

# The Relationship Between the Needs of Intensive Care Patients' Relatives and the Frequency of Depressive Symptoms

## Yoğun Bakım Hasta Yakınlarının Gereksinimleri ve Depresif Belirti Sıklığı İlişkisi

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### ABSTRACT

**Objective:** As a result of patients being admitted to and staying in the intensive care unit, their family members experience different emotional disorders such as psychological breakdown, stress, and depression. This study was carried out to determine the relationship between the needs of intensive care patient relatives and the frequency of depressive symptoms.

**Materials and Methods:** The study was conducted in a descriptive design with the relatives of 53 patients hospitalized in the intensive care unit. Personal Information Form, Relatives Needs Scale in Intensive Care Units, and Beck Depression Inventory were used to collect data.

**Results:** In the study, it was found that the patients' relatives' score for Beck's Depression Inventory had a positive, weak, and significant relationship with the patients' total score for Glasgow Coma Scale and the patients' relatives' age, and there was a negative, weak, and significant relationship between the patient relatives' age and their score for Patients' Relatives' Needs in Intensive Care Units Scale ( $p<0.05$ ).

**Conclusion:** It can be asserted that the intensive care unit patients' relatives' frequency of depressive symptoms decreases as their needs are met. During the patients' treatment and care process, their relatives should also be examined in terms of emotional breakdown. Patients' relatives' needs are often not taken into consideration during the patients' admission to intensive care unit, and therefore, they may develop feelings such as fear, anxiety, or curiosity about the process. If patients' relatives feel neglected, this undermines their trust in the health care workers and the service provided by them.

**Keywords:** Intensive care, Patients' Relatives' Needs, Depressive symptoms

### Öz

**Amaç:** Yoğun bakım ünitesindeki hastaların aile üyeleri yoğun bakıma kabulün ve yoğun bakımda kalmamın bir sonucu olarak psikolojik kriz, stres ve depresyon gibi duygusal bozukluktan oluşan farklı deneyimler yaşarlar. Bu çalışma yoğun bakım hasta yakınlarının gereksinimleri ve depresif belirti sıklığı ilişkisinin belirlenmesi amacıyla yapıldı.

**Gereç ve Yöntem:** Çalışma tanımlayıcı desende, yoğun bakım ünitesinde yatan 53 hastanın yakını ile yapıldı. Verilerin toplanmasında, Kişisel Bilgi Formu, Yoğun Bakım Birimlerinde Hasta Yakınları Gereksinim Ölçeği ve Beck Depresyon Envanteri kullanıldı.

**Bulgular:** Araştırmada yalnızca hasta yakınlarının Beck Depresyon Envanteri ile hastaların Glasgow Koma Skalası total puanı ve hasta yakınlarının yaşı ile arasında pozitif zayıf anlamlı ilişki, Yoğun Bakım Birimlerinde Hasta Yakınları Gereksinim Ölçeği ile hasta yakınlarının yaşı arasında zayıf anlamlı negatif bir ilişki saptandı ( $p<0,05$ ).

**Sonuç:** Yoğun bakım hasta yakınlarının gereksinimleri karşılandıkça depresif belirti sıklığının azaldığı söylenebilir. Hastaların tedavi ve bakım sürecinde hasta yakınları da duygusal bir kriz yönünden incelenmelidir. Hastanın yoğun bakıma kabul edilmesinde hasta yakınlarının gereksinimlerine çoğunlukla yer verilmediği ve bu sırada bireylerde korkuya kapılma, endişelenme ya da sürece yönelik merak gibi duyguların gelişebildiği belirtilmektedir. Hasta yakınlarının ihmâl edildikleri düşüncesi, çalışana ve verilen hizmete güvenlerini sarstığı belirtilmektedir.

**Anahtar kelimeler:** Yoğun bakım, hasta yakını gereksinimleri, depresif belirtiler

Received/Geliş: 14.03.2023

Accepted/Kabul: 24.07.2023

Published Online: 30.12.2023

Cite as: Yazar A, Yazar B. The relationship between the needs of intensive care patients' relatives and the frequency of depressive symptoms. Jaren. 2023;9(3):214-222.

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The study was presented as an oral presentation at the 55th National Congress of Turkish Anesthesiology and Reanimation held in Antalya on 28-31 October 2021.

