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SYMPTOMS AND CHARACTERISTICS OF FAMILY INTENSIVE CARE UNIT SYNDROME AMONG FAMILIES OF CRITICALLY III PATIENTS: A SCOPING REVIEW

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ABSTRACT

Family Intensive Care Unit Syndrome (FICUS) is a cluster of psychological, emotional, and physical symptoms experienced by family members of critically ill patients in response to prolonged stress, medical uncertainty, and the burden of decision-making during ICU care. Although research exploring this condition has grown in recent years, available evidence remains fragmented, highlighting the need for a comprehensive synthesis of symptom manifestations, risk factors, and emerging patterns across studies and contexts. This scoping review aimed to map the symptoms of FICUS systematically reported in the literature over the past 10 years and to identify key characteristics and thematic patterns emerging across various research designs and contexts. This study followed the methodological framework of Arksey and O'Malley, refined by Levac et al., and was reported according to PRISMA-ScR guidelines. A comprehensive search was conducted across five databases (PubMed, Scopus, ScienceDirect, CINAHL, and ProQuest) using a combination of keywords and MeSH terms related to ICU, critically ill patients' families, psychological distress, and FICUS symptoms. The search was limited to full-text articles published in the last ten years (2015-2025) in English or Indonesian. Of 2,977 identified records, 1,240 duplicates were removed. A total of 1,737 titles and abstracts were screened, 184 full texts were reviewed, and 15 studies met the inclusion criteria. Data were extracted and analyzed using thematic narrative synthesis. FICUS symptoms were categorized into three domains: psychological (anxiety, depression, PTSD), emotional (sadness, anger, worry, psychological threat), and somatic/functional (sleep disturbance, fatigue, impaired concentration). Anxiety and depression were the most consistently reported symptoms, while emotional constructs—such as uncertainty, role identity threat, and spiritual distress—were predominantly identified in qualitative studies. The characteristic Major risk factors included younger caregiver age, female gender, patient mortality, longer ICU stay, and poor communication quality. FICUS is a multidimensional phenomenon consistently observed across different countries and ICU care contexts. Findings highlight the urgency for routine psychological screening, improved communication strategies, and structured emotional support interventions for families of critically ill patients.

Keywords: critically ill patients' families; family intensive care unit syndrome; psychological distress

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INTRODUCTION

Family-centered care is defined as a participatory approach to decision-making that enables family members to be actively involved in the patient's care. Increasing awareness of the family's role in the Intensive Care Unit (ICU) has encouraged greater family engagement in the delivery of critical care. Moreover, family members often serve as surrogate decision-makers, responsible for supporting and managing the patient's treatment decisions. When a patient is unexpectedly admitted to the ICU, family members typically do not have sufficient time to psychologically or practically prepare for the situation, which may lead them to experience a life-altering crisis. This crisis can disrupt their daily functioning and normal routines. The impact of ICU hospitalization on family members is significant, to the extent that they may neglect their own basic needs such as rest and nutrition, resulting in a reduced ability to effectively cope with stress and decision-making demands (Secunda, 2022). Ineffective coping may lead to various psychological problems, including stress, anxiety, hopelessness, depression, and post-traumatic stress disorder among family members of ICU patients (Saeid & Moradian, 2023). These symptoms—referred to as Post-Intensive Care

Syndrome-Family (PICS-F)—may persist long after hospital discharge. Families of ICU patients also often experience financial strain due to work disruptions or caregiving responsibilities. This burden may have long-term consequences on their well-being and exacerbate PICS-F symptoms. Previous studies have shown that more than one-third to one-half of family members continue to experience PICS-F symptoms over time. A retrospective cohort study from Japan reported that 12.8% of spouses of ICU patients sought medical treatment for mental health disorders within six months.

