OPTIMISM, SATISFACTION WITH NEEDS MET, INTERPERSONAL PERCEPTIONS OF THE HEALTHCARE TEAM, AND EMOTIONAL DISTRESS IN PATIENTS’ FAMILY MEMBERS DURING CRITICAL CARE HOSPITALIZATION

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• BACKGROUND Families of critical care patients experience high levels of emotional distress. Access to information about patients’ medical conditions and quality relationships with healthcare staff are high-priority needs for these families.
• OBJECTIVES To assess satisfaction with needs met, signs and symptoms of acute stress disorder, interpersonal perception of healthcare staff, level of optimism, and the relationships among these variables in patients’ family members.
• METHODS Family representatives of 40 patients were administered a brief version of the Critical Care Family Needs Inventory, the Acute Stress Disorder Scale, the Brief Symptom Inventory, the Impact Message Inventory, and the Life Orientation Test shortly after admission of the patients to the intensive care unit and after discharge.
• RESULTS Levels of dissociative symptoms associated with acute stress disorder were elevated in family members just after admission but decreased significantly after discharge. Needs the families thought were least satisfactorily cared for after admission involved lack of information. Interpersonally, attending physicians were viewed as more controlling than bedside nurses at admission; nurses were viewed as more affiliative than physicians both at admission and after discharge. At admission, higher optimism of the family members was strongly related to greater satisfaction with needs met, to perceptions of affiliation from physicians, and to perceptions of not being controlled by physicians.
• CONCLUSIONS More interpersonal contact with medical staff can help meet the information needs of patients’ families. Nurses may aid in families’ adjustment by fostering a sense of optimism in family members and encouraging them to participate in the patients’ care. (American Journal of Critical Care. 2005;14:202-210)

Meeting the needs of families members of patients in the intensive care unit (ICU) is a primary responsibility of ICU physicians and nurses and an important criterion in assessment of quality of care in the ICU.1 Although experiencing emotional turmoil, patients’ family members are called on to actively represent the patients and participate with healthcare staff in making crucial decisions about the patients’ care. As patients recover and regain awareness, their family members become their most important source of personal support and link to the healthcare team. The most pressing single documented need of patients’ family members during ICU hospitalization is access to clear, understandable, and honest information about the patients’ medical condition.2-4 In addition, the manner in which this information is transmitted and the development of trusting and mutually respectful relationships between the family members and the healthcare team are crucial factors in helping families adjust to this traumatic situation.

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The most pressing need of family members of patients in the intensive care unit is to receive clear, understandable, and honest information about the patient’s condition.

Purpose of the Study
The purpose of the study described here was to analyze the following in family representatives of patients in the ICU:

- representatives’ appraisal of the extent to which their needs were being met,
- representatives’ emotional stress and level of psychopathological dysfunction,
- representatives’ interpersonal appraisal of beside nurses and primary physicians caring for the patients, and
- the interrelationships among these variables.

High levels of both depression9,10 and anxiety9,11,12 in family members of critically ill patients have been reported. Moreover, recent interest has increased in assessing the prevalence of signs and symptoms of anxiety disorders in both patients and patients’ families. Signs and symptoms of posttraumatic stress disorder (PTSD) have been detected in traumatically injured ICU patients.12,13 In addition, patients’ family members who are indirectly exposed to the trauma may experience a level of emotional distress that can approach that of patients.14,15 This “secondary traumatization”16 has been observed in emergency workers, psychotherapists, and children raised in dysfunctional families17,18 but has not been directly examined in the family members of ICU patients.

We assessed patients’ family members for indications of acute stress disorder (ASD) and overall emotional disturbance early in the patients’ hospitalization and again after discharge. ASD is regarded as an acute form of PTSD that occurs in the early stages after exposure to a traumatic stressor (2 days to 4 weeks after trauma) and thus was most appropriate for our study.

Because quality interpersonal relationships with healthcare staff are a high priority for patients’ family members, another focus of the study was the nature of the relationship that develops between patients’ family members and the patients’ attending physicians and bedside nurses. To evaluate the role of physician and nurse interpersonal variables, we used the Impact Message Inventory (IMI)19,20 in which family members of patients subjectively appraised the interpersonal impact both physicians and nurses had on the family members at 2 points (admission and discharge) during each patient’s hospitalization.

