Critical Care Nurses' Experiences During the Illness of Family Members: A Qualitative Study

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Abstract

Introduction: A loved one's hospitalization in a critical care unit is a traumatic experience for families. However, because of their status and professional competence, a family member who is also a critical care nurse has additional obstacles and often long-term consequences.
Objectives: To describe the experiences of critical care nurse-family members when a loved one is admitted to a critical care unit at the Hotel-Dieu de France hospital.
Methods: A qualitative path based on van Manen's hermeneutic phenomenology combining both descriptive and interpretive models were adopted.
Results: The lived experience of critical care nurses in providing care for their family members admitted into the same critical care were summarized in five themes. Nurses were torn between roles, consisting of confounding roles, their registered nurse status, and watchfulness. The lived experience of critical care nurses in providing care for their family members admitted into the same critical care was summarized into specialized knowledge that included a double-edged sword of seeking information and difficulty delivering the information. Critical nurses compete for expectations, including those placed on self and family members, resulting in emotional and personal sacrifice while gaining insight into the experiences.
Conclusions: Critical care nurse-family members have a unique experience compared to the rest of the family, necessitating specialized care and attention. Increased awareness among healthcare providers could be a start in the right direction.

Keywords

critical care nurses, family presence, nurse-family member dual role, qualitative study

Introduction

Admitting a loved one to the hospital in critical condition is usually an unexpected event, which leaves family members (FMs) feeling helpless, hopeless, scared, anxious, and emotionally distressed (Eshah & Rayan, 2015; Vandall-Walker et al., 2007). Critical illness and the sudden admission of an FM to the intensive care unit (ICU) is seen as an extremely traumatic experience for both the patients and their families (Cypress, 2012; Eshah, 2016; Giles & Williamson, 2015; Sabyani et al., 2017; Stayt, 2007). Since these kinds of admissions are sudden and unplanned, they leave little time for families to adequately cope with the situation, therefore, causing them to be psychologically distressed (McNamara, 2007). In fact, according to Eggenberger and Nelms (2007), while critically ill patients are admitted for

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a physical crisis, their families are usually in a psychological crisis.

Review of Literature

Caring for an ill FM has a huge impact on Nurse-FM's quality of life. Going through this experience requires many compromises and it affects many aspects of the Nurse-FMs life: personal, professional, and their relationships with others (Mills & Aubeeluck, 2006). From a personal perspective, Nurse-FMs felt it had a negative impact and caused an emotional imbalance in their lives (McNamara, 2007; Mills & Aubeeluck, 2006). Professionally, this experience changes the Nurse-FMs ways of addressing FMs in their professional life, they now relate to them and use that experience to develop professionally (Carlsson et al., 2016). The relationship between Nurse-FMs and other relatives was sometimes shaken by the whole experience, therefore some relationships required healing in the aftermath (Mills & Aubeeluck, 2006).

Acquiring important information from staff is key to alleviating Nurse-FMs anxiety and strengthens the relationship between these two parties (Salmond, 2011). Seeking information, even bad information was shown to increase confidence and make Nurse-FMs feel in control. Being given detailed information is also a way for Nurse-FMs to keep other relatives in the loop. It also increases professional respect from the staff and therefore reduced Nurse-FM's levels of stress and anxiety (McNamara, 2007).

The burden of expectation is seen in many studies involving different healthcare professionals (HCPs). In a systemic review using a thematic synthesis of qualitative research, Giles and Hall (2014) interpreted and synthesized Nurse-FM experiences when a critically ill loved one is admitted to the hospital. They presented certain expectations that were placed on Nurse-FMs by themselves, by the patient, by other FMs, and by HCPs. The constantly competing expectations placed on Nurse-FMs by themselves and others, increased their anxiety, distorted their professional and personal boundaries, and made them feel inadequate when they failed to meet any of them (Giles and Hall, 2014).

