job when he fell ill. I thought he will be well, but I don't know... The treatment is also expensive. I have asked my father in law to take him home, but he isn't ready. There's no one in this place to call them ours. All our money has been finished. I was willing to take him but my father in law isn't ready. I don't know what to do. I am managing by burrowing money from others. I don't have any money with me. I have a loan as I have sent my daughter abroad recently.*"

P6: "*During the caregiving, I had financial issues as we were not informed prior regarding the cost and everything. Today, I had to pay the bill for CT scan and take the blood sample to outside hospital for investigation as well. I only had 1600 rupees, which wasn't sufficient. I called up my brother and asked him to send the money, and then only we could do the investigations. If only those things were said earlier, it would have been easy for us.*"

P8: "*We have borrowed money from relatives to cover the medical expenses."*

Sub-theme 4.2: Importance of Financial Stability in Caregiving

One caregiver emphasized the ease of having family assistance to meet any financial requirements.

P7: "*My family members also supported me financially. Even though they couldn't be present here but they did financial support. Therefore there were less difficulties for me.*"

Theme 5: Experience of the Critical Care Unit (CCU)

Sub-theme 5.1: Expectations of ICU Care

Four participants believed that patients received greater care and attention in the ICU or HDU, which lessened the strain on the family. The quality of care offered in these units is trusted by caregivers. There was belief among family members that healing will be aided by the appropriate setting and attention in HDU and ICU.

P2: "*I imagined it as a place where there will be better care and facilities for my son and that he can be treated. The doctor reassured me, saying, "Uncle, you don't need to worry. We have sedated him. He is being treated for pneumonia, and half of the treatment is already done. The rest will be completed in the next two days." They explained that due to his pneumonia, he needs to be on a ventilator.*"

P3: "*My expectations? Ah.... There are sisters (nurses) looking after my patient, I thought things might go well as days passed by*".

P4: "*I felt like my husband will be good now. I felt his difficulty with breathing and all other problems will be resolved after coming to this ward.*"

P6: "*I was very positive about this unit because I thought my patient will be safe and will get more care and attention. We may have fewer burdens. Even though there will be less time for us to visit, but the care for the patient will be good.*"

Sub-theme 5.2: Familiarity with HDU and ICU Settings

One participant revealed their prior experiences-especially those involving severe illnesses helped them manage the difficulties and responsibilities.

P3: "*I knew HDU is little high care unit and i thought this as a sensitive unit. I knew everything about HDU and ICU because of previous hospitalizations so i felt nothing like that. I had kept my mom in ICU so i knew about this.*"

Sub-theme 5.3: Growing Fear over Time

Three caregivers stated they worried about the illness's severity and possible consequences over time. The caregiverss eventually grew anxious about possible bad outcomes, even though their initial anxieties weren't great, especially when they considered the possibility of losing their loved one.

P4: "*I had no fears at the beginning and felt he will be okay but as time passed by I started thinking about a lot of things that might happen and now I am being fearful.*"

P5: "*At first, I was not afraid (silence.....), but as time went on, I started to worry about what I would do if something happened to her, and who I should tell and who I should discuss this to? What will the doctor tell? Gradually with time I became determined and strong after thinking anything that has to happen will happen for sure.*"

P8: "*I didn't have fear that time I wasn't restless at my first visit to ICU but I have restlessness now, because when he was shifted to ICU he was in full consciousness, but now he is depressed as we are not present with him. He becomes calm when we are with him, but he is restless and agitated when we are not there. I have fear now that he will jump out of bed and run away. Yesterday at 2:04 am, I woke up and had sudden urge in my heart to go inside and have a look; he was sitting alone in bed. So, I came out and slept. But at 3 am, he was agitated and started walking out of bed again, almost naked, throwing away the foley's pipe (urine pipe) and tried to jump out of the window. Then, he came out of ICU through the gate door, another visitor saw him. Then we came to know about his actions*".

Theme 6: Seeking Social Support

Sub-theme 6.1: Family and other visitors as support system

Two caregivers stated that their difficulties are lessened by the financial and emotional assistance of family members. Even if they were not present in person, relatives found peace in speaking with family members as sharing with family helped lessen the emotional strain.

