Family Coping During Critical Illness

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While some family members of critically ill patients effectively manage the stress of critical illness, others invoke coping responses that are ineffective and hinder patients' recovery. Critical care nurses and advanced practice nurses can enhance positive coping strategies of family members. This study examines the use and effectiveness of coping responses of family members. Strategies are suggested to facilitate effective coping of family members during the crisis of critical illness, including family attendance during invasive procedures and resuscitation efforts.

Recent trends toward unrestricted visiting hours in critical care units often bring family members to the bedside for prolonged periods of time. Family members of critically ill patients may have coping needs that require the expertise of critical care nurses and advanced practice nurses. In addition to caring for unstable patients, critical care nurses can take a leadership role in supporting effective coping for family members.

Nursing interventions to support family coping can promote timely recovery of patients and provide a positive crisis experience for families.[1] Family members who cope ineffectively may be nonsupportive to patients and interfere, intentionally or unintentionally, in patients' recovery. For example, families who cope ineffectively may distort facts of the patient's illness, communicate ineffectively with the patient, make decisions detrimental to the patient's well-being, have unrealistic expectations of the patient or nurses, and display negative emotions that affect the patient's physiological and psychological stability. Critical care nurses can assess coping strategies of family members, support effective strategies, and diminish ineffective strategies in order to achieve desirable patient outcomes and increased family satisfaction.

Background

Critical care nurses recognize that family members of critically ill patients experience stress.[2-5] As visiting hours expand and family members spend more time at the bedside, knowledge of family concerns and coping responses is essential for critical care nurses. The following review of research summarizes what is known about family stress and coping during critical illness.

Family Needs

Needs of family members of critically ill patients are well documented through research across a variety of sample groups. Identified needs include hope, information, proximity to patient, and reassurance that the patient is receiving the best possible care.[3,6-13] Family members also report the need to adjust role responsibilities as a source of stress during critical illness.[2]

Differences exist in the needs of family members as perceived by the family and by critical care nurses.[14,15] Nurses may not recognize the intensity of family needs, and family needs may not be satisfactorily met during critical illness.[2] Unmet needs may create stress during the experience of critical illness.[16-22]

Family Coping

Research findings that focus on coping responses of family members during critical illness suggest that:

- Family members of critically ill patients use confrontive and optimistic styles of coping most often and most effectively.[16]
- Family members experience deep emotional turmoil during critical illness and need to use focused coping responses.[17]
- Behavioral responses of family members during critical illness include increased use of alcohol, cigarettes, medications, talking, eating, and sleeping poorly.[18]

Nurses' Responses To Family Visiting

A lack of consensus exists across research studies regarding the perceptions of critical care nurses related to frequent family visiting in critical care units. For example, nurses report that patients benefit psychologically from extended time with families but that some patients experience physiological setbacks related to prolonged family visiting.[6] Nurses in other studies cited no physiological detriment to patients from frequent family visits, especially when patients were able to control visits.[23-25]

Further variance exists in nurses' perceptions of open visiting hours in critical care units, with some nurses viewing unrestricted visiting as disruptive and time-consuming for nurses,[6,26] while other nurses favor unrestricted family visiting, especially if the patient is not to be resuscitated.[27]

Nursing Interventions for Family Coping

A small number of studies have examined the effects of nursing interventions to meet common family needs, including the use of written educational materials and group support sessions.[8,28-30] However, no studies have examined the effects of nursing interventions that reduce stress and promote effective coping for family members. Nurses can design research-based interventions when research confirms the types of coping strategies used most often and most effectively by family members of critically ill patients.

Study

The purpose of this study was to examine the extent to which family members used selected coping strategies and the extent to which the strategies were effective in managing the critical illness experience. The methods employed in this descriptive, correlational study are described in Research Methods.

Findings

Total adjusted mean scores for the use and effectiveness scales are reported in Figure 1 (page 103). Participants used approximately half of the possible coping strategies. Overall coping effectiveness of the strategies was low.

Adjusted mean scores for use and effectiveness of each coping style scale are reported in Figure 2 (page 104). Family members used supportant, optimistic, and confrontive styles most often. Least frequently used styles of coping were emotive and evasive. Family members reported that the coping styles used most frequently were most effective. Least effective coping styles were also the least frequently used.

