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RESEARCH ARTICLE

# Experiences of Families of Patients Admitted in Intensive Care Unit at a Faith-Based Referral Hospital, Kenya: A Qualitative Descriptive Study

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## ABSTRACT

Intensive care unit (ICU) admissions and bed capacity have increased with rising critical illness, improved infrastructure and resource allocation. Sudden, life-threatening admissions strain families emotionally, financially and psychologically, yet few Kenyan studies guide family support. This study explored the emotional, physical and psychological responses, communication experiences, socioeconomic burden and coping strategies of family members of patients in an adult ICU in a tertiary hospital in Kenya. A qualitative descriptive study was conducted from October to November 2025 in the five -bed adult ICU of a faith-based referral hospital in Kiambu County, Kenya. Twelve family members (N=12) from 10 families were purposively recruited. We audio-recorded and transcribed semi-structured interviews (30-60 minutes, in English or Kiswahili), then analysed them using Braun and Clarke's reflexive thematic analysis. Sample adequacy was evaluated using Malterud's information power framework. Four themes emerged. First, emotional, physical, and psychological turmoil, marked by widespread fear, anxiety, and viewing the ICU as a place of death. Second, a communication and information gap: inaccessible clinicians, inconsistent updates, and one participant's perception of culturally insensitive communication by a foreign clinician. Third, socioeconomic burden: high bills and debt despite having health insurance, fear of detention over unpaid bills, and livelihood disruption. Fourth, coping strategies: spiritual faith and prayer, family role adaptation and informal social networks, whose support waned over time. Families experienced emotional, physical and psychological turmoil, communication gaps and substantial socioeconomic burden despite all having health insurance. Spiritual faith, family role adaptation and informal networks were the coping strategies described, although network support waned. Structured multi-professional communication, spiritual and psychosocial support for families who want it, and a review of insurance cover for ICU costs are recommended.

**Keywords:** *Communication; psychological; socioeconomic burden; insurance; spirituality; health; critical care*

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# INTRODUCTION

With an ageing population, rising rates of non-communicable and emerging diseases, and frequent natural disasters, demand for intensive care unit (ICU) facilities in both developed and developing countries is increasing (Crawford et al., 2023). As families support patients in the ICU, they face various health and financial challenges requiring adjustment (Abdul Halain et al., 2022; Rückholdt et al., 2021). Families, therefore, require support through the provision of care that is individualised, which aims at improving quality of life (Jennerich et al., 2020; Leong et al., 2023; Scott et al., 2019).

Taking care of families with patients admitted to ICU is part of the necessary care in ICU posited by Asadi and Salmani (2024). This could be achieved by adopting and implementing family-centred care, which is recognized as an essential component of quality ICU care (Hwang et al., 2025). The importance of family-centred care is documented by Schwartz et al. (2022) and, for family-focused care interventions more broadly, Smith et al. (2020). However, most Kenyan health facilities have not implemented family-centred care despite its benefits (Mwangi et al., 2023).

There is a dearth of literature, with few studies exploring the experiences of families within the African context (Imanipour et al., 2019). Some studies have been done in Malawi and Ethiopia. These studies adopted qualitative approaches (Kalolo et al.2023; Kehali et al. 2020) and hence shed some useful insights about the needs of families with patients admitted to critical care units.In study design, Kehali et al. (2020) adopted a phenomenological design, whereas Kalolo et al. (2023) used a qualitative descriptive design.

These important observations are attributed to Kalolo et al. (2023) and Kehali et al. (2020). However, these findings, insightful as they are, fall short of elucidating the experiences of families with patients in the ICU within the Kenyan context. These studies were conducted in different national contexts, where health system structures, ICU capacity, cultural practices, financing models, and policy frameworks may differ from those in Kenya. Kenya has limited ICU capacity, with many counties lacking an ICU (Barasa et al., 2020). These differences highlight a significant gap in knowledge about the needs of families of patients admitted to Kenyan ICUs.

Kenya's critical care capacity has grown but remains limited. A 2014 survey identified 130 critical care beds in 21 hospitals as summarised by Mwangi et al. (2023), and an estimated 537 ICU beds and 256 ventilators were reported in 2020, with only 22 of the 47 counties having at least one ICU (Barasa et al., 2020). A national survey of critical care units published in 2023 reported a total of 598 critical care (ICU and high dependency) beds in 60 of 75 identified units, with a median of 6 beds per unit; 26% of these beds (n = 157) were non-functional (Mwangi et al., 2023). The units generally had basic monitoring and ventilation resources and a nurse-to-bed ratio that was mostly 1:2 (Mwangi et al., 2023). More recent data from the 2023 national health facility census recorded 899 adult, 196 paediatric and 258 neonatal ICU beds, and 951 adult high dependency unit (HDU) beds and 275 HDU cots, in 381 facilities providing critical care (Ministry of Health, Kenya,2023). These sources use different methods and definitions and are not directly comparable. With the expansion of ICU infrastructure, more families of patients admitted to ICU are exposed to a profound level of stress. However, there is a gap in guidelines or approaches for supporting families of patients admitted to ICU. This study was therefore designed with the intention of generating knowledge on the needs of families of patients admitted to ICU and to address context-specific issues arising from their experiences within the Kenyan healthcare system.

