RESEARCH ARTICLE

CYPRUS
JOURNAL OF MEDICAL SCIENCES

DOI: 10.4274/cjms.2025.2025-37
Cyprus J Med Sci 2025;10(6):406-413

"Behind Closed Doors…" The Loneliness Experience of Patients in the Adult Intensive Care Unit: A Qualitative Study

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Abstract

BACKGROUND/AIM: Staying in the intensive care unit (ICU) can be a very stressful experience for patients. This stressful experience can cause patients to be isolated and feel lonely. This study aimed to explore the loneliness experiences of ICU patients.

MATERIALS AND METHODS: This phenomenological study used thematic analysis to identify. The patients hospitalized in the ICU of a state hospital in the south of Türkiye between 01 January and 01 December 2020 were selected using purposive sampling . Data was collected from 29 patients through face-to-face individual in-depth interviews. The consolidated criteria for reporting qualitative studies checklist was used to ensure research reporting guidelines were met.

RESULTS: Two main themes were revealed: "Tides of loneliness" and "Whispers in the void". ICU patients suffered from loneliness faced with various psychosocial problems. The findings highlight ICU processes that influence patients' loneliness and their emotional, social, and physical well-being.

CONCLUSION: To further enrich our understanding of loneliness in the ICU, future research could include the perspectives of patients' families or caregivers. This would offer valuable insights into how family involvement, visitation policies, or the absence of support impact patients' emotional experiences in the ICU. A more holistic view of the loneliness phenomenon would also encompass the role of the patient's immediate circle. To facilitate this, ICUs should be designed to foster daily communication between healthcare professionals, patients, and their families, ensuring that care is truly centered around the individual and their support system.

Keywords: Intensive care unit, loneliness, nursing, patient experience, qualitative study

INTRODUCTION

The experience of critical illness is a life-altering event, often marked by physical, emotional, and psychological distress. Patients who are critically ill face not only the challenges of their medical conditions but also the overwhelming environment of the intensive care unit (ICU), a place where complex treatments, high levels of surveillance, and often life-threatening conditions intersect. While the ICU is designed to provide life-saving interventions, it is also a space where patients experience profound isolation, uncertainty, and vulnerability. For many, the physical environment of the ICU can amplify feelings of loneliness, as patients are cut-off from their loved ones, unable to engage in normal social interactions or find comfort in familiar surroundings. Loneliness is a distressing emotional state caused by perceived deficiencies in one's social connections, leading to feelings of isolation and distress.[1-3] The key aspect of this subjective experience is that loneliness is a painful

To cite this article: Alaçam E, Kaya Tekgüzel G, Altundal Duru H, Yılmaz M. "Behind closed doors…" the loneliness experience of patients in the adult intensive care unit: a qualitative study. Cyprus J Med Sci. 2025;10(6):406-413

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Received: 14.04.2025
Accepted: 14.08.2025
Epub: 30.09.2025
Publication Date: 16.12.2025

and difficult feeling to cope with.[1,2] This intercultural, universal and psychosocial phenomenon makes loneliness inevitable, and people experience various degrees of loneliness, pain and distress in different periods of their lives.[1,3-5] As stated by Sha'ked and Rokach[2], "loneliness is intertwined with our being, just like joy, hunger, and self-actualization. People are born alone, often experience the horrors of loneliness at death and desperately try to avoid the loneliness in between".[2]

Critical illness, compounded by the ICU experience, can lead to emotional and psychological strain. Loneliness has emerged as a significant aspect of the ICU patient experience, impacting both their mental and physical well-being.[1-3] Emotional loneliness, stemming from a lack of close relationships and the absence of social support, is often heightened in the ICU due to the physical separation from family and friends. Social isolation further exacerbates feelings of abandonment and distress, with patients struggling to cope with the absence of personal connections in an environment dominated by medical staff and machines.[6]