## INTRODUCTION

Intensive Care Units (ICUs) are different from other hospital units in that they have a different physical structure and unit-specific equipment, provide care and treatment for high-risk patients, and are staffed by specially trained healthcare workers <sup>(1)</sup>. After patients start to stay in the intensive care unit, their family members experience different emotional disorders such as psychological breakdown, stress, and depression <sup>(2,3)</sup>. In the late 1970s, the needs of family members of critically ill patients were identified as follows, in order of importance: to feel that there is hope, to feel that the patient is being taken care of, to have waiting rooms close to patients, to be called and informed about the changes in the patient's condition, to know the prognosis, and to receive sincere and understandable answers to questions <sup>(4,5)</sup>. During the patients' treatment and care process, their relatives should also be examined in terms of emotional breakdown. Patients' relatives' needs are often not taken into consideration during the patients' admission to ICU, and therefore, they may develop feelings such as fear, anxiety, or curiosity about the process. Ignoring patients' relatives' needs in this regard may cause them to have negative feelings and to be anxious and angry. If patients' relatives feel neglected, this undermines their trust in the health care workers and the service provided by them <sup>(6)</sup>. Ulutaşdemir et al.<sup>(1)</sup> reported that patients' family members needed assurance and information the most. Also in another study, it was reported that family members needed assurance, proximity, and information <sup>(2)</sup>. Moreover, it was asserted that there was a significant relationship between the patients' family members' satisfaction and the support and clear and complete information provided to them in the intensive care unit <sup>(5)</sup>. Therefore, it is important for the patients' family members to be close to the patient, support the patient in terms of care, to be able to communicate comfortably when they are asked to provide care, to be able to visit when appropriate, and to be informed by phone about any changes in the patient's clinical picture <sup>(7)</sup>. In addition, it is important to reduce the anxiety and perceived care burden of the relatives of the patients. In the view of this information, the purpose of this study was to examine the relationship between the ICU patients' relatives' needs and their frequency of depressive symptoms.

## MATERIALS AND METHODS

### Research Design

This study was designed as a descriptive, cross-sectional, and correlational research.

### Participants

The study was carried out with the participation of the family members of the patients hospitalized between March and September 2020 in the Tertiary Internal and Surgical Intensive Care Unit, Batman Regional State Hospital. No sample size was calculated for this study, and it was planned to reach all the family members of the patients who were hospitalized within the specified period. In the preliminary interview with the relevant intensive care officials in the institution where the study will be conducted before starting the study, it was determined that the average number of patients hospitalized in the intensive care unit for more than 48 hours in a six-month period was ninety-five (N=95). It was aimed to reach more than one patient's relatives for each patient, and the study was planned to be conducted with at least 190 patient relatives. However, due to the COVID-19 pandemic, the study could be completed with the participation of 53 family members of patients. The data were collected by one-on-one interviews (10-15 minutes) between the researcher and the family members of the patients.

### Inclusion Criteria

Among the family members of the patients (spouse, parents, children or siblings) who were hospitalized in the intensive care unit for more than 48 hours, those who were 18 years old or older, had not been diagnosed with a psychiatric disorder according to the Diagnostic and Statistical Manual of Mental Disorders-V (DSM-V), and agreed to participate in the study were included.

### Data Collections Tools

The data were collected using Personal Information Form, Beck's Depression Inventory (BDI), and Patients' Relatives' Needs in Intensive Care Units Scale (PRNICUS).

**Personal Information Form:** Personal Information Form was created by the researchers based on the related literature <sup>(2,5,6)</sup> and filled by one of the

researchers. It has two parts. The first part includes the patient's characteristics, the reason for admission to the intensive care unit, history of chronic disease, previous experience in intensive care, and the information about the relationship between Glasgow Coma Scale (GCS) score and ventilator. The second part includes information about the sociodemographic characteristics of the patient's family members, such as age, gender, marital status, educational level, religion, degree of affinity, and the time allocated for patient visits in the intensive care unit.

**Glasgow Coma Scale (GCS):** The Glasgow Coma Scale (GCS) is a scale used to objectively describe the degree of any level of consciousness. The scale evaluates patients on three parameters: eye opening, motor and verbal responses. Each of these reactions is evaluated separately to obtain information about the general condition of the patients.

