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# Views of Intensive Care Nurses on Determining and Meeting the Psychological Care Needs of Patients: A Qualitative Study

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**Abstract**

**Background:** Patients hospitalized in intensive care units may experience many psychological symptoms such as weakness, hopelessness, anxiety, anger, depression, sleep deprivation, sensory overload, sensory deprivation, agitation, delirium, and difficulty in adjustment. In order to prevent these psychological symptoms, it is possible to define these needs by supporting the patients and providing the necessary psychological care services by the nurses who are experts in their fields.

**Aim:** This study was evaluate of the views of intensive care nurses on the psychological care needs of patients.

**Methods:** A qualitative descriptive approach was taken in the study. Fifteen intensive care nurses were selected with reference to maximum variation sampling method from purposeful sampling method, and individual in-depth interviews were handed with a semi-structured interview form. The data obtained from the study were analyzed using the content analysis method.

**Results:** The average age of the nurses participating in the research was 29.8; 40% of them were undergraduates and 53.3% of them worked in tertiary intensive care. Nurses have been working for an average of 7.43 years, and they have worked in intensive care for 4.36 years. As a result of analyses, it was determined that the views of intensive care nurses on patients' psychological care needs and practice were gathered under 4 main themes. These were psychological care in intensive care, communication, patient reactions, and approach to psychological problems. In addition, sub-themes such as empathy, reassurance, support, holistic care, communication style and difficulties in communication, psychological and physiological reactions, psychological problem solving, and the quality of psychological caregivers were also reached. Eight of the 15 nurses who participated in the interview believed that the psychological care needs of intensive care patients should be met by a specialist nurse (consultation liaison psychiatric nurse).

**Conclusion:** Although nurses are aware of the first- and second-level psychological care needs of patients, their knowledge levels were insufficient in practice, and the intensive pace of work, long working hours, and a stressful work environment meant that they could not meet this need. In the light of this information, specialist psychiatric nurses (consultation liaison psychiatric nurses) should be employed in intensive care units, where the psychological care of patients can be met and intensive care nurses can receive support.

*Keywords: Intensive care unit, psychological care, consultation liaison psychiatric nursing*

## Introduction

Physical illness is a life crisis which has physical, mental, and social aspects. It can have various effects at different levels from temporarily affecting health to disability and disrupting the unity and functionality of the body. The effort to cope with situations like a breakdown in health or illness can affect a person's mental state.[1,2] In serious life-threatening illnesses, individuals often come up against psychosocial difficulties both associated with their illness and during the treatment process, and this is frequently met with in the intensive care unit (ICU).[3] While the physical needs of patients undergoing treatment in the ICU may be met successfully, their physiological and social needs may be ignored.[4,5] Thus, according to the World Health Organization's definition of health, not only the physical needs but also the mental and social needs of patients must be met for total well-being. In this way, factors such as their life being under threat, restriction of movement, being bedridden, painful invasive procedures, strange people and a strange environment, not seeing friends and relatives, and insufficient

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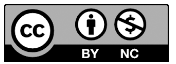

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information being given about the illness and treatment can result in a large number of psychological symptoms such as helplessness, hopelessness, anxiety, anger, depression, sleeplessness, sensory overload, sensory deprivation, agitation, delirium, and accommodation difficulty.[6,7]

The prevention of psychological symptoms of patients in the ICU is possible if specialist nurses with knowledge and skills in the field sufficient to identify these needs support patients and provide the necessary psychological and social care services. However, nurses working in the ICU can frequently not go beyond giving physical care to patients, both because of their heavy workload and because they do not have adequate knowledge and skills to recognize patients' physiological and social needs. Accordingly, this study was conducted with the objective of evaluating the awareness of nurses working in the ICU about patients' psychological needs, investigating psychological care practices, and determining the nurses' views on whether they feel the need for professional support on this topic [Consultation Liaison Psychiatric Nursing (CLPN) application] and their training needs.

### Research Questions

1. What do you think is "psychological care"? How is the psychological care of intensive care patients? What are the psychological care needs of ICU patients?
2. How do you communicate with ICU patients (intubated, unconscious, and conscious) and which communication methods do you use during communication?
3. What are the reactions of patients during treatment or care in the ICU? Which reactions catch your attention the most? Why is that? What are the psychological symptoms you observe in the patients you care for in the ICU? What are your interventions for these symptoms?