Comparable needs among families of critically ill patients have also been documented outside East Africa, including in the United States (Basile et al., 2021; Harlan et al., 2020), Iran (Jafarpoor et al., 2023), Greece (Koukouli et al., 2018) and Australia (Digby et al., 2023), and in conceptual work on defining critical illness and critical care (Kayambankadzanja et al., 2022).The lack of national guidelines on how to address challenges faced by family members of patients admitted to ICU across hospitals in Kenya limits healthcare professionals' ability to adequately meet their needs. There exists a gap in understanding family members' experiences in the Kenyan context. This gap hinders the development of clear, culturally realistic, and responsive guidelines. Evidence on how families in Kenya experience ICU admission may inform future efforts to support families in resource-limited settings.

Coding was inductive and was not guided by theory. Family systems theory (Bowen, 1978), which views the family as an interconnected emotional unit in which stress on one member affects the whole, and the transactional model of stress and coping (Lazarus & Folkman, 1984), which views coping as an evolving response to appraised threat, were used in the discussion to interpret findings on role adaptation

and coping strategies. The general objective of this study was to explore the experiences of family members of patients admitted to the intensive care unit at a faith-based referral hospital in Kenya. Specifically, the study sought to explore the emotional, physical, and psychological responses of family members of patients admitted to the intensive care unit; to describe their perceptions of communication between healthcare providers and family members in the unit; to explore the socioeconomic burden of the admission on families; and to understand the coping strategies used by the families.

# METHODS

## *Study Design*

The study adopted a qualitative descriptive design analysed using Braun and Clarke's (2006, 2019) reflexive thematic analysis to explore the experiences of families of patients admitted to the intensive care unit at a faith-based referral hospital in Kenya. A qualitative descriptive design was chosen because it allows a close, low-inference account of participants' experiences without the additional philosophical and procedural commitments of a phenomenological analysis, such as bracketing and the identification of essential structures of experience (Sibeoni et al., 2020), which were not undertaken in this study. In previous studies with similar aims, researchers adopted different qualitative designs to investigate comparable experiences. For example, Kehali et al. (2020) adopted a phenomenological design, whereas Kalolo et al. (2023) used a qualitative descriptive design in investigating the experiences of families of patients admitted to intensive care units.

## *Study Setting*

The study was conducted in the adult ICU of a 350-bed faith-based tertiary and referral hospital in Central Kenya. The adult ICU contained five beds and admitted surgically and medically critically ill patients. The hospital register recorded a mean ICU length of stay of 12 days and a mortality rate of 30–40% from January to December 2024. Patients were managed by a multidisciplinary team that at times included foreign clinicians, and families received updates through conferences held in a designated room within the unit.

## *Study Population*

A total of 12 individual participants (N=12; 4 males and 8 females) were recruited from 10 distinct families (two families had two participating members). The target population was immediate family members of adult patients admitted to the intensive care unit in Kenya. The accessible population comprised immediate family members aged 18 years and above of patients admitted to the adult intensive care unit of the study hospital for at least 48 hours and either still in the unit or within 48 hours of discharge.The 48-hour threshold minimised recall bias while ensuring meaningful exposure to the intensive care experience.

Immediate family members who were the next of kin, or appointed by the next of kin, directly involved in the care of a patient admitted to or discharged from the intensive care unit for at least 48 hours and either still in the unit or within 48 hours of discharge, were included. Those excluded from the study were:

1. Family members who were grieving following a patient's death were excluded for ethical reasons because distress would be heightened

2. Those who were below 18 years were excluded because of consent and sensitivity,

3. Those whose relatives were admitted only briefly for post-operative observation were excluded because exposure was too short.

## *Sampling Procedure*

Purposive sampling was used to recruit participants meeting the inclusion criteria, with attention to diversity in gender, religion, length of stay, and age. The ICU manager was informed about the intent of the study and approved data collection. Researcher contact information was posted for recruitment purposes. Clinicians assisted in identifying families during visits. The numbers of families approached and consented, and the response rate, are reported in the results.

