



**ERASMUS MUNDUS JOINT MASTER'S DEGREE IN EMERGENCY AND
CRITICAL CARE NURSING (EMJMD NURSING)**

**Counselling support for critically ill patients and their families following a
critical care experience: A qualitative study**

Sharad Rayamajhi

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Sharad Rayamajhi

Author

Dr. Claire Kydonaki

Supervisor





ERASMUS MUNDUS MASTER COURSE IN EMERGENCY AND CRITICAL CARE NURSING

Dr. Claire Kydonaki
PhD, MSc Nursing, BSc Hons, SEDA Recognised Fellow
Lecturer in Adult Nursing, Critical care researcher
Programme Leader MSc Advanced clinical practice
Honorary Senior Research Fellow, City University, London

CERTIFY:

That the master's Thesis submitted by Ms. Sharad Rayamajhi, entitled '**Counselling support for critically ill patients and their families following a critical care experience: A qualitative study**' carried out under our supervision in the Erasmus Mundus Joint Master's Degree in Emergency and Critical Care Nursing, meets the necessary requirements to be approved as a Master's Thesis.

And for the record, and for the relevant purposes, the present certification is issued in Edinburgh in February 2022.

MASTER'S THESIS SUPERVISOR

**Counselling support for critically ill patients and their families following a
critical care experience: A qualitative study**

Sharad Rayamajhi

40513818

A dissertation submitted in partial fulfilment of the requirements of Edinburgh
Napier University for the Erasmus Mundus Joint Master's Degree in Emergency
and Critical Care Nursing

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Abstract

Background

Patients recovering from the critical illness and their family members can suffer significant psychological distress affecting activity of daily living, family relationship, social participation and professional life. There are few initiatives where the psychological interventions were provided to patients and family group which have shown significantly beneficial impact on psychological health. However, there is a limited number of studies that address the psychological needs of patients, family members and bereaved family members with critical care experience.

Objectives

The aim of this study was to explore patients', family members' and bereaved family members' experiences of counselling provision.

Methods

We conducted a qualitative study in three Scottish Intensive care units (ICU) between 2015-2017. Counselling service was provided to former ICU patients and their family members, including those bereaved following a critical illness experience by a qualified, professionally accredited counsellor who had a background in Intensive Care nursing. Participants self-referred to the service. Semi-structured interviews were conducted to explore participants' experience of accessing the counselling service, their expectations and experiences of the counselling sessions, and their recommendations for future development. Thematic analysis was used to analyse the data. Data reporting was done using Consolidated Criteria for reporting qualitative research checklist (COREQ).

Results

All twelve participants (Patients n= 3, Family members n = 7 and Bereaved family members n=2) considered their overall experience of the counselling support positive. Four key themes were identified: perceived benefits, feasibility, appraisal and context of care. Conduit to resilience, enhanced coping, relief through disclosure, maintaining family relationship and individualised support were the main perceived benefits experienced by participants. The nurse-counsellor's counselling expertise and critical care background was appreciated by the

majority of the participants.

Conclusion

In conclusion, the counselling support provided to patients, family members and bereaved family members was considered a feasible and acceptable intervention.

Relevance to future research: A full-scale randomised control trial is required to measure the impact of counselling service on patient and family outcomes.

Keywords: Critical care, counselling, patients, family members, and bereaved family members.

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Abbreviations

AACN = American Association of Critical-Care Nurses

APN = Advance Practice Nurse

BFM = Bereaved family member

CORE = Clinical Outcomes in Routine Evaluation

COREQ = Consolidated criteria for reporting qualitative research

ENU = Edinburgh Napier University

FM = Family member

HADS = Hospital anxiety and depression score

ICU = Intensive care unit

PICS-F = Post intensive care syndrome family

PTSD = Post-Traumatic Stress Disorder

PFCC= Patient and Family-Centred Care

MMAT= Mixed Method Appraisal Tool

PRISMA= Preferred Reporting Items for Systematic Reviews and Meta-Analyses

RCT= Randomised control trial

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Chapter 1

1.1 Introduction

Admission in ICU is usually stressful and affects patients, family members, and the bereaved family members (Fergé et al., 2018; Kleinpell et al., 2018; Tang et al., 2021). Report from the Scottish Intensive Care Society reveals that the annual admission of the patients in Scottish intensive care unit (ICU) is greater than 15,000 (Hall, 2020). Approximately 65% of patients survive to hospital discharge, however discharge is not an endpoint (Rosenberg & Kalhan, 2011). It is increasingly acknowledged that survival is associated with significant burden of psychological morbidity (Hatch et al., 2018) that has been repeatedly identified as a problem (Parker et al., 2015; Nikayin et al., 2016). In this project, a specialist counselling service was offered to patients, family members (FM) and bereaved family members (BFM) with critical care experience and was delivered by a dedicated, professionally accredited counsellor with specialist knowledge of both Intensive Care and psychological sequelae. The intervention was designed and implemented as part of a feasibility study funded by the Edinburgh and Lothian Health Foundation, which aimed to evaluate the impact of the counselling service on psychological outcomes of former critically ill patient, and family members in order to build a business case for implementation in the NHS. The feasibility study used a mixed method design including the exploration of the participants' experiences of using the counselling service and the measurement of psychological outcomes (HADS, CORE10) following the counselling service. This thesis will report only on the exploration of experiences of the participants who used the service.

The subjective experience of the participants towards counselling support has been analysed thematically (Braun & Clarke, 2006) and reported using COREQ guideline (Tong et al., 2007). Future recommendations and implications are suggested at the last section of this

dissertation.

This dissertation is guided by patterns of activities to answer the set objectives. Following this, the second part of this dissertation has revealed the evidence and literature to explore the current practices in relation to psychological interventions and its impact to address psychological health of patients and family group with ICU experience. The third part explains in detail about the methodology and approaches used to analyse data. Additionally, the fourth chapter entails the detailed perspective of the participants towards counselling support which was analysed thematically. Furthermore, the fifth chapter discusses the findings in view of the contemporary literature to show commonalities and differences. Finally, the conclusions were made based on the discussion for future implementation in practice and research recommendations. Also, the supporting figures, tables and notes are presented in the appendices.

1.2 Background

Apart from the ICU admissions, there are multiple studies which reported upon the prevalence of the psychological morbidity in patients, FMs and BFMs. For instance, a prospective longitudinal study conducted in USA by Petrinec & Martin, (2018) revealed that 45.8%, 25% and 11.1% of FMs with critical care experience reported anxiety, depression and Post Intensive Care Syndrome-Family (PICS-F), respectively. Similarly, 54% of family members showed Post-Traumatic Stress Disorder (PTSD) after critical care experience (Alfheim et al., 2019). In a study by Hatch et al., (2018) it was revealed that 46%, 40% and 22% of the survivors of ICU in the UK suffered from anxiety, depression and PTSD respectively. Likewise, there are reports showing psychiatric morbidity such as long term social distress of requiring professional help, complicated grief and PTSD (Anderson et al., 2008; Jones et al., 2018; Pattison et al., 2020) among the FMs whose relative died in ICU.

However, there doesn't exist a robust evidence-based practice to address the consequences of the ICU admission on psychological morbidity.

1.3. Rationale for the Study

Few available supportive services

Over the past decades, there has been a number of studies that have detailed the psychological morbidity of the patients (Petrinec & Martin, 2018; Rabiee et al., 2016) and FMs (Abdul Halain et al., 2021; Anderson et al., 2008). In addition, it has been identified that approximately one third of patients required referral for psychological support, and the support services were rarely available or had significant waiting list (Hatch et al., 2018). Although the benchmarking of nurse led counselling in ICU was introduced in 2005 by using two nurse counsellors (Christina Jones et al., 2008), there are no reported evidence on the effect of counselling intervention on patients and FMs and continuation of such services. In recent years, some of the initiatives such as ICU diary (Blair et al., 2017; Schofield et al., 2021), discharge summary (Castillo et al., 2020), and home based rehabilitation (Elliott et al., 2011) has been introduced to address the psychological health of patients and family group. In comparison with those approaches there are very few approaches based on psychological interventions (Erikson et al., 2019; Wade et al., 2015; White et al., 2018). On the top of that, those interventions are found to be used as a multicomponent approach with other support programs such as family support (Naef et al., 2021), bereavement support (Casey Jones et al., 2018), and relaxation and recovery program (Wade et al., 2018).

Reported benefits of psychological support on patients, FMs and BFMs

There are reported evidence on the benefits of psychological support to other patient populations such as cancer patients (Beesley et al., 2020) , patients with long-term illness

(Thabrew et al., 2018) and cardiac patients (Richards et al., 2017); however there remains few studies showing the impact of psychological interventions to ICU patients' outcomes. Meanwhile, looking at the research on psychosocial interventions among FMs and BFMs also provides generally positive evidence of the alleviation of psychological distress, improved quality of life and enhanced coping (Erikson et al., 2019; Naef et al., 2020; White et al., 2018). A qualitative study carried out by Beesley et al., (2020) described the impact of counselling on FMs of cancer patients and the outcome was that the FMs reported of getting emotional and individualised support. However, currently there is little evidence of impact of counselling intervention on critical care population. We would like to find out if psychological support, in the form of counselling, would be helpful for former ICU patients and their FMs.

Benefits of nurse-led initiative on patients and family group

Nurses are considered the bridge informant between the patients and FMs (Ghiyasvandian et al., 2014). When it is specifically about the involvement of person on delivery of intervention, various studies showed the initiatives of nurse led psychological interventions (Naef et al., 2021; Wade et al., 2018; White et al., 2018) had positive impact. For example, a quasi-experimental study by Naef et al., (2021) implemented the nurse-led psychoeducational intervention to FMs of ICU which demonstrated that the intervention was positively associated with their satisfaction and wellbeing. Understanding the unfamiliar environment, easy-to-understand information, and having a knowledgeable information presenter help to decrease FMs emotional vulnerability and lead to a feeling of being cared for and less stressed (McCallum et al., 2018). Thus, in this study a qualified nurse with critical care background was chosen to provide counselling session to find out the impact of nurse-led

intervention on the study group.

1.4 Research question

A **PICO** framework (Santos et al., 2007) was used to foreground the questions for this study which stands for broad **P**opulation - **I**ntervention - **C**omparison – **O**utcome (PICO). PICO helps to formulate the search strategy in order to recognise the key ideas that needs to be searched and to have precise results.

The PICO elements with relation to this study are mentioned in the table below: -

Table 2.1 PICO framework for research questions

S. N	PICO abbreviation	Context of this review
1	P atient / p opulation / p roblem	<ul style="list-style-type: none"> - Patients - Family members - Bereaved family members Having critical care experience of more than or equal to 24 hours
2	I ntervention	Counselling support.
3	C omparison (optional)	With usual care in ICU.
4	O utcome	Psychological outcomes, wellbeing, quality of life, and satisfaction.

Based on the PICO framework, the research question is outlined below: -

- a. What is the impact of a counselling intervention on psychological distress of patients, family members and bereaved family members post critical care experience?
- b. Is the counselling support feasible and acceptable to patients, family members and bereaved family members?

1.5 Aim of the study

To explore patients, family members and bereaved family members experiences of counselling provision.

1.6 Operational definition

Counselling support: - It is the provision of professional support and guidance in solving the personal or psychological problems delivered by a qualified, professionally accredited counsellor who had a background in Intensive Care nursing.

Patients: - Individual admitted in one of the Scottish ICUs for 24 hours or more and received counselling support.

Family members: - Family members whose relative was admitted in ICU for 24 hours or more and received counselling support.

Bereaved family members: - Family members of deceased patients who were admitted in ICU for 24 hours or more and received counselling support.

1.7 Theoretical framework

In our study, the intervention counselling support was based on concept of patient-family-centred care (PFCC) approach. PFCC is an approach to planning, delivering, and evaluating health care supported in mutually beneficial partnerships among patients, families, and health care workers (Frakking et al., 2020). A PFCC is also recommended as the best theoretical model for patient and family care in ICUs by key critical care organizations such as the American Association of Critical Care Nurses (AACN, 2016) and the Institute For PFCC (PFCC, 2015) and Australian Critical Care Society (ACCS) (Mitchell & Aitken, 2017). Thus, to deliver the person centered care with an aim to have optimal outcome in their wellbeing, counselling sessions were coordinated and tailored according to need of patient, FM and BFM by a nurse counsellor in our study.

Chapter 2: - Literature review

2.1 Introduction

Critical care experience is stressful to patients as well as their family members. It is identified as ‘a dark vortex’ in a study by Di Gangi et al., (2013) meaning that having possible fears of either dying or having an impaired quality of life causing stressful environment to the patient and family members. A multicentre survey revealed that over half of the former ICU patients in UK, report symptoms of psychological disorder (Hatch et al., 2018). There is a growing awareness of psychological comorbidities following a critical care experience on patients (Hatch et al., 2018; Parker et al., 2015) , FMs (Fumis et al., 2015; Stefan et al., 2017) and BFMs (McAdam & Puntillo, 2018) with a need for psychological support for both patients and family groups (Harlan et al., 2020; Niecke et al., 2020). There are variety of post ICU support interventions to address psychological morbidity such as, ICU follow-up services (Jónasdóttir et al., 2016), ICU diaries (Parker et al., 2015), home based rehabilitation (Elliott et al., 2011) and support programs (Teixeira & Rosa, 2018) to the individuals with critical care experience. As explained on chapter one, there are also reported benefits of psychological support on patients, FMs and BFMs. However, standard evidence-based approach in relation to psychological intervention to address the psychological recovery of the patients and FMs and BFMs remains still under-explored.

As part of this dissertation, it was important to conduct a literature review in order to critically appraise the evidence and understand further the impact of psychological interventions including counselling support on patients, FMs and the BFMs after their critical care experience. The following part of this paper explores the methodology, findings, and discussion of the review and critical synthesis of the evidence.

2.2 Research questions

In literature review, the PEO framework (Bettany et al., 2012) was used to foreground the questions which stands for broad **P**opulation – **E**xposure – **O**utcome (PEO). PEO helps to formulate the search strategy by identifying the key concepts that need to be searched that can answer the question.

