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RESEARCH

STRESS AND COPING IN FAMILIES OF PATIENTS IN AN INTENSIVE CARE UNIT

ESTRESSE E *COPING* DE FAMILIARES DE PACIENTES EM UMA UNIDADE DE TERAPIA INTENSIVA

ESTRÉS Y AFRONTAMIENTO EN FAMILIARES DE PACIENTES EN UNA UNIDAD DE CUIDADOS INTENSIVOS

Tatiele Galli Zanetti¹, Eniva Miladi Fernandes Stumm², Liamara Denise Ubessi³

ABSTRACT

Objective: Evaluate and compare phases of stress and coping of family members of patients in an ICU of a hospital in the northwestern region of Rio Grande do Sul. **Method:** Quantitative, analytical, descriptive, transversal, with 22 families. To collect the data was used demographic data and "Symptoms of Stress Inventory", plus an open question as to cope with the stress experienced. **Results:** Most are women, married, with children and low education. As the evaluation of stress, the vast majority were in middle or late phase stress and the coping strategy most frequently mentioned by relatives of the patients was "pray, ask God for help". **Conclusions:** Important for nurses to accept and follow the patients' families so that they feel equally cared for. **Descriptors:** Family, Physiological stress, Psychological stress, Intensive care unit, Nursing, Psychological adaptation.

RESUMO

Objetivo: Avaliar e comparar fases de estresse e *coping* de familiares de pacientes internados em uma UTI de um hospital da região noroeste do Rio Grande do Sul. **Método:** Quantitativa, analítica, descritiva, transversal, com 22 familiares. Para a coleta, foram usados dados sociodemográficos e "Inventário de Sintomas de Stress", acrescido de uma pergunta aberta quanto ao enfrentamento ao estresse vivenciado. **Resultados:** A maioria é mulher, casada, com filhos e baixa escolaridade. Quanto à avaliação do estresse, a grande maioria encontrava-se na Fase Intermediária ou Final do estresse e a estratégia de enfrentamento mais mencionada pelos familiares dos pacientes foi "rezar, pedir ajuda a Deus". **Conclusões:** Importante que o enfermeiro acolha e acompanhe as famílias dos pacientes para que elas se sintam igualmente cuidadas. **Descritores:** Família; Estresse fisiológico; Estresse psicológico, Unidade de terapia intensiva, Enfermagem, Adaptação psicológica.

RESUMEN

Objetivo: Evaluar y comparar las fases de estrés y afrontamiento de los familiares de pacientes ingresados en una UCI de un hospital en la región noroeste de Rio Grande do Sul. **Método:** Cuantitativo, analítico, descriptivo, transversal, con 22 familias. Para recoger los datos sociodemográficos se han utilizado y "Inventario de Síntomas de Estrés", y una pregunta abierta como para hacer frente al estrés experimentado. **Resultados:** La mayoría son mujeres, casados, con hijos y bajo nivel educativo. En cuanto a la evaluación del estrés, la gran mayoría se encontraba en la fase intermedia o final de estrés y afrontamiento estrategia más frecuentemente mencionados por los familiares de los pacientes era "orar, pedirle ayuda a Dios." **Conclusiones:** Importante para las enfermeras de aceptar y seguir las familias de los pacientes para que se sientan igual de cuidados. **Descriptores:** Familia, Estrés fisiológico, Estrés psicológico, Unidad de cuidados intensivos, Enfermería, Adaptación psicológica.

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INTRODUCTION

The illness of a loved one causes countless feelings in its family, and when hospitalization in an intensive care unit - ICU becomes necessary, this can be a generator of stress and anxiety for both the patient and the family¹. The ICU, for its specific features, which differentiates it from other inpatient units, is considered a stressor environment for relatives, as well as for patients and workers.²

The disease itself may constitute a threat to the patient's life, with changes in family homeostasis. The apprehension of the family may increase while in the waiting room of the ICU, even progressing to stress while they follow the movement of both patients and professionals and other relatives, coupled with restriction of visits and, especially, of information. Luz et al.³ reported that for family members, equipment and procedures in the ICU resemble instruments of torture. All the technology, according to the authors, can disturb people's imagination, leading them to mythologize this unit and assign it a number of adjectives, such as place of death, suffering, pain, among others.