Correlations between demographic variables, selected family perceptions and use and effectiveness of coping styles indicated the following:

- Age of family members was significantly related to the use and effectiveness of coping styles, as reported in Table 1 (page 105).
- Effectiveness of coping responses was correlated with relationship of the participant to the patient ($rho=.31$, $p<.01$), indicating that spouses and children of critically ill patients coped less effectively with critical illnesses than siblings, grandchildren or grandparents.
- Perceptions of the patient's chance of recovery were directly related to the effectiveness of optimistic ($rho=.30$, $p.<.01$), supportant ($rho=.27$, $p<.05$) and palliative ($rho=.23$, $p<.05$) coping styles.

Research Methods

Sample

The convenience sample consisted of 59 family members of critically ill patients hospitalized less than seven days in a critical care unit in one midwestern regional medical center. Patients experienced coronary, pulmonary, neurological, gastrointestinal and traumatic disorders. The majority of family members were female (66%) and Caucasian (93%) with an average age of 52 years. Family members were patients' spouse or significant other (39%), child (23%), sibling (10%), parent (10%), grandchild (5%) and grandparent (2%).

Instrumentation

Participants completed the Jalowiec Coping Scale (JCS),[34] which consisted of two subscales to measure use and effectiveness of 60 specific coping strategies. The 60 strategies were grouped into eight coping styles labeled confrontive, optimistic, emotive, evasive, fatalistic, palliative, supportant and self-reliant. Effectiveness was defined as the extent to which the strategy was "helpful" to the respondent.

Previous examination of the psychometrics of the JCS support its validity and reliability.[34,35] Internal consistency reliabilities for the use and effectiveness scales in the present sample were .85 and .93, respectively, with reliabilities for specific subscales as follow: confrontive (.83), optimistic (.72), fatalistic (.51), emotive (.44), palliative (.52), supportant (.51), self-reliant (.71) and evasive (.66). Reliabilities were higher in subscales with more items.

Responses for the coping use scales ranged from 0 (not used) to 3 (used often). Responses for the coping effectiveness scales ranged from 0 (not helpful) to 3 (very helpful). Participants responded to the use and effectiveness of the coping strategies within the context of the critical illness of a family member. Participants completed brief demographic information and also responded to one-item measures of the perceived suddenness of onset of hospitalization and expected prognosis for recovery of the patient.

Procedure

The study was approved by the Institutional Review Boards of the participating university and hospital. The investigator approached family members in the waiting areas of the critical care units, provided information about the study, and invited family members to participate. Completion of the study instrumentation constituted consent to participate in the study. Respondents completed the instrumentation anonymously and returned completed forms to a central collection site in the hospital. Respondents were not paid for their participation. Response rate was 80%.

Data Analysis

Adjusted mean scores were calculated for the total use scale, total effectiveness scale, and use and effectiveness of the eight coping style scales. Adjusted mean scores were computed by dividing participants' raw scale scores by the total number of items on the specific scales. Data were analyzed by Pearson r correlations and Spearman rho correlations.

Investigator

For more information on the methods or for replication of this study, contact Renee Twibell, DNS, RN, School of Nursing, Ball State University, 2000 University Avenue, Muncie, IN 47306-0265.

- The extent to which family members anticipated the patient's hospital admission was not significantly related to coping effectiveness.

Discussion

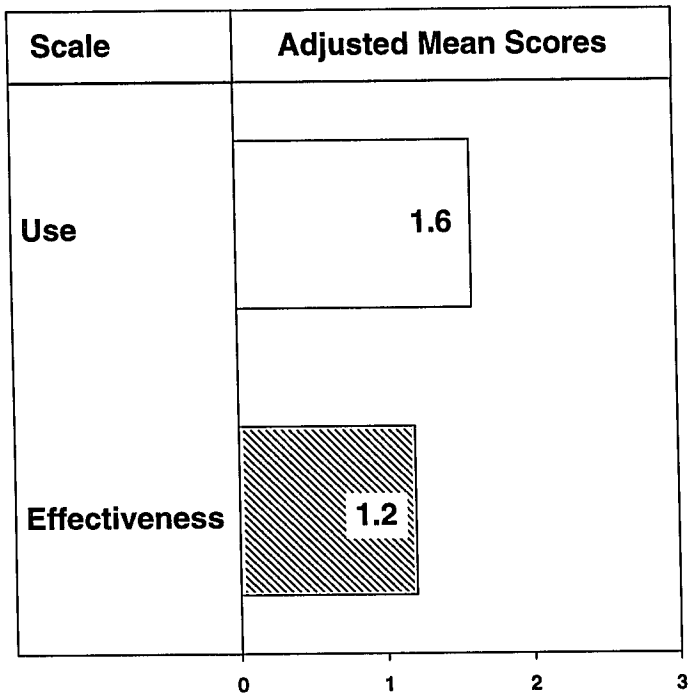
Family members used a variety of coping responses to manage the critical illness of a loved one, but overall the strategies were only slightly effective. Family members require expert nursing support to adjust to hospitalization during critical illness. Family members reported that they used supportant, optimistic and confrontive coping styles most often and most effectively. This finding is partially consistent with Koller's[16] results from a smaller sample of family members.

