REVISTA
TÉCNICO-CIENTÍFICA
CEJAM
Transformando a vida das pessoas por meio da comunicação científica

OPEN ACCESS

Original Article

Authorship

Luana Santos Chagas da Paixão[1*]
ORCID: https://orcid.org/0009-0004-1004-3845

Jucinei Araujo de Jesus[2]
ORCID: https://orcid.org/0000-0002-3159-4273

***Corresponding:** luanacpaixão7@gmail.com

Institution

[1]Comissão de Residência Multiprofissional em Saúde, Secretaria Municipal da Saúde de São Paulo, São Paulo, Brasil.

[2]Secretaria Municipal da Saúde de São Paulo, São Paulo, Brasil.

How to cite this article • Copyright©

Paixão LSC, Jesus JA. Experiences and Impacts of the Process of Hospitalization in an Intensive Care Unit for Family Members. Rev. Tec. Cient. CEJAM. 2026;5:e202650048. DOI: https://doi.org/10.59229/2764-9806.RTCC.e202650048.

Editors

Submitted	Accepted
09-22-2025	10-26-2025

Experiences and Impacts of the Process of Hospitalization in an Intensive Care Unit for Family Members

Experiences and Impacts of the Process of Hospitalization in an Intensive Care Unit for Family Members

Experiencias e impactos del proceso de hospitalización en la unidad de cuidados intensivos para el familiar acompañante

Abstract

Objective: To analyze the emotional impact and suffering of accompanying family members resulting from the hospitalization of patients in the adult Intensive Care Unit (ICU) and relate the care provided by the multidisciplinary team to the principles of the National Humanization Policy. **Method:** A qualitative, descriptive, and exploratory field study was conducted between June and August 2025 with family members accompanying patients at imminent risk of death admitted to the Adult Intensive Care Unit of a municipal hospital in São Paulo. Data were collected through semi-structured interviews and analyzed using content analysis, and methodological quality was assessed using the Consolidated Criteria for Reporting Qualitative Research. **Results:** Family members experience intense emotional suffering, expressed through fear, anxiety, and anticipatory grief. Visits proved essential for emotional bonding, while communication from the team directly influenced the perception of acceptance. Spirituality stood out as a resource for support and reframing, reinforcing the importance of humanized practices. **Conclusion:** Accompanying a loved one in critical condition in the ICU is a stressful experience, marked by uncertainty, visiting restrictions, and difficulty accessing clear information. We conclude that it is essential to incorporate humanized multidisciplinary practices that also include care for family members.

Descriptors: Hospitalization; Intensive Care Unit; Family; Emotional Distress; Anticipatory Grief.

Resumo

Objetivo: Analisar o impacto emocional e o sofrimento dos familiares acompanhantes decorrentes da internação de pacientes em Unidade de Terapia Intensiva (UTI) adulta e relacionar os cuidados prestados pela equipe multiprofissional aos princípios da Política Nacional de Humanização. **Método:** Estudo de campo, de abordagem qualitativa, descritiva e exploratória, realizado entre junho e agosto de 2025, com acompanhantes de pacientes em risco iminente de morte internados na Unidade de Terapia Intensiva Adulta de um Hospital Municipal de São Paulo. Os dados foram coletados por meio de entrevistas semiestruturadas e analisados segundo o método de análise de conteúdo e a qualidade metodológica se deu pelo *Consolidated Criteria for Reporting Qualitative Research*. **Resultados**: Os familiares enfrentam intenso sofrimento emocional, expresso por medo, ansiedade e luto antecipado. A visita mostrou-se essencial para o vínculo afetivo, enquanto a comunicação da equipe influenciou diretamente a percepção de acolhimento. A espiritualidade destacou-se como recurso de apoio e ressignificação, reforçando a importância de práticas humanizadas. **Conclusão:** Acompanhar um ente querido em estado crítico na UTI é uma experiência desgastante, marcada por incertezas, restrições de visita e dificuldade de acesso a informações claras. Conclui-se que é essencial incorporar práticas multiprofissionais humanizadas que incluam também o cuidado aos familiares.

Descritores: Hospitalização; Unidade de Terapia Intensiva; Família; Sofrimento Emocional; Luto Antecipado.