## *Sample Size Determination*

Sample size sufficiency was guided by the information power model, which considers the narrowness of the study aim, sample specificity, and the density of interview dialogue, rather than rigid saturation metrics (Malterud et al., 2016; Tight, 2024). A formula-based sample size calculation was not undertaken because this was a qualitative study, in which the number of participants is determined by the information power of the sample rather than by statistical power. We planned to recruit 10-15 participants on this basis. Recruitment stopped at 12 participants from 10 families because the final two interviews produced no substantially new codes, and the research team judged that the data held sufficient information power to address the study aim.

Adequacy was assessed iteratively through ongoing coding and team discussion after each interview.

## Data Collection Tool

A semi-structured in-depth interview guide, adapted from the guide used in a study of family members' perception of their needs in critical care units at a tertiary hospital in Malawi (Kalolo et al., 2023), was used to collect data. Data collected were related to family members' physical and psychological experiences, their perceptions of communication, the financial and logistical burden of the ICU admission, and how they coped with the admission. The guide was translated from English into Kiswahili and back-translated into English by the principal researcher; an independent person with language expertise cross-checked the versions to confirm they were consistent. The main domains were physical and psychological experiences; communication with the team; and coping strategies.

It was pre-tested with three family members in the high dependency unit to assess the clarity, comprehensibility, and cultural appropriateness of the questions; no changes were made after the pre-test. These family members were not recruited into the study.

## Data Collection Procedure

Between October and November 2025, the principal researcher (first author) and a trained female research assistant conducted interviews in a staff resting area in the hospital basement, away from the ICU. The research assistant holds a Bachelor of Science in Health Systems Management and has coordinated research projects at the Ford Family Program in Human Development Studies in Nairobi, Kenya. The research assistant has also participated in 10 qualitative research projects at the faith-based hospital. In this study, the research assistant conducted four of the 12 interviews (the principal researcher conducted the other eight), received refresher training on qualitative data collection from the principal researcher for 2 weeks, and was not involved in the clinical care of participants' relatives. The principal researcher and research assistant had no relationship with the participating families or their relatives. Sessions lasted 30 to 60 minutes and were conducted in English or Kiswahili, based on participant preference. If a participant experienced emotional distress during the interview, the session was immediately paused, supportive listening was provided, and the option to resume, defer, or terminate the session was offered. Free referrals to the hospital chaplaincy and the psychological counselling department were available.

## Data Quality Control

An independent researcher with experience in qualitative research conducted a peer debriefing, examining coded transcripts and themes, auditing potential bias, and reviewing thematic logic, which strengthened the confirmability of the results. In addition, a description of the developed themes in plain language was given to a separate group of three families with ICU experience, two females and one man, who were not study participants. They were purposively recruited from families of patients discharged home or to the ward; written consent was obtained at discharge. Four families were approached; one declined because of time constraints, and three were given the report of the findings; this was a form of respondent feedback on the plausibility of the themes rather than member checking in the strict sense, since member checking returns findings to the people who provided the data. This group confirmed that the themes of emotional and psychological turmoil, communication gap, socioeconomic burden, and coping strategies resonated with their own experience. These steps, together with the audit trail kept throughout analysis, supported the credibility and confirmability of the findings; as only interview data were used, no triangulation across data sources or methods was undertaken.

## Data Management and Analysis

Audio recordings were transcribed verbatim and, where necessary, translated into English by the principal researcher; to confirm they were consistent, back-translation checks were performed on a 20% random sample of transcripts by an independent person with language expertise to verify semantic equivalence. Analysis followed the six phases of reflexive thematic analysis described by Braun and Clarke (2006, 2019): familiarisation with the data, generating initial codes, constructing candidate themes, reviewing themes, defining and naming themes, and writing up. Coding was inductive, that is, driven by the content of the data rather than by a pre-existing coding frame. The principal researcher first coded the 12 transcripts manually, generating 450 codes. Family systems theory (Bowen,1978) and the transactional model of stress and coping (Folkman,2013) did not guide the coding; they were used only in the discussion to interpret the findings on role adaptation and coping strategies. The principal researcher first coded the 12 transcripts manually, generating 450 codes.When the codes were organised in NVivo software (v12), 50 were identified as duplicates and removed. The principal researcher reviewed each one individually, agreed that they were duplicates of earlier codes, and removed them, leaving 400 nodes. The reduction from 450 to 400

therefore reflects removal of duplicated codes generated during manual coding, not conceptual merging. The 400 nodes were first sorted by shared meaning into candidate themes, and these candidate themes were then reviewed against the transcripts and each other, with overlapping ones merged and weak ones dropped, until they were defined and named as the four final themes. The final structure comprised four main themes and 13 subthemes. The analysis was carried out by the principal researcher alone; the co-authors acted as supervisors and guided the process. In keeping with reflexive thematic analysis, which treats the researcher's interpretation as part of the analysis and does not require inter-coder agreement, no second coder was used.