This dual-role conflict also includes the struggle Nurse-FMs face about whether to reveal or hide their registered nurse (RN) status to the staff taking care of their loved ones. For instance, Nurse-FMs want to avoid being treated differently or judged by the staff if their status is revealed (Giles & Williamson, 2015). This uncertainty of status reveal was also seen in a study by Lines et al. (2015). Nurse-Parents were uncertain about if or when to reveal their RN role so they don't "bother" the staff. This constituted a barrier to communication between Nurse-Parents and staff, therefore failing to successfully build a relationship between these two entities. Other nurses were happy to reveal their RN status without hesitation because they saw it as an opportunity for them to help staff and

perform certain nursing acts without them being concerned (Giles & Williamson, 2015).

Nurse-FMs experience different emotional turmoil than other FMs due to their familiarity with the hospital environment. When an FM is hospitalized in the same institution where the Nurse-FM also works, closer monitoring and early intervention was performed (Fulbrook et al., 1999). These Nurse-FMs also feel they were "part of the team." The care plan was freely and openly discussed with them (Salmond, 2011). However, when hospitalization happens in another institution, Nurse-FMs were constantly trying to build a relationship with the staff to be able to get more information (Fulbrook et al., 1999; Sabyani et al., 2017; Salmond, 2011).

However, understanding the experiences and needs of FMs during this critical time is crucial for HCPs to deliver effective care (Giles & Williamson, 2015). Many researchers have explored this area of study, using different theories. The current literature present explores the nurses' and other HCPs' experiences regarding this matter. However, only a few studies focused specifically on critical care nurses (CCNs) who are specialized in caring for critically ill patients. Additionally, and more significantly, there is no data available concerning Lebanese CCNs regarding their experience with family illness to this day. This indicates a need for further studies. Therefore, this study aims to explore the Lebanese CCNs experiences when an FM is admitted to the ICU for critical illness.

Purpose of the Study

The overarching goal of this study was to learn more about the experiences and requirements of Lebanese CCN-FMs when an FM is admitted to a critical care unit (CCU). Therefore, our study aims (1) to identify the psychological challenges experienced by CCN-FMs during an FM's critical illness, (2) to explore CCN's view on the "dual-role": the nurse-self and the family-self, and (3) to explore CCN's needs during this experience.

Methods

Design

A qualitative path based on Van Manen's (2016) hermeneutic phenomenology combining both descriptive and interpretive models was adopted in this study to obtain thorough and detailed evidence about the experience of CCNs during the illness of FMs.

Setting

This study was conducted at Hotel-Dieu de France hospital in Beirut, Lebanon on September 2021. This hospital opened its doors in 1923 on land purchased by the French Government

back in 1911. In 1984, the management of the hospital was transferred to Saint Joseph University but remained the property of the French State. Despite the turmoil of the Lebanese civil war between 1975 and 1990, Hotel-Dieu de France never failed to provide care to thousands of wounded. The hospital continued to grow by introducing the central building with new facilities and departments in 2001, a private clinic tower in 2005, and adopting a new governance system to keep up with the permanently changing and growing world of health. Today, Hotel-Dieu de France is one of the top hospitals in Lebanon welcoming more than 29,000 patients yearly, with 430 functional beds and over 40 departments.

Population and Sampling

The study's population involved nurses working in CCUs at Hotel-Dieu de France hospital. CCUs include the ICU, cardiac ICU (CICU), pediatric ICU (PICU), and neonatal ICU (NICU). The participants were recruited through a theoretical sampling technique. This sampling method was initiated by intentionally choosing participants for their designation as FMs of critically ill patients and working as CCNs at the institution. Subsequently, with all of these encounters, a purposeful approach to include CCN-FM was undertaken. In addition, CCN-FMs with diverse family positions and various critical care-nursing specialties were pursued to refute or affirm the trends that emerged from data analysis. A snowball technique was also used to acquire participants. CCN colleagues were asked if they had or knew someone who had experienced the hospitalization of a critically ill relative or loved one within the last two years.

Inclusion/Exclusion Criteria

The inclusion criteria included (1) being an RN working at Hotel-Dieu de France, (2) being a nurse working in a CCU at Hotel-Dieu de France hospital including ICU, CICU, PICU, and NICU, and (3) having experienced a critically ill FM in the past 2 years. CCNs who do not have experience with caring for a loved or relative one for at least two years were excluded.