Resumen

Objetivos: Analizar el impacto emocional y el sufrimiento de los familiares acompañantes derivados de la hospitalización de pacientes en la Unidad de Cuidados Intensivos (UCI) para adultos y relacionar los cuidados prestados por el equipo multidisciplinario con los principios de la Política Nacional de Humanización. **Método:** studio de campo, de enfoque cualitativo, descriptivo y exploratorio, realizado entre junio y agosto de 2025, con acompañantes de pacientes en riesgo inminente de muerte ingresados en la Unidad de Cuidados Intensivos para adultos de un hospital municipal de São Paulo. Los datos se recopilaron mediante entrevistas semiestructuradas y se analizaron según el método de análisis de contenido, y la calidad metodológica se evaluó mediante los Criterios Consolidados para la Presentación de Informes de Investigación Cualitativa. **Resultados:** Los familiares enfrentan un intenso sufrimiento emocional, expresado por miedo, ansiedad y duelo anticipado. Las visitas resultaron esenciales para el vínculo afectivo, mientras que la comunicación del equipo influyó directamente en la percepción de acogida. La espiritualidad se destacó como un recurso de apoyo y resignificación, reforzando la importancia de las prácticas humanizadas. **Conclusión:** Acompañar a un ser querido en estado crítico en la UCI es una experiencia agotadora, marcada por incertidumbres, restricciones de visita y dificultad para acceder a información clara. Se concluye que es esencial incorporar prácticas multiprofesionales humanizadas que incluyan también el cuidado de los familiares.

Descriptores: Hospitalización; Unidades de Cuidados Intensivos; Familia; Sofrimento Emocional; Aflicción.

INTRODUCTION

Hospitalization in an Intensive Care Unit (ICU) is a complex and stressful experience that affects not only the patient but also their family members. The context of clinical severity, imminent risk of death, and lack of clear information intensifies feelings of fear, anguish, and helplessness, directly impacting the emotional well-being of those accompanying the patient[1-2].

Family members, often assuming the role of caregivers, face a high level of stress and emotional fragility, which can lead to changes in family dynamics. In this scenario, it is essential to recognize their importance in the care process and expand humanization strategies that include support and care for companions as well[3].

Despite this, the family is often neglected in hospital settings, with care focused exclusively on the patient[4]. The quality of communication and the relationship with the multidisciplinary team is crucial: when clear and empathetic, it contributes to coping, minimizing emotional damage; when it fails, it increases suffering[5].

Spirituality also emerges as a central resource for coping, functioning as a source of comfort, reframing, and support in the face of uncertainty[6]. Its relevance, although recognized in the literature, is still little explored in hospital practices, especially in the context of the ICU[7].

In this process, the work of the multidisciplinary team, especially hospital psychology, is strategic in promoting acceptance, qualified listening, and emotional support. The psychologist acts as a mediator between the team, patient, and family members, promoting communication and the elaboration of the suffering experienced[8].

In light of the biopsychosocial model[9] and the guidelines of the National Humanization Policy (NHP)[10], it is essential to understand the impact of hospitalization from the family's perspective as well, expanding practices that integrate technical care and emotional support.

Thus, this study aims to analyze the emotional impacts and suffering experienced by family members accompanying patients admitted to adult ICUs, relating them to multiprofessional care and the principles of the National Humanization Policy.

METHOD

Design, Period, and Setting

This is a qualitative field study, descriptive and exploratory in nature, conducted in the Adult ICU of the Dr. Fernando Mauro Pires da Rocha Municipal Hospital, a public hospital located in São Paulo. The unit has 20 beds, two of which are isolation beds, and receives patients from clinical and surgical areas.

The research was conducted between June and August 2025, with the participants being family members accompanying patients classified by the medical team as being at imminent risk of death. This condition was defined based on clinical criteria, such as the need for invasive mechanical ventilation, high SOFA score, severity of prognosis, or indication for palliative care.

To ensure methodological quality and transparency, the study followed the guidelines of the *Consolidated Criteria for Reporting Qualitative Research* (COREQ) tool.

Research Participants

Participants were selected by invitation during visiting hours and approached by the researcher, who explained the objectives of the research and clarified any questions. All invited family members agreed to participate and formalized their participation by signing the Informed Consent Form (ICF).

Inclusion and Exclusion Criteria

Family members who were constantly present with the patient during hospitalization for a minimum period of 48 hours and who had a direct parental relationship with the patient participated in the study. Paid or hired companions who were not related to the patient were excluded.