### *Ethical Considerations*

Ethical approval was granted by the Hospital Institutional Scientific and Ethics Review Committee (ISERC Approval Ref: KH/ISERC/00103/2025, issued 25 September 2025) and the National Commission for Science, Technology, and Innovation (NACOSTI License: NACOSTI/P/25/4180902, issued 25 September 2025). Adherence to the Declaration of Helsinki was maintained. Both the ethical approval and the research licence were obtained before data collection began in October 2025. Written informed consent, including explicit consent for audio recording, was secured from all participants before the interviews. Participation was voluntary, and participants were informed that they could withdraw at any time without any effect on their care. Confidentiality and anonymity were maintained; Participants were assigned codes (P1-P12), and names and other identifiers were removed from the transcripts. All electronic data were stored on a password-protected computer, accessible only to the principal researcher. The procedure for managing participants' distress is described under Data collection procedure. No compensation or incentive was provided. To prevent gatekeeping selection bias and protect participants from perceived clinical repercussions, clinicians only alerted research staff to eligible admissions; consent procedures and interviews were conducted strictly independently of clinical staff. The three families who gave feedback on the developed themes gave written consent at discharge, and this activity was covered by the ethical approval.

## RESULTS

### *Participant Characteristics*

Thirteen families were approached; ten consented (response rate 77%); three families declined, citing financial concerns and time constraints. Twelve family members from the ten participating families took part. Most were young (58% aged 18-40), female (67%), and Christian (83%), and were children (33%), spouses (33%), or siblings (25%) of the patient. Seven (58%) had primary education only, and seven (58%) were unemployed. All had health insurance through the Social Health Authority (SHA) alone (n=10) or SHA plus private cover (n=2). Patients' ICU stays ranged from 3 to over 10 days, with half staying 3-5 days. (Table 1).

**Table 1:** *Demographic Characteristics, Health Insurance Status and Length of ICU stay of Participants (N=12)*

| Participant | Characteristics | N=12 |
|---|---|---|
| Age | 18–40 | 7 |
| | 41–60 | 4 |
| | >60 | 1 |
| Sex | Male | 4 |
| | Female | 8 |
| Religion | Christians | 10 |
| | Muslims | 2 |
| Relationship to the patient | Children | 4 |
| | Spouses | 4 |
| | Grandparents | 1 |
| | Siblings | 3 |
| Level of Education | Primary | 7 |
| | Secondary | 3 |

| | | |
|---|---|---|
| | Tertiary | 2 |
| Employment status | Employed | 5 |
| | Unemployed | 7 |
| County of Origin | Kiambu | 4 |
| | Nairobi | 4 |
| | Kisii | 1 |
| | Kisumu | 1 |
| | Kajiado | 1 |
| | Narok | 1 |
| Residence | Rural | 8 |
| | Urban | 4 |
| Health Insurance status | SHA Only | 10 |
| | SHA + Private Insurance | 2 |
| | Cash payer | 0 |
| Number of days in ICU | 3–5 | 6 |
| | 6–10 | 4 |
| | >10 | 2 |

Note. N=number of participants; SHA=Social Health Authority; ICU=Intensive Care Unit.

Table 2 gives the anonymized descriptors (relationship to patient, age and age band) of each participant: four children, four spouses, three siblings, and one grandparent, aged 25 to 65 years. Quotations in Tables 3-6 are labelled with the participant number only (P1-P12),which can be matched to Table 2.

**Table 2:** *Participant Descriptors Used to Label Quotations*

| Participant | Relationship to patient | Age (years) | Age band |
|---|---|---|---|
| P1 | Child | 25 | 18–40 years |
| P2 | spouse | 44 | 41–60 years |
| P3 | Spouse | 45 | 41–60 years |
| P4 | Child | 40 | 18–40 years |
| P5 | Child | 37 | 18–40 years |
| P6 | Sibling | 30 | 18–40 years |
| P7 | Sibling | 37 | 18–40 years |
| P8 | Spouse | 28 | 18–40 years |
| P9 | Child | 38 | 18–40 years |
| P10 | Spouse | 45 | 41–60 years |
| P11 | Sibling | 50 | 41–60 years |
| P12 | Grandparent | 65 | >60 years |

*Note. P1-P12=participant identifiers(pseudonyms)*

### *Overview of Themes*

Analysis of the 12 interviews produced four themes and 13 subthemes that correspond to the study objectives: (1) emotional, physical and psychological turmoil, (2) communication and information, (3) socioeconomic burden and (4) coping strategies (Tables 3–6). Quotations are labelled with participant number.

