

# The experiences of nurses in providing psychosocial support to families of critically ill trauma patients in intensive care units

A study in the Durban metropolitan area



School of Nursing, Faculty of Health Sciences, University of KwaZulu-Natal, Durban  
**P Brysiewicz, CCRN, PhD**  
**B R Bhengu, CCRN, PhD**

**Background.** Critically injured trauma patients are often admitted to an intensive care unit (ICU), which can be a very unfamiliar and intimidating environment for their families. Health organisations have a responsibility to foster an environment that protects the physical and emotional health of the severely stressed family members who assemble in their facilities.

**Purpose.** The purpose of the research was to explore the experiences of ICU nurses in providing psychosocial support to families of critically ill trauma patients.

**Research approach.** Using an interpretive hermeneutic phenomenological approach, two semi-structured interviews were conducted with each participant to explore their experiences of providing psychological support to families of ICU patients. The study was conducted in the surgical ICUs of two private hospitals and one public hospital in the Durban metropolitan area.

**Findings.** Four main themes emerged from the data: cultural awareness, communication challenges, providing assistance, and lack of training.

**Conclusion.** These findings provide implications for practice that, if applied, would improve the ICU experience for both the nursing staff and the families they support.

## Background

For families of the critically injured trauma patients who are admitted to an intensive care unit (ICU), the ICU can be a very unfamiliar and intimidating environment. The hospitalisation is unexpected and the family faces the possibility that their loved one may die or be severely disabled. Involvement of families in the ICU has been necessitated by the need for decision-making on behalf of critically ill and sedated patients.<sup>1</sup> Families assist in end-of-life decisions, decisions about use of life-sustaining therapies, etc. and therefore play an important role in the ICU.<sup>2</sup>

Health organisations have a responsibility to foster an environment that protects the physical and emotional health of the severely stressed family members who assemble in their facilities.<sup>3</sup> Interventions are needed that address the stress experienced by families when a loved one is admitted to an ICU, and that help to develop

their coping mechanisms.<sup>4</sup> It is essential that health professionals understand how important it is for families to have some form of control in their vulnerable situation and reflect on how they would like to be treated in a similar situation.<sup>5</sup> Factors associated with poor outcomes for the family included incomplete information provided to them.<sup>6,7</sup>

Attempts to assess the needs of families with a loved one in an ICU date back to the 1970s, when Molter<sup>8</sup> reviewed the effects of serious illness on relatives in critical care settings. This resulted in extension of the role of the critical care nurse to include assessment of family needs.<sup>9</sup> The nurse in the ICU plays an essential part in attending to these needs, as he or she is the member of staff who has the closest and most frequent contact with patients' families and spends the most time with them. For this reason the nurse is also the person families look to first to supply information about their loved one.<sup>9</sup>

## Purpose of the study

The purpose of this study was to explore the experiences of ICU nurses in providing psychosocial support to families of critically ill trauma patients.

## Methods

### Research approach

Using an interpretive hermeneutic phenomenological approach, two semi-structured interviews were conducted with each participant to explore their experiences of providing psychological support to families in the ICU.

### The setting

The study was conducted in the surgical ICUs of two private hospitals and one public hospital in the Durban metropolitan area. These hospitals were selected because they have dedicated surgical ICUs that frequently admit severely injured trauma patients.

### The participants

Purposive sampling was used to identify the nurses working in the surgical ICUs in the hospitals. The inclusion criteria included any nurse registered with the South African Nursing Council who was currently employed to work in an ICU, had at least 6 months' experience in the unit, and was interested in participating in the study. The researchers also asked the unit managers to participate in the interviews. It was anticipated that three staff members from each hospital would be interviewed, although data were collected until no new data emerged. A description of the participants is set out in Table I.

### Data collection

Once permission had been obtained from the individual hospitals, the unit managers of the ICUs were contacted and the research team arranged to meet them and discuss the proposed research. The purpose, objectives and significance of the study were explained and the researchers requested permission to interview the staff. Interviews were conducted during on-duty time in a private room in the unit.

