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
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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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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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ABSTRACT

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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

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

[2]Jane 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 nursesdo 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]

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

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

[5]Evans, op. cit., p. 146.

[6]Albert 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]

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[7]Meltzer, op. cit., pp. 50-51.

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

[9]Ibid., p. 88.

[10]Frances 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

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

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

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

[14] Jane 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 redefining 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]

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[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

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

[3]Catherine 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. . .
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> . . . . . .
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> What I am saying is that the feelings of the patient should be the unashamed professional concern of all of us. . .
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> . . . . . .
>
> . . . 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]

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

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

[6]Taylor, op. cit., p. 47.

[7]Sidney 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]

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[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

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

[12]Catherine 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

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

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

[15]Irene L. Beland, Clinical Nursing: Pathophysiological and Psychosocial Approaches (2nd ed.; New York: Macmillan Co., 1910), p. 220.

[16]Janet 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

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

[17]Carol 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.

[18]Ibid.

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-

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[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.

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

[24]Jane 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.

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[25]Carol 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 catagories 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 understanding 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 insecurity 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