**Beck's Depression Inventory (BDI):** The scale was developed by Beck et al. in 1961. Beck's Depression Inventory is a 21-item self-assessment scale designed to determine the level of depression in emotional, cognitive, and motivational dimensions. Each item consists of statements, rated from low to high, that express a behavioral pattern specific to depression. This four-point Likert-scale is scored between 0 and 63. The statements are associated with the symptoms of depression: being pessimistic, feeling guilty, crying spells, being dissatisfied, being mentally depressed, feeling of failure, restlessness, loss of appetite, social withdrawal, difficulty in making decisions, feeling tired, distorted physical appearance, sleep disturbance, somatic preoccupations, decreased desire to work, and decreased sexual desire. The Turkish validity and reliability of the scale were tested by Hisli<sup>(8)</sup>. Hisli reported the cutoff score as 17 and the Cronbach's alpha coefficient as 0.92.

**Patients' Relatives' Needs in Intensive Care Units Scale (PRNICUS):** PRNICUS is a self-report scale developed by Molter<sup>(4)</sup> in 1979 in order to evaluate the patients' relatives' needs in intensive care units. The Turkish validity and reliability of the scale were tested by Büyükçoban et al.<sup>(9)</sup> in 2015. The Turkish version of the scale, which originally consists of 45 items and 5 subscales, has 40 items and 3 subscales. The answers are on a four-point Likert scale ranging from one to four. The higher the score, the higher the degree of needs. The Cronbach's alpha coefficient of the scale was reported to be 0.92.

### Ethics of Research

The study adhered to the Declaration of Helsinki. A written approval was obtained from the Non-Interventional Clinical Research Ethics Committee of Dicle University (06.02.2020/65) and Batman Regional State Hospital (20.02.2020/804). Verbal and written consent was obtained from the participants who met the inclusion criteria of the study.

### Statistical Analysis

The data analysis was carried out using SPSS 25.0 in the study. Minimum, maximum, mean, standard deviation, count, and percentage were used in descriptive data analysis. The means of the total scale scores were calculated, and it was examined whether each group exhibited a normal distribution. Normality was tested using Skewness, Kurtosis, and Shapiro-Wilk tests. Student's t test and ANOVA test were used to analyze the sociodemographic variables. Pearson correlation was used in examining the relationship between BDI and PRNICUS; Spearman correlation in examining the relationship between the scales and the patients' age, the patients' relatives' age, length of stay in the ICU, and GCS score; and simple linear regression in examining the effect of BDI on PRNICUS. Cronbach's alpha coefficient was used to test the internal consistency of the scales. The statistical significant was set at  $p < 0.05$  in all analyses.

## RESULTS

Table 1 shows the sociodemographic characteristics of the patients and their relatives. As can be seen in the Table 1, the patients' mean age was  $68.50 \pm 19.01$  and their relatives' mean age was  $40.73 \pm 10.90$ , 58.5% of the patients and 73.6% of their relatives were male, and 94.3% of the patients and 90.6% of their relatives were married. It was found that, of the patients' relatives, 71.7% were their sons and 56.6% were primary school graduates. As for the patients' medical conditions, 84.9% of them had a chronic disease, 54.7% received ventilator support, and 81.1% had never stayed in the ICU before. It was found that their mean duration of stay in the ICU was  $3.09 \pm 1.13$  days, and their mean total score for GCS was calculated to be  $3.18 \pm 0.92$ .

When the participants' sociodemographic characteristics were analyzed in relation to their mean total scores for the scales, it was found that there was a positive, weak, and significant relationship between the patients' relatives' BDI score and the patients'

**Table 1. Comparison Of The Sociodemographic Data Of The Patients And Their Relatives And The Total Mean Scores Of BDI And PRNICUS Of Sociodemographic Data**

