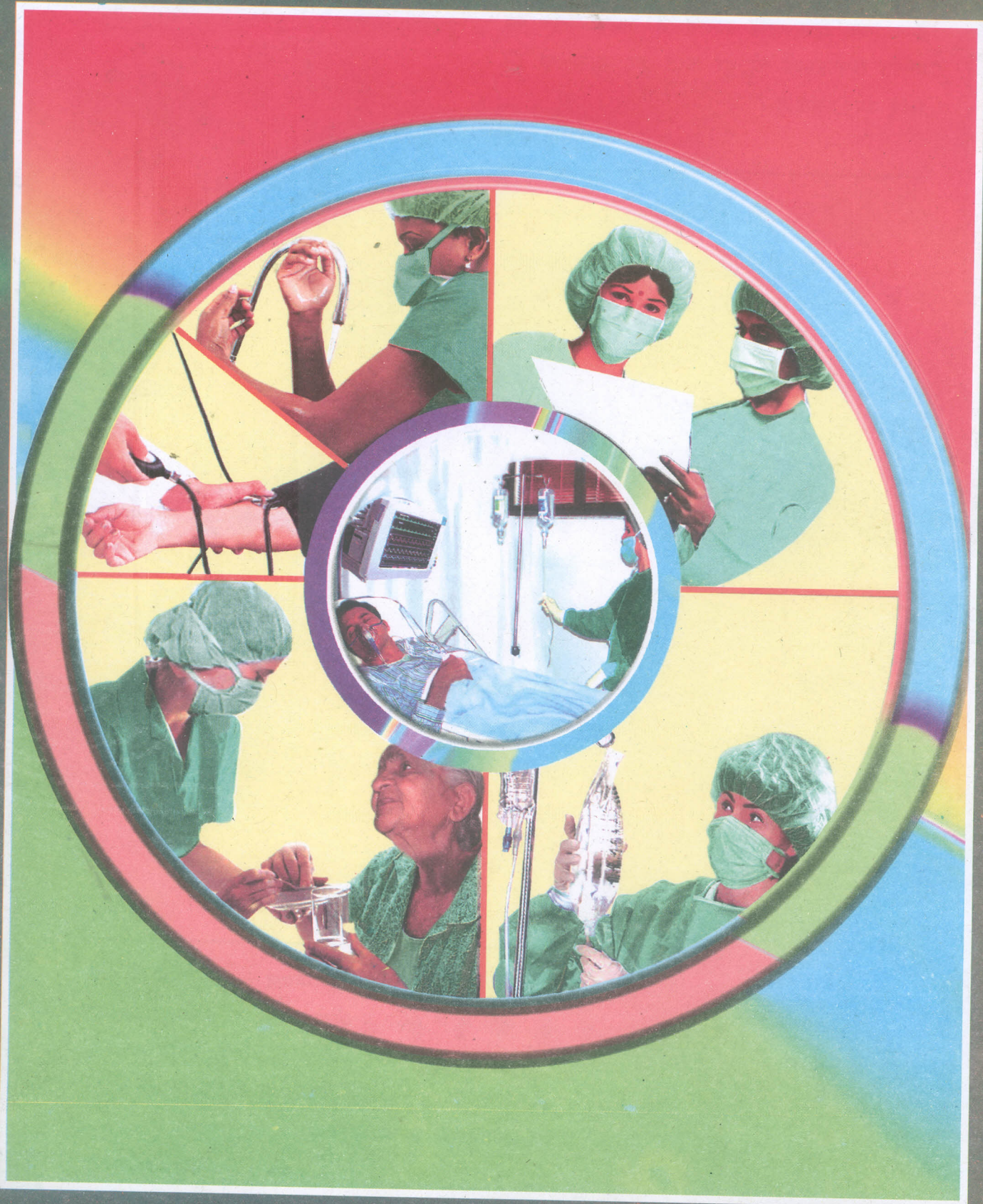




ignou
THE PEOPLE'S
UNIVERSITY

Indira Gandhi
National Open University
School of Health Sciences

BNS-031 **Concepts and Principles in** **Critical Care Nursing**



Psychological and Social Aspects in
Care of Critically ill Patients

2

“शिक्षा मानव को बन्धनों से मुक्त करती है और आज के युग में तो यह लोकतंत्र की भावना का आधार भी है । जन्म तथा अन्य कारणों से उत्पन्न जाति एवं वर्गगत विषमाताओं को दूर करते हुए मनुष्य को इन सबसे ऊपर उठाती है ।”

- इन्दिरा गांधी

“Education is a liberating force, and in our age it is also a democratising force, cutting across the barriers of caste and class, smoothing out inequalities imposed by birth and other circumstances.”

- Indira Gandhi



Indira Gandhi
National Open University
School of Health Sciences

BNS-031
Concepts and Principles in
Critical Care Nursing-I

Block

2

PSYCHOLOGICAL AND SOCIAL ASPECTS IN CARE OF CRITICALLY ILL PATIENTS

UNIT 1

Individual and Family Response to Critical Illness 5

UNIT 2

Stress and Crisis Management in Critical Care 18

UNIT 3

Guidance and Counselling 30

UNIT 4

**Therapeutic Communication and Interpersonal
Relationship** 44

EXPERT COMMITTEE

Prof. Usha Malik
Principal, Laxmi Bai Batra
College of Nursing
Batra Hospital and Research
Center Tuglakabad, New Delhi

Ms. Sujana Chakraborty
Principal, College of Nursing
Jamia Hamdard University,
Hamdard Nagar, New Delhi

Ms. Sneha Lata Waman
Nimbalkar
Superintendent of Nursing
Services, Directorate of Health
Education & Research, Dental
College Building, Mumbai-
400001

Prof. Prasanna Kumari
Principal
Govt. College of Nursing
Trinanthapuram Kerala

Prof. Panamma Ranadev
Principal
St. Stephens College of Nursing
Delhi

Ms. Srinanda Gosh
Principal
Woodland Medical Center Ltd.
Kolkata

Ms. Mala Gosami
Principal, State College of Nursing
107 Chander Nagar, Dehradun-001

Dr. Mrs. Kiran Batra
Principal
Silver Oaks College of Nursing
Village Post Office
Khizrabad District Mohali
Adhipur Punjab

Prof. Sherly David
CMC, Vellore

Ms. Selliana Kuruvila
Associate Professor
Govt. College of Nursing
Kottayam, Kerala-8

Ms. Doli Biswas
Mission of Mercy Hospital and
Research Centre 125/1 Park Street
Kolkatta-700017

Faculty Members, SOHS

Prof. Bimla Kapoor
Director, SOHS,
IGNOU, New Delhi

Prof. Pity Koul
Programme Coordinator
SOHS, IGNOU, New
Delhi

Ms. Neerja Sood
Lecturer
SOHS, IGNOU, New
Delhi

Ms. Reeta Devi
Lecturer, IGNOU,
SOHS, New Delhi

Mr. Laxmi
Lecturer, SOHS,
IGNOU, New Delhi

BLOCK PREPARATION TEAM

Writer

Unit 1-2

Ms. Srinanda Gosh
Principal, Woodland Medical
Centre Ltd., Kolkatta

Unit 3-4

Mrs. Ashru Bagchi
Senior Lecturer, West Bengal Govt.
College of Nursing, S.S.K.M. Hospital
Campus, Kolkatta-700020

Editor

Ms. Seema Sane
Vice Principal
Plot No.1, 2nd Floor,
Bhagwati Niwas,
TH Kataria Road, Mahim,
Mumbai, Maharashtra

Unit Transformation

Prof. Pity Koul
Professor & Programme
Coordinator
IGNOU, New Delhi

Prof. Ratni Thassu
Sr. Consultant, SOHS,
IGNOU, New Delhi
(11.02.2011 to 23.05.2011)

CO-ORDINATION

Director

Prof. (Dr.) Bimla Kapoor
SOHS, IGNOU, New Delhi

Course Coordinator

Prof. (Dr.) Pity Koul
SOHS, IGNOU, New Delhi

Programme Coordinator

Prof. (Dr.) Pity Koul
SOHS, IGNOU, New Delhi

PRINT PRODUCTION

Sh. S. Burman
D.R.(P) MPDD

Sh. Tilak Raj
A.R.(P) MPDD

Sh. Yash Pal
S.O.(P) MPDD

September, 2018 (Reprint)

© Indira Gandhi National Open University, 2006

ISBN : 978-81-266-5448-2

All rights reserved. No part of this work may be reproduced in any form, by mimeograph or any other means, without permission in writing from the Indira Gandhi National Open University.

Further information on the Indira Gandhi National Open University courses may be obtained from the University's office at Maidan Garhi, New Delhi-110068 or visit University's <http://www.ignou.ac.in>.

Printed and published on behalf of the Indira Gandhi National Open University, New Delhi by the Registrar, MPDD.

Printed at : SG Print Packs Pvt. Ltd., F-478, Sector-63, NOIDA (U.P.)

BLOCK 2 INTRODUCTION

You have learnt about various conditions in medical and surgical nursing in your basic training programme. As you know that critical illness is a traumatic event for both the patient and family. Patient and family face psychological trauma. Providing nursing care in critical care unit is a challenge and also stressful. It is essential for you as a critical care nurse to understand the individual and family response to critical illness, for which you need to have the knowledge of guidance and counselling, develop communication skills and the concept of Interpersonal Relationship (IPR) and therapeutic communication to help the family to cope with the crisis situation. It is also essential for you to learn the crisis management in critical care, reduce the emotional exhaustion and personal accomplishment. This block is organised in the following units.