Staying in the ICU can be a very stressful experience for patients.[4,5,7,8] This stressful experience can cause patients to be isolated from the environment they are used to, and to feel lonely.[5,8,9] Yildirim et al.[10] found in their study that cardiac ICU patients had moderate levels of loneliness and that this was associated with death anxiety.[10] It has been reported that patients feel lonely, especially at certain times of the day or night, because of the slow passage of time in the ICU.[5,9] Especially the mechanical noises coming from the complicated technological equipment used in the ICU, the voices of other patients and being unable to talk to their relatives, cause patients to feel lonely, scared, anxious and abandoned.[4,5,8,11,12] As a result of this experience, patients often feel lonely, and thus, they need love, respect, privacy, and psychological and spiritual support.[8] Psychological psychological care and spiritual interventions, for instance, the use of cognitive behavioral therapy for anxiety, mindfulness practices, or social support interventions (such as virtual visits), could be considered evidence-based approaches to address loneliness and improve patient outcomes.[13,14] Bulut et al.[15] found that the spiritual care intervention implemented in the ICU positively affected the loneliness levels of patients. Thus, understanding patients' experiences can help ICU nurses improve care by reducing psychological distress and loneliness.[6]

In the ICU, the nurse-patient interactions are important. Therapeutic communication techniques like active listening, empathetic responses, and presence (simply being there for the patient) are effective in mitigating loneliness in ICU patients. However, the therapeutic interactions between nurse and patient are affected by the potential challenges nurses face in providing emotional care, such as time constraints, the high acuity of patients, and institutional pressures that prioritize physical care. Understanding these challenges can provide a benefit on how to improve nurse-patient interactions. The studies highlight that loneliness can significantly affect patients' emotional and psychological well-being in the ICU, emphasizing the critical role of nurses and healthcare teams in addressing these needs.[6,16] In a recent systematic review, it is reported that the display of a positive attitude by health personnel towards ICU patients is of great importance.[17] However, there is inadequate evidence to support their effectiveness in the psychological recovery of ICU patients.[18] It is well known that with the holistic approach, both physiological and psychological care of the patients is met and that they receive high quality care.[7,19] Despite the growing recognition of loneliness as a significant concern for ICU patients, there remains a gap in the literature regarding the depth of this experience. While much is known about the medical and physiological aspects of critical illness and recovery, less is understood about how patients perceive and cope with the profound loneliness they experience in the ICU. Existing research often focuses on the clinical aspects of ICU care, with limited exploration of the emotional and psychological impacts on patients' well-being, particularly regarding their coping mechanisms and interactions with nursing staff. The aim of this study is to explore the lived experience of loneliness among adult patients in the ICU, shedding light on the emotional, social, and physical dimensions of isolation in this setting. Through a qualitative approach, the study seeks to deepen our understanding of the factors that contribute to ICU patients' loneliness and the ways in which they cope with this experience. Nurses can create better outcomes for patients and help them to have better ICU experiences through a better understanding of patients' experiences. Nursing protocols or patient care routines are developed to create a more compassionate, supportive environment. In addition, hospital policy changes (e.g., extending visitation hours, allowing family members to stay overnight) can play an important role in mitigating loneliness for ICU patients. Finally, this study's findings might contribute to improving patient care in ICUs globally. By addressing this gap in knowledge, the study aims to provide valuable insights into how nursing interventions and ICU environments can be optimized to support patients' emotional and psychological needs during their critical illness.

MATERIALS AND METHODS

Study Design

In this study, the phenomenological method, a qualitative descriptive approach, was used. Qualitative descriptive studies explore participants' detailed thoughts, experiences, social processes, and working styles and offer a comprehensive summary of an event.[20,21] The phenomenological research design focuses not on the measurement of facts but on individuals' beliefs, perceptions, feelings, and experiences about a phenomenon.[20] In this type of study, the researcher determines "what" individuals experience and "how" they experience it.[22,23] The reporting of this study was performed in line with the consolidated criteria for reporting qualitative studies.[24]