Features	Mean± SD	Min-Max	BDI	PRNICUS
Patient Age	68,509±19,019	21-98	r: 0,147 p:0,293	r: -0,133 p:0,343
Patient Gender	N	%		
Female	22	41,50	t: -0,023	t: -1,055
Male	31	58,50	p: 0,981	p: 0,296
Marital Status of the Patient				
Married	50	94,30	t: 1,078	t: -0,368
Single	3	5,700	p: 0,286	p: 0,714
Comorbidities of the Patient				
Yes	45	84,90	t: -1,498	t: 0,798
No	8	15,10	p: 0,140	p: 0,444
Ventilator Support				
Yes	24	54,70	t: 0,905	t: -0,737
No	29	45,30	p: 0,369	p: 0,465
Previous ICU Experience				
Yes	10	18,90	t: -0,682	t: -0,600
No	43	81,10	p: 0,499	p: 0,551
	<b>Mean± SD</b>	<b>Min-Max</b>		
Duration of Stay in ICU (day)	3,094±1,113	1-4	r: 0,169 p:0,227	r: -0,109 p: 0,438
GCS Total Score	3,188±0,921	2-5	<b>r: 0,377**</b> <b>p &lt;0,001</b>	r: 0,244 p: 0,079
Patients' Relatives Age	40,735±10,900	18-64	<b>r: 0,298*</b> <b>p: 0,031</b>	<b>r: -0,381**</b> <b>p &lt;0,001</b>
Patients' Relatives Gender	N	%		
Female	14	26,40	t: 1,183	t: -0,247
Male	39	73,60	p: 0,242	p: 0,806
Patients' Relatives Education Level				
Illiterate	1	1,90	F: 0,308	F: 0,133
Primary School	30	56,60	p:0,819	p:0,940
High School	20	37,70		
Graduate	2	3,80		
Marital Status of the Patients' Relatives				
Married	48	90,60	t: -1,301	t: 1,327
Single	5	9,40	p: 0,192	p: 0,195
Kinship to the Patient				
Daughter	8	15,10	F: 1,227	F: 0,307
Son	38	71,70	p:0,311	p:0,906
Spouse	1	1,90		
Mother	1	1,90		
Father	1	1,90		
Sibling	1	1,90		

t: Student t Test, \*: Correlation is significant at the p:0,05 level.

r: Spearman Correlation, \*\*: Correlation is significant at the p:0,01 level.

F: ANOVA

**Table 2. Mean Total Scores For BDI And PRNICUS And The Relationship Between Them**

Scales	Mean±SD	Min-Maks	BDI	PRNICUS
BDITotal Score	32,943±8,932	21-60	-	r: -0,341 p:0,013
PRNICUSTotal Score	143,094±11,657	103-160	r:- 0,341 p:0,013	-
Support/Comfort	65,320±6,366	48-76	r:- 0,282 p:0,041	r:0,944 p<0,001
Assurance/Proximity	29,528±2,325	22-32	r:- 0,323 p:0,018	r:0,847 p<0,001
Information	30,264±2,237	20-32	r:- 0,309 p:0,024	r:0,806 p<0,001

r: Pearson Correlation

**Table 3. The Effect OfBDI OnPRNICUS**

Dependent Variable	Independent Variable	B	β	t	p	F	Model (p)	R <sup>2</sup>
PRNICUS	Constant	157,742		26,915	0,000	6,697	0,013	0,011
	BDI	-,261	-0,341	-2,588	0,013			

GCS total score, and the patients’ relatives’ age; and a negative, weak, and significant relationship between the patients’ relatives’ PRNICUS score and their age (p<0.05). Table 2 shows the mean total scores for BDI and PRNICUS and the relationship between them. It was found that all the relatives of the patients who participated in the study had a BDI total score above 17. According to the Pearson’s correlation analysis, a negative, weak, and significant relationship was found to exist between the BDI score and the scores for PRNICUS and its subscales (p<0.05).

The model created in the simple linear regression analysis carried out to determine whether there is a relationship between the scores for BDI and PRNICUS was found to be statistically significant (F:6.69, p:0.01). It was found that the depressive symptoms were statistically significant as a determinant (explanatory power) of the needs of the relatives of the patients (R<sup>2</sup>=0.011). In the model, the needs of the relatives of the patients in ICU explained approximately 10% of their depressive symptoms (Adjusted R Square = 0.099) (Table 3).

**DISCUSSION**

After patients start to stay in the intensive care unit, their family members experience different emotional disorders such as psychological breakdown, stress,

and depression <sup>(2,3)</sup>. The purpose of this study was to investigate the relationship between the ICU patients’ relatives’ needs and their frequency of depressive symptoms.

In this study, it was found that there was no relationship between the participants’ depressive symptoms and needs and their descriptive characteristics such as gender, educational status, and degree of affinity with the patient. Previous studies in the literature reported different results in this regard. In one of these studies, it was reported that there was no significant relationship between the caregivers’ unmet needs and their gender, marital status, degree of affinity with the patient, and income level <sup>(10)</sup>. In another study examining the patient’s relatives’ scores for the State Anxiety Scale and the Pittsburgh Sleep Quality Index on the 1st and 21st days, it was asserted there was no statistically significant difference in their State Anxiety Scale scores in terms of gender on the 1st day, but women’s scores were higher on the 21st day; and no significant difference was found to exist in their Pittsburgh Sleep Quality Index scores in terms of gender, and the scores of both women and male were found to increase on the 21st day <sup>(11)</sup>. On the other hand, in another study it was reported that no significant relationship was found to exist between the patients’ relatives’ needs and their gender, but women were

found to have a higher level of depressive symptoms than men<sup>(12)</sup>. We are of the opinion that the reason why there was no significant difference in terms of gender in the present study may be due to the fact that the majority of the participants were male.