UNIT 1

Individual and Family Response to Critical Illness

UNIT 2

Stress and Crisis Management in Critical Care

UNIT 3

Guidance and Counselling

UNIT 4

Therapeutic Communication and Interpersonal Relationship.

By M. B. ...

ST. JOHN'S UNIVERSITY

THE UNIVERSITY OF THE SACRAMENT

ST. JOHN'S UNIVERSITY

THE UNIVERSITY OF THE SACRAMENT

ST. JOHN'S UNIVERSITY

THE UNIVERSITY OF THE SACRAMENT

ST. JOHN'S UNIVERSITY

THE UNIVERSITY OF THE SACRAMENT

ST. JOHN'S UNIVERSITY

THE UNIVERSITY OF THE SACRAMENT

ST. JOHN'S UNIVERSITY

THE UNIVERSITY OF THE SACRAMENT

ST. JOHN'S UNIVERSITY

THE UNIVERSITY OF THE SACRAMENT

ST. JOHN'S UNIVERSITY

THE UNIVERSITY OF THE SACRAMENT

UNIT 1 INDIVIDUAL AND FAMILY RESPONSE TO CRITICAL ILLNESS

Structure

- 1.0 Introduction
- 1.1 Objectives
- 1.2 Effect of Critical Illness on Individual and Family
 - 1.2.1 Individual's Response to Effects of Critical Illness and Nursing Intervention
 - 1.2.2 Family Response to Effects of Critical Illness and Nursing Intervention
- 1.3 Sociocultural Factors Affecting Critical Care
 - 1.3.1 Key Sociocultural Terms
 - 1.3.2 Sociocultural Assessment
 - 1.3.3 Sociocultural Factors in Planning Care
- 1.4 End of Life Issues
 - 1.4.1 Death and Dying
 - 1.4.2 Organ Donation and Autopsy
 - 1.4.3 Grief Response
- 1.5 Let Us Sum Up
- 1.6 Glossary
- 1.7 Answers to Check Your Progress
- 1.8 References

1.0 INTRODUCTION

Critical illness is a traumatic event for both the patient and the family. Patients who experience trauma or sudden critical illness are admitted in the critical care unit. They face psychological trauma in addition to their physiological illness or injury. This psychological trauma affects the patient as well as the family. There is an interrelationship between psychological and physiological stressors and responses. Psychological responses e.g., fear and anxiety can exacerbate or worsen physical symptoms viz., pain or haemorrhage. As a critical care nurse you need to understand these psychosocial concerns of the patients and families and help them cope with the situation.

While providing the care you may come across with the patients and health team members from various cultures. In order to provide culturally competent care you require an understanding of cultural differences in health care practices and patients' cultural beliefs and practices. In this unit we shall discuss about effects of critical illness on individual and family, sociocultural factors in critical care and end of life issues.

1.1 OBJECTIVES

After completing this unit you will be able to:

- describe the effect of critical illness on a patient and the emotional responses arising out of it;

- discuss the effect of critical illness of the patient on his family and the emotional responses of the family arising out of it;
- appreciate the relevance of cultural ideas in critical care;
- systematically assess one's cultural ideas and needs;
- plan culturally competent care in order to improve effectiveness of care and patient's satisfaction; and
- explain the end of life issues.

1.2 EFFECT OF CRITICAL ILLNESS ON INDIVIDUAL AND FAMILY

This section will deal with various psychosocial responses of the patients and their families due to critical illnesses and sociocultural influences in the care of critically ill patients.

1.2.1 Individual's Response to Effects of Critical Illness and Nursing Intervention

Patients admitted in the critical care unit are at a most vulnerable stage. Critically ill patients are attached to tubings and equipment, covered with dressings, experiencing pain, nausea, thirst or hunger, having difficulty in breathing, swallowing or moving, frequent needle sticks, frequent examinations and procedures causing sleep disruptions. They are dependent on others to meet their most basic and intimate needs. Lack of control and altered self-concept gives rise to loss of self-esteem and grief over what is lost or changed. Anxiety and fears about the treatment, the unknown and even death occurs.

Admission to a critical care unit causes significant disruption in life. Everything in the environment is stress producing e.g., unusual machines, unfamiliar sounds, odour, sights, constant light and constant attention, staff conversation, lack of privacy, physical restraints, uncomfortable beds, room too hot or cold and separation from family and friends. Critically ill patients are controlled by other people, procedures and protocols of the unit. They do not know when they will be able to resume their former activities and relationships. So the patients in critical care units respond to all these stressors physically, psychologically and environmentally.

Physical responses of the patient are exhibited by changes in vital signs e.g., tachycardia, tachypnoea, hypertension, dysrhythmias, diaphoresis, anorexia, changes in elimination pattern, increased pain, increased haemorrhage, restlessness and altered circadian rhythm.

Psychological responses of the patient include anxiety, fear, anger, grief, dependency, frustration, powerlessness, helplessness, hopelessness and spiritual distress. Few patients can even develop intensive care unit syndrome.

Environmental responses of the patient are sensory overload, sensory deprivation and intensive care unit syndrome.

Intensive care unit syndrome is a syndrome (group of symptoms) that usually occur after 48 hours of stay in an ICU/CCU. Common features of the syndrome

are disorientation, clouding of the consciousness, decreased attention span, memory loss, hallucinations and emotional instability. The symptoms disappear within 48 hours after the patient is transferred out of the ICU/CCU. The factors contributing to ICU syndrome are advanced age, very severe illness, and prolonged surgery, use of cardiopulmonary bypass, history of psychiatric illness, electrolyte imbalances, endocrine disorders, sleep deprivation, sensory overload and sensory deprivation.

Nursing interventions in caring of critically ill patient

- Promote physical comfort to the patient as much as possible.
- Relieve or control pain by administering analgesics as prescribed.
- Plan nursing activities carefully to provide adequate period of uninterrupted sleep.
- Explain the procedure to the patient before carrying out any procedure.
- Allow patient to ventilate his feelings and concerns.
- Keep patient informed about treatment options prognosis and encourage patient's involvement in related decision making.
- Provide emotional and maintain spiritual support.
- Promote privacy and dignity of the patient.
- Avoid conversation about other patients and personal issues within patient's hearing range.
- Provide comfortable environment.
- Provide a calendar or clock within the patient's visual field.
- Ask family to bring some personal objects to place at the bedside.

1.2.2 Family Response to Effects of Critical Illness and Nursing Intervention

Critical illness always induces a crisis state in families regardless of their coping skills. Critical illnesses can be sudden or expected e.g., open heart surgery. In either case critical illnesses disrupt the structure and function of the family. A critical illness with sudden onset gives the family little or no time to prepare for the crisis. Families always experience shock and disbelief on hearing the news of the sudden illness and disorganization in the structure and function of the families may follow.

Although critical illnesses vary in intensity they are usually a burden for the family. In spite of using varieties of coping behaviours the families feel **helpless, hopeless, powerless and confused**. In addition to the critical illness the hospital environment is stressful for the family. Sight of the critically ill member connected with tubes and machines in the critical care environment is often a major source of discomfort.

Not all families when faced with the same stressful events will be in crisis. Family's potential to be in crisis depends upon various factors e.g., perception of

the event (understanding the seriousness or nature of the event), available situational support, and the type of coping mechanisms. Although families react differently to stress and discomfort associated with critical illnesses, a common pattern of responses and behaviours are frequently seen in most of the families.

The responses that are frequently observed are given below:

Decreased ability to concentrate and use incoming information: During crisis people have difficulty hearing and understanding information. After the patient is admitted the families are in need of receiving a lot of information about the patient, the unit, scheduled tests and treatment procedures. Since the families have difficulty in understanding information it is frequently seen that they are asking same question to different health team members repeatedly.

Decreased ability to make decisions and solve problems: Very often families of critically ill patients need to make difficult decisions regarding the life of the patient e.g., consenting for surgery or whether treatments should be withheld or not. In addition to making difficult decisions regarding treatment and care of patient they are frequently found to have problems in deciding about daily routines also.

Decreased sensitivity to or awareness about the environment: It is frequently seen that the families exhibit lack of awareness about their surroundings e.g., ICU. This lack of awareness about the surroundings makes the family members standing in the doorway and blocking the passage or talking loudly in the waiting room disturbing other families.

Decreased sense of personal effectiveness: Since the conditions of the critically ill patients are so complex and critical, their care is totally under the control of the critical care nurses and other health team members. Families not being able to provide any care feel themselves help less and ineffective.

Stress related to the changes in structure and roles in the family: Families experience stress as the critical illness and hospitalization of their loved ones affect their ability to function. Critical illness may disrupt the family's structure and functions when the family's energy and efforts are totally directed towards the patient. Drastic role reversals by wife or husband of the patient contribute to an intense sense of loss and stress for family.

Nursing interventions to meet the emotional needs of the family

A critically ill patient not only requires support from the critical care team but also requires support from his family. So while taking care for a critically ill patient the nurse has to see that the family's needs are also met. The family who is coping well with the critical situation, will be able to provide a supportive environment for the recovery of the patient. The nursing interventions to meet the needs of the families includes following:

Provide information

- Provide accurate information according to the need and understanding ability of the family.
- Give precise, simple information in nontechnical terms.
- Discuss with family the difficulties or probable events that may occur in future.

Provide assurance

- Assure the family that the patient will be made comfortable as much as possible.
- Explain to the family that the patient will be closely monitored and will receive highly skilled care.
- Provide accurate information regarding patients condition from time to time

Provide support

- Assess the family structure, functions and usual coping mechanisms.
- Respect family's coping behaviour and intervene only when it is harmful for the patient or the family.
- Allow families to ventilate emotions.
- Provide necessary information and guide the family to take decisions.
- Inform family of available resources e.g. finances.

