



How do nurses in critical care units assist patients and families to decrease fear and anxiety
by Michael Anne Scheer

A thesis submitted in partial fulfillment of the requirements for the degree of MASTER OF NURSING
Montana State University

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Abstract:

The problems dealt with in this study were; 1) to determine what causes patients and family members fear and anxiety when the patient is admitted to a critical care unit; 2) what nursing actions are helpful to them in decreasing this fear and anxiety; and 3) what do nurses perceive as causing fear and anxiety for the patient and family, and how do they perceive themselves assisting the patient and family to overcome this fear and anxiety while the patient is in the critical care unit.

Patient and family data was collected by means of open-ended questionnaires devised by the investigator. The patient was interviewed by the investigator during the third to fifth day of hospitalization in the critical care unit, A family member was requested to complete the family questionnaire while the investigator interviewed the patient.

The nurses' questionnaire was a combination open and closed-ended questionnaire, The questionnaire was explained to them and they were requested to complete and return it to the investigator during the two week period of the study. The geographical areas used in the study were the northern and southern sections of Montana and northern Colorado, A total of 46 patients were interviewed in the five hospitals; 31 family members completed the questionnaire as requested; and 63 nurses in these hospitals responded to the nurses' questionnaires, Patient and family respondents identified the following factors as causing them fear and anxiety when sudden illness struck; 1) the fear of death 2) the fear of being incapacitated 3) the fear of the unknown 4) the suddenness of the illness 5) concern about the family Nurse respondents identified the above first four factors also® In addition they saw the machinery and equipment necessary to sustain life as being a cause for patient and family fear and anxiety. Also they cited the unit's activities and the large number of people working there as a causative factor for fear and anxiety on the part of the patient and family.

Nursing actions that the patient and family found helpful in

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ASSIST PATIENTS AND FAMILIES TO
DECREASE FEAR AND ANXIETY

by

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A thesis submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF NURSING

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Bozeman, Montana

June, 1975

ACKNOWLEDGEMENTS

Sincere appreciation is extended to Miss Virginia Felton, committee chairman, Mrs. Barbara Hauf, Miss Ruth Vanderhorst, Mrs. Ethel Nelson and Dr. George Rice for their generous assistance, patience and understanding which made the completion of this study possible. Special thanks is extended to the Sisters of Charity of Leavenworth for their advice and encouragement during this study.

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ABSTRACT

The problems dealt with in this study were: 1) to determine what causes patients and family members fear and anxiety when the patient is admitted to a critical care unit; 2) what nursing actions are helpful to them in decreasing this fear and anxiety; and 3) what do nurses perceive as causing fear and anxiety for the patient and family, and how do they perceive themselves assisting the patient and family to overcome this fear and anxiety while the patient is in the critical care unit.

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A total of 46 patients were interviewed in the five hospitals; 31 family members completed the questionnaire as requested; and 63 nurses in these hospitals responded to the nurses' questionnaires.

Patient and family respondents identified the following factors as causing them fear and anxiety when sudden illness struck:

- 1) the fear of death
- 2) the fear of being incapacitated
- 3) the fear of the unknown
- 4) the suddenness of the illness
- 5) concern about the family

Nurse respondents identified the above first four factors also. In addition they saw the machinery and equipment necessary to sustain life as being a cause for patient and family fear and anxiety. Also they cited the unit's activities and the large number of people working there as a causative factor for fear and anxiety on the part of the patient and family.

Nursing actions that the patient and family found helpful in

assisting them to decrease their fear and anxiety were:

- 1) Confidence in the staff
- 2) The constant attention of the nurses and that the nurses did everything they could for them
- 3) The calmness and efficiency of the staff
- 4) Being physically more comfortable
- 5) Being treated as a human being
- 6) Their faith and the prayers of others
- 7) Receiving explanations

Four or 9% of the patients stated they were not worried during this time of illness, while three or 7% of the family members stated that the fear and anxiety they experienced was not lessened.

Nurses reported the following nursing activities as being helpful to decrease patient and family fear and anxiety:

- 1) Teaching and explaining to them tests and examinations they will undergo; teaching them about their illness
- 2) Listening and talking to them
- 3) Being approachable and concerned about them
- 4) Treating them as human beings
- 5) Being calm and efficient

Thirty-one or 49% of the nurses reported that allowing the family to "peek" at the patient if he/she were asleep would be helpful to decrease patient and family fear and anxiety. Twenty-three or 36% of the nurses reported allowing the family to remain at the bedside outside of visiting hours as being helpful in decreasing patient and family fear and anxiety.

CHAPTER I

INTRODUCTION

Millions of Americans are admitted to our hospitals yearly because of cardiac disorders. It is estimated that one million persons suffer from acute myocardial infarction yearly, while 650,000 persons die yearly from ischemic heart disease.¹ These facts cannot be disputed. Yet the fact that this illness is disruptive to the patient and family is often overlooked or relegated to the background while treatment regimens are instituted.

Any illness that requires hospitalization can be expected to produce fear and anxiety on the part of the patient and family. When this illness affects the functioning of a vital organ, fear and anxiety are intensified.²

When the patient is admitted to the hospital he experiences uneasiness, concern, and fear about his health and welfare. Many things take place that are unknown and unfamiliar to him and to his family. Some patients may have to completely change their pattern of living or relationship to death because of illness. No man is above this fear and

¹Archer S. Gordon (chairman), "Standards for Cardiopulmonary Resuscitation and Emergency Cardiac Care," Supplement to JAMA, 227:7, February 18, 1974.

²Jane Secor, "Nursing and Medical Therapies," Coronary Care: A Nursing Speciality, (2nd printing; New York: Appleton-Century-Crofts, 1971), p. 43.

anxiety. To help him meet, accept and grow in this experience, he needs the companionship and support of others. These others need not only be family, but doctors, nurses and other paramedical personnel can also fulfill this need.

The focus of this study was threefold. The patient with cardiovascular disease admitted to the critical care unit during the acute phase of illness, the patient's family, and how both the patient and family thought nurses assisted them to decrease the fear and anxiety they experienced. The third focus was how nurses saw their role in decreasing patient and family fear and anxiety.

STATEMENT OF THE PROBLEM

Patients who are admitted to a critical care unit not only suffer from physical pain due to their illness, but also from fear and anxiety due to the unpredictable outcome of their illness.

The problems investigated in this study were:

1. What do patients and family members indicate that nurses do for them that is helpful to them in decreasing their fear and anxiety?
2. How do nurses assist patients and family members decrease fear and anxiety during the acute phase of illness (the first three (3) to five (5) days of hospitalization) in a critical care unit?

PURPOSE OF THE STUDY

The nurse, because of her position on the health team and the amount of time she spends with the patients and family members, is the most likely person to assist them during this period of illness. Some nurses are frustrated in their efforts to give emotional support due to work load and their own anxieties about their inadequacies. This may result in patients and family members being left in fear and doubt about their illness, their recovery and their future.

To accomplish the purpose of the study, answers to the following questions were evaluated:

QUESTIONS TO BE ANSWERED

1. What do patients indicate as being fear or anxiety provoking during the acute phase of illness (the first 3-5 days of hospitalization) in the critical care unit?
2. What do family members indicate as being fear or anxiety provoking during the acute phase of illness (the first 3-5 days of hospitalization) in the critical care unit?
3. What nursing actions are helpful in decreasing fear and anxiety for patients and family members during the acute phase of illness from the viewpoint of the patient, family, and nurse.

ASSUMPTIONS

The patient encountered fear and anxiety when he was admitted to the critical care unit.

Family members encountered fear and anxiety when a member was admitted to a critical care unit.

Nurses working in these units were cognizant of these emotions of fear and anxiety on the part of patient and family.

LIMITATIONS

The validity of the composed questionnaires had been established only by face validity.

The study was limited to patients in critical care units who were suffering from cardiovascular problems.

Patients were limited to those who were able to communicate verbally.

Interviews and questionnaires were completed at five (5) different hospitals at differing time periods.

GENERAL PROCEDURE

The study was approached by means of three composed questionnaires in four Montana hospitals and one metropolitan hospital in Colorado. The Montana hospitals were comparable in size, 206 to 230

bed capacity. The Colorado hospital was a six hundred (600) bed complex.

Questionnaires were presented to the nursing staff in the critical care units of the hospitals utilized in the study by the investigator for a period of two weeks. Patients admitted with a cardiovascular illness were interviewed by the investigator on the third to fifth day of hospitalization in the critical care unit. Family members (one member from each patient's family) were requested by the investigator to complete their questionnaire while the investigator was interviewing the patient.

One investigator conducted all the patient interviews. Patient population was selected by the investigator on the basis of the patient's meeting the above criteria. They were able to communicate verbally with the investigator.

Ten to twenty patients were sought at each hospital to participate in the study, as was a member of each patient's family. All of the registered nurses working in the unit of each hospital were requested to take part in the study.

DEFINITION OF TERMS

Anxiety:

A state of "apprehension or uneasiness which stems from the anticipation of danger. The source of the threat is largely unknown or

unrecognized."³

Arrhythmia:

Disturbance of the rate, rhythm and conduction of the heart's electrical impulse.⁴

Critical Care Unit:

In this study, critical care unit will mean a designated area in the hospital set aside for the care of the seriously ill patient suffering from coronary heart disease. (Coronary and intensive care units are included in this definition.)

Fear:

"An emotional response to a consciously recognized and usually external threat of danger."⁵

Incapacitation:

"The inability to carry on in one's accustomed way for many years or even for life"⁶

³Frances Monet Carter Evans, Psychosocial Nursing (New York: Macmillan Company, 1971), p. 146.

⁴Lawrence E. Meltzer, Faye G. Abdellah, J. Roderick Kitchell, Concepts and Practices of Intensive Care (Philadelphia: Charles Press, 1969), p. 51.

⁵Evans, op. cit., p. 146.

⁶Albert Parets, "Emotional Reactions to Chronic Physical Illness." Medical Clinics of North America, 51:1, November, 1967, p. 1400.

Myocardial Infarction:

"Local death to a portion of the heart muscle due to lack of oxygen to the myocardium because of an obstruction in the coronary arteries or their branches."⁷

Need:

"An organismic condition which exists within the individual and which demands certain activity. . . . Evolves from a state of tension which disrupts the individual's equilibrium and produces a relative degree of discomfort which, in turn, propels him to do something about it in order to re-establish equilibrium."⁸

Non-verbal Communication:

"The attitude, feelings, and thoughts that we convey either intentionally or unintentionally through such media as our posture, gestures, facial expressions, vocal tone and inflection."⁹

Self-awareness:

A healthy awareness of one's strengths and limitations.¹⁰

⁷Meltzer, op. cit., pp. 50-51.