With regards to the feelings experienced by family members of ICU patients, Oliveira et al.⁴ stated that since they are going through a difficult situation, they experience feelings and emotions sometimes ambiguous. This can occur because the hospital admission is differentiated, in a unit full of regulations that restrict the role of family participation, setting the patient away from its family and interfering in the familiar bond itself³. Stumm et al.⁵ reported to the movement, the sounds of equipment and admission of critically ill patients, which together contribute so that the community in general consider the ICU as a stressful environment.

To Lipp⁶ stress is a normal and necessary reaction for the survival of human beings, it is R. pesq.: cuid. fundam. online 2013. abr./jun. 5(2):3608-19

what prepares the organism to face risky situations or strong emotions. Greenberg⁷ states that the source of stress is varied, with any event being able to trigger stress. In this perspective, Sanzovo and Coelho⁸ reported the subjectivity of the individual responses to stress, that is, it occurs differently in each person, and the analysis of the stressor will depend on the understanding of each person on this regard.

The manifestations of stress occur in three phases, each of which comprises a set of physical and psychological symptoms. According to Lipp⁶ the phases of stress are: Alarm Reaction or Initial Phase, Resistance or Intermediate Phase and Exhaustion or Final Phase.

In the Initial Phase of stress the main symptoms are: cold extremities, dry mouth, stomach discomfort, teeth grinding, transient diarrhea, insomnia, tachycardia, hyperventilation, increased motivation and sudden urge to start new projects, among others. In the Intermediate Phase, there is an adaptation of the body to the stressor, and some symptoms from the Initial Phase can carry on or not and others may arise, such as: memory problems, discomfort, ulcers, dizziness, increased sensitivity, focused thought on a subject, among others.⁹

The Final Phase of stress is characterized by depletion of the energy used in the previous phase, i.e., of resistance to stress, as a result of the prolonged exposure to the stressor agent⁷. Moreover, Lipp⁶ points out that at this stage, the body can be targeted at both the physical and emotional field, so there is a propensity to illness of the weaker body.

Faced with the challenges posed by this new situation of life and to avoid the symptoms of stress to become harmful to the body, it is important for the individual to develop coping strategies. Telles and Pimenta¹⁰ define coping as a dynamic process with many dimensions, aiming at

preserving the balance, at mitigating the results experienced by stressful situations. The same can be considered important for the responses of the organism to stressors, as responsible for the physical and emotional well-being of the individual.¹¹

It is considered that from the moment the team responsible for the care of patients in ICU, more specifically, nursing, recognizes the needs of patients' relatives, as well as the stress experienced by them, it will be able to guide actions aimed at minimizing stressors and qualifying assistance. Silveira et al.¹ claim that the team must value the family-patient relationship, by interfering with the patient's recovery and it is for the nursing team to understand that the patient integrates a fragile family for experiencing a disease and that its restructuring, at this time, is fundamental both for the patient's recovery and for the redefinition of the family structure itself.

Faced with an ICU admission, there is a disruption in family structure, a critic situation resulting from the absence of the family member, the fear of loss, the change in schedules and family dynamics.¹² Faced with this scenario it is considered that the relatives are exposed to stressors and susceptible to stress, thus this study seeks to evaluate and compare the phases of stress from relatives of patients admitted to an ICU, as well as the coping mechanisms used by them to deal with stress.

METHODOLOGY

A quantitative, analytic, descriptive, transversal research with 22 family members of patients in an adult ICU of a general hospital in the northwestern region of Rio Grande do Sul, size IV. It has 243 beds and assists various levels of complexity. The ICU has 11 beds, with a monthly R. pesq.: cuid. fundam. online 2013. abr./jun. 5(2):3608-19

average length of stay in days of 3.42 patients and monthly occupancy rate of 82.15%.

All ethical precepts involved in a research with people were observed, and the research project was submitted and approved by the Ethics in Research Committee of the Regional University of Northwestern Rio Grande do Sul, under approval n° 009/2010, in 01/18/2010.

Data collection occurred in February 2010, with all family members at the ICU waiting room being invited to participate in the research. Of the 30 invited to participate, 8 did not agree to participate and 22 agreed. Inclusion criteria listed were: being a family member and/or considered a family member of the patient in the ICU, to be 18 years of age or older and to agree to participate in the study.