During the ICU stay, many family members develop psychological symptoms, a phenomenon identified as Family Intensive Care Unit Syndrome (FICUS). The impaired capacity for decision-making among family members of critically ill patients receiving prolonged or acute hospitalization is also referred to as FICUS. Family Intensive Care Unit Syndrome is a comorbid response to another individual's ICU hospitalization and is characterized by emotional distress, poor sleep health, and decision-making fatigue (Grant et al., 2023). FICUS may result in consequences such as impaired decision-making processes among family members. Since critically ill patients are often unable to participate in decisions regarding their care due to their condition, clinicians frequently rely on family members to make treatment decisions. Therefore, integrating family support and addressing family members' symptom burden is essential to improving their decision-making capacity and overall participation in patient care, while also preserving their own health. Although FICUS has been recognized as an important issue in ICU settings, existing literature describing the core symptoms remains scattered and has not yet been systematically mapped. Therefore, this article aims to identify symptoms of FICUS reported among families of ICU patients, describe the instruments and methods used to define these symptoms, and identify research gaps related to the characteristics of FICUS.

METHOD

This study employed a scoping review design based on the methodological framework proposed by Arksey and O'Malley, later enhanced by Levac et al., and reported in accordance with the PRISMA-ScR guidelines. Eligible studies included those that examined symptoms of Family Intensive Care Unit Syndrome among family members of critically ill patients, were published in English or Indonesian, were available in full text, and used any research design. Studies that focused solely on patients, opinion articles, editorials, commentaries, or publications without relevant symptom-related findings were excluded.

A comprehensive literature search was conducted in PubMed, Scopus, ScienceDirect, ProQuest, and CINAHL using a combination of keywords and MeSH terms related to the topic, including "Intensive Care Unit," "critical illness," "family members," "Family Intensive Care Unit Syndrome," "FICUS," "psychological symptoms," "emotional disturbance," "anxiety," "depression," "stress," "sleep disturbance," "fatigue," and "caregiver burden." The search was restricted to studies published within the past 10 years (2015-2025).

All retrieved records were imported into reference management software, and duplicates were removed. Title and abstract screening were conducted independently by two reviewers, followed by full-text assessment to determine eligibility. Discrepancies were resolved through discussion or consultation with a third reviewer. Data extraction was performed using a standardized extraction form that documented the author's name, publication year, country, study design, sample characteristics, measurement instruments, and reported symptoms related to FICUS. Extracted data were analyzed using a descriptive narrative synthesis and organized into thematic categories based on the symptom types reported in the included studies.