Sample and Setting

The purposive sampling method was used in the present study. The inclusion criteria of patients were as follows: being ≥18 years old, volunteering to participate in the study, being conscious, oriented, and cooperative, being a native speaker of Turkish, having no communication problems, having no mental health problems, and staying in the ICU for at least one week without any intervals. In determining the sample size in qualitative studies, researchers use an approach that requires them to continue collecting data until the saturation point is reached. Saturation is considered the cornerstone of rigor in determining sample sizes in qualitative research, such as a narrow range of interviews (9-17) or focus group discussions (4-8). In addition, the study goal, nature of the study population, sampling strategy used (i.e., inductive vs. deductive), type of data, and saturation goal affect this number.[20,21] In the present study, the researcher stopped conducting interviews once data saturation was achieved and no new data or codes emerged. The researchers announced the study to ICU patients through ICU charge nurses. ICU patients who met the inclusion criteria and volunteered to participate in the study were contacted verbally. In the ICU, interviews

were conducted face-to-face. Accordingly, 30 ICU patients participated in the study, but one was excluded because the patient was in delirium. The study was completed with 29 ICU patients.

Data Collection Tools

The study data was collected by the researchers using the personal information form and semi-structured individual in-depth interview form. The personal information form prepared by the researchers was in line with the current literature, and it made inquiries in terms of the participants' sociodemographic characteristics (gender, age, marital status, educational background, childbearing status).[3,6,7] Semi-structured individual in-depth interview form prepared by the researchers was in line with the current literature.[7,12,16,17] For the semi-structured individual in-depth interview form, the expert opinion was obtained from two independent faculty members who specialize in psychiatric nursing. Before the form was administered, it was revised based on the opinions, and the final version of the form has the following five questions (Table 1).

Data Collection

The research data were collected through face-to-face interviews using a qualitative study with semi-structured interviews between 1 January and 1 December 2020. To assess the applicability of the semi-structured questionnaire, a pilot interview was conducted with two patients who met the inclusion criteria. The patients in the pilot study were included in the study sample because the research questions were not revised. Before starting the interviews, detailed information about the purpose and methodology of the study was provided. In-depth interviews were conducted until no new information about the phenomenon was obtained. Data saturation was judged to have been reached when no new information emerged. After the 26 interviews, the researchers did not observe any new data on loneliness among ICU patients. However, three more verification interviews were conducted to confirm that no new data emerged.[25] The interviews were conducted face-to-face and lasted between 20 and 47 minutes (mean 29 minutes). Repeated interviews were not required. During the analysis process, the field notes recorded by the interviewer were considered. One of the researchers was working as a nurse in the same hospital during the research period. The data collection process, which was conducted by two researchers, was, carried out during the night shift when there was a gap in the care plans of the health care professionals to avoid disrupting health care services and affecting the interview. For the patient to express themselves more comfortably during the interview, the patient's bed was enclosed with a folding screen, creating an environment only the researcher and the patient would be present. To ensure consistency, the same interview method, form, and voice recorder were used in all the interviews. No participant objected to the use of the voice recorder. To ensure credibility, the opinions of the patients were presented with explanatory notes in the conclusion section. The patients participating in the study were coded as "Patient (P-1, P-2 and so forth)," and their names were kept confidential.

Table 1. Semi-structured interview form

Questions
What does staying in the ICU mean to you?
What are your thoughts about staying in the ICU?
How do you feel about staying in the ICU?
What does loneliness mean to you? Have you experienced loneliness in the ICU?
In your opinion, how can one cope with the feeling of loneliness?

ICU: Intensive care unit.

The study was conducted by four female researchers trained and experienced in qualitative research. Two of the researchers work as academicians at a state university, while the other two work as specialist nurses in different state hospitals.

Statistical Analysis

In the data evaluation process, all recorded interviews were transcribed verbatim by four researchers. Computerized algorithms were not used in the data analysis; the recordings were manually transcribed. Raw data were obtained by combining the transcripts with the observation notes. After transcription, interview texts were shared with all researchers for their feedback. Researcher conducted the analysis independently, considering the field notes during this process. Transcripts were returned to participants for comment or correction. Inductive thematic analysis was employed to analyze the ICU patients' experiences of loneliness, encompassing stages of open coding, category creation, and abstraction. The data obtained from the interview form were evaluated using thematic analysis, which included the following steps: (1) familiarization with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report.[26]