## Materials and Methods

### Setting

The study was conducted at a university hospital in İzmir, which is the third largest city in Turkey. This hospital was opened in 1851 and now has a capacity of 1100 beds. There are a total of 6 ICUs including coronary ICU, anesthesia ICU, internal medicine ICU, neurosurgical ICU, neurology ICU, and cardiovascular surgery ICU. The total number of nurses working in all ICUs is 121.

### Design and Sample of the Research

The study was conducted qualitative design as a State-Holistic Single State. This study was conducted between July 2015 and December 2015. The data were collected from 15 nurses selected according to the maximum diversity sampling method from 112 nurses working in 6 ICUs of a university hospital and volunteering to participate in the research. The criteria to be included from the research are presented in Table 1. The study was grounded in a realist epistemological framework in which participant responses were assumed to represent reality: realism recognizes that there is a real world independent of our experience whilst acknowledging that we are suspended in webs of meaning that we ourselves spin and that, therefore, there can be many layers to our reality. The methods are reported adhering to the consolidated criteria for reporting qualitative studies.

This study was written using COREQ (consolidated criteria for reporting qualitative research), which provides guidance in reporting qualitative research.[8]

Table 1. Features of Participants Who Were Selected According To Maximum Variation Sampling Method

| Attendants | Age | Education | Unit of Work | Working Time | IC Working Time | Psychological Support Status |
|---|---|---|---|---|---|---|
| Nurse 1 | 27 | Undergraduate | level 1 ICU | 4 years | 4 years | Received |
| Nurse 2 | 36 | Associate degree | level 1 ICU | 15 years | 9 years | Received |
| Nurse 3 | 30 | Undergraduate | level 2 ICU | 6 years | 4 years | Received |
| Nurse 4 | 33 | Postgraduate | level 2 ICU | 10 years | 1,5 years | Not received |
| Nurse 5 | 28 | Undergraduate | level 2 ICU | 4 years | 6 months | Not received |
| Nurse 6 | 35 | Associate degree | level 3 ICU | 18 years | 4 years | Not received |
| Nurse 7 | 37 | MCC | level 3 ICU | 8 years | 8 years | Received |
| Nurse 8 | 25 | Postgraduate | level 3 ICU | 4 years | 2 years | Received |
| Nurse 9 | 25 | Undergraduate | level 3 ICU | 5 years | 5 years | Not received |
| Nurse 10 | 35 | Postgraduate | level 3 ICU | 11 years | 7 years | Not received |
| Nurse 11 | 35 | Associate degree | level 1 ICU | 10 years | 10 years | Not received |
| Nurse 12 | 34 | Associate degree | level 1 ICU | 14 years | 4 years | Not received |
| Nurse 13 | 22 | Undergraduate | level 3 ICU | 3 months | 9 years | Received |
| Nurse 14 | 21 | MCC | level 3 ICU | 3 months | 4 years | Not received |
| Nurse 15 | 24 | Undergraduate | level 3 ICU | 2 years | 1,5 years | Not received |

ICU, intensive care unit; MCC, medical career college.

### Participants

In the first step of the study, all nurses working in 6 ICUs were included in the study, and sample selection was not made. About 112 out of 121 nurses who worked actively in the ICU while the study was being conducted and who volunteered to participate in the study filled out the Introductory Information Form.

The second step of the study includes qualitative data collection processes. The participants consisted of 112 nurses who filled the Introductory Information Form in the first step. Maximum diversity sampling, which is one of the purposive sampling methods, was used to select the participants.

Purposeful sampling methods provide an in-depth investigation of situations that were thought to have full of information; furthermore, they are useful in discovering and describing facts and events. The purpose of maximum diversity sampling is to create a small sample and to reflect the diversity of the individuals in this sample. However, in order to assure diversity for this sample selection method, the study results cannot be generalized to all population; only the types of similarities or uniformity that exist between different situations can be found.[9] In this study, 15 nurses have been selected through the maximum diversity sampling method and in line with the following criteria: intensive care clinics (coronary ICU, anesthesia ICU, internal medicine ICU, brain surgery ICU, neurology ICU, and cardiovascular Surgery ICU) where they work, working experience, age, educational status (health vocational high school, bachelor, master, and doctoral), and whether they had previous training in psychological care of ICU patients (Table 1). Participants provided feedback on the findings.