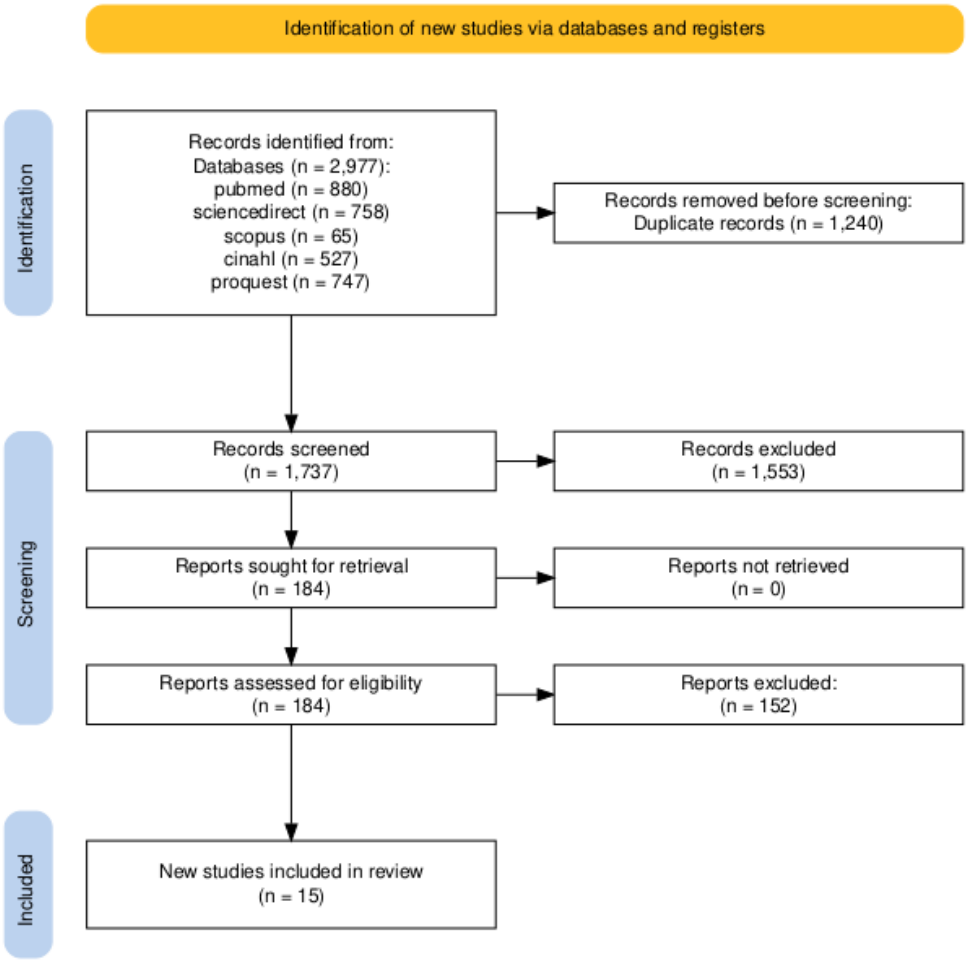

Figure 1. PRISMA Flow Diagram of Study Selection Process

RESULT

1.1 Study Selection Process (PRISMA Flow Chart)

The study selection process in this scoping review followed the PRISMA guidelines, which ensure transparency and traceability in every step of article identification and selection. During the initial identification stage, a total of 2,977 records were retrieved from five major electronic databases: PubMed (n = 880), ScienceDirect (n = 758), Scopus (n = 65), CINAHL (n = 527), and ProQuest (n = 747). This number reflects a broad range of literature on psychological conditions and family experiences among relatives of intensive care patients.

After merging all records, 1,240 duplicates were removed, leaving 1,737 unique records for title and abstract screening. This initial screening resulted in the exclusion of 1,553 records due to noncompliance with inclusion criteria, including irrelevant population, non-ICU settings, or lack of relevance to FICUS symptoms or psychological conditions among family members.

A total of 184 full-text articles were retrieved and assessed for eligibility. Of these, 152 articles were excluded for reasons such as lack of full-text access, non-family-ICU populations, methodological irrelevance, or the absence of symptom-related findings. Ultimately, 15 studies met all eligibility criteria and were included in the scoping review, forming the basis for narrative analysis and thematic synthesis.