Facilitate proximity (the need to be with the patient)

- prepare family members for visits, individualized visiting may be allowed according to need of patient and family.
- Assess the family's need to be with the patient.
- Prepare family member for visits.
- Assist family member to be near or to touch the patient if they wish. Encourage family member to communicate with the patient.
- Teach family member how to assist with patient care as appropriate.
- Advise family member to take adequate rest, nutrition and exercise.

Provide comfort

- Show waiting room, telephone, cafeteria etc. near the unit to the family.
- Provide information on resources and facilities that may be needed near the hospital.

Check Your Progress 1

Select the best possible response against each statement

- i) Anxiety occurs when a patient
 - a) is totally dependent on the nurse.
 - b) knows that he will take a long time to recover.
 - c) thinks that he may die due to the illness.
- ii) The best way to relieve anxiety in a patient is to
 - a) reassure him that the health team members are providing best possible care.
 - b) provide direct and honest explanations.
 - c) help him to express his fears and concerns.

- iii) Intensive care unit syndrome
 - a) occurs after 72 hours of stay in an ICU.
 - b) usually occurs in a patient who had undergone a prolonged surgery.
 - c) is a life-threatening condition.
- iv) Which of the following conditions is most likely to cause crisis in a family?
 - a) Permanent disability in the patient due to critical illness.
 - b) Inadequate problem solving ability of the family.
 - c) All of the above.
- v) In order to promote sense of personal effectiveness in a family member, the nurse should
 - a) provide required information in writing.
 - b) teach family member how to assist with patient care.
 - c) allow the family to ventilate emotions.

1.3 SOCIO CULTURAL FACTORS AFFECTING CRITICAL CARE

In this section we shall discuss about sociocultural concepts, assessment and planning care. The working environment of the critical care nurse is full of tension. The patient has life threatening problems, which have to be taken care of immediately in a highly mechanized environment. Effective care can only be provided when there is cooperation between the nurse, patient and the family members. This cooperation is dependent upon the mutual understanding of each person's viewpoint. At this point the cultural factors emerge as important for the well-being of the patient. Disharmony between the patient and the nurse regarding cultural issues will lead to friction and loss of cooperation.

1.3.1 Key Socio-cultural Terms

Culture

Culture is the sum total of knowledge, values, beliefs, art, morals, law, customs and habits of the members of a society. Cultural patterns of behaviour develop over time and are shared by members of the same cultural group and transmitted from one generation to the next. Culture affects ways of perceiving, behaving, and evaluating the world and serves as a guide for people's values, beliefs and practices including those related to health and illness.

Values

Values are the sets of rules or ideas and principles observed by individuals, groups or community. Values determine our beliefs, attitudes and behaviours. Cultural values develop gradually. A child may unconsciously develop these values and learn acceptable and unacceptable behaviours, though individuals within a cultural group may have similar values, beliefs and practices, all individuals are culturally unique. This uniqueness may be based on age, sex, marital status, educational level, family structure, income, religious beliefs and life experiences.

Cultural Imposition are imposing (forcing) one's own cultural beliefs, values and practices on another person or group.

Transcultural Nursing

Transcultural nursing is a speciality that studies and compares the differences between various cultures and subcultures. The goal of Transcultural nursing is to provide culturally competent care to patients from different cultures.

1.3.2 Sociocultural Assessment

Nurse's self assessment

Sociocultural assessment of the patient forms the basis for providing culturally competent care to the critically ill patient. Before performing patient's sociocultural assessment nurses should assess their own cultural background, values and beliefs, especially those related to health and health care practices. If the nurse is not clear about her own culture. She cannot objectively consider her patient's cultural orientation and needs. Several tools or guides are available by which the nurse can evaluate her own cultural assessment as well as patient's cultural assessment.

Patient's sociocultural assessment

The critical care nurse should perform a cultural assessment of her patient and include it in the nursing process. Cultural assessment like any other assessment procedure may be completed over a period of time as the nurse and patient come to know each other.

Cultural assessment can be performed by using Giger and Davidhizar's model of cultural assessment guide as modified and discussed below :

- **Communication** which includes verbal and nonverbal communication pattern of the individual;
- **Social organization** i.e., the form of family and community from which the individual comes;
- **Time** – whether the person is past, present or future oriented;
- **Time dimension** – this factor determines how a person views his experience:
- **Past oriented** – experience and tradition are given more importance e.g., from which culture you have come.
- **Present oriented** – only here and now is important, past is past and future is unpredictable.
- **Future oriented** – past is gone and how the actions of the present can improve the conditions of the future.

Past oriented people may have strong belief about the causes of illness and its treatment, which s/he has learned from his experience. S/he may not cooperate with treatment plans if they do not support his/her beliefs. S/he may consult with a senior member of the family for treatment options. For the present oriented person the moment's comfort and sensations are only important. Future oriented person will agree to any unpleasant treatment and /or procedure **if that improves his/her health in future.**

- **Environmental control** is the degree to which the individual feels in control of surroundings and events;
- **Biological variations** – racial factors e.g., skin color, color and texture of hair, susceptibility to disease etc.

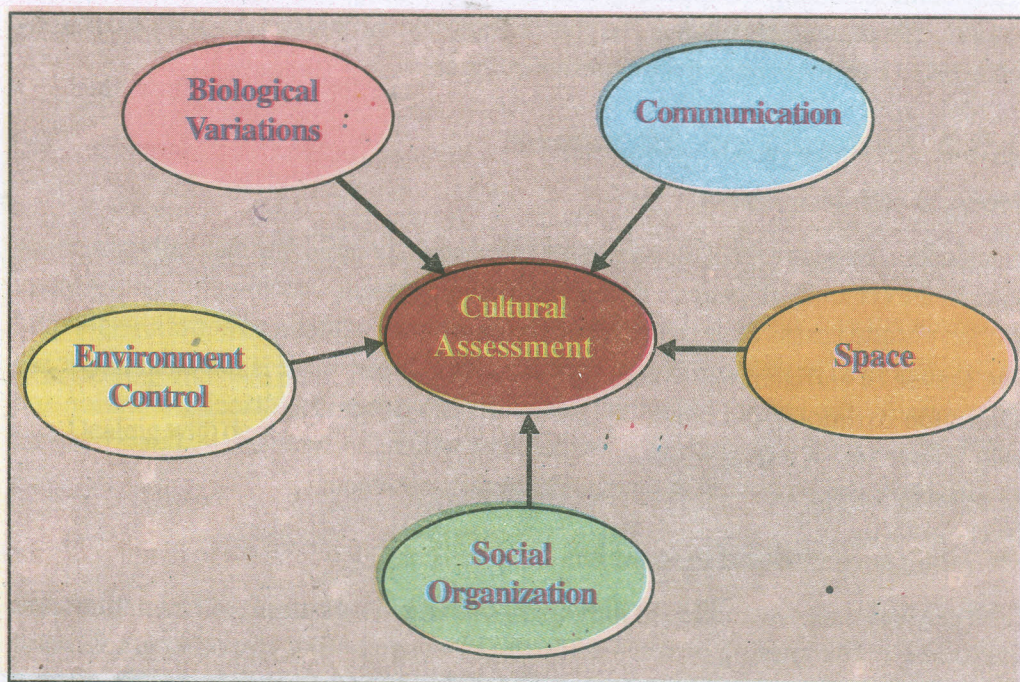


Fig. 1.1: Cultural Assessment Model Adopted from J. Giger Source and R. Davidhizar

1.3.3 Sociocultural Factors in Planning Care

The findings of sociocultural assessment of the patient will guide the nurse in planning culturally competent care. The sociocultural factors which have to be taken into consideration are given below:

Communication

Establishing effective communication with the patient is absolutely essential for providing holistic care to the patient. Effective communication occurs when meanings are mutually understood whether that communication is through spoken words, written materials, gestures or voice tones. To show respect to the patient, communication should take into account the patient's usual communication style.

Nurses may find it difficult to establish effective and meaningful communication when the patient does not understand the common language, is critically ill, has difficulty in communicating, patient is unconscious or has an endotracheal tube in place.

With experience critical care nurse can develop and will be able to develop alternate means of communication. Many means of alternative communication are available in the critical care environment e.g., use of picture boards; use of sign language; use of gestures; mime and use of a trained interpreter. All these means have their advantages and limitations. So care should be taken while these are used. The nurse should keep in mind the following while communicating with the patient who has difficulty in understanding the nurse:

- While meeting a patient or his family member the nurse should introduce herself.

- Address patient by name.
- While communicating take adequate time. Do not be in hurry.
- Avoid communication in a noisy environment.
- Make the patient comfortable before beginning communication.
- Sit or stand in front of the patient in such a way that s/he can see the nurse's face clearly.
- Speak slowly and clearly, using simple short sentences.
- Do not raise voice.
- Use gestures with caution as their interpretation vary from culture to culture.
- Use any word that you might know in patient's language. This shows that the nurse is aware of and respects patient's culture.
- Ensure that the patient understands by having him repeat the instruction, demonstrate the procedure or act out the meaning.

You will also be learning concept of communication in unit 4 of this block.

Cultural Health Practices

Individuals belonging to different cultural groups may show diverse health related cultural beliefs and practices. The critically ill patient may believe that his illness is due to the punishment by God and may feel hopeless. The patient may believe on some folk healers and may engage in some type of cultural healing practices e.g., use of herbal medications, massage or wearing of some charms to discourage evil spirits. Patient may have taken some traditional and folk remedies that might affect the treatment procedures prescribed by the physician. So the critical care nurse has to ask the patient regarding the use of such traditional medicines and other beliefs and plan her nursing care accordingly.