Confrontive and optimistic coping responses include efforts to cognitively manage the threat of critical illness, strategies identified as effective in other studies.[21,31] Consensus is developing across studies that family members cope with critical illness by trying to control and adjust their mental outlook.

In the present study, older participants used more coping styles and coped more effectively than younger family members, which may explain in part Reider's[4] finding of an inverse relationship between age and anxiety in family members of critically ill patients. Through increased life experiences, older family members may develop and refine more coping mechanisms, thus resulting in improved coping effectiveness.

The finding that closely related family members (spouses and children) coped less effectively with critical illness than more distantly related family members (siblings, grandchildren and grandparents)

Figure 1. Adjusted Mean Scores for Total Use and Total Effectiveness of Coping Responses



may be explained by the increased sense of actual or potential loss that likely exists when critical illness affects relationships central to individuals' well-being. Appraisals of stress may intensify and coping effectiveness may decrease when primary relational commitments are threatened and more is at stake for the family member.[32]

While other studies have suggested that anxiety among family members increased when the onset of critical illness was acute,[4,33] suddenness of admission was not related to coping effectiveness in this study.

Limitations of the study include the collection of data at one site and the one-item measure of perceptions related to anticipated admission and chance of recovery. While the sample size in this study was comparable or larger than other studies of family stress and coping,[4,16] an increase in sample size may further increase reliability of the coping style scales.

Nursing Applications

The findings of this study have implications for critical care nurses in supporting family members during the crisis of critical illness. Nurses can enhance patient outcomes and family satisfaction by designing and evaluating strategies to strengthen effective family coping efforts.

Assess Family Coping

Nurses can assess family coping through conversation with family members. Flexible visiting hours and increased family time at the bedside provide nurses with opportunities for close assessment of coping responses. Direct questions, such as: "How are you dealing with this hospitalization?" "What helps you deal with this change in your family?" or "What interferes with your ability to deal with this illness?" may give an overall indication of coping strategies used and the effectiveness of the strategies.

Nurses can observe family members for signs of increased stress that may result from ineffective coping. Alternately, family members can complete pen-and-paper instruments, such as the JCS,[34] which has usefulness for research and clinical assessment.

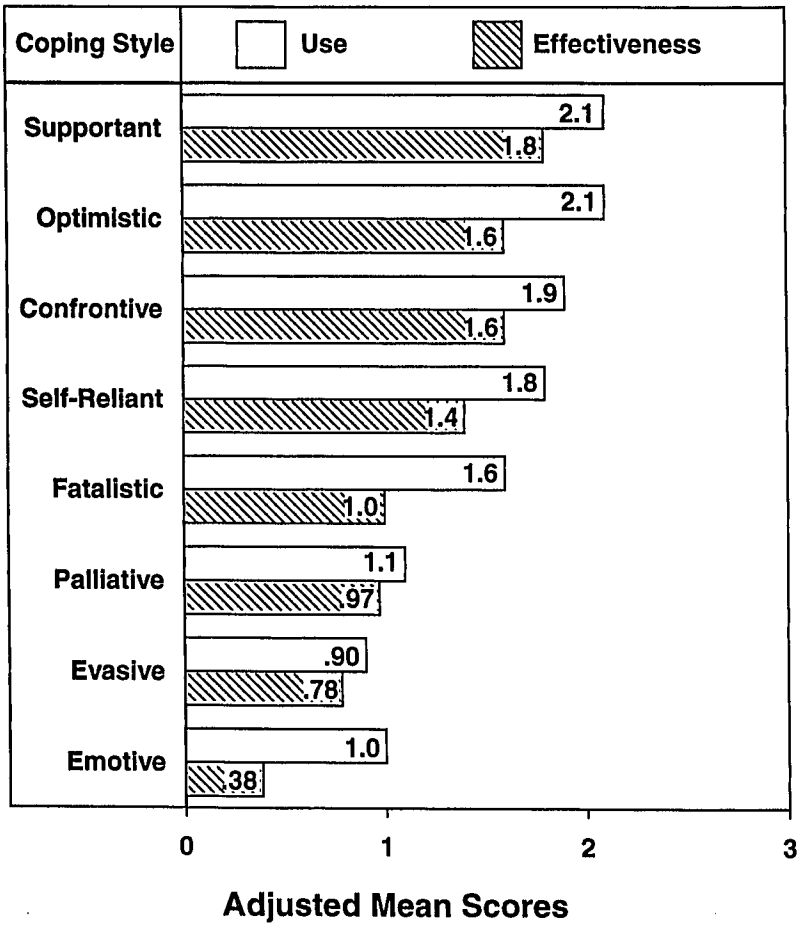
The nurse can quickly review marked responses to identify coping responses used frequently and how effective they are. Statistical analysis is not necessary to derive information for clinical practice about specific strategies used by individual family members.

