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The lived experiences of family members of Covid-19 patients admitted to intensive care unit: A phenomenological study

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A B S T R A C T

Introduction: The family members of a patient admitted to a COVID Intensive Care Unit (COVID-ICU) could not communicate with and stay close to their loved one, which resulted in them becoming dependent on hospital staff for remote updates.
Objective: To describe the lived experiences of families with a member admitted to a COVID-ICU.
Methods: A phenomenological study was conducted. The subjects were interviewed with open-ended questions to allow them full freedom of expression. The researchers involved in the analysis immersed themselves in the data, independently reading and rereading the transcripts to gain a sense of the entire dataset.
Results: Fourteen first-degree family members were recruited. Five main themes emerged: fear, detachment, life on standby, family-related loneliness in the COVID-ICU, and an unexpected event.
Conclusions: Knowing the experience of families who have a relative in the COVID-ICU is essential for recognizing and reducing the risk of developing symptoms of post-intensive care syndrome.
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Introduction

The health and economic impact of the Coronavirus Disease 2019 (COVID-19) pandemic continues to expand worldwide, highlighting the strengths and weaknesses of our health systems, political institutions, media, and economies.[1] COVID-19 was identified for the first time in Wuhan, China, in December 2019. Since then, the entire world has experienced COVID's rapid spread, and the World Health Organization (WHO) declared Sars-CoV-2 a pandemic emergency.[2] On March 31, 2021, there were 128 million confirmed COVID-19 cases, including 2.81 million deaths; Europe had 45.11 million confirmed cases.[3]

The restricted visitor guidelines[4,5] enforced by many hospitals resulted in feelings of severe distress, even suffering, among family members who found themselves unable to visit or participate in the care of their loved one.[6,7] Family separation is becoming commonplace as hospitals struggle to contain the spread of COVID-19. In some cases, these restrictions have prevented the most vulnerable from having family members support them during, and even at the end of life (EOL).[8]

Regarding an intensive care unit (ICU), the separation of the relative is particularly problematic and disruptive regarding the coping and pain processes of families for different reasons.[9] In ICUs, families play many roles beyond decision makers[10]; they are direct comfort providers, advocates of patients' wishes, and informants.[11,12] For several years, attention has been focused on the ICU being the origin of patients' and their families' abnormality following or resulting from a disease or injury or treatment (i.e., sequelae),[11,12] such as "post-intensive care syndrome" (PICS), which causes physical, cognitive, and psychological repercussions on family members.[13,14] Research studies have suggested the relevance of determining and addressing the families' needs.[15-17] Also, separating families from their loved

Abbreviations: COVID-19, Coronavirus Disease 2019; COVID-ICU, COVID intensive care unit; EOL, end of life; FS-ICU, family satisfaction in the intensive care unit; ICU, Intensive care unit; NOK, next of kin; PICS, Post-Intensive Care Syndrome; PPE, personal protective equipment

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ones could make the patients feel insecure about their conditions and the course of the disease; this may affect the outcome for the patients and their families.[7]

Indeed, a family member's hospitalization in the ICU provokes changes not only in the family routine but also in the suddenly interrupted shared life, which contributes to the modification of family needs. The anguish, possible loss, cause of the separation, and the length of the severe patients' hospitalization are factors that interfere with the family's personal needs.[18]

Attention should be paid to the emotional needs of family members experiencing extreme difficulty,[11] especially during a health emergency due to COVID-19 since the pandemic obliges the detachment of the hospitalized person and his or her family members.[19] Patients' family members who are unable to communicate depend completely on hospital staff for remote updates. This, along with being unable to be beside their loved ones, and their concerns about the medical conditions, raises anxiety, frustration, and a sense of loss of control.[20] With quarantine restrictions (i.e. March 2020), family members cannot be at the bedside to provide comfort and say their goodbyes. There is a concern that, in their grief, COVID-19 families feel very distant from others who have had the opportunity to be with their loved ones in the ICU during the dying phase.[21]

Although several studies have analyzed the experience of family members in the ICU,[22-25] few have examined their experiences with a relative admitted to the COVID-ICU.[17,26] In a recent study, the experiences of families of COVID-19 patients admitted to the ICU during the first wave were analyzed, from which different themes emerged: (a) reactions to the COVID-19 diagnosis, (b) COVID-19 as a destabilizing force on the family unit, (c) COVID-19′s effects on bereavement outcomes, (d) desperately seeking information, (e) family member needs, (f) conflicting feelings about video calls, and (g) appreciation of care.[26]

Since a return to normality is probably not imminent soon, health care workers in ICUs can take several steps to help mitigate the trauma experienced by these families.[9] Considering the dearth of knowledge about the experiences of relatives of patients admitted to COVID-ICU, this paper aims to describe the lived experiences of family members who have a relative confined to a COVID-ICU (and their changing needs), with hospital restriction policies still in place a year after the pandemic began.