The PEO elements with relation to this study are mentioned in the table below: -

Table 3.1 PEO framework to develop research question (literature review)

S. N	PEO abbreviation	Context of this review
1	P atient / p opulation / p roblem	<ul style="list-style-type: none"> - Patients - Family members - Bereaved family members Having critical care experience of more than or equal to 24 hours
2	E xposure	Psychological interventions OR counselling support.
4	O utcome	Psychological outcomes, wellbeing, quality of life, and satisfaction

Based on the PEO framework, the research questions are outlined below.

1. What is the evidence of the impact of psychological interventions post intensive care experience on patients, FMs and BFMs?
2. What is the evidence of counselling as an intervention to reduce psychological distress of patients, FMs and BFMs post a critical care experience?

2.3 Methods

While searching the studies, it was found that counselling or nurse-led counselling is not widely used in practice; therefore, a broad search was conducted by expanding inclusion and

exclusion criteria related to psychological interventions OR counselling support for the patients, FMs and BFMs after critical care experience. The retrieved studies were heterogenous in their design; hence, it was considered to conduct an integrative review where experimental and non-experimental studies are included and reviewed (Hopia et al., 2016).

2.3.1 Search Strategy

The search strategy was intended to explore available published studies with full text between January 2011 to November 2021. A comprehensive search strategy was undertaken by using the databases PubMed, CINAHL, APA psycinfo, and ProQuest and search engines such as google scholar and Edinburgh Napier University library followed by an analysis of the text word contained in Title/abstracts (Appendix 1). Also, the search was undertaken by combining free words and indexed with Boolean operators like ‘OR’ and ‘AND’ (Table 2.2). Thesaurus, medical subject headings (MeSH) and truncated terms were used where appropriate. The use of MeSH allows to search common themes and concept in systematic manner (Dai et al., 2020). The search results were uploaded in the reference manager Endnote version 20 and checked for screening.

Keyword selection

The following table represents the similar Keywords generated using thesaurus and Medical Subject headings (MeSH).

Table 2.2 keywords selection

Counselling	Patients	Family	Bereaved relatives	Intensive care unit
Psychological support, counselling, counseling, counsellor*, ‘‘psychological	Patient*	Relatives, family members, family	Bereaved	ICU, Intensive care unit, critical care

intervention''				
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2.3.2 Selection criteria

The selection of the studies was based on the broad **Population - Intervention - Comparison – Outcome (PICO)** framework recommended by Santos et al., (2007). In addition, pragmatic approach was considered while selecting the articles such as availability, age of participants, language and date of publications as illustrated in table 2.3.

Table 2.3 Inclusion and exclusion criteria for literature review

	Inclusion Criteria	Exclusion criteria
Population	<ul style="list-style-type: none"> - Patients - Family members - Bereaved family members Having critical care experience of more than or equal to 24 hours.	-Health care professionals. -Patients, family and bereaved relatives less than 24 hours of critical care experience or no critical care experience.
Intervention	Studies with interventions as counselling support during or after critical care experience. Studies with intervention with any type of psychological support during or after critical care experience.	-Studies having intervention not related to psychological support.
Comparison (optional)	Comparison with usual care in intensive care unit.	Comparison not in intensive care units care.
Outcomes	Outcomes related to psychological health of the patients, family or bereaved family members such as:- psychological distress, anxiety, depression, quality of life, satisfaction and wellbeing.	Outcomes relating to measurement of knowledge or perception of the participants.
Year of publication	Articles published between 2011 to 2021.	Articles published before 2011.
Language	English or translated in English	Other than English
Availability	Full text articles	Articles with only abstract or heading.
Type of study	Qualitative, quantitative and mixed methods studies	Grey literatures
Age group of participants	Adults more than 18 years	Less than 18 years

2.4 Results

2.4.1 Data Extraction

The whole process of selection of relevant articles is demonstrated on the ‘Preferred Reporting Items for Systematic Reviews and Meta-analysis’ (PRISMA) flowchart (Yepes-Nuñez et al., 2021) on Figure 2.1. Finally seven studies were included whose data extraction was done following the Cochrane database of systematic reviews guidelines which included the tabular presentation with details of author, year of publication, setting, design, sample, participants demographics, intervention, methodology, key findings and MMAT critical assessment (Noyes et al., 2018). The data extraction table was reviewed by supervisor in order for the check the accuracy of the study characteristics.

2.4.2 Quality appraisal

The studies were critically appraised on the basis of Mix Method Appraisal Tool (MMAT) version 2018 (Hong et al., 2018). The MMAT tool is valid and reliable tool that allows a detailed presentation of the ratings of each section of study and permits the methodological appraisal of the studies. The ratings of the study were varied from moderate to strong and no study were excluded based on MMAT rating.

2.4.3 Study characteristics

The included studies were heterogenous in nature such as two were cluster randomised control trial (Wade et al., 2019; White et al., 2018), one was before and after study (Naef et al., 2021), two were qualitative (Erikson et al., 2019; Naef et al., 2020), one was quantitative (Peris et al., 2011), and one was mixed study (Wade et al., 2018). All the studied were carried

out in high income countries where two were from UK (Wade et al., 2018; Wade et al., 2019) one from USA (Erikson et al., 2019; White et al., 2018), two from Switzerland (Naef et al., 2020; Naef et al., 2021) and one from Italy (Peris et al., 2011). In all studies, the psychological interventions were implemented as multicomponent approach which are detailed in finding section of this review. The characteristics of the studies included in this review are detailed in the following table 2.4.

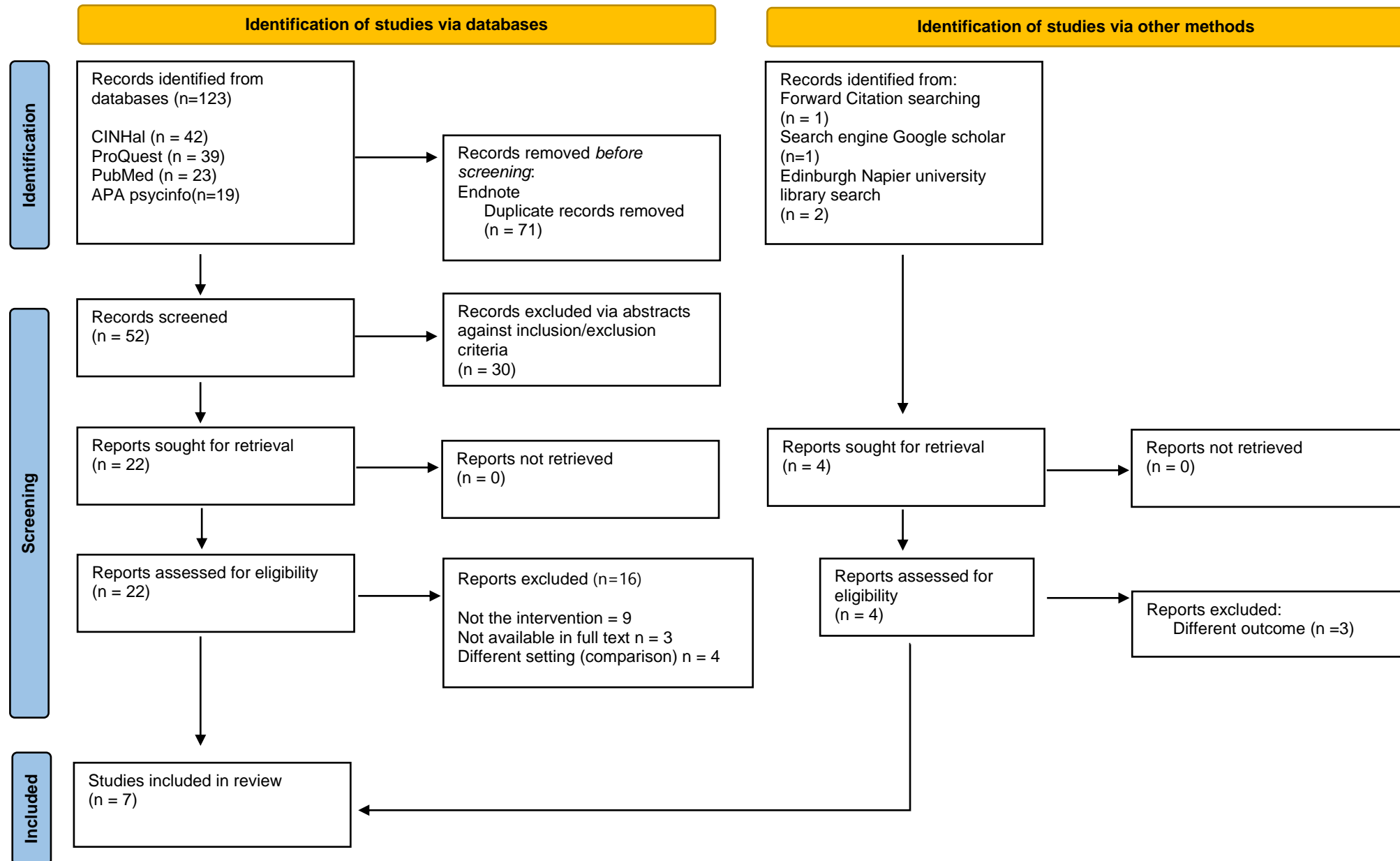


Figure 2.1 Prisma Flow diagram

Table 2.4 Data extraction table

Citation/place of study	Design	Aims/objectives	Participants	Sampling strategy/setting	Measures/analysis	Intervention/Exposure	Findings	Overall rating
(Naef et al., 2021) Impact of a nurse-led family support intervention on family members' satisfaction with intensive care and psychological wellbeing. Place: - Zurich Switzerland	Quasi experimental before and after observational study.	To examine the effect of an advanced practice nurse-led family support intervention on family members' satisfaction, wellbeing, and psychological distress.	Family members including bereaved relatives more than 18 years age with having critical care experience Control group N=139 Intervention group N=75 Qualitative N=19	Consecutive sampling strategy. Swiss University Hospital.	Quantitative: - Family satisfaction in ICU -24 survey, Hospital anxiety and depression score (HADS) and impact of event scale-revised -6, Advanced Practice Nurse Care Quality Questionnaire, intervention log and demographics. Data analysis: - Logistic regression analysis Descriptive statistics Qualitative Family members perception of intervention's impact on their wellbeing via Semi structured interview. Data analysis: - Inductive content analysis	Engagement with family, family assessment, psychoeducational intervention , relationship focused intervention, transition and follow up support and liaison and coordination activities. by certified advance practice nurse.	Quantitative The intervention was significant for depression (HADS-D differed by 1.706, 95% CI from 0.16 to 3.25, p ¼ 0.03) and nonsignificant for overall psychological distress (HADS total differed by 2.202, 95% CI from -0.66 to 5.07, p ¼ 0.13), anxiety (HADS-A differed by 0.463, 95% CI from -1.15 to 2.08, p ¼ 0.57), and post-traumatic stress (IES-R-6 differed by 0.965, 95% CI from -0.75 to 2.68, p ¼ 0.27). A positive association between APN intervention quality (APN-BQ) and family satisfaction with ICU care. negative association between the APN-BQ score and depression (HADS depression). Qualitative themes Feeling cared for, well informed, better to cope. Integrated finding Family members experience a nurse-led support intervention as beneficial for their wellbeing. It increased their satisfaction, but was unable to demonstrate a favourable impact on psychological distress.	Strong

Citation/place of study	Design	Aims/objectives	Participants	Sampling strategy/setting	Measures /analysis	Intervention/Exposure	Findings	Overall rating
<p>(Wade et al., 2019)</p> <p>Effect of a Nurse-Led Preventive Psychological Intervention on Symptoms of Posttraumatic Stress Disorder among Critically Ill Patients: A Randomized Clinical Trial.</p> <p>Place: - United kingdom</p>	Cluster randomized clinical trial	To determine whether a nurse-led preventive, complex psychological intervention, initiated in the ICU, reduces patient-reported PTSD symptom severity at 6months.	<p>Critically ill patients</p> <p>Number of participants = 1458 (control = 669, Intervention = 789)</p> <p>Number of ICU 24</p>	<p>Randomised sampling</p> <p>24 ICUs in United Kingdom</p>	<p>Randomization of ICU; Control: Intervention 1:1.</p> <p>After six-month PTSD measures via PTSD Symptom Self-Report questionnaire.</p> <p>Data analysis: - Hussey and Hughes method, Jacobson and Truax method, linear mix models and descriptive statistics</p>	Nurse led psychological intervention.	<p>At 6 months, the mean PTSD Symptom Scale–Self-Report questionnaire score in intervention ICUs was 11.8 (Baseline period) compared with 11.5 (intervention period) (difference, -0.40 [95%CI, -2.46 to 1.67]) and in control ICUs, 10.1 (baseline period) compared with 10.2 (intervention period) (Difference, 0.06 [95%CI, -1.74 to 1.85]) between periods. There was no significant difference in PTSD symptom severity at 6 months (treatment effect estimate [difference in differences] of -0.03 [95%CI, -2.58 to 2.52]; $P = .98$).</p> <p>Among critically ill patients in the ICU, a nurse-led preventive, complex psychological intervention did not significantly reduce patient-reported PTSD symptom severity at 6months.</p>	Strong
<p>(Wade et al., 2018)</p> <p>Providing psychological support to people in intensive care: Development</p>	Mixed method studies	To develop and test the feasibility of a psychological intervention to reduce acute stress and prevent future morbidity.	Patients admitted in critical care unit (n = 127)	<p>Randomised sampling</p> <p>Setting 4 general adult critical care units</p>	Mixed method Phase 1: - Development of model of Nurse-led Provision of Psychological Support to people in Intensive care (POPPI)	Nurse-led Provision of Psychological Support to people in Intensive care (POPPI) which included: Creating	Overall: 93 %; helped express fears : 93 %; nurse understanding: 100 %; nurse normalised fears: 100 %; fewer stressful thoughts: 87 % ; fewer stressful feelings : 80 %; number/duration of sessions: 80%	Strong

and feasibility study of a nurse-led intervention to prevent acute stress and long-term morbidity. Place: - United Kingdom.				in UK	Phase 2- Deliver psychological intervention to patients, analyse the process and procedure for feasibility and piloting. Patient satisfaction with stress support sessions (% with 4 or 5 (0-5) or 'good')	therapeutic environment, identification of patients with the stress, deliver a stress support session and a relaxation and recovery program to patients.	Patient qualitative feedback:- Stress support from nurses was very helpful. The 'POPPI' psychological intervention to reduce acute patient stress in critical care and prevent future psychological morbidity was feasible and acceptable.	
Citation/place of study	Design	Aims/objectives	Participants	Sampling strategy/setting	Measures and analysis	Intervention/Exposure	Findings	Overall rating
(Peris et al., 2011) Early intra-intensive care unit psychological intervention promotes recovery from post-traumatic stress disorders, anxiety and depression symptoms in critically ill patients Place: - Florence, Italy	Quantitative study	To determine whether intra-ICU clinical psychologist interventions decrease the prevalence of anxiety, depression and post traumatic disorder after 12 months from ICU discharge.	Patients admitted in ICU (N = 209) Control group= 86 Intervention group = 123	Purposive sampling Setting ICU	Quantitative Observational Interventions delivered during ICU admission 12 month follow up conducted by the trained nurses. Students t-test Mann-Whitney U test Fisher exact test	"Psychological intervention" That includes provision of emotional support and coping strategies. People involved: - Clinical psychologist and a trained and supervised staff of intensivists and nurses.	Patients in the intervention group showed lower rates of anxiety (8.9% vs. 17.4%) and depression (6.5% vs. 12.8%) than the control group on the basis of HADS scores. High risk for PTSD lower in patients receiving early clinical psychologist support than in the control group (21.1% vs. 57%; P < 0.0001) Early intra-ICU clinical psychologist Intervention may help critically ill trauma patients recover from this stressful experience.	Moderate