To determine which family members might adjust best to the stress of the ICU, we also used a measure of dispositional optimism. Optimistic persons adjust better to a range of stressors, including important life transitions,21 failure at in vitro fertilization,22 and coronary artery bypass surgery.23 We thus expected that compared with family representatives who scored low in optimism, those who scored high would view healthcare staff more positively, feel more satisfied with the care the family members and their relatives received, and have lower levels of emotional distress.

Methods
Setting and Participants
This study was conducted on the surgical trauma ICU of the Virginia Commonwealth University Health System, a level I trauma center for central Virginia, located in Richmond. This 772-bed tertiary care university medical center is a teaching hospital. Participating physicians were all attending trauma surgeons (dedicated ICU staff) who were board certified in surgical critical care. Study subjects were 40 family representatives of patients hospitalized on the surgical trauma ICU. Only family of trauma patients hospitalized on this unit were included to maximize standardization of conditions confronting families and the relationship between healthcare staff and the families. Although more than a single family member often was involved in interactions with the healthcare staff, for the sake of consistency and clarity, the person designated as the primary spokesperson and legal representative for each patient served as the respondent for the patient’s family.

Measures
Critical Care Family Needs Inventory. The Critical Care Family Needs Inventory (CCFN1)24,25 has been used to assess the perceptions of patients’ family members of the importance of various family needs. The 45-item inventory consists of 5 subscales: support, comfort, information, proximity, and assurance. The reported Cronbach α reliability is .96.24 Construct validity was confirmed with predicted factor loadings. In our study, a modified 14-item version26 was used so that family members rated how well perceived
needs were met (the higher the score, the more needs were unmet) rather than the importance of the need statement. This version has been used in this way by other investigators.27-29

Acute Stress Disorder Scale. ASD is a new diagnostic category included in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*30 in recognition of the high levels of distress that persons can experience in the acute phase of a traumatic experience.31 The Acute Stress Disorder Scale (ASDS)32 is a 19-item self-report measure with items based on DSM-IV criteria. Evidence for convergent and predictive validity of the ASDS has been reported.33

Brief Symptom Inventory. The Brief Symptom Inventory (BSI)34 is a 53-item measure of “current, point-in-time, psychological symptom status.” Cronbach α internal consistency coefficients for the 9 clinical scales (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism) are between .80 and .90. Scores on the individual clinical scales and the summary General Severity Index (GSI) fluctuate appropriately in response to stressful medical situations.35 More than 500 studies on the criterion-related validity of the BSI have been published.36

Impact Message Inventory. The IMI20 is used to characterize a target person’s interpersonal behavior via assessment of the IMI respondent’s covert reactions evoked during encounters with the target. Examples of items include “When I was with this person, he/she made me feel . . . ‘bossed around,’ ‘appreciated by him/her,’ ‘distant from him/her.’” In this study, a 28-item short version of the IMI (the IMI-C)37 was used by patients’ family representatives to evaluate the interpersonal impact the patients’ attending physicians and bedside nurses had on the representatives. The IMI-C produces 4 raw scores, dominant, hostile, submissive, and friendly, and 2 axis scores, control (dominant minus submissive) and affiliation (friendly minus hostile). Reliability and validity have been reported.36-38 We determined internal consistency reliabilities for the 4 raw scores but analyzed only the 2 axis scores, control and affiliation.

Life Orientation Test. The Life Orientation Test,39 an 8-item self-report measure (plus 4 filler items), was used to assess dispositional optimism. Patients’ family representatives were asked to indicate the representatives’ degree of agreement (on a 5-point Likert scale) with statements such as “In uncertain times, I usually expect the best,” and “I hardly ever expect things to go my way.” The Cronbach α reliability for this test in a sample of more than 4000 undergraduates was .82.40

Procedure
Data were obtained twice: at admission (ie, in the early stage of patients’ hospitalization, a mean of 3 days after admission to the ICU) and at discharge (a mean of 30 days after admission to the ICU). For each potential family representative, initial contact was made after the representative’s relative had been admitted to the ICU and was made by a staff nurse assigned to the patient. Family members who expressed interest in participating in the study were contacted by the researcher, who answered any questions and gave each potential representative a consent form for consideration. A convenience sample was studied.