Methods

Design

This study was based on Cohen's methodology, which combines descriptive (Husserlian) and interpretive (Gadamerian) phenomenology. Phenomenology is an inductive qualitative research tradition rooted in the twentieth-century tradition.[27] As suggested by Husserl, the founder of this descriptive methodology, phenomenology suspends all suppositions, but it is related to consciousness and is based on the meaning of the individual's experience. In descriptive phenomenology, everyday conscious experiences are described, while preconceived opinions are set aside and bracketed.[27] In contrast, interpretative qualitative research is a qualitative approach that provides detailed examinations of lived personal experiences. It is a particularly useful methodology for examining topics that are complex, ambiguous, and emotionally laden.[28]

This method, which was used in a prior study,[29] was chosen because of its suitability for gaining a deeper understanding of both lived experiences and the meanings attributed to such experiences of a family.

Setting

The enrollment took place at Sant'Andrea University Hospital's Post-Operative ICU, which was turned into a COVID-ICU on March 1, 2020. At the time, the ICU had nine beds. Before becoming a COVID-19 ICU, the Unit normally received post-operative patients who underwent major surgery and had a potential risk of complications such as septic shock or hemorrhagic shock.

Before the Post-Operative ICU was turned into a COVID-ICU, the typical ICU visitor guidelines allowed family members to enter and visit their loved ones anytime between 1PM and 6PM, with a limited number of four visitors per patient. After March 1, 2020, hospital guidelines forbade patients' family members and other visitors from entering the hospital. At the time of this current study, no visitors were allowed inside the building, clinical information was shared only by telephone, and communication with patients, such as video calling, had to be authorized.

Participants

The sample was a convenience sample and was recruited at Sant'Andrea University Hospital in the north of Rome, Italy, between January and February 2021. The participants were contacted by telephone within 24 h of their family member's admission to the COVID-ICU to request consent to participate in the study. Telephone numbers were obtained during the patient's admission to the hospital's emergency department. Family members who provided consent to participate in the study were enlisted.

Before signing the consent form, the family members were informed of the study's purpose and nature. Confidentiality at all stages of the study was guaranteed to the family members, and they were assured that the data would not contain identifying information. The free choice to withdraw from the study was guaranteed to the family members. Family members were also informed that their refusal to participate in the study or withdraw would not affect the quality of care provided.

Inclusion criteria

The inclusion criteria were that each participant had to be 18 years or older, a next of kin (NOK) of the patient admitted to the COVID-ICU, have a smartphone that allows for video calls, having a signed informed consent (sending by email to researchers), and speak the Italian language. Length of time in the ICU or disease severity did not factor into the inclusion criteria.

Data collection

The first step, which entailed "bracketing" was performed by the two main researchers. *Cohen* et al.[30] defined "bracketing" as a critical reflection technique that may help investigators be rigorous during their analysis. In accordance with the phenomenological method, critical reflection requires setting aside the researchers' ideas (i.e., their preconceptions) about the phenomenon being studied. Each investigator who collects the data is requested to describe his or her preunderstandings and perceptions of the phenomenon under investigation. This approach reduces the probability of influencing the extrapolation of themes. The interviews should be performed in the participants' natural environments. As suggested by the phenomenological method, conducting interviews in the participants' natural environments makes it easier for them to describe their experiences.

For this current study, due to the social restrictions imposed by the pandemic, interviews were conducted by telephone. Social platforms such as *WhatsApp, Telegram*, and *FaceTime* were used to video interview family members. The video interview was conducted at an agreed time between the relative and the authors, typically in the afternoon when relatives were at home. To collect socio-personal data and better understand the sample's composition, a structured and validated demographic questionnaire from a previous study was used: Family Satisfaction (FS) -ICU[31] (see Appendix 1).