Social Organisation - Family

Social organization refers to the form and family form. It is important to find out the type of family the patient belongs to. In some culture there is an emphasis on traditional joint families. Individual from this type of family tend to be interdependent rather than independent. Critically ill Patients from this type of family usually get lot of support and help from family members during this crucial period. There are also cultural differences related to expectations of family members in providing care. Some patients may expect that family members will provide all care along with the health care provider. In contrast some patients may like to resume self care as soon as possible. Information in this regard will help the critical care nurse in planning care of the patient by utilizing family support whenever possible.

Decision making in Critical Illness

Family roles differ from culture to culture. Critical care nurse must find out who should be contacted for providing necessary information related to care of the patient and who will take decision about the treatment of the patient. In some culture there is strong belief in autonomy and the individual is expected to make decision about his own health care and may be expected to sign the consent form. In many cultural

groups it may be another family member who is expected to make decisions regarding patient's treatment. Patients belonging to this type of family may be in conflict and may delay required urgent treatment procedures. Being aware of these types of values of his patients will prepare the critical care nurse to advocate for his patients.

Diet

Food is an important contributory factor to good health. It is also an important part of cultural practices. Foods that are eaten and rituals and practices that are associated with food are learned as part of growing up in the family and society. A critically ill patient may have to undergo major changes in his diet because of his health problem. Sometimes the patient's family may be quite desperate to see that the feeding has started for his patient. If nurse's advice seems contrary to the patient's beliefs and customs s/he may quite simply refuse to comply. Hence it is important that dietary factors are discussed with the patient or the family so that the changes planned is acceptable to the patient and at the same time healthy nutritional practices are maintained.

1.4 END OF LIFE ISSUES

In this section we shall discuss about issues related to death and dying, organ donation, autopsy and grief response.

1.4.1 Death and Dying

Death is inevitable and a universal experience of human beings. In critical care environment death is a frequent phenomenon. One of the nurse's primary responsibilities is to allow the patient peaceful and dignified death when it is inevitable. Every culture has some specific rituals connected with dying. Although the nurse may have knowledge regarding the needs of various cultural groups in this regard, she should always seek guidance from the bereaved family in this respect.

1.4.2 Organ Donation and Autopsy

Persons who are legally competent may choose to donate any body part or entire body. The decision to donate organs or entire body may be made by the person before his death. The decision to donate an organ may be taken from the immediate family members after the patient's death.

Sometimes following death an autopsy may be required in some specific situations. This is an unexpected situation for the family and families may particularly dislike the procedure and may not allow for the same unless it is required by law.

Critical care nurse should try to learn the family's views in this regard and obtain family permission before organ donation or autopsy.

1.4.3 Grief Responses

Bereavement is an individual's emotional response to the loss of a significant person and grief develops from bereavement. Grief is one of the most powerful emotional state and affects individual's thoughts, feelings and behaviours.

People from different cultures have different reactions to death and dying. People from western culture believe that death and dying is a private matter and can be shared only with significant members. They even repress or internalize the feelings of grief and may not express themselves when they are experiencing tragic loss.

Some cultural groups express their feelings and emotions more easily. Kinship is very strong in those cultures. Family members both immediate and extended provide support for one another. In some Indian communities members are hired to express feelings of grief.

Check Your Progress 2

Tick the most appropriate answer:

- i) Cultural assessment is best performed by —
 - a) asking help from a colleague from patient's cultural background.
 - b) observing patient's behaviours.
 - c) using a cultural assessment guide.
 - d) the nurse's previous experience of patients of similar cultural group.
- ii) Before planning culturally competent care the nurse should first —
 - a) assess patient's cultural beliefs and practices about health and health care.
 - b) assess her own cultural values and practices regarding health and healthcare.
 - c) equip herself with knowledge of cultural beliefs and practices of different groups of people.
 - d) learn different health care beliefs and practices of various groups of people.
- iii) To communicate with a patient whose language the nurse does not understand, it is best to —
 - a) observe the patients nonverbal communication.
 - b) take help from the patient's family member.
 - c) call a trained medical interpreter.
 - d) use pictures and mime.

1.5 LET US SUM UP

A patient with critical illness when admitted in a critical care unit is confronted with various physical, psychological or environmental stressors and responds to those stressors physically, psychologically and environmentally. Physical responses of the patient include alteration in vital signs, alteration in elimination pattern, increased pain or haemorrhage etc. Psychological responses include fear, anxiety, powerlessness, hopelessness etc. Environmental responses include sensory overload, sensory deprivation and intensive care syndrome. The family members also experience crisis and to cope with this crisis they need to get necessary information, assurances and emotional support from the health care members. They also need to visit patient frequently and need to be comfortable while waiting in the hospital.

Providing culturally competent care is also an important responsibility of the critical care nurse. Nurse must assess her own cultural values and practices before assessing patient's cultural values and practices.

Self activity: By using Giger and Davidhizar's model of cultural assessment guide assess your own cultural beliefs and practices regarding health and health care practices.

1.6 GLOSSARY

- Stress** : A psychological and physiological response in a person that arise in a demanding situation.
- Stressors** : Internal or external events or situations that cause stress in an individual.
- Grief** : A universal response to any loss.
- Sensory deprivation** : Reduced stimulation of the sense organs leading to disorientation in time and space, unclear thinking and hallucinations.
- Sensory overload** : Too many stimuli stimulating the sense organs of the patient at one time at a level that is greater than normal and are thus causing confusion.
- Circadian rhythm** : The rhythm of certain biological activities that take place daily within 24 hours e.g., sleep and wakefulness.

1.7 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

- i) c
- ii) c
- iii) b
- iv) c
- v) b

Check Your Progress 2

- i) c
- ii) b
- iii) c

1.8 REFERENCES

- 1) Bare B. G., Hinkle J. C., Smeltzer S. C. & Chenner K. H. Brunner & Suddarth's Textbook of Medical Surgical Nursing. (11th ed.) Lipincott Williams & Wilkins.

- 2) Black J.M & Hawks J. H. Medical Surgical Nursing- Clinical Management for Positive Outcomes. (8th ed.) Elsevier.
- 3) Bucher Linda and Melander Sheila. Critical Care Nursing. (1st.ed.) W. B. Saunders Company.
- 4) Burnard P. & Millar B. Critical care Nursing: Caring for the Critically Ill Adult. (1st. ed.) Paston Press Ltd.
- 5) Clochesy J. M & Christine B. Critical Care Nursing. (2nd ed.) W. B. Saunders Company.
- 6) Lewis S. M., Hitkemper M. M., Dirkson S. R. Medical Surgical Nursing (6th ed.) Mosby.
- 7) Morton PG, Fontaine DK, Hudak CM and Gallo BM. Critical Care Nursing - A Holistic Approach. (8th ed.). Philadelphia: Lippincott Williams Wilkins. 2005, p.12 - 35.

UNIT 2 STRESS AND CRISIS MANAGEMENT IN CRITICAL CARE

Structure

- 2.0 Introduction
- 2.1 Objectives
- 2.2 Concept of Stress, Crisis and Burn Out
 - 2.2.1 Meaning and Definition of Terms
 - 2.2.2 Factors Affecting Response to Stress
 - 2.2.3 Occupational Stressors for Nurses
 - 2.2.4 Physiological Response to Stress
 - 2.2.5 Manifestation of Stress
 - 2.2.6 Emotional Reaction to Stress - Crisis
 - 2.2.7 Burn Out
- 2.3 Managing Stress in Critical Care
 - 2.3.1 Nurses' Own Actions
 - 2.3.2 Coping Strategies
 - 2.3.3 Importance of Education and Training
 - 2.3.4 Role of the Organization and Nurse Administrator in Preventing Burn out
- 2.4 Let Us Sum Up
- 2.5 Glossary
- 2.6 Answers to Check Your Progress
- 2.7 References

2.0 INTRODUCTION

In the previous unit you have learned that critical illness and the critical care unit expose the patient and the family to various physical, psychological and environmental stressors. Common responses of the patient and family arising out of those stressors and the nursing interventions to deal with those responses were also discussed. Nurses often express that the critical care unit is challenging and rewarding place to work, but at the same time it is also a stressful work area. Rapidly changing technological advances, need for rapid decision-making, and continuous noise from different machines, staff conversation, and emotional reactions that take place while dealing with life and death situations, place a lot of stress on the nurses working in these units. In this unit you will learn in detail about general concept of stress including occupational stressors, coping and crisis situation for nurses working in critical care units. You will also learn about stress and crisis management.

2.1 OBJECTIVES

After completing this unit you should be able to:

- review the concepts of Stress, Stressor and Coping;

- discuss occupational stress for nurses working in critical care area and factors affecting response to stress;
- identify manifestations of stress in a client and in self;
- describe various coping strategies; and
- implement methods of reducing stress while working in a critical care unit.

2.2 CONCEPT OF STRESS, CRISIS AND BURN OUT

In this section we shall discuss about the definition and meaning of stress, stressors and coping with stress.

2.2.1 Meaning and Definition of Terms

Stress is a state that results from an event or a change in the environment of an individual which is perceived by him as challenging, threatening or damaging to his health or wellbeing. The individual is unable to meet the demands of the event or the new environment. Stress has been defined as a situation that exists when an organism is faced with any stimulus that causes disequilibrium between psychological and physiological functioning. All hormone levels can be altered by stress.

Stressor: An event or the change in the environment (internal or external stimuli) that produces stress is known as stressor. An event or a change that is stressful to a person may not be stressful to another and an event that is stressful to a person at one time or place may not be stressful at another time or place.