Table 1.
Characteristics of Included Studies

Author & Year	Country/Setting	Research Objective	Study Design	Population & Sample	Instrument/ FICUS Indicators	FICUS Symptoms Identified	Key Findings
Sarigiannis et al., 2021	United States (Rush University Medical Center, Chicago)	To identify changes in anxiety and depression symptoms among family members of ICU patients during hospitalization	Longitudinal clinical trial	Family members of COVID-19 ICU patients	HADS (Anxiety & Depression)	Increased anxiety and depression before ICU discharge	Significant increase in anxiety (b = 1.44; p = 0.002) and depression (b = 0.72; p = 0.043)
Faramarzi et al., 2023	Iran (Azar Hospital, Gorgan)	To examine the relationship between PTSD and sleep quality among family members of trauma-related ICU patients	Cross-sectional	Family members of trauma patients in the ICU	PTSD scale; Sleep quality score	High PTSD levels and a significant decline in sleep quality after one month	Mean PTSD score: 67.8; Sleep quality worsened from 3.9 to 9.3 (p < 0.001)
Saeid et al., 2019	Iran (Three hospitals in Tehran)	To explore family experiences related to FICUS	Qualitative (Content analysis)	Family members of ICU patients	In-depth interview	Psychological, physical, social threats, and spiritual role changes	Four thematic categories of comprehensive FICUS symptoms were identified
Bolosi et al., 2018	Greece (ICU of "G. Hatzikosta" Hospital)	To assess anxiety and depression levels among family members of ICU patients and their support needs	Observational, Structured interview	Family members of ICU patients	Anxiety and Depression Questionnaire	Anxiety remained unchanged; depression increased significantly from 38% to 58.3%	Increasing depression and limited involvement in decision-making are reported
Pignatiello et al., 2023	United States (Ohio)	To examine longitudinal relationships between FICUS symptoms	Repeated-measures correlational	Family members of critically ill patients	Anxiety, depression, sleep disturbance, fatigue scales	Strong correlation between anxiety, depression, sleep disturbance, and fatigue	Early sleep disturbance is associated with anxiety, depression, and fatigue by day 7
Gürbüz & Demir, 2023	Türkiye	To identify anxiety and depression symptoms among ICU patients' family members	Prospective cohort	Family members of ICU patients	Anxiety & Depression scale	Anxiety: 52.4%; Depression: 67.9%; difficulty understanding medical information	Acute illness and patient mortality are associated with increased family depression.
Yaser Saeid et al., 2020	Iran (Baqiyatallah University of Medical Sciences,	To define FICUS, identify symptoms, and	Integrative review (PRISMA-based)	20 studies including family members of ICU patients	DASS, IES-R, HADS, GSDS, LFS, PSQI	Psychological symptoms: anxiety (70–80%), depression	No universal FICUS definition found; predictors include demographic and psychosocial

Author & Year	Country/Setting	Research Objective	Study Design	Population & Sample	Instrument/ FICUS Indicators	FICUS Symptoms Identified	Key Findings
	Tehran)	determine predictors				(35–70%), PTSD (54%); physical symptoms: fatigue, sleep disturbance (80%)	factors.
Shirasaki et al., 2024	International review (primarily France and multiple countries)	To clarify concepts, risk factors, screening tools, prevalence, and management strategies for PICS-F	Comprehensive review	Family members of ICU patients	HADS, PHQ-9, PHQ-8, CES-D, IES-R, PCL-5, ICG, PSQI, FS-ICU 24, Zarit-12	Psychological: anxiety, depression, PTSD, acute stress, complicated grief; physical: fatigue, sleep disturbance; socioeconomic impact	PICS-F is described as "a broken life"; prevalence: psychological symptoms 20–40%, fatigue 15% up to 6 months post-ICU.
Lobato et al., 2022	Brazil	To identify risk factors for PICS-F among family members	Prospective cohort	184 family members of ICU patients	HADS, IES-R, PSQI, Fatigue scale	Anxiety, depression, PTSD, sleep disturbance, fatigue	High HADS and sleep disturbance scores; major risk factors: prolonged ICU stay, mechanical ventilation.
Dijkstra et al., 2025	Netherlands	To examine family involvement in ICU care and its association with PICS-F symptoms	Multicentre stepped-wedge cluster RCT + narrative analysis	306 family members of ICU patients	Anxiety, depression, PTSD, and family satisfaction	Anxiety, depression, PTSD, helplessness	Family involvement alone did not reduce PICS-F; improved communication and education were required.
Asadi & Salmani, 2024	Iran	To explore family experiences while caring for ICU patients	Qualitative phenomenology	Family members of ICU patients	Interview guide on emotional and caregiving burden	Stress, anxiety, depression, fatigue, sleep disturbance, disrupted social roles, spiritual changes	Family distress and unmet needs indicate the necessity for psychosocial and communication interventions
Johnson et al., 2019	Multiple regions (Europe, US, Asia, South America, Canada, Australia)	To document prevalence of depression, anxiety, and PTSD among family caregivers of critically ill patients and identify risk factors	Systematic review	40 included studies	HADS, BDI-II, CES-D, PHQ-9, IES-R, PCL-C, GAD-7	Depression, anxiety, PTSD	Prevalence ranged: depression 4–94%, anxiety 2–80%, PTSD 3–62%; young age and female gender as key risk factors.
Harlan et al., 2020	United States (Michigan)	To understand emotional experiences and coping strategies among ICU family members	Mixed methods (semi-structured interview + follow-up survey)	40 family members of ICU patients	HADS, PCL-C	Depression, anxiety, PTSD, sadness, anger, fear	65% showed psychological distress; emotional burden influenced coping strategies.