Trustworthiness

The research team consisted of four female researchers (a Master of Science, two PhD candidates, and a PhD). All the researchers were trained in qualitative research techniques and had previously conducted research. Lincoln and Guba explained trustworthiness, credibility, transferability, dependability, and confirmability.[27] To improve the credibility of the findings, a methodological approach was adopted in the data analysis phase, and this process was explained in detail. The fact that the data were analyzed and interpreted by more than one researcher also reinforced reliability. In addition, participant triangulation was ensured by including participants from 6 ICUs. Thus, multidimensional information on the loneliness experiences of ICU patients was obtained. Credibility is ensured through patients' opinions in the findings section. Also, selection criteria were established to provide data diversity for the socioeconomic status of the patients, and interviews usually took a long time. The researchers addressed the potential cognitive limitations of ICU patients during interviews. For instance, they used simple language or allowed extra time for responses. They took steps to ensure patients' emotional readiness for the interview, especially if they were in a vulnerable or altered state. Two preliminary interviews were held to review the interview questions, and these interviews, which were included in the analysis, were evaluated by two associate professors in the field of psychiatric nursing who had experience in qualitative research. For transferability, purposeful sampling was used, and the purpose and technique of the research were explained to ICU patients in detail. For dependability, the same interview form and voice recorder were used in each of the interviews conducted.

Ethics Approval

Before the study was conducted, ethics committee approval was obtained from the relevant institution (approval number: 2018/432, date: 07.11.2018), and institutional permission was obtained from the institution where the study was to be conducted (approval number: 27868579-605.01). Before the interviews were started, the participants were informed about the scope of the study and confidentiality of the data to be obtained from them in detail, and they were told that the interviews would be recorded.

RESULTS

The mean age of the patients participating in the study was 54.55±9.12 years. Of them, 18 were women, 9 were primary school graduates, 22 were married, and 26 had children (Table 2). After the thematic analysis of the data, two main themes ("Tides of loneliness" and "Whispers in the void") and five sub-themes were synthesized.

Theme 1. Tides of loneliness

Emotional Isolation

Patients described their experiences of loneliness as worse than the fear of death, with the ICU environment exacerbating these feelings. According to the patients, the ICU connoted the following negative meanings: illness-death, prison, privacy, prejudice-tension, uneasiness, fear-uncertainty, worry, longing, difficulty, desolation, loneliness, suffering, torment, sadness, and distress. The patients attributed positive meanings to the ICU such as comfort, excitement, happiness, and joy. In addition, patients stated that they felt pity for the ICU nurses and other patients staying in the ICU. Some patients defined the ICU as a safe place where immediate treatment was given and severely ill patients were treated. The patients hospitalized in the ICU defined loneliness as desolation, not being with their loved ones, abandonment, nothingness, non-existence, being at loose ends, suffering, torment and difficulty.

"We do not have our clothes on here; we are only covered with sheets; this bothers me. We can't go to the toilet or something, we use diapers for toileting, which is a very bad situation, but unfortunately there is nothing we can do. I want to get well soon. You are alone for days in a room, it is like a prison life, there is nothing you can do" (Patient-5).

"Experiencing loneliness can be highly challenging, especially for a daughter. May God not leave anyone alone! It is difficult if you do not have relatives and children near you. You are away from them. Loneliness is worse than death. Loneliness means having no human being around" (Patient-20).

Table 2. Descriptive statistics for the participants (n=29)