Emotional, physical and psychological turmoil was the most widely shared experience (Table 3). Distress, comprising overwhelming fear, anxiety and despair, was described by nine participants, including fear of the patient dying and of the unknown. Seven saw the ICU as a place of death and hopelessness, with immediate grief and loss of hope. Six reported physical and cognitive effects, namely inability to eat or sleep, weakness and trembling, and poor concentration. Five described hope and relief, which were tied to visible clinical improvement in the patient. As one participant put it, "I started having some hopes especially on day four of his ICU admission when at least he was off the machine and could smile at me." (P12).

**Table 3:** *Theme on Emotional, Physical and Psychological Turmoil*

| Main Category | Theme | Subtheme | Code | Extract |
|---|---|---|---|---|
| Emotional, physical and psychological turmoil | ICU as a place of death and Hopelessness | ICU associated with Death | ICU perceived as a place of death | "ICU for me, let me say I normally see it as a place where people die, a place where there is no hope for life again." (P10) |
| | | Immediate grief reaction | Crying and anticipation of death | "I started crying; I knew my brother was dying any moment from then." (P7) |
| | | Loss of hope | Perceived end of life | "I concluded that it is the end for my brother, no hope of him returning home alive" (P6). |
| | Distress (Overwhelming Fear, Anxiety, and Despair) | Fear of patient death | Fear of losing a loved one | "My main fear while she is in ICU is that she might die and leave me, yet she is still having a young child." (P2) |
| | | Fear of the unknown | Uncertainty about patient outcome | "When someone is in ICU, there are two possibilities: either she will get well, or she will die now you keep thinking which one is it, fear of the unknown." (P10) |
| | | Emotional breakdown | Feeling weak and overwhelmed | "For a moment I felt weak, no energy; what rang through my mind was the possibility of her being dead." (P11) |
| | | Somatic and cognitive manifestation of stress | Inability to eat or sleep | "For the three days she has been in ICU, I am not able to do any job for daily living…I cannot even sleep." (P2) |
| | | | Physical weakness and trembling | "I felt weak and almost fainted; my joints could not support my body." (P8) |
| | | | Loss of concentration | "Him being in ICU also affected my concentration; many times I could just be sitting lost in thought." (P12) |

| | | | | |
|---|---|---|---|---|
| | Hope and Emotional Relief | Hope from clinical improvement | Renewed hope following clinical improvement | "I started having some hopes especially on day four of his ICU admission when at least he was off the machine and could smile at me." (P12) |
| | | Relief from survival | Relief that the patient was alive | "For a moment I was relieved just knowing that he is still alive." (P12) |
| | | Positive signs from patient | Confidence from patient improvement | "He is improving…that also gives me confidence." (P6) |

*Note: P1-P12=participant identifiers (Pseudonyms); quotations are verbatim extracts from interview.*

Communication was perceived as a gap in care (Table 4). Four participants described inaccessible and inconsistent information: doctors were often unavailable, nurses were restricted from sharing updates, and information felt withheld. Three struggled with medical jargon and asked for simpler explanations or interpretation into the local language; one of them (P3) perceived a foreign clinician's delivery of a prognosis as culturally insensitive. Three participants advocated for themselves and proposed family conferences, greater transparency and nurse-led updates.One participant said, "The hospital staff were not willing to give us information. We were in the dark to be honest." (P11).

**Table 4:** *Theme on Communication and Information*

| Main Category | Theme | Subtheme | Code | Extract |
|---|---|---|---|---|
| Perception on Communication | Communication and Information | Inaccessible and Inconsistent Information Flow | Doctors unavailable | "No, in most cases I could not get a doctor, I was just talking to nurses." (P12) |
| | | | Nurses restricted from sharing | "Nurses cannot give you the information, they keep on telling us to wait for the doctor." (P7) |
| | | | Information withheld | "The hospital staff were not willing to give us information. We were in the dark to be honest." (P11) |
| | | Clarity and Compassion in Explanations | Use of medical jargon | "They use medical terms which us we cannot understand." (P7) |
| | | | Need for translation | "They should have simple way of explaining things to us who are old…if possible, they should have someone to translate for us in the local language." (P12) |
| | | | Cultural insensitivity | "White doctor…they are not culturally sensitive…if the white doctor has told you that there is nothing else, they can do, even if you had little faith left in Gods healing hand that instantly vanishes." (P3) |

| | | | | |
|---|---|---|---|---|
| | | Family advocacy and partnership | Request for family conference | "We demanded for a family conference. That was the first time we had a meaningful conversation." (P11) |
| | | | Desire for transparency | "It would be better if after doing surgery they come and tell me this and that is what we found." (P10) |
| | | | Suggestion for nurse-led updates | "Why are nurses not allowed to update relatives yet they are the one who are with our loved ones?" (P2) |