Meetings with family representatives took place in a conference room adjacent to the ICU or, occasionally, at the patient’s bedside. At the first data collection period, the representatives were instructed to respond to questionnaires in terms of how they were feeling during the initial 48 hours their relatives were in the ICU. They were contacted again when the patients were scheduled to be discharged. The representatives either responded to the questionnaires at that time or were given the questionnaires and asked to return the material in a stamped, addressed envelope that was provided. Because of time constraints, some family representatives did not provide data on all measures.

Results
Characteristics of the Sample
The 40 family representatives were 18 to 69 years old (median 45 years). Years of education ranged from 9 to 19 (median 13). A total of 65% were women. Among the sample, 45% were African American, 45% were white, 5% were Hispanic American, and 5% were Asian American.

Appraisal of Needs Met
The 14-item version of the CCFNI used in the study was an internally consistent, homogeneous scale (α = .90 at admission and .83 at discharge). As indicated by the mean item scores (Table 1), the extent to which family representatives reported unmet needs differed for the 2 times. At admission, the most prominent cluster of unmet needs reflected lack of information about the patient’s condition and why things were being done and a lack of explanations of the medical equipment being used. Another major item of dissatisfaction was the unavailability of a comfortable waiting room area. Compared with CCFNI total scores obtained at admission, family representatives’ CCFNI scores at discharge indicated a trend toward increased satisfaction with the extent to which the representatives’ over-

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all needs were being met \((t = 1.74, P = .09)\). Significantly greater satisfaction (lower scores) was reported in 4 areas (Table 1).

### Emotional Distress

At admission, family representatives experienced moderate to high levels of symptoms characteristic of ASD. The mean ASDS score (44.65) was approximately the same as that (44.93) of patients admitted to the PTSD unit of a psychiatric hospital. The representatives’ responses were markedly elevated in 2 of the 3 areas of dissociative symptoms that serve as distinctive criteria for a diagnosis of ASD: reexperiencing (eg, “Memories of what happened kept entering my mind,” “I’ve had dreams or nightmares about what happened”) and hyperarousal (eg, “I’ve had trouble sleeping,” “I sweat or tremble or my heart beats faster when I am reminded of what happened”). As indicated in Table 2, ASDS scores declined significantly at discharge. Family representative’s mean score at discharge (38.13) was less than (but remained within 1 SD of) the mean of the previously cited sample of PTSD patients. Largest reductions were in avoidance and emotional numbing symptoms (eg, “numb or distant from my emotions,” “feeling as if things were unreal or dreamlike”).

As expected, at both admission and discharge, family representatives’ scores on the ASRS were significantly correlated (Pearson product moment correlation coefficients 0.62 and 0.74, respectively, \(P < .001\) for both), with scores on the GSI of the BSI (a summary measure of overall emotional dysfunction). At admission, the mean GSI score was moderately higher than the mean score obtained by a normative sample of adult nonpatients and was more than 1 SD less than

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**Table 1** Scores on the Critical Care Family Needs Inventory items at admission and discharge