Patient no	Gender	Age	Marital status	Educational background	Childbearing status
P-1	Female	41	Married	Graduate	Yes
P-2	Male	48	Married	Graduate	Yes
P-3	Female	55	Married	Illiterate	Yes
P-4	Female	64	Married	Primary school	Yes
P-5	Male	51	Married	Primary school	Yes
P-6	Male	63	Single	Secondary school	No
P-7	Female	68	Married	Primary school	Yes
P-8	Female	53	Married	Illiterate	Yes
P-9	Male	50	Married	High school	Yes
P-10	Female	49	Married	Primary school	Yes
P-11	Female	55	Married	High school	Yes
P-12	Female	39	Single	High school	No
P-13	Female	56	Divorced	Primary school	Yes
P-14	Male	69	Married	Secondary school	Yes
P-15	Female	55	Divorced	Secondary school	Yes
P-16	Male	29	Single	Graduate	No
P-17	Male	48	Married	High school	Yes
P-18	Female	45	Divorced	Secondary school	Yes
P-19	Male	69	Married	High school	Yes
P-20	Female	65	Divorced	Primary school	Yes
P-21	Female	57	Married	Illiterate	Yes
P-22	Male	52	Married	High school	Yes
P-23	Male	65	Married	Primary school	Yes
P-24	Female	51	Married	Secondary school	Yes
P-25	Male	64	Married	High school	Yes
P-26	Female	52	Married	Primary school	Yes
P-27	Female	55	Married	Illiterate	Yes
P-28	Female	63	Married	Primary school	Yes
P-29	Female	54	Married	Graduate	Yes

Social Isolation

Patients expressed a longing for human connection, which significantly affected their mental health. They wished for more communication from nurses and other staff. According to the patients, the ICU negatively affects their mental health. The patients stated that they would like to have a companion in the ICU, that if they were accompanied, they would feel less lonely, that their longing for their relatives would be relieved, that they would be happy, and that their mental health would improve. Moreover, patients wanted the nurses working in the ICU to be friendly and communicate effectively. They also stated that they wanted nurses to talk to patients at short intervals every day, and to approach them with respect and love. The patients stated that they wanted teams that would provide them with morale and psychological support in the ICU.

"The only thing I want them to do is to put themselves in place of patients and to tell patients" "You will get through this; you will regain your health and will be with your family, with your children again; you shouldn't worry" They can help us get rid of this negative psychology. They can provide psychological support" (Patient-22).

Physical Isolation

The patients stated that they were bored in the ICU and wanted some physical arrangements to be made. Patients were unable to engage in basic activities such as sleeping or reading because of environmental discomforts like noise and low temperatures. The patients stated that they would pass the time better if there were a television, radio, newspapers, magazines, and books in the ICU. Additionally, if there was a telephone, they could talk to their relatives, overcoming their longing; their morale would recover, and their time would pass more easily and efficiently. In addition, the patients stated that they could not sleep in the ICU due to sounds coming from machines, light, and cold.

"I want to leave here as soon as possible. We have had enough of noise from machines and other sounds, as well as disturbances from light and insomnia. I am no longer patient. This machine is always beeping. The nurse comes and checks for issues, but there is always a persistent noise. I can't sleep at night. Moreover, it is very cold here. I can't sleep in a cold environment. I like heat. I have no patience any longer, believe me." (Patient-23).

Theme 2. Whispers in the Void

This theme examines how patients cope with their loneliness; distinguishing between adaptive and maladaptive responses, and exploring the role of nurse-patient relationships.

Adaptive Responses to Loneliness

The patients stated that they coped with the loneliness they experienced during their stay in the ICU by turning to religion, praying and being patient. Moreover, the patients stated that they tried to cope with loneliness by thinking positively, such as considering the positive aspects in their lives, making suggestions for their own health, and hoping to reunite with their loved ones when they get better.

Positive interactions with nurses, such as compassionate care and communication, provide comfort and support. Patients appreciated the therapeutic relationship, even when nurses were busy with their duties. The patients stated that there was a therapeutic relationship between patients and nurses, the nurses gave good care to patients, fed them, chatted with them, came when they were called, and showed a very high level of interest. The patients also stated that the nurses working in the ICU did their best despite their heavy workload and that they appreciated them.

"In the ICU, the only thing I do is to be patient, I pray a lot, by God, I cannot do anything else" (Patient-15).

"They do their task. What else can they do? They cannot stop doing their task to come near us. Nonetheless, they still come and chat. They are interested. You can feel their presence that they are here" (Patient-1).

Unhealthy Escapes From Loneliness

Some patients resort to negative coping strategies due to a lack of care or attention from nurses. These behaviors include excessive stress, crying, and a sense of abandonment in patients when nurses fail to meet their basic needs. The patients stated that nurses lacked interest, caring, and empathy. Moreover, the patients stated that the nurses did not come when they were called, did not give water when they were asked for it, and did not take care of them. Some patients stated that they could not cope with the feeling of loneliness in the ICU and that they experienced stress, and cried thus.