P1: "*I talk to my family members and share things with them. I have felt light then after. They said it was in your destiny, don't be sad.*"

P5: "*My brother-in-law sends me money, so I don't have a financial problem, hence I haven't faced many difficulties.*"

Sub-theme 6.2: Observing Others in Similar Situations and sharing feelings

Participants stated that seeing other visitors in comparable situations created a sense of connection, comfort and realization that others are struggling too. This shows how community and communication helped family members deal with the emotional strain of having a loved one in critical care. They found solace, support, and a way to share their burdens by forming connections with comparable others, which is essential for maintaining mental stability during these difficult circumstances.

P1: "*To cope…. I saw other visitors as well and realized this has happened to other people also. I consoled myself. When my patient was admitted here, I saw two deaths in this ward, and thought everyone is struggling here.*"

P2: "*I discuss matters with other patients' visitors. We have to kill time at night so we talk to each other.*"

Theme 7: Emotional Regulation and Acceptance

Sub-theme 7.1: Emotional Strengthening Over Time

One participant gained emotional strength and fought back against difficult situations over time.

P1: "*I now understand this ward is for the better care of patient and he is improving well now. There are sisters looking after my patient, I thought things might go well as days passed by.*"

Sub-theme 7.2: Acceptance of Caregiving Responsibilities

Caregivers frequently embraced their role seeing it as their duty to care for their loved one. They didn't perceive their caregiving tasks as burdensome because they believed it was their responsibility to support their family members.

P6: "*My thought is we should all care for the patient. I don't have much of a stress while taking care of my mother. I am here to take care of my mother and I am doing that.*"

P7: "*It is my responsibility to take care of my patients. I am only child here in Nepal so it is my duty.*"

Theme 8: Coping Mechanisms

Subtheme 8.1: Internalizing Emotional Burden

One participant felt overburdened but decided to conceal his feelings in order to protect his loved ones from the situation. Sometimes, as a coping strategy, people hide or repress their unpleasant emotions and emotional suffering. Participant 2 demonstrated the complexity of caregiving, highlighting emotional suppression, the desire to protect family members from grief, and the burden of fear.

P2: "*I have kept everything to myself. Neither crying nor screaming can help with the worries. The tension and sadness is here. If sharing to others was going to heal my son, I would share it to everyone roaming around Kathmandu. He is not going to be well even if I share it to others (watery eyes, crying). I say to everyone to pray to god. If anything happens inside, if doctors say something more or less bad news, I don't share it to my daughter in law. Not even to my family members while talking on the phone. What do I do? I have kept all my worries in my heart to myself. If I scream or show my worries my daughter in law starts to lose her control. That's why I have consoled her that everything is going to be fine (low tone).*"

Sub-theme 8.2: Emotional Reassurance

One caregiver found it helpful to repeat internal mantras like "*I will face everything that comes my way.*" Self-assurance became crucial for the participant to manage the stress of uncertainty.

P5: "*I assured myself that I would deal with any situation that might arise.*"

Sub-theme 8.3: Faith and Spirituality

Five caregivers expressed prayer and faith were important coping techniques for them. They felt that divine intervention was required to remedy the situation because it is outside of human control. For caregivers, prayer and faith were important coping techniques.

P1: "*I have prayed to god to at least give him the sense of urine and stool continence.*"

P2: "*What do I say? May my son be alright by any means. I am praying to god (crying). I'm having trouble sleeping and don't even want to eat. I say up all night…. (crying)*"

P3: "*We referred to traditional healers to ask if there's anything wrong in the house and we performed puja in house.*"

P4: "*I have remembered all the Gods (crying…). There's nothing that we can do (there's nothing in our hand). We are forced to face the punishment god gave us…..*"

P5: "*I left everything in God's hand and thought he will do good. I started thinking whatever is meant to happen will happen and if something wrong happens i will call everyone and do the needful.*".

Sub-theme 8.4: Emotional Release through Crying

Participant 4 expressed a deep understanding of the inevitability of death but struggled with the natural emotional responses that came with this realization. Crying acted as a release, helping to calm and strengthen emotionally. Over time, she developed resilience, recognizing that while emotions are powerful, they must be managed in order to face life's challenges with strength.

P4: "*I am well aware that we must die someday after being born to this world, yet occasionally we are unable to control our emotions, which causes me to cry. However, as soon as I stop crying, I feel at ease and at peace. I've become stronger because I know that crying won't make the issue go away.*"

Sub-theme 8.5: Planning for Future Care

One participant stated thinking about long-term care and rehabilitation gave her a sense of control. It captured a combination of liberty, hope, and the understanding that the therapeutic process is necessary for healing.