Author & Year	Country/Setting	Research Objective	Study Design	Population & Sample	Instrument/ FICUS Indicators	FICUS Symptoms Identified	Key Findings
Naef et al., 2021	Switzerland	To identify determinants of psychological distress post-ICU (depression, anxiety, PTSD) among family members	Prospective observational single centre	214 family members	FS-ICU-24, HADS, IES-R-6	Depression, anxiety, PTSD	Higher satisfaction with ICU care is associated with lower distress; patient death and younger patient age increased symptom severity.
Herlina et al., 2020	Indonesia (RSUD H. Abdul Aziz Marabahan & RSD Idaman Banjarbaru)	To identify factors associated with family anxiety in ICU	Cross-sectional correlation	30 family respondents	Hamilton Anxiety Rating Scale (HARS)	Anxiety (tension, restlessness, worry, sleep disturbance)	Age, education level, experience, and knowledge were significantly associated with anxiety (p = 0.000); no association with gender or health services

Symptoms of Family Intensive Care Unit Syndrome (FICUS)

Based on synthesis from the 15 included studies, FICUS symptoms were categorized into three major domains: (1) psychological symptoms, (2) emotional symptoms, and (3) somatic-functional symptoms. These domains are interrelated and collectively form a multidimensional representation of the burden experienced by family members of ICU patients.

Psychological Symptoms

Psychological symptoms are the most dominant and consistently reported components of FICUS, primarily anxiety, depression, and post-traumatic stress disorder (PTSD).

Anxiety

Anxiety is the most frequently identified psychological symptom among family members of ICU patients. Johnson et al. (2019) reported that anxiety prevalence ranged from 2% to 80%, reflecting wide variability depending on timing of assessment, patient condition, and healthcare culture. Foundational studies by Azoulay et al. (2003) and Pochard et al. (2005) demonstrated that anxiety rates may reach 73% during the first week of ICU hospitalization, confirming that early ICU exposure is the most critical period. In Indonesia, Herlina et al. (2020) found that 50% of families experienced moderate anxiety, indicating that emotional burden is also significant in local contexts.

Depression

Depression levels also showed high and variable prevalence. Johnson et al. (2019) reported a range of 4% to 94%, indicating that families of ICU patients are highly vulnerable to emotional exhaustion and mood disturbances. A longitudinal study by Sarigiannis et al. (2021) demonstrated significant increases in anxiety (b = 1.44; p = 0.002) and depression (b = 0.72; p = 0.043) during ICU hospitalization, suggesting that depressive symptoms evolve alongside prolonged critical illness.

PTSD Symptom

Post-traumatic stress emerged as another important psychological component of FICUS. Johnson et al. (2019) reported a prevalence range of 3% to 62%, indicating frequent traumatic responses to uncertain and stressful ICU environments. Faramarzi et al. (2023) documented a mean PTSD score of 67.8 among family members of trauma-related ICU patients—indicating severe trauma exposure. These findings highlight the ICU as a high-risk psychological trauma environment not only for patients but also for their families.

Emotional Symptoms

Beyond psychological symptoms, ICU family members experience complex emotional responses.

Persistent worry

Alfheim et al. (2018) reported that 91% of participants experienced persistent worry regarding the patient's condition, medical procedures, clinical decisions, and mortality risk. This worry often continues even if the patient shows signs of improvement.