⁸Martha M. Brown, Grace R. Fowler, Psychodynamic Nursing: A Bio-social Orientation (3rd ed.; Philadelphia: W. B. Saunders, 1966), p. 16.

⁹Ibid., p. 88.

¹⁰Frances Monet Carter Evans, Psychosocial Nursing (New York: Macmillan Company, 1971), pp. 127-128.

Self-concept:

All the person's ideas, conscious and unconscious feelings, beliefs and attitudes.¹¹

Self-esteem:

A feeling of self-reliance, independence.¹²

Verbal Communication:

The use of words to convey meaning and purpose of thoughts and to clarify one's ideas, thoughts or feelings to another.¹³

SUMMARY

Illness and hospitalization subject the patient to unfamiliar and threatening surroundings. He fears the unknown outcome of his illness, the pain to which he is subjected, and the possibilities of invalidism, mutilation or death.¹⁴ To assist the patient and his family through this period of illness, the nurse must be willing to

¹¹Irene Beland, Clinical Nursing: Pathophysiological, Psychosocial Approaches (New York: Macmillan Company, 1970), p. 220.

¹²Albert Parets, "Emotional Reactions to Chronic Physical Illness," Medical Clinics of North America, 51:1, November, 1967, p. 1400.

¹³Martha M. Brown, Grace R. Fowler, Psychodynamic Nursing: A Bio-social Orientation (3rd ed.; Philadelphia: W. B. Saunders, 1966), p. 87.

¹⁴Jane Secor, "Nursing and Medical Therapies," Coronary Care: A Nursing Speciality (2nd printing; New York: Appleton-Century-Crofts, 1971), p. 43.

become involved with the total patient and his family. She must be willing to accept the responsibility for instituting care; for interacting with physicians on behalf of the patient and family members in planning and implementing physical and psychological care.

CHAPTER II

REVIEW OF LITERATURE

INTRODUCTION

A review of medical and nursing literature shows a need for re-defining the role of the nurse in the care of the seriously ill in our critical care units. Patients and their families suffer not only from the physical pain of the illness, but also from the psychological strain of the illness and hospitalization.

THE ROLE OF THE NURSE IN THE CARE OF THE SERIOUSLY ILL PATIENT

In her role of clinical expert, the nurse needs to develop a deep understanding and genuine caring for patient and family.

Anselm Strauss stated in 1968 that:

A characteristic feature of intensive nursing care is that the nurse's focus is very intense and narrow . . . During survival crisis, her work is even more focused and intense. She has immense responsibility for her patient's welfare. And because this is such a medically and procedurally orientated service, she tends to concentrate far more on the medical aspects of her patient than on the "patient as a whole."

.
As a consequence of the intense procedural and medical focus of the Intensive Care Unit nurse, she tends to pay less attention to the psychology of her patient. Most of her formal and informal training for Intensive Care Unit nursing is not concerned with psychological and social relationships.¹

¹ Anselm Strauss, "The Intensive Care Unit: Its Characteristics and Social Relationships," Nursing Clinics of North America, 3:1, March, 1968, pp. 9-10.

E. M. Taylor sees intensive care nursing as never lacking in meeting the physical needs of patients in the unit. However, nurses are prone to overlook the psychological needs of the patient, not because they are orientated toward mechanical tasks, but rather because the patient is often seen as "another inanimate and insensate object."²

Coronary care units also have a similar problem. Nurses often give top priority to operating the electrical equipment found in the unit, interpreting the patient's cardiographic rhythm strip, rather than giving attention to the frightened and anxious patient or family. Attention to the electrical equipment that assists nurses does not necessarily insure excellent individualized care. Excellent nursing care implies that the total patient is cared for and his needs are met, whether they are physical, psychological, social or spiritual.³

R. D. Ryder states:

Today medicine and nursing could, and I believe should, be once again revolutionized . . . by the realization that feelings and attitudes of patients and staff are of crucial importance in the professional alleviation of suffering and the treatment of physical as well as psychological disorders.

.
. . . Hitherto the emphasis upon research and cure has rather

²E. M. Taylor, "Problems of Patients in an Intensive Care Unit," International Journal of Nursing Studies, 8:1, February, 1971, p. 47.

³Catherine Baden and Jacquelyn Huebsch, "Fostering Patient Centeredness in Coronary Care Units," Nursing Clinics of North America, 6:2, June, 1971, pp. 365-366.

taken priority over concern for the feelings of the patient--even where a patient is dying, therapists may have regarded themselves too often as potential miracle-workers rather than as skilled comforters. . .

.
What I am saying is that the feelings of the patient should be the unashamed professional concern of all of us. . .

.
. . . I believe that the natural spark of compassion should be professionally utilised for the benefit of the patient . . .

.
. . . What is required is a warm, broad minded concern for the client because he is a suffering fellow creature, regardless of any disgusting or unpleasant symptoms or peculiar moral qualities he may have.⁴

Nursing today is not just helping the physician cure patients. It includes helping patients and families find meaning in their illness.⁵ It is through the "kindness and sympathy" of the nurse working in the critical care unit that patients and families are assisted in achieving the worthwhile objectives of health, comfort, and freedom from pain and suffering. Nurses also create an atmosphere of gentleness and concern for both patient and families.⁶⁻⁷

⁴R. D. Ryder, "Feelings in Physical Illness," Nursing Mirror, 135:7, August, 1972; pp 20-21.

⁵Joyce Travelbee, "To Find Meaning In Illness," Nursing '72, 2:12, December, 1972, p. 6.

⁶Taylor, op. cit., p. 47.

⁷Sidney Jourard, The Transparent Self (New York: D. Van Nostrand Company, 1971), p. 204.

Nurses interact therapeutically with patients when they attempt to alleviate anxiety through their communication to them that they care.⁸

HOW DOES HOSPITALIZATION IN A CRITICAL CARE UNIT
AFFECT THE CORONARY PATIENT AND HIS FAMILY

When patients enter the hospital, they bring with them their life styles, their financial and social roles, their beliefs and fears. They leave behind their families and friends and their co-workers. They forfeit accustomed social roles and take on the role of patient, in an environment where they may have to face threats of disfigurement and possible death.⁹

Illness itself is a threatening experience for some people.

Jane Secor states that:

. . . Every patient and family afflicted with an illness experiences anguish, anxiety, and fear. They fear the unknown, and the possibilities of pain, invalidism, mutilation and death. All of the fears become intensified if the function of a vital process is being threatened. The patient suffering from a cardiac illness knows that his life is in jeopardy. He further knows that he is helpless to do anything about it and must depend on others to help him recover . . .¹⁰

⁸ Lisa Robinson, "Introduction," Psychological Aspects of the Care of the Hospitalized Patient (Philadelphia: F. A. Davis Company, 1968), pp. 69-70.

⁹ Roslyn R. Elms and Donna K. Diers, "The Patient Comes to the Hospital," Nursing Forum, 2:3, 1963, p. 89.

¹⁰ Jane Secor, "Nursing and Medical Therapies," Nursing Speciality, (2nd printing; New York: Appleton-Century-Crofts, 1971), p. 43.

Many times admission to a critical care unit is seen by patients and families as tangible proof that their fears and anxieties are justified, that their lives are in danger. Both patients and families see a myocardial infarction as a threat. According to Doctor Meltzer:

. . . Even those patients who are unaware of the frightening mortality associated with the attack are nevertheless fearful and anxious because of the symbolic importance of the heart--the "vital" organ of life. For these reasons, as well as thoughts of invalidism and economic ruin, major psychological reactions are prominent in almost every patient. . .¹¹

That patients and families view the heart differently than the medical and nursing professions, seems evident. To the lay person, the heart is the center of life with all other organs dependent on it for survival. They know they have only one heart and that life depends on the heart continuing to beat; if it stops death occurs. Once a patient has suffered a myocardial infarction, when his heart has stopped beating for a short period of time, and he feels he can no longer rely on it with assurance;¹² then comes the threat of loss of independence, self-esteem and security. Accompanying these threats of loss is the

¹¹Lawrence E. Meltzer, Rose Pinneo, J. Roderick Kitchell, Concepts and Practices of Intensive Care for Nurse Specialists (Philadelphia: Charles Press, 1969), p. 85.

¹²Catherine A. Smith, "Body Image Change After Myocardial Infarction," Nursing Clinics of North America, 7:4, December, 1972, p. 664; see also Frederick A. Whitehouse, "The Psychosocial Aspects of Cardiovascular Disease," Nursing Forum, 2:2, January, 1963, p. 40.

threat of death, a threat that resides in the foreconscious of the patient and possibly in the foreconscious of the family. This occurs more consistently than the medical and nursing profession realize.¹³

Doctor Gerald Wipple states that the fear of death is probably the most pronounced characteristic of patients and families facing impending or established myocardial infarction.¹⁴

The patient who has sustained a myocardial infarction also experiences a threat to his self-concept. His role and status in the family and community changes because of the illness. He may well face the loss of job and financial security. He may question his adequacy as a marriage partner, and his ability to continue to hope and dream for tomorrow.¹⁵

Other factors that cause patient and family fear and anxiety during illness and hospitalization are: 1) being placed in a highly mechanical environment where he is surrounded by beeping monitors, noisy respirators, continuous lighting, continuous noise;¹⁶ 2) finding

¹³Albert D. Parets, "Emotional Reactions to Chronic Physical Illness," Medical Clinics of North America, 5:16, November, 1967, p. 1400.

¹⁴Gerald H. Wipple, et al., Acute Coronary Care (Boston: Little, Brown and Company, 1972), p. 147.

¹⁵Irene L. Beland, Clinical Nursing: Pathophysiological and Psychosocial Approaches (2nd ed.; New York: Macmillan Co., 1970), p. 220.

¹⁶Janet S. Smith, "Adverse Effects of Critical Care Units," Crit-

himself in the unfamiliar surroundings of the critical care unit causes him to feel uneasy; 3) being subjected to numerous and unknown tests and procedures which may have been poorly explained or not explained at all; and 4) being requested to answer innumerable questions and to understand and abide by the hospital and unit policies.¹⁷

To help the patient and family adjust to this acute phase of illness, the nurse must display an attitude of approachability, an attitude that she is someone who cares about them as persons, and that she is someone that they can trust.¹⁸

HOW CAN NURSES WORKING IN CRITICAL CARE UNITS
ASSIST PATIENTS AND FAMILIES
DECREASE FEAR AND ANXIETY

Since the primary purpose of nursing is to maximize patient and family centered care, nurses must recognize patients and family members as unique individuals. Their needs must be identified and met by the staff to the highest degree possible.