Data Collection

Data collection involved semi-structured interviews with family members and gathering information from patient records for clinical characterization (main diagnosis, length of hospitalization, and ventilatory support).

Data collection was carried out in the reception room for companions, located within the ICU. Only one companion per patient was interviewed. All family members received and signed the ICF, answered a sociodemographic questionnaire (age, gender, kinship, education, occupation, religion, marital status, and length of hospital stay), and participated in semi-structured interviews.

Six interviews were conducted, each lasting between 8 and 33 minutes, by the researcher — a final-year resident psychologist working in the ICU. Family members were approached during visiting hours and invited to participate in the study, and all accepted. The interviews were audio-recorded and transcribed in full.

A reflective journal was kept to support supervision, reflect on possible interpretive biases, and ensure greater rigor in data analysis. It recorded observations about the participants' behavior and emotions during the interviews, reflections on the researcher's performance and possible interference resulting from his professional connection with the ICU, decisions made throughout the data collection and analysis process, as well as notes on unexpected reactions, difficulties, or interpretive doubts. The use of this diary minimized biases related to the researcher's performance, providing greater methodological transparency and increasing the reliability of the interpretation of the interviews.

The sampling was intentional, consisting of family members accompanying patients at imminent risk of death. The number of interviews (n=6) was defined by thematic saturation, identified from the iterative analysis of the discourses. The thematic categories explored included: emotional suffering, family visits, relationship with the healthcare team, spirituality, and communication.

Data Analysis

Data analysis followed the thematic categorical content analysis methodology proposed by Bardin[11], with the support of *MaxQDA* software.

The process involved exhaustive reading, coding of units of meaning, grouping into thematic categories, and interpretation of the core meanings, using a predominantly inductive approach guided by dimensions previously recognized in the literature on ICU hospitalization.

The interviews were transcribed verbatim by the researcher between June and August 2025 and reviewed by a second researcher to ensure content fidelity.

Ethical and Integrity Aspects

The study was submitted to and approved by the Research Ethics Committee of the Dr. Fernando Mauro Pires da Rocha Municipal Hospital, registered on the Brazil Platform under CAAE 77947324.6.0000.5452, with opinion no. 7,252,006.

All participants received detailed information about the research, signed an informed consent form, and were assured of their right to refuse or withdraw at any time without prejudice to their care.

The data were stored in a password-protected electronic folder, accessible only to the researcher, and will be kept for five years, in accordance with Resolution No. 466/12 of the National Health Council.

After this period, the files will be destroyed. All stages complied with the General Data Protection Law (Law No. 13,709/2018), ensuring the anonymization of information and the protection of participants' identities.

In cases of emotional distress identified during or after the interview, family members were referred for psychological support offered by the institution's own psychology service.

RESULTS

The interviewees were identified only by codes ("F1," "F2," "F3," "F4," "F5," and "F6"), ensuring anonymity and confidentiality. Table 1 presents the sociodemographic characteristics of the family members who comprised the sample.

Table 1 - Sociodemographic profile of family members, São Paulo, Brazil, 2025.

Family	Length of hospitalization	Relationship	Gender	Age	Education	Religion	Occupation	Marital status
1	14 days	Granddaughter	F	33	High school graduate	Christian	Housewife	Single
2	9 days	Father	M	69	High school graduate	Christian	Retired	Married
3	90 days	Mother	F	61	High school graduate	Christian	Housewife	Married
4	6 days	Granddaughter	F	23	Elementary school	Umbanda practitioner	Hairdresser	Single
5	15 days	Cousin	F	32	Higher education	Catholic	Nurse	Single
6	7 days	Wife	F	48	Higher education	Christian	Teacher	Married

Legend: F = Female; M = Male.
Source: Prepared by the author

The sociodemographic analysis revealed a predominance of females (83%), mostly adults of working age (30 to 60 years old). There was diversity in family ties (granddaughters, wife, father, mother, and cousin) and a marked presence of religiosity (5 Christians and 1 Umbanda practitioner). These elements highlight the central role of women in caregiving, the plurality of family ties, and spirituality as a coping resource.

Content analysis of the interviews identified five central themes, presented in Table 2.

Table 2 - Summary of interviews categorized by dimension of analysis, subthemes, and product generated, São Paulo, Brazil, 2025.