If specific coping styles or responses are identified as strongly effective or ineffective, nurses can design strategies to address or enhance specific responses. Sample coping responses and interventions by the critical care nurse are illustrated in Table 2 (page 106).

Identify High-Risk Family Members

Nurses can identify family members who are at high-risk for ineffective coping responses. High-risk individuals, as identified in this study, include younger family members and spouses, parents, and adult children of critically ill pa-

Figure 2. Adjusted Mean Scores for Use and Effectivenss of Coping Styles



tients. Critical care nurses can give particular attention to family coping during times of change in patient situations, such as the institution of neuromuscular blocking agents, intubation, resuscitation efforts, invasive procedures and room transfers.

Develop Supportive Nurse-Family Relationships

Supportive nurse-family relationships are necessary to promote effective coping in a high-tech environment. Nursing actions may include:

- Make eye contact with family members when entering the room.
- Learn family members' names and call them by name.
- Use touch as appropriate, for example, shake hands when meeting.
- Volunteer information about the patient's condition on a regular basis.
- Provide information that is consistent across caregivers.
- Involve the family in decision-making processes.

Nurse managers can hold nurses accountable for therapeutic relationships with family members through such strategies as:

- Rate family satisfaction with nurse interactions on discharge surveys.
- Give recognition on job performance evaluations.
- Design rewards for effective work with family members, such as "Family Advocate Award."

Arrange Time

Developing relationships with families requires time but can be integrated into patient care. Nurses can converse with family members and foster relationships while administering slow intravenous medications or during dressing changes, linen changes and range of motion exercises. Nurses can be caring even as they set limits on the time spent in family interaction. For example, the nurse may say, "There is so much that I wish you and I could discuss, but I know you'll agree that my priority is to keep close check on your family member. If his condition stabilizes, there may be time later for talking about your adjustment to all that has happened."

Diminish Ineffective Coping

From assessment data, nurses can identify thoughts or behaviors that represent ineffective coping strategies, bring them to the family member's attention, and suggest alternate responses. The critical

Table 1: Pearson r correlations between age of family member and coping variables.

Coping Variables	r
Effectiveness of:	
Confrontive Style	.32**
Optimistic Style	.44***
Fatalistic Style	.27*
Supportant Style	.30*
Self-Reliant Style	.34**
Use of:	
Confrontive Style	.29*
Optimistic Style	.46***
Number of Coping Styles Used	.29*

*$p < .05$; **$p < .01$; ***$p < .001$

care nurse can be alert for indications of severely ineffective coping that does not respond to common nursing interventions. A psychiatric nurse may serve as a resource person for the critical care nurse, as a family-nurse liaison, or as a direct care provider for family members.

Critical care nurses are challenged when dealing with family members who do not have a positive influence on the patient. The nurse can identify specific patient indicators that suggest nonsupportive interaction, such as patient's negative facial expressions, changes in vital signs, or body positioning. The nurse can share observations and impressions with the family member, eliciting the family's help in modifying the tone of the interaction or limiting interaction temporarily.