To meet and care for patients and families on this individualized level, nurses must develop a self-awareness that leads to

ical Care Nursing, eds. Carolyn M. Hudak, Barbara M. Gallo, Thelma Lohr (Philadelphia: J. B. Lippincott & Co., 1973), pp. 16-25.

¹⁷Carol Carroll and Cynthia Becker, "Nursing Care of the Medical Cardiac Patient," The Cardiac Patient: A Contemporary Approach, ed. Richard G. Sanderson (Philadelphia: W. B. Saunders, 1972), p. 409.

¹⁸Ibid.

self-acceptance and the acceptance of others. "The nurse who knows herself can love and trust the patient enough to work with him professionally, rather than for him technically, or at him vocationally."¹⁹ Her self-awareness allows her to assist patients and families to reduce their fear and anxiety by assisting them to increase their feelings of identity and self-worth.²⁰

David Sobel states that, "There is no doubt that in the coronary care unit the nurse is the most important person responsible for the patient's emotional well-being."²¹ There are instances when she is the patient's sole support; when she is the only person available to assist him to allay his fears and misgivings. She does this by listening to him, encouraging him to verbalize and clarify his feelings and thoughts.²²

Gerald Wipple also sees the nurse in this major interpersonal role "because she constantly interacts with the patient at the bed-

¹⁹ Lydia Hall, Genrose Alfano, "Myocardial Infarction: Incapacitation or Rehabilitation," American Journal of Nursing, 64:11, November, 1964, p. c-24.

²⁰ Sidney Jourard, The Transparent Self (New York: D. Van Nostrand Co., 1971), p. 195.

²¹ David E. Sobel, "Personalization on the Coronary Care Unit," American Journal of Nursing, 69:7, July, 1969, p. 1440.

²² Arthur H. Griep, Sister de Paul, "Angina Pectoris," American Journal of Nursing, 65:6, June, 1965, p. 72.

side."²³

She enables him to clarify his thinking by allowing him to verbalize his thoughts and feelings; she supports him when he is in need; and she reassures him of his progress as much as possible. If the nurse fulfills this role for patients, it seems evident that there are times that she must also fulfill this role for members of the patient's family as well.

This type of nursing is seen by Jane Secor as the therapy that supports the body during illness, while it enables the person to direct his energy toward achieving wellness. She goes on to say:

. . . Nursing measures assist with the fulfillment of physical and emotional needs, some of which are intensified because of the internal disequilibrium. Nursing provides rich opportunities for establishing unique relationships with people, permitting the nurse to be very close to others--to touch them and to let them know that she cares. . . .

. . . When nursing care is rendered with knowledge, understanding, sincerity, and compassion, the relationship becomes highly personalized and a close bond emerges, uniting the group with shared trust and a very special kind of caring.²⁴

Through the nurses' "patient, empathetic and frequent explanation of equipment, procedures, and medicine," much of the apprehension and fear that patients and family members experience can be resolved.

²³Gerald Wipple, et al, Acute Coronary Care (Boston: Little, Brown and Company, 1972), pp. 50-51.

²⁴Jane Secor, "Nursing and Medical Therapies," Coronary Care: A Nursing Speciality (2nd printing; New York: Appleton-Century-Crofts, 1971), p. 43.

The manner in which the nurse performs her duties, her promptness in answering call lights and requests, can do much to reassure the patient and family members that they are in a well controlled and caring environment.²⁵

SUMMARY

Illness and hospitalization cause fear and anxiety in most patients even when the illness is not life threatening. Myocardial infarction is always seen as a life-threatening illness and thus brings with its crushing pain the fear of death or incapacitation. This fear is shared by the patient and his family. The nurse working in the critical care unit to which the patient is admitted has it in her power to assist both the patient and the family during this period of acute illness to decrease the fear and anxiety by explaining, teaching and conversing with them as unique individuals.

²⁵Carol Carroll and Cynthia Becker, "Nursing Care of the Medical Cardiac Patient," The Cardiac Patient: A Contemporary Approach, ed. Richard G. Sanderson (Philadelphia: W.B. Saunders, 1972), p. 409.

CHAPTER III

METHODOLOGY

This was a descriptive study undertaken to determine what created fear and anxiety for the patient during the acute phase of illness; what created fear and anxiety for the family members during the patient's acute phase of illness; what nurses perceived as causing patient and family fear and anxiety; and what nursing actions were found to be helpful in decreasing the fear and anxiety of the patient and his family. This study was directed toward the viewpoint of the patient, the family and the nurse.

SELECTION OF THE POPULATION

All patients, regardless of age or sex, admitted to the critical care unit for open heart surgery, admitted with probable or established myocardial infarction, and admitted with heart block or other cardio-pulmonary illness were considered as potential participants. One family member (the closest relative) from each family group was requested to participate in the study. All registered nurses working in the critical care units of the five hospitals used in the study were also requested to take part in the study.

METHOD OF COLLECTING DATA

For a two week period, the investigator checked the critical

care unit daily at each hospital in the study. Permission to interview the patient and his family was obtained verbally from the attending physician by the investigator. One physician from hospital A and one physician from hospital B requested that their patients not be interviewed while they were in the critical care unit.

The patient and family were approached. The investigator presented herself as a graduate student in nursing, doing a study on the way nurses assisted patients and families in decreasing their fear and anxiety during the patient's stay in the critical care unit. Each patient and family member was assured that anonymity would be observed. All patients and family members were cooperative and willing to participate in the study. Patient interviews took place in the patient's room during the third (3rd) to fifth (5th) day of hospitalization. Each question was recorded on the questionnaire, by the investigator, as it was answered. The family member's questionnaire was explained. Family members were requested to complete the questionnaire while the patient interview was in progress. Some family members preferred to complete the questionnaire at home. Thirty-one of the forty-six questionnaires submitted to family members were returned.

All registered nurses working in the critical care units were contacted during the two week period of the study. They were requested to complete the nurse questionnaire and leave it in the critical care unit. Envelopes addressed to the investigator were provided. The

questionnaires were collected daily by the investigator.

Hospitals utilized in the study were a 600 bed hospital in northern Colorado, two 206 bed hospitals in southeastern Montana, and two hospitals in northern Montana of 298 and 213 beds respectively. These five hospitals were chosen because of their availability to the investigator. In addition, these hospitals had large critical care units with considerable patient turnover. This provided a larger patient and family population for the study.

During the period of data collection, a total of 46 patients were interviewed by the investigator. Thirty-one family questionnaires were returned. The total number of nurse questionnaires returned was sixty-three.

INSTRUMENT

Data was collected by means of three questionnaires developed by the investigator. The patient and family questionnaires consisted of fifteen open-ended questions. Questions attempted to ascertain the types of fear and anxiety they experienced about the illness; how the illness affected them; and how nurses could assist them during this time of illness. There were nine additional items on the patient questionnaire which pertained to medication, diagnosis, prognosis and other identifying data. This additional information was obtained from the patient's chart. On the family questionnaires there were five addi-

tional items, and these served as identifying data. They were: name, sex, relationship to the patient, and the name of the hospital. The nurse questionnaire consisted of fifteen statements describing nursing actions that could be helpful in decreasing patient and family fear and anxiety. These were answered by nurses checking the degree of agreement or disagreement with the statement. Four additional open-ended questions were included to allow nurses more freedom in responding. These questions ascertained whether or not nurses recognize that the patients and families experience fear and anxiety upon admission to a critical care unit, and how they attempted to assist them in decreasing this fear and anxiety. The nurse questionnaire contained five additional items of information that served as identifying data. This data included the hospital in which they were employed, age, sex, marital status, and full or part-time employment.

Initially, the investigator interviewed seven patients who had been in the critical care unit and their families. These interviews aided the investigator in determining what fears and anxieties had been experienced by the patient and his family while the patient had been in the critical care unit. The investigator then developed close-ended questionnaires utilizing this information. To improve the validity and reliability of the questionnaires, a pilot study was done in a 180 bed hospital in western Montana. Five patients and family members were used in this study. Patients were interviewed by the investigator, who

recorded patient responses on the questionnaire as the patients responded to each question. Family members were asked to complete their questionnaire while the investigator interviewed the patient. Several problem areas were identified relating to responses with closed-ended questions in the patient and family questionnaires. Revisions were made to produce the open-ended questionnaires used in the actual study.

The nurse questionnaire was also developed from the above information and used in the pilot study. Seven nurses working in the critical care unit responded to the study. They were requested to complete the questionnaire and to make suggestions as to clarity and construction of the questionnaire. No further changes were made in the nurse questionnaire. The final questionnaires used in the actual study are found in Appendix A (Patient Questionnaire), Appendix B (Family Questionnaire), and Appendix C (Nurse Questionnaire).

CHAPTER IV

ANALYSIS OF DATA

Data was obtained from forty-six (46) patient, thirty-one (31) family member, and sixty-three (63) nurse questionnaires. All data was hand tabulated. All responses were classified into broad categories according to responses to each open-ended question. Two nurses, actively employed in critical care nursing, analysed and classified data from ten patient, family, and nurse questionnaires independently. The total number of classifications to the open-ended questions and the identifying data for the patient and family members was twenty-four (24). The percentage of nurse agreement with that of the investigator's analysis ranged from 70% to 83% for the patient and family questionnaires. The least agreed upon items in any one questionnaire numbered seventeen, while the highest number agreed upon was twenty. The percentage of nurse agreement to the four open-ended questions of the nurse questionnaire was 94%

The majority of patients interviewed in the study were 55-65 years of age, while the majority of family members ranged in age from 45-64. Eighty-four percent (84%) of the nurses were in their thirties or younger.

Of the forty-six (46) patients responding to the questionnaire, thirty-five (35) or 76% were male. The majority, thirty-seven (37) or

80% were married. Thirty-nine (39) or 61% of the nurses participating in the study were married or had been married. All of the nurses were female.

Of the total number of patients responding to the questionnaire, twenty-seven (27) or 58% were Protestant, thirteen (13) or 28% were Catholic, and the remaining six patients had various other religious affiliations.

Thirty-two (32) or 69% of the patients interviewed were diagnosed as probable or confirmed myocardial infarction. Eight (8) or 17% were diagnosed as heart block. The remaining six patients suffered from other cardio-pulmonary diseases.

Forty (40) patients, or 86%, received some type of medication during their hospitalizations in the critical care unit; either tranquilizers, narcotics or a combination of both. Six patients received no medication during their hospitalization in the critical care unit.

The prognosis for the majority of the patients, or 80%, was judged by the investigator to be good. This judgement was based on information from the patients' charts, their color, alertness, and/or calmness during the interview.

On almost every question in the study, there were some non-respondents. In some cases, this was an indication of reluctance to answering the questions. In other instances it was due to misinterpretation.