Data Collection Toll and Procedures

The nurses' age, gender, years of experience, critical care area of competence, and when they experienced the occurrence were all gathered using a sociodemographic data questionnaire. After filling out the demographic questionnaire, the participants were invited to participate in semistructured interviews to gather qualitative information on their experience as a CCN-FM to a critically sick FM. Five of the six participants met with the investigator in the conference room on their respective floors, while one wanted to meet at her house.

When the conference began, the researcher gave an overview of the study and its purpose. The participants were told that the talk would be completely anonymous and that any information that could identify them would be coded for privacy. Participants were informed that their identities would be kept anonymous by assigning each interviewee a unique identification number (such as Nurse 1, Nurse 2, etc.). Furthermore, participants were given the option to withdraw from the study at any time without being judged or facing any consequences. The discussions were audio-recorded and interpreted with consent. Participants were reminded that the recordings would only be listened to by the researcher and would be stored in a secure computer file accessible only by the principal investigator. To acquire extensive data, the interviews were expected to last up to 60 min. Participants were initially asked to recount the tale of their FMs becoming dangerously ill and being admitted to the ICU during the interviews.

The following open-ended questions were asked:

Q1 How did the healthcare team operating at the unit view you as an FM?
Q2 How would you describe your role as a nurse FM in caring for your ill relative?
Q3 What were the major stressors you faced as a nurse FM?
Q4 How would you describe your emotional responses while your relative was admitted? How did you deal with them?
Q5 How would you describe the quality of nursing care that was rendered?

Data Analysis and Trustworthiness

In this study, the analysis was guided by van Manen (2016) suggests we "think of the phenomenon described in the text as approachable in terms of meaning units, structures of meaning, or themes." The goal is to reach a level of depth that consequently reveals the essential themes of the phenomenon as being common to all human beings. Therefore, a thematic analysis was adopted as an approach to data analysis. To extract those themes, the researcher used two of the three methods suggested by Van Manen: the holistic and selective approaches: the holistic approach consisted of viewing the text as a whole and trying to capture its meaning. The selective or highlighting approach involved extracting statements in the text that appear important to the experience by listening and reading the text several times. Using van Manen's framework, the extracted themes were then placed within the four world existential: lived body, lived relations, lived space, and lived time (Van Manen, 2016)

To ensure credibility, the study must measure what it is intended to and be a true reflection of the participant's experience, therefore, peer checking was employed. The collected and analyzed data was presented to each participant and they were asked if it was accurate and a true reflection of their

experience. Participants had the opportunity to review and modify their transcripts, thus, credibility was ensured. The second criterion, transferability, is related to the capability of transferring the study findings to other settings. Dependability was achieved by sharing verbatim interview texts to enable other researchers to use them as references for further studies.

Institutional Review Board Approvals

Given that this research implicates nurses, ethical approval from all stakeholders participating in the study is required. Therefore, a proposal form was sent to the Beirut Arab University (BAU) faculty institutional review board for ethical approval. This study was approved by the ethics committee of BAU (ECM/BAU#21-4402) and Hotel-Dieu de France (ECM/HDF#21-0902-14). The form included the key elements of the research project: introduction to the study, its purpose, design, procedure, data collection, population, and ethical considerations. The research study proceeded after approval was granted. Consent was also obtained from the ethical board of Hotel-Dieu de France as well as the Nursing Director and Head of the Research department. Moreover, a consent form and an information sheet were signed by participating nurses in this study before the interview. Lastly, throughout the research process, the investigator guaranteed the autonomy, anonymity, and confidentiality of all participants.

Results

Sample Characteristics

The sample of this study included six CCNs who have experienced the hospitalization of an FM in a CCU within the last two years. All of the participants were female (100%). Participants had a mean of 9.6 years of experience in their respective CCUs. Two out of the six nurses worked in the PICU (33.33%), two in the NICU (33.33%), one in the adult ICU (16.67%), and one in the CICU (16.67%). All participants experienced the hospitalization of their loved ones between 2019 and 2021.