Coping is the process of recognizing the stressor and adjusting or adapting to the changing situation to maintain one's health and wellbeing. It is a compensatory process with physiologic and psychological components. Stress will be experienced if there is a mismatch between perceived demand and perceived ability to cope with meeting the demand.

2.2.2 Factors Affecting Response to Stress

Do all of us respond to stress in similar manner? Think of a stressful situation that you have experienced in your family or work place. You must have noticed that every individual who experienced the same stressful situation responded in different manner. Factors that affect an individual's response to stress include **internal factors** e.g., health status, genetic background, previous experience with stressors and personality characteristics, **external influences** e.g., cultural, religious or spiritual influences, socioeconomic status and social support.

2.2.3 Occupational Stressors for Nurses

Occupational stressors for nurses working in critical care area may be grouped into **intrapersonal**, **interpersonal** and **extrapersonal**. We shall discuss each one of these stressors as follows:

Intrapersonal

- Meeting needs of patients and significant others

- Lack of knowledge or skill
- Inability in rapid decision making
- Responsibility for patients' lives
- Lack of support
- Life stresses
- Role conflicts.

Interpersonal

- Poor communication between staff members and different departments
- Poor communication between senior nursing and medical staff
- Uncertainty about patient's treatment
- Dealing with inexperienced nurse and physician
- Dealing with demanding or difficult patients.

Extrapolpersonal

- Too much of workload, of physical work and Inadequate staffing
- Shift duty, floating duty to some other department or units
- Equipment failure, new equipment or technology
- Noise
- Inconvenient work environment, disorganized physical layout
- Poor unit management
- No continuity in patient assignment
- Lack of time to give emotional support to client
- Dealing with interruptions and new admissions.

2.2.4 Physiological Response to Stress

The physiological response to any kind of stressor is a protective and adaptive mechanism to maintain the steady state or homeostatic balance of the individual. Hans Selye named this physiologic response to stress as the general adaptation syndrome (GAS). The GAS has following three phases:

Alarm reaction: In this phase an individual perceives a stressor physically or mentally and the sympathetic fight or flight response is initiated. At this phase hormone level rises, heart rate, increased blood flow to muscles increase, Oxygen intake increase, and there is greater mental alertness. This alarm reaction is defensive but self-limited. So the person moves into second phase.

Resistance: During this phase, the body stabilizes, and hormone levels, heart rate, blood pressure and cardiac output returns to normal, thus adaptation to the stressor may occur. The amount of resistance to the stressor varies among different individuals depending on the number and intensity of stressors, person's internal physical and psychological reserves and external social support from family, friends providing support required for adaptation. If this internal reserves and external support are adequate then individual may successfully recover from a

stress and return to his or her previous steady state. If adaptation does not occur the person may move to the stage of exhaustion.

The stage of Exhaustion: It occurs when all the energy for adaptation has been spent. The magnitude of the stressor is too great compared to the person's physiologic and psychological reserves. The individual in the stage of exhaustion usually becomes ill and may die if assistance from outside sources is not available. Although stress response is usually protective, it can lead to pathologic conditions. With repeated episodes of stress or an excessive number of stressors, diseases may occur for e.g. hypertension, heart disease, neurologic diseases, infections, metabolic diseases, renal disease and digestive diseases.

2.2.5 Manifestations of Stress

Manifestations of stress may be observed directly (objective) or reported by the person (subjective). Manifestations may be physiological, psychological or behavioural. These are shown in Table 2.1.

Table 2.1: Manifestations of Stress

Physiological	Psychological	Behavioural
Insomnia, Fatigue, and palpitation	Irritability and depression	Impulsive behaviour
Excessive perspiration	Desire to cry, scream or run	Disturbed behaviour
Increased frequency of urination	Loss of interest and anxiety	Nervous laughter
Low back pain or pain in neck	Restlessness, pacing, moving about vaguely	Grinding of teeth
Headache and muscle tension Change in menstrual cycle	Inability to concentrate	Increased use of anxiolytics or antidepressants
Dryness of throat and mouth, Diarrhoea, vomiting	Emotional instability	Increased smoking
Loss of appetite or excessive appetite	Trembling, nervous tics, Stuttering	Alcohol and drug addiction

2.2.6 Emotional Reaction to Stress – Crisis

Crisis is the emotional reaction to a stressful event. Stress itself does not cause crisis, but the cognitive appraisal of the event may result in crisis. When an individual perceives the problem or the stressful event as insolvable, and struggles to regain his control and the control of the environment, it becomes a crisis. Usually a person reacts to a stressful event with various coping mechanisms. Crisis results when these coping mechanisms do not allow the person to reach to a lower level of anxiety. Outcome of crisis depends on how the person deals with the crisis and what outside support is available during the period of crisis:

Phases of Crisis

Four distinct phases of crisis have been noticed as given below:

- Phase 1:** In this phase a person is confronted with a problem or stressor or a conflict that threatens the self-concept. He or she responds with anxiety. The anxiety stimulates the usual problem solving techniques and other coping mechanisms in an effort to solve the problem and lower the anxiety.
- Phase 2:** If the problem solving and other coping mechanisms fail and the threat persists, anxiety continues to rise. This rise in anxiety produces extreme discomfort. Person's functioning becomes disorganized. He or she begins to make trial and error attempts to solve the problem and restore a normal balance.
- Phase 3:** If the trial and error attempts fail, anxiety intensifies to severe and panic levels. These extreme levels of anxiety mobilize automatic relief behaviours e.g. withdrawal and flight. Some form of resolution may be made in this phase by either compromising needs or redefining the situation to make an acceptable solution.
- Phase 4:** If the problem is not solved, anxiety may overwhelm the person and lead to serious personality disorganization. This disorganization may be exhibited as yelling, confusion, running about aimlessly, immobilization with fear, violence against others or suicidal behaviour.

The final stage of the general adaptation syndrome and crisis may be seen in nurses experiencing prolonged unrelieved occupational stressors of critical care unit, which is often referred as 'burnout'.

2.2.7 Burnout

The term burnout was first used by Freudenberger in 1975 and he described this as negative self-concepts and job attitudes with a loss of concern and feelings for clients. Burnout is a progressive stress process by which a previously committed professional person disengages from work as a result of the appraised stressful transactions experienced within the job. (Bailey, 1985).

Maslach, 1986 described burnout as a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment.

Signs and Symptoms

- Feeling tired and exhausted daily
- Frequent headaches and gastrointestinal disturbances
- High resistance towards going to work each day
- Frequent absenteeism
- Stereotyping of patients
- Rigidity in thinking and resistance to change
- A feeling of failure

- Suspicious and paranoia
- Avoiding discussion at work with colleagues
- Isolation and withdrawal
- Excessive use of drugs
- Negativism
- Loss of purpose.

Check Your Progress 1

i) Define the following terms:

a) Stress

.....
.....
.....

b) Stressor

.....
.....
.....

c) Coping

.....
.....
.....

ii) Explain briefly physiological response to stress.

.....
.....
.....
.....

iii) Describe the phases of crisis.

.....
.....
.....

iv) List eight signs and symptoms of burn out.

.....
.....
.....
.....

2.3 MANAGING STRESS IN CRITICAL CARE

Managing stress in critical care and thus preventing burnout in nurses are discussed under the following three headings:

2.3.1 Nurse's own Actions

You as a critical care nurse have to make an effort to reduce stress in yourself so you need to take following action:

Recognition of presence of stress in self and others is the first step in stress management. A nurse should give close attention to physical sensation of her own body. This will help in differentiating positive stresses and when mismatch between demand and coping is present e.g., **tachycardia** and **tachypnoea** experienced by a nurse during dealing with cardiac arrest situation are the normal response of the body in preparation for the fight i.e., fighting for the patient's life.

Stress Resistance: Stress resistance involves decreasing the body's response to stress by taking care of oneself and includes health maintenance activities e.g., **proper nutrition, adequate sleep and rest, regular exercise, taking breaks and vacations to be out of the unit for some time, strengthening friendship outside the workplace** and spending off duty hours in some interesting and diversional activities e.g., reading a story book, going to cinema, watching a game, listening to music etc. All these measures increase the tolerance of stress by recharging the internal physiological and emotional energy.

Effective Coping Strategies: Coping is an individual's cognitive and behavioural efforts to manage, master, tolerate or alter specific external or internal stressors so that they are not threatening. Nurses may adapt to various coping strategies in order to reduce or manage their stress and thus prevent crisis or burnout.

2.3.2 Coping Strategies

Let us learn about direct and indirect coping strategies that are used by nurses to overcome stress.

i) Direct coping strategies

Direct coping strategies are directed to overcome the demand itself and involve strategies to solve the problem. For example, when an inexperienced nurse feels fearful of not being able to manage sudden crisis situation arising in a patient (cardiac arrest) she can solve this problem by gaining up-to-date knowledge and skills on Advanced Life Support. Gain of knowledge and skills will produce a positive feeling in the nurse and thus reduce stress and burnout.