The video interviews were conducted by the two authors, who did not know the COVID patients or the patient's family members. The

authors who led the interviews were not ICU-COVID personnel, as suggested by the chosen methodology. To familiarize the interviewer with the method, the interviewers were trained in qualitative interviews. The interviews' effectiveness was tested on two individuals who were not included in the study. Following the phenomenological methodology, open-ended questions were used to provide wide freedom of response to the participants. Respondents were asked to describe their experiences when their family member was admitted to the COVID-ICU. The interview began with an open-ended question: *"Tell me about your experience of having a relative hospitalized for COVID-19. How did you handle the situation when your relative was admitted to the COVID-ICU?"* To facilitate the conversation, the interviewer maintained a cordial attitude[29] during the interviews.

As suggested by this methodology, the interviewer recorded field notes regarding the environment, interview setup, interviewee's body language, and potential reflections in a journal. Also, when the participants stopped describing their experiences, the interviewer asked if they had more to say. The interview ended when the participants had nothing more to say. Each interview was recorded on video and lasted between 10 and 40 min. Consistent with Cohen's methodology, the interviews stopped when data saturation was achieved, specifically the redundancy of themes and the storage of the 16 transcribed interviews. The interviews were conducted first in Italian and then translated into English. Two researchers with experience in a COVID-ICU and who are fluent in English and Italian translated the interviews from Italian into English. Then, a mother-tongue English professor with experience in medical translation translated the interviews from English into Italian. The translator was blinded to the original version. This method was used to ensure that the English translation was accurate.

Data analysis

Data analysis was performed by two researchers (DB and FT). The interviews were transcribed verbatim and supplemented using field notes. Each transcription was read several times, with the first reading summarizing the participants' experiences. Then, each researcher reread each transcription line-by-line and assigned indicative themes to the various passages of the text. The researchers then compared the various extrapolated themes; no discrepancies were noted between the researchers' findings at this stage. The researchers confirmed the extrapolated themes by proposing the same themes to the participants. The researchers, who had become immersed in the data, carefully reinterpreted the interviews and field notes.

The extracted themes were then confirmed or corrected by each family member via telephone during the second interview. During this interview, the researchers explained the theme labels to each family member to confirm the accuracy of their experience theme reports. By asking the participants to confirm the accuracy of the interview excerpts, the final validity of the results was guaranteed. The data were analyzed in Italian. The translation of the data was performed by an independent translator. The authors compared the versions, and no discrepancies were found.

Ethical considerations

For this study, the Ethics Committee (Medical Research Ethics Committees of Sapienza University, Faculty of Medicine and Psychology) granted medical ethics approval, and the local hospital research protocol was provided on April 22nd, 2020 with research number N.5773.

Results

The study sample (see Table 1) consisted of 14 first-degree family members, of which 14% were men and 86% were women. The sample's degree of kinship consisted of seven daughters, four sisters, two sons, and one wife, whose average age was 47.57 years.

Only three participants had previous experience in the ICU. Only one lived with a COVID-ICU patient; five family members saw their relative more than once per week, five less than once per week, and three participants at least once per month. Nine family members lived near the hospital, and five outside the city. Their average level of education is a high school diploma.

On average, patients were confined to the COVID-ICU for about 17.79 days (SD = 9.83) before being transferred to a subintensive COVID area. From the analysis of the interviews, five main themes emerged (Table 2).

Fear

The theme of fear was divided into three subthemes, as all the interviewed relatives related it to three common variables. This theme emerged from the onset of the first symptoms, which ultimately led to the sudden hospitalization of loved ones. From that moment on, families lost communication, not knowing what was happening to their hospitalized relatives. Because of this, families forced to be home due to social restrictions started to base their thoughts on the imaginary given through media or stories lived by other family members or acquaintances.

Fear linked to the disease's course and feelings of the unknown

Many family members described how the symptoms suddenly evolved, which led to abrupt hospitalization. From that moment on, feelings of the unknown surfaced, which were linked to the uncertainty of what would happen to their loved ones after hospitalization.

A daughter (AL) described this: "[...] At first, he (the father) was quite well. He had only a little fever, and then his oxygen saturation started to drop. I was afraid of it. So, under the advice of the GP (general practitioner), we called the ambulance, knowing, unfortunately, or at least imagining what we could expect, that is, no longer seeing him [...]".