Study Themes

A qualitative path based on Van Manen's (Van Manen, 2016) hermeneutic phenomenology combining both descriptive and interpretive models was applied in this study. The lived experience of gaining a deeper understanding of Nurse-FMs' experience of having an FM hospitalized in the ICU for critical illness has been summarized into five themes.

We found five themes that are summarized below. The first main theme was namely "Torn between two roles" and had three subthemes: "Confounding roles," "RN status," and "Watchfulness." The second theme that arose was titled, "Specialized knowledge." The latter had also three subthemes: "Double-edged sword," "Seeking information," and "Difficulty delivering information." The third extracted theme, "Competing expectations," had two subthemes, namely "Expectations placed on self" and "FM expectations." Other main themes include "Gaining deeper insight" and "Emotional and personal sacrifice." The themes, subthemes, and participants' excerpt quotes are displayed in Table 1.

Theme 1: Torn Between Two Roles

Confounding Roles. CCN-FMs have continuously highlighted the fact that they have experienced a constant intertwinement of two identities at the time of the hospitalization of a loved one in a CCU: the *nurse self* and the *FM self*. The Nurse-FM, therefore, felt she was carrying a double burden as she experienced both clinical and human concern for her relative. Participants were faced with boundary issues between the confounding roles. Another nurse also stated, "…It was confusing because sometimes I went there as her daughter and didn't really care about anything else and what they were doing and sometimes I was there as a nurse…" (Nurse 6). Similarly, a NICU nurse with a critically ill mother expressed, "…I had difficulties separating between being her daughter and being her nurse…I was the nurse with a sick mother and at the same time a daughter that was suffering knowing that this is her mother she might lose…" (Nurse 3).

RN Status. Along with the role battle between being a nurse versus being a relative to the ill FM, Nurse-FM also faced a conflict between wanting to disclose or hide their RN status to the staff. Some participants wanted to stay anonymous for fear of being treated differently or being judged. One participant in particular, who withheld her RN status, had her cousin critically ill in the hospital she worked at but in a different CCU:

> …I didn't want them to know that I was a nurse here, I didn't want the nurses to know me as the nurse whose cousin was hospitalized there…Only two nurses knew who I was, I used to sleep there and leave before the shift handover so no one would see me… (Nurse 1).

Watchfulness. In her daily professional life, one of the responsibilities of the CCNs is to constantly monitor, surveil, and advocate for their patients. As a result, Nurse-FMs in this study felt compelled to continuously watch over their ill loved ones as well as ensure that appropriate care was provided to them. While looking after her father-in-law, one of the nurses disclosed "…When I used to visit him, I didn't focus only on him but also his surroundings…" (Nurse 5).

Table 1. Themes Identified Through Interviews With Critical Care Nurses.