<table>
<thead>
<tr>
<th>Item</th>
<th>Admission Mean</th>
<th>SD</th>
<th>Discharge Mean</th>
<th>SD</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Best possible care</td>
<td>1.36</td>
<td>0.58</td>
<td>1.38</td>
<td>0.63</td>
<td>-0.18</td>
</tr>
<tr>
<td>Personnel care about patient</td>
<td>1.20</td>
<td>0.52</td>
<td>1.25</td>
<td>0.49</td>
<td>-0.53</td>
</tr>
<tr>
<td>Explanations can be understood</td>
<td>2.28</td>
<td>0.72</td>
<td>1.88</td>
<td>0.82</td>
<td>3.25*</td>
</tr>
<tr>
<td>Honest information</td>
<td>1.62</td>
<td>0.74</td>
<td>1.63</td>
<td>0.74</td>
<td>-0.07</td>
</tr>
<tr>
<td>Understand what is happening</td>
<td>2.21</td>
<td>0.76</td>
<td>2.08</td>
<td>0.86</td>
<td>1.13</td>
</tr>
<tr>
<td>Staff have been courteous</td>
<td>1.26</td>
<td>0.49</td>
<td>1.33</td>
<td>0.57</td>
<td>-0.82</td>
</tr>
<tr>
<td>Staff interested in how I’m doing</td>
<td>1.95</td>
<td>0.64</td>
<td>1.48</td>
<td>0.68</td>
<td>3.83†</td>
</tr>
<tr>
<td>I will be called if there is a change</td>
<td>1.55</td>
<td>0.71</td>
<td>1.35</td>
<td>0.58</td>
<td>1.67</td>
</tr>
<tr>
<td>Equipment has been explained</td>
<td>2.55</td>
<td>0.75</td>
<td>2.13</td>
<td>0.82</td>
<td>2.88‡</td>
</tr>
<tr>
<td>Satisfied with medical care</td>
<td>1.43</td>
<td>0.68</td>
<td>1.33</td>
<td>0.53</td>
<td>0.94</td>
</tr>
<tr>
<td>Medical care could be better</td>
<td>1.53</td>
<td>0.64</td>
<td>1.85</td>
<td>1.03</td>
<td>-1.97</td>
</tr>
<tr>
<td>Comfortable visiting the patient</td>
<td>1.63</td>
<td>0.74</td>
<td>1.33</td>
<td>0.52</td>
<td>3.12*</td>
</tr>
<tr>
<td>Waiting room is comfortable</td>
<td>2.30</td>
<td>0.79</td>
<td>2.25</td>
<td>1.01</td>
<td>0.57</td>
</tr>
<tr>
<td>Feel alone in waiting room</td>
<td>1.88</td>
<td>0.99</td>
<td>2.03</td>
<td>1.12</td>
<td>-1.10</td>
</tr>
</tbody>
</table>

*\(P < .005\) (2-tailed), †\(P < .001\) (2-tailed), ‡\(P < .01\) (2-tailed).

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**Table 2** Scores on optimism, emotional adjustment, satisfaction with needs met, and interpersonal appraisal of physicians and nurses at admission and discharge

<table>
<thead>
<tr>
<th>Measure</th>
<th>Admission Mean</th>
<th>SD</th>
<th>Discharge Mean</th>
<th>SD</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimism</td>
<td>21.58</td>
<td>7.19</td>
<td>21.63</td>
<td>7.75</td>
<td>-0.09</td>
</tr>
<tr>
<td>Brief Symptom Inventory</td>
<td>0.45</td>
<td>0.44</td>
<td>0.39</td>
<td>0.41</td>
<td>1.19</td>
</tr>
<tr>
<td>General Severity Index</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Stress Disorder Scale</td>
<td>44.65</td>
<td>15.45</td>
<td>38.13</td>
<td>14.70</td>
<td>3.17*</td>
</tr>
<tr>
<td>Critical Care Family Needs Inventory</td>
<td>24.71</td>
<td>6.50</td>
<td>23.25</td>
<td>6.02</td>
<td>1.74</td>
</tr>
<tr>
<td>Impact Message Inventory</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control, physician</td>
<td>0.71</td>
<td>0.72</td>
<td>0.63</td>
<td>0.83</td>
<td>0.72</td>
</tr>
<tr>
<td>Affiliation, physician</td>
<td>0.44</td>
<td>1.15</td>
<td>0.37</td>
<td>1.00</td>
<td>0.49</td>
</tr>
<tr>
<td>Control, nurse</td>
<td>0.15</td>
<td>0.51</td>
<td>0.34</td>
<td>0.73</td>
<td>-1.56</td>
</tr>
<tr>
<td>Affiliation, nurse</td>
<td>1.63</td>
<td>1.04</td>
<td>0.67</td>
<td>0.65</td>
<td>4.25†</td>
</tr>
</tbody>
</table>

*\(P < .005\) (2-tailed), †\(P < .001\) (2-tailed).