### Data Collection Instruments

1. Introductory Information Form: The researcher examined the relevant literature and prepared the Introductory Information Form. This form consists of 18 open- and-close-ended questions to determine the sociodemographic and professional characteristics of nurses. In the first step of the study, the Introductory Information Form was given to 112 nurses who work in the ICUs.
2. Interview form: It is a semi-structured interview form prepared by a researcher by examining the related literature and taking expert opinion.[2,4,7,13,16,19,28] This form evaluates psychological care needs, psychological care practices, and the need for professional support for nurses who work in the ICUs. In this study, the interview form was used in individual interviews with 15 nurses that constitute the study sample.

### Data Collection Process

Qualitative data were collected through an interview conducted with 15 nurses who were chosen according to maximum diversity sampling method in the study, among 112 nurses who filled the Introductory Information Form in line with a semi-structured interview form. Before the interview, the nurses were informed about what is a semi-structured interview, will using a voice recorder during interviews and about research. Interviews were conducted by giving an appointment to each nurse by determining the days and hours when nurses were available and when there was no work intensity. In accordance with the semi-structured interview form, an average of 25-40 minutes of face-to-face interviews with each nurse was conducted. The interviews were conducted in a hospital room arranged to be quiet, calm, and not distracting the participant.

Individual interviews with the participants were performed once by the first author. The interviews were made who worked as a nurse for 6 years and was graduate student by nurse.

Participants do not recognize the interviewer when they meet during the research. Three nurses were pre-interviewed, and these nurses were not included in the study. These interviews were made with the aim of seeing the questions, duration, and the researcher's deficiencies.

### Rigor and Trustworthiness of Qualitative Analysis

The strategies of credibility, transferability, consistency, and confirmability were used to ensure the validity and reliability of the research.

For credibility, the researcher must have a long-term interaction with the participants. As the interaction period progresses, the initial influence of the researcher on the participants decreases and the interviewee can be more sincere in his answers. Therefore, the validity of the data collected in long-lasting interviews is higher.[9] In this study, care was taken to ensure that the in-depth interviews with the participants lasted at least 25 minutes.

Transferability means reaching tentative judgments about the applicability of results in such environments and forming testable hypotheses, without generalizing research results directly to similar settings.[9] In this study, the researcher conveyed the findings to the reader by avoiding generalization of the findings, without adding comments, and by being faithful to the nature of the data as much as possible.

Consistency is the researcher's consistent treatment of interviewers at all stages of the research.[9] In this study, the researcher tried to ensure this consistency by using the same interview form for all participants during data collection and by recording all the interviews on a voice recorder.

Confirmability should not affect the collected data in any way by its existence or by its assumptions and beliefs.[9] For this reason, all data collection tools, audio recordings, raw data, codes, and themes created during the analysis were examined by the expert. In addition, all of these have been retained for review when necessary.

### Data Analysis

A total of 342 minutes of interview records obtained by individual interviews were documented in the same way without any changes in the records which were to be analyzed by the first researcher. Each of the 2 researchers read the report over and over again, identifying codes and themes. Content analysis was performed by the researcher[9] in order to reach the concepts and relations that could explain them on the data obtained. In the content analysis, the inductive analysis approach was preferred.

### Ethical Consideration

Permission to conduct the study was obtained from the Non-Interventional Research Ethics Committee of a university (IRD: 117, Prof. Recep Sütçü) and from the General Secretariat of the Public Hospitals Association relating to the hospital where the research was to be performed. Informed consent was obtained from the nurses during the interviews by using a voice recorder, after explaining the research to them.

## Results

The average age of the nurses participating in the research was 29.8; 93.3% of them were women, 40% of them were undergraduate graduates, and 53.3% of them worked in tertiary intensive care. Nurses have been working for an average of 7.43 years, and they have worked in intensive care for 4.36 years.

In the evaluation of the qualitative data obtained in the study, it was observed that the views of ICU nurses on the needs and practice of psychological care of patients were grouped under 4 main themes: psychological care in the ICU, communication, patient reactions, and approach to psychological problems (Table 2).

### Main Theme 1: Psychological Care in the Intensive Care Unit

Fifteen participants answered psychological care in the ICU in the 5 sub-themes of empathy, showing greater concern, giving security, being supportive, and holistic care.

In the sub-theme of empathy, nurses defined psychological care in the ICU as understanding patients' psychologies by establishing empathy, establishing empathy in a spiritual way, and empathy.