Categorical analysis of interviews with family members of patients admitted to the ICU

Dimension of Analysis	Indicators (Subtopics)	Evidence from Interviews
Emotional Suffering	Fear, distress, helplessness, anxiety, anticipatory grief	*"I feel like I am losing him little by little"* (F6); *"Anxiety consumes me"* (F2).
Family Visits	Expectation, displays of affection, symbolic farewell	*"The visit is the only time I can touch him"* (F3); *"I told him he could rest, that we would be fine"* (F6).
Relationship with the Health Team	Welcoming, active listening, specific criticism	*"The doctor was very clear with me, which helped me"* (F4); *"I missed feedback from the nurses"* (F5).
Spirituality	Belief in miracles, surrender to God, resignation with faith	*"The last word belongs to God"* (F6); *"I pray a lot, I know that He can do anything"* (F2).
Communication	Clarity, empathy, insufficient information	*"They failed to explain better what is happening"* (F3); *"I felt welcomed by the psychologist"* (F6).

Source: Prepared by the author

Meaningful themes from interviews with family members of critically ill patients in the ICU.

Emotional suffering

All participating family members reported high levels of psychological distress during the hospitalization period. The main feelings identified were:

- Fear: present in 100% of participants (6/6);
- Anxiety: reported by 83% (5/6);
- Anticipatory grief: mentioned by 50% (3/6);
- Distress and helplessness: reported by 66% (4/6).

This core shows that the experience of accompanying critically ill patients in the ICU is strongly marked by intense emotional impact, permeated by feelings of apprehension, vulnerability, and anticipation of loss.

Participants experienced a high level of psychological distress, marked by fear, anguish, anxiety, and deep sadness. This distress oscillated between hope for recovery and anticipation of loss, constituting a process of anticipatory grief.

In the initial interviews (F1, F2), anxiety and expectation of improvement predominated; in F3 and F4, signs of emotional exhaustion were observed; in F5 and F6, greater resignation and acceptance of the possibility of loss emerged.

Family Visit

The visit period was described as an intensely awaited moment, permeated by strong emotions. Expressions of affection, prayers, words of encouragement, and symbolic farewells were reported.

In the initial interviews, feelings of nervousness and hope prevailed; in the final reports (F6), serenity and gestures of farewell emerged. The visit represented an opportunity to preserve emotional bonds in the face of the restrictions imposed by hospitalization.

Relationship with the Health Team

Experiences with the team were mixed. There was criticism of the nursing staff, associated with a lack of welcome and information, while doctors and psychologists were remembered as sources of empathy and support.

In F1 and F4, positive experiences of welcome were reported; in F5, more incisive criticism of nursing; in F6, the role of psychological support was highlighted as fundamental in moments of fragility.

Spirituality

Faith and spirituality emerged as central coping resources, reported by all family members. Manifestations ranged from hope for a miracle to acceptance of divine will.

In some reports, spirituality was pointed out as a mediator of emotional suffering, providing comfort and support in the face of uncertainty and the possibility of loss.

Communication

Communication was described as a determining factor in the experience. When clear and empathetic, it was associated with reduced distress and the building of trust. When vague or insufficient, it generated insecurity and increased suffering.

In addition to the statements by F3 and F6, other reports reinforced this finding: *"I didn't understand the medical terms and left feeling more* worried" (F1); *"I wish they had explained the* tests better" (F2); *"There was a lack of feedback at* times" (F3); *"I wasn't always able to talk to someone on the* team" (F4). These examples reinforce communication as a modulator of the relationship between family members and the healthcare team.

DISCUSSION

Hospitalization in the ICU significantly impacts not only patients but also their accompanying family members, generating profound emotional repercussions. The results of this study revealed intense psychological distress, the presence of anticipatory grief, fluctuations between hope and acceptance of the severity of the clinical condition, difficulties in communicating with the healthcare team, and the use of spirituality as a coping resource. These findings corroborate research that highlights the family experience as an integral part of the hospital care process[12-15].

Emotional distress manifested itself in various ways, ranging from fear, anxiety, anguish, and sadness, reflecting the perception of finitude and anticipatory grief[16]. This phenomenon was marked by alternating between hope for recovery and gradual acceptance of the possibility of loss, highlighting the complexity of coping as a family in critical situations. Recent studies show that this process can have prolonged repercussions, associated with the development of *Post-Intensive Care Syndrome – Family*[17], which reinforces the importance of continuous support for family members.