In this study, when the participants' mean total scores for PRNICUS and BDI were compared in terms of educational level, it was found that there was no statistically significant difference. There are different results in the literature in this regard. Padilla-Fortunatti et al.<sup>(13)</sup> reported that there was no significant difference in the patients' relatives' needs in terms of their educational status. In another study, it was asserted that as the level of education increased, a decrease was observed in anxiety rates. of education, it was asserted that there were significant differences in the levels of importance given by the participants to the dimensions of assurance, proximity, and information in terms of educational level, and no difference was found to exist in the dimensions While the rates of anxiety level were reported to be 26.7% and 15.4% on the 1st and 7th days, respectively, in the participants with a high educational level; they were found to be 40% and 61.5% on the 1st and 7th days, respectively, in the participants with a low educational level<sup>(14)</sup>. In a previous study on the relationship between the sub-dimensions of the needs scale and the level of comfort and support<sup>(2)</sup>.

In this study, when the participants' mean total scores for PRNICUS and BDI were compared in terms of degree of affinity, it was found that there was no statistically significant difference in this regard. Alsharari et al.<sup>(2)</sup> reported that while the parents of ICU patients had the highest level of need for assurance, proximity, information, and support, they felt less need for comfort. In their study, Ölçüm et al.<sup>(12)</sup> reported that, among the family members of the patients, the spouses needed information the most. Unlike the results found in the present study, in the literature, it was reported that there were significant relationships between the patients' family members' degree of affinity and their needs such as assurance, information, support, and comfort<sup>(14-16)</sup>. Alike to the results of the present study, there are also some previous studies reporting no difference in terms of the subscales of the patients' family members' needs and the degree of affinity<sup>(17)</sup>. We are of the opinion that this result is due to the fact that the majority of the participants in the present study were male and the patients' sons.

In the present study, it was found that the patients' family members were mostly male, all of them had a moderate depressive symptom, and as the patients' GCS scores and their relatives' age increased, so did the depressive symptoms of the patients' relatives. In the literature, it was reported that some depressive symptoms were observed in the family members of the patients in intensive care units<sup>(11,14)</sup>, and these symptoms began with the patient's admission to the intensive care unit and continued until discharge or being close to death, and were affected by the severity of the disease<sup>(18)</sup>. In their study carried out with the participation of 35 family members of patients, Midega et al.<sup>(5)</sup> reported that 54.3% of the family members had depression symptoms, and the clear and complete information provided by intensive care specialists and the support received in the intensive care unit significantly affected the family members' level of satisfaction. It was also reported in the literature that depression scores increase with increasing age<sup>(19-21)</sup>. The results of the present study are in line with those in the literature in this regard.

In the current study, all the patients were found to be in coma according to their GCS score. It was found that there was a relationship between the patients' coma levels and their family members' depressive symptoms. As the patient's GCS scores increased, so did their family members' BDI scores. In other words, an increase in GCS score indicates the "well-being" of the patients, while an increase in BDI score indicates an increase in the patients' family members' depressive symptoms. The reason for this result may be due to the fact that the patients and their relatives in the sample were mostly men, the patients had an advanced age, there is a perception in the society that elderly men do not contribute to housework and grandchild care like women do, and the elderly are seen as a burden. Another reason may be the uncertainty about the process. Uncertainty, defined as the condition of uncertain future expectations or uncertain future<sup>(22)</sup>, has been reported to be associated with depression<sup>(23)</sup>. In the present study, it was found that as the patients' relatives' age and depressive symptoms increased, their needs decreased. This can be explained by the decrease in the interest in and desire for the environment due to the increase in depressive symptoms. Similar to the result of the present study, Ölçün et al.<sup>(12)</sup> also reported that there was a significant relationship between the patients' relatives' levels of anxiety and depressive symptom and their needs for assurance

and proximity.