Core emotional triad

Harlan et al. (2020) identified three dominant emotional responses—sadness, anger, and fear—reported by 65% of family members during initial assessments. These emotions were associated with perceived loss of control, prognostic uncertainty, and decision-making burden.

Psychological Threat

Qualitative findings from Saeid et al. (2019) identified a theme of "psychological threat," referring to emotional distress caused by fear of death, family tensions, and confusion regarding medical information.

Somatic and Functional Symptoms

Psychological distress also manifests physically and functionally.

Sleep Disturbance

Faramarzi et al. (2023) found a significant decline in sleep quality among family members of trauma patients, with scores increasing from 3.9 to 9.3 ($p < 0.001$) after one month. Sleep disturbance serves not only as a symptom but also as a mediator that exacerbates anxiety, depression, and fatigue.

Physical and Cognitive Symptoms

Alfheim et al. (2018) documented a median of nine co-occurring symptoms (range: 0–24), including severe fatigue, impaired concentration, and other somatic complaints, which interfered with daily functioning.

Stress-Related Physical Threat

Saeid et al. (2019) also identified "physical threat" as a dimension of the FICUS experience, illustrating how severe emotional distress may produce significant physical symptoms.

Characteristics of Included Studies

The fifteen included studies demonstrated considerable diversity in study design, geographic representation, sample characteristics, and measurement instruments, collectively enriching the understanding of FICUS phenomena. Most studies employed quantitative approaches, particularly cross-sectional and prospective cohort designs, while others used mixed-methods, longitudinal approaches, qualitative analyses, or systematic reviews. This variation indicates that FICUS has been examined through a wide and interdisciplinary methodological lens.

Geographically, the studies originated from multiple regions, including Asia (Iran, Indonesia), Europe (Greece, Norway, Switzerland, France), North America (United States), and other locations, reflecting diverse sociocultural contexts. This geographical variation reinforces that FICUS is not a localized phenomenon but a universal condition experienced by families of ICU patients across healthcare systems.

All studies focused on family members of ICU patients—either as primary caregivers, surrogate medical decision-makers, or individuals actively involved in supporting critically ill patients. The

measurement instruments used to assess FICUS symptoms varied widely and included internationally validated psychological assessment tools such as the Hospital Anxiety and Depression Scale (HADS), Impact of Event Scale-Revised (IES-R), PTSD Checklist (PCL-C or PCL-5), General Sleep Disturbance Scale (GSDS), Pittsburgh Sleep Quality Index (PSQI), and other emotional and functional assessment instruments.

These instruments enabled the identification of core psychological symptoms such as anxiety, depression, and post-traumatic stress, as well as sleep disturbance, fatigue, caregiving burden, and other emotional or somatic features related to FICUS. Therefore, the characteristics of the included studies offer a comprehensive basis for mapping FICUS symptoms and conducting deeper thematic analysis.

DISCUSSION

Findings from this scoping review demonstrate that Family Intensive Care Unit Syndrome (FICUS) is a complex and multidimensional condition that evolves as families are exposed to the critical and emotionally demanding environment of the ICU. The fifteen included studies indicate that FICUS is not merely a cluster of isolated psychological symptoms, but rather a comprehensive phenomenon affecting cognitive, emotional, somatic, and social aspects of the lives of family members of critically ill patients (Wen, 2025). The symptom patterns identified across studies show that families experience substantial psychological strain not only due to the patient's clinical status, but also because of ICU environmental factors, decision-making responsibilities, medical uncertainty, limited communication, and restricted interaction with both the patient and healthcare staff. These findings support the growing consensus that FICUS develops dynamically, influenced by multiple risk factors and moderated by specific protective elements (Putowski et al., 2023).