Hospital visits were a moment of emotional and symbolic relevance, serving as a space for preserving bonds and expressing affection. Verbal and nonverbal expressions showed that this contact maintained emotional cohesion between patients and family members, even in the face of imminent death, corroborating the classic literature on the importance of bonds in the grieving process. Recent reviews reinforce this finding, pointing to visits as an essential strategy for family care and support in ICUs.

Among the five central nuclei identified, two stood out as determinants of the suffering of companions in the ICU: the heterogeneous relationship with the healthcare team and communication as a determining factor of the experience. These aspects are closely related to organizational and institutional actors, such as the institution's culture, mission, vision, and values, the care model, and the working conditions offered. These elements directly influence the quality of professional relationships, the ethical behavior of healthcare professionals, and the effectiveness of communication.

When the organizational culture is predominantly oriented toward technical performance and centered on the disease, it tends to reproduce asymmetrical and hierarchical relationships between professionals, patients, and family members. In contrast, institutions that promote a culture of collaboration, cooperation, and patient-centered care tend to favor empathetic and welcoming behaviors, reducing inequalities and improving the quality of communication between staff and companions.

The different levels of acceptance between professional categories, particularly between doctors and nurses, are also noteworthy.

Nursing, because it remains more constantly in the ICU and deals directly with the emotional demands of patients and family members, is more exposed t d intense occupational stressors, such as work overload, scarcity of resources, and lack of institutional psycho-emotional support. These factors contribute to less affective behaviors and the difficulty of maintaining a continuous humanized attitude.

Thus, impaired communication and imbalance in the companion-physician/companion-nurse relationship should be understood as expressions of an organizational context that still lacks integration, institutional empathy, and collaborative interdisciplinary practices. Strengthening institutional policies of humanization, communication training, and emotional support for professionals could mitigate these inequalities and promote more ethical, sensitive, and patient- and companion-centered care.

The relationship with the healthcare team emerged as a determining factor in the experience of companions. Clear communication, empathy, and active listening were perceived as elements that facilitated emotional coping, while information gaps intensified feelings of insecurity and helplessness. This data converges with the principles of the NHP[10] and with studies that highlight communication as a central axis of care in critical contexts[20-21]. The COVID-19 pandemic further emphasized this aspect: the absence of face-to-face contact and insufficient communication aggravated family distress and suffering[22].

Spirituality stood out as a relevant psychological and symbolic resource, mobilizing hope, resignation, and the attribution of meaning to suffering. Whether through religious beliefs or prayer practices, family members reported that faith contributed to reframing the experience and maintaining hope, even in the face of clinical severity. This finding is consistent with studies that point to spirituality as a mediator of suffering in ICUs, favoring emotional elaboration and resilience[15].

Finally, the role of the hospital psychologist proved essential in mediating family suffering, providing qualified listening, clear information, and continuous emotional support. Recent research confirms that humanized practices in ICUs, centered on multiprofessional care, strengthen bonds and reduce the emotional burden on family members.

In summary, the results indicate that the impact of ICU hospitalization goes beyond the patient, involving emotional, relational, spiritual, and organizational dimensions that shape the family experience.

The analysis highlighted five central themes: (1) emotional suffering marked by anticipatory grief; (2) visits as a privileged space for bonding; (3) heterogeneous relationship with the healthcare team; (4) spirituality as a coping resource; and (5) communication as a determining factor of the experience. These findings reinforce the need for multidisciplinary practices that promote acceptance, effective communication, and comprehensive support, in line with humanization policies and recent scientific research[19].

Study Limitations

Among the limitations, we highlight the small number of participants (n=6) and the fact that the study was conducted in a single center, which restricts the generalization of the results. There is also the possibility of selection bias, since only family members present during the visit period were included.

The fact that the interviews were conducted by the researcher himself, who worked at the unit, may have influenced the responses. In addition, systematic document triangulation was not performed, which limits the expansion of the analyses.

Contributions to Science

The study contributes to science by broadening the understanding of the impacts of ICU hospitalization on family companions, highlighting the need for psychosocial support and subsidizing more humanized and integrative care practices.