P1: "*If the patient is better here, I consider taking him to a paralysis therapy session. I feel then only something might happen.*"

Theme 9: Communication and Trust in Healthcare Providers

Sub-theme 9.1: Importance of Good Communication

The importance of effective and transparent communication between the family and the medical personnel is emphasized by participant 6. He thinks that effective staff communication can reduce anxiety and foster trust between medical staff and caregivers. Keeping a good rapport with medical personnel is seen to be essential to guaranteeing high-quality care.

P6: "*I think there won't be any issues if all staff members communicate effectively with the patient and their family. I have an obligation to treat every employee with respect. Later, I might have to bring my father for treatment as well. That's why my role is to maintain peace and good relation with everyone.*"

Sub-theme 9.2: Trust in Healthcare Providers

Despite some challenges, caregivers trusted that their loved one will receive appropriate care in critical care settings. They highlighted the comfort that comes from having faith in medical professionals' ability and judgment.

P2: "*The patient's recovery has been assured to me. Regardless of how long it takes, I have faith that he will be alright. I trust the doctors' words and believe in their assurance that he will be fine. (Long breath and low tone of voice)... The treatment is ongoing... The doctors here are like gods. Doctors are gods.*"

P7: "*Doctor said that there could be possibility that he may or may not survive as the situation of the patient was critical. But there was also a hope that he will be fine and will get care.*"

Theme 10: Maintaining Physical Health

Sub-theme 10.1: Taking Care of Own Health

Despite the emotional instability, five caregivers had strong commitment to managing their health. In order to continue being effective in their caring jobs, caregivers prioritized their health. They managed the physical and emotional demands of caregiving by practicing self-care, which included eating properly, getting enough sleep, and drinking plenty of water.

P1:"*I have taken care of my health. I became unwell when we were in general ward, I had diarrhoea. Then, when we came to this ward, I had fever here as well. I took medicine and I am fine now. Patient is patient, who will do the works if I didn't care for myself. So I took care of myself as well. I have made myself strong now. Earlier I had no appetite but now I eat properly and sleep at night also.*"

P4: "*I am certain that I can look after myself. My only concern now is my husband needs to be okay and for that I can solely take care of him and myself. I eat properly in the morning and evening and I am taking good care of myself.*"

P5: "*I take care of myself but now I am suffering from gastritis. I eat properly 3 times per day but I am facing difficulty falling asleep in this hospital environment.*"

P6: "*I am taking care of my health in a balanced way. I eat properly and I take rest in between. I have a good sleep here. I drink plenty of water; I start my day by drinking water as soon as I wake up. I think this is the reason that I don't have any health issues till now.*"

P7: "*I take care of my health because if I'm not feeling well, how can I care for my patients? I walk around the hospital premises early in the morning, do exercise/ yoga. I am fully conscious about my health. I eat fruits, take care of my food and rest as well*".

Sub-theme 10.2: Neglecting Self-care

Two caregivers struggled with their own needs which are frequently brought on by the demands and strains of their caregiving jobs. Participant 3 stated that he felt his current state of health was adequate to handle his caring responsibilities and had not taken any steps to maintain it while the participant 8 admitted that the strain of providing care was negatively affecting her own health.

P3: "*Hmm... my health is good till date, so there hasn't been any need of taking extra care.*"

P8: "*I am having a headache. I haven't slept while staying here. I can't take risk as I may be sleeping and what if something happens to him. Even though I eat, I'm not hungry. I am stressed.*"

Discussion

The study found that a caregiver's stress level increased when they didn't receive a clear explanation of the patient's condition, diagnosis and prognosis. This outcome aligns with the research stating, family members emotional response becomes more severe when they are unsure of the patient's prognosis and recovery.[8] However, one study suggested that correct and clear information, skill assistance, and good communication could reduce stress.[9] It was also mentioned that family members' prior ICU and HDU experience aid them in coping, which is supported by a research that shows prior exposure improves coping.[8]