Psychological symptoms such as anxiety, depression, and post-traumatic stress disorder (PTSD) emerged consistently as core components of FICUS. Johnson et al. (2019), in an extensive systematic review, reported wide prevalence ranges—2% to 80% for anxiety, 4% to 94% for depression, and 3% to 62% for PTSD. These variations reflect differences in ICU context, cultural background, care system structure, assessment instruments, and timing of measurement (Tanaka et al., 2025). This evidence is further supported by longitudinal findings from Sarigiannis et al. (2021), which reported a significant increase in anxiety and depression scores over time, especially near patient discharge or transition phases. The increase in anxiety ($b = 1.44$; $p = 0.002$) and depression ($b = 0.72$; $p = 0.043$) suggests that prolonged exposure to medical uncertainty and critical illness stressors heightens psychological vulnerability among families both short- and long-term (Vich et al., 2024).

The highly dynamic and unpredictable ICU environment also contributes to the development of PTSD symptoms. Faramarzi et al. (2023) reported a mean PTSD score of 67.8 among family members of trauma patients, indicating severe traumatic distress. Their findings further suggest that sleep disturbances may amplify PTSD symptoms. A significant decline in sleep quality (from 3.9 to 9.3; $p < 0.001$) highlights a bidirectional relationship between psychological distress and sleep disruption, where emotional strain interferes with biological recovery, and sleep impairment subsequently intensifies emotional burden, leading to a reinforcing cycle of symptoms.

Beyond psychological manifestations, broader emotional experiences were also prominent. Qualitative studies by Asadi & Salmani (2024) and Saeid et al. (2019) revealed that families frequently experience intense fear, prolonged uncertainty, helplessness, and internal conflict regarding medical decision-making. Saeid et al. (2019) described these responses as "psychological threats," capturing how families internalize clinical uncertainty as a threat to their mental equilibrium. Similarly, Harlan et al. (2020) identified three dominant emotional responses—sadness, anger, and fear—reported by 65% of families during early ICU exposure, indicating that

emotional distress is immediate and strongly influenced by early care experiences.

Somatic and functional impairments also appeared as significant elements of FICUS. Family members reported severe fatigue, impaired concentration, physical tension, and persistent sleep disruptions. Alfheim et al. (2018) found that families experienced up to nine concurrent symptoms, reflecting a phenomenon of multiple symptom burden rarely emphasized in earlier conceptual models of FICUS. These physical symptoms not only represent manifestations of emotional distress but also indicate diminishing adaptive capacity and heightened need for psychosocial support.

Multiple risk factors were identified as contributing to FICUS, including younger age, female gender, lower educational level, minimal prior ICU experience, and poor understanding of the patient's medical condition (Herlina et al., 2020; Johnson et al., 2019). Clinical factors such as severe illness, mechanical ventilation, and patient death significantly increased emotional burden (Naef et al., 2021; Lobato et al., 2022). Naef et al. (2021) specifically identified patient death as one of the strongest predictors of post-ICU depression and PTSD among relatives, suggesting that the most critical psychological impact may occur after the acute care phase ends.

In contrast, several protective factors were identified. Family satisfaction with communication, quality of interaction with healthcare providers, and involvement in decision-making emerged as key protective mechanisms. Naef et al. (2021) found that higher satisfaction with ICU care was associated with significantly lower levels of depression, anxiety, and PTSD. Effective, transparent, and empathetic communication increased families' sense of control and emotional stability. However, Dijkstra et al. (2025) highlighted that involvement in decision-making may not always be protective, particularly when communication or support is insufficient. These findings emphasize that the quality, rather than the frequency, of interaction determines emotional and clinical outcomes.

From a methodological standpoint, this review indicates that measurement of FICUS remains inconsistent across studies. A diverse range of instruments—including HADS, IES-R, PCL-C, PSQI, GSDS, and various fatigue scales—were used, each with different sensitivity and specificity, limiting comparability across studies. The lack of a universal definition of FICUS, as identified in the integrative review by Saeid et al. (2020), continues to hinder the development of standardized clinical guidelines and preventative strategies. This signifies the need for global consensus on definitions, symptom domains, and standardized measurement tools.