Citation/place of study	Design	Aims/objectives	Participants	Sampling strategy/setting	Measures/analysis	Intervention/Exposure	Findings	Overall rating
<p>(Naef et al., 2020)</p> <p>Family and health professional experience with a nurse-led family support intervention in ICU: A qualitative evaluation study</p> <p>Place: - Switzerland</p>	Qualitative evaluation study	To investigate family and health professional experience with a nurse-led family support intervention in intensive care	Family members ($n = 19$); health professionals ($n = 19$)	Purposive sampling	<p>Qualitative Semi structured evaluative interviews</p> <p>Data analysis Inductive content analysis</p>	<p>APN-delivered family support Delivery: Advanced practice nurse</p> <p>Includes psychosocial education</p>	<p>Themes</p> <ul style="list-style-type: none"> -A valuable, essential part of ICU care -Promoting quality of family care -Enabling ICU staff to better care for families -A person who facilitates staff-family interaction and communication <p>The intervention was valuable, essential part of ICU care; the APN was experienced as one who facilitates staff-family interaction and communication, promoting quality of family care.</p>	Moderate
<p>(White et al., 2018)</p> <p>A Randomized Trial of a Family-Support Intervention in Intensive Care Units.</p> <p>Place: - USA</p>	Multicentre, stepped-wedge cluster-randomized trial	To compare a multicomponent family-support intervention delivered by the interprofessional ICU team with usual care.	<p>Surrogates (intervention group $n = 308$; control group $n = 501$; ($N = 807$))</p> <p>patients intervention group $n = 547$;</p>	Randomized sampling. 5 ICUs in USA	<p>Baseline data collected</p> <p>Interventions delivered simultaneously</p> <p>After six months of intervention and critical care experience follow up and data collection was done. HADS measured</p>	<p>Nurse-driven emotional support and relationship building paired with re-engineered ICU teams. Delivery: interprofessional ICU team</p>	<p>There was no significant difference in the surrogates' mean anxiety, depression, and clinician-family communication.</p> <p>Whilst the intervention had a small effect size on the surrogates' quality of communication (<i>Hedges' g</i> = 0.27) as was the effect on the perceived patient-centeredness of care (<i>Hedges' g</i> = 0.23). The mean length of stay in the ICU was shortened by 0.7 days.</p>	Moderate

Citation/place of study	Design	Aims/objectives	Participants	Sampling strategy/setting	Measures/analysis	Intervention/Exposure	Findings	Overall rating
(Erikson et al., 2019) Family members' opinions about bereavement care after cardiac intensive care unit patients' deaths. Place: - USA	Qualitative study	To describe cardiac intensive care unit patients' families' opinions on six common components of a bereavement programme.	Bereaved family member =12	16 bed cardiac ICU USA	Qualitative study Six components of bereavement program were delivered following the death of their relatives Semi structured interview Data analysis: - Qualitative descriptive techniques	Intervention: - Six components of bereavement program were delivered: - bereavement brochure, follow-up, follow-up phone call, memory box, Counselling and memorial service.	Bereavement brochure, follow-up, follow-up phone call, memory box, Counselling and memorial service, and overall support was positive. Many participants favoured unit offering counselling services because they found therapy helpful in their grieving process.	Moderate

2.4.4 Findings

After the critical analysis of the included studies the findings of the articles are reported into three broad headings such as demographics, psychological interventions and outcomes.

Demographics consists of the characteristics of the studies which include the age group of participants, setting of the study, methodology used and ICU experience of participants of all included studies. The psychological interventions explain in detail about the types of psychological interventions used in all of the considered studies. Finally, the outcomes section entails the impact of the interventions on the population group.

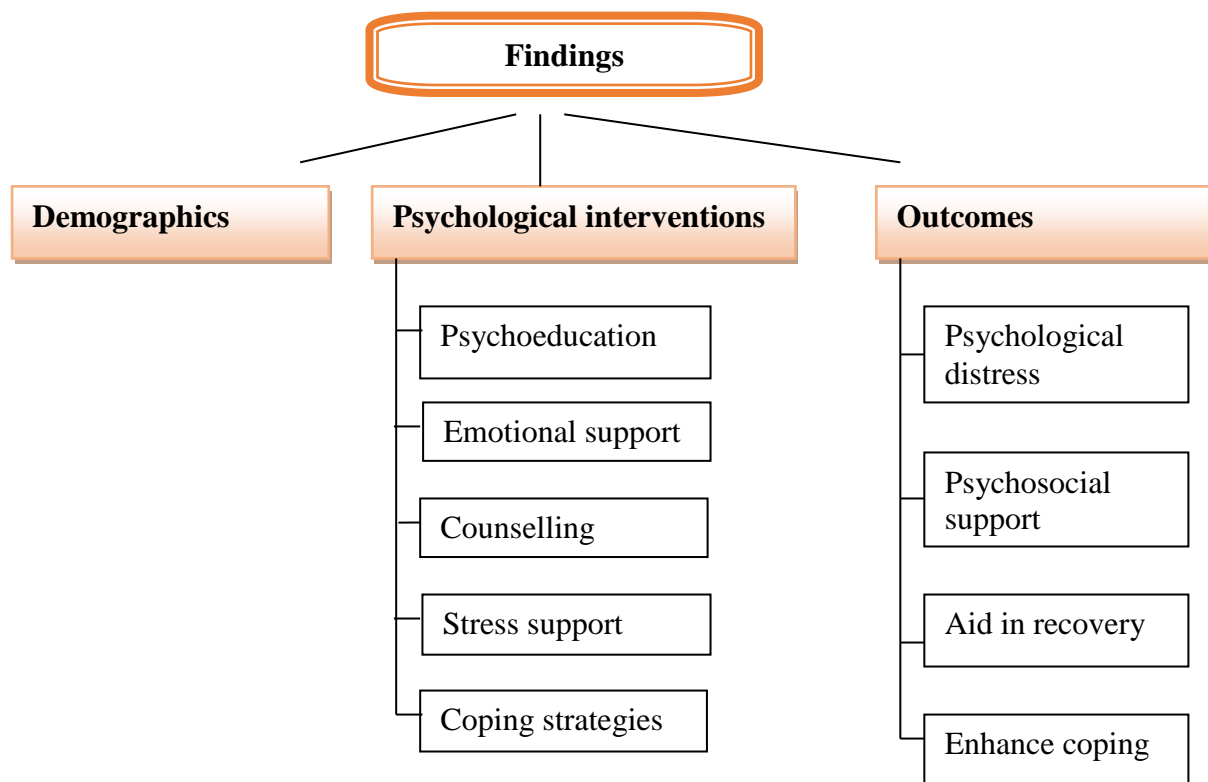


Figure 2.2 Findings of literature review

Demographics

The reviewed articles included the patients, FMs and BFMs as participants making it a total of 4237. Among these the number of patients and family group was 3229 and 1073 respectively. All of the participants were more than 18 years of age with critical care experience minimum of 24 hours. The following table represents the demographics of the studies which were included in this review.

Table 2.5 Demographic characteristics of review articles

S N		Number of participants		Age	Critical care experience	Participants
		Quantitative	Qualitative			
1	(Wade et al., 2019)	1458		>18 years	>24hours	Patients
2	(White et al., 2018)	Surrogates (Family members or relatives) N= 809 Patients N=1420		>18 years	≥24hours	Patients and Surrogates (Family members or relatives)
3	(Peris et al., 2011)	209		>18 years	>24 hours	Patients
4	(Naef et al., 2020)		19	>18 years	>24 hours	Family members and bereaved family members
5	(Erikson et al., 2019)		12	>18 years	≥24hours	Bereaved family members
6	(Wade et al., 2018)	127	15	>18 years	>24hours	Patients
7	Naef et al., 2021)	214	19	>18 years	>24hours	Family members and bereaved family members
Total		4237	65			

Psychological interventions

All of the considered studies implemented the psychological interventions however the approaches and delivery strategies were different. For instance, form of intervention was emotional support to patients and FMs in study by White et al., (2018) and the counselling support to the BFMs in study by Erikson et al., (2019). Furthermore, the psychosocial education was delivered to FMs and bereaved BFMs in the form of nurse- led support by Advance Nurse Practitioner (APN) in two consecutive studies by Naef et al., (2020) and Naef et al., (2021). Among all the included studies, Peris et al., (2011) was only the study in this review which provided the only forms of psychological interventions such as psychological supports and education on coping strategies to patients in a mixed Italian ICU. This study was single-centre observational study where interventions were delivered by the clinical psychologists. Additionally, Wade et al., (2018) and Wade et al., (2019) used the nurse led psychological support intervention that included stress support and relaxation along with other support components to the patients with critical care experience. The latter one Wade et al.,(2019) was the cluster RCT done after testing the feasibility of the intervention (Wade et al., 2018). Although all the considered studies included the psychological interventions to address the psychological symptoms of the patients and family groups however, except for one , Peris et al., (2011) all the other studies bundled the intervention with other types of interventions.

Outcomes

Included studies illustrated that there is diverse impacts on the psychological health of patients , FMs and BFMs having critical care experience with the psychological

interventions. Four themes were originated by analysing the overall impact of the psychological interventions which are detailed below.

Psychological distress

This theme explains the impact of the various forms of psychological support on the psychological distress of the patients and family group. The Italian study by Peris et al., (2011) showed that an early intra-ICU clinical psychologist delivered psychological intervention resulted in lower rates of anxiety in the intervention group (8.9%) vs. the control group (17.4%) and depression (6.5% vs. 12.8%) using the HADS score among patients. For FMs and BFMs, it was demonstrated that the psychoeducational intervention delivered had no significant impact on psychological distress, anxiety, and PTSD (Naef et al., 2021). In line with this, there was an interesting finding from a multi-center cluster RCT study by White et al., (2018) where they compared multicomponent family support intervention that included emotional support as psychological intervention which was delivered by interprofessional ICU team. In their result they reported that the intervention has shortened the length of stay of patient in ICU but there was no significant difference in the family members mean anxiety, depression and clinician-family intervention. Furthermore, a cluster RCT done in UK also revealed that the patient reported PTSD symptoms and severity at 6 months was unaffected (difference -0.03 [95%CI, -2.58 to 2.52]; $P = .98$) by the nurse led psychological intervention among critically ill patients (Wade et al., 2019).

Aid in recovery

Outcomes by facilitating the recovery of patients and family group in relation to psychosocial support are explained in this theme. There was positive attitude expressed by the BFMs

towards the counselling support they received after loss of their close ones (Erikson et al., 2019). They found it helpful in their grieving process to have space to talk and vent out the stress. Furthermore, a multicentre cluster RCT revealed that the patients' acute stress was reduced by the nurse led psychological intervention (Wade et al., 2018). In one of the before and after observational study, FMs including BFMs expressed that the nurse-led family support intervention made them feel cared for and well informed (Naef et al., 2021). Also, they appreciated that the intervention was beneficial for their wellbeing and family satisfaction. Likewise, similar intervention delivered in a qualitative survey by Naef et al., (2020) elicited the experience of the FMs and they found it helpful in promoting quality of family care and facilitating staff family interaction.

Enhance coping

Coping is an ability to deal with and make an effort to overcome difficulties and thoughts to manage internal and external stressful situations (Stroebe & Schut, 1999). In this review there were studies in which participants found the psychological support interventions helpful in enhancing their coping. For example, family members including the bereaved family members found the psychoeducational intervention helpful in boosting coping ability to deal with the stress caused by critical care experience (Naef et al., 2021). They expressed that they felt more in control of the situation and capable to seek and get support that helped them deal with their trauma. Likewise, another study where the BFMs found the counselling service that was delivered as part of the bereavement support helpful in coping with their grieving process and accomplish mental health and wellness goals (Erikson et al., 2019). On other hand, from the perspective of patients, nurse led psychological support was helpful in relieving the stress and facilitating in maintaining their mental wellbeing (Wade et al., 2018).