Teach Families How To Visit

Critical care nurses can provide family members with verbal or written information on "how to visit" in the critical care unit so that patients benefit from family contact. For example, the nurse could suggest that family members:

- Speak in a moderate voice, if patient is not hard of hearing.
- Use gentle touch to communicate warmth and reassurance.
- Express encouragement and hope for recovery as appropriate.
- Put into words the emotions the patient may be feeling.
- Refrain from discussions that may negatively affect the patient.
- If unpleasant news must be shared, consult with health care providers.
- Be comfortable with silence, especially when rest is needed.
- Ask questions about the patient away from bedside.

Pamphlets are available from professional nursing organizations that provide suggestions for visiting critically ill family members.

Negotiate Role In Patient Care

Critical care nurses can negotiate with family members the extent to which they want to participate in the patient's care. Family members who use confrontive coping styles may be frequently at the bedside and express a desire to participate in direct patient care.

Possible activities in which the critical care nurse may involve the family are dependent on specific patient situations and they may include:

- Partial bath
- Uncomplicated skin care
- Mouth and hair care
- Back rub
- Foot massage
- Coaching during weaning from mechanical ventilation
- Feeding meals
- Orienting patient to person, place and time

In negotiating extent of family involvement in patient care in the critical care unit, nurses can analyze benefit to the patient and possible risk for interference in achieving patient outcomes, including physiological stability and sleep.

Sharing patient goals with family members may elicit their supportive involvement or assist them in understanding the need to restrain from active involvement.

Manage Family Factions

Critical care nurses may need to manage repercussions of family discord that often surfaces during the stress of a critical illness. Nurses may encounter obstacles to clear communication among disenfranchised members and to family consensus on care issues.

Nurses can evaluate family communication patterns, determine individuals who are legally responsible, and negotiate how information will be shared among members. In addition, nurses can develop working relationships with all factions and assist in negotiating time for incompatible parties to visit.

Table 2: Sample Coping Responses and Interventions

JCS* Coping Style	Sample Coping Response	Nursing Interventions
Supportant	Talk with others	• Ask family member to share perceptions of present and future impact of the critical illness. • Use techniques of active listening, reflecting and clarifying. • Use open-ended questions. • Assist family member to identify support persons (relatives, friends and professionals). • Role model listening skills to support persons and positively reinforce. • Encourage family member to set aside regular times with a support person expressly for the purpose of talking about their situation. • Recommend that family member make and receive phone calls from support persons.
	Prayer	• Pray with family member or be present during prayer. • Refer to clergy as appropriate. • Reaffirm verbalized perceptions of a Greater Strength. • Encourage to keep a prayer journal.
Optimistic	Positive Thinking	• Assist family to designate a realistic "Daily Positive Thought" and post in patient's room. • Acknowledge family strengths to increase awareness of personal resources. • Reaffirm family member's ability to manage situation. • Note indicators of personal growth through adversity.
	Hope	• Report signs of patient's improvement to family. • Assist family to visualize and verbalize realistically how the situation could have a positive outcome. • Identify short-term goals for patient or family that can be met each day.
Confrontive	Gain information	• Initiate contact with the family to provide information. • Offer appropriate and specific explanations initially and throughout hospitalization. • Use visual aids and repetition. • Be honest and accurate to increase professional credibility. • Encourage family to ask questions. • Verify understanding and clarify misconceptions. • Arrange a time each day with family for patient updates. • Consider usefulness of regular telephone contacts with family.
	Control/change situation	• Acknowledge family's expressions of powerlessness and identify factors that contribute. • Request suggestions from family about case management. • Enlist family participation in patient care. • Allow flexibility in visiting pattern. • Share with family members that they can control their self-talk processes.
Self-Reliant	Self-talk	• Increase awareness of self-talk content. • Emphasize the relationship between negative self-talk, negative emotions and decreased physical, mental, and social functioning. • Teach positive self-talk and reframing strategies, using written materials as appropriate to stretch nurses' time.
	Withdraw socially	• Provide private quiet space. • Arrange time alone if desired. • Identify potential advantages of contact with others during stress. • Initiate conversation, even if brief.