The instruments of data collection were the "Stress Symptom Inventory" of Lipp¹³, in addition to an open question: Tell me, how has it been for you sir (madam) to experience this situation? And a questionnaire with identification and demographic data of the relatives, answered by them. The open question was recorded digitally, transcribed verbatim and from it, the coping mechanisms to deal with stress referred by them were extracted.

Data analysis was performed with the "software" SPSS and descriptive statistics and data presented in tables and figures.

As for the instrument "Stress Symptoms Inventory " used, it includes physical and psychological symptoms, present in all three phases of stress, counted according to the number of occurrence. Of the total of symptoms reported by family members of the research, the level of stress they were at the time of application of the instrument was determined. Accordingly, to analyze the phases of stress, the procedure was as follows: F0 = eustress, with sum less than five; F1 = Initial Phase of the Stress or Alert Phase, with sum equal to or greater than five; F2 =

Intermediate Phase or Phase of Stress Resistance, a sum equal to or greater than three; F3: Final Phase of Stress or Exhaustion Phase, with a sum greater than or equal to eight symptoms.

DISCUSSION AND RESULTS

Twenty-two (22) family members of adult patients admitted to the ICU of a hospital in the northwestern state of Rio Grande do Sul, size IV, participated in the survey. It is important initially to characterize the respondents. Of the total family members, 17 (77.3%) are female, with a mean age of 44.36 years, while 10 (45.5%) were aged between 38 to 57 years, 7 (31.8%) aged 18 to 37 years of age, and 5 (22.7%) over 58 years of age.

Regarding marital status, 13 (59.1%) family members are married and 9 (40.9%) are single, widowed or separated. Of the total respondents, 19 (86.4%) have children, and of these, 36.4% only one child. It appears that 22 (100%) of the family members have some sort of religion or belief and more than half, i.e., 13 (59.1%) profess the Catholic religion. Regarding education, 16 (72.8%) family members, i.e., the majority, have only elementary education.

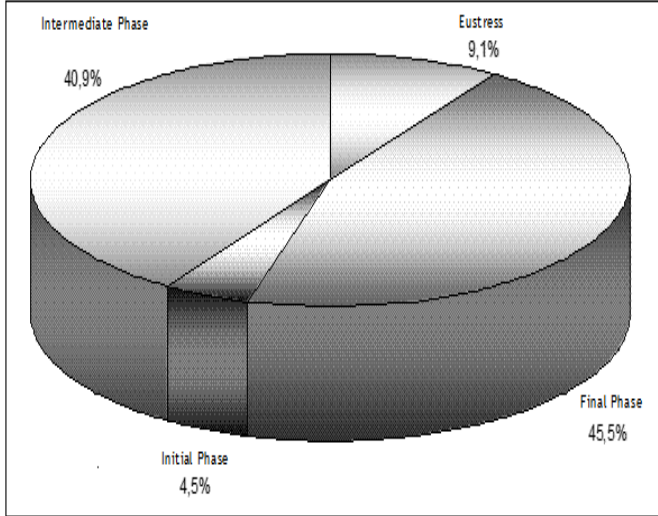
Among the inclusion criteria listed for this research, one of them was that the participant would have some degree of kinship or considered itself a family member of the patient in the ICU. In this context, it appears that 5 (22.8%) of them have fraternal bonds, i.e., they are siblings, 4 (18.2%) spouses, 2 (9.1%) are children and the same number and percentage are mothers and brothers-in-law, and uncles. The remaining were nominated others, for a total of 5 (22.5%) of family members.

Concerning the time of admission to the ICU, it is observed that this varied between the extremes, and (40.9%) were hospitalized for less than 3 days, 9 (40.9%) for more than 8 days, and the remaining, from 3 to 8 days. Regarding the R. pesq.: cuid. fundam. online 2013. abr./jun. 5(2):3608-19

age of the patients, the highest percentage was of adults above 44 years of age, i.e., 13 (59.1%) of all inpatients. With regard to the reason for hospitalization of these individuals in the ICU, the highest percentages were postoperatively, 12 (54.5%), followed by multiple traumas⁶ (27.3%).