Themes	Subthemes	Supporting statement (excerpts)
1. Torn between two roles	1. Confounding roles	"…I had this confusion between being a nurse or being a family member, the roles were very intertwined and I couldn't separate them. And because of this confusion, the experience greatly impacted me and I am suffering a lot of repercussions…" (Nurse 1).
	2. RN status	"…They knew I was a nurse. I didn't care if they knew or not but maybe it was easier if they knew so that they could answer me in a way they felt comfortable doing and with the medical terms they are used to using because I understand…" (Nurse 4).
	3. Watchfulness	"…When I used to visit him, I didn't focus only on him but also his surroundings…" (Nurse 5).
		"…If I saw something wrong, I always told them and it's frustrating…but at the same time that was my mother so I couldn't keep quiet…" (Nurse 6).
2. Specialized knowledge	1. Double-edged sword	"…The medical knowledge I had made me lose hope compared to the rest of the family who was very hopeful…" (Nurse 4)
		"…because you are a nurse…you are the person who knows way more than the others but can't say everything so you always carry that burden…you know that things are going to get worse, like for me I was sure she was going to die…" (Nurse 3).
	2. Seeking information	"…I preferred to know everything even if it was bad news even if it was the worst news ever, I preferred to know everything from A to Z because I scientifically take the news At least I can prepare myself for the worse and not be surprised if suddenly something happens after being told he was stable…" (Nurse 4).
	3. Difficulty delivering information	"…There is this thing because you are a nurse, you are always the one who carries that responsibility to tell the whole family, the person that knows way more than the others but can't say everything so you always carry that burse…" (Nurse 3).
3. Competing expectations	1. Expectations placed on self	"…I was the one who stayed with her because I understood the most…everything that had to do with the medical field was my responsibility…" (Nurse 1).
		"…I hid my emotions. I never vented to my family so that I don't upset them…I was the one who needed to be strong for everyone and I knew the situation more than anyone…" (Nurse 6).
	2. FM expectations	"…My family pressures me…they give you responsibilities that you aren't supposed to take…they also ask you to give them some kind of hope that you cannot give because you know there wasn't any…" (Nurse 1).
		"…I was extremely involved. My mom also played a role in that involvement because she's attached to me and because she knows I know and she didn't want me to leave so I was forced to stay with her the whole time…" (Nurse 2).
4. Emotional and personal sacrifice	—	"…I hid my emotions and I suffered the consequences, the psychological consequences…I was feeling depressed and I couldn't support anyone because I didn't have anyone to support me…" (Nurse 4).
		"…I lost a lot of weight in that small period; you don't have the time to eat and if you do it's always junk food and you throw half of it away. My lifestyle was terrible. You don't have the energy to do anything…" (Nurse 6).
5. Gaining deeper insight	—	"…The positive thing about it all is that my patient's parents now tell me that I am different from other nurses because I make them feel that I am there for them without them knowing what I went through of course…" (Nurse 1).
		"…I now see things I didn't before, for example, a patient's position in bed, that was one of the main things that frustrated my mom…now I pay more attention to small details so if I feel that the patient isn't comfortable, I immediately try to help…" (Nurse 6).

Unfortunately, with constant surveillance, some participants encountered mistakes that made them more determined to keep an eye on their loved ones. The nurses were thrown into a vicious cycle forcing them to step in and advocate for their FMs when things got out of hand. One of the nurses in this study had to deal with several mistakes that made her obsessed with every single detail of her mother's care; "…Sometimes I saw things that were unacceptable for example the rate of the feeding tube was wrong or bedsore from the infusion valve…I mean I know it's not going to heal her but some things are not acceptable…" (Nurse 2).

Occasionally, even when the Nurse-FM tried to advocate for her FM, the staff was not always understanding. While taking care of her father-in-law, one of the participants revealed:

…He was put on a BiPAP in his last few days and I used to see that there was a lot of air leak but when I told the staff they didn't take me seriously…I wanted to come to visit him as a member of his family, I didn't like to get involved in his care as a nurse, but when you see something wrong you can't keep quiet like the air leak in his BiPAP. I mean the BiPAP is useless with that much air leak… (Nurse 5).

Theme 2: Specialized Knowledge

Double-Edged Sword. As highly qualified HCPs, CCNs possess specialized knowledge and expertise. Nurse-FMs believed that their medical knowledge made them different than other FMs and increased their anxiety. This knowledge was useful in a way but knowing the signs of deterioration and knowing what could go wrong, from previous experiences with patients, was a constant source of stress for them. At the same time, nurses had to keep that knowledge to themselves to protect their families. With her mother in the ICU, one participant pointed out "…Having this information was very stressful. I wasn't able to tell my family we were at the end of the road. Having her uncle intubated in the ICU after complications from the coronavirus disease-2019 (COVID-19)," one nurse said "…The medical knowledge I had made me lose hope compared to the rest of the family who was very hopeful…" (Nurse 4).