CONCLUSION

This qualitative study highlighted the emotional impacts experienced by family members accompanying patients admitted to adult ICUs. Psychological distress was marked by fear, anxiety, anticipatory grief, and exhaustion, oscillating between hope for recovery and acceptance of loss.

Visiting the patient was described as a central space for bonding and emotional expression, also taking on the character of a symbolic farewell in critical situations. Communication with the healthcare team directly modulated the family's experience: when clear and empathetic, it provided comfort; when insufficient, it intensified feelings of insecurity.

The relationship with the healthcare team proved to be decisive for emotional support and acceptance, consisting of both verbal and nonverbal communication—predominantly affective language capable of influencing individual and group behavior and attitudes.

When clear and empathetic, this relationship fostered bonding and biopsychosocial well-being; when insufficient, it intensified feelings of insecurity and helplessness.

The coordinated work of the multidisciplinary team—doctors, nurses, physical therapists, nutritionists, psychologists, and other professionals—aligned with the principles of the NHP, proved essential in providing continuous support to patients and their families.

Spirituality emerged as a fundamental coping resource, promoting a reframing of suffering and emotional support in the face of finitude. The presence of the hospital psychologist proved strategic, offering qualified listening and emotional support.

From a practical standpoint, the results reinforce the need to extend ICU care beyond the patient to include family members as individuals who are equally impacted by the illness process.

Multidisciplinary strategies that prioritize active listening, skilled communication, and emotional and spiritual support are the pillars of humanized care.

Multidisciplinary strategies that prioritize active listening, humanized relational communication, and emotional and spiritual support are the pillars of humanized care, fulfilling the study's objective of analyzing the emotional impact on family members, understanding the stress associated with hospitalization, and demonstrating how the care provided by the multidisciplinary team, integrated with the principles of NHP, promotes humanized care and continuous support for the patient and family.

AUTHORS' CONTRIBUTION

Transparency in authors' contributions according to the CRediT Taxonomy.

Conceptualization	Luana Santos Chagas da Paixão; Jucinei Araujo de Jesus
Data Curation	Não aplicável
Formal Analysis	Luana Santos Chagas da Paixão
Funding Acquisition	Não aplicável
Investigation	Luana Santos Chagas da Paixão
Methodology	Luana Santos Chagas da Paixão; Jucinei Araujo de Jesus
Project Administration	Luana Santos Chagas da Paixão
Resources	Luana Santos Chagas da Paixão
Software	Não aplicável
Supervision	Jucinei Araujo de Jesus
Validation	Luana Santos Chagas da Paixão
Visualization	Luana Santos Chagas da Paixão
Writing - Original Draft Preparation	Luana Santos Chagas da Paixão
Writing – Review & Editing	Luana Santos Chagas da Paixão; Jucinei Araujo de Jesus

STATEMENTS

Conflicts of interest	Not applicable
Funding	Not applicable
Ethical approval	Not applicable
Acknowledgments	Not applicable
Preprint	Not applicable
Artificial Intelligence	Not applicable

TRANSLATION

The translation of this article was assisted by DeepL Translator artificial intelligence from the original version written in Portuguese (Brazil). The translated version was submitted to the editorial team for curation, consisting of a limited scope editorial review. Translations assisted by artificial intelligence may vary from the native language.

REFERENCES

1. Digby R, et al. Family experiences and perceptions of intensive care unit care and communication during the COVID-19 pandemic. Aust Crit Care 2023;36(3):350-60. doi: 10.1016/j.aucc.2022.03.003.

2. Lima Junior JRM, et al. Percepção da espiritualidade e religiosidade de pacientes hospitalizados em Unidade de Terapia Intensiva. Contribuciones a las Ciencias Sociales 2024;17(9):e10779. doi: 10.55905/revconv.17n.9-261.

3. Vieira AG, Waischunng CD. A atuação do psicólogo hospitalar em Unidades de Terapia Intensiva: a atenção prestada ao paciente, familiares e equipe, uma revisão da literatura. Rev SBPH 2018;21(1):51-66. doi: 10.57167/Rev-SBPH.21.269.

4. Cobo MA, Moscardi R, Ortega J. Impacto psicológico en los cuidadores principales de familiares bajo tratamiento paliativo: una revisión sobre la calidad de vida. Rev Fac Cien Med Univ Nac Cordoba. 2024;81(2):415-431. doi: 10.31053/1853.0605.v81.n2.44824.