With respect to the phases of stress that family members of patients surveyed were in (see Figure 1), it is revealed that 10 (45.5%) were in the Final Phase of stress, 9 (40.9%) in the Intermediate, 2 (9.1%) in Eustress and 1 (4.5%) in the Initial Phase of stress.

Graphic 1. Phases of stress of Family members of adult patients admitted to the ICU of a size IV hospital with. - February/2010.



Sequentially, Table 1 presents results for the crossing of variables "Gender" and "Phases of stress." It turns out of 77.3% of women, 9 (40.9%) were in the Final Phase of stress and 5 (22.7%) in the Intermediate.

Table 1. Gender according to the phases of stress of Family members of adult patients admitted to the ICU of a size IV hospital - Stress Symptom Inventory - February/2010

Gender	Phases of Stress				Total n(%)
	Eustress n(%)	Initial Phase n(%)	Intermedi ate Phase	Final Phase n(%)	
Female	2(9.1)	1(4.5)	5(22.7)	9(40.9)	17(77.3)
Male	-	-	4(18.2)	1(4.5)	5(22.7)
Total	2(9.1)	1(4.5)	9(40.9)	10(45.5)	22(100)

When crossing the "Length of stay" with "Phases of stress" (see Table 2), it appears that of 9 respondents who have family members in the ICU for less than 3 days, 5 (22.7%) were in the Intermediate Phase of stress and 4 (18.2%) in the Final. Equally, it is clear that of the family members surveyed, regardless of length of stay of their loved one, the vast majority were in the Intermediate or Final Phases of stress.

Table 2. Length of hospital stay according to the Phases of Stress from family members of adult patients admitted to the ICU of a size IV hospital - Stress Symptom Inventory-February/2010

Length of Stay	Phases of Stress				Total n(%)
	Eustress	Initial Phase	Intermediate Phase	Final Phase	
	n(%)	n(%)	n(%)	n(%)	
Less than 3 days	-	-	5(22.7)	4(18.2)	9(40.9)
3 --- 8 days	1(4.5)	-	1(4.5)	2(9.1)	4(18.2)
More than 8 days	1(4.5)	1(4.5)	3(13.6)	4(18.2)	9(40.9)
Total	2(9.1)	1(4.5)	9(40.9)	10(45.5)	22(100)

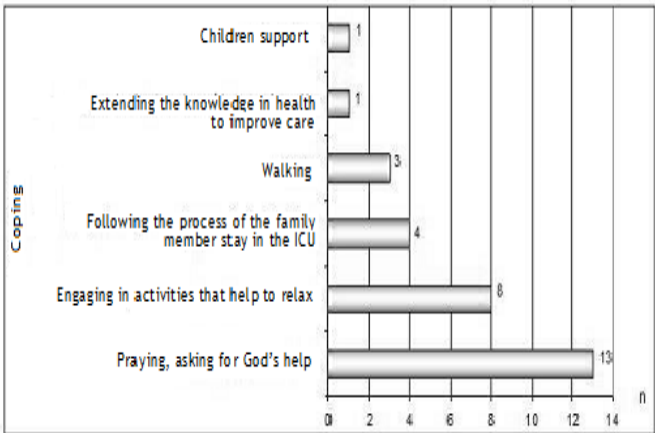
When analyzing the data in Table 3, the result of interbreeding between "Reason for hospitalization" according to "Phases of stress" in which the family members were, it appears that the reasons for ICU admission, with higher percentages, were postoperative followed by multiple injuries and these were mostly in the Intermediate or Final Phase of stress.

Table 3. Reason for hospitalization of patients according to the Phases of Stress of the family members surveyed at an adult ICU of a size IV hospital- Inventory of Stress Symptoms - February/2010.

Reason	Phases of Stress				Total n(%)
	Eustress n(%)	Initial Phase n(%)	Intermediate Phase n(%)	Final Phase n(%)	
Postoperative	1(4.5)	-	6(27.3)	5(22.7)	12(54.5)
Multiple traumas	-	1(4.5)	1(4.5)	4(18.2)	6(27.3)
Hepatic cirrhosis	-	-	1(4.5)	1(4.5)	2(9.1)
Cardiopathy	1(4.5)	-	1(4.5)	-	2(9.1)
Total	2(9.1)	1(4.5)	9(40.9)	10(45.5)	22(100)

It is noteworthy that of two family members of patients hospitalized with a diagnosis of hepatic cirrhosis one was in the Intermediate Phase and the other in the Final Phase of stress. Regarding the coping strategies used by the respondents, they are explained in Figure 2, as follows. It is important to note that these were grouped based on the statements obtained and that the family members reported more than one coping strategy to deal with the stress caused by the presence of their loved one in ICU.