Another daughter (AI) declared: *"[...] I was afraid because you never have the perception of what is happening in there (the ICU), of how he (the father) is, and what they (healthcare providers) are doing [...].*

A daughter (AA) claimed: *"[...] Then when you are in the situation of seeing the oxygen saturation going down, the fever that is no longer under control, then you worry. And so it was our case, and Dad was hospitalized; we did not know what to expect, just nothing [...]."*

Fear related to previous beliefs about the ICU

Because of the COVID-19 pandemic's social restrictions that limit the COVID-19 pandemic, family members forced to stay home can only imagine what the ICU is and what happens inside it. Many thoughts are linked to the imagination based on the information given by the media or on stories of acquaintances.

A sister (AP) stated: *"[...] The word 'intensive care' is so scary, isn't it? It is also very scary because not everyone has the chance or bad luck to know about the ICU, so you do not know what to imagine. I am a fan of 'Grey's Anatomy;' my sister always teases me* – she described, laughing and shaking her head. *The other day, she said, 'The residents are here!' We laughed so much! And then you relate everything to reality, and it is not like that. Because your mind opens the drawers of imagination [...].*

A daughter (AC) described the experience: "*[...] When they tell you that she's (the mother) in the ICU, you can only see a real possibility of intubation [...]. Obviously, it's the worst scenario, and so is the thought that you'll never see her again, that she's going from a drowsiness state to death. That is, what grips you* - with her voice broken by emotion – *because you do not get it* – said, crying – *you just don't get what can happen in the ICU [...]."*

Fear related to the information processed by families

The COVID-19 pandemic has given everyone a strong attachment to the news presented by the media and to the stories told or lived by

Table 1
Socio-demographic characteristics of participants (n = 14).

ID	Gender	Age	Relationship With patients	ICU Experience	Lives With Relatives	WhatYour Relative Sees	Where Live	Educational status	Recovery of Relative In ICU (Days)	Type of patient's Ventilation	State of patient's consciousness
AA	F	36	daughter	no	no	once a week	in city	Degree	13	NIV	A
AB	F	59	wife	yes	yes		out town	High School	24	ETT	S
AC	F	54	daughter	no	no	more than one a week	in city	High School	9	ETT	S
AD	F	62	sister	no	no	once a week	in city	High School	19	ETT	S
AE	F	41	sister	no	no	once a week	in city	Degree	39	NIV	A
AF	F	39	daughter	no	no	once a week	in city	Degree	12	NIV	A
AG	M	48	son	no	no	more than once a week	in city	High School	8	NIV	A
AH	F	48	daughter	yes	no	more than once a week	in city	High School	16	ETT	S
AI	F	37	daughter	no	no	more than once a week	in city	Degree	27	T	A
AL	F	36	daughter	no	no	once a week	out town	High School	23	ETT	S
AM	F	64	sister	no	no	once a week	out town	High School	8	ETT	S
AN	M	34	son	no	no	once a week	in city	High School	31	T	A
AO	F	57	daughter	yes	no	once a week	out town	Degree	6	ETT	S
AP	F	51	sister	no	no	more than once a week	out town	High School	14	NIV	A

Notes:
F= Female; *M*= Male; NIV= Non-Invasive Ventilation; ETT= Endotracheal Tube; *T*= Tracheostomy; *A*= Awake; *S*= Sedated.

other family members and acquaintances. This continuous flow of information has had a different effect on the families of COVID-19 patients admitted to the ICU.

A daughter (AH) described her fear: "*[...] Among the news that circulates on the internet and television, we are often influenced by friends who tell you 'do they (doctors) give him (the father) that, do they do that;' they have all become professors, all doctors and everyone knows everything. Instead, you feel at the mercy of the situation, and you are afraid [...]. Did you ask them whether they gave him the antibiotics or not? [...]. But if they are telling me that my father is not breathing, how can I ask them whether they give him antibiotics or not? [...]. Then, at the end of all this situation, there is also the detachment from some people you know, because you not only have to detach from a loved one; there is also the detachment from those who still drive you crazy, raise doubts, insinuate that you may not be capable of relating to a doctor who's giving you information [...].*"