> *"...the first thing that comes to my mind when we talk about psychological care is understanding people, what they feel, understanding what they're thinking, and being able to care for the patient in this way."* (Nurse 4)

> *"...care given by putting ourselves in the patient's position from a spiritual point of view... Care given by psychologically thinking from their point of view, thinking if it was me what would I do."* (Nurse 9)

Table 2. Main and Sub-themes Emergent From the Analyses

| Main Theme | Sub-theme |
|---|---|
| Psychological care in the ICU | Empathy<br>Showing greater concern<br>Giving trust<br>Being supportive<br>Holistic care |
| Communication | Type of communication |
| | Verbal |
| | Non-verbal |
| | Difficulties experienced with communication |
| | Arising from patients<br>Arising from language difficulties<br>Environmental factors |
| Patient reactions | Physiological reactions<br>Psychological reactions<br>Neutral reactions |
| Approach to Psychological problems | Psychological symptoms<br>Solving psychological problems<br>Quality of psychological caregivers |

In the sub-theme of showing greater concern, 5 nurses emphasized that in psychological care in the ICU, greater concern should be shown and that it should be more meticulous, more compassionate, more humane, and warmer.

> *"...I think ICU patients have a greater need of attention and more psychological care."* (Nurse 3)

> *"You have to be more attentive. After all they're in a closed environment away from their families and loved ones. You have to concentrate more on them."* (Nurse 14)

In the sub-theme of giving trust, nurses emphasized psychological care in the ICU as a calm approach to patients, helping them to feel secure and them to trust the team.

> *"I generally say 'Leave everything to us, you're in a safe place now. We'll do our best for you'...."* (Nurse 15)

> *"They have to know that they're not alone, that when they need help we can see them and that we can take action."* (Nurse 11)

In the sub-theme of being supportive, nurses emphasized psychological care in the ICU as practices to make patients feel better, helping with loneliness and enabling them to feel comfortable.

> *"A patient may need attention and may need loneliness to be relieved. We must show that we are paying attention to them and that they are not alone there."* (Nurse 14)

> *"...Generally we get patients up and mobilize them; we send them out to their relatives or bring the relatives inside to eat. Apart from that we try to look cheerful and joke with them, to raise their morale a bit...."* (Nurse 5)

In the sub-theme of holistic care, psychological care in the ICU was emphasized as providing holistic care to meet patients' physiological, emotional, social, and psychological needs.

> *"Psychological care is providing all kinds of care which the patient needs for spiritual health. Their physiological needs are included in this, taking all of this as a whole."* (Nurse 11)

> *"...meeting patients' needs from an emotional or social direction."* (Nurse 8)

### Main Theme 2: Communication

Fifteen participants answered communication with ICU patients in 2 sub-themes—type of communication and difficulties experienced with communication.

In the type of communication sub-theme, nurses stated that in communicating with ICU patients they used verbal communication techniques with patients who were conscious and non-verbal communication with patients who were not conscious or could not communicate verbally.

> *"According to the patient's condition, if they are conscious we communicate verbally."* (Nurse 7)

*"Individually, we generally call them by name: Mr A..., Mr M...."* (Nurse 11)

*"We communicate by eye with the intubated patients, or use eye contact or hand movements with patients who can't make sounds. Lip-reading...."* (Nurse 2)

*"We use big letters on paper. So for example we show A, then B, then L, then A, which spells ABLA ('sister')."* (Nurse 5)

*"...with gestures, mime. We express ourselves in words, and we understand their gestures...."* (Nurse 4)

In the sub-theme difficulties experienced with communication, nurses expressed their communication difficulties arising from language difficulties or environmental factors.

*"They have a tube in their mouths, and their arms and hands aren't free. Whether they want to or not, they can't understand us. We have the most difficulty with them – conscious intubated patients."* (Nurse 9)

*"We have difficulty with very agitated patients, ones who don't want to stay, who have dementia or Alzheimer's... We have difficulties with patients who are disoriented in place and time."* (Nurse 13)

*"Sometimes we have Kurdish or Arabic-speaking patients. We try to explain using body language. Problems can occur, language problems can occur or they may really misunderstand what we are trying to tell them."* (Nurse 14)

*"Sometimes they want to say something about their illness. But you really don't have time. At that moment another patient has come, the phone is ringing or you're about to carry out care. I think we can't set aside enough time, and that makes them unhappy."* (Nurse 12)

### Main Theme 3: Patient Reactions

When the 15 participants were asked about reactions which they had observed in ICU patients, they stated that they had observed psychological reactions like fear, anger, gratitude, confidence and discomfort, and physiological reactions such as dyspnea and pain and that because of pressure of work, they had not responded to them.