Many of the coping strategies which are frequently adopted by critical care nurses are, by being out for some time from a stressful situation so that more effective coping measures may be adopted later on. Among the various coping strategies relaxation techniques and meditation are found to be very popular and beneficial to health. Successful relaxation promotes feelings of well-being, peacefulness and sense of control, decreases physiological effects of stress e.g., lowers blood pressure, pulse rate and respiratory rate. With practice one can achieve instant or

momentary relaxation within 30-60 seconds and may be employed during a quick tea break. This is useful to deal with on the spot situations which are likely to produce stress response.

ii) Indirect coping strategies

Nurses use indirect coping strategies while dealing with situations, which are not possible to change. Care of a dying patient or failed resuscitative attempt may be extremely stressful for a critical care nurse. During this type of situation the critical care nurse usually adapts by considering the death as relief from pain and sufferings and changes her rôle from being a 'life-saver' to one of promoting a peaceful death. Death has been reappraised as no longer being the problem (as it is not possible to change), but helping to provide a dignified and peaceful death within the scope of a skilled critical nurse. This type of restructuring or changing the perception or interpretation of stressful events to less threatening events is called **Cognitive reappraisal**. One of the coping technique is reappraisal at it assists when stress is being perceived in an exaggerated way. Reappraisal and standing back from the situation, employing logic and reason in an appropriate way may produce increased perception of coping ability.

Reappraisal may also be achieved by removing irrational non productive thoughts. A critical care nurse may have an irrational idea that 'I must be perfect at everything I do'. This irrational stressful fact has to be identified by the nurse first and then accept the fact that no one is perfect.

Another way of eliminating a stressful thought by substituting a new and more useful thought is rethinking technique. An inexperienced nurse who is obsessed with the idea that 'I cannot perform', can consciously substitute the stressful thought with a more positive productive thought e.g., 'I can perform'.

Learning certain interpersonal skills helps the nurse in dealing with interpersonal conflict and to cope with stress effectively. Skills which are necessary to deal with interpersonal conflict are assertiveness, giving and receiving of support and ability to set limits and scope of one's responsibility at work. Learning and practicing effective communication skills are also very important to minimize stress within oneself and in the work environment.

Another method, a nurse may employ in dealing with stress is seeking instrumental or emotional social support either at work or outside. Discussing the problem with competent persons and finding out effective coping strategies is one of the most effective ways of dealing with stress and prevent burnout.

2.3.3 Importance of Education and Training

Increasing clinical knowledge base and skills by critical care nurses are extremely important. Clinical knowledge and skills assist in direct coping strategies related to the clinical nature of nursing. It also increases the ability to deal with stressful situations. Extensive knowledge and expertise influence both perception of demand and perception of coping ability. The nurse who is educationally prepared in dealing with the stressor death and dying is able to view it as challenging rather than threatening.

2.3.4 Role of the Organization and Nurse Administrator in Preventing Burn out

The following measures taken by the organization and managers may help in reducing stress in critical care nurses and thus prevent burnout:

- Adequate staffing to maintain an optimum nurse patient ratio.
- Careful selection of staff for critical care as much as possible. Hard working committed, challenging staff during interview or already working in some other areas may be identified and posted in critical care units.
- Induction training and regular in-service training for the staff should be conducted.
- Careful planning and organization may minimize inconvenient working environment and noise level.
- An open two-way communication system must be established between the managers and staff by conducting regular group meetings to encourage active participation in decision-making process by various levels of staff.
- The in-charge nurse should pay particular attention to the new staff and provide work related support as much as possible.
- If the staff under stress requests for transfer or rotation to a less stressful area the manager should consider her request without any bias.
- To reduce continuous work stress the in-charge may alternate the frequency and intensity of patient care among the nurses.

Check Your Progress 2

Explain the following with examples:

i) Direct coping strategies

.....

.....

.....

.....

.....

ii) Indirect coping strategies

.....

.....

.....

.....

.....

.....

2.4 LET US SUM UP

Nurses in critical care units are confronting with numerous stressors. These stressors can be categorized as intrapersonal (e.g., lack of knowledge and skill), interpersonal (e.g., poor communication), and extra personal (e.g., disorganized working environment). Nurses experiencing stress in their working environment frequently present with different physical ailments (e.g., headaches, low back pain, loss of appetite or excessive appetite etc.), psychological (e.g., anxiety, irritability, depression etc.) and behavioral (impulsive behaviour, increased use of legally prescribed drugs, smoking, etc.). Continued stress in critical care nurses may result in 'burnout'. Burnout is a progressive stress process by which a previously committed professional disengages from work as a result of the appraised stressful transactions experienced within the job. Reduction of stress and prevention of burnout in critical care has been described which includes nurses' own actions e.g., recognizing stress within herself and her colleagues, increasing resistance to stress by looking after oneself well, and by practicing various effective coping skills e.g., direct coping, indirect coping and the importance of education and training; and the responsibilities of the organization and administrators.

2.5 GLOSSARY

Adaptation	: an alteration or a change designed to assist in adjusting to a new environment or a situation.
Coping	: cognitive or behavioural strategies employed by an individual to influence a threatening demand (stressor) to a less threatening demand.
Homeostasis	: the normal steady state within the body, the stability of the internal environment.
Stress	: a condition that occurs in response to a change in the internal or external environment of an individual that is perceived by him as threatening.
Demand	: an internal or external stimulus which is perceived by an individual as requiring adaptive response

2.6 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

- i) **Stress** has been defined as a situation that exists when an organism is faced with any stimulus that causes disequilibrium between psychological and physiological functioning. All hormone levels can be altered by stress.

Stressor: An event or the change in the environment (internal or external stimuli) that produces stress is called a stressor.

Coping: It is the process of recognizing the stressor and adjusting or adapting to the changing situation to maintain one's health and wellbeing.

ii) **Physiological Response to Stress**

The physiologic response to any kind of stressor is a protective and adaptive mechanism to maintain the steady state or homeostatic balance of the individual, it has three phases:

- 1) **Alarm reaction** – in this phase an individual perceives a stressor physically or mentally and the sympathetic fight or flight response is initiated. That is the hormone levels rise, heart rate increases, increased blood flow to muscles, increased Oxygen intake, and greater mental alertness. This alarm reaction is defensive but self-limited. So the person moves into second phase.
- 2) **Resistance** – during this phase, the body stabilizes, and hormone levels, heart rate, blood pressure and cardiac output returns to normal, thus adaptation to the stressor may occur. The amount of resistance to the stressor varies among different individuals depending on the number and intensity of stressors, person's internal physical and psychological reserves and external social support from family, friends, providing energy required for adaptation.
- 3) **The stage of Exhaustion** occurs when all the energy for adaptation has been spent. The magnitude of the stressors is too great compared to the person's physiologic and psychological reserves. The individual in the stage of exhaustion usually becomes ill and may die if assistance from outside sources is not available.

iii) **Phases of Crisis**

Phase 1: In this phase a person is confronted with a problem or stressor or a conflict that threatens the self-concept. He or she responds with anxiety. The anxiety stimulates the usual problem solving techniques and other coping mechanisms in an effort to solve the problem and lower the anxiety.

Phase 2: If the problem solving and other coping mechanisms fail and the threat persist, anxiety continues to rise. This rise in anxiety produces extreme discomfort. Person's functioning becomes disorganized. He or she begins to make trial and error attempts to solve the problem and restore a normal balance.

Phase 3: If the trial and error attempts fail, anxiety intensifies to severe and panic levels. These extreme levels of anxiety mobilize automatic relief behaviours e.g., withdrawal and flight. Some form of resolution may be made in this phase by either compromising needs or redefining the situation to make an acceptable solution.

iv) **Signs and Symptoms of Burn out**

- Feeling tired and exhausted at all times
- Frequent headaches and gastrointestinal disturbances at all times
- High resistance to going for work each day
- Frequent absenteeism
- Stereotyping of patients
- Rigidity in thinking and resistance to change

- A feeling of failure
- Suspicions and paranoia
- Avoiding discussion of work with colleagues at work
- Isolation and withdrawal
- Excessive use of drugs
- Negativism
- Loss of purpose.

Check Your Progress 2

i) Direct coping strategies

Direct coping strategies are directed to overcome the demand itself and involve strategies to solve the problem. For example, when an inexperienced nurse feels fearful of not being able to manage sudden crisis situation arising in a patient (cardiac arrest) she can solve her problem by gaining up-to-date knowledge and skills on Advanced Life Support. Gain of knowledge and skills will produce a positive feeling in the nurse and thus reduce stress and burnout.

Many of the coping strategies which are frequently adopted by critical care nurses by being out for some time from a stressful situation, so that more effective coping measures may be adopted later on. Among the various coping strategies relaxation techniques and meditation are found to be very popular and beneficial to health. Successful relaxation promotes feelings of well-being, peacefulness and sense of control, decreases physiological effects of stress e.g., lowers blood pressure, pulse rate and respiratory rate. With practice one can achieve instant or momentary relaxation within 30-60 seconds and may be employed during a quick tea break. This is useful to deal with on the spot situations which are likely to produce stress response.

ii) Indirect coping strategies

Nurses use indirect coping strategies during dealing with situations, which are not possible to change. Care of a dying patient or failed resuscitative attempt may be extremely stressful for a critical care nurse. During this type of situation the critical care nurse usually adapts by considering the death as relief from pain and sufferings and changes her role from being a 'life-saver' to one of promoting a peaceful death. Death has been reappraised as no longer being the problem (as it is not possible to change), but helping to provide a dignified and peaceful death

2.7 REFERENCES

- 1) Potter PA and Perry AG (2001). Fundamentals of Nursing (5th ed). St. Louis: Mosby. P644 – 667.