Table 2.6 key findings of literature review

Intervention(Author)	Outcomes investigated	Comparision of outcomes after the intervention		
		Improved	Remained unchanged	Deteriorated
(Wade et al., 2019) Nurse led psychological intervention	Patient-reported PTSD symptom severity at 6months		✓	
(Wade et al., 2018) Nurse led psychological intervention	Acute stress in patients.	✓		
(Naef et al., 2021) Psychoeducational intervention along with other interventions	Family members'(including bereaved family members) satisfaction, wellbeing, and psychological distress (HADS)			
	Psychological distress		✓	
	Anxiety		✓	
	PTSD		✓	
	Family satisfaction	✓		
	Coping	✓		
(Peris et al., 2011) 'Psychological intervention' That includes provision of emotional support and coping strategies	Patients Anxiety depression and PTSD after 12 months (HADS).			
	Anxiety	✓		
	Depression	✓		
	PTSD	✓		
(Erikson et al., 2019) Counselling along with other support	Bereaved family members			
	Opinions of support programs			
	Grieving process	✓		

(Naef et al., 2020)	Family members			
APN-delivered family support Delivery: Advanced practice nurse	Experience with the interventions.			
	Positive experience	✓		
	Quality of family care	✓		
(White et al., 2018)	Long term psychological distress(anxiety and depression at 6 months) (HADS)		✓	

2.5 Discussion of the finding

There are plenty of studies showing the incidences of psychological trauma caused by critical illness (Hatch et al., 2018; Nikayin et al., 2016; Pattison et al., 2020). However, there is dearth of literature measuring the long-term trauma and confounding factors that may result in psychological morbidity following discharge from ICU. Thus, it is difficult to capture the evidence of the psychological morbidity following critical care experience.

This review revealed the evidence of psychological approaches to address the psychological morbidity of the patients, FMs and BFMs. The majority of the studies which included nurse-led interventions also had positive impact on psychological health of the participants such as improved wellbeing and coping mechanism in FMs and BFMs (Naef et al., 2021), decreased stress in patients (Wade et al., 2018) and promotion of quality of family care among family members (Naef et al., 2020). As it is also considered that the nurse patient relationships affect the health-related outcome of the patient (Karam et al., 2021), the use of a nurse led approach might have contributed in having a positive outcome in the patients since the nurse is the one who is more in contact with the patients and their family members. Unlikely, there were non

significant effects on long term psychological health of the patients (Wade et al., 2019), FMs and BFMs (Naef et al., 2021; White et al., 2018) from the interventions such as nurse-led psychological and psychoeducational intervention. Thus, it is possible to argue that the use of short term psychological intervention provided in these studies might have resulted in causing no impact on longterm psychological morbidity.

However, positive impacts of psychological interventions outweigh the negative ones because the majority of the participants reported the beneficial aspect of the intervention on their mental wellbeing. Therefore, overall these studies support the view that psychological interventions play an important role in improving mentalhealth and wellbeing of patients and families. Although there are different outcomes reported in different studies, those outcomes cannot be considered as a result psychological intervention solely because all the psychological interventions are delivered in combination with other support. Due to this reason the exact impact of the psychological intervention remains vague.

There are reported evidence on the benefits of psychological support in the form of counselling to other patient populations such as cancer patients (Beesley et al., 2020). In context of critical care, benchmarking of nurse led counselling in ICU was introduced in 2005 by using two nurse counsellors (Christina Jones et al., 2008), however there are no reported evidence on the effect of counselling intervention on patients and FMs and continuation of such service.

Limitation of the review

The primary limitation of the study would be the search strategy which might have resulted in the exclusion of potentially relevant articles. The other limitation is mainly linked to the search strategy which might have resulted in elimination of possibly relevant studies. The

main weakness, however are heterogeneity of the studies, deficiencies in the study methodology and low number of studies. Majority of the studies were conducted in a single setting, with inadequate information on their usual practice hence there might be generalisability bias. We were unable to include the studies written in languages other than English due to lack of translation provision within the study resource. This may have introduced the selection bias. The strict inclusion criteria for the publication dates of the articles might have resulted in missing of important articles. In this review, the number of BFM and FM are relatively low thus it is possible that the findings did not capture the full range of experience. Although the studies included the large group of participants including the multicentre studies but setting of the study was limited to developed country only.

Gap in Literature

Since the studies comprised of psychological interventions which are delivered in combination with other forms of support thus the robust evidence of accurate impact of the psychological support might be confounded with the impact from other support interventions. To the researcher's knowledge, no study was found to have examined the impact of sole counselling support intervention delivered to patients, FMs and BFMs with critical care experience. Counselling is the art of provision of professional support and guidance in solving personal or psychological problems that would help person to deal with mental trauma (McLeod, 2013). Hence this study will be carried out to analyse the impact of counselling provision on patients, FMs and BFMs. Only one study has demonstrated the before and after analysis of the measures of psychological distress to patients and family members, but no other studies have measured the baseline psychological distress. There is a greater acknowledgement that both quantitative and qualitative evidence can be combined in

a mixed synthesis which can be helpful providing the robust evidence on particular intervention (Noyes et al., 2019) and can offer a better understanding of the connection between theory and empirical findings (Östlund et al., 2011). However, in this review only three studies were mixed method studies.

2.6 Conclusion

In this review, we explored the variety of psychological interventions with their impact on patients, FMs and BFMs. Although majority of studies showed the positive impact on their psychological health however the use of psychological intervention as a multicomponent approach resulted in lack of identifying robust evidence on exact impact of psychological support. Therefore, as a part of this dissertation we would like to find out if psychological support, in the form of counselling, would be helpful for former ICU patients and their FMs.

Chapter 3 - Research methodology

3.1 Introduction

This chapter of the study deals with the approaches carried out to evaluate the study. This section explains the research design, nature, sampling techniques and inclusion/exclusion criteria of participants for the study. In similar way, details of the setting of the study, data collection procedures, instruments used for data collection are also provided. Furthermore, the details of data analysis and ethical considerations are given for qualitative methods.

3.2 Design

This study is a prospective pilot study of a counselling service for ICU patients and their family members, including those bereaved during the ICU or subsequent hospital stay. A qualitative approach was implemented to meet the aims of this study. The intervention was designed and implemented as part of a feasibility study funded by the Edinburgh and Lothian Health Foundation, which aimed to evaluate the impact of the counselling service on psychological outcomes of former critically ill patient, and family members in order to build a business case for implementation in the NHS. This thesis will report only on the exploration of experiences of the participants who used the service using a qualitative approach. The primary and secondary endpoint of the study are mentioned below: -

Primary and secondary endpoints

Primary: Six weeks after the final counselling session

Secondary: Twelve weeks after the final counselling session

3.3 Participants

The participants of the study were the patients and family members including the bereaved relatives who stayed in ICU in three hospitals in Scotland more than 24 hours and received

counselling support from this study during 2015 to 2016. The participants self-referred to the counselling sessions.

3.4 The intervention

The intervention of this study was provision of counselling sessions which were offered to patients, and their family members, including those bereaved during the ICU or subsequent hospital stay. Participants were provided a counselling session (lasting approximately 1 hour each, approximately weekly) with a qualified, professionally accredited counsellor who had a background in Intensive Care nursing. The approach of counselling was based on patient and family centered (PFCC) approach where the counselling sessions were coordinated and tailored according to need of patient, FM and BFM by a nurse counsellor in our study.

The average session attended by the participant was 13 where the number of the sessions were determined by the need of the participants. These sessions took place in NHS facilities.

3.5 Service evaluation

The intervention was evaluated using a mixed methods approach; however, the author will report only on the qualitative evaluation of this study, as the quantitative analysis is under development. The quantitative evaluation included: Measures of psychological distress (HADS, PCL at 6 and 12 weeks after the final counselling session; measures of self-efficacy – Coping Self-Efficacy scale and social support – MOS SSS; and a measure of psychological support satisfaction – CORE10) and perceived need for support.

Qualitative evaluation: Previous research suggests that questionnaire-based approaches alone may fail to capture participants' experiences of service provision. The qualitative evaluation aimed to explore participants experiences of the counselling service at six weeks

after their final counselling session. (Al-Busaidi, 2008) The epistemology used was constructivism with an inductive approach, which means that the analysis emerged from the data, rather than examining it with a predetermined framework (Howel, 2013). This helped in providing the broader view on the application and scope of the counselling service to the targeted population.

3.5 Sampling

Type of sampling was the purposive sampling for both studies. The inclusion and exclusion criteria for the study are listed below: -

Inclusion criteria

- Patients who stayed in ICU for 24 hours or more and received counselling support.
- FMs and BFMs whose relative was admitted in ICU for 24 hours or more and received counselling support.
- Willing to participate in study.
- FMs and BFMs were adult individuals who visited in ICU and had a close, continuing relationship with the patients.
- The patients, FMs and BFMs whose age group was more than 18 years.

Exclusion criteria

- Patients, FMs and BFMs with critical care experience but did not receive counselling support.
- Patients, FMs and BFMs whose critical care experience lasted less than 24 hours.
- Patients, FMs and BFMs of other wards than ICU.
- Patients, FMs and BFMs whose age group was less than 18.
- Patients, FMs and BFMs who did not want to participate.

3.6 Recruitment of participants

The advertisement of pilot counselling service was done in each of the 3 general ICUs across Lothian, using a combination of posters, leaflets and business cards. Also, advertisement of the counselling service was done with the ICU Bereavement Support Team at the Hospitals, none of whom were trained counsellors. With the agreement of senior clinicians at each site, a leaflet or business card to the ICU discharge booklets were attached which were provided as part of routine care. A series of information seminars were provided to inform and engage clinical staff in all three ICUs prior to the start of the study. Participants referred themselves and contacted the designated counsellor using the telephone number provided in the business cards, leaflets and posters. It is evident from various studies that psychological distress can be a complication of critical illness for some patients and family members and that they may reach a decision about participation after hospital discharge (Chung et al 2017 ; Milton et al., 2017). Potential participants who contacted the counsellor were provided with an information sheet and given as much time as they required to decide their participation (with a minimum of 24 hours).

3.7 Setting of the study

The study took place in one of the NHS facilities in Scotland.

3.8 Data collection and instrumentation

3.8.1 Clinical, demographic and questionnaire data

With participants' permission, routine clinical and demographic data were collected from the existing ICU clinical database (Wardwatcher). These data were used to explore and identify patient/family groups with greatest perceived need e.g., gender, age, severity of illness, length

of ICU stays, length of mechanical ventilation, etc. The designated counsellor, as a member of the direct care team had access to the participants' clinical records.

3.8.2 Qualitative data

After the completion of counselling sessions, twelve participants volunteered themselves to share their experience of counselling offered as a part of the study. Semi structured interviews were conducted using the question guide (APPENDIX 3) to gain the perspectives of patients and family members towards counselling session. Separate consent was obtained prior to the interview by a member of research team having Good Clinical Practice training (GCP).

3.9 Data analysis

Qualitative data analysis

The interviews were verbatim transcribed, with pseudonyms used in place of real names. An inductive approach was used to develop themes combining the analytical strategies from thematic analysis (Braun and Clarke, 2006). Transcript's grouping was performed with the evolving patterns of the data with common keywords and phrases to create a set of codes using Microsoft word. As thematic analysis aims to explore the viewpoints of diverse research participants, emphasizing similarities and differences, and producing unanticipated insights which aligns with the aim of our research (Guest et al., 2014). The six-step approach of thematic analysis described by Braun and Clark (2006) was used for the data analysis which is illustrated on table 3.1.

Table 3.1 Steps of thematic analysis

No of Steps	Name of steps	Explanation
Step 1	Familiarization with data	As the initial step to data analysis the interviewer transcribed audio files verbatim. The transcripts were read and re-read to understand the significance and connection in order to recognise the patterns and relation among the viewpoints of the participants.
Step 2	Generating codes	The transcription was coded line to line using Microsoft word and transferred on the table.
Step 3	Themes identification	The identified codes were categorised into sub-themes. And, the sub-themes were analysed and assembled which formed main themes. The similar subthemes were categorised into one broad theme.
Step 4:	Themes review	The identified themes were reviewed against the collected data extracts. After that, the thematic map was drawn with the subthemes and themes. Following this, the themes were verified by the supervisor. Finally, four themes were drawn with the consensus of the supervisor and student researcher.
Step 5	Defining and naming themes	The operational definitions were developed for each theme (Table 4.4) which are detailed in following section (Chapter 4) of this dissertation.
Step 6	Presenting and discussing results	Finally relevant extraction of the findings with relating with the objectives of this study were done. After that, discussions were done with relation to literature review which is detailed in following chapters (Braun & Clarke, 2006).

In addition to above, the data were reported following the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007). This method of reporting provided a chance to report the findings explicitly and comprehensively. The criteria included

in the checklist helped the researcher to systematically explain the aspects of the research team, study methods, context of the study, findings, analysis and interpretations.

3.10 Ethical consideration

The ethical approval for this study was taken by the lead academic supervisor from Ethical board of Edinburgh University and NHS Lothian before commencing the study. Ethical considerations for the data collection and storage are stated below.

3.10.1 Consent

The participants were notified about the voluntary nature of the participation and their freedom to withdraw the study if they want. Both oral and written consent was acquired from all the participants before proceeding with the study. Anonymity and confidentiality were maintained throughout and after the interview as transcripts were anonymised and audio files were erased after transcription. This is important in any research to develop trust and rapport with study participants, and to maintain ethical standards and the integrity of the research process (Wiles et al., 2008).

3.10.2 Data protection

All data collected, processed and stored for the purposes of this project was done with compliance with GCP guidelines and the principles of the Data Protection Act 1998 and remained confidential at all times. All investigators and study staff adhered to the obligations of the Data Protection Act (1998) with regards to the collection, storage, processing and disclosure of personal information and upheld the Act's core principles. All written data were kept in a locked filing cabinet to which only the Chief Investigator have access. All digital data were password protected and encrypted. The password was known only by the Chief Investigator and the research team. Published data did not contain any personal or incidental data that could allow identification of individual participants.

3.10.3 Data storage

With participants' consent, routine clinical and demographic data were collected only from our existing clinical NHS Lothian database (Ward Watcher electronic database). Only members of the direct care team had access to clinical records with the participants' consent. Only anonymised data were transferred via email between NHS and University networks. The transfer of data was made using existing Data Protection recommendations and policies. Caldicott approval was sought prior to any data transfer. For the qualitative interviews, digital recording devices were utilised for the purposes of transcription and data analysis. Participants were informed of their use, the anonymity of their data and of the destruction of voice files immediately following transcription. Published quotations from participants' interviews were anonymised. Participants were informed of this arrangement in the Participant Information Sheet and informed consent forms. Transcription was performed by trained individuals who are fully aware of the existing guidance on confidentiality and data protection. Electronic and written personal data were stored for less than 3 months after the end of the study. Then they were destroyed. Computers used to collate the data had limited access measures via usernames and passwords.