As described by a sister (AP): "*[...] The wave of information, which is still spreading today, [...] that is the news you read, that they want you to get, the way they transmit it to you... You realize, when you have a relative in a COVID-ICU, the media does not reflect the reality [...], and it is just a cauldron of stuff they throw you, which in the end gives you the wrong feelings [...].*

A son (AN) said, *"[...] I was afraid because of what the media transmitted to us [...]; you always have images of intubated patients [...]. So, during the COVID-19 emergency, there is the anxiety that a parent must go into intensive care[...].*"

Detachment

This theme emerged in each video interview. In this case, it was also necessary to divide this subject into subthemes about different circumstances. Detachment related to physical and mental distancing from loved ones due to their sudden hospitalization, which was forced by hospitals' restrictions on visits policies; consequently, this theme is also related to both lack of communication and physical contact between the hospitalized relatives and their families, which made families at home suffer from the obligated distance.

The trauma of detachment related to sudden hospitalization and compliance with the pandemic's isolation rules

The hospitalization of a family member to the ICU for any unexpected illness leads to physical and mental detachment. This detachment was accentuated during the COVID-19 pandemic due to hospital restrictions that prevented family members from visiting. In this regard, a daughter (AL) said about the detachment from her father: "*[...] The detachment was...it was bad, because we live in the same building, so we have a daily relationship. Not having that person here, not knowing if he is okay, whether he needs something, it is difficult [...]. The ugly thing about COVID is that you don't have any information, and you can't go see the person, so it all comes down to one phone call a day [...].*

A daughter (AL) claimed: *"[...] For me, it was a bit traumatic because I didn't expect it. Moreover, I have a very close relationship with my mother. Let's say we talk several times a day. We see each other every day, so it's hard for me not to see her all these days [...].*

A family member (AA) said: *"[...] I would do anything to be able to come there. Detachment is terrible [...] for everyone; of course, the father is important, but I feel like saying that the relationship that I have with my father is special, too special, and therefore feeling separated is something that tears me inside [...].*

The detachment that limits communication and contact with the hospitalized relative

Sentiment about lack of communication with their loved ones, or the need to have physical contact was repeated in the description of detachment. As expressed by a daughter (AL): "*[...] Just the possibility, 10 min a day, five minutes a day, just to see him (the father), even to let him know that we're here, is vital [...]. He knows very well that we are here, that we are next to him. But not having contact, hearing a person, not speaking to him, and not seeing him, it hurts because the physical contact is lost [...].*"

A sister (AL) admitted: "*[...] The real detachment is [...] the fact of seeing that person leave, and you do not know if they will return, or if you will hug them once again [...].*"

A son (AN) defined the experience: *"[...] This detachment is not nice. We don't even know how it is, how time passes by [...], what's in his (the father's) mind at that very moment when there is no communication with the family member..., thus the lack of communication and lack of contact have a strong emotional impact[...].*"

Life on standby

The time that elapsed between daily calls was synonymous with waiting and impotence; the 24 h separating relatives from receiving news about their loved ones subjected them to a feeling of suspension and anguish, unaware of any improvement or worsening of their clinical condition. While families are waiting for news, unaware of what is happening to their loved ones, their lives stop.

As expressed by a daughter (AD): *"[...] It's like living a parallel reality... living a reality that is not that [...], not knowing anything...waiting for the evening...The only thing is that you always wait for them (the doctors) to call you [...].*"

Table 2
Themes emerged in the study.

THEME	*SUB-THEMES*
Fear *Detachment* *A Life on Standby* *Family-Related Loneliness In ICU-COVID* *Unexpected Event*	*1.1. Fear Linked To The Disease Course And The Feeling Of The Unknown,* *1.2. Fear Related To Previous Beliefs About The ICU,* *1.3. Fear Related To The Information Processed By The Family Member;* *2.1. Trauma Of Detachment Related To Sudden Hospitalization And Compliance With Pandemic Isolation Rules* *2.2. Detachment That Limits Communication And Contact With The Hospitalized Relative.* *3.1. Life on Stand-by Characterized by the Expectation of Receiving Clinical News from Doctors* *4.1. The Unexpected Event That Causes A Sense Of Disorientation,* *4.2. The Unexpected Event That Causes A Sense Of Guilt.*