The following data arranged in tabular form with accompanying discussion, is an effort to report the specific responses of the participants as to what caused patients and families fear and anxiety, and what nursing actions they saw as helpful to them in decreasing their fear and anxiety. From the nurse's point of view, the data shows what nurses saw as causing patient and family fear and anxiety, and what actions they performed that helped to decrease patient and family fear and anxiety.

Patient responses were fairly equally distributed when asked whether they experienced fear and anxiety upon admission to the critical care unit. Twenty-four (24) or 52% admitted they experienced feelings of fear and anxiety, while twenty-one (21) or 46% denied these feelings. This finding may have influenced some patient responses to other questions in the study, as examination of other Tables shows.

Family responses show that the majority, or 94%, experienced fear and anxiety when their family member was admitted to the critical care unit. Twenty-nine of the thirty-one family members responded yes to question 1 on the questionnaire, "Did you experience fear, worry or concern when your loved one was admitted to the Intensive-Coronary Care Unit?" The majority of nurses also saw admission of patients to the critical care unit as a time of fear and anxiety for patient and family. Sixty-two (62) or 98% of the nurses responded yes to Statement 1 on the nurse questionnaire, "Patients and families are fearful and anxious when

the patient is admitted to the Intensive-Coronary Care Unit." Data is presented in Table 1 below.

Table 1

PATIENT FAMILY NURSE RESPONSES INDICATING THAT
ADMISSION TO CRITICAL CARE UNIT PRODUCES
FEELINGS OF FEAR AND ANXIETY

	YES	NO	DON'T KNOW	TOTAL
Patients N = 46	24 (52%)	21 (46%)	1 (2%)	46 (100%)
Families N = 31	29 (94%)	2 (6 %)		31 (100%)
Nurses N = 63	62 (98%)		1 (2%)	63 (100%)

In answer to study question 1, "What do patients indicate causes them fear and anxiety during the acute illness," twelve patients or 26% responded that they were not fearful or anxious. Ten patients or 22% reported that they feared death. Ten patients stated that the "unknown" caused them to experience fear and anxiety, and eight patients reported the "fear of being incapacitated" as causing them fear and anxiety. Responses are reported in Table 2 on page 29.

Table 2

RESPONSES INDICATING WHY PATIENTS FELT FEAR AND ANXIETY
DURING ACUTE PHASE OF ILLNESS

PATIENT'S REASON for FEAR AND ANXIETY	Number	% of Patients Responding	% of Total Responses
Not worried	12	26.0	22%
Fear of death	10	22.0	18%
Fear of the unknown	10	22.0	18%
Fear of incapacitation	8	17.0	15%
The sudden serious illness	6	13.0	11%
Concerned about the family	4	9.0	7%
Other	4	9.0	7%
Total responses*	54		98%

* Some patients reported more than one reason for experiencing fear and anxiety.

Reasons given under other were:

1. Either you get better or you don't
2. Financial worries
3. Was lonely
4. No answer

When patients were asked if they continued to have fear and anxiety after admission to the critical care unit, twenty (20) or 43% of the patients responded that they continued to have these same fears and anxieties; eighteen (18) or 39% reported that they no longer felt this same fear and anxiety. Data is presented in Table 3 below.

Table 3

CONTINUATION OF EXPERIENCING FEAR AND ANXIETY
AFTER ADMISSION TO THE CRITICAL CARE UNIT

RESPONSES	PATIENT No.	PATIENT %	FAMILY No.	FAMILY %
Yes	20	43%	14	45%
No	18	39%	16	52%
Don't think so	3	7%	1	3%
No answer	3	7%		
Other	2	4%		
Total	46	100%	31	100%

The two patients who responded other gave the following reasons:

1. If anything can be done, it will be.
2. They should get on with the care.

Factors that did not assist the patient to lessen his fear and anxiety were reported as follows: Thirty-two or 70% of the patients

reported "nothing" took place that did not assist them to lessen their fear and anxiety in some way. Three patients or 7% reported that the lack of information given them in the emergency room and the critical care unit was not helpful. A third factor that was not helpful was the lack of understanding and concern shown patients by the staff. Results of this data are reported in Table 4.

Table 4

CONTRIBUTING FACTORS TO PATIENTS' FEAR AND ANXIETY

PATIENT RESPONSES	Number	%
Nothing	32	70%
Lack of information in the emergency room and critical care unit	3	7%
Lack of staff under- standing and concern	3	7%
Concern for family	2	4%
Dependence on staff	2	4%
Other	4	8%
Total	46	100%

Other reasons cited were:

1. The bed

2. Personal home problems
3. Don't know
4. No answer

Family responses to the second study question, "What did family members indicate as being fear or anxiety provoking . . .", are similar to those of patients above. Nine(9) or 29% of the family members reported their greatest fear was that of the possible death of their relative. A second cause of fear for the family was the "unknown"; seven (7) or 22% of the family members reported this as a factor. The number and percentage of responses are found in Table 5 on page 33.

Table 5

NUMBER AND PERCENT OF REASONS WHY FAMILY MEMBERS FELT
FEAR AND ANXIETY DURING THE ACUTE PHASE OF ILLNESS

Family Reasons for Fear and Anxiety	Number	% of Families Responding	% of Total Responses
Fear of death	9	29%	24%
The unknown	7	22%	19%
Not worried	5	16%	14%
Fear of incapacitation	4	13%	11%
The sudden serious illness	4	13%	11%
Concerned about the family	4	13%	11%
Unable to assist their spouse	2	6%	6%
No answer	1	3%	3%
Total Responses*	36		99%

* Some family members stated more than one reason.

When the family was asked if they continued to experience fear and anxieties after the patient was admitted to the critical care unit, sixteen or 52% responded no, while fourteen or 45% responded yes. Data is found in Table 3 on page 30.

In response to the question, "What did not help you lessen your

fear, worry or concern?", eight (8) or 25% of the family members responded "nothing" took place that did not help them. The seriousness of the illness was reported by five or 16% of the family members as causing them sustained fear and anxiety after the patient was admitted to the critical care unit. Four family members stated that the lack of information in the emergency room and the critical care unit was not helpful to them in decreasing their fear and anxiety. Data is presented in Table 6.

Table 6

CONTRIBUTING FACTORS IN THE FEARS AND ANXIETY EXPERIENCED BY
FAMILY MEMBERS AFTER ADMISSION TO THE CRITICAL CARE UNIT

Family Responses	Number	% of Families Responding	% of Total Responses
Nothing	8	25%	25%
Seriousness of illness	5	16%	16%
The unknown	5	16%	16%
Lack of information in the emergency room and the critical care unit	4	13%	13%
Lack of staff understanding and concern	2	6%	6%
Dependence on staff	2	6%	6%
Other	5	16%	16%
Total Responses	31	98%	98%

The reasons cited under other were:

No answer (4 responses)

Each attack makes the situation worse.

Fifty-four or 85% of the nurses perceived patient and family fear and anxiety to be caused by the equipment and the activity of the unit. Twenty-five or 39% of the nurses saw the element of the "unknown" as fear and anxiety producing for the patient and family. The seriousness of the illness was cited as another factor by nineteen or 30% of the nurses. Ten or 15% of the nurses saw the fear of death as being fear and anxiety producing for the patient and family. Other factors included were: knowing and seeing other patients with similar illness; rudeness of staff members; financial worries; and fear of being incapacitated.

The unfamiliar terminology, the unit disorganization, and the staff insecurity were reported as factors causing patient and family fear and anxiety by three nurses. Data is presented in Table 7 on page 36.

Table 7

FACTORS CAUSING FEAR AND ANXIETY FOR PATIENTS AND
FAMILIES FROM NURSES'S VIEWPOINT

Nurses Responses	Number	% of Nurses Responding	% of Total Responses
The machinery and equipment	28	44.4%	15%
Activity of the unit and large number of people	26	41.2%	14%
The unknown	25	39.6%	14%
The serious sudden illness	19	30.1%	10%
Having no control of situation	15	23.8%	8%
No explanations or incomplete explanations	15	23.8%	8%
Fear of death	10	15.8%	5%
Knowing and seeing others with similar illness	10	15.8%	5%
Rudeness and lack of staff interest	10	15.8%	5%
Fear of incapacitation	7	11.1%	4%
Financial worries	6	9.5%	3%
New media	5	7.9%	2%
Unfamiliar terminology	3	4.7%	2%
Disorganization and insecu- rity of staff	3	4.7%	2%
Total responses*	182		97%

* Some nurses stated more than one reason.

An examination of Tables 2, 5 and 7 reveals similarities in some instances. Patients, family members and nurses recognize that the "unknown" causes fear and anxiety. Seven patients and family members reported this factor, while twenty-five nurses recognized this as a factor. The "fear of death," was reported by eight patients, nine family members and ten nurses. "Fear of incapacitation" was reported by seven patients, four family members and seven nurses. Six patients saw the suddenness of the illness as causing them fear and anxiety, and this was also reported by four family members. Nineteen nurses reported this as a cause for patient and family fear and anxiety. No patient or family member reported the machinery or unit activity as a cause of fear or anxiety.

In response to the question of what helped the patient and the family members overcome their feelings and thoughts of fear and anxiety, fifteen or 32% of the patients reported that they began to improve and this was a help to them. Nine or 29% of the family members reported that the care their family member received was a help to them in decreasing their fear and anxiety. Being able to accept the illness was reported as a help by eight or 17% of the patients and three or 9% of the family members. Five patients stated that there was no change in their thoughts and feelings concerning their fear and anxiety after their admission. Six family members also reported no change in their thoughts and feelings concerning fear and anxiety about the illness

after admission. Three patients indicated that they were unable to discuss their thoughts and feelings, and when asked what caused them to experience relief from their fears and anxiety, they stated that they "harbored them." Data is presented in Table 8 below.

Table 8

MEANS WHICH AIDED PATIENTS AND FAMILIES TO OVERCOME
THOUGHTS AND FEELINGS OF FEAR AND ANXIETY

Patient/Family Responses	Patient Number	% of Patients Responding	Family Number	% of Families Responding
Improvement in condition	15	26%	4	13%
Accepted illness	8	17%	3	9%
No change	5	10%	6	19%
None, fears and anxiety just left	4	8%	1	3%
Was not concerned	3	6%	-	-
Harbored them (Unable to discuss)	3	6%	-	-
Relieved because of care given to patient	-	-	9	29%
No answer	8	17%	4	13%
Other	-	-	4	13%
Total Responses	46	100%	31	100%

Four family members responded "Other" to the question. Reasons given were:

1. The panic is lessening.
2. God is in control.
3. I had to be strong.
4. Able to talk with friends and other family members.