*"...it varies from patient to patient. One might scream when we are caring for the slightest little injury; another might remain silent even when we are taking care of very large wounds...."* (Nurse 4)

*"I'm giving something on a central catheter and she goes 'ah-ooh'. What can you do – maybe it's because she really feels pain, or maybe she's just afraid something's going to happen... But then you just go automatic. Stretch out your arm, I'm going to take blood...."* (Nurse 15)

### Main Theme 4: Approach to Psychological Problems

The approaches of the 15 nurses to psychological problems were grouped under 3 sub-themes—psychological symptoms, psychological problem solving, and quality of psychological caregivers.

In the sub-theme of psychological symptoms, the nurse said that they had observed psychological symptoms such as delirium, deorientation, agitation, harm to themselves and their environment, anxiety, uneasiness, fear, hopelessness, and depression in ICU patients.

*"Depression... agitation, delirium, emotional deprivation."* (Nurse 2)

*"Delirium occurs in patients, after they've been here a long time...."* (Nurse 6)

*"Sometimes patients withdraw into themselves, they may have trouble communicating, things like depression may happen."* (Nurse 11)

*Patients who have been here a long time are generally very afraid of dying, especially if a patient next to them has died."* (Nurse 8)

In the sub-theme of solving psychological problems, nurses said that they used methods such as establishing communication, getting expert support, getting pharmacological support, and giving or explaining information to solve psychological problems with ICU patients.

*"We generally try to talk. If there's really anything we can do we try to do it, and a psychiatric consultation is requested."* (Nurse 4)

*"When they go into delirium, they don't know where they are. I try to calm the patient by telling them that this is a hospital, telling them the time, the place, and who they are, and telling them about the treatment process."* (Nurse 10)

*"Depending on how the patient is, we try to set up good communication with them and provide psychological support from a social point of view... we use pharmacological treatment with the prescription of a doctor."* (Nurse 2)

In the sub-theme of quality of psychological caregivers, they upheld the giving of care to ICU patients by psychiatrists, psychologists, IC physicians, specialist psychiatric nurses, patients' relatives, and CLP nurses.

*"Maybe if there was a unit in the hospital like these bedsore nurses... if they told us in the hospital how to identify and care for it...."* (Nurse 13)

*"They could give a psychiatrist to the ICUs, to each ICU."* (Nurse 12)

*"First psychiatrists should see it, then they should decide. Whether drug treatment is needed, that is, or what treatment is needed...."* (Nurse 6)

*"Definitely CLP nursing or CLP service should be given. Both from the point of view of the health staff and the patients, that is, it would certainly be a great help and we feel this need."* (Nurse 10)

*"There should be someone with training in this who should give it, I think... it could be someone who is experienced or who has training in these topics... it could be a psychiatric nurse."* (Nurse 8)

*"... a nurse should give it. It should be a CLN nurse, a nurse we can ask what we can do for this patient, how we can treat them. When*

*the nurse feels the need for it, it should be possible to consult a psychiatrist, and we should go on that way."* (Nurse 11)

*"There should definitely be CLN nurses, because both in ICUs and in surgery, they're ideally suited for it."* (Nurse 4)

*"If only there was a specialist nursing position or something, people whose job it was, but there aren't...."* (Nurse 15)

*"I think there ought to be a doctor or a nurse for these things. Or at least special clinical nurses for this, supported by a doctor. Like if they came one by one for wound care... Then they'd understand that we can't cope. But if they took on that sort of people for this, they could take a one-to-one interest. Or we could get support from them as well, I think."* (Nurse 12)

## Discussion

In the interviews, the nurses defined psychological care in the ICU as empathy, paying greater attention, providing security, being supportive, and holistic care. In the literature, psychological care is stated to be listening to patients' psychological needs, observation and establishing empathy, and the need for emotional security of patients in ICUs where there are patients who are sedated, unconscious, or intubated.[10,11] Moghaddasian et al[12] established that nurses would encourage patients and their families regarding care by means of empathic communication. Wilkin et al[13] stated as a conclusion of semi-structured interviews with nurses that they employed empathy while putting the patients in a position or during care.