Table 2 (continued)

JCS* Coping Style	Sample Coping Response	Nursing Interventions
Fatalistic	Expect the worst outcome	• If the worst outcome is likely, offer emotional support and acknowledge the possibility of a poor outcome. • If the worst outcome is unlikely, provide accurate information, encourage thought-replacement, and reaffirm the benefits of hope.
Palliative	Eat, drink, smoke	• Identify and replace negative thoughts that drive behavior. • Encourage moderation, such as mild foods, nonalcoholic beverages. • Delay modification plan for long-standing behaviors until after crisis stage of critical illness.
	Exercise	• Relate benefits of physical activity. • Encourage to walk indoors or outdoors daily. • Identify community sites for short-term exercise.
	Distraction	• Arrange for recreational diversions in waiting area, such as a television, videocassette player and movies, table for playing cards, and writing supplies.
Evasive	Blaming others	• Label negative emotions, for example "frustration," "anger." • Identify and replace thoughts associated with negative emotion. • Identify thoughts to modify or replace negative thought. • Note that disenchantment with others may be a phase in the coping process. • Reaffirm the capacity of people for positive change. • Recall that placing blame externally may be effective coping during the crisis stage of illness.
Emotive	Ventilate negative emotions	• Encourage family to ventilate outside of the unit so as not to convey negative emotions to patient. • Encourage family member to tell the "story" of the illness to diffuse emotions. • Verbalize acceptance of feelings. • Maintain eye contact.
	Worry	• Coach in worrying constructively, as in formulating a worst outcome plan. • Assist family to identify pointless fretting. • Supply thought management guidance to replace unuseful ways of thinking. • Engage family members in holding each other accountable for diminishing nonconstructive worry.

* *Jalowiec Coping Scale (Used with permission of Anne Jalowiec, RN, Ph.D., FAAN)*

In keeping a patient focus, nurses can verbalize to the patient a willingness to work with all factions. Nurses can also extend hope that crises can provide opportunities for healing.

Support During Critical Events

Nurses are challenged to support family coping when family members are present during critical events, such as resuscitation efforts and performance of invasive procedures. While nurses may perceive advantages and disadvantages of family attendance during critical events, family requests to attend become more frequent as flexibility in visiting hours increases and families spend more time at the patient's bedside.

If family members are present during invasive procedures, nurses can support coping in the following ways:

- Explain procedures to the family, including sensations that the patient may experience.
- If appropriate, arrange for family member to touch or verbally comfort the patient during the procedure.
- Answer questions and check validity of family members' perceptions after the procedure.

If family members express a desire to stay with the patient dur-

ing resuscitation efforts, the critical care nurse can intervene both before and during resuscitation efforts to support family coping. For example, beforehand the nurse can:

- Identify the family representatives who desire to be present.
- Negotiate the number of family members who can be present.
- Discuss family preference to stand near or away from the patient.
- Discuss what may occur and what the patient outcome would be.
- Tell family members that they may need to leave the room under some circumstances.
- Inform the family that vivid memories of the event may persist over time and could be distressful.

During actual resuscitation efforts, the critical care nurse can support family coping in the following ways:

- Use short, simple sentences to explain what is occurring.
- Interpret for family members the significance of bedside events.
- Monitor family for signs of severe emotional or physical distress.
- Expect and support emotional expressions.
- If near the patient, encourage family to assure patient of their presence.
- Reaffirm the potential benefit to the patient of having family nearby.
- Ensure safety from electrical shock, needle sticks, and blood exposure.
- Warn family member *before* ceasing resuscitation efforts, if interventions appear futile.
- Provide privacy for a debriefing time afterward to answer questions and check validity of perceptions.

Conduct Family Conferences

Critical care nurses can plan and conduct multidisciplinary family conferences to discuss coping issues. Attendees may include all interested family members, primary and associate nurses, physicians, social workers, chaplains, and psychological clinicians.

Successful family conferences may follow many formats. Arrangements may include a private setting, an adequate length of time to avoid a hurried tone, face-to-face seating, name tags in large print for all participants, tissues, and a written agenda. During a family conference, the nurse may encourage:

- A recorder to write key points on a flip chart.
- Health care providers to share current patient information.
- Family members to identify coping concerns.
- Attendees to design strategies to support family coping.
- Attendees to agree on a plan to increase coping effectiveness.
- A recorder to provide a verbal summary and later a written summary.