Graphic 2. Coping strategies reported by relatives of adult patients admitted to the ICU of a size IV hospital- February/2010



Still in regards to the data contained in Figure 2, it is evident that the highest percentage of responses was referring to "praying, asking God for help," mentioned by 13 (59.1%) of the family, followed by "activities that help to relax" by 8 (36.4%) family members.

The vast majority of family members surveyed are female. This finding is consistent with a study conducted in 2004, with 52 family members of patients in an ICU of a university hospital, in the interior of the State of São Paulo, which aimed at validating the range of family needs in ICU ¹⁴. According to precepts of society the woman is the caregiver, which supposedly carries the gift of caring for others. In this context, Gasperi and Radünz¹⁵ claim that the care comes from the nature of human beings, historically related to maternal care, the female

figure, whose function is to care for children, husband and family.

For Bicalho, Lacerda and Catafesta¹⁶ the caregiver is the one who, regardless of gender, is dedicated to provide necessary care to the diseased and that often exposes itself to the risk of compromising its own health for the sake of the loved one. The authors mention that the burden imposed by the care and the differentiated routine, in which the caregiver has to assume roles that were not inherent to it, may be a generator of stress.

By associating the "Genre" of respondents to the "Phases of Stress," explained in Table 1, it is evident that women are not only the primary caregivers, they also show high levels of stress. In this context, stressful events may be experienced by them not only because of the situation of having a family member in the ICU, but also because of activities related to their life, i.e., the work, other members of the family who also need attention and care, domestic activities, among others.

A study conducted by the staff of an Emergency Care Unit, of a Health Center School in the interior of the State of São Paulo, which sought to identify the stress and coping of their professional, showed similar results to this study, in which women were at high stress levels, being assigned to double or triple shift working developed daily.¹⁷

The average age of family member participants in this research was 44.36 years, indicating that they are adults, with responsibilities that go beyond care. This result is similar to that found in a study conducted in 2007, with 39 relatives in a waiting room of a hospital in São Paulo, which sought to identify the needs of family members admitted to an ICU.¹⁸

Still referring to the variable age of family members, it is revealed that 17 (77.3%) of them were aged 18 to 58 years of age, i.e., in a period

of intense social and productive activity. This demands several responsibilities with work, family formation and maintenance, study, among others, which ultimately overwhelm the family member who now have to take on new roles, due to the illness of a family member. Corroborating, Urizzi et al.¹² reported that with the hospitalization of a family member in the ICU, the family's daily life changes, so the tasks previously carried out by the ill member accumulate or need to be assumed by another family member.

More than half of the family members is married and have children, which indicates that they have a family to care for besides the family member hospitalized, suggesting a slight family de-structuration, which may generate stress for those who live in this environment. In this perspective Wernet and Ângelo¹⁹ punctuate that any event interferes and changes the form of family functioning, and this searches for rearrangements seeking balance. Carter and McGoldrick²⁰ exemplify factors such as death and serious illness of a family member as responsible for the disruption of the family balance. These, according to the authors, can be considered factors generators of stress.

Moreover, it is observed that relatives without conjugal bond, i.e., single, married and widowed, represent 40.9% of respondents. This situation may generate stress, because this family member will not have anyone with whom to share their daily tasks and even their feelings. In this context Iwamoto et al.²¹ in a study that sought to assess the psychological stress of caregivers of pediatric patients with juvenile idiopathic arthritis, found that single members had higher stress levels than those of married ones, attributing this result to the fact that these individuals are "alone" conjugally, not having someone to share the concerns and tasks of caring.

Religion is the base of support for most people in moments of despair and discomfort. In relation to this variable, it appears that all family members interviewed professed some kind of religion. According to Vila, Rossi and Costa²² religion and belief in a Higher Being fosters understanding and coping with the disease and the various treatment modalities, which are often difficult and painful.