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Unmet needs were lack of information about the patient’s condition and why things were being done, and absence of explanations about medical equipment being used.
the mean of a normative sample of psychiatric outpatients. In contrast to ASDS scores, family representatives’ GSI scores declined only slightly at discharge (Table 2). Of the 9 BSI subscales, only the score on the Anxiety subscale was more than 1 SD greater than the mean at admission, and this was the only subscale for which the mean score decreased significantly over time \( t = 3.36, P = .002 \).

**Scores on the Acute Stress Disorder Scale for family members were about the same as those for patients admitted to a posttraumatic stress disorder psychiatric unit.**

**Optimism**

Family representatives’ mean optimism level at admission (21.58) was almost identical to the mean (21.25) reported by Scheier and Carver for their normative sample.

**Interpersonal Appraisals of Nurses and Physicians**

As indicated by scores on the IMI, large and consistent differences occurred in how family representatives perceived the physicians and the nurses. On the control dimension, at admission, the representatives perceived the physicians as more controlling than the nurses \( t = 3.30, P = .002 \). At discharge, these differences were in the same direction but were of lesser magnitude and no longer statistically significant. Family representatives perceived their nurses as significantly higher in affiliation than physicians at both admission and discharge \( t = 3.99 \) at admission and \( t = 4.00 \) at discharge, \( P < .001 \) for both.

**Family representatives perceived their physicians as more controlling (dominant) than nurses and their nurses as more friendly and less hostile than physicians.**

**Optimism and Interpersonal Perception of Physicians and Nurses as Determinants of Satisfaction With Needs Met and Emotional Distress**

Because relationships among variables at admission and at discharge were similar and because implications for intervention with patients’ family members are most important during the early period after admission, the correlations in Table 3 were calculated solely for data obtained at admission. The correlations revealed a pattern of significant interrelationships between family representatives’ optimism, their perceived relationships with their physicians and nurses, and their perception of needs met. High levels of optimism were strongly related to a high level of satisfaction with needs met (CCFNI). Optimism was associated with perceptions of low control and high affiliation in the physicians. Measures of emotional adjustment (scores on the BSI-GSI and the ASDS) were not significantly related to optimism. However, poorer emotional adjustment was associated with perceiving physicians as low in affiliation.

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**Table 3 Intercorrelations among measures obtained at admission**

<table>
<thead>
<tr>
<th></th>
<th>Control, physician</th>
<th>Affiliation, physician</th>
<th>Control, nurse</th>
<th>Affiliation, nurse</th>
<th>Brief Symptom Inventory, General Severity Index</th>
<th>Acute Stress Disorder Scale</th>
<th>Critical Care Family Needs Inventory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimism Impact Message Inventory (IMI)</td>
<td>-0.40*</td>
<td>0.47*</td>
<td>-0.06</td>
<td>0.29</td>
<td>-0.29</td>
<td>-0.14</td>
<td>-0.65†</td>
</tr>
<tr>
<td>Control, physician</td>
<td></td>
<td></td>
<td>-0.73†</td>
<td>0.01</td>
<td>-0.06</td>
<td>0.15</td>
<td>0.06</td>
</tr>
<tr>
<td>Affiliation, physician</td>
<td></td>
<td></td>
<td>0.21</td>
<td>0.04</td>
<td>-0.44*</td>
<td>-0.17</td>
<td>-0.55†</td>
</tr>
<tr>
<td>Control, nurse</td>
<td></td>
<td></td>
<td></td>
<td>-0.29</td>
<td>-0.03</td>
<td>0.22</td>
<td>0.26</td>
</tr>
<tr>
<td>Affiliation, nurse</td>
<td></td>
<td></td>
<td></td>
<td>0.29</td>
<td>-0.18</td>
<td>-0.03</td>
<td>-0.27</td>
</tr>
<tr>
<td>Brief Symptom Inventory, General Severity Index</td>
<td></td>
<td></td>
<td></td>
<td>0.29</td>
<td>0.62†</td>
<td></td>
<td>0.31</td>
</tr>
<tr>
<td>Acute Stress Disorder Scale</td>
<td></td>
<td></td>
<td></td>
<td>0.04</td>
<td>0.04</td>
<td></td>
<td>0.33</td>
</tr>
<tr>
<td>*P &lt; .01.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>†P &lt; .001.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Several associations between IMI relationship variables and CCFNI scores were significant. The more family representatives perceived their physicians as controlling, the less the representatives reported their needs as being met. In contrast, their perception of nurses’ control showed no relationship to scores on the CCFNI. The more family representatives perceived their physicians as affiliative (friendly, not hostile), the more the representatives reported their needs as being met and the less they reported psychological disturbance.