*Note: P1-P12=participant identifiers (Pseudonyms); quotations are verbatim extracts from interviews.*

All participants were insured, yet the admission carried a heavy socioeconomic burden (Table 5). Four described debt, including very high procedure costs (at least 100,000 shillings per procedure in one account), depleted personal finances and fear that the patient would be detained over unpaid bills. Four described logistical strain, including transport and accommodation costs and lost income because caregiving left no time for work. Two described worry about family survival and legacy, such as young children being orphaned and loss of the patient as the family's hope for the future. One participant said, "Having been admitted five times and being taken to theatre 7 times, the procedure costing not less than 100,000 shillings per procedure." (P10).

**Table 5:** *Theme on Socioeconomic Burden*

| Main Category | Theme | Subtheme | Code | Extract |
|---|---|---|---|---|
| Healthcare related Burden | Socioeconomic Burdens | Financial Debt | High medical bills | "Having been admitted five times and being taken to theatre 7 times, the procedure costing not less than 100,000 shillings per procedure." (P10) |
| | | | Depletion of personal finance and assets | "Am having undisclosed debt." (P10) |
| | | | Fear of detention for bills | "I am worried about the hospital bill…I think he will be detained in the hospital due to the bill." (P12) |
| | | | Transport costs | "We come all the way from Magadi, which is far, to get a vehicle to come here cost a lot for transport fee." (P4) |
| | | | Loss of income | "None of us is employed…if someone calls me for the work, am not able to do, because all |

| | | | | |
|---|---|---|---|---|
| | | Logistical strain and Role disruption | | my attention and concentration is diverted to my dad." (P5) |
| | | | Accommodation Challenges | "I moved to my cousin's place...to reduce the traveling fee expenses." (P8)<br><br>"At the motel... I can only afford one room for my mother-in-law…for me I sleep in the car" (P10). |
| | | Family Survival and Legacy | Patient as family hope | "He was my hope for the future of my generation." (P12) |
| | | | Worry over orphaned children | "I was afraid that my children will be left orphan at an early age." (P8) |
| | | | Fear of generational discontinuity | "My main worry was that in an event he dies who will hold the hands of his siblings yet am growing old and weary." (P12). |

Note: P1-P12=participant identifiers (Pseudonyms); quotations are verbatim extracts from interviews.

Coping took three forms, each described by only two or three participants (Table 6). Three described spiritual faith, including prayer, trust in divine healing alongside medical care and bargaining with God. Two described adapting family roles, with shared responsibilities, decisions led by the first-born and new roles taken on. Three described support networks that were initially present but faded, with no support from the hospital and a feeling of abandonment.As one participant said, "I believe and trust that God has the power to heal. So, I prayed for him and also for doctors." (P5).

**Table 6:** *Theme on Coping Strategies*

| Main Category | Theme | Subtheme | Code | Extract |
|---|---|---|---|---|
| Coping Strategies | Coping Strategies | Spiritual Faith | Prayer as a coping strategy | "I pray a lot because its only God." (P1) |
| | | | Trust in God's divine healing along with medical care | "I believe and trust that God has the power to heal. So, I prayed for him and also for doctors." (P5) |
| | | | Spiritual bargaining in moment of desperation | "I was asking lamenting to God that instead of my grandson it is better if am the one who should be in the ICU bed." (P12) |
| | | | Role sharing as survival strategy | "We share roles to ensure that family continues to be united and no one is left behind." (P6) |

| | | | | |
|---|---|---|---|---|
| | | Family Unity and Role adaptation | Hierarchical family structure | "Our first born assume the responsibility as the head of family, every decision must pass through him." (P6) |
| | | | Assuming new responsibilities | "I have now taken up the role of a husband, my life has changed 360 degrees." (P2) |
| | | Support networks | Initial support from relatives/friends | "Even relatives have tried but now it has become like a song, they are not interested anymore." (P10) |
| | | | Lack of hospital support | "No support has been given to me up to now." (P2) |
| | | | Feeling of abandonment | "For now, there is no support, it is only phone call am getting." (P7) |

*Note: P1-P12=participant identifiers (Pseudonyms); quotations are verbatim extracts from interviews.*

Distress was the most widely shared subtheme (n=9), followed by the ICU as a place of death (n=7) and somatic stress (n=6). The communication, financial, logistical and support-network subthemes were each reported by three to four participants, whereas family survival and legacy and family role adaptation were each reported by two. Counts are of participants contributing to each subtheme and are not measures of importance.