UNIT 3 GUIDANCE AND COUNSELLING

Structure

- 3.0 Introduction
- 3.1 Objectives
- 3.2 Concept of Guidance and Counselling
 - 3.2.1 Definition and Meaning of Guidance
 - 3.2.2 Definition and Meaning of Counselling
 - 3.2.3 Relationship Between Guidance and Counselling
 - 3.2.4 Principles of Guidance and Counselling
- 3.3 Counselling Process
 - 3.3.1 Phases of Counselling
 - 3.3.2 Qualities of a Counsellor
 - 3.3.3 Counselling Skills Required in Critical Care Settings
- 3.4 Guidance and Counselling in Critical Care Settings
 - 3.4.1 Individual and Family Needs of Guidance and Counselling
 - 3.4.2 Scope of Guidance and Counselling in Critical Care Units
- 3.5 Let Us Sum Up
- 3.6 Answers to Check Your Progress
- 3.7 References

3.0 INTRODUCTION

In the previous two units you have learnt about the stress and crisis situations occurring in critically ill patients, their family members and also in nurses working in critical care units.

Admission in a critical care unit is traumatic experience. It can be traumatic, both socially and psychologically, for the patient. It may also be traumatic for the family and friends of the patient. Effective guidance and counselling skills are a vital prerequisite of skilled and compassionate care in this field.

In this unit you will learn about effective guidance and counselling skills in order to enable yourself to help the patients, their family members and also your colleagues to overcome stress and crisis that frequently accompany critical illnesses and critical care personnel.

3.1 OBJECTIVES

After completing this unit you should be able to:

- explain the concept of guidance and counselling;
- describe the relationship between guidance and counselling;
- apply the principles of guidance and counselling;
- describe the phases of counselling;
- recognize the scope of guidance and counselling in critical care settings;

- discuss the qualities of an effective counsellor; and
- develop the skills of counselling to be applied while working in critical care unit.

3.2 CONCEPT OF GUIDANCE AND COUNSELLING

In this section we shall focus on definition meaning and principles of guidance and counselling and relationship between guidance and counselling.

3.2.1 Definition and Meaning of Guidance

Guidance means to guide, direct or to lead.

Guidance: “Guidance is the help given by one person to another in making choices and adjustments and in solving problems Jones (1971). It aims at aiding the recipient to grow in his independence, and ability to be responsible for himself.”

Guidance is the assistance made available by the qualified and trained person to an individual of any age to help him to manage his own life activities, develop his own point of view, make his own decisions and carry on his own burdens.

In critical care settings, guidance helps the patient to cope with the life-threatening condition which a patient is experiencing. It also fulfils the family needs of support, comfort, information, proximity and reassurance.

3.2.2 Definition and Meaning of Counselling

Counselling: Counselling is a specialized service of guidance and basically an enabling process. Counselling involves helping others to make constructive changes in behaviour and to find better ways to deal with stressful situations.

“Counselling is the helping relationship that includes someone seeking help, someone willing to give help who is capable or trained to help, in a setting that permits help to be given and received” (Cormier & Hackney, 1987).

In essence, counselling is a human process by which one individual who has counselling skills assists another person who is having difficulty in dealing with various aspects of life to find better ways of handling these problems.

In general, counselling includes:

- Someone seeking assistance,
- Someone capable of assisting and willing to give assistance, and
- A safe setting for the process to occur.

Counselling does not mean:

- giving of information, though information may be present.
- giving of advice.
- influencing attitude, beliefs, and behaviours by persuading, admonishing threatening, or compelling without the use of physical force.
- selection and assignment of individual to a job.

3.2.3 Relationship Between Guidance and Counselling

Although guidance and counselling are different terms, they are closely related to each other as shown in Table 3.1:

- Guidance comprises information, given to a person to solve the problem. Information is also given in counselling. But all information given is not counselling.
- Guidance is preventive, whereas counselling is curative to change the personality of an individual to enable her/him to make adjustment in life.
- Guidance information makes the basis for counselling sessions. Guidance may be done by any guidance worker, whereas counselling requires a high level skills as well as special professional training.
- Guidance may be given in any normal set up whereas counselling requires a special set up or a separate room to conduct the interview.
- Counselling has a broader perspective and scope than guidance. It is required in all the fields.
- In guidance, decision making operates at intellectual level, whereas counselling operates at emotional level.

Table 3.1: Difference between guidance and counselling

	Guidance	Counselling
To whom given?	Patient, family members and friends	Patients and family members
By whom given?	Nurses, counsellors	Counsellors
Where it is given?	Every where	In a special setting, conducive to giving and receiving help for interviewing
How it is given	Giving information and helping patient and family members understand the situation	Giving guidance with a view to enable patient and family members to make decision
Purpose	To cope with the crisis and stressful situations	Helping patient his family members and friends to adjust to life strategies.

3.2.4 Principles of Guidance and Counselling

Guidance and counselling includes following principles. It is —

- unique to individual.
- concerned with the "Total" individual.
- always goal oriented and goal directed.
- a professional activity.
- it should be based on thorough knowledge of the stages of human growth and development.
- meant for all those who need help.

- not specific to any stage of development.
- it should be based on reliable data.
- it should have a flexible approach.
- it is a continuous and slow process.

3.3 COUNSELLING PROCESS

You have learnt about the concepts and principles of guidance and counselling. In this section you will be learning about the phases of counselling.

3.3.1 Phases of Counselling

Counselling is best described as a process, in which steps are to be followed in a sequential manner. There are some distinct phases of counselling process. The phases are given below:

- Establishing relationship
- Assessment
- Setting goals
- Intervention
- Termination and follow up.

Establishing relationship

It is the core phase in the process of counselling. It should be recognized that each counsellee-counsellor relationship is unique. The relationship is not established in just a single session but may require several sessions before s/he becomes comfortable with the counsellor and accepts his/her inner world. You should go through all the stages of nurse-patient relationship and should be able to develop a good therapeutic relationship with the patient. It will give the patient a feeling of respect and trust in you and provide psychological comfort.

Assessment

In this phase individuals are encouraged to talk about their problems. Counsellor asks questions, collects information, seeks his/her views, observes and possibly helps the individual to clearly state his/her problem. The tasks of this phase include:

- Determining the primary purpose of the counselling interaction.
- Assessment of the client's total condition—physical, emotional, social and spiritual.
- Evaluating the presenting complaint of the client.
- Determining if goals can be mutually agreed upon.
- Identifying client expectations for the counselling process.
- Examining the here and now situation of the client.
 - Presence of anxiety and how it may interfere with communication.
 - Developmental level of the client.
 - Ability to communicate clearly
 - Ability to verbalize concerns and identify problems.

Setting goals

The major purpose of this phase is to provide direction to the individual and the counsellor. It involves making a commitment to a set of condition, a course of action or an outcome. Generally the goals of counselling include:

- To assist the client to be more constructive to deal with stressful situations.
- To use the interviewing process to facilitate accomplishment of a goal.
- To assist the client to build more effective coping mechanisms.

Intervention

This phase is more influenced by the viewpoints a counsellor holds about the counselling process. The intervention used will depend upon the approach used by the counsellor, the problem and the individual. Intervention is a process of adaptation and the counsellor should be prepared to change the intervention when the selected intervention is not working. This is similar to medical treatment. During the intervention phase, the counsellor should —

- Remain goal-directed during the counselling session.
- Establish the client's reasons/problem for seeking counselling.
- Utilize therapeutic communication techniques.
- Establish an open, honest relationship to facilitate trust.
- Set time limits.
- Select and implement behaviour alternatives.
- Improve the client's self-esteem.
- Increase the client's ability to use problem solving techniques.
- Make self-disclosure when appropriate but do not focus on self.
- Communicate clearly and congruently and be aware of all levels of communication.

Termination and follow up

Relationship between a counsellee and a counsellor should not be terminated abruptly rather it should follow a particular phase. Follow up should be done to ensure that the problem solving ability of the individual is increased and s/he can better respond to a stressful situation.

3.3.2 Qualities of a Counsellor

Three elements are essential for an effective counsellor-client relationship. These are given below:

Unconditional positive regard and acceptance

This concept encompasses the thought that all human beings have value and worth. Without a sense of client's worth, effective communication cannot take place.

Empathy, warmth and interest

Empathy (the intellectual or emotional identification with another) leads to an understanding that involves an accurate sense of the client's world and an understanding of how the client perceives things.

Genuineness, authenticity and honesty

A genuine and authentic manner of behaving is reflected in a free and spontaneous response by the counsellor, responses that are bound by ethics and judgement. A counsellor, to be effective, must be in touch with his personal humanness.

3.3.3 Counselling Skills Required in Critical Care Settings

The key skills in counselling process are judgemental listening and the giving of full attention. The aim, as you have already noted, is to emphasize and enter the world of other person to attempt to see the world as they see it. The techniques of counselling are discussed below:

a) Listening and attending

Listening is the most important skill of all. The most skilled counsellor listens far more than they talk. The acceptable behaviours related to listening are suggested by Egan and these are:

Sit squarely: Face the client rather than sit next to him or her. Sitting facing the client means that we are able to see his/her expressions, gestures nonverbal aspects of speech, his/her eyes. The client is also able to see your eyes and eyes have a great role to play in communication.

Sit in an open position: Do not fold your arms or cross your legs. The more open you can be in your posture, the more open you are likely to appear to the client.

Lean slightly towards the other person: Slight leaning towards the client you are counselling, shows that you are with him.

Maintain comfortable eye contact.

Relax: For counselling a client, you have to sit, relax and listen to his/her story. Initially it is difficult.

As you develop counselling skills, you will learn to internalize this skill.

Egan suggests the acronym SOLER as an easy method of remembering these behaviors:

S: sit squarely

O: open position

L: lean forward

E: eye contact

R: relax

Remember that cultural differences come into play when listening takes place. Do not assume that SOLER behaviours will necessarily be appropriate in all situations. When you are counselling people from different cultures, read as much as you can about those cultures to be an effective counsellor.