Seeking Information. Nurse-FMs exhibited a strong need to seek out specialized information about their loved ones. They needed to be given information that was different than the one given to the rest of the family. Some also acknowledged the fact that they felt more comfortable and in control knowing what was going on even if it was negative; "…I wanted to know everything." At the same time, Nurse-FMs tried their best not to disturb the team while asking for information;

…When I asked about him, I asked as a nurse without being very pushy or anything but if I felt that something was off, I asked about it….as a nurse, I could ask and the team knew how to answer with medical terms and in more details than they would give other family members… (Nurse 4).

Difficulty Delivering Information. Aside from the responsibility of procuring information about the critically ill loved one, CCN-FM also becomes the family educator to whom all the inquiries and concerns are directed. The Nurse-FM acquired and then disseminated important information to the rest of the family that is unable to be there, however, that task was not as easy as it seemed; "…with Covid-19 visitors were restricted so I was the one taking care of her and being there next to her, on top of that, no one understood like my siblings and father, I tried explaining everything…" (Nurse 6).

Theme 3: Competing Expectations

Expectations Placed on Self. Most of the participants spoke about the high expectations they placed on themselves because of their dual role and to maintain control of things by being the anchor that held the family together. Likewise, a third nurse caring for her mother stated:

…I know everything, all the doctors are focused on me and I was the only one present with her at the hospital. Because I am at the hospital, I work here, I have a negative PCR test, and because I am a nurse and I know everyone and I am the one who has to ask and do everything… (Nurse 3).

FM expectations. Nurse-FMs in this study felt considerably under pressure from other FMs to do certain things because of their status. Aside from constantly providing them with meaningful information about the patient's condition, participants were pressured to "be in charge" or to provide emotional support to the rest of the family. There was one nurse in particular who constantly repeated the fact that she was under immense pressure from her family while her cousin was in the ICU: "…My family pressures me…they give you responsibilities that you aren't supposed to take…they also ask you to give them some kind of hope that you cannot give because you know there wasn't any…" (Nurse 1).

Theme 4: Emotional and Personal Sacrifice

In their professional life, nurses usually try to avoid developing deep feelings toward their patients to keep focusing on the care given. However, when an FM is hospitalized for critical illness, Nurse-FMs are thrown into an emotional rollercoaster. With their special dual role, the Nurse-FM prioritized attending to her family's needs putting aside her own, heightening her anxiety. Nurses wore a mask to hide their emotions to keep everyone at ease but under that mask, the Nurse-FMs were extremely overwhelmed. One of the nurses verbalized the huge toll this experience had on her mental health: "…I hid my emotions and I suffered the consequences, the psychological consequences…I was feeling depressed and I couldn't support anyone because I didn't have anyone to support me…" (Nurse 4).

Theme 5: Gaining Deeper Insight

All of the nurses in this study believed that they understood families' experiences as relatives of critically ill patients. However, stepping in their shoes provided CCN-FMs with a new perception of the experience. This new perception enhanced nurses' skills when it came to nurse–family relationships or nurse–patient relationships. One of the nurses stated:

…The positive thing about it all is that my patient's parents now tell me that I am different from other nurses because I make them feel that I am there for them without them knowing what I went through of course… (Nurse 1).

Discussion

CCN-FMs are faced with significant challenges and needs that are not encountered by the rest of the family such as "dual-role" conflict. All the CCN-FMs in this study experienced being "torn between two roles," the role of the nurse and the role of the relative. The latter finding was consistent with previous studies where Nurse-FMs suffered the burden of a role conflict by experiencing both clinical and human concern for their relatives. Participants struggled to balance between supporting the ill FM as a relative or making sure adequate care was provided to their loved one by bringing in their professional persona. Boundary issues between the confounding roles were previously discussed by Giles and Williamson (2015), Giles and Hall (2014), and Mills and Aubeeluck (2006) emphasizing that Nurse-FMs felt different than the general public FMs due to that unique dual role. In previous studies, Nurse-FMs also struggled between wanting to reveal or conceal their RN status (Giles & Williamson, 2015). However, in the current study, only one CCN-FM struggled with wanting to stay anonymous for fear of being judged by HCPs who worked in the same hospital as she did. Other participants had no problem being known as nurses. They preferred to have their RN status known to staff to try to create a sense of trust between them.