## DISCUSSION

The study generated four main themes. The first, emotional, physical and psychological turmoil, was characterised by fear and anxiety, and many participants perceived the intensive care unit as a place of death. The second theme concerned communication and information: participants described clinicians as often inaccessible and updates as inconsistent, and one participant described a prognosis delivered by a foreign clinician as culturally insensitive. The third theme was socioeconomic burden. All participants had health insurance (SHA, with or without private cover), yet they described high bills, debt, fear that the patient would be detained over unpaid bills, and disruption of livelihoods through transport, accommodation, and lost-income pressures; the data do not show which costs were not covered. The fourth theme was coping. Three participants described prayer and trust in divine healing, including bargaining with God, two described adapting family roles, and three described support networks that were limited or waned over time.

### *Participant Demographic Characteristics*

Participants were aged 25 to 65 years, and most (7 of 12) were aged 18–40 years, that is, young adults rather than middle-aged. Employment was mixed: five participants were employed and seven unemployed (Table 1). Several participants nevertheless described losing income or work opportunities because the admission demanded their time and attention. Adults in this age group are likely to be balancing work and caregiving responsibilities, but the study did not collect data on participants' roles as providers, so this is offered as interpretation only. Eight of the twelve participants were women, which may reflect the gendered pattern of caregiving for sick relatives in Kenya, although the data do not test this.

### *Experiences of Family Members in the ICU*

ICU experiences are shaped by systemic, economic, and cultural factors. In this study, families experienced emotional and psychological disturbances, consistent with reports from other settings (Abdul Halain et al.,

2022; Harlan et al., 2020; Su et al., 2020). Many participants perceived the ICU as a place of death and described beginning to grieve soon after admission. Communication gaps were also described, as physicians were not readily available to provide updates on patients' progress and the support families needed. Hope was tied to visible improvement in the patient, which served as an emotional anchor for some participants.

The exclusion of bereaved families should be considered when interpreting these emotional findings. Because families whose relatives had died were excluded, the sample over-represents families of patients who survived or were improving. This probably shaped the "Hope and Emotional Relief" subtheme and left out the most severe emotional experiences, such as acute grief and distress around death and end-of-life decisions in the ICU. The turmoil reported here may therefore understate the full emotional impact of ICU admission, and the hope and relief described may not be shared by families whose relatives die. Future studies should include bereaved families, with appropriate ethical safeguards.

Families described high medical costs, debt and fear of the patient being detained over unpaid bills (Table 5). Financial burden is a recurring theme in ICU family research in Ethiopia (Kehali et al., 2020) and, to a lesser extent, in Malawi, where cost appeared as one of several physical needs (Kalolo et al., 2023). Such strain may add to the psychological distress that family members already experience after unplanned hospital admission, which can persist for months while coping strategies change over time (Rückholdt et al., 2021). All participants had health insurance (SHA only, n=10; SHA plus private insurance, n=2), so the burden in this sample does not reflect an absence of cover. It may instead reflect costs that insurance did not cover or coverage limits, but the data do not allow this to be specified, and this deserves further study. Participants also described physical effects of the admission, including sleeplessness, weakness, and loss of concentration (Table 3).

### *Perception on Communication*

Major gaps exist in communication between healthcare providers and families. Four participants described difficulty accessing information; three described unclear explanations, and one (P3) described cultural insensitivity.Family perceptions of physician unavailability may reflect heavy clinical workloads, emergency procedures, and scheduled round times in a 5-bed unit rather than a deliberate policy of institutional non-disclosure. One participant (P3) described a foreign clinician's delivery of a difficult prognosis as culturally insensitive and said they would prefer a local doctor. This finding rests on a single account and is reported as one participant's perception, not a general pattern. The perception may stem from the distressing content of the message (communicating medical futility and the end of curative intent) or from differences in professional linguistic register, rather than from the clinician's nationality or cultural origin. Further research should explore how families perceive cultural sensitivity in prognostic communication. Communication between staff and families in adult ICUs is often experienced as inadequate (Digby et al., 2023). Structured communication guides for discussing personalised prognosis have been developed for other serious illnesses, such as amyotrophic lateral sclerosis, and may offer a model that could be adapted for ICU families (van Eenennaam et al., 2020). Evidence from neonatal intensive care suggests that parents' educational levels may influence their understanding of medical information (Wege et al., 2023), and limited proficiency in the language of care may compound this (Barwise et al., 2019).

Nurses spend more time with patients but are not allowed to share certain information due to institutional policy (Yoo et al., 2020). Nursing staff are also central to communication with families, as reported among older people and family caregivers (Peerboom et al., 2025). Structured family–clinician communication approaches have also been trialled in ICUs elsewhere, including a cluster randomised trial of shared decision making in China (Liu et al., 2022).