5. Midega TD, Oliveira HSB de, Fumis RRL. Satisfação dos familiares de pacientes críticos admitidos em unidade de terapia intensiva pública e fatores correlacionados. Rev Bras Ter Intensiva. 2019;31(2):147-155. doi: 10.5935/0103-507X.20190024.

6. Neves JL, Schwartz E, Echevarría-Guanilo ME, Spagnolo LML, Bazzan JS, Lise F. From the waiting room to the bed: Observation of families on the Intensive Care Unit. Res Soc Dev. 2021;10(1):e12111. doi: 10.33448/rsd-v10i1.12111.

7. Sampaio AA, Zonta JB, Ferreira FY, Okido ACC. Cuidado centrado na família em unidade de terapia intensiva pediátrica: percepção dos profissionais. Rev Rene (Online). 2017;18(4):515-520. doi: 10.15253/2175-6783.2017000400013.

8. Digby R, Manias E, Haines KJ, Orosz J, Ihle J, Bucknall TK. Family experiences and perceptions of intensive care unit care and communication during the COVID-19 pandemic. Aust Crit Care 2023 May;36(3):350-60. doi: 10.1016/j.aucc.2022.03.003.

9. Lima Junior JRM, Mendes CdeJL, Santos KCBD, Medeiros THReS, Santos DLN, Gouveia AJG, Oliveira RDN, Gonçalves EdS. Percepção da espiritualidade e religiosidade de pacientes hospitalizados em Unidade de Terapia Intensiva. Contrib Cienc Soc. 2024;17(9):e10779. doi: 10.55905/revconv.17n.9-261.

10. Brasil. Ministério da Saúde. Humaniza SUS: Política Nacional de Humanização. Brasília: Ministério da Saúde; 2006. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_humanizacao_pnh_folheto.pdf. Acesso em: 20 ago. 2025.

11. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2016.

12. Maynart WH, Albuquerque MC, Brêda MZ, Jorge JS. A escuta qualificada e o acolhimento na atenção psicossocial. Acta Paul Enferm 2014;27(4):300-3. doi: 10.1590/1982-0194201400051.

13. Silva MA, Morais JD, Batista AAF. Humanização ao paciente e família na unidade de terapia intensiva (UTI). Rev JRG Est Acad 2024;7(15):e1625. doi: 10.55892/jrg.v7i15.1625.

14. Meneguin S, Pollo CF, Benichel CR, Cunha LK, Miot HA. Comfort and religious-spiritual coping of intensive care patients' relatives. Intensive and Critical Care Nursing. 2020;58:102805. doi: 10.1016/j.iccn.2020.102805

15. Silva MA da, Morais JD, Batista AAF. Humanização ao paciente e família na unidade de terapia intensiva. Rev JRG Est Acad. 2024;7(15):e1625. doi: 10.55892/jrg.v7i15.1625.

16. Mussart KM. Implementação de diário em terapia intensiva: percepção de familiares e da equipe de enfermagem. Esc Anna Nery. 2024;28(1):e20230172. doi: 10.1590/2177-9465-EAN-2023-0172pt.

17. Delgado LD, Rincón Elvira EE, León Gómez VE. Apoyo emocional de las familias a los pacientes en Unidades de Cuidados Intensivos: revisión bibliográfica. Rev Enferm Soc Canar. 2020;14(3):1-10.

18. Smith AC, Ferguson HN, Russell RM, Savsani P, Wang S. Post-Intensive Care Syndrome Family. Crit Care Clin 2025 Jan;41(1):73-88. doi: 10.1016/j.ccc.2024.08.008.

19. Vieira AR. A humanização do cuidado hospitalar e a atuação das equipes multiprofissionais. Cad Saude Publica 2018;34(3):e00123417. doi: 10.1590/0102-311X00123417.

20. Dural G. Spiritual care experiences of nurses working in intensive care units: a qualitative study. Nurs Crit Care 2024 May;29(3):545-54. doi: 10.1111/nicc.12975.

21. Dural G. Spiritual care experiences of nurses working in intensive care units: a qualitative study. Nurs Crit Care 2024;29(3):545-54. doi: 10.1111/nicc.12975.

22. Checa-Checa A, et al. Family support strategies during intensive care unit: a systematic review. Inquiry 2025;62:469580251368654. doi: 10.1177/00469580251368654.