The nurses believed that psychological care in the ICU could be carried out by taking a greater interest in the patients and by being more meticulous, more communicative, more compassionate, and more humane and warmer. The lack of autonomy of patients in units like the ICU and their dependence on health staff mean that the staff may need to be more attentive and compassionate in meeting their needs.

In the interviews, nurses defined psychological care in the ICU as giving patients security, a calm approach, helping them to feel that they were safe, and the patients' feeling of confidence in the team. In the literature, it has been determined that in ICUs where there are sedated, unconscious, or intubated patients, patients need emotional security.[10] In the study by Wilkin et al.[13] it was emphasized that in order for ICU nurses and patients to be more comfortable, it was essential to provide security and for patients to have confidence in the team. Pattison et al[14] stated that patients having confidence in the ICU staff gave them positive feelings about the future. In a place with strange people and equipment like the ICU, invasive procedures, a change in patients' routine, stress, and uncertainty may create a need in patients for greater security.

In the interviews, nurses stated that psychological care in the ICU could be practices and words to make patients feel better, tackling their loneliness and providing them with support. Rotondi et al[15] emphasized that 39.6% of intubated patients in the ICU felt lonely and Hofhuis et al[16] stated that the best care experienced by ICU patients was support from nurses. In these studies, it can be seen that ICU patients need support and that they mostly expect this support to come from nurses.

In the interviews, the nurses defined psychological care in the ICU as providing holistic care by meeting physiological, emotional, social, and psychological needs. However, in practice, the workload in the ICU is heavy, and it is a stressful place, so that patients' psychological and social aspects are forgotten and only their physiological needs are focused on. Nevertheless, it must not be forgotten that people are biopsychosocial beings, and they need holistic care.

In the interviews, 2 sub-themes, type of communication and difficulties experienced with communication, emerged. It was determined that the nurses started communicating with ICU patients by addressing them by name and introducing themselves and continued by chatting and giving information about procedures. In a series of studies, conscious patients were interviewed, and they stated that they had heard speaking while unconscious.[17] For this reason, it should not be forgotten that patients hear, and it should be realized that an unconscious patient cannot be thought of as not there. Patients should be addressed by name, and communication should be established using simple and basic terms and short concise sentences.[18-20]

Nurses stated that when they were establishing communication with ICU patients they used smiles, eye contact, body movements, touching, lipreading, and writing. In the literature, it was found that when nurses are establishing communication with ICU patients, the nonverbal methods used are mostly eye contact, lipreading, communication cards with pictures, alphabet cards, facial expressions, and body movements.[21,22] Also, it was mentioned that when a nurse held a patient's hand during a painful procedure, the patient later said to the nurse "holding my hand during the procedure was more supportive than giving me information about the procedure," and this had caused the nurse to accord more importance to touching.

The nurses stated that the difficulties they had experienced when communicating with ICU patients arose when working with patients who were aggressive, excessively demanding, and afraid or those who were refusing treatment or had language problems or that they derived from environmental factors. In a study by Fesci et al.[23] nurses stated that the patient groups that they frequently had difficulties with were patients who showed aggressive attitudes (73.8%), patients who made excessive demands (61.3%), and patients in the terminal stages (57.5%). In our study, nurses mentioned excessively demanding patients and patients who always wanted them to be with them because of a fear of being alone or of their condition worsening. Magnus et al[21] stated that one of the hindrances to communication with ICU patients was a language problem. Being in what to the patient is a foreign country and not having autonomy and being in an environment where they are dependent on health staff causes a perception of the ICU as a frightening and insecure environment. In this way, caring for a patient who is uncooperative and does not express his problems can result in a delay in treatment and recovery. Nurses identified environmental factors resulting from the heavy workload and the ICU environment as another difficulty which they experienced when communicating. Wilkin et al[13] stated that obstacles to care such as a shortage of staff and stress arising from the ICU environment caused difficulty in communication, and Magnus et al[21] stated that the fact that the ICU was noisy was an obstacle to communication. Similarly in our study, nurses stated that they were unable to communicate with patients because of noise and pressure of work.

In the interviews, the nurses stated that they noticed psychological reactions such as fear, anger, gratitude, confidence, and discomfort in the ICU patients. Samuelson,[24] in a study researching the experiences

of patients on mechanical ventilation, found that they had such experiences as fear, anxiety, discomfort, anger, and panic.