"I had very severe pain. I called them, but they didn't come. When I'm cold, I call them to warm me up, but they don't come. I'm tired of calling them. For instance, if I were very sick, I would call them and shout at them, but no one would care." (Patient-4).

DISCUSSION

The results obtained from the present study are expected to make a significant contribution to ICU nurses' understanding of patients' thoughts about the ICU, their experiences of loneliness, and the strength of the nurses. Within the scope of the sub-themes of the first theme derived from the results obtained in this study, it is determined that individuals receiving treatment in intensive care experience loneliness, while emotional, social, and physical factors emerge prominently within the context of their loneliness. The participants hospitalized in the ICU defined loneliness as desolation, not being with their loved ones, abandonment, nothingness, non-existence, being at loose ends, suffering, torment, and difficulty. In a study, patients defined loneliness as the feeling of abandonment, being unnoticed, and experiencing unmet needs.[28] Within the scope of emotional isolation, according to the patients in the present study, the ICU evokes negative meanings such as illness, death, imprisonment, loss of privacy, prejudice, and tension. However, the participants also attribute positive meanings to the ICU such as comfort, excitement, happiness, and joy. Furthermore, the participants define the ICU as a safe place, which indicates their positive feelings. Examining their definitions and feelings, it becomes apparent that the participants have feelings of ambivalence towards the ICU. Literature was supporting this finding,[1,5,6,11,29,30] and it is seen that patients define intensive care in many ways.[30-32] Within this concept, the differing attribution of positive and negative meanings to the ICU is probably due to individual and cultural differences. The patients who participated in the study stated that they felt pity for the ICU nurses and other ICU patients. The patients' pity for nurses and other patients suggests that they focus on the positive aspects of the situation they are

in, by thinking that their own health and comfort areas are better, and thus they thank God. This sense of pity, associated with compassion-defined in the literature as "being sensitive to the suffering of others", can mean that loneliness, which is a common human experience, is welcomed.[14]

Within the scope of social isolation, the participants stated that they wished for companionship in the ICU, believing it would ease their loneliness and improve mental health. Moreover, the participants wanted nurses working in the ICU to smile, to communicate with patients, and to approach patients with respect and love. Similar to the findings of the study, Mattiussi et al.[33], patients stated that having relatives accompanying them in the ICU increased and motivated their life energy. They also reported that the most important factor improving the quality of care given by healthcare professionals is treating patients friendly and establishing a relationship of trust.[33] Previous studies have determined that receiving spiritual care positively affects the loneliness of patients.[15,34] In Özer and Akyil[35], it was determined that patients who were informed about intensive care preoperatively had lower rates of discomfort from loneliness compared to those who were not. Within this context, ICUs are settings where the use of therapeutic communication skills is important and patients are psychosocially encouraged to cope with their loneliness experiences. It is also very important to provide information on patients' experience of loneliness in intensive care. Furthermore, staffing levels and nurse-patient ratios they affect the quality of care, especially in terms of providing the emotional support patients need.

Within the scope of physical isolation, patients stated that they wanted some physical arrangements, so that their loneliness and distress would be relieved. A few patients stated that they could not sleep in the ICU due to sounds, light and cold. In the literature, as in our study, patients go through negative experiences and suffer from sleep problems due to physical conditions such as noise, cold, and lack of privacy, because men and women stay together.[6,7,17,19,30] Gunnels et al.[36] stated that the most disturbing factors for ICU patients were sleep problems due to pain and the presence of device-equipment cables and tubes , while the least discomforting factor was the absence of a telephone.[36] According to Soh et al.[37], ICU stressors perceived by patients are boredom, longing for spouses, and being in a very cold/hot environment.[37] In a meta-synthesis including seven qualitative studies, it was emphasized that the three main themes affecting the sleep quality of ICU patients were complex interactions with the environment, intense feelings, and care of a similar standard.[38] Environmental planning in the ICU will increase the quality of patient care and ensure that patients' psychosocial needs are met, and they are strengthened spiritually.