This study demonstrated that caregivers are usually overworked and overburdened with physical and emotional demands as a result of their caregiving responsibilities. Because they must make important decisions, caregivers are frequently left feeling helpless. This is consistent with finding showing that length of care, terror of family emergency and quick decision making were the main contributors of familial stress.[9] Furthermore, family members feel extreme levels of concern, anxiety, and sorrow when a loved one is critically ill, which is consistent with a research that fear, anger, and sadness were the primary emotions felt.[10]

The results highlight the significance of clear and efficient communication between the family and the medical professionals showing how good staff communication can lessen worry and promote trust. It is believed that maintaining a positive relationship with medical staff is crucial to ensuring high-quality service. This approach aligns with findings that self-reliance and proactive information-seeking are key coping strategies for family members managing the stress.[7] In contrast one study found that family members' satisfaction with communication and emotional support is somewhat lower. This study found that certain aspects of the hospital environment, such as the extremely stressful nature of the work, can make it difficult for ICU staff and family members to communicate about the patient's condition and care.[11]

According to this study, people typically experience stress and difficulty managing their financial responsibilities, especially when family members were not notified in advance about the expense. This conclusion aligns with the research showing that most families were concerned about finances, and they wanted to know about financial concerns prior to the patient's discharge from ICU.[12]The findings revealed that caregivers frequently sacrifice their personal lives and physical well-being to meet the demands of caregiving, including leaving jobs and neglecting household responsibilities. Some expressed that their commitment to patient care felt like a lifelong obligation. These experiences align with research which found that caregivers often face significant challenges, including social isolation and increased difficulties managing their own lives.[13]

The emotional anguish that caregivers experienced as a result of inadequate communication and knowledge is explained by the Transactional Model of Stress and Coping.[14] Anxiety, fear, and helplessness were caused by the caregiver's interpretation of the circumstances- an uncertain diagnosis, insufficient information, and sudden transfers- as a threat (primary appraisal). Due to their lack of control and limited knowledge, they had a low secondary appraisal, or perceived ability to manage. Their ability to cope with problems was diminished, and they ended up having to utilize emotion-focused coping mechanisms like crying praying, or repressing their feelings. The communication break exacerbated emotional strain by acting as a stressor and a coping mechanism barrier.

Some of the caregivers, according to this study, took good care of themselves by eating on time; taking breaks when they could, and walking around the hospital premises. The dread of losing loved ones, on the other hand, caused some individuals to disregard their physical health by not eating on time, sleeping, or resting. This result is in line with a study that found that family members frequently suffered from physical stress brought on by frequent hospital stays, sleep deprivation, and disruptions to their daily routine, all of which adds to the load and lead to poor health.[15,16]

Study's findings showed family members use social support networks, such as visiting relatives and other family members, as coping mechanisms. It also demonstrated the significance of spirituality and faith in God as coping mechanisms. This result is in line with a study that found coping strategies like seeking social support and religiosity were employed to manage stress and anxiety.[17] This study highlights the critical role financial stability plays in caregiving, with caregivers highlighting how financial preparedness eases the challenges associated with meeting future expenses. This finding aligns with research which demonstrated that utilizing social support strategies significantly improves caregiver's ability to manage the stress of a family member's hospitalization.[18]

The findings of this study are well-explained by social cognitive theory, which emphasizes the interplay between individuals, their behaviors, and their environment in shaping coping strategies.[19] Caregivers in this study demonstrated the importance of imitation, social modeling, and observational learning in developing effective ways to manage stress. They actively sought social support by engaging with other visitors and family members, observing how others coped with similar challenges, and adapting those strategies to their own situations fostering a sense of connection and reassurance.

Due to the qualitative approach of the study, correlation or cause and effect relationship couldn't be established. This research was conducted only in Nepal Armed Police Force Hospital. Thus, this research only targeted the relatives of critical care patients admitted in Nepal APF Hospital, and the finding couldn't be generalized to the rest of the population owing to its descriptive nature as well as limited sample size. This investigation didn't evaluate the extent of the patient's illnesses, thus variations in the patients' conditions may contribute to the findings of this study.

Conclusions

This study concludes by highlighting the significant financial, psychological, and emotional stress that care givers in ICU and HDU settings experience. Coping mechanisms, including self-care, spiritual activities, and seeking out social support, are essential for resilience. With the help of focused support networks and improved communication and trust with healthcare professionals, caregiver's stress can be reduced and overall results can be improved. The necessity of caregiver-centred interventions in critical care settings is highlighted by these findings.

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