Expressing these thoughts during the video interview, AD had lucid eyes, and her voice was broken by emotion. A daughter (AL) declared: *"[...] Practically during these days, life stops, as if it is on standby. You can't work; you can't do anything. The most complicated part is the fact that you don't have any information, that you depend on just one phone call a day, praying that there are no others because that would mean, unfortunately, not good news [...]."*

In another interview, a daughter (AO) described this: "*...how to (live) hanging by a thread."* Another daughter (AD) said, *"[...] I would like to talk to him, even just a message...Instead, we are like that, in a situation of standby, as if life had stopped [...]."*

Family-related loneliness in the ICU

Thinking about your loved ones, left alone in the ICU without being able to communicate with them and amid the impossibility of comforting them, is a recurring thought that emerged in the video interviews.

A daughter (AB) reported: *"[...] These patients are alone in there, without their family members, without being able to see them [...]."*

A sister (AD) declared, referring to his brother: "*The thought that he...in those days when he wasn't sedated, he wasn't sleeping, he was there alone; who knows what he thought, who knows what [...], that we might try to call him, but he couldn't answer the phone[...].*"

Still, a daughter (AF) referring to the father said: *"[...] I would like to go in there, to come and touch him, to show him that we are next to him [...]."*

Unexpected event

Many of the video interviews were characterized by the *unexpected event* theme. Relatives expressed a feeling of disbelief when they realized that such a dramatic event may have affected their household. Again, it was necessary to divide this subject into two subthemes based on what had consequently resulted after that event: the feeling of disorientation and guilt. Some passages from the video interviews helped us to better understand the feelings that emerged.

A sister (AE) reported: *"[...] So far, I have always thought of it (COVID-19) as something far away. I've never thought it was a situation that would involve me so closely [...]. It's a strange feeling because it's as if I was a bit 'doubled' in my person [...]; there's another part of me that doesn't understand, that it's just afraid of what it could be [...]. I've always seen it as something which, yes, there it is, but that will never hit me, and instead...[...]."*

A daughter (AI) declared: *"[...] I did not expect it [...]. I had seen her (mother). She was quite well; then, suddenly, everything collapsed [...]. So, for me, it was a bit of a shock, knowing that I would never be able to hear from her again [...]. You never have the perception of what's going on in there, how it is, and what they're doing [...].*

The feeling of guilt emerged in these passages: "*[...] We didn't even believe he was so sick"* – a daughter (AF) declared – *"because dad always complained a lot, and the thing that makes me feel worse, is not having understood it [...]"* – AF sighed, with her gaze lost in the void – *"This is the thing that hurts me more [...]."* Her brother (AG) shared his sister's guilt: *"[...] I feel bad at the thought that maybe I could have fixed it and help him a little earlier [...]."*

Discussion

This study described the experiences of family members regarding their loved one's hospitalization at a COVID-ICU. The families mainly experienced: (1) *fear*, (2) *detachment*, (3) *life on standby*, (4) *family-related loneliness in the COVID-ICU,* and (5) *unexpected events*. Some of these themes have been highlighted in the literature.[9,19,26,32]

The first theme is fear, which is linked to feelings of the unknown. It is deeply connected to observing loved ones' worsening clinical conditions, along with the pathology's sudden evolution. Family members watch their relatives taken away from home to be isolated in the hospital, leaving behind a void of information until they enter the emergency room or ICU, thus generating a sense of fear and anxiety. One way to reduce this mood is to ensure that communication is unequivocal because uncertainty tends to increase fear.[33] When people with COVID-19 enter the hospital, they literally disappear from their relatives' lives, and information on their state of health was provided by doctors, later only by telephone.[34] Many of our sample's family members had no ICU experience; this generated a mutual association between hospitalization in an ICU and a feeling of family loss because they related the intensive environment to intubation, tracheostomy, sedation, coma, and inaccessibility: imagining, as pointed out in some of the talks, the body "violated" by the devices necessary for the survival of their loved ones. In addition, some family members reported that acquaintances and friends felt able to make clinical judgments, thus causing even more anxiety about the work of health workers and more isolation from the family. An important factor in this subtheme is the processing of media information (e.g., images of the ICU on television and social media) that exposed the family to a sense of fear. In particular, the observed relationship between media exposure and the fear of COVID-19 suggests that increased media exposure can lead to greater fear. If this is really the causal connection between these constructs, then there are opportunities for policymakers and journalists to over-influence fear.[35]