### Data analysis

All interviews were tape recorded with the permission of the participant and transcribed verbatim. The data were manually analysed to derive patterns and themes from the recorded data.<sup>10</sup>

### Trustworthiness

The researchers attempted to establish trust and a good rapport with the participants, thus making it more likely that rich, useful data would be collected.<sup>11</sup> All the participants were given the opportunity to refuse to participate, which meant that those interviewed and included were interested and willing to take part in the study. The participants were encouraged to be frank in telling their stories, and it was emphasised that there was no 'one truth'.<sup>10</sup> Feedback on the themes emerging from the data was provided to the participants in order to obtain their reactions and to explore whether the interpretations were a true representation of the participants' reality.<sup>11</sup>

### Ethics

Ethical approval was obtained from the University of KwaZulu-Natal Ethics Committee, as well as from all the hospitals involved. Participation was voluntary and written consent was obtained from the participants,

**Table I. Description of the participants**

Pseudonym	ICU experience	General comments
Carol	9 years	Completed her ICU course and has been working on night duty
Storm	4.5 years	Currently studying
Sindi	8 years	Has completed the ICU course
Melissa	10 years	Completed a course in high-care nursing
Oprah	More than 10 years	Completed the ICU course
Garfield	7 years	Completed the ICU course
Nemo	8 years	Completed a course in high-care nursing
Prenusia	3 years	Completed the ICU course
Trinesha	8 years	Only has ICU experience

who were informed of their right to withdraw from the research at any time. Confidentiality was assured through use of pseudonyms so that data could not be traced back to individuals. The data were kept in a secure place available only to the research team.

## Findings

Four main themes emerged from the data, namely cultural awareness, communication challenges, providing assistance, and lack of training.

### Cultural awareness

Most of the participants described how important it is to attend to the diverse cultural needs of the families of their patients. One participant explained that it was important to have religious tolerance and to respect different religions, prayers, etc. This participant also mentioned that different cultural groups had different ways of dealing with their feelings, and certain cultural groups were therefore more likely to be referred to the psychologist for additional psychological support.

One of the nurses said:

*We know there is cultural diversity; they [the family] usually come back after the person has demised to collect the spirit because they believe the spirit of the person is still here ... so we do allow them to do that.*

Another said:

*We ask from them [the family] about their religious beliefs and how they want support, like some have got their ministers and others have got the support of elders at home who come with them.*

One of the participants did, however, describe some potential areas of conflict between the health care professionals and the family, saying:

*They [the family] want their people to come and do a ritual and sometimes you feel it's not in the best interest of the patient and you also don't want to step on anybody's toes.*

### Communication challenges

One of the main areas of concern for the participants in providing psychological support for the families was communication challenges. Communication between health care professionals themselves (doctors and nurses) and that between health care professionals and the families of their patients both pose challenges.

A participant said:

*... it's very difficult for you to actually interact with the family ... you will always have the barrier of a doctor because of how much the doctor is telling the family and how much you are telling the family ... so you always have the barrier where you cannot overstep the mark.*

Another participant reported:

*There is another staff that I've worked with that had the experience(s) when they gave more information than they were supposed to and they got 'shot down' – 'you are not supposed to be saying this, you say what I said' ... you are not allowed as an individual to think.*

Participants suggested that they were not always fully aware of what the doctors had told the family, which often made the communication problem worse.

One of the participants explained:

*... they [the family] go to the doctor's rooms and you don't know what has happened and what has been said.*

She added that because of this the nurses leave most of the discussion with the family to the doctor, saying:

*... we have like a block put in between us, so it makes it very, very difficult.*

Another participant felt that:

*... some of the nurses are scared to talk to the doctors.*

One of the participants was of the opinion that, when dealing with the family, there were times when doctors kept giving the family hope that the patient would recover, but the nurses felt that there was no chance of this. The nurses would then speak to the doctors about this. She added:

*... sometimes they [the doctors] will say that is what the family wants.*

Some of the participants from the state hospital did, however, comment on how well the doctors communicated with the families and how they went out of their way to provide information to the families:

*... we have got doctors who are willing to help and are so kind to our relatives ... we keep them informed immediately ... but at times you can't because others [families] they are from poor communities with no telephones.*

One participant mentioned being asked by the doctor to 'sit in' when they had a discussion with the family, although this appeared not to be the norm.

A participant described how some doctors do not talk to the families. She stated that very often the nurses had to 'push the button' and facilitate this. Another participant explained:

*... we would be forthright and tell them [the doctor] that you know you need to talk to this patient's relatives and he would make time.*

One of the participants stated:

*I feel the doctors are very cold at times. They don't have the answers and it is like sometimes they don't care.*

Another participant added that this made it difficult for them. She said:

*... there is no feedback [from the doctors] ... at the end they [the family] don't know what's happening and they*

are relying on the nurse for that. At the same time our [the nurses'] hands are tied because we are not allowed to divulge as much as we can unless we have spoken to the doctor and we know that they have gotten some certain information ... We have to now try and keep them [the family] going with what information we can without giving anything away until the doctors have seen them.