Some ICU nurses stated that they were unable to focus on patients' reactions because of the pressure of work. In the literature, it has been found that nurses working in the ICU are exhausted because of their workload and become insensitive to patients.[25,26] In our study also, nurses stated that they could not pay attention to patients' reactions but were only able to meet their physiological needs. This suggests that, as the nurses stated in both the quantitative and qualitative data-gathering processes, this derives from the long and excessive working hours and the stressful and busy environment of the ICU.

In the interviews, the nurses stated that they observed psychological symptoms in ICU patients such as delirium, disorientation, agitation, harming both themselves and others, anxiety, fear, hopelessness, despair, and depression. In the literature, it is stated that symptoms such as depression, anxiety, fear, sleep disorders, powerlessness, despair, delirium, disorientation, and emotional deprivation or overload are frequently seen in ICU patients.[6,7,27-29]

The nurses stated that they used methods such as establishing communication, getting expert support, getting pharmacological support, and giving information or explanation in order to solve psychological problems in ICU patients. In the literature, 4 levels of psychological care are seen. The first level includes basic communication and diagnostic skills such as information giving, interviewing, listening and empathy skills, the ability to identify psychological needs, presentation, and the ability to get information on a problem which is transferred; the second level includes protective psychological care such as the skill of coping with patient/family stress, establishing a therapeutic relationship, making it easier to express feelings, and the ability to get information on transferred problems; the third level includes specialized psychological approaches such as institutional models and various skills training-based psychological approaches; and the fourth level includes psychotherapy applications such as cognitive therapy and behavior change.[30,31,32] In our study, nurses generally met first- and second-level psychological care needs, were inadequate in coping with patient–family stress in the second level, and were seen to be unable to meet third- and fourth-level needs. It is thought that nurses cannot meet psychological care needs at this level because third- and fourth-level psychological care must be conducted by experts with specialized knowledge and skills on this topic.

In the interviews, nurses supported the idea that psychological care of ICU patients should be given by a psychiatrist, a psychologist, an ICU physician, a specialized psychiatric nurse, patients' relatives, or a CLN nurse. According to Alaca,[4] 92.4% of nurses want to consult and work with a colleague who has received specialist training in the field of psychiatric nursing. In our study also, most nurses at both the quantitative and qualitative data collection stages thought that psychological care of ICU patients should be met by nurses specially trained on this topic, even if they did not mention CLN nurses directly.

Evaluating the study findings as a whole, it can be said that nurses were inadequate in meeting the psychological care needs of ICU patients and that they needed training and professional support. Legally also, although the Regulation on Making Changes in Nursing Management No 27910[33] which came into force on April 19, 2011, recognized the sub-specialization of psychiatric nursing for providing service in this area (The Regulation on Making Changes in Nursing Management No 27910.), it is observed that in practice there is insufficient setup and staff in hospitals. Therefore, it is thought that ICU patients' psychological care needs will be met at an adequate level by necessary changes and the employment of nurses who are specialized in the field such as psychiatric nurses and CLN nurses, and in this way an increase in the quality of patient care will be achieved by providing holistic patient care.

### Limitations

The study had some limitations. There was difficulty in planning interviews because the participants had shifts and intense and tiring working conditions in ICU. This extended the data collection time. The fact that the interviews were tape-recorded initially worried the participants. The anxiety of the participants was reduced by taking the necessary permissions before each interview and emphasizing the principle of confidentiality. The data of this research are limited to those obtained from the participants during the in-depth interviews.

## Conclusion

Because nurses recognize psychological care needs and are aware of them but their knowledge on this topic is partly adequate or inadequate, it is seen that they are unable to carry it into practice. It is thought that this is because of not knowing how to perform psychological care because of their heavy workload, their long working hours, the stressful nature of the ICU environment, and not having the resources or the time. In this regard, it may be recommended that specialists such as psychiatric nurses and CLN nurses should be employed in ICUs in order to perform this type of care. They would have the requisite knowledge, skills, and experience on this topic and could concentrate their energies on psychological care alone. Intensive care units must not be places where only patients' physiological needs are met, because care is a physiological, psychological, and social whole. At this point, evaluating the quantitative and qualitative research findings together, it is shown that patients' psychological care needs cannot be met in the heavy and stressful work environment of the ICU, and for this reason, it is important and significant to employ specialists who have the knowledge, skills, and abilities for these units for integrated quality care.

It will contribute to the field that to reveal the necessity of employing specialized professionals/nurses (psychiatric nurse and CLP nurse) who have knowledge, ability, and experience in performing psychological care in ICUs and who focus his/her energy on psychological care.

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