Develop Personal Confidence

Nurses may lack experience and confidence in supporting family coping. Fear of "saying the wrong thing" may breed reluctance in developing therapeutic nurse-family relationships. Ways nurses can increase self-confidence in supporting family coping include:

- Rehearse, evaluate and refine phrases for communicating with families about coping behaviors.
- Share "what works" with colleagues through displays and discussion in unit meetings.
- Design posters that highlight research on interventions with families.
- Attend or conduct inservices on family coping.
- Enroll in academic courses on crisis intervention and stress management.

Construct Family-Friendly Units

Nurse managers and critical care nurses can design critical care units and waiting areas that promote family comfort and acceptance. Families who feel unwelcome or unsettled in the critical care environment may display ineffective coping responses. Small details are important, such as color, texture and the availability of pillows, blankets, tissues, and couches.

Provisions for families within patient rooms can promote family comfort and inclusion during the experience of critical illness. In addition, private areas in waiting rooms allow family members to express support and talk freely among themselves or with health team members. Nurses can serve on committees that make decisions about structural matters and be advocates for positive family experiences.

Evaluate Outcomes

Critical care nurses can evaluate the extent to which family members cope effectively with a patient's critical illness. Outcome criteria for family members within 48 hours of the patient's admission may include:

- Average score of 2.0 or higher on effectiveness scale of the JCS.
- Seeks assistance from support persons.
- Defines primary situational concerns.
- Identifies specific coping strategies that are effective.
- Relates accurate perceptions of patient's condition and prognosis.
- Communicates with patient in supportive manner.
- Manages negative emotions constructively.
- Verbalizes realistic expectations of patient and health care team.

Case Study

The following case study demonstrates how nursing interventions worked for the family of W.B.[§], a male in his mid-50's who was admitted to the intensive care unit (ICU) with acute hemorrhagic pancreatitis. He had been ill for a week but continued to work in construction. During a severe episode of abdominal pain, company employees called his wife, who brought him to the emergency department.

Mrs. B. related that Mr. B. had experienced a recent fall from a scaffolding, resulting in fractured ribs and gastrointestinal bleeding, for which he was hospitalized in a nearby city. He was discharged two weeks ago. Other medical history included moderate chronic obstructive pulmonary disease secondary to tobacco use. His medications included bronchodilators and a histamine antagonist.

Mr. B. was placed on hemodynamic monitoring and mechanical ventilation for deteriorating blood gases. Medical diagnoses included acute respiratory distress syndrome (ARDS), severe fluid volume deficit, hypocalcemia and prerenal acute renal failure.

Despite fluid and blood administration, antibiotics, analgesia, and nasogastric decompression, Mr. B. developed frequent premature ventricular contractions and subsequent ventricular fibrillation. He was successfully resuscitated but remained oliguric, febrile and tachycardic. He opened his eyes to verbal stimuli but did not follow commands and required 100% oxygen to maintain oxygen saturation levels at 92%.

Mrs. B. remained constantly at Mr. B.'s bedside, joined for brief times by his adult son from another marriage and friends from her church. Mrs. B. would not leave the bedside to eat, rest or make phone calls because she "has to be here to give him strength."

Mrs. B. paced, cried and tearfully told the nurse that "I know he's going to die. I just can't live without him."

Assessment

The primary nurse learned that Mrs. B. was a homemaker, was 12 years younger than her husband, and had no children. Mr. B. was his wife's "whole life. I can't go on if anything happens to him. It's my fault I didn't bring him in sooner." She paced, cried and tearfully told the nurse that "I know he's going die. I just can't live without him."

The nurse then inquired about Mrs. B.'s past experiences with similar stressful situations and about her usual means of managing difficulty. Mrs. B. described her husband's current illness as the "worst thing I've ever been through." Mrs. B. responded affirmatively when the nurse asked if she could complete a pen-and-paper index about how she was coping with Mr. B.'s hospitalization.

Analysis

Using a score sheet, the nurse determined that Mrs. B. used 25 of the 60 possible coping strategies on the JCS.[34] Her primary coping responses represented the supportant, fatalistic, palliative and emotive coping styles, all of which were consistent with the nurse's clinical assessment of Mrs. B.

From a quick averaging of scores on the four-point scales, the nurse found that overall coping was slightly effective ($x=1.4$). The supportant style had the highest effectiveness scores but was only moderately effective ($x=2.1$). Most effective individual strategies included "learning more about the situation," which was a strategy from the confrontive style, and "talking with others," which was a strategy from the supportant style.