When the patient and family members were asked how this illness affected their work, nineteen or 41% of the patients responded that it would not affect their jobs. Ten family members also reported that the illness would not affect their jobs. Eleven or 24% of the patients saw the illness as affecting their jobs, while ten or 32% of the family members saw the illness affecting their jobs. Table 9 on page 40 indicates the number and percentage of responses.

Table 9

PATIENT AND FAMILY PERCEPTION OF HOW ILLNESS
AFFECTS THEIR JOBS

Patient/Family Responses	Patient Number	Patient %	Family Number	Family %
Will not affect my job	19	41%	10	32%
Will affect my job	11	24%	10	32%
Don't know	8	17%	3	9%
Retired	4	9%	-	-
Will stop working	-	-	2	6%
Need to be more supportive and accepting of spouse	-	-	4	13%
Other	4	9%	2	6%
Total Responses	46	100%	31	98%

Other reasons reported by patients were:

1. Self-awareness was increased and they would seek advice from knowledgeable others as to how best to care for themselves in the future. (2 responses)

2. Need to change residence.

3. I have brains to figure that out.

Family members gave the following reasons why this illness would

affect their jobs.

1. Our life will be more complicated.
2. Will continue to be worried.

In response to how this illness affected their diet, twenty or 43% of the patients responded that they did not know. Fifteen or 33% of the patients stated they would not need to make any dietary changes. Data is presented in Table 10 below.

Table 10

WHAT DIETARY CHANGES DO PATIENTS FORESEE BECAUSE OF ILLNESS

Responses	Patient Number	Patient %
Don't know of any	20	43%
None	15	33%
Will need to make some changes	9	20%
Other	2	4%
Total Responses	46	100%

The two other reasons reported were:

1. I can figure that out.
2. I will seek advice on what is best for me.

Family members did not respond to this part of the questionnaire

nor did they respond as to how this illness would affect the patient's exercise regimen.

When the patient was asked if he would need to make changes in his exercise program, fourteen reported that they would have to make no changes. Thirteen or 28% of the patients reported that they would have to "slow down." Twelve or 26% of the patients did not know if they would need to change their exercise programs. The number and percentage are reported in Table 11 below.

Table 11

CHANGES IN EXERCISE REGIMEN PATIENTS FORESEE NECESSITATED BY ILLNESS

Patient Responses	Patient Number	Patient %
Will have to make none	14	30%
Will have to slow down	13	28%
I don't know	12	26%
In some ways, (change residence)	5	11%
Other	2	4%
Total Responses	46	99%

Again, the two reasons reported under other were:

1. I can figure that out for myself.
2. I will seek advice.

When asked how ill the patients thought they were, twenty-seven or 59% responded that they were severely ill. Twenty-four or 77% of the family members also saw the illness as severe. Data is presented in Table 12 below.

Table 12

SEVERITY OF ILLNESS AS PERCEIVED BY THE PATIENT AND FAMILY

Patient/Family Responses	Patient Number	% of Patients Responding	Family Number	% of Family Responses
Severely ill	27	59%	24	77%
Moderately ill	12	26%	2	6%
Mildly ill	6	13%	4	13%
No answer	1	2%	1	3%
Total Responses	46	100%	31	99%

When patients and family members were asked at the time of the interview how they felt, thirty-one or 67% of the patients responded "better." The majority of family members, twenty-three or 74%, felt "reassured." Table 13 on page 44 indicates the responses given.

Table 13

RESPONSES TO PHYSICAL AND EMOTIONAL WELL BEING
AT TIME OF INTERVIEW

Patient/Family Responses	Patient Number	Patient %	Family Number	Family %
Better	31	67%	4	13%
Weak	6	13.0%	-	-
Reassured	5	11.0%	23	74%
Anxious	3	7.0%	4	13%
Angry	1	2.1%	-	-
Total Responses	46	100%	31%	100%

Ways in which patient fear and anxiety was decreased are found in Table 14, page 45. Twenty-nine patients, or 63%, stated that their confidence in the staff was a help to them in decreasing fear and anxiety. Twenty-six patients or 56% reported that treatments, medications, and just feeling better physically proved helpful to them.

Table 14

FACTORS THAT HELPED PATIENTS DECREASE FEAR AND ANXIETY

Patient Responses	Number	% of Patient Responses	% of Total Responses
Confidence in staff	29	63%	41%
Physically more comfortable (Medications-Treatments.)	26	56%	36%
Religion	5	11%	7%
Resignation to illness	4	9%	5%
Explanations	3	6%	4%
Not worried	4	9%	5%
Total Responses*	71		98%

* Some patients stated more than one factor as being helpful to them in decreasing their fear and anxiety.

Table 15 presents factors that the family found helpful in decreasing fear and anxiety. Twenty-one or 68% of the family members reported that their confidence in the staff was helpful in decreasing their fear and anxiety. Ten or 32% of the family members reported that seeing the patient more comfortable was helpful, while six or 19% were aided by the explanations of the nurses.

Table 15

FACTORS THAT HELPED FAMILIES DECREASE FEAR AND ANXIETY

Family Responses	Number	% of Families Responding	% of Total Responses
Confidence in staff	21	68%	48%
The patient was physically more comfortable	10	32%	23%
Explanations that were given	6	19%	13%
Religion	4	13%	9%
Fear and anxiety was not decreased	<u>3</u>	7%	<u>7%</u>
Total Responses*	44		100%

*Some family members stated more than one factor as being helpful to them in decreasing their fear and anxiety.

Nursing activities that assisted the patient to decrease his fear and anxiety were reported as follows: Twenty-one or 45% of the patients stated that nurses did everything they could for them, while twelve or 26% of the patients stated that their constant attention was helpful. That nurses were kind, thoughtful and courteous was reported as helpful by ten patients, or 22%. Seven or 15% of the patients were aided by the nurses' calmness and efficiency. Five or 11% of the patients re-

ported that explanations of treatments and procedures was helpful.

Data is presented in Table 16.

Table 16

NURSING ACTIVITIES THAT ASSISTED PATIENTS TO DECREASE
FEAR AND ANXIETY FROM PATIENTS VIEWPOINT

Patient Responses	Number	% of Patient Responses	% of Total Responses
They did everything they could for me	21	45%	35%
They were in constant attendance	12	26%	20%
They were kind, thoughtful and friendly	10	22%	17%
They were calm and efficient	7	15%	12%
They explained treat- ments and procedures	5	11%	8%
They encouraged me	4	8%	7%
Total Responses*	59		99%

* Some patients reported more than one nursing activity that assisted them.

The nursing activities that were of greatest assistance to the family were the explanations they were given about treatments and procedures. Twelve family members or 39% cited this. The kindness,

thoughtfulness and friendliness of the nurses was reported as helpful by eight family members, or 26%. Five or 16% of the family members reported the nurses' calmness and efficiency as being helpful to them in decreasing their fear and anxiety. The number and percentage of responses are found in Table 17.

Table 17

NURSING ACTIVITIES THAT ASSISTED FAMILIES TO DECREASE
FEAR AND ANXIETY FROM FAMILY VIEWPOINT

Family Responses	Number	% of Families Responding	% of Total Responses
They explained treatments and procedures	12	39%	34%
They were kind, thoughtful and friendly	8	26%	23%
They were calm and efficient	5	16%	14%
None	3	9%	8%
No answer given	3	9%	8%
They did everything they could for me	2	6%	6%
They were in constant attendance	2	6%	6%
Total Responses*	35		99%

* Some family members gave more than one reason for nurses being of assistance.

In response to the open-ended questions, nurses saw explanations and teaching patients and families as the most meaningful way in which they could assist to decrease fear and anxiety. Fifty nurses, or 79%, cited this as being helpful. Talking and listening to patients and families was reported by thirty-five or 55% of the nurses as being helpful to patients and families. Another factor nurses saw as being of assistance was that of being approachable, showing concern and understanding for them. Twenty-nine nurses or 46% cited this response. Treating the patients and families as human beings was a factor reported by twenty-seven nurses, or 43%, as being helpful to patients and their families in decreasing fear and anxiety. Nursing data is reported in Table 18 on page 50.

Table 18

NURSING ACTIVITIES THAT ASSIST PATIENTS AND FAMILIES
TO DECREASE FEAR AND ANXIETY FROM NURSES VIEWPOINT

Nurse Responses	Number	% of Nurses Responding	% of Total Responses
Explaining and teaching	50	70%	26%
Talking and listening to them	35	55%	18%
Being approachable and showing concern and understanding	29	46%	15%
Treating them as human beings	27	43%	14%
Being efficient, self- confident and calm	20	32%	10%
Answering questions honestly	13	21%	7%
Giving reassurance	12	19%	6%
Having in-service and staff development classes to assist the nurse to meet patient, family and staff needs	7	11%	3%
Relieving fear and anxiety after transfer from unit	1	1%	0.5%
Total Responses*	194		99.5%

* Some nurses reported more than one reason.

In regard to the check list of statements, sixty-two or 98% of the nurses reported that explaining the equipment would be helpful to decreasing patient and family fear and anxiety.

Sixty-one or 97% of the nurses saw visiting with the patient and family as helpful in decreasing their fear and anxiety.

Sixty or 95% of the nurses saw pre and post operative teaching as helpful, while fifty-seven or 90% reported coronary teaching as being helpful.

Explaining how the patient was doing and conveying concern for the patient and family was reported as helpful by 58 or 92% of the nurses.

Fifty-four or 86% of the nurses reported that explaining to the patient and family that pain would recur; requesting family assistance in planning care for the patient would be helpful. Fifty-four or 86% of the nurses saw themselves as the most likely persons to assist the patient and family to decrease their fear and anxiety.

Protecting the patients and families from seeing and hearing other patients was reported as helpful in decreasing fear and anxiety by fifty-three or 84% of the nurses.

Fifty or 79% of the nurses reported that allowing the family to "peek" at the patient if he/she were asleep was helpful.

Thirty-one or 49% of the nurses saw protecting the patients and families from overhearing nurses talking with other patients and family

members as being helpful.

Allowing the family to remain at the bedside outside of visiting hours was seen as helpful by twenty-three or 36% of the nurses. Twenty-two or 35% of the nurses reported this was not helpful. This data is presented on Table 19, pages 54 and 55.

An examination of the open-ended nurse data in Table 18 on page 50 and the closed-ended nurse data in Table 19, pages 54 and 55, reveals some similarity in responses.

Fifty or 79% of the nurses responded that nurses assisted the patient and family in decreasing fear and anxiety through teaching and explanations. In response to the list of statements, sixty-two or 98% of the nurses stated that explaining equipment being used was helpful. Sixty or 95% stated that pre and post operative teaching was helpful, and fifty-seven or 90% stated that coronary teaching was helpful. Fifty-eight or 92% of the nurses reported that explaining how the patient was doing was helpful in decreasing patient and family fear and anxiety, while fifty-four or 85% of the nurses reported that explaining to the patient and family that things such as pain would recur was helpful.