### *Coping Strategies*

Participants described three coping strategies: spiritual faith, family unity and role adaptation, and support networks, in keeping with coping strategies described among families of critically ill patients elsewhere (Harlan et al., 2020; Koukouli et al., 2018). Spiritual coping, including prayer, trust in divine healing alongside medical care and bargaining with God, was described by three of the twelve participants (P1, P5, P12). It was therefore important for some families but was not described by most participants, and the data do not support describing religion as the main coping mechanism. Two participants (P2, P6) described reorganising family roles, including a first-born relative leading family decisions. Three participants (P2, P7, P10) described support networks that were limited, waned over time or were absent from the hospital, in line with reports that social support declines as fatigue sets in (Kalolo et al., 2023; Kehali et al., 2020). These findings are consistent with family systems theory (Bowen, 1978) and the transactional model of stress and coping (Folkman, 2013).

### *Practical Implications*

These findings point to practical steps that hospitals could take in the study setting, set out in the Recommendations: scheduled, structured family updates and regular family conferences; training for multi-professional teams in compassionate prognosis delivery; a clearer role for senior nurses in giving routine, non-prognostic updates; social work navigation for families facing high ICU costs; and chaplaincy for families who want it. Because every participant was insured yet reported high costs, the adequacy of insurance cover for ICU admission warrants review.

## STRENGTHS AND LIMITATIONS

This study has several strengths. The qualitative descriptive design was appropriate for exploring the lived experiences of ICU families in a Kenyan faith-based hospital. Methodological rigour was enhanced through reflexive thematic analysis, peer debriefing with an independent researcher, respondent feedback on the developed themes, and a documented reflexivity process. Interviews were conducted in English or Kiswahili, depending on participant preference, and Kiswahili transcripts were translated while preserving semantic meaning. Purposive sampling captured diverse participant characteristics across 12 participants (4 males, 8 females) from 10 families. Recruitment stopped at this point because the final two interviews yielded no substantially new codes, indicating sufficient information power for the study aim. Ethical approval was obtained from ISERC and NACOSTI, with reflexivity measures to mitigate researcher bias.

However**,** this study has several limitations. First, recruitment was conducted at a single faith-based referral hospital, limiting direct transferability to public regional or national referral centres with different financing and staffing structures. Second, initial participant identification relied on clinical gatekeepers, which carries potential selection bias. Third, the sample included two multi-member family pairs whose perspectives were not strictly independent of one another. Fourth, the sample skewed toward shorter ICU stays, limiting insights into very long-term critical illness trajectories. Fifth, grieving families whose relatives died in the ICU were excluded for ethical reasons, omitting the experiences of acutely bereaved surrogates. The implications of this exclusion for the emotional findings are discussed above.

### *Future Research*

Future studies should include bereaved families, with appropriate ethical safeguards; explore how families perceive cultural sensitivity in prognostic communication; examine which ICU costs insured families still pay and why; and be conducted across multiple public and private tertiary centres to test transferability.

## CONCLUSION

This study explored experiences of families of patients admitted to the intensive care unit using a qualitative descriptive approach, focusing on emotional, physical and psychological responses, perceptions of communication with healthcare professionals, socioeconomic burden and coping strategies during life-threatening illness. Results

indicate that, in this setting, ICU admission was described as causing emotional, physical, and psychological turmoil and socioeconomic strain for families, even though all participants had health insurance. Inconsistent communication and technical jargon were described as adding to distress. Spiritual faith, described by a subset of participants, and family role adaptation were among the coping strategies reported, while support from wider networks tended to wane. Strengthening the family experience therefore requires structured, timely, and culturally sensitive communication, including empowering nurses to share appropriate information and holding regular family conferences, alongside access to spiritual and psychosocial support for families who want it. These measures are central to humane, family-centred critical care in the study setting.

## RECOMMENDATIONS

Clinical practitioners should set a structured daily schedule for family updates, train multi-professional teams in compassionate prognosis delivery, and empower senior nurses to give routine, non-prognostic updates. Hospital administrators should provide a family conference room and protected time for family meetings, formalise social work navigation for families facing high ICU costs, and offer chaplaincy to those who want it. County health management teams and the Ministry of Health should review whether current insurance cover is adequate for ICU admission costs and evaluate psychosocial support models for families. Policymakers should develop national family-centred ICU guidelines. Researchers should conduct multi-centre qualitative studies across public and private tertiary centres, along with studies of bereaved families.

## Conflict of Interest

The authors declare no conflicts of interest.

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## Author Contributions

The first author led conceptualisation, methodology, investigation, data collection, formal analysis, interpretation, and writing of the original draft. The co-authors provided supervision and critical review and editing of the manuscript. All authors read and approved the final manuscript.

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