Furthermore, consistency of findings across countries illustrates that FICUS is a universal phenomenon, transcending healthcare systems and cultural boundaries. Studies from Iran, Indonesia, Turkey, Switzerland, the United States, Brazil, and Greece reported comparable symptom patterns, despite differences in ICU protocols and sociocultural dynamics. However, qualitative evidence (Asadi & Salmani, 2024) indicates that cultural interpretations may shape emotional and spiritual responses, suggesting that interventions should be culturally adaptive.

Overall, this review yields several important implications. First, FICUS should be detected early through structured screening using validated tools, particularly for anxiety, depression, and PTSD. Second, psychosocial support must be systematically integrated into ICU care, including family education, communication pathways, clinical psychological support, and post-ICU recovery programs. Third, family-focused interventions targeting sleep disturbance, fatigue, and emotional distress are warranted. Finally, future research should aim to establish a comprehensive conceptual model of FICUS, standardize definitions and assessment tools, evaluate evidence-based interventions, and employ longitudinal designs to understand long-term trajectories.

Collectively, these findings demonstrate that FICUS is a clinically significant, multidimensional,

and universal condition requiring targeted attention in modern critical care. FICUS affects not only family well-being but also the quality of decision-making, communication patterns, and patient recovery. Therefore, integrating a family-centered biopsychosocial approach is essential to improving the overall quality of ICU care.

Implications and Limitations

Findings from this scoping review present important implications for clinical practice, future research, and policy development related to family support in the Intensive Care Unit. The consistent reporting of core FICUS symptoms—particularly anxiety, depression, sleep disturbance, and PTSD—highlights the urgent need to implement routine psychological screening for family members of ICU patients, especially during early hospitalization when emotional burden and clinical uncertainty are most significant. Additionally, evidence indicates that communication-based interventions, family education, and psychosocial support programs may serve as effective preventive strategies. Therefore, these results underscore the need to strengthen healthcare providers' capacity in identifying psychological distress and support the structured implementation of Family-Centered Care practices, including counseling services, peer-support networks, and long-term psychological monitoring after ICU discharge.

Theoretically, this review contributes to the growing understanding of FICUS as a multidimensional construct that remains only partially defined in the international literature. The consistency of reported symptoms across the fifteen included studies provides empirical justification for establishing standardized definitions, conceptual frameworks, and assessment instruments applicable across countries and healthcare systems. While anxiety, depression, and PTSD dominate current assessments, emotional, spiritual, and physical dimensions also emerge as relevant components that require further exploration through quantitative and mixed-methods research. Thus, findings highlight the need for multimodal approaches—including longitudinal methodologies—to better understand the progression of FICUS before, during, and after ICU care.

Despite its contributions, this scoping review has several limitations. First, most included studies originated from high-income countries, limiting the representation of global cultural and healthcare contexts, including lower-resource regions. Second, variation in measurement tools introduced heterogeneity, limiting direct comparability across findings. Third, as this review does not include a meta-analysis, the statistical strength of the associations could not be determined, and the findings are presented narratively. Furthermore, restricting publications to the last ten years and to English or Indonesian studies may introduce selection and publication bias.

Nevertheless, despite these limitations, this review provides a strong foundation for future FICUS research. It may serve as a reference for healthcare institutions seeking to design evidence-informed interventions to improve the well-being of families of ICU patients.

CONCLUSION

This scoping review demonstrates that Family Intensive Care Unit Syndrome (FICUS) is a complex condition encompassing a spectrum of psychological, emotional, physical, and cognitive symptoms, with anxiety, depression, PTSD, sleep disturbances, fatigue, excessive worry, and emotional dysregulation identified as the most common manifestations. Multiple risk factors were identified, including family demographic characteristics, the patient's clinical condition, medical uncertainty, and the quality of communication with healthcare professionals. These findings highlight the need for a comprehensive approach to identifying, preventing, and managing FICUS through multidisciplinary interventions, improved communication practices, and more structured family support within the ICU environment.

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