Thirty-five or 55% of the nurses stated in the open-ended questions that talking and listening to the patient and family was helpful in assisting the patient and family to decrease fear and anxiety. Twenty-seven or 43% of the nurses stated that treating the patient and the

family members as human beings would be helpful. In the close-ended questions, sixty-one or 97% of the nurses reported that visiting with the patient and family would be helpful.

Twenty-nine or 46% of the nurses stated in the open-ended questions that being approachable and showing concern and understanding was helpful to the patient and family in decreasing their fear and anxiety. Fifty-eight or 92% of the nurses responded that this would be helpful in the close-ended questionnaire.

Table 19

NURSING ACTIONS NURSES PERCEIVE AS HELPFUL IN DECREASING
PATIENT AND FAMILY FEAR AND ANXIETY

Nursing Response Statements	Strongly agree Agree Yes		Slightly agree Slightly disagree Don't know		Strongly disagree Disagree No		No answer		Total %
	No.	%	No.	%	No.	%	No.	%	N=63
1. Explaining equipment used in care of family member	62	98.0	1	2.0					100
2. Visiting with patient and family	61	97.0	2	3.0					100
3. Doing pre and post operative teaching	60	95.0	1	2.0			2	3.0	100
4. Explaining how the patient is doing	58	92.0	4	6.0			1	2.0	100
5. Conveying concern ver- bally and non-verbally	58	92.0	2	3.17	1	2.0	2	3.0	100
6. Allowing patient to control environment as much as possible	57	90.0	6	10.0					100
7. Doing coronary teaching when vital signs are stable	57	90.0	2	3.17	2	3.1	2	3.1	99
8. Explaining to them that pain may recur	54	85	7	11.0	1	2.0	1	1.0	100

Table 19
(continued)

Nursing Response Statements	Strongly agree Agree Yes		Slightly agree Slightly disagree Don't know		Strongly disagree Disagree No		No answer		Total %
	No.	%	No.	%	No.	%	No.	%	N=63
9. Requesting family assistance in preparing care plan	54	85.0	7	11.0	1	2.0	1	2.0	100
10. Nurses are the most likely persons to help patients and families overcome fear & anxiety	54	85.0	9	14.0					99
11. Protecting patient and family from seeing and hearing other patients	53	84.0	9	14.0	1	2.0			100
12. Allowing family to "peek" at patient if he/she is asleep	50	79.0	12	19.0	1	2.0			100
13. Protecting patient and family from overhearing nurse conversation with other patients	31	49.0	23	36.0	8	13.0	1	2.0	100
14. Allowing the family to remain outside of visiting hours	23	36.0	17	27.0	22	35.0	1	2.0	100

-55-

An examination of tables 16, 17, 18, and 19 indicates that patients, families and nurses saw that being kind, thoughtful and friendly was a help in decreasing patient and family fear and anxiety. Receiving explanations and teaching about the illness, the treatments and procedures was also seen as helpful by family members and nurses, and to a lesser degree by the patient. Another factor reported by the patient and family as being helpful in decreasing fear and anxiety was the nurses' calm, efficient manner. This was also reported by the nurses. Nurses also reported honesty and reassurance as being helpful in decreasing patient and family fear and anxiety.

When the patient and family member was asked "How could the nurses be more helpful?", the majority of patients, forty-three or 93%; and twenty-two or 71% of the family members responded that they could not have been more helpful. Six patients, or 13%, and seven or 23% of the family members stated that nurses could have been more helpful by giving more explanations and teaching. Data presented in Table 20 on page 57 gives the number and percentage of responses for each group.

Table 20

WHAT NURSING ACTIVITIES COULD NURSES PERFORM THAT WOULD BE MORE HELPFUL IN
DECREASING PATIENT AND FAMILY FEAR AND ANXIETY

Patient/Family Responses	Patient Number	% of Patients Responding	% of Total Responses	Family Number	% of Family Responses	% of Total Responses
None	43	93%	74%	22	71%	56%
More explanations and teaching	6	13%	10%	7	23%	18%
Better unit staffing	4	9%	7%	1	3%	3%
Being more friendly	4	9%	7%	5	16%	13%
No opinion/answer	1	2%	2%	4	13%	10%
Total Responses*	58		100%	39		100%

-57-

*Some patients and family members gave more than one response.

When patients were asked if nurses showed an interest in them and how they conveyed this, twenty-five or 54% of the patients responded by the things they did for me. Fourteen or 30% of the patients stated that nurses showed interest in them by their kindness and courtesy. One patient stated that he did not know, and another patient stated that nurses did not show any interest in him. Data presented in Table 21 gives the number and percentage of responses.

Table 21

NURSES VERBAL AND NON-VERBAL BEHAVIOR CONVEYING
TO PATIENTS THEIR INTEREST IN THEM

Patient Responses	Number	% of Patient Responses	% of Total Responses
By the things they did for me	25	54%	39%
By their kindness, concern and friendliness	14	30%	22%
Respected you, talked with you	10	22%	16%
Smiled and had a sense of humor	7	15%	11%
Were efficient and knowledgeable	5	11%	8%
Did not show an interest in me	1	2%	1%
I don't know	1	2%	1%
No answer	1	2%	1%
Total Responses*	64		99%

* Some patients stated more than one factor as being responsible for nurses' showing an interest in them.

Fourteen or 45% of the family members stated that nurses showed an interest in them by their kindness and courtesy. However, five or

16% of the family members stated that nurses did not show an interest in them, and four did not answer the question. Number and percentages of responses are given in Table 22 below.

Table 22

NURSES VERBAL AND NON-VERBAL BEHAVIOR CONVEYING
TO FAMILIES THEIR INTEREST IN THEM

Family Responses	Number	% of Family Responses	% of Total Responses
By their kindness and concern and friendliness	14	45%	36%
By the things they did for me	7	22%	18%
Respected and talked with me	7	22%	18%
Did not show an interest in me	5	16%	13%
No answer	4	13%	10%
Cared for family member	2	6%	5%
Total Responses*	39		100%

* Some family members stated more than one factor as being responsible for nurses' showing an interest in them.

Twenty-two or 48% of the patients reported that nurses showed an interest in their families by their kindness and courtesy, while thirteen patients or 28%, saw their flexibility in not enforcing vis-

iting hours as a display of interest. Table 23 below presents the number and percentages of responses.

Table 23

NURSES VERBAL AND NON-VERBAL BEHAVIOR CONVEYING TO PATIENTS
THEIR INTEREST IN THEIR FAMILIES

Patient Responses	Number	% of Patient Responses	% of Total Responses
They were kind and courteous	22	48%	41%
Lenient with visiting hours	13	28%	24%
I don't know	9	17%	17%
Explained things to them	3	7%	5%
Relayed messages	3	7%	5%
No answer	3	7%	5%
Talked to me about my family	1	2%	2%
Total Responses*	54		99%

* Some patients reported more than one factor as being responsible for nurses' showing an interest in their families.

The nurse questionnaire utilized in this study allowed for additional comments to be made by the respondents. Twenty-six nurses used this option. Comments can be found in Appendix D.

CHAPTER V

SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

SUMMARY

A purpose of this study was to determine what creates fear and anxiety in a patient and family member when the patient is admitted to the critical care unit. Other purposes of the study were to determine what nurses perceived as the cause for patient and family fears and anxieties and to discover what nursing actions were helpful in reducing fear and anxiety for the patient and family member.

The study was based on data collected from 46 patients interviewed by the investigator. Survey questionnaires were collected from 31 family members related to patients hospitalized in critical care units. Survey questionnaires were also collected from 63 nurses working in critical care units.

The patient and family member questionnaires utilized open-ended communication techniques. The nurse questionnaire used was a combination of open-ended and closed communication techniques. All three questionnaires were developed by the investigator.

The patient and family questionnaires consisted of fifteen open-ended questions. There were nine (9) identifying items on the patient questionnaire. These items identified name, sex, age, marital status, religion, diagnosis, prognosis, medications, and the name of

the hospital to which the patient was admitted. There were five (5) identifying items on the family questionnaire which elicited the family member's name, age, his/her relationship to the patient, religion, and the name of the hospital. The identifying items on the nurse questionnaire elicited age, marital status, working hours, and the name of the hospital which employed her. The names of patients and family members were requested for purposes of possible later comparison of responses.

CONCLUSIONS

With reference to the foregoing data, the following findings were summarized by the investigator.

1. Twenty-four or 52% of the patients interviewed verbalized that they had experienced fear and anxiety upon admission to the critical care unit. Twenty-one or 46% of the patients interviewed denied these feelings.

2. Twelve or 26% of the patients interviewed reported that they were not worried about the illness at the time of interview.

3. Twenty-nine or 94% of the family members surveyed reported that they had experienced feelings of fear and anxiety upon seeing their relative admitted to the critical care unit.

4. Five or 16% of the family members surveyed reported that they were not worried about the illness at the time of interview.

5. Sixty-two or 98% of the nurses surveyed reported that they

viewed admission to a critical care unit as a time of fear and anxiety for both the patient and family members.

6. Patients, family members and nurses agreed that fear of death, fear of incapacitation, fear of the unknown, and the suddenness of the illness precipitated feelings of fear and anxiety for the patient and family.

7. Twenty or 43% of the patients interviewed reported that they continued to experience fear and anxiety concerning their illness after admission to the critical care unit.

8. Fourteen or 41% of the family members surveyed reported that they continued to experience fear and anxiety concerning the illness after their relative was admitted to the critical care unit.

9. Fifty-four or 85% of the nurses surveyed reported that they believed equipment and unit activity was a major factor creating fear and anxiety in the patient and family. No patient or family member reported this as a factor.

10. Other factors that nurses believed could create fear and anxiety in the patient and family were seeing and knowing other patients with a similar illness, staff rudeness, financial worries, unfamiliar terminology, and unit disorganization.

11. Four or 9% of the patients interviewed reported that the unit could be better staffed. This was reported most often in one hospital. One family member also reported this.

12. Fifteen or 26% of the patients interviewed reported that they overcame feelings of fear and anxiety because of physical improvement. Eight or 17% of the patients interviewed reported that they "accepted their illness." Five or 10% of the patients interviewed stated that they experienced no change in their feelings of fear and anxiety. Three or 6% of the patients interviewed stated that they "harbored" their thoughts and feelings of fear and anxiety.

13. Nine or 29% of the family members surveyed reported that they overcame their feelings of fear and anxiety because of the care the patient received. Four or 13% of the family members surveyed reported that they experienced a lessening of fear and anxiety when they saw improvement in the patient's condition. Six or 19% of the family members surveyed reported no change in their feelings of fear and anxiety.