As for *detachment*, this theme is related to the lack of physical contact, which is expressed by the impossibility of seeing and touching their loved ones, and the impossibility of communicating with and reassuring them. The families lived anxiously awaiting the doctors' calls, configuring them as the only contact left with their relatives who, subjected to sedation, could no longer communicate through messages sent to patients' phones. Some studies have stated that they faced this problem by launching videoconferences with mobile devices, but only if the family was not susceptible to seeing their loved one in a coma and connected to a mechanical ventilator.[9]

Life on standby is another theme expressed by our participants. They feel they are living a parallel life because they know their relatives' critical state of health but can do nothing, not even comfort them since they were forced to stay at home waiting for the evolution of events. For family members, the days suspended have begun: days closed at home and attached to the phone, spend hours waiting to talk to the father or see him through the tablet screen. Families of patients who were unable to communicate were completely dependent on hospital staff for remote upgrades. This problem, along with not being able to be next to loved ones and their concern for medical

conditions, has raised anxiety, frustration, and a sense of loss of control and impotence.[20]

The *loneliness of the family member in the ICU,* which emerged for many participants, is defined as the concern that their loved ones are left alone, helpless (because of sedation), absent the possibility of comforting them, and making them understand that even if the family is not present, they are close to them. A study[26] stated that families had difficulties with understanding the situation's seriousness and were not sure that their loved ones felt comfortable and well cared for or that they might be likelier to want to do anything to fight for survival. Possible options have been proposed to solve the loneliness of critical COVID-19 patients, proposing several alternatives to bring companionship to the deathbed, including seeing the family through a shield or even pets.[36]

Since our research sample was predominantly female, the literature confirms the natural predisposition of the female gender to take care, especially during the EOL period.[37] Women are more expressive in showing their emotions, especially in face-to-face communication.[38] The results obtained in this study may have been influenced by the fact that most of the sample was female. As described in several studies,[39,40] female caregivers experience higher fear and loneliness than male caregivers. Fear, isolation, and loneliness have serious implications for caregivers' mental and physical health.[41] Indeed, studies[41,42] have shown that chronically lonely people have a significantly higher incidence of heart disease, are likelier to have metastatic cancer, and are at an increased risk of stroke neurodegenerative diseases such as Alzheimer's. It would also be interesting, through a mixed-method design, to analyze any differences with the male gender.

Limitations

This study has several limitations. As with all qualitative studies, our results cannot be generalized, and they can be used only with caution in other countries. This study was conducted only in an Italian region (Lazio) and in a single hospital. There may be slight cultural differences between Italian regions and other countries. Another limitation may be related to the fact that many field notes related to the environment and situation were circumscribed because the only environment that could be noted was taken from a camera.

Conclusion

This study is one of few that evaluates the experiences of relatives during hospitalization in a COVID-ICU. Before the COVID pandemic, relatives could visit their patients during the ICU period. However, the situation turned out to be slightly different. Indeed, in this pandemic context, due to COVID-related restrictions, the possibility of visiting hospitals has been denied. This certainly had an emotional impact on the relatives, who not only found themselves worried about their loved ones' clinical condition but also worried about having been excluded from the care process. This study highlighted the significant emotional impact on the participants. Being excluded from the healing process results in increased fear of the future. Not seeing their loved ones and not being able to access the hospital due to restrictions made them feel frightened and helpless.

The detachment was more evident. Not being close to one's loved one and not speaking directly with nurses and physicians are issues that should make organizations reflect on the importance of developing entry protocols that do not exclude relatives from the care process, even in a pandemic context. This research aims to promote a clearer care approach toward COVID-ICU patients' families, identifying their emotions and needs. It is proposed that future research should conduct studies that analyze the experiences of male family members and the impact that visitation restriction policy has on them to gain a comprehensive approach to the entire family unit's needs regarding COVID patients admitted to an ICU.

Authors' statement

All persons who meet authorship criteria are listed as authors, and all authors certify that they have participated sufficiently in the work to take public responsibility for the content, including participation in the concept, design, analysis, writing, or revision of the manuscript.

Furthermore, each author certifies that this material or similar material has not been and will not be submitted to or published in any other publication.

Declaration of Competing Interest

The author declares no conflicts of interest.

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