The phenomenon of role conflict and its afflicting consequences have been previously documented by several role theorists throughout time. According to Biddle (1986), role conflict is a result of different and incompatible expectations placed on a person in a certain context. Being subject to those conflicting pressures in question can disrupt a person's behavior. Competing expectations were placed on CCN-FMs by themselves and by other FMs, emphasizing the conflict between *nurse-self* and *family-self*. Many studies have underlined these expectations; Giles and Williamson (2015) drew attention to the fact that Nurse-FMs felt personally obligated to "be there" and to maintain control, being the anchor keeping everyone from breaking down. Aside from self-expectations, family expectation plays a huge role in the identity crisis of the nurses. This concept was consistent with previous studies where nurses felt a huge pressure from their families and from the patient to be "all things to all people" (Chen, 2001; Giles & Williamson, 2015; Mills & Aubeeluck, 2006). CCN-FMs were expected to disseminate important medical information to the family, always be updated on the patient's condition and progress, answer all and any questions related to the loved one's illness, and give hope and emotional support to the rest of the family. With all those undue responsibilities, Nurse-FMs felt extremely overwhelmed. The novel

finding in this study and unlike other research papers was the fact that no expectation was placed on participants by the staff taking care of their loved ones. In many studies, the pressure was put on Nurse-FMs to personally take care of their ill FM in the hospital, outside work hours, due to their RN status (Giles & Hall, 2014; Giles & Williamson, 2015). Critically ill FMs also felt safe when CCNs were present, therefore expecting them to be by their side around the clock (Giles & Hall, 2014). Two ill FMs in this study expected their Nurse-FM to stay by their sides and sometimes perform acts that they felt more comfortable being done by them than any other FM.

Another important concept that was underlined in this study is the concept of "knowledge." Nurse-FM is found to suffer heightened emotions compared to the rest of the family due to their specialized knowledge. According to Carlsson et al. (2016) and Salmond (2011), HCP-FMs' specialized knowledge led to increased fear and anxiety by knowing what could go wrong from the disease perspective and the never-ending "what-ifs." Indeed, having that unique information was a constant source of stress for CCNs in this study. In addition to theoretical knowledge about diseases and their effects on the human body, CCNs also possess knowledge about standards of practice, therefore, being able to evaluate the care provided to patients (Giles & Williamson, 2015; Lines et al., 2015). With a constant vigilant observation of the patient and his surroundings, CCN-FM found themselves faced with nonchalance and avoidable mistakes from staff. In this study, when the care was perceived as poor, CCN-FMs were forced to step in and advocate for their critically ill FMs, consequently increasing their anxiety. Two participants also reported having their complaints ignored by HCPs caring for their ill FM which was a source of distress and disappointment. This phenomenon was also seen in Giles and Williamson's (2015) study where one nurse participant was ignored while speaking up for her husband wanting one basic human right: having her husband covered and dignified in front of strangers.

According to Biddle (1986), a person subjected to conflicting expectations develops emotional distress, subsequently adopting coping behaviors. All the CCNs in this study coped by trying to create a sense of trust between them and HCPs taking care of their FM. This relationship was sought to gain access to meaningful information. Many studies underlined this behavior as being a way to enhance care, gain satisfaction, and decrease anxiety (Giles & Williamson, 2015; McNamara, 2007; Salmond, 2011). Consistent with Salmond's (2011) study, participants emphasized that even receiving "negative" information was better than not receiving any at all. Despite that most of the participants in this study had no problem acquiring information, one CCN's questions and concerns were ignored by staff which is an issue previously discussed by Salmond (2011) and Fulbrook et al. (1999). Some HCPs appeared stressed

and unwilling to have direct contact with Nurse-FMs for fear of being intimidated, consequently making it difficult and frustrating to build that relationship. To avoid appearing demanding or judgmental, HCP-FMs tried their best to "fit in" and reduce their demands so to avoid bothering the staff (McNamara, 2007). These behavioral changes, however, were a source of anxiety for the Nurse-FMs by trying to balance between wanting the best care to be provided to their ill loved ones and trying not to trouble the staff because they know what it is like to be in their shoes.