3.10.4 Confidentiality

Data were only collected for participants who have consented. All participant data collected were anonymised and kept confidential. Client notes taken by the designated counsellor during the sessions were kept anonymised in accordance with the British Association for Counselling and Psychotherapy (BACP) guidance on record keeping and separately in the counsellor's folder and were not used for analysis. Data collected (demographic

characteristics, completed questionnaires and interview data) were kept in a secure storage area in the research office with limited access.

3.10.5 Dissemination of findings

Findings would be disseminated as a report and then as a manuscript for publication in a peer reviewed academic journal through the publication in the academic journal.

3.11 Rigor

In order to establish consistency in the methods and findings of a research study (Thomas & Magilvy, 2011) qualitative rigor was maintained by thoughtful and deliberate planning following the measures of rigor. Firstly, credibility was enhanced by getting feedback from participants, spending adequate time during the interview and addressing feedback from supervisor. Secondly, transferability was obtained by using the standard and analytical approach to data collection. The transparency in the analysis was enhanced by development of codes with continuous revision, categorisation and discussion with the supervisor. Thirdly, dependability included the brief description of the research methods used and applying it step by step. Fourthly, confirmability was ensured by continuous reflection during the data collection and analysis process. The data reported are based on the Consolidated Criteria for reporting qualitative research (COREQ) checklist (Tong et al., 2007) (Appendix4).

3.12 Reflexivity

The interviews were conducted by one member of research team and the data analysis was done by another member after long duration thus unfamiliarity of the situation and participants was evident. This approach reduced bias in the analysis as it was conducted by a

third person that had not experience or knowledge in critical care and so pre-assumptions were not used to influence the analysis. Next, the open-ended questions with probes were asked which might have taken more effort and time for the participants to answer.

Furthermore, analysis was done by the student of master's degree and had done the qualitative analysis for the 1st time thus, there might be some limitations in inducing themes during thematic analysis.

Chapter 4 - Research Finding

This chapter presents the findings from the analysis of qualitative data derived from the interviews with the participants.

4.1 Description of the participants

The participants in this study were former critically ill patients and their family members including the bereaved family members who were admitted to three hospitals in Scotland. They received the counselling support from the nurse-counsellor, which was offered as a part of this intervention study. In total, 12 respondents participated in this study where three were patients, and nine were family members of critically ill patients. Two participants were bereaved family members of deceased critically ill patients. Nine participants were female, and three were male. The mean age of the participants was 49 years. Average counselling sessions they received was 13. Also, seven of the participants had previous counselling experience; however, five participants did not have counselling experience before. The detailed characteristic of the participants is illustrated in table 4.1.

Table 4.1 Demographic characteristics of the participants

Code	Sex	Category	Ethnicity	Age	Previous experience of counselling	No of sessions attended	Date of the last session	Type of ending
Patients								
1.P1	M	Patient	White	30	No	23	22/12/16	Planned
2. P2	F	Patient	White	39	Yes	4	22/12/16	Planned
3. P3	M	Patient	White	61	Yes	33	20/12/16	Planned
Family members								
4. FM2	F	Relative (spouse/partner)	White	57	Yes	18	05/04/16	Planned
5. FM3	F	Relative (mother)	White	55	Yes	8	02/06/16	Loss of contact
6. FM4	F	Relative (spouse/partner)	White	34	Yes	12	12/05/16	Planned
7. FM5	F	Relative (sibling)	White	53	Yes	7	11/10/16	Planned
8. FM7	F	Relative (spouse/partner)	White	34	No	3	03/9/2015	Client did not want to continue
9. FM9	M	Relative (spouse/partner)	White	64	No	11	17/11/15	Planned
10. FM6	F	Relative (spouse/partner)	White	68	No	6	24/11/16	Client did not want to continue
Bereaved family members								
11. BFM1	F	Bereaved (adult child)	White	45	Yes	24	22/12/16	Planned
12. BFM8	F	Bereaved (adult child)	White	46	No	11	20/12/16	Planned

4.2 Qualitative analysis

Four main themes emerged from the transcribed data in the context of the research objectives:

(a) Perceived benefits, (b) Feasibility, (c) Appraisal and (d) Context of care Table 4 .2.

Themes are operationalized and described in Table 4.3. The thematic map of the participants is detailed in Figure 4.1.

Table 4.2 Themes and subthemes

SN	Themes	Sub themes
1.	Perceived benefits	<ul style="list-style-type: none"> ❖ Conduit to resilience <ul style="list-style-type: none"> • Enhance self-efficacy • Reduction in PTSD symptomatology • Control anxiety ❖ Relief through disclosure ❖ Enhance coping ❖ Maintain family relationship ❖ Individualised support
3.	Feasibility	<ul style="list-style-type: none"> ❖ Overall experience ❖ Accessibility
4	Appraisal	<ul style="list-style-type: none"> ❖ Nurse counsellor knowledge ❖ Individualised support ❖ Public acknowledgement
2.	Context of care	<ul style="list-style-type: none"> ❖ Negotiation <ul style="list-style-type: none"> • Physical setup • Availability ❖ Recommendation <ul style="list-style-type: none"> • Publicity • Group session

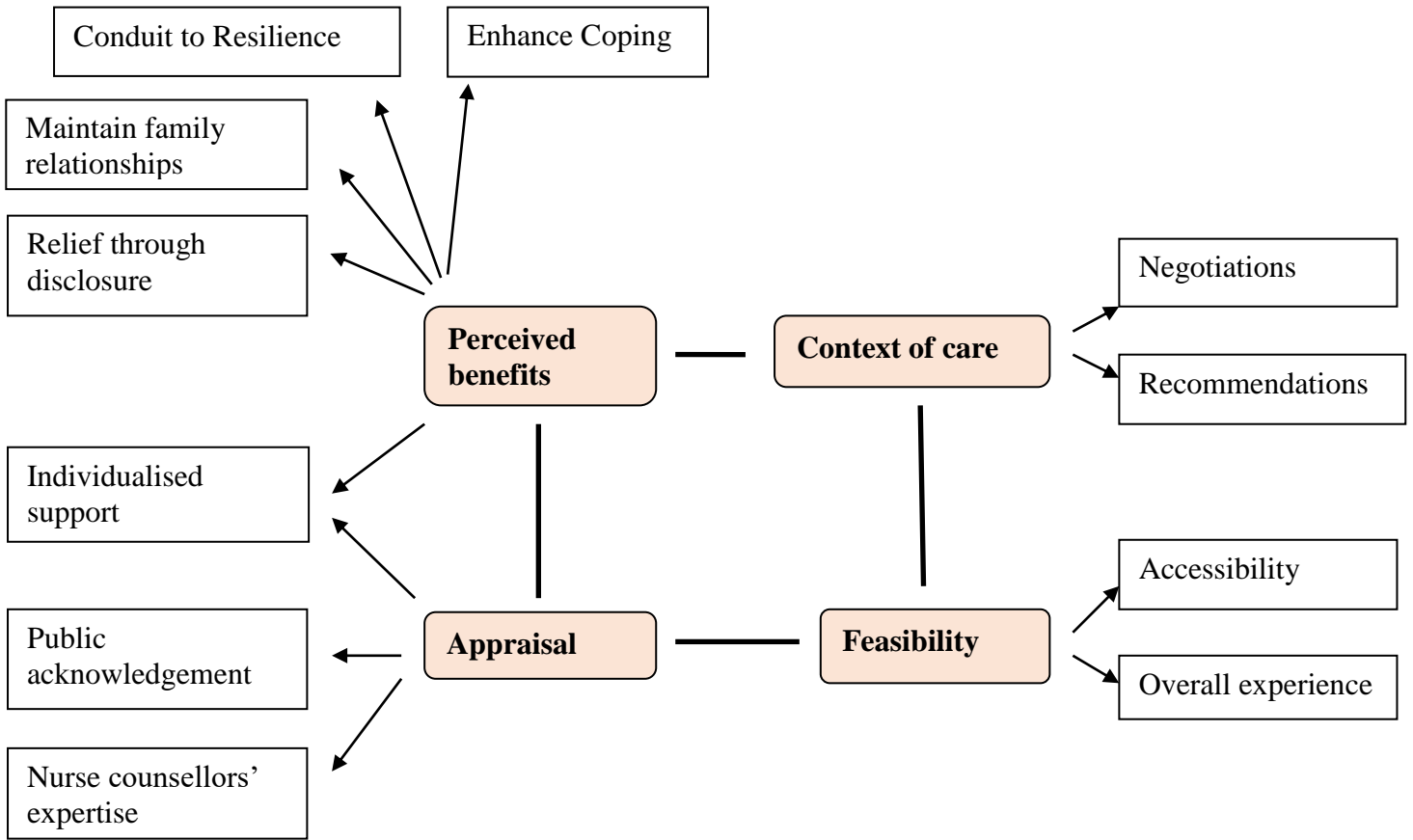


Figure 4.1 Thematic map of Qualitative analysis

Table 4.3 Operational definition of themes of the study

S.N	Themes	Sub themes	Descriptions
1	Perceived benefits	Conduit to resilience	The theme ‘Perceived benefits’ encompasses the overall benefit of the counselling support experienced by participants. It is determined by analysing how the counselling support was helpful in gaining resilience, relief through disclosure, coping, individualised support and maintaining family relationship.
		Relief through disclosure	
		Enhance coping strategies	
		Maintain family relationship	
2	Appraisal	Individualised support	This theme is derived from the particular feature of the counselling service by which respondents were motivated to continue the counselling service. The identified attributes of counselling are individualised support, nurse counsellors’ expertise background, and public acknowledgement.
		Nurse counsellor	
		Public Acknowledgement	
3	Context of care	Recommendation	This theme comprises of the recommendations and negotiation in the context of care from the perspectives of participants. Recommendations such as publicity, and continuity of group sessions were made while negotiations regarding physical setup and availability were made.
		Negotiation	
4	Feasibility	Overall experience	Feasibility is defined as the practicability of the counselling service for future implications. It is measured by analysing the accessibility of counselling service to respondents and their completion rates. In addition, overall experience of the respondents was also considered to determine the feasibility of the counselling service.
		Accessibility	

4.2.1 Perceived benefit of the counselling

4.2.1.a Conduit to resilience

Participants discussed that counselling helped them to gain confidence in their ability to persevere back to normal life which was imbalanced by the critical care experience. Eight out of twelve participants (Family n = 6, Patients n = 2) supported this theme. It was also a common theme for both male and female participants. Interestingly those who had not had counselling experience before also appreciated the counselling service and expressed that it helped them to gain resilience.

One of the female family members verbalised '*...it was almost like you were walking in fog ... I have got a clear head now...*' (FM6). Another response made by male patient '*...it's (counselling service) made me stronger from what I'm actually going through...*' (P3) also justifies that counselling service helped the participants to gain the resilience.

Additionally, participants also expressed that various contributing factor such as enhancement of self-efficacy, reduction in PTSD symptoms, and anxiety control also acted as a conduit to resilience. According to participants, these domains were helping to regain one's ability to recover back from trauma. The number of participants supporting these domains are presented in table 4.4.

Table 4.4 Conduit to resilience (response from participants)

1	Conduit to resilience	P1	P2	P3	BFM1	FM2	FM3	FM4	FM5	FM6	FM7	BFM8	FM9
		Enhance self-efficacy	✓	✓	✓	✓			✓	✓			
Reduction on PTSD symptoms	✓	✓	✓	✓			✓		✓			✓	

		Control Anxiety		✓		✓		✓				✓	✓	✓	✓
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A variety of perspectives were expressed where half of female and all male participants reported a reduction in PTSD symptoms such as flashbacks and panic attacks related to critical care experience. All the patients appreciated counselling service for being able to reduce the **PTSD symptomatology**. For instance, one of BFMs stated that he was able to get rid of flashbacks of trauma by counselling ‘...*I had a lot of problems with kind of flashbacks, and she was able to help me work on that...*’ BFM8. Similar viewpoint regarding reduction in PTSD symptoms were presented by patients as well ‘...*I was getting nightmares about being back in the hospital, I was getting flashbacks.*’ P1

Patients and FMs felt often overwhelmed and apprehensive with critical care experience as expressed ‘...*lose all sense of self...*’ BFM1 however they appreciated counselling as it helped them to increase their belief of own capacity and enhance **self-efficacy**. They expressed that counselling facilitated them to gain confidence to improve in their performance of doing daily activities. ‘...*This felt like it was helping me for being me...*’ (BFM1)
‘...*I feel more confident in myself...*’ P3

Majority of FMs expressed that the use of various techniques in counselling helped them to reduce the stress and **anxiety** caused by the admission of their loved ones in hospital ‘...*you know it was a really stressful time... you need to process all that somehow, so it (counselling) was, yeh it was helpful to have it...*’ (FM)7. Similar view was presented by all BFM who also valued counselling to relieve ‘...*debilitating pain ..*’ caused by lose of loved ones and expressed ‘...*I don’t feel that the kind of level of anxiety that I have experienced...*’.

Relating to patients, only a female patient expressed that the counselling support helped her to release emotions and reduce fear of being incapable to lead a normal life again.

4.2.1.b Individualised approach

This theme is particularly supported by the majority of family members (n=6) who stated that another important positive aspect of the counselling support was getting individual specific approaches to solve their issue. They acknowledged that the counsellor was able to identify their problem and addressed them as per their needs and unique circumstances. For instance, one of the female FMs (FM5) whose sister was admitted to ICU and having family issues as well verbalised that

'...she (the counsellor) understood the trauma that I had encountered... she knew all that.. I mean it's fine to say go and speak to your best friend but they don't really know how to deal with something like that whereas this (counselling service) helped you in different ways to deal with your trauma...'(FM5)

Similarly, those who had counselling service before also appreciated the counsellor's person-centered approach as mentioned below: -

'..she(counsellor) taught me some things like centred to me..' (FM4)

'..feeling very distressed about G's illness.. my emotional needs were getting taken care of...'(FM2)

4.2.1.c Relief through disclosure

Participants reported that counselling helped them to release their emotions related to the hospital admission and provided 'space to talk' which ultimately helped to build up their confidence and relief stress.

'...I didn't tell anybody about it all, and she helped me open up and she got a lot of things sorted.... I feel more confident in myself...'(P3)

In addition, the majority of male (66%) respondents felt that venting out their feeling helped them become optimistic towards life and become happy.