The participants mentioned that this was a particular problem in the private institutions, where communication difficulties become further complicated by the fact that there are often multiple doctors caring for a patient. One of the participants described this situation:

... it is even worse when there's more than one doctor involved. So there is a neurosurgeon, there is a general surgeon, there is a physician involved and each one has their own thing, they all have their say on just their part of the body ... the doctors don't discuss anything with each other.

One of the participants described the difficulty attached to trying to care for a critically injured trauma patient who has been admitted to the unit, while at the same time attempting to support the family and keep them informed. She said:

The family comes in and it's quite dramatic for us settling the patient and I always notice that the family needs much more attention at that time ... we are trying to work with our patient and you have the family that is wanting to know more.

She explained further:

... you can't give any information that is going to shock them. You don't want to overload them and [with] them not having a good understanding.

An added communication challenge was identified by one of the participants, who said:

... you have relatives that are subservient and they don't want to talk so they are afraid and they say 'in case I ask too many questions' ...

### Providing assistance

A number of participants described the assistance that was made available to the families. Some examples of assistance included a private area for family to sit together and talk to the health care professionals, providing tea or coffee, and arranging transport home. Participants mentioned that if a patient is critically ill, they try to maintain flexible visiting hours and allow relatives to come into the unit at any time.

A participant said:

... we involve them [the family] in the nursing care of the critically ill patients so they know what is happening ... we phone them now and again to let them know about the condition of their patients and they choose a spokesperson whom we liaise with so that we can give them the news.

In some cases family members of a critically ill patient are given assistance with accommodation. One of the participants explained:

... sometimes we allow them [the relatives] to stay in the hospital if some of them ... are from far.

A participant mentioned that it is important to try and promote continuity of care and allocate the same nurse to the same patient, to allow the nurse to build up rapport with the family. She explained:

They usually choose to speak to someone that they know, and even if you are nursing him on that day they'll come looking for you in the next day and will chat to you as much as they can.

Another participant elaborated further:

I just notice that the family just wants someone to just listen to them. Even if you can't say anything back ... sometimes there is nothing you can say back, even silence sometimes is the best answer.

One of the participants mentioned that in some cases she provided assistance to the family by referring them to a professional psychologist. She said she would:

... call in a psychologist if necessary, but then again families don't always want that, so you always give them the options, 'would you like to speak to someone professional or you're just going to speak to me'.

Participants mentioned that although their units did have some resources to assist families, other resources were nevertheless needed. Some of the participants described how a social worker had been available in the past, who used to sit with the family, talk to them and provide support, as well as providing support for the staff. The nurses went on to report that the social worker had left the department and had not been replaced. Another participant mentioned how their department used to have a qualified psychologist on call who could assist if there was a traumatic situation. She said:

... she could deal with that [the traumatic situation] and she had the right words and sometimes we don't have the right words because we are traumatised too.

Unfortunately this person is no longer available to the unit, and the participant added:

... now we are in a really bad shape because we need somebody like that again.

One of the participants explained that a big weakness in the unit was that staff do not have direct access to a telephone and are consequently not able to phone the families of critically ill patients without first getting permission from the matron.

### Lack of training

The participants mentioned that they have to make use of their own experience when dealing with the families. One of the nurses explained:

*... there is no specific training ... we don't have anything, we just use our experience so there is no specific training that we have done.*

Participants were of the opinion that the amount of support experienced by the family of a critically ill patient varied according to which nurse was looking after the patient. One of them said:

*... not all of them [the nurses] have ICU experience and not all of them are able to communicate and relate to family and understand how they fit to the whole picture of ICU holistic care.*

One participant explained that she had not been prepared for the stressful environment of the ICU and that there was no psychological support for the staff when their patients died. She felt that this affected the way in which the staff then offered support to the family. She said:

*... if they [the nurses] can't handle that [the psychological stress of the ICU] they're going to shy away from offering that support.*

## Discussion

South Africa is a pluralistic country with multiple racial and ethnic groups, cultures, religions and languages. For example, as at mid-2007 South Africa was populated by 79.6% black Africans, 9.1% whites, 8.9% coloureds and 2.5% Asians. There are 11 African languages, with isiZulu dominating, especially in KwaZulu-Natal.<sup>12</sup> In KwaZulu-Natal the population distribution is 85% black African, 8.33% Indian, 5.05% white and 1.46% coloured. It follows that the patient population in health care facilities is predominantly black, and it is therefore important for the nurses to understand their culture and provide culturally appropriate support to the families of critically ill patients in their care. Because the families of these patients bring their cultures into the nurse-patient interaction, most authors advocate awareness of and sensitivity to the relevant culture.<sup>13-15</sup> It has been argued, however, that even anthropologists now agree that culture is flexible and dynamic, and culture sensitivity based on the ethnicity of patients and their families alone is therefore challenged.<sup>16</sup> These authors argue that health care settings such as hospital units have their own cultures, including the biomedical culture itself. It is therefore suggested that the health care workers should be aware of the health-illness beliefs of their patients, reflect on how these interact with the health care system, and acknowledge the biomedical perspective as a diverse and developing cultural system. Cultural requests by the family should therefore be weighed against the biomedical culture to establish whether any clashes exist for the safety of the patient.