In an attempt to better understand the relationships among these variables, an exploratory path model was constructed in which optimism was conceptualized as a predictor variable, interpersonal relationship measures as psychological mediators, and satisfaction with needs met as a criterion variable (see Figure). We reasoned that optimism is a relatively stable personality trait that potentially can be predictive of which family representatives will respond relatively well or poorly to the stress of the ICU. Optimism should also influence good interpersonal relationships with staff, which, in turn, should directly increase satisfaction with care (CCFNI). Because the measures of emotional distress were only moderately related to the other variables (Table 3), they did not meet the requirements for inclusion in the model and were not evaluated.

We selected perceptions of control and affiliation of the physicians (rather than of the nurses) as the interpersonal relationship variables to evaluate because only IMI scores for physicians were significantly related to both optimism and CCFNI scores. The path model was tested by using a series of regression equations as specified by Barron and Kenny. The standardized weights depicted in the figure were derived from the regression equations. The number of days between patients’ admission and family representatives’ initial evaluation was entered in the first step as a covariate in each regression analysis. The highly significant relationship between optimism and CCFNI ($\beta = -0.54$) represents the direct effect of optimism on family representatives’ needs met: the greater the representatives’ optimism, the less needs were reported as unmet. Although the IMI relationship variables were significantly correlated with CCFNI scores, after the direct effect of optimism on CCFNI scores was controlled for, IMI scores for physicians’ control and affiliation contributed only 19.4% of the total variance in CCFNI scores. Optimism continued to account for significant variance in CCFNI scores after the mediational influence of the physicians’ control and affiliation was included and accounted for more than twice the variance as these IMI relationship variables. Thus, no evidence indicated that family representatives’ perceptions of physicians’ interpersonal behavior mediated or explained the effect of the representatives’ optimism score on the CCFNI.

**Discussion**

Consistent with previous researchers, we found elevated levels of distress among patients’ family members. Just after the patients’ admission to the ICU, the family members also had the dissociative symptoms characteristic of ASD. The data strongly suggest that experiencing sudden hospitalization of a loved one is indeed a traumatic event. On the BSI, a broad-based measure of psychological symptoms and distress, overall scores were elevated but were within the reference range. The only BSI subscale on which family representatives had a clinically significant elevation was Anxiety, a measure of situational stress that taps cognitions associated with apprehension and fearfulness and some somatic manifestations of anxiety. Consistent with the findings of Halm et al., we found that family representatives’ scores on the BSI Anxiety subscale and on the ASDS decreased significantly after the patients’ discharge from the hospital. A major reason for the inclusion of ASD in DSM-IV was the idea that it is predictive of PTSD. Our findings suggest that although family representatives had significant elevation in some ASD symptoms, and in that sense some evidence of secondary traumatization, the transitory nature of the observed symptoms makes development of PTSD as a result of the ICU experience unlikely for most family members.

Satisfaction with needs met was assessed by using a brief version of the CCFNI. The most prominent cluster of needs that family members felt were least satisfactorily cared for just after admission were related to medical information: the clarity of explanations given, family representatives’ knowledge of equipment being used, and the representatives’ understanding
of the patients’ treatment. These findings are generally consistent with those of the many previous studies conducted with families of critical care patients.

Although receipt of clear information about patients has been identified as a primary need of patients’ families, the specific aspects of the hospital staff’s communication process most important to the family members was addressed in only one study. In a study of family members of trauma patients dying in the emergency department or the ICU of a level I trauma center, Jurkovich et al found that along with the clarity of the communication, the most important feature in the process of receiving bad news was the attitude of the news giver. This feature was even more important than the news giver’s knowledge or ability to answer questions.