In the current study, when the relationship between the subscales of the Patients' Relatives' Needs in Intensive Care Units Scale and depressive symptoms was examined, it was found that the depressive symptoms increased with the decrease in assurance/proximity, support/comfort, and information. In their study carried out with the participation of 233 family members of ICU patients, Alsharari et al.<sup>(2)</sup> reported that the most important need of the family members of the patients was assurance, followed by information, proximity, comfort and support. In this context, based on the literature, we think that depressive symptoms may increase due to the decrease in individuals' assurance and comfort, the increase in their need for information, and the increase in their feeling of uncertainty. In a previous study carried out to identify the unmet needs of the caregivers of the patients receiving chemotherapy, the burden of care, their anxiety and depression levels; the caregivers' mean score for unmet needs was reported as  $2.4 \pm 0.39$ , their mean score for health care and information needs as  $2.1 \pm 0.64$ , their mean score for psychological and emotional needs as  $2.6 \pm 0.35$ , and their mean score for work and social needs as  $1.7 \pm 0.67$ . In the same study, it was also reported that the caregivers' mean depression score was  $9.8 \pm 4.05$ , and there was a moderately positive significant relationship between their unmet needs and their level of depression and the burden of care<sup>(10)</sup>. The individuals' depression levels were found to increase with the increase in the burden of care in the present study, and the results reported in previous studies support ours in this regard<sup>(24,25)</sup>. So, it can be asserted that unless the caregivers' needs are met, depressive tendencies increase as a result of the increase in the burden of care and the decrease in coping power<sup>(10)</sup>. The results of the present study support the previous studies in the literature in that a significant relationship was found to exist between BDI and PRNICUS and that depression levels can be decreased by meeting the patients' family members' needs such as assurance and information<sup>(6,12)</sup>.

### Limitations

This study has some limitations. First, the targeted sample could not be reached in the data collection phase due to the onset of the COVID-19 pandemic. Second, the results of the study cannot be generalized because it was carried out in a single center.

### CONCLUSION

In sum, it can be asserted that the ICU patients' relatives' frequency of depressive symptoms increases as their needs are not met. Family members of the patients in intensive care units ask more questions about the medical condition of the patient than those of the patients in other health care units. Moreover, they are more likely to look for sufficient information in terms of decisions and expectations about their patients. Informing family members of patients in the intensive care unit in an understandable way is extremely important in terms of their emotional reactions. During the patients' treatment and care process, their relatives should also be examined in terms of emotional breakdown. Patients' relatives' needs are often not taken into consideration during the patients' admission to ICU, and therefore, they may develop feelings such as fear, anxiety, or curiosity about the process. Ignoring patients' relatives' needs in this regard may cause them to have negative feelings and to be anxious and angry. It should be remembered that if patients' relatives feel neglected, this may undermine their trust in the health care workers and the service provided by them. Therefore, physicians should meet the information needs of the family members of the patients in the intensive care process, and nurses should be aware of the needs of these individuals who experience intense stress and fear and help them cope with the crisis. By this means, they can help patients and their family members be mentally healthier. Moreover, we recommend that future studies be carried out with a larger sample size in order to determine the needs of the family members of the patients in all intensive care units in the region where this study to be carried out.

### Author contribution

Study conception and design: RS, ÇS and FG; data collection: RS, ÇS and FG; analysis and interpretation of results: RS, ÇS and FG; draft manuscript preparation: RS, ÇS and FG. All authors reviewed the results and approved the final version of the manuscript.

### Ethical approval

The study was approved by the Non-Interventional Clinical Research Ethics Committee of Dicle University (Protocol no. 06.02.2020/65) and Batman Regional State Hospital (Protocol no. 20.02.2020/804).

### Funding

The authors declare that the study received no funding.

### Conflict of interest

The authors declare that there is no conflict of interest.

### Yazar katkısı

Araştırma fikri ve tasarımı: RS, ÇS ve FG; veri toplama: RS, ÇS ve FG; sonuçların analizi ve yorumlanması: RS, ÇS ve FG; araştırma metnini hazırlama: RS, ÇS ve FG. Tüm yazarlar araştırma sonuçlarını gözden geçirdi ve araştırmanın son halini onayladı.

### Etik kurul onayı

Bu araştırma için Dicle Üniversitesi Girişimsel Olmayan Klinik Araştırmalar Etik Kurulu ve Batman Eğitim ve Araştırma Hastanesi Etik Kurulundan onay alınmıştır (Karar no: 06.02.2020/65) ve (Karar no: 20.02.2020/804).

### Finansal destek

Yazarlar araştırma için finansal bir destek almadıklarını beyan etmiştir.

### Çıkar çatışması

Yazarlar herhangi bir çıkar çatışması olmadığını beyan etmiştir.

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