Referring to the majority claiming to profess the Catholic religion, this result is consistent with a study performed at the clinic of a medical school in the state of São Paulo, which sought to identify and characterize caregivers of heart transplant candidates. The authors explain this result by stating that in Brazil, despite the great cultural and religious diversity, there is still a predominance of judeo-christian religions.²³

The educational level of a person is important since it gives the support needed to discern the events, and related to this, it is evident that of the family members participants of the study, sixteen, i.e., 72.8% attended only part of elementary education. This result may interfere with the processing of information by the family member and generate anxiety by having insufficient depth of knowledge to understand the very process of hospitalization and illness of the family member. Luft et al.²⁴, in a research which translated the scale of perceived stress to Portuguese and the measurement of stress in the elderly, identified that as educational level decreases, the level of stress increases.

Concerning the degree of relatedness of respondents with ICU patients, the results of this study differ from the study by Maruiti, Galdeano, Farah²⁵, in the waiting room of a private hospital in São Paulo. It was performed with 39 families, with the goal of identifying the occurrence of symptoms of anxiety/ depression in family members of ICU patients. They identified the children as primary caregivers in different and R. pesq.: cuid. fundam. online 2013. abr./jun. 5(2):3608-19

larger percentage than this study, which were siblings and spouses.

As for the time of admission, it ranged from less than three days (40.9%) and more than eight days, with the same percentage. This result goes against this research, with an average of 41.6 days.²⁵

Analyzing the "Period of hospitalization of the patients" under the "Phases of stress" of those surveyed, it was found that, regardless of the length of stay, stress occurred at high levels. In this context, Lunardi Filho et al.²⁶ reported that the different stages of patient adaptation is also experienced by the family. They claim that the initial stage is denial, i.e., no acceptance of the truth, a defense mechanism of the family. For Pescador²⁷ the situation of the hospitalization of a family member in the ICU generates numerous feelings and discomforts to the family members by the situation experienced. Maruiti, Galdeano and Farah²⁵ found no relationship between length of stay and presence of symptoms of anxiety and depression in family members who joined the search.

Regarding the age of the patients admitted, 59.1% were 44 years of age or more. This result is similar to that found in a study of patients admitted to the ICU of a private average size hospital, with the aim of identifying whether the patient would like to have a companion during their ICU stay and relate its opinion with some variables.²⁸ It can be inferred that the hospitalized patients are adults in their productive age, with family, which can contribute to raise the caregiver stress, since this is a family member.

Most patients were admitted to the ICU after undergoing surgery or having suffered multiple traumas. This result differs from Koury, Lacerda and Barros Neto²⁹, who characterized the population hospitalized with sepsis in the ICU of a hospital in Recife. The same showed that

hospitalization due to surgery or multiple trauma occupied the second and third place respectively.

When crossing the variables "Reason for hospitalization" according to the "Phases of stress," it appears that the relatives of patients admitted to the ICU after surgery, multiple trauma and liver cirrhosis, showed high level of stress, since the majority was in the Intermediate and Final Phases of stress.

Family members of patients in the postoperative period, in addition to coping with the ICU, have previously experienced the anguish caused by waiting for the surgical procedure and even prior hospitalization, which may contribute to the incidence and maintenance of high levels stress. In a study of pre-surgical patients and their relatives at a hospital in Sao Paulo, which sought to measure the frequency and intensity of anxiety and depression of patients and the control group formed by the family members, the result surprised by the fact that the authors identified high levels of anxiety in the family, stating that these people were under stress and attributed this fact to concern for the family member who would be subjected to a surgery.³⁰

Multiple traumas constitute a serious health hazard, unexpected, usually due to an accident. This condition impacts on family members and can be stress-inducing, because according Lipp⁶ it is triggered by any factor other than the routine that the person is accustomed. Complementing, Almeida et al.³¹ reported that many feelings are triggered in the family who experiences a sudden experience of hospitalization and that this can lead to illness.