Delivering information to the rest of the family is yet again a source of stress for HCP-FMs. Nurse-FMs tried to filter some of the information received before transferring it to the family. This allowed to ease the experience for the rest of the family and each FM could be able to cope in his way at his own pace. Salmond (2011) briefly spoke about this issue as being a technique used to try to explain the situation in the most hopeful way possible for the family. This concept is not been deeply examined in many previous studies about Nurse-FMs; therefore, this study adds a new dimension to the experience.

The emotional toll placed on the Nurse-FMs stands out by the many challenges faced and described earlier. The experience intensely impacted CCN-FMs psychologically. The term that was repetitively used was "emotional sacrifice." According to Sabyani et al. (2017), the experience created an emotional imbalance in the HCP-FMs personal lives. Instead of externalizing their feelings like other FMs, Nurse-FMs hide their emotions under a mask worn throughout the whole experience. CCN-FMs had to keep control of things putting everyone's emotional needs above their own. The phenomenon of holding back emotions was discussed in the literature as being a coping response used to keep families from breaking down in front of the patient (Hupcey, 1999; Johansson et al., 2002). Nurse-FMs adopt this strategy not only to protect the patient but also to keep the whole family at ease. Another unique finding in this study was the long-term personal damage that this emotional experience created. CCN-FMs spoke out of the different ways this affected them like seeking professional help, being medicated, becoming emotionally numb, and skipping the grieving phase. The damaging aftermath of the experience was the result of internalized feelings and a lack of emotional support.

The whole experience is undeniably hard in many ways; however, one positive thing was able to come out of it. Consistent with other studies, Nurse-FMs realized that their experiences enhanced their professional skills by finally understanding the family's perception of things and stepping in their shoes (McNamara, 2007; Sabyani et al., 2017). Nurse-FMs now understand being "on the other side," subsequently changing their care acknowledging not only the patient, but also his family. This adjustment made these particular CCNs stand out in the eyes of their patients and their families.

Strengths and Limitations

Further qualitative studies in this field are required to explore this phenomenon on a wider scale to gain a much deeper understanding of the experience. Another recommendation is to offer CCN-FMs professional counseling and support even if it is not directly requested. Listen and consider CCN-FM's concerns regarding their loved one, creating a trusting environment. And last but not least, asking CCN-FMs how their needs can best be met, makes them feel acknowledged.

A sample limitation was the absence of male Nurse-FMs. Moreover, it must be pointed out that this study was limited to only one hospital in Beirut, Lebanon, therefore sample size was limited and therefore a larger sample would provide a greater depth of understanding of this particular phenomenon. Because of the latter, the transferability of recommendations beyond the typical context of this study should then be limited.

Conclusion

This study captures the experience of CCN-FMs when a critically ill FM is admitted to a CCU and highlights the different challenges and emotional hardships of it. The findings suggest that CCN-FMs are indeed different than the general FMs with additional stressors and unique needs that are often unmet therefore throwing them into an emotional roller-coaster.

Findings from this study resonate and build upon previous research papers about this specific phenomenon. Participants developed a deeper understanding of their patient's relatives, therefore, adapting their care to incorporate them. Unique to this study is the long-term repercussions that this experience had on CCN-FMs when their needs were unmet. A raised awareness around this matter could potentially adapt and enhance the quality of care HCPs provide to CCN-FMs.

Implication for Practice

The current study reinforces the need to recognize CCN-FMs as being different than the rest of the family, with added stressors and unique needs. The latter needs could be met by different approaches; developing a relationship with the CCN-FM, without fearing retribution, could alleviate a substantial amount of anxiety by facilitating communication and seeking information.

Authors' Contribution

WE, MF, and MB contributed to design; WE, AR, and MB contributed to data collection; MB, MS, AR, and AA contributed to data analysis; MB, MS, MK, MF, and RM contributed to preparing the manuscripts for publication; and MS contributed to revising the manuscript.

Declaration of Conflicting Interests

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