It was apparent that the participants in our study were aware of the importance of cultural diversity and its impact on the psychosocial support that they needed to offer. The diverse needs of different cultures have been noted in many studies,<sup>16,17</sup> and these researchers

also found that nurses perceived the importance of meeting the cultural needs of a family in the provision of psychosocial support.

The participants identified the need for effective communication with other health professionals as well as the families of their critically ill trauma patients in providing psychosocial support, and this is supported by the literature.<sup>17-21</sup>

Participants also experienced difficulties associated with being perceived by families as the primary source of information. Researchers have suggested that families first look to the nurse for information because he or she 'is there', whereas doctors are perceived as being difficult to access.<sup>22</sup> Our participants experienced poor communication channels within the multidisciplinary team, particularly with the doctors, and this was also found in a similar study.<sup>18</sup> It has been recommended that sufficient, scheduled time be set aside for communication with families of critically ill patients; authors have claimed that this need is the least well met, yet it is rated in many studies as the most important.<sup>2,6,23,24</sup> It has been suggested that families do not just need information but also the opportunity to be heard, whereas their cognitive ability to process information is compromised by anxiety, depression and trauma or grief.<sup>24</sup> However, doctors and nurses often do not have sufficient time to communicate with families because of competing needs, including administration and teaching responsibilities, although it has been reported that nurses perform better than doctors because of the hours they spend at the bedside.<sup>2</sup> It has therefore been recommended that a nurse practitioner or member(s) of the interdisciplinary team, such as a social worker, psychologist or chaplain, or a volunteer such as a case manager, be allocated to a family to give information and reassurance during an emergency or investigative procedures such as resuscitation in the accident and emergency department or ICU.<sup>25,26</sup> The use of families of former ICU patients to enlighten the family about issues that might not be mentioned in sessions led by health care providers has also been suggested.<sup>25</sup>

The participants in our study acknowledged the need to provide practical assistance to the families of their critically ill trauma patients, and this was echoed in a study done in Sweden and Norway,<sup>18</sup> where the nurses identified the need for other resources. Many of the practical examples of assistance given<sup>18</sup> were the same as those mentioned in this study, namely food, drink, sleep, and a chaplain or social worker. The role of a social worker or psychologist in providing support to both family and staff was identified by our participants (from both the provincial and the private hospitals) as being very important. In both cases such a person had been in place, but was no longer available. The assistance provided by such professionals has been mentioned,<sup>18</sup> and the importance of their role is highlighted in situations where staff levels are low and where there is little continuity due to shift work.

In an earlier study in Sweden<sup>21</sup> staff training was identified as a means of improving the psychosocial support offered to families of patients in the ICU. It was concluded that *'through multidisciplinary training such as clinical supervision, both nurses and physicians could develop their self-insights about their own and other team members' perspectives on the significant others' experiences and needs'* (p. 13).<sup>21</sup> The nurses in this study also identified this need, with the participants acknowledging that they were not specifically trained in offering support and reporting that this made the ICU environment stressful to both themselves and the families of critically ill trauma patients.

## Conclusion

The experiences of nurses in providing psychosocial support to families of critically ill trauma patients in ICUs in the Durban metropolitan area were explored in this study. Most of the participants in this study felt that four main factors impacted on the psychosocial support they could offer: cultural diversity, communication barriers, insufficient resources, and insufficient staff training. These factors have been identified in other studies<sup>13-21</sup> as having a significant impact on the psychosocial support received by the families of critically ill patients. These findings provide implications for practice that, if applied, would improve the ICU experience for both the nursing staff and the families they support.

The researchers acknowledge the assistance of Ms T Goodenough. This material is based on work supported financially by the National Research Foundation. Any opinions, findings and conclusions or recommendations expressed are those of the author(s), and the NRF therefore does not accept any liability in this regard.