**Family members were more likely to feel their needs were met when they felt positive (more friendly and less hostile) about the physician.**

Our study was the first in which specific family members’ attitudes were assessed in the form of the members’ interpersonal perceptions of the critical care team. Not surprisingly, because of physicians’ acknowledged role as healthcare team leaders, at the crucial early stage of a patient’s hospitalization, the patient’s physician was viewed as more controlling (more dominant and less submissive) than was the patient’s bedside nurse. Nurses were viewed as more affiliative (more friendly and less hostile) than physicians at both admission and discharge. This last finding may reflect the fact that in contrast to physicians, whose personal contact with patients’ families is often quite limited, bedside nurses are in continual contact with patients’ families and are the families’ primary source of information and support until the patients’ discharge from the ICU. On the other hand, family representatives’ interpersonal appraisals of physicians (rather than nurses), especially just after admission, were more strongly associated with the representatives’ satisfaction with needs met. Specifically, they responded unfavorably when they viewed the physicians as controlling and unfriendly. This finding suggests that family members not only want to feel accepted by, interpersonally close to, and emotionally supported by their physicians (affiliation), they also want to feel that they can participate, are included, and can have some impact on decisions being made (control).

Little research has been done on interventions for families of critically ill patients, and almost none has been done on how to improve communication between the ICU healthcare team and patients’ family members. One promising approach is to schedule formal physician-led conferences with patients’ family members early in the patients’ critical care hospitalization. In our experience, this approach is not used routinely and it requires concerted effort by the nursing and medical staff.

We are investigating an ICU adaptation of a conference model that has been used effectively in the oncology setting. Formal surgeon-led conferences, scheduled within 48 hours of a patient’s admission to the ICU, are audiotaped; the patient’s family representatives are then offered a personal copy of the audiotape that they may review at their leisure. In one study, audiotapes of consultations provided to oncology patients stimulated families to seek more information and initiate consultations with healthcare staff who otherwise were not available on an ongoing basis. Masera et al concluded that providing parents an audiotape of the initial communication of the diagnosis of leukemia in the parents’ child “reinforced the rapport and trust between the family and the healthcare team, and became the basis of a therapeutic alliance between doctor and patient.”

High levels of optimism among family representatives were strongly related to greater satisfaction with needs met, to feelings of affiliation with both physicians and bedside nurses (the latter at discharge), to feelings of not being controlled by the physicians, and to lower levels of emotional distress after patients’ discharge from the hospital. These findings have implications for working with the family members of critical care patients. Persons who dwell on the negative aspects of a traumatic experience (on the cause of the event, on how it could have been undone), blame others, or in other ways dwell in the past experience more distress. One potential intervention is to accentuate the positive, for example, to foster problem-focused coping by encouraging family members of ICU patients to get involved in the care of the patients.

Although participation in patients’ care in the ICU has been associated with better satisfaction in patients’ family members, and although most ICU caregivers are supportive, family members do not often participate in patients’ care during hospitalization.

**Compared with family members with less optimism, members with greater optimism were more likely to feel their needs were met.**
In a study involving patients dying of AIDS, engagement of the patients’ family members in even mundane tasks such as changing bed linens or administering medication seemed to give the family members a sense of being effective and in control. In turn, this helped them combat feelings of helplessness. In the longer term, as the recovery of ICU patients progresses, patients’ family members can be encouraged to use “positive reappraisal,” for example, to identify and emphasize ways in which a patient’s injury although traumatic may have helped the family member grow as an individual in the course of dealing with the injury, and how ultimately the patient also may learn and grow from the experience as he or she copes and recovers. In general, because they are a central source of emotional support for patients’ family members, ICU nurses are in a unique position to aid in the families’ adjustment by fostering a sense of family optimism and enhancing perception of control.

In terms of the limitations of our study, family members’ satisfaction, optimism, and perceptions of the healthcare team most likely were influenced somewhat by the patients’ recovery status, but we did not obtain data on recovery. Also, because the data were obtained at a single institution, generalization of the findings to ICU settings that differ in timing and degree of staff contact with patients’ family members may be limited.

Commentary by Mary Jo Grap (see shaded boxes).

REFERENCES