'...because an opportunity to get things off my chest, to vent that is the right way to say things... just being really generally unhappy.... the counselling helped...'(P1)

In addition to that, female spouse and another participant who was the mother of the recovered patient also appraised counselling service as it helped them to release the trapped emotions of the ICU trauma, the supporting quotations are given below: -

'..it gave me something else apart from J and his accident to talk about..'(FM3)

'..it was almost like you were walking in fog... '..I have got a clear head now..' (FM6)

4.2.1.d Enhance coping strategies

Participants explained that the counsellor ascertained healthy coping mechanisms and reinforced their value and suggested new strategies. Participants who did not have counselling before expressed that they discovered the new way to approach to the problem.

'...I felt invincible, I felt amazing because I had beaten something that had tried to kill me.'

(P1). However, participants who had counselling before expressed that they also learned the new techniques to deal with their issue. They said that counselling experience was different

from previous ones because of different scenarios (critical care experience) and counsellor

helped them to manage painful emotions from critical illness *'..I was getting to the stage*

where I was starting to, my head was clearing and I was beginning to cope with things..'

(FM6).

Furthermore, the bereaved family members stated that counselling helped them to deal with

identity crisis and cope with the grieving process ‘*..coping mechanisms that they could teach me then I felt that would be invaluable.....This(counselling service) felt like it was helping me for being me..*’ (BFM1).

4.2.1.e Maintain family relationship

This theme emerged from the patients and FMs perspectives. A common view amongst middle-aged bereaved female FMs having children at home reported that counselling helped them to maintain family relationship and harmony in family. Admission of their loved ones had created stressful environment in the family and challenged them to balance family life taking as example as a mother that had to take care of the child and the family.

‘...I really don’t know how I would have coped... it meant not coping with only family life... with a full-time job, the two children, husband who relies on you so much... I am just in a completely different place than I was this time a year ago after counselling....’ (BFM1)

Similarly, one of the male patients told that after his admission to hospital he was having negative perspectives towards life and was not communicating properly with the family members. He expressed that he got emotional and behavioural support that helped him to control his anxiety, frustrations and even self-destruction tendencies. Eventually, counselling helped him in leading to good family relationship and enhance self-care.

‘..... my temper since coming out of hospital had changed, me myself had changed, I was a different person...Counselling helped me to avoid that... completely destroying myself...I can be a bit calmer now rather than start shouting at people (girlfriend, mum and brother)...’ P1.

Table 4.4 perceived benefits (response from participants)

1	Perceived benefits	P 1	P 2	P 3	BF M1	FM 2	FM 3	FM 4	FM 5	FM 6	FM 7	BF M8	FM 9
	Individualised approach			✓		✓		✓	✓		✓	✓	✓
	Relief through disclosure	✓		✓			✓			✓			✓
	Enhance coping	✓	✓		✓		✓			✓		✓	
	Maintain family relationship	✓			✓			✓	✓		✓		

4.2.2 Feasibility

The practicability of the counselling support was assessed by measuring the accessibility, completion rates and overall experience of the participant.

Overall, participants thought the counselling support by the study was an excellent service that they would recommend to others as well. When asked about the overall experience of the participants towards counselling support, all the patients, FMs and BFMs appreciated the counselling service and expressed that they found it very helpful ‘*..I thought it was really helpful, it was actually a lifesaver for me to be honest..*’ (BFM8).

Participants expressed that the counselling service was easily accessible for them, and they could reach the counsellor when they needed to. Since the counselling support was made rightly available, they did not find any difficulty accessing it. ‘*..good about it but it was readily available...*’ (FM4)

Coming to the completion rates on counselling sessions, nine of the participants completed

the required sessions without any constraints, which is 75 % of all participants. The remaining two did not want to continue because they thought they do not require counselling support anymore and one of them lost the contact. To sum up, the counselling support was accessible and feasible for the participants to follow.

4.2.3 Appraisal

4.2.3.a Nurse – counsellor specialist background

Majority of participants highly valued the counsellor’s background as a former intensive care nurse and her knowledge. Only few participants knew that she was a nurse before counselling (n=5) and some discovered during their counselling (n=3) and some during the interview (n=4) however their perception was similar. Most of the participants realised that the counsellor’s familiarity, knowledge and experience in critical care definitely helped to recognise their problem, understanding their situation, helping them to clear out the insight of ICU setting and event analysis. They also recommended that it would be very helpful in the future to have the counsellor with expertise in critical care. The supporting quotations are mentioned on table 4.7.

Table 4.7 Supporting quotations for nurse counsellor’s specialist background

<i>‘..I think it was very important she really was able to understand and she had good insight into that environment...she was able to talk me through different things and help me understand maybe some things that I was not sure about why they happened, maybe why they did happen so yeh..’</i>	<i>(BFM8)</i>
<i>‘Yeh, so to talk through it with somebody who actually understands what would have happened and you know what all the medical terms mean and what the implications of those medical issues are, I preferred that...’</i>	<i>(FM7)</i>
<i>‘..L was an excellent counsellor, a really nice person, very knowledgeable and very helpful..’</i>	<i>(P1)</i>

One of the patients supported that their main motivation to join the counselling service was

the counsellors' past experience of a critical care.

'.... what motivated me in this case is that it was aimed specifically at people being in Intensive Care.....and the counsellor herself has a background in Intensive Care nursing..'

(P2)

4.2.3.b Public acknowledgement

Concerns regarding the view of **Scottish culture** towards counselling support were raised by participants. One of the female FMs mentioned that Scottish culture usually doesn't accept counselling while one of male FMs stated that male is considered weak if they availed counselling support. However, both of them stated that they approached this counselling support due to its publicity that created the **public acknowledgement** that this service is specifically designed to patients and FMs with critical care experience. Also, they suggested that the designation of this counselling may help to remove stigma of '**Scottish culture**' towards its view on counselling support. The supporting quotations are mentioned on following table 4.8.

Table 4.8 Supporting quotations for public acknowledgement

<i>'..it is a service to Intensive Care patients and their families so you know there was a public acknowledgement of the need for that...' '..I think Scottish culture does not really accept counselling because you are supposed to like, just that's weak..'</i>	FM2
<i>'..Thinking that it showed weakness on their part, if they had never experienced that's a typical Scottish male response you know..'</i>	FM9

Table 4.9 Appraisal (response from the participants)

1	Appraisal		P 1	P 2	P 3	BF M1	F M2	F M3	F M4	F M5	F M6	F M7	BF M8	F M9
		Nurse counsellor specialist background	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
		Individualised approach			✓		✓		✓	✓		✓	✓	✓
		Public acknowledgement					✓							✓

4.2.4 Context of care

There were key recommendations and negotiations made by the participants in the context of care to improve the service which are mentioned below.

4.2.4.a Recommendations

Participants recommended about approaches to publicise counselling service and suggested to include group session in future perspective which are explained below.

Publicity

Suggestions regarding the approach to publicise the counselling service were made.

Some of the patients suggested that making counselling a routine practice in ICU care to patients as well as family members during and after the ICU experience would be beneficial.

This is because there is ongoing stress among family members and patients during hospital stay. One of the young (34 yrs) family member quoted a point about ‘**standard offering**’ as ‘..it could even be something like recommended by the nurses that look after the person

standard offering by health professionals' (FM4). She meant that if the counselling service was offered by the health care personnel who was involved in the care, they would have benefited from the service rather than advertising via leaflet and pamphlets. She also added a point that this would help bring awareness to the importance of counselling to patients and a family member. This was in line with the response from another female bereaved relative member who also supported that if the availability of the counselling service was directly communicated to them by the ICU staff, they would have been more responsive to join the service. '..I know the cards are in the waiting room and there is a poster and stuff but I wonder how much the staff in the ITU could potentially have you know communicated with families...counselling promoted by staffs you know..*' (BFM8).*

While one of the patients suggested this kind of critical care focused counselling should be back up running by NHS as he considers counselling is helpful for mental health. '*...if the NHS took it a bit more seriously and actually saw it as a proper useful service...*' (P1).

One of the aged family members suggested to publicize the **feedback sheet** of previous participants of counselling on waiting area so that the people could be influenced to attend counselling support. '*...Maybe, in the ICU waiting room area, there could be a sheet with feedback from people who used the service like a trip adviser. This could encourage other people to use the counselling service...*' (FM9).

Similarly, suggestions to make the leaflet more visible and include the visual reminder of the techniques taught during counselling on leaflet were also presented by participants '*...for people that have had the counselling, whether it's just a wee note or a visual reminder of some of the techniques...*' (BFM1)

'...it was a very wordy leaflet...' (FM3)

Group session

Majority of the patient participants suggested including group counselling sessions as they felt that sharing a common problem would help to cope better and develop self-awareness by listening to others with similar issues '*..if it would be better one on one with people or a group, I suppose a group would be, everybody that was suffering the same thing, they are going for the same thing, so a group would work as well..*' (P3).

4.2.4.b Negotiation

Negotiations, in our study discussed about the perspectives of participants towards the physical setup and availability. They mentioned that the outcome of the counselling would have been better if they had opportunity to negotiate following aspects of physical setup and availability.

Physical set up

The bereaved relative whose mother passed way in the same hospital where she was having counselling sessions, expressed that it was challenging to have counselling on the same hospital area because the location made her automatically recall her previous traumatic experience of critical care.

'..I found that very very difficult to cope with, I found it difficult to go back into that environment, so that was hard I think....' (BFM8)

This was in line with the response from the family member as well who also found it stressful to go back to the same location.

'...I think the location thing maybe works for some people, maybe doesn't work for others

because they are maybe some people that don't want to go back to that same place...'(FM2).

In contrast, the response from one of the patients indicated that she wanted to revisit the place where she was admitted during the course of counselling as she thought it would help her in clearing out the vivid experience in ICU. *'..I don't know now whether it is offered regularly for former ICU patients if they desire it, or wish to go back and see...'(P2)*

During interview, some of the patients and family members commented on the structure of counselling room being narrow and small *'..probably the room wasn't that nice... I was in a rabbit burrow..'(FM5)* .In addition, some of the members complained about the unavailability of parking as well *'...getting parked at the hospital, at the (hospital name) is always really stressful..'(FM3).*

Availability

Although the participants appreciated the accessibility of counselling service, participant commented on urgency and flexibility of timing of the service.

Two of the family members who were employed shared that if the timings were flexible, it would have been better and less stressful because she had difficulty in arranging time for counselling and work.

'..I don't know whether that is to do with the room availability, or L's availability,but certainly from a stress point of view, even if there had been a 4 or a 4.30 appointment, that would have been amazing... 'BFM1

The family members of the patients whose relatives ICU stay was more than 40 days expressed urgency for counselling because they felt overwhelmed by the events in ICU. They shared their viewpoint that they would have benefitted if they had got counselling support just after the ICU admission or during the ICU admission. Following are the participants

quotations :-

'..it is extremely important that it is accessible immediately...' (FM4)

*'...I think it is ideally linked into the process, either during or very immediately afterwards...'
(FM9)*

Chapter 5 - Discussion and analysis of findings

5.1 Introduction

This study aimed to evaluate the feasibility of a pilot counselling service offered in NHS Lothian for critically ill survivors, their family members and bereaved family members. The counselling sessions were offered by a certified counsellor with critical care experience and expertise. Participants approached to counselling support based on the self-referral in between 2015-2016. The findings suggested that the counselling service was feasible and acceptable. However, few negotiations and recommendations were also presented by the participants towards improving the counselling service. The paragraphs below present the discussion of key findings and their explanations with respect to results from similar studies.

5.2 Key findings of the study

The qualitative exploration of the study identified the four major themes such as perceived benefits, feasibility, appraisal, and context of care. The theme ‘Perceived benefits’ encompasses the overall benefits of the counselling support experienced by the participants. The reported benefits of counselling support were helpful in gaining resilience, enhancing coping, individualised support, relief through disclosure and maintaining family relationship. Likewise, the theme ‘Feasibility’ presented the practicability of the counselling service for future implications by analysing the overall experience, accessibility, and completion rates. Another theme ‘Appraisal’ expressed about the features of the counselling service that made participants motivated to continue counselling which included nurse counsellors’ expertise background, public acknowledgement, and individualised support. Regarding ‘Context of care’, the participants suggested some areas of improvements with negotiations. They shared the concerns on the physical setup and availability of the counselling service. Also, suggestions were made such as making counselling service part of routine care in ICU setup,

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including group session along with one-to-one session in counselling support structure and standard offering for patients, FM and BFM with critical care experience.

5.3 Current findings with respect to available research

In this section, the findings of the current research are being highlighted with relation to the broad literature.

5.3.1 Benefits of counselling

There are five main benefits of the counselling support reported by the participants in the current study which are namely conduit to resilience, enhance coping, maintain family relationship, relief through disclosure and individualised support. The detailed explanation is presented in the following paragraphs.

5.3.1.a Conduit to resilience

Resilience refers to the positive adaptation, or the capacity to retain or regain mental health, despite experiencing adverse situation (Herrman et al., 2011). The importance of the resilience in reducing psychological distress of the patients and caregiver with ICU experience has received considerable attention in the literature (Meyers et al., 2020). The finding from the current study revealed that the counselling service acted as a conduit in gaining resilience of the patients, FMs and BFMs. It is identified that the factors such as therapeutic alliance, and the strengthening of attitudes and behaviours known to facilitate resilient outcomes (Herrman et al., 2011) which is provided in the process of the counselling support in this study as well. After the counselling experience, participants in the current study reported enhanced self-efficacy and self-care, reduction in PTSD symptoms, and controlled anxiety which were considered as indicator to gain resilience. For instance, when looked at the literature also the early intra intensive psychological intervention was helpful decreasing anxiety (8.9% vs. 17.4%), depression (6.5% vs. 12.8%) and PTSD symptoms

(21.1% vs. 57%; $P < 0.0001$) compared to control group among the patients ($n=209$) with critical care experience (Peris et al., 2011). However, in the studies by Naef et al., (2021) and White et al., (2018), the impact of the psychoeducational intervention and nurse driven emotional support intervention respectively was non-significant in controlling anxiety, depression and PTSD symptoms of the patients and family members. Thus, it is possible to argue that the type of psychological support provided in both of the studies were bundled with other support systems to participants which might have impacted on the outcomes measures; however, in the counselling intervention, the counselling sessions were delivered independently by the expert nurse counsellor with strong ICU background.