In this research, as mentioned earlier, the family members of patients with cirrhosis also showed high levels of stress and, accordingly, Smeltzer and Bare³² say that cirrhosis is a chronic liver disease. By being progressive, it can trigger wear, suffering and continuous tension in the family members, which, according to the authors, R. pesq.: cuid. fundam. online 2013. abr./jun. 5(2):3608-19

may contribute to exhaustion, i.e., to the Final Phase of stress.³³

Based on the results obtained in this study, it was observed that the vast majority of participants were in high levels of stress, i.e., the Intermediate or Final Phase of stress. This result leads to reflections and actions of health professionals who work in Intensive Care Units, with emphasis on nursing interventions directed towards the care of family members of patients. Silveira and Ângelo³⁴ reported that, depending on how the healthcare team interacts with family, this may influence the emotional responses of family members to the hospital admission.

In this perspective, Maruiti, Galdeano and Farah²⁵ mentioned that the nurse for being involved with patient care ultimately does not realize the anguish and suffering of the family. Therefore, according to the authors, it is important that the team is prepared to establish a relationship of empathy and respect for the family, aware that poor information and uncertainty can cause apprehension and anxiety in the family. Corroborating, Maruiti and Galdeano¹⁸ punctuate that besides nursing assistance to patients, this should also refer to family members, in order to help them understand the new situation that they are facing, seeking acceptance and better coping, ranging from treatment modalities to be established to the probable consequences thereof.

Coping with stress can be accomplished through the use of strategies. These, according Panzini and Bandeira³⁵ constitute a set of cognitive and behavioral strategies, used by individuals in order to handle situations experienced and perceived by them as stressful. Among the coping strategies mentioned by participants in this research, "praying, asking God for help" and "engaging in activities that relax", had the highest number of responses. A similar result was found in a study with 30 mothers of

autistic children, which sought to identify strategies to deal with this situation. The most frequently mentioned were distracting followed by seeking social/religious support.³⁶ The one that referrers specifically to religion, Almeida et al.³¹ point out that the family seeks in religion for comfort and an explanation for the situation they are facing. In this perspective, Maruiti, Galdeano and Farah²⁵ say that religious beliefs provide tranquility, minimize stress and anxiety and are considered scientifically as coping strategies to stress.

The analysis of the data obtained from this research in light of the authors makes possible to state that family members suffer because of experiencing the hospitalization of their loved ones in the ICU and this is confirmed by high levels of stress presented by them. Given this scenario, they resort to coping strategies and the main one was the faith in a Higher Being, God.

CONCLUSION

The research included 22 relatives of patients admitted to an ICU, and, based on these results, it can be stated that the fact that a family member is hospitalized in an ICU stress-inducing factor.

Family members were at high levels of stress, which is harmful to their well-being and health. In this sense, it is the duty of professionals who work in ICU, to direct a look at families of hospitalized patients, aware that they represent an important role in recovery. Prolonged stress experienced by respondents, as well as causing numerous physiological and psychological symptoms may contribute to the development of diseases and even premature death.

The crossing of the variable "Length of ICU stay" according to "Phases of stress," shows that, regardless of the time the patient is in the ICU, the stress of family emerges, hence the

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importance of the work of professionals in the unit, with emphasis in nursing in order to accommodate and monitor patients' families, so that they feel equally cared for.

The fact that most of the family members of this research present low level of education may contribute to exacerbation of stress levels and, consequently, there is increased risk of damage to health, as elucidated in the literature.

As for stress-coping strategies used by family members, the ones of a religious nature stand out. One justification of the high number of responses regarding the same may be related to the conception of individuals related to the ICU setting, associated with death, suffering, pain, among others, hence the search for faith and belief in a Higher Being.

During the construction of this research, several difficulties were experienced. One was related to the expectation of having a larger number of family members, which was not possible, supposedly by the degree of suffering implicit in both interviews, and in the gestures and attitudes and explicit by the phases of stress in which participants were at the time of data collection.

Another difficulty faced concerns the scarcity of studies on the subject, which shows the relevance of research in both a quantitative and qualitative approach, to aggregate knowledge and stimulate reflections and actions directed to the family of the patient in the ICU, and thus qualify nursing care.

It is considered that the results of this research may contribute to both health professionals and managers, researchers and students, to encourage them to mobilize actions and interventions in hospitals and in the primary care network, aiming at a comprehensive care to the individual suffering and those that equally need to be cared for, the family member.

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