After evaluating Mrs. B.'s coping responses, the nurse added the nursing diagnosis "Ineffective Family Coping" to Mr. B.'s care plan. The nurse judged Mrs. B. to be at high-risk for continued ineffective coping if nursing interventions were not instituted.

Nursing Interventions for This Family

The nurses successfully used the following interventions for this family:

- *Strengthened current responses.* To optimize Mrs. B.'s effective coping strategies, nurses prompt-

ed Mrs. B. to talk about "how you are doing with all this," encouraged her to pray and share feelings with visitors, and explained pancreatitis and possible treatments using diagrams.

- *Identified ineffective coping strategies.* On a chart (Table 2), nurses highlighted strategies Mrs. B. currently used and guided her in diminishing such responses as pacing around the bed and referring to the ICU as a "death camp."
- *Introduced self-reliant strategies.* Nurses introduced positive self-talk responses to reframe the illness experience and reduce negative emotions.
- *Offered optimistic strategies.* Nurses affirmed confidence in Mrs. B.'s ability to manage the hospitalization and emphasized indicators in Mr. B.'s condition that fostered a realistically hopeful outlook.
- *Reassessed coping responses.* Nurses monitored evidences of Mrs. B.'s coping progress, including self-reports of positive thoughts, evidence of mood lifts, and time spent verbalizing with support persons.

Coping Outcomes

The week held setbacks in Mr. B.'s condition. Hemodialysis began after pancreatic debridement, and septic shock resulted in deeper nonresponsiveness. When Mr. B. again went into ventricular fibrillation, Mrs. B. stayed in the room for the short, successful resuscitation effort and later thanked the nurses for allowing her to "be close enough to pull him back to life."

During the second week, as improvements began, Mrs. B. finally left Mr. B.'s bedside to go home for brief periods, carrying a card on which she had scribbled, "Although it will be a challenge, I can manage whatever happens."

The nurses continued to support Mrs. B. in developing key thoughts that sustained energy and clear thinking. Mrs. B. began to eat more regular meals and left Mr. B.'s room to visit with friends in the waiting area.

As septic shock and ARDS resolved, ventilation and renal function remained problematic. Mr. B. transferred to a step-down unit for further evaluation. In a note, Mrs. B. credited critical care nurses with "keeping me sane on the trip to hell and back."

Over the next three months, Mr. B. repeatedly returned to ICU following surgery, pneumonia or new episodes of renal failure. Nurses conducted family conferences, as Mrs. B. and her stepson periodically expressed frustration and anger with the health care team, with Mr. B., and with life. The nurses helped the family to label negative emotions, identify thoughts associated with negative emotions, and keep expectations realistic.

One night on the step-down unit, Mr. B. abruptly cardiac arrested and died. Within 24 hours, a designated ICU nurse contacted Mrs. B. at home. After a time of tears, they worked on thoughts to sustain her through the funeral process and the weeks ahead. Mrs. B. visited the ICU occasionally in the following months, and the nurses, when available, continued to support her coping efforts.

Three years after Mr. B.'s death, Mrs. B. became a volunteer in the ICU waiting area, listening attentively as others described a quite familiar experience.

Summary

Results of this study indicated that coping strategies used by family members of critically ill patients were only slightly effective in managing the stress of the hospitalization. Findings also identified the types of coping responses used most frequently and effectively by family members. These results provide a basis for coping assessment and for planning innovative actions to increase coping effectiveness, improve patient outcomes, and foster a positive experience for family members.

Clinical Research Questions

Additional questions related to coping of family members of critically ill patients include:

- How do family members' use and effectiveness of coping strategies change over time during the critical illness?
- How does coping effectiveness of family members relate to effective patient coping?
- How does coping effectiveness of family members relate to family satisfaction with the health care experience?
- How does coping effectiveness of family members relate to patient's length of stay?
- How does coping effectiveness of family members relate to symptoms of stress-related illness in family members during the hospitalization of a patient?
- What are the effects of specific nursing strategies on coping effectiveness of family members during critical illness?
- How effective are critical pathways for family coping in meeting coping outcomes?

- What is the lived experience of being supported by a nurse during the critical illness of a family member?

Key words

Family, coping, coping effectiveness, critical care, family visiting

§ The names and insignificant characteristics of this case have been changed for confidentiality; any resemblance to a real person is coincidental. The views expressed in this article are those of the author and not necessarily that of DCCN, the publisher or editors.

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