It is frequently reported in the literature about occurrences of the psychological distress in patients (Hatch et al., 2018) , FMs (Abdul Halain et al., 2021), and BFM's (Ishida et al., 2012) during and after the critical care experience. This is exemplified in the work undertaken by a recent prospective multicentre follow-up study done by the researchers at the university of oxford on survivors of ICU in the UK which revealed that there was prevalence of 46%, 40% and 22% of anxiety, depression and PTSD respectively (Hatch et al., 2018). Similarly it is revealed on a study by Petrincic & Martin, (2018) that 45.8%, 25% and 11.1% of family decision-makers with critical care experience reported anxiety, depression and Post Intensive Care Syndrome -Family (PICS-F), respectively. And for the bereaved family members there are reports showing psychiatric morbidity such as long term social distress of requiring professional help, complicated grief and PTSD (Anderson et al., 2008; Jones et al., 2018; Pattison et al., 2020).

Given the prevalence of psychological morbidities of the patients, family and bereaved family there are also various psychological and non-psychological approaches to address these issues. The widely used non psychological approach include provision of information

via ICU diary (Blair et al., 2017; Schofield et al., 2021) discharge summary (Castillo et al., 2020), and home based rehabilitation (Elliott et al., 2011). In comparison with those approaches there are very few approaches based on psychological interventions (Wade et al., 2015). On the top of that those interventions are found to be used as a multicomponent approach with other support programs such as family support (Naef et al., 2021), bereavement support (Casey Jones et al., 2018), and psychological support (Peris et al., 2011). Also, there are initiatives from the health authorities and various organisations in UK that are focused to address the psychological distress. Concerning to the benchmarking of nurse led counselling in ICU, it was introduced in 2005 by using two nurse counsellors (Christina Jones et al., 2008). However, to my knowledge there are no reported evidence of continuation of such initiatives that involves the sole counselling support provided to the patient's family and bereaved relatives specially focused in critical care area. Thus, counselling provision and its impact on psychological distress makes this study unique and valuable for the future implications.

Self-efficacy reflects confidence in ones the ability to exert control over one's own motivation, behaviour, and social environment (Zulkosky, 2009) and its reported that after the traumatic life experience like critical care experience (Cypress, 2011), an individual tends to be ambiguous in his own beliefs and performance (Abdul Halain et al., 2021). Studies have shown that high levels of self-efficacy can improve quality of life, mental state, and health behaviours of patients with cancer (Xu et al., 2018). Nonetheless our data also acknowledged that the majority of the patients felt counselling made them more confident and clear out the negative feelings caused after the hospitalisation; making them improve in their performance of doing daily activities. It could be understood that the patients have to suffer from both mental and physical trauma after hospitalisation (Parker et al., 2015) as compared to family

members who is more vulnerable for the psychological trauma (Abdul Halain et al., 2021). Thus, in this study patients group might have found the counselling service helpful in enhancing their self-efficacy and self-care because their self-efficacy might have been affected more due to hospitalisation.

5.3.1.b Individualised support

In the last decade, the focus of Patient-Family-Centered Care (PFCC) (Yoo & Shim, 2020) in context of health care system has gained utmost importance due to its broad benefits which recognizes that patients, families and staff are central to the delivery of better healthcare (Mitchell et al., 2016). Our counselling service was also based on this principle and in our study majority of the female participants (patients and family members) appreciated the counsellor's approach to address their needs and unique circumstances. They felt that their emotional needs were taken care off and got the individual specific approach to solve their issue. Thus, the incorporation of PFCC principle in counselling service might act as a good catalyst in having positive outcome on the service user.

5.3.1.c Relief through disclosure

Another important benefit that the participants reported was the relief through disclosure which was reported mostly by the female family participants and male patients. Patients expressed that having counsellor to listen to their concerns, they were immensely relieved since they had vague mixed feelings and stress due to ICU experience. Whereas the female family members appreciated the non-judgemental environment to vent their feeling since they felt that sharing their stress to other member of the family would increase stress to them as well. Overall, patients, family members and the bereaved family members benefited from the

sharing their feelings. Similar finding was also reported by the family members in a study by Naef et al., (2020) where they had a family support intervention with psychoeducational package and they expressed that they had positive experience with it. Furthermore, Wade et al., (2018) also reported that the acute stress was relieved on critically ill patients after the implementation of the stress support psychological intervention. Although there are dearth of the literature having intervention as counselling to ICU survivors and their relatives, it can be inferred from the finding that counselling plays an important role in relieving stress by facilitating in venting out feelings.

5.3.1.d Coping

Counselling support helped to develop healthy coping mechanisms to the patients, FMs and BFMs. Even if the participants had the previous experience of counselling, they mentioned that they found new ways of approaching and solving the problem. It is often reported in the literature as well that the psychological intervention helps in improving the coping strategies of a person (Erikson et al., 2019; Naef et al., 2021). The qualitative result of a study showed that the BFM got help with coping with the grieving process after the counselling experience (Erikson et al., 2019). Similarly coping mechanism was enhanced in FMs and BFMs after having nurse led psychoeducational interventions (Naef et al., 2021). It is also been reported frequently that the implementation of ICU diary promotes psychological health and enhance coping of patients (Blair et al., 2017) and family members (Schofield et al., 2021) after critical care experience. However, there is lack of robust evidence which explains the role of counselling on coping mechanism of patients, FMs and BFMs.

5.3.1.e Family relationship

In the current study, the patients expressed that they had frustrations and doubt in self-identity after the critical care experience. Whereas for the BFMs, they reported that loss of the family member resulted in the existence of hopelessness and feeling of isolation. Similar feeling was reported by the family members as well along with the increase in the anger and loneliness. Due to above mentioned changes after critical care experience participants reported having decreased communication and harmony among their family members. However, the participants reported that having counselling support helped them in acknowledging and accepting the current situation and maintaining the family relationship. Existing literature also stated that having family support interventions lead to family satisfaction and quality of family care (Naef et al., 2020). The relationship of patient and family members are intertwined in such a way that admission of patients impacts the entire family functioning (Pryzby, 2005). Therefore, the hospitalisation of a family member effects on the whole family systems equilibrium. To be able to help family function in crisis related to critical illness they need additional support systems including psychosocial support (Cypress, 2011). In line with the mentioned recommendation, current study also implemented the counselling provision to the participants and the outcome was positive to maintain family relationship.

Another important advantage highlighted by the majority of the family members and patients were having emotional and behavioural support. It is often reported in the studies that there is emotional disturbances and behavioural deviations after the critical care experience leading to PICS and PICS-F to patients and family members (Hatch et al., 2018; Petrincic & Martin, 2018). In the present study as well, the patients reported presence of anger and frustrations whereas for the family members they reported of having irritable mood after the critical care

experience. Our data acknowledged that the various techniques used in the counselling sessions were helpful in maintaining the emotional and behavioural disturbances. Most of the participants appraised about the breathing and guided imagery technique provided during counselling sessions and that helped them to stay focused and calm. Hence, it can be inferred that use of techniques can be encouraged during counselling session.

5.3.2 Appraisal

5.3.2.a Nurse-counsellor specialist background

The most appraised feature of this counselling service was nurse counsellor specialist background. In the present study, the counsellor was a former ICU nurse with expertise in counselling practice. Participants reported that since the counsellor had the background in ICU, it made them build trust and rapport easily. Also, there were participants who didn't know the counsellor was a former ICU nurse but still they felt comfortable in sharing because counsellor used to provide detailed information of ICU events which the participants had doubt of. Understanding the unfamiliar environment, getting focused, easy-to-understand information, and having a knowledgeable information presenter helped to decrease family members' emotional vulnerability and lead to a feeling of being cared for and less stressed (McCallum et al., 2018). Therefore, in the current study the nurse's expertise in ICU background played a crucial role to address the participants psychological health. It is also recommended by participants that in the future, it is good to include the nurse counsellor if possible. To my knowledge there is one study where counselling interventions was delivered by expertise nurse and the population was the cancer patients (Beesley et al., 2020), but no existing literature was found where the expert nurse provided counselling support in context of critical care setting. This aspect of the intervention makes this study novel and different

from other studies. The nurse is considered the bridge informant between the patient, FM and BFM (Pryzby, 2005) and psychological support is an important aspect of holistic nursing (Papathanassoglou, 2010). When it is specifically about the involvement person on delivery of intervention, some literature showed the initiatives of nurse led psychological interventions (Naef et al., 2020; Naef et al., 2021; Wade et al., 2018; White et al., 2018). The difference is that in all of those studies nurses were trained for few days and were prepared to deliver the form of psychological support along with other forms of support but in our study the nurse is herself an expert counsellor and had intensive care background and whole focus on counselling.

Effective communication is one of the essential component of the health care system and is highest rated family and patient's needs (Adams et al., 2017). Researchers have elicited the importance of good communication to improve family comprehension and decrease the family stress in context of ICU care (Scheunemann et al., 2011). Given the importance of communication on reducing stress in the current study also the participants appraised about the communication approach by a nurse counsellor. Participants felt that the non-judgemental and confidential communication approach of counsellor helped them to build trust and open up their thoughts. Thus, communication and maintenance of the confidentiality can be considered as an essential component of the counselling service.

5.3.2.b Public acknowledgement

Since the counselling service advertisement was done in the hospital setting, participants stated that this facilitated them to utilise the service. Two of the male participants shared about presence of the stereotype *Scottish culture* where it is thought that men are supposed to be strong and getting psychological supports makes them weaker in the view of the society.

However, those participants appreciated the way the counselling was offered at hospital that created a feeling of public acknowledgement and acceptance of need of counselling support. From this it can be implied that the way of publicizing the availability of current counselling support and its designation for patients, FMs and BFMs has left the good impression on the public awareness.

5.3.3 Feasibility

The overall experience of the participants in this study towards the counselling support they received was positive. In addition, considering 75% of completion rates and sound experience of accessibility; it is worth acknowledging that the counselling service provided was feasible could be considered to inform larger multicentre studies to investigate impact of counselling provision after critical illness to build a business case for implementation in the NHS.

5.3.4 Context of care

In the context of care, there were few recommendations and negotiations made by the participants. Most BFMs and FMs expressed that if counselling service was provided to other family members a well, they could have benefited by the service. Literature also suggest that the admission of loved one in ICU (Schmidt & Azoulay, 2012) or loss of someone one significant in the life affect the family as a whole (Casey Jones et al., 2018). This creates the need for support to family members (McCallum et al., 2018) and in current scenario various supports are available in the form of psychological (Erikson et al., 2019; Wade et al., 2015) and non- psychological interventions (Castillo et al., 2020; Schofield et al., 2021). However, there are confounding factors that might affect to avail those support by service users. Thus, in present study also the participants recommended to have improvement in counselling

service so that in future the similar group of patients, FMs and BFMs would get benefited.

One of the aspects raised by the family participants was provision of standard offering by the health professionals who were involved in the care of the patients. According to them if the information regarding the counselling service was provided and offered by the one involved in the patient care, the family members would have accepted the service without hesitation and taken advantage of it. They felt sceptical about the counselling service been offered as a part of a study. In addition, some of the participants who had previous experience of counselling told that they spend lot of money on their previous counselling sessions. So, they shared a possible cause of people not attending a counselling service could be economic demand. For this reason, some suggestions were also raised regarding the provision of counselling service from NHS service so that everyone can benefit. Thus, this can be understood as if the counselling service is made a routine practice with usual care in ICU then more patients and family group could be benefitted.

Another recommendation made by the patients and BFMs was the provision of the group sessions during the counselling. As literature also suggests that group session allows individuals to develop self-awareness by mirroring to others with similar issues and develop a shared feeling (Cherry, 2021). Similar perspective was presented by the patients' groups as well because they felt that if they were having sessions in a group with similar trauma, they could have been coped well by sharing and adapting the similar and unique techniques.

Additionally, availability of the flexible timing and the physical set up was the element of negotiation from the family members. Since the timing of the counselling session provided was fixed so the family members who had job and kids found it hard to accommodate on the given time. Whilst regarding the physical setup some participants commented on the parking space and some of them felt the counselling room to be narrower. Thus, for the further

implication of the counselling these aspects could be considered according to the available resources to have proper management and services.

5.4 Strengths of the study

The qualitative approach was used as the methodological orientation of the study. Qualitative research allows respondents to talk in their own perspective which helps the researcher to develop a real sense of a person's dynamic understanding of the situation (Tenny et al., 2021). In similar way, in the present study as well the semi structured interviews of the participants allowed to express their experience of counselling in their own perspective and that was analysed by a researcher. Over the decades, there has been greater acceptance of the qualitative methods in the health care field since there has been promising outcomes through the use of this method (Al-Busaidi, 2008; Naef et al., 2020). It is convincing to choose qualitative method in this study as it has got implication on broader area. For instance, understanding of the new technology in health care such as implementation of the National Health System information technology programme in the UK (Hendy et al., 2007) and the perceived impact of certain intervention (Erikson et al., 2019), qualitative research has always been a step forward.

Next, the use of the semi-structured interview based on flexible topic guide with open questions proved a chance to explore the experiences of the participants. Semi structured interview has a potential to draw people's own opinions and explanations and have the advantage of revealing issues or concerns that have not been expected by the researcher (Kallio et al., 2016).

Another major component of this study is the epistemology which is followed by constructivism (Tenny et al., 2021) and thematic analysis strategy (Braun and Clarke, 2006).

This approach allows to express the views of the individual which are directly influenced by

their experiences, and those experiences shape the perspective of reality. In line with this approach our study has formulated the robust exploration of the impact of the counselling service from the perspective of the patient's family and the bereaved family.

Next strength of the study is the characteristics of the population where we tried to include not only the patients but also the family members and bereaved family members. The correlation among the different and similar viewpoints of the participants were explored in this study which allowed the reader to understand the perception of the participants from different angles.

The interviews were conducted by one member of research team and the data analysis was done by another member after long duration thus unfamiliarity of the situation and participants was evident. This approach reduced bias in the analysis as it was conducted by a third person that had not experience or knowledge in critical care and so pre-assumptions were not used to influence the analysis.