14. Nineteen or 41% of the patients interviewed stated that they did not feel this illness would affect their jobs. Eleven or 24% of the patients interviewed felt that their illness would affect their jobs.

15. Ten or 32% of the family members surveyed stated that the illness of their relative would not affect their (the family members) jobs. Ten or 32% of the family members surveyed felt that the illness of their relative would affect their jobs.

16. Thirty-five or 76% of the patients interviewed reported

that they would have to make no dietary changes because of their illness.

17. Fourteen or 30% of the patients interviewed reported that they would need to make no changes in the amount of exercise they received. Thirteen or 28% of the patients interviewed reported that they would have to "slow down."

18. Twenty-seven or 59% of the patients interviewed reported the illness as severe. Twelve or 26% of the patients interviewed stated that they were moderately ill.

19. Twenty-four or 77% of the family members surveyed reported that they viewed their relative's illness as severe. Four or 13% of the family members reported that they viewed their relative's illness as mild.

20. Thirty-one or 67% of the patients interviewed reported that they felt "better" at the time of interview. Twenty-three or 74% of the family members surveyed reported that they felt "reassured."

21. Twenty-nine or 63% of the patients interviewed stated that their fear and anxiety was lessened because of their confidence in the staff. Twenty-one or 68% of the family members also reported this as being helpful in allaying their fears and anxieties.

22. Thirty-three or 71% of the patients interviewed stated that nurses did everything they could for them and were in constant attendance. This assisted them to decrease their fear and anxiety.

Four or 12% of the family members surveyed reported the same finding.

23. Twelve or 39% of the family members surveyed reported that the verbal explanations nurses gave them were helpful in assisting them to decrease their fear and anxiety. Five or 11% of the patients interviewed reported the same finding.

24. Ten or 22% of the patients interviewed reported that the nurses' kindness, thoughtfulness, and friendliness was helpful to them in decreasing their fear and anxiety. Eight or 26% of the family members surveyed reported this same finding.

25. Sixty-one or 97% of the nurses surveyed reported that they believed that their visiting with the patient and family would be helpful in assisting the patient and family to decrease the fear and the anxiety.

26. Sixty or 95% of the nurses surveyed reported that teaching the patient and family members about the illness, its treatments, and procedures would be helpful in lessening patient and family fear and anxiety.

27. Fifty-six or 89% of the nurses surveyed reported that showing concern, treating the patient and family members as persons, and being approachable would be helpful ways to assist the patients and families to lessen their fear and anxiety.

28. Fifty-four or 85% of the nurses surveyed reported that requesting family assistance in preparing care plans for the patient

would be helpful to allay the patient's and family member's fear and anxiety.

29. Fifty-four or 85% of the nurses surveyed stated that they believed nurses were the most likely persons to help the patient and family members overcome their feelings of fear and anxiety.

30. Fifty or 79% of the nurses surveyed reported that allowing the family to "peek" at the patient if he/she were asleep would be helpful to the family in decreasing their fear and anxiety.

31. Twenty-three or 39% of the nurses surveyed reported that permitting the family to remain with the patient beyond visiting hours would be helpful in decreasing fear and anxiety experienced by both the patient and family member. Twenty-two or 35% of the nurses surveyed reported that this would not be helpful to allay patient and family fear and anxiety.

32. Seven or 11% of the nurses surveyed reported that in-service education would assist them to help patients and families cope with their feelings of fear and anxiety.

33. Forty-three or 93% of the patients interviewed reported that nurses could not have been more helpful to them. Twenty-two or 64% of the family members surveyed also reported this.

34. Thirty-nine or 84% of the patients interviewed reported that nurses showed an interest in them by their nursing activities and kindness. One patient reported that nurses did not show an interest

in him, one patient did not know if nurses were interested in him, and a third patient did not answer the question.

35. Twenty-one or 67% of the family members surveyed reported that nurses showed an interest in them by their kindness, concern and friendliness. Five or 16% of the family members surveyed reported that nurses did not show an interest in them (the family members), and four or 13% of the family members did not answer the question.

36. Twenty-two or 48% of the patients interviewed reported that nurses were kind and courteous to their families. Thirteen or 28% of the patients interviewed stated that nurses showed an interest in their families by being lenient with visiting hours.

IMPLICATIONS FOR NURSING

Based upon the data collected from patients in the critical care unit and their family members, this investigator believes that nurses can alleviate the feelings of fear and anxiety experienced by both the patients and the family members.

It is apparent from this study that survival of the illness is uppermost in the patient's mind. This implies that nurses, knowing this fact, could greatly enhance their nursing abilities by demonstrating empathy and understanding of patients' overt behavior. This in turn would help nurses to plan their approach in a way that would utilize communication techniques which assist patients to express their

fears and anxieties. Nurses must be cognizant of the fact that some patients are reluctant to verbalize their thoughts and feelings of fear and anxiety. Nurses must, therefore, be sensitive to clues given by the patient so that they can perceive his emotional needs.

Nurses should continue to develop their knowledge and skills so that they may function as competent, caring and concerned persons. This inspires confidence in both patients and family members.

Nurses need increased awareness that family members desire information concerning the illness, treatments, procedures, and the patient's progress from the time of admission until the patient is well again. It is helpful if family members are viewed in a positive manner and seen as allies. This creates an effective milieu in which to decrease both patient and family fear and anxiety, as this better enables the family member to be supportive to the patient.

Nurses are aware of the fact that teaching is an important aspect of patient care. Sixty or 95% of the nurses surveyed reported this finding. However, only five or 11% of the patients interviewed reported that teaching and explanations about the illness would be helpful to them in decreasing their fear and anxiety. Twelve or 39% of the family members surveyed reported that teaching and explanations would be helpful to them (the family members).

RECOMMENDATIONS FOR NURSING

Based upon the findings and implications, it is recommended that:

1. Continued emphasis should be given to teaching nurses the necessity of treating the total patient, meeting his psychological and physiological needs. Continued efforts to create a personalized atmosphere for the patient are necessary and individualized care is very important.

2. In-service education should be provided for nurses working in the critical care unit to enable them to become proficient in recognizing and handling the emotions of fear and anxiety which patients, families, and staff may exhibit. New personnel should be well oriented and possess nursing skills and abilities which will enable them to care efficiently for critically ill patients and their families.

3. Teaching and explanations about the illness, the patient's progress, and the family's role in the care of the patient should be provided for the patient and family soon after the patient's admission to the critical care unit. Brief explanations of the illness, the treatment regimen, and procedures should be given to the patient and the family members upon the admission of the patient to the critical care unit. It should be kept in mind that elaborate explanations are unrealistic, as both patients and family members cannot absorb extensive

amounts of instruction. Nurses must, therefore, be alert as to when the patient and family member is ready to accept and assimilate more detailed information about the illness.

4. Family members should be seen as resource persons concerning the patient's needs, likes and dislikes. They should be allowed to assist the patient with minor nursing activities such as shaving and feeding the patient.

5. This study should be replicated in three years to compare and validate these findings. A similar study should be undertaken using one hospital over a longer period of time to provide more consistency and depth of findings.

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APPENDIX - A

PATIENT QUESTIONNAIRE

NAME _____

AGE _____ MARITAL STATUS _____

RELIGION _____

SEX _____

DIAGNOSIS _____

PROGNOSIS _____

TRANQUILIZERS _____

HOSPITAL _____

1. On admission to the Intensive or Coronary Care Unit, did you experience (have) fear, worry, or concern, about your illness? Could you relate it?

2. Tell me about your feelings, your thoughts, when you became ill.

3. Did you have these same feelings, thoughts, later? (After your operation, or when you began to feel better?)

4. Could you explain what these thoughts and feelings were?

5. What happened to these thoughts or feelings?
6. How do you feel now?
7. How does this illness affect you? Will you change your work patterns, diet changes, exercise programs?
8. How would you rate the severity of your illness?
9. What caused you to lessen your worry, concern, or fear?
10. What did not diminish (lessen) your fear, worry, or concern?

11. In what ways were the nurses helpful in lessening your fear, worry, or concern? (How did they help you during your illness?)

12. In what ways could the nurses have been more helpful?

13. In what ways were the nurses not helpful in assisting you in lessening the fear, worry, or concern you felt during your illness?

14. In what ways did the nurses show an interest in you?

15. In what ways do you feel the nurses showed an interest in your family?

APPENDIX - B

FAMILY MEMBER QUESTIONNAIRE

INSTRUCTION SHEET FOR FAMILY QUESTIONNAIRE

This list of fifteen (15) questions is presented to you as a research study as part of the requirement of Masters in Nursing.

It is presented to you to determine your attitude about how you feel nurses met the needs of your family member in the Intensive or Coronary Care Unit.

Take as much time as you need to complete the questionnaire. Please complete all pages, answering all the questions, and please feel free to make any comments on the back of the pages if you so desire. The questionnaire will take approximately fifteen to twenty minutes to complete.

Your name is requested only for the purpose of comparing your answers with those of your loved one. No names will be used in the tabulation of results and in no way will anyone know who is responding to the questions.

My sincere appreciation is expressed to you for taking time to complete this questionnaire and for the sincerity of your answers.

Thank you.

NAME _____

RELATIONSHIP TO PATIENT _____

RELIGIOUS PREFERENCE _____

AGE _____

HOSPITAL _____

1. When your family member was admitted to the Intensive or Coronary Care Unit, did you experience (have) fear, worry or concern about his (or her) illness?

2. Could you relate it?

3. Could you explain your feelings, thoughts, at that time?

4. Did you have these same thoughts and feelings later when he/she was settled and free from pain, or after the operation?

5. Could you explain what these thoughts and feelings were?

6. What happened to these thoughts or feelings?

7. How do you feel now? (About your loved one's progress, your feelings, and how he is getting along?)

8. How does this illness affect you? (Work plans, school plans, and so forth)

9. How would you rate the severity of this illness?

10. What caused your worry, concern or fear to diminish?

11. What did not diminish your fears, worry, or concern?

12. In what ways were the nurses helpful in lessening your fear, worry, or concern? (How did they help you during this illness?)

13. In what ways could the nurses have been more helpful?

14. In what ways were the nurses not helpful in assisting you in lessening your fear, worry and concern?

15. In what ways did the nurses show an interest in you?

APPENDIX - C

NURSE QUESTIONNAIRE

INSTRUCTION SHEET FOR NURSE OPINIONNAIRE

This list of fifteen (15) statements is presented to you as a research study as part of the requirement of Masters in Nursing.

It is presented to you to determine your attitudes about the psychological needs of patients and families during the patients' stay in the Critical Care Unit.