1. Truog RD, Campbell ML, Curtis JR, et al. Recommendations for end-of-life care in the intensive care unit: a consensus statement by the American Academy of Critical Care Medicine. *American Academy of Critical Care Medicine* 2008;36(3):953-963.

- Gay EB, Pronovost PJ, Bassett RD, Nelson JE. The intensive care unit family meeting: Making it happen. *J Crit Care* 2009;24(4):629.e1-629.e12.
- Dowling J, Wang B. Impact on family satisfaction. The critical care family assistance program. *Chest* 2006;28(3):76s-80s.
- Leske JS. Comparison of family stresses, strengths and outcomes after trauma and surgery – psychosocial issues. *AACN Clinical Issue. Advanced Practice in Acute and Critical Care* 2003;14(1):33-41.
- Johansson I, Fridlund B, Hildingh C. What is supportive when an adult next-of-kin is in critical care? *Nursing Crit Care* 2005;10(6):289-298.
- Auerbach SM, Kiesler DJ, Wartella J, Rausch S, Ward KR, Ivatury R. Optimism, satisfaction with needs met, interpersonal perceptions of the healthcare team and emotional distress in patient's family members during critical care hospitalization. *Am J Crit Care* 2005;14(3):202-210.
- Azouly E, Pochard F, Kentish-Barnes N, et al. Risk of post traumatic stress symptoms in family members of intensive care unit patients. *Am J Respir Crit Care Med* 2005;171:987-994.
- Molter NC. Needs of relatives of critically ill patients: A descriptive study. *Heart Lung* 1979;8:332-339.
- Paul F, Rattray JE. Relatives of intensive care patients – a review of the literature. *J Adv Nurs* 2008;62(3):276-292.
- Van Manen M. *Researching Lived Experience. Human Science for an Action Sensitive Pedagogy*. 2nd ed. Ontario: Althouse Press, 2003.
- Shenton AK. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information* 2004;22:63-75.
- Statistics South Africa. StatsOnline. 2007. <http://www.statssa.gov.za/publications/statsdownload.asp?PPN=P0302&SCH=3952>
- Hjelm K, Bard K, Nyberg P, Apelqvist J. Religious and cultural distance in beliefs about health and illness in women with diabetes mellitus of different origin living in Sweden. *Int J Nurs Stud* 2003;40(6):627-643.
- Herselman S. The anthropology of health. In: Tjale AA, De Villiers L, eds. *Cultural Issues in Health and Health Care*. Cape Town: Juta Academic, 2004: 134-158.
- Olarte N, Guillen DG. Cultural issues and ethical dilemmas in palliative and end-of-life care in Spain. *Cancer Control* 2001;8(1):46-54.
- Chan LS, Macdonald ME, Cohen SR. Moving culture beyond ethnicity: examining dying in hospital through a cultural lens. *J Palliat Care* 2009;25(2):117-124.
- Chein W, Chiu YL, Lam L, Ip W. Effects of a needs-based education programme for family carers with a relative in an intensive care unit: A quasi-experimental study. *Int J Nurs Stud* 2006;43:39-50.
- Takman C, Severinsson E. A description of healthcare providers perceptions of the needs of significant others in intensive care units in Norway and Sweden. *Intensive Crit Care Nurs* 2006;22(4):228-238.
- Omari F. Perceived and unmet needs of adult Jordanian family members of patients in ICUs. *J Nurs Scholarsh* 2009;41(1):28-43.
- Azoulay E, Pochard F, Chevret S, et al. Meeting needs of intensive care unit patient families. *Am J Respir Crit Care Med* 2001;163:135-139.
- Takman CA, Severinsson EI. The needs of significant others within intensive care – the perspectives of Swedish nurses and physicians. *Intensive Crit Care Nurs* 2004;20(1):22-31.
- Vandall-Walker V, Jensen L, Oberle K. Nursing support for family members of critically ill adults. *Qual Health Res* 2007;7(9):1207-1218.
- McKiernan M, McCarthy G. Family members' lived experience in the intensive care unit: A phenomenological study. *Intensive Crit Care Nurs* 2010;26:254-261.
- Holden J, Harrison L, Johnson M. Families, nurses and intensive care patients: a review of the literature. *J Clin Nurs* 2002;11:140-148.
- Sacco TL, Stapleton MF, Ingersoll GL. Support groups facilitated by families of former patients: Creating family-inclusive critical care units. *Critical Care Nurs* 2009;29(3):36-45.
- Maxwell KE, Steunkel D, Salor C. Needs of family members of critically ill patients: A comparison of nurse and family perceptions. *Heart Lung* 2007;36(5):367-376.