Within the scope of the second theme, the participants tried to cope with the loneliness they experienced during their stay in the ICU by engaging in positive thoughts such as hoping and turning to religion. Similarly, the patients in a study tried to cope with the negativities they experienced by turning to religion, such as talking to God and praying.[39] In the present study, the participants emphasized that the presence of nurses in the ICU had both positive and negative effects on them. Some patients stated that they resorted to negative coping strategies due to a lack of care from nurses. Studies stated that patients' dependence on health professionals and inability to communicate cause experiences of anxiety, fear, loneliness, and uncertainty in the ICU.[1,6,29,30] In a systematic review performed in Türkiye, it is stated that nurses express both positive and negative reflections regarding patient care.[17] In their study, Hophuis et al.[16] stated that the patients could not tell the nurses what they wanted to consult, due to their nurses' angry appearance, and nearly half of the patients described their ICU experience as bad or very bad.[16] Hintistan et al.[39] stated that the patients' satisfaction level with care in the ICU was moderate[39] while Adsay and Dedeli[19] stated that the patients' satisfaction was at a very high level compared to that in the literature. In Alexandersen et al.[40], it was determined that most of the participants felt safe due to factors such as healthcare professionals being kind, confident, and providing information. Some patients could not get enough information, and could not communicate with some healthcare professionals, and experienced loneliness.[40] These differences between the results of the studies may be due to ICUs not having a common standard; patients having different experiences of ICUs; and individual differences. ICU nurses should be able to empathize with ICU patients' experiences of loneliness and provide emotional and social support to patients, so that ICU nurses can improve patient care by eliminating traumatic and negative experiences.

Study Limitations

The study's findings may not be fully generalizable to other contexts or patient populations. In addition, this study highlights how the cultural context (e.g., Turkish norms around family care and hospital interaction) may shape how patients perceive loneliness and the availability of social support. ICU patients with different characteristics (e.g., marriage status, having a chronic disease, living in poor economic conditions) may have different stressors and coping styles. Thus, these different characteristics may affect ICU patients' loneliness experience.

CONCLUSION

In this study, it was determined that the participants experienced loneliness and wanted physical and social changes to be made, and that nurses pay attention to therapeutic communication techniques to reduce their loneliness experiences and increase their mental health during the treatment process in intensive care. In this context, it is recommended that nurses providing health care services in intensive care should receive training on therapeutic communication techniques, strengthen the social support systems of individuals by including the family in care plans, and make physical arrangements appropriate to the care conditions. Moreover, to better understand the loneliness experiences of individuals treated in intensive care, future studies can include families or involve qualitative research with a larger and different sample. To reduce the loneliness experiences of individuals receiving treatment in intensive care and to protect their mental health, it is recommended that quantitative studies measuring the functionality of evidence-based practices be planned, and the results obtained be transferred to clinical practices.

MAIN POINTS

- Intensive care unit (ICU) patients suffered from loneliness.
- ICU patients faced with various psychosocial problems.
- This study identifies ICU-related factors that shape how patients experience and cope with loneliness.

ETHICS

Ethics Committee Approval: Before the study was conducted, ethics committee approval was obtained from the relevant institution (approval number: 2018/432, date: 07.11.2018),and institutional

permission was obtained from the institution where the study was to be conducted (approval number: 27868579-605.01).

Informed Consent: Then their written consent was obtained from the participants.

FOOTNOTES

Acknowledgements

We are grateful to all the ICU patients for their useful contributions to this study and to the ICU healthcare team that worked there for your supporting to us.

Authorship Contributions

Concept: E.A., G.K.T., H.A.D., M.Y., Design: E.A., G.K.T., H.A.D., M.Y., Data Collection and/or Processing: G.K.T., H.A.D., Analysis and/or Interpretation: H.A.D., M.Y., Literature Search: E.A., H.A.D., Writing: E.A., G.K.T., H.A.D., M.Y.

Conflict of Interest: No conflict of interest was declared by the authors.

Financial Disclosure: The authors declared that this study had received no financial support.

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