Take as much time as you need to complete the opinionnaire. Please complete all four pages and feel free to make any comments on the back of the sheets. The opinionnaire will take approximately twenty to twenty-five minutes to complete.

You are not asked for your name; the results of the opinionnaire will be tabulated in such a way as to insure complete confidentiality to the person who is responding.

My sincere appreciation is expressed to you for taking the time to complete this opinionnaire and for the sincerity of your answers.

Thank you

NURSE OPINIONNAIRE

AGE _____ SEX _____ MARITAL STATUS (PLEASE CIRCLE ONE) Single Married Div. Widow

HOSPITAL _____ DO YOU WORK FULL TIME? PART TIME? (CIRCLE ONE)

PLEASE INDICATE THE NUMBER OF DAYS YOU WORK PART TIME _____

Below are several statements that pertain to patient and family fear and anxiety. Please indicate in the columns on the right-hand side of the page how you feel about each statement.

	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
1. Patients and their families are fearful and anxious when the patient is admitted to the Intensive Care or Coronary Care Unit.						
2. In your opinion, would the following allay fear and anxiety patients and families experience?						
A. By explaining to them the reasons for the equipment that is being used. (Monitors, respirators, etc.)						
B. Explaining to them the outcome of the treatment started, such as that pain may recur after hypodermic and to report it.						

	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
C. Explaining how the patient is doing. (That his heartbeat is all right and so forth.)						
D. Requesting the family's assistance when preparing the care plan.						
E. Allowing the family to remain at the bedside outside of visiting hours.						
F. Allowing the family to "peek" at the patient if he or she is asleep.						
G. Visiting with the patient and family.						
H. Conveying concern for them through non-verbal as well as verbal communication.						
I. Allowing the patient to control his environment to some degree. (Bath time, etc.)						
J. Protecting the patient and family from seeing and hearing other critically ill patients.						
K. Protecting the patient and family from hearing the nurse talk with and to other patients.						

	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
3. Pre and Post Operative teaching aids in lessening fear, anxiety and concern.						
4. Coronary teaching, when vital signs are stable, aids in allaying fear and anxiety and concern.						
5. Nurses are the most likely persons on the health care team to give patients and families assistance in overcoming fear, anxiety and unnecessary concern.						

PLEASE COMPLETE THE FOLLOWING:

6. Do you feel a person can "SEE" fear and anxiety in patients and family members or are these emotions too masked?

7. Do you feel that as nurses we can meet and decrease fear and anxiety for the patient and family? Please elaborate.

8. What types of things do you feel cause patients and families to experience fear and anxiety?

9. How do you think we as nurses can lessen the patient and/or family anxiety, fear level?

APPENDIX - D

VERBATIM NURSE RESPONSES

NURSE RESPONSES TO ADDITIONAL COMMENTS
ON NURSE QUESTIONNAIRE

The following are examples of responses made to each statement on the check list of the nurse questionnaire.

Statement 1. Patients and their families are fearful and anxious when the patient is admitted to the intensive or coronary care unit.

"Yes if it is totally unfamiliar to them.

Statement 2. In your opinion, would the following allay fear and anxiety patients and families experience?

Part A.) By explaining to them the reasons for the equipment that is being used. (Monitors, respirators, etc.)

"Would help but by itself could not completely alleviate the patients and families anxiety."

"Depends on if the patient and family are able."

"Not all patients and families can comprehend the use of equipment. Therefore may feel they are never going to get well."

"A very brief explanation of equipment, etc. is offered to the new admission if he is having severe pain. A more elaborate explanation is offered as the patient stabilizes. Hopefully someone can be offering emotional support and explanations to the family immediately."

Part B.) Explaining to them the outcome of the treatment started, such as that pain may recur after hypodermic and to report it.

"Circumstantial"

"In some cases"

"Would help but by itself does not alleviate completely the patients or families anxiety."

"Psychological judgement is used here. Some patients may not wish to know the outcome of any treatment."

Part C.) Explaining how the patient is doing. (That his heart-beat is all right, and so forth.)

"Would be helpful, but by itself cannot alleviate the patient's and families' anxiety."

"Partial explanation"

"Needs frequent repetition."

"Depending on the situation."

"However, more tactful. A patient may not have known something was wrong with his heart. However, if he id, it would allay some anxiety."

"A brief comment like 'sounds good,' or 'normal' after checking vital signs is reassuring."

Part D.) Requesting the family's assistance when preparing the care plan.

"Would be helpful; however, by itself it cannot completely alleviate patients' and families' anxiety."

"But time is a factor that doesn't always permit this -- (not practical)."

"Depends on some families."

"Involve family but take care not to overwhelm them too much. Feeling of contribution is what is important."

"Family is usually unrealistic about patient's capabilities while he is in intensive or coronary care."

"Depends on the family"

"To convalescence, the family is extremely important in the care. The first few days can be a hindrance."

"Depends on the family"

Part E.) Allowing the family to remain at the bedside outside of visiting hours.

"Should not be abused. Only when the patient's condition is stable enough, that family are helping rather than hindering care."

"Circumstantial"

"Depends on the patient and condition."

"Only if the patient is very unstable or soon to die."

"There are circumstances with individual patients when it should be allowed, but not as a general rule."

"Depends on the circumstances. (Child, etc.) Circumstances and the patient's situation dictates. Some families increase patient's anxiety and overtire them."

"Only for short periods."

"Very short spaced visits."

"Depends on the time of day."

"Disagree -- the patient becomes too tired."

"Family visiting privileges must each be considered on a totally individual basis. Allowing extra visiting privilege can be very therapeutic, it can be detrimental to the patient, therefore there cannot be any pat rule in this area."

"Usually the patient needs care and rest between visiting hours."

"Some family members can help by staying with the patient but I believe basically in restricting patient's visiting times."

"Depends on the family. Yes, I agree if their presence is helpful to the patient. If they are apprehensive and in turn relate the apprehension to the patient, then I enforce strict visiting hours after talking to the family"

relating to them it is best for the patient--a loved one."

"Unless the patient is definitely terminal, the continued presence of family at the bedside seems contraindicated. Many times the patient seems to feel that he should visit with family and cannot settle down and sleep."

"Within limits."

"Generally. Families are at times quite anxiety producing. They worry in the room and cause the patient worry. Also they exhaust and tire the patient, who generally is too sick or too kind to ask them to leave. True, in some cases a family member present at the bedside can be calming, but this is certainly an exception and the family member must also be exceptional."

Part F.) Allowing the family to "peek" at the patient if he or she is asleep.

"If it does not interfere with work."

"If you can depend upon them not to awaken. You can learn this readily."

"Depends on circumstances."

Part G.) Visiting with the patient and family.

"A closer and more trusting relationship develops between family and patient if the nurse visits and tries to know and understand each situation other than bedside care. Helps the nurse keep an individual attitude toward patient and family."

"Aids the family, especially when non-verbal cues are used."

"Visiting with the family as well as the patient has strong merit once the family understands what is happening and can be given reassurance, ultimately they in turn can help comfort and reassure their loved ones. When the patient sees that his family is relaxed and expresses confidence he invariably loses some of his fear which speeds his road to recovery."

Part H.) Conveying concern for them through non-verbal as well as verbal communication.

"Our concern can frighten family, so be careful. Must be tempered with hope and self-confidence."

"The warmth and concern, the presence of oneself, touching your patient or just holding his hand with no verbal communication can mean ever so much and can be even more therapeutic than many drugs you may administer."

"Don't understand the question entirely."

Part I.) Allowing the patient to control his environment to some degree. (Bath time and so on.)

"This is rather difficult to do at times."

"Circumstantial"

"Time does not always permit."

"This is fine in theory but not always possible with a heavy work load."

"Within reason."

"It seems certain routines have to be met to have a smooth functioning unit. However, they should never become so ritualistic and time oriented that they do not allow for fluctuation of the patient's needs and desires."

Part J.) Protecting the patient and family from seeing and hearing other critically ill patients.

"In case of a death in the unit, other patients are aware of this, even though they are in separate rooms. I feel that if the other patients inquire about the expired patient's condition, honesty is the best policy. They will find out about the death anyway. Even if they don't ask any questions, you can tell if they know what has occurred, and I feel it may be well to offer them the opportunity to talk about it, or even open the subject yourself."

"Depending on unit set-up. It is sometimes very hard to do. Nurses must be most careful regarding conversation around others if patients are in the room."

"As much as possible, but sometimes this is impossible in open area."

"Depends on circumstances, patient's personality."

"Impossible to do in intensive and coronary care unit. Unrealistic."

"Not always possible in semi-private room."

Part K.) Protecting the patient and family from hearing the nurse talk with and to other patients.

"It may do some patients good to know that there are other sick people who are getting well. It's also good to hear a nurse talk to an unconscious patient. They are still human. Other people realize this and feel better."

"Difficult to do in close quarters."

"Impossible with this set-up."

"Not always possible in semi-private room."

"If physical facilities were such as to provide privacy then this is practical."

Statement 3. Pre and post operative teaching aids in lessening fear, anxiety and concern.

NO ADDITIONAL COMMENTS.

Statement 4. Coronary teaching, when vital signs are stable, aid in allaying fear and anxiety and concern.

"Coronary teaching in the unit should be well assigned and done in association with the Doctor's overall plan of care. For the patient, I believe it should be limited to specific information about categories A-B-C-D. and general information about categories E-F and G.

A. Reason for coronary care and length of stay.

- B. What is a heart attack.
- C. How a heart attack develops.
- D. How it is diagnosed.
- E. What is course of hospital treatment following coronary intensive care unit.
- F. When will probable discharge occur.
- G. What is post hospital course.

The family may require more information on E-F and G."

"Generally agree, but not always."

"Vital signs could take 2 hours to 3 days to stabilize. Teaching is necessary but gear to patient, not the vital signs."

"Patients don't remember much about intensive care even though they are awake and alert."

Statement 5. Nurses are the most likely persons on the health team to give patients and families assistance in overcoming fear, anxiety and unnecessary concern.

"Because nurses are in constant attendance, they are the likely ones to provide the necessary assistance for families, etc. However, there should be definite goals and plans for this so that the 24 hour approach shows some continuity. It is also essential to know what the patient has been told by the Doctor so that the information presented is consistent and correct."

"Although social workers and religious can be most beneficial for having more time to assist family and patient."

"It is always good to hear it from the Doctor before the nurse."

"The Doctor's reassurance is the real climax. Does the trick."

"Other members seem reluctant to step into this area."

"Poor question. Nurses usually do this, but excellent job done by Licensed Practical nurse and nurses' aide, depending on bases of fear and anxiety. These bases should determine who can do the best job."

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