In order to establish consistency in the methods and findings of a research study (Thomas & Magilvy, 2011) a qualitative rigor was maintained by thoughtful and deliberate planning following the measures of rigor.

The data reported were based on the Consolidated Criteria for reporting qualitative research (COREQ) checklist (Tong et al., 2007). This method of reporting provided a chance to report the findings explicitly and comprehensively. The criteria included in the checklist helped the researcher to systematically explain the aspects of the research team, study methods, context of the study, findings, analysis and interpretations.

5.5 Limitations of the study

This qualitative study has certain methodological limitations. This study only focused on the perspective of patients, family and the bereaved family members however lacked to present the perspective of the counsellor. This study was conducted in three Scottish ICUs, so generalisation cannot be done to other critical care areas in the UK or internationally. Also, the lower number of participants specially patients and bereaved family members might impact on the generalisability. Nevertheless, since this is a feasibility study thus the sample size can be considered as adequate (Eldridge et al., 2016). In addition, the economic demand to conduct this study is also not mentioned in the study. All the participants in our study were white and more work is needed to determine the acceptability and usefulness of this analogous interventions in other ethnic groups. In this dissertation, only qualitative finding was reported which was the descriptive account of the participants experience. The integration of the quantitative data would have provided a more rich and robust account of the effect of the counselling intervention (Noyes et al., 2019). Therefore, efforts to broaden the evidence base of counselling support ought to utilize mixed method evidence synthesis. We did not present the findings on the basis of type of illness the patient had, length of hospital stays, socio-economic, and cultural background of participants to make the correlation analysis of the findings.

Not all the participants who took counselling service preferred to take part in the interview. It is likely that they could not avail counselling service because the timing for the session was not flexible for them, or they were fearful to share their experience. Thus, it could be possible that their experience of counselling might differ from those who participated that might result in failure to obtain the full range of experience with counselling.

In summary, this pilot feasibility study adds to the evidence base regarding the provision of

counselling on patients, family members and the bereaved family members. The findings indicate the potential value of a nurse-led counselling support in critical care to address psychological morbidities and reduce unmet needs of the targeted population. We believe a larger trial is warranted to measure the effect of the counselling intervention on patient and family-centred outcomes.

Chapter 6 – Conclusion, implication and recommendation

6.1 Conclusion

A qualitative study was conducted to explore perspectives of patients, family members and bereaved family members with critical care experience on counselling provision, using individual qualitative interviews with an independent researcher. Counselling sessions were offered by certified counsellor with critical care experience and expertise. Semi-structured interviews were conducted to participants at six weeks after the final counselling session where the participation was on voluntary basis. This interview was done to explore experiences of accessing counselling (the self-referral process); expectations and experiences of the counselling sessions, acceptability and recommendations for future development. Thematic analysis was done to analyse the interview of the participants which was reported based on COREQ checklist.

The findings from the study suggest that the counselling provision was feasible and acceptable to patients' family and bereaved relatives. Four major themes were identified: perceived benefits, feasibility, appraisal and context of care. There were different viewpoints from the participants along with some similar viewpoints. For instance, for all three group of participants counselling provision was found to be a conduit for resilience. Where patients group found the counselling sessions mostly helpful in enhancing self-efficacy and most of the female family members including the bereaved family members found counselling was important in maintaining family relationship. In addition, the benefits such as enhanced coping, reduction in PTSD symptoms, controlled anxiety and individualised support were also recorded. Participants valued the nurse counsellor's expertise and background during to build the trust and vent out the feelings. While some recommendations on the context of care were also made that includes continuation of counselling in routine care, its availability

according to the participants demand, and nature of counselling.

In conclusion, the counselling support provided to patients, FMs and BFMs was feasible and acceptable intervention as per the analysis. Although this study was a pilot study that included small population but the positive outcome of this study on the patients, family and bereaved family couldn't be ignored. Hence, it can be taken as an evidence base for the future implication in context of healthcare system. A full scale randomised controlled trial is required to determine the impact of counselling provision on patients, FMs and BFMs.

6.2 Implication

Future research

The findings from the current study opens a broader scope to conduct the future research in large multicentre approach to form robust evidence in order to generalise and implement counselling as an evidence-based practice in health care system.

Nursing practice

Implication 1: - Our findings from the study supported that there were number of psychological benefits on patients, FMs and the BFMs. Also, the overall experience of the participants was positive. Thus, it would be important to consider the implementation of counselling support to ensure the adoption of the intervention in routine clinical care in order to address the psychological needs and mental wellbeing of the patients, family and bereaved family.

Implication 2: - The most valued feature of the counselling service was the nurse counsellor's expertise background. It is reported in the literature that the counselling support

by a expert clinician qualified in psychological therapies and counselling was helpful in reducing anxiety symptoms and improving quality life (Chang et al., 2020). In addition, various evidences about the involvement of the nurse in delivering the interventions in health care has gained significant positive outcomes (Jónasdóttir et al., 2016; Naef et al., 2021) as nurse being the close person in bridging the gap between the healthcare system, and patients, and family members (Kourkouta & Papathanasiou, 2014; Park, 2021). Thus, integration of nurse-led intervention with the expertise of counselling provision could be considered to implement in practice due to its promising outcomes.

Nursing education

The importance of nursed-led counselling in nursing care could be highlighted as a part of nursing education in order improve health care quality and promote holistic nursing care.

6.3 Recommendation

1. Further research on impact of counselling provision on patients' family and bereaved family on larger population is recommended to improve the generalisability.
2. Previous studies have reported the impact of the psychological intervention on the psychological distress of the patients, FMs and BFMs qualitatively and quantitatively. However, to my knowledge there are no reported evidence of counselling provision on critical care area. Thus, efforts to broaden the evidence base of nurse-led counselling interventions could be utilised.
3. This study only focused on the measures of subjective experience of the participants thus, the objective measures could also be implemented to have robust evidence on the impact of the counselling provision.

4. There is no estimated cost analysis of this project thus, if similar research is going to be conducted it would be good idea to calculate and present the cost analysis for the project compared with usual care so that it would be easier for the future implementation.

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APPENDIX 1: - Example of database searches

S. N	Data base	Boolean Search
1	CINHAL	(MH "Counseling") OR (MH "Death Counseling") OR "Psychological intervention" OR (MH "Counselling") AND (MH "Patients") OR (MH "Critically Ill Patients") OR (MH "Terminally Ill Patients") OR (MH "Family") OR (MH "Bereavement") AND (MH "Intensive Care Units") OR (MH "Critical Care") OR (MH "ICU")
2	APA Psycinfo	DE "Counselors" OR DE "Counseling" OR DE "Counseling Psychology" AND DE "Patients" OR DE "Family members" OR DE "Bereaved relatives" AND DE "Intensive Care" OR DE "Critical care" OR DE "ICU"
3	PubMed	(((((counseling [Title]) OR (psychological intervention [Title])) OR (counseling [Title])) AND (patients[Title])) OR (family members[Title])) OR (relatives[Title])) OR (bereaved[Title]) AND (ICU[Title])) OR (critical care[Title])) OR (intensive care unit[Title])
4	ProQuest	ti(Counselling) OR ti(psychological intervention) OR ti(psychological support) OR ti(counseling) AND ti(patients) OR ti(family) OR ti(bereaved) AND ti(icu) OR ti(Critical Care) OR ti(intensive care unit)

APPENDIX 2: Critical appraisal of the Review articles

Critical Appraisal

High – low (10- 0)

0-3 = weak Yes = 2

4-7 = moderate No =1

8-10 = strong Can't tell = 0

MMAT Critical Appraisal for Mixed method studies ((Naef et al., 2021; Wade et al., 2018)

S.N	Author Year	Is there an adequate rationale for using a mixed methods design to address the research question?	Are the different components of the study effectively integrated to answer the research question?	Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Comments
1	(Naef et al., 2021)	Yes	Yes	Yes	Can't tell	Yes	Strong There is lack of randomisation and the following differences at baseline between the study groups.
3	(Wade et al., 2018)	Yes	No	Yes	Can't tell	Yes	Strong The background for the recruitment of the POPPI nurses hasn't been mentioned.

MMAT Critical Appraisal for Randomized control trail (Wade et al., 2019; White et al., 2018)

S.N	Author Date	Is randomization appropriately performed?	Are the groups comparable at baseline?	Are there complete outcome data?	Are outcome assessors blinded to the intervention provided?	Did the participants adhere to the assigned intervention?	Comments
1	(Wade et al., 2019)	Yes	yes	yes	Yes	Can't tell	<p>Strong</p> <p>There is lack of discussion about impact on the other psychological morbidity after critical care.</p> <p>3-day training for ICU staffs for stress support might cause lack of expertism in delivering the intervention.</p>
2	(White et al., 2018)	Yes	Yes	Can't tell	Can't tell	No	<p>Moderate</p> <p>The strategies used for the trial was automated which was used to abstract data from electronic medical records. This might have resulted in failure to analyse the changed care process surrounding family communication.</p>

MMAT Critical Appraisal for quantitative methods (Peris et al., 2011)

S.N	Author and date	Is the sampling strategy relevant to address the research question?	Is the sample representative of the target population?	Are the measurements appropriate?	Is the risk of nonresponse bias low?	Is the statistical analysis appropriate to answer the research question?	Comments
1	(Peris et al., 2011)	Yes	Can't tell	Yes	Can't tell	Yes	Moderate There is lack of description about the extraneous variables that can have effect on the outcome of the study

MMAT Critical Appraisal for qualitative methods ((Naef et al., 2020; Erikson et al., 2019)

S. N	Author and date	Is the qualitative approach appropriate to answer the research question?	Are the qualitative data collection methods adequate to address the research question?	Are the findings adequately derived from the data?	Is the interpretation of results sufficiently substantiated by data?	Is there coherence between qualitative data sources, collection, analysis and interpretation?	Comments
1	(Naef et al., 2020)	yes	Yes	Can't tell	No	Yes	Moderate The rigour of the study is not adequately maintained as this study restricts the transferability due to data collection done in surgical unit only.
2	(Erikson et al., 2019)	yes	Yes	Can't tell	Can't tell	yes	Moderate There were range of the interventions provided to participants which, might have resulted in participants overwhelmed to share experience of each intervention.

APPENDIX 3: - Question guide for Interview questions

1. Could you please tell me about your counselling experience?
2. What was the purpose of visiting the counselling service?
3. Do you think it is important to provide such counselling services to people who have experience of intensive care and to family members?
4. What were the techniques you found useful?
5. What did you find most helpful in this counselling service?
6. Do you think that anything could be improved about the service?

APPENDIX 4: - COREQ checklist

No.	Item	Description	Section
Domain 1: Research team and reflexivity			
Personal characteristics			
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group?	Page - 12
2.	Credentials	What were the researcher's credentials? <i>E.g. PhD, MD</i>	Title page
3.	Occupation	What was their occupation at the time of the study?	Title page
4.	Gender	Was the researcher male or female?	N/A
5.	Experience and training	What experience or training did the researcher have?	Title page
Relationship with participants			
6.	Relationship established	Was a relationship established prior to study commencement?	Yes, (Methodology section)
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? <i>E.g. Personal goals, reasons for doing the research</i>	Reasons for doing research, (Result section)
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? <i>E.g. Bias, assumptions, reasons and interests in the research topic</i>	N/A
Domain 2: Study design			
Theoretical framework			
9.	Methodological orientation and theory	What methodological orientation was stated to underpin the study? <i>E.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis</i>	Constructivist approach with inductive thematic analysis (Methodology section)
Participant selection			
10.	Sampling	How were participants selected? <i>E.g. purposive, convenience, consecutive, snowball</i>	Purposive (Methodology section)
11.	Method of approach	How were participants approached? <i>E.g. face-to-face, telephone, mail, email</i>	Face-face (Methodology section)
12.	Sample size	How many participants were in the study?	12, (Result section)
13.	Non-participation	How many people refused to participate or dropped out? What were the reasons for this?	2- did not want to continue 1-Lost contact (Result section)
Setting			
14.	Setting of data collection	Where was the data collected? <i>E.g. home, clinic, workplace</i>	NHS facility, Methodology section
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?	No (Methodology section)

16.	Description of sample	What are the important characteristics of the sample? E.g. demographic data, date	(Results section)
Data collection			
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	N/A
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?	N/A
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?	Audio recording, (Methodology section)
20.	Field notes	Were field notes made during and/or after the interview or focus group?	Yes (Methodology)
21.	Duration	What was the duration of the interviews or focus group?	Approx. 1 hour Average counselling =13 (Result section)
22.	Data saturation	Was data saturation discussed?	Yes, (Methodology section)
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	No
Domain 3: analysis and findings			
Data analysis			
24.	Number of data coders	How many data coders coded the data?	One, (Methodology section)
25.	Description of the coding tree	Did authors provide a description of the coding tree?	Yes, (Result section)
26.	Derivation of themes	Were themes identified in advance or derived from the data?	Derived from data, (Result section)
27.	Software	What software, if applicable, was used to manage the data?	Microsoft word (Methodology section)
28.	Participant checking	Did participants provide feedback on the findings?	N/A
Reporting			
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? <i>E.g. Participant number</i>	Yes, (Result section)
30.	Data and findings consistent	Was there consistency between the data presented and the findings?	Yes (Methodology section)
31.	Clarity of major themes	Were major themes clearly presented in the findings?	Yes (Result section)
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Discussion of minor themes as well (Result section)

APPENDIX 5: - Gant chart

Dissertation title: - Counselling support for critically ill patients and their families following a critical care experience: A qualitative study

Student name: - Sharad Rayamajhi

Matriculation: 40513818

<u>Pattern of activities</u>	Months (1 to 9) = (June to February)								
	1	2	3	4	5	6	7	8	9
Meet with supervisor	■								
Review of protocol	■								
<u>Dissertation write up</u>									
Chapter 1 - Introduction		■							
Chapter 2 – Literature review		■	■						
Chapter 3 – Methodology and methods			■	■					
Chapter 4 - Analysis of data (Result)				■	■				
Chapter 5 Discussion						■	■		
Chapter 6 – Conclusion and recommendations							■	■	
Draft Submission								■	
Mock defence								■	
Final submission									■