Now let us learn how to ask questions from a patient while counselling:

Asking questions/Questioning

Asking questions is a major part of the task of being a counsellor. The counsellor uses questions in order to help the client and the counsellor to illuminate the client's world. The counsellor does not seek out information for its own sake, but more to clarify. The questions can be open ended and closed ended.

Open and closed ended questions

The **open question** is the question to which the counsellor cannot guess the answer. Open questions are not usually answered with one word but by a series of sentences. The following are the examples of open questions:

- How do you feel about that?
- What happened after that?
- What are your thoughts about that?

Open questions are particularly useful in helping the client to open up and to expand on what s/he is saying.

Closed questions, on the other hand, usually have a definite answer, and one that the counsellor can usually make a guess. The following are the examples of closed questions:

- How many children do you have?
- Has your wife visited you today?

Closed questions are useful for gathering particular pieces of information. It is probably better to restrict the number of closed questions that you use. Too many closed questions soon lead to silence.

Questions to avoid

There are certain questions that should not be asked. A few examples of these types of questions are:

Loaded questions: These are questions that reveal the counsellor's own particular beliefs and prejudices about the client. An example of a loaded question is: "Did you feel guilty about the way you treated your family?" the implication is that the client should have felt guilty.

Multiple questions: Sometimes in the quest to get things right, it is possible to roll number of questions into one: "How did you feel about being in hospital? Did you think that you were treated fairly well? Did you feel you could have managed better on your own....?" The obvious problem here is: which question is the client supposed to answer? Try to ask one question at a time.

Unclear questions: This is a variant of multiple questions. When we are anxious or trying hard to be clear, it is possible to do exactly the opposite and to become very muddled. As a rule, short questions are usually more effective than lengthy ones.

Intrusive questions: The aim of counselling is to help the client to solve problem. The aim is not to collect very personal data about the other person. It is important that we do not ask questions that could embarrass or offend the client, such as "Are you sexually attached to him?"

Empathy building

Empathy is the ability to enter into the other person's frame of reference: to feel as they feel. Empathy building is the process of conveying that you are sharing experience with the client.

Empathy building statements, are those which illustrate that you are matching the feelings and experiences of the other person. Examples of empathy building statements are: "It feels as though...", "I get the impression that...", "is it the case that...?"

You should not try too hard to build empathy. It can not be forced also. It develops with the development of the counselling relationship.

Reflection

Reflection (sometimes called echoing) is a familiar and well known counselling strategy. Two sorts can be described. First there is straightforward reflection of the last thing that the client said. Thus, when the client begins to falter in what s/he is saying, the counsellor repeats back the last few words that were spoken. The second type of reflection is where something is reflected back from the middle of what the client has been saying: something that was emphasized by them or which appears to be an emotional issue.

Checking for understanding

When we are counselling it is important to understand what the other person is saying and what is s/he talking about. The intervention, known as checking for understanding, refers to the idea that we need to stop occasionally and check what the other person is meaning. If we do not, we run the risk of either getting confused or by missing the point.

Two sorts of checking for understanding can be described. First, there is checking that can take place during a counselling session and to check what exactly is other person saying. Examples: "So you are saying that you were accepted at home but not so much at work...."

The second sort of checking for understanding occurs when the counsellor sums up what has been talked about at the end of a session or whenever a natural break occurs. Example: "So let me sum up, if I can, what we have been talking about so far...." This sort of checking for understanding can be used to close a counselling session.

Levels of disclosure

As the counselling relationship deepens and the counsellor and client get to know each other better, the amount and depth that a client reveals will deepen. The level at which disclosure takes places depends upon client trust and counsellor.

Moving on

The initial period of exploration naturally leads on to the next stage of identifying priorities. It is very important to remember that priorities emerge with the maturation of the relationship. Sometimes, the client will acknowledge particular issues as important ones. Then, s/he naturally leads the counselling relationship into the next phase.

Coping with feelings

Counselling people means coping with emotions. A considerable part of the process of helping people in counselling is concerned with the emotional or 'feelings' side of the person. Sometimes, just letting a person express his/her feelings can be therapeutic. It is notable that the suppression of feelings can lead to certain problems in living that may be clearly identified. But at the same time you should be able to recognize the individual differences. Some people, for example, do not particularly like or want to express strong feelings. There should be no hint from the counsellor that people should release or face emotions. It is important to pay close attention to the individual's needs and wants.

Exploring possible alternatives

The client identifies a course of action in this stage though sometimes s/he is still confused and uncertain about what needs to be done. It is often easier to remain in the domain of thinking and feeling than doing. Sometimes the people want the things to change but they do not want to change themselves. Though the truth is that if we want change to occur in our lives then we must also change.

Problem solving

Formal problem solving is sometimes useful. The stages of problem solving cycle are the following:

- Identification of the problem
- Generation of all possible solutions
- Selection of a particular solution
- Institution of the particular solution
- Evaluating the effectiveness of the solution.

The process of brainstorming is the most useful way of generating a wide range of possible solutions.

Recording counselling

At this point, it is important to consider whether or not you will record your counselling sessions. Advantages of recording counselling can be listed as:

- a series of records allow you to check the progress of the counselling sessions.
- records allow you to review what has happened between you and the client.
- records enable other people to see what you have been doing in your counselling sessions.

The disadvantages are:

- records can give a false sense of what is happening in a person's life.
- the real problem and potential disadvantage is the issue of confidentiality. If you make a record, you make a formal document which is the property of the hospital or the health care organization. Anonymity of the client may not be maintained.

You need to think in great detail about this issue, discuss it with your senior nurse and then make a decision. It may be possible to write notes in other documents relating to the patient's care as a contrast to keeping separate 'counselling notes'.

Taking action

Effective counselling must always lead to action on the part of the client. The client has to change something about the way they do things or the way they live. In the end, counselling can never just be about talking; action has to occur. And this is very often the most difficult part of the whole process.

It is helpful if the counsellor talks through this 'action' phase of the relationship very carefully with the client and helps to plan the course of action. Both parties allow the change element to take place successfully before termination is initiated.

Check Your Progress 1

i) Discuss the relationship of guidance and counselling.

- a)
- b)
- c)
- d)
- e)

ii) Write five general principles of guidance and counselling.

- a)
- b)
- c)
- d)
- e)

iii) Discuss the phase of counselling.

.....
.....
.....
.....

iv) List the skills required for counselling in critical care unit.

- a)
- b)
- c)
- d)
- e)
- f)
- g)

3.4 GUIDANCE AND COUNSELLING IN CRITICAL CARE SETTINGS

Now let us turn our attention towards guidance and counselling in critical care unit.

3.4.1 Individual and Family Needs of Guidance and Counselling

Critical care units have been recognized as stress-provoking environment because of their focus on the prevention or intervention in life-threatening events. Critically ill patients are physiologically and psychologically unstable experiencing pain and anxiety, aging, confusion and agitation, altered cognition level and so on.

Families of critically ill patients have discrete need for support because of the uncertainty, anxiety, and stress of having a critically ill family member. The crisis often occurs without warning, giving family member little time to employ coping strategies. Ineffective coping potentiated by the fear of the loss of a loved one, may engender behaviours which require proper guidance and counselling by the caregivers.

Quality care is focused on the perception of the hospital experience by patients and families. Family-focused care should be provided through identification of family roles and responsibilities, as defined by the patient and significant others, to meet the needs of the critically ill patient within the context of the family.

The development of the Critical Care Family Needs Inventory describes the dimensions of family's needs. These are as follows:

- Support
- Comfort
- Information
- Proximity
- Reassurance

All the situations discussed above validate the needs of extensive guidance and counselling of the critically ill patients and their families throughout hospitalization and thereafter.

3.4.2 Scope of Guidance and Counselling in Critical Care Units

You have learnt about the need of guidance and counselling for family and individuals. Now you will study the scope of guidance and counselling which is given below:

Guidance and counselling helps clients and family in the following:

- adjust with the environment of critical care unit.
- overcome the stress of experiencing life-threatening illness
- maintain patient's cognitive integrity and the contact with reality.
- enhance the individual coping mechanism of the patient.

- identify the family roles and responsibilities in the care of the patient.
- family to cope with the situation of one of the family members being admitted in critical care unit with life-threatening condition.
- ensures that quality care is provided to the critically ill patient by the caregiver and thereby the organization.
- the nurses to resolve their stress and prevent burnout syndrome.

Check Your Progress 2

i) List the dimensions of family needs.

.....

.....

.....

.....

.....

ii) Describe the scope of guidance and counselling in critical care unit.

.....

.....

.....

.....

.....

3.5 LET US SUM UP

In this unit you have learnt that guidance is the assistance made available by the qualified and trained persons to an individual of any age to help him to manage his own life activities, develop his own point of view, make his own decisions and carry on his own burdens. Counselling is an integral part of nursing activities in caring for a critically ill patient. Counselling is basically a helping relationship that includes someone seeking help, someone willing to give help who is capable or trained to help, in a setting that permits help to be given and received. Although guidance and counselling are different terms, they are closely related to each other.

There are certain situations which validate the needs of extensive guidance and counselling of the critically ill patients and their families throughout hospitalization and thereafter. Guidance and counselling follows certain general principles and pass through some distinct phases such as establishing relationship, assessment, setting goals, interventions, termination and follow up.

Nurses should plan to guide and counsel the critically ill patients and their families by mastering certain special skills.

3.6 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

- i) a) Guidance comprises information given to the persons to solve the problem. But all information given is not counselling.
- b) Guidance is preventive, whereas counselling is curative
- c) Guidance information makes the basis for counselling sessions.
- d) Guidance may be given in any normal set up. Whereas counselling requires a special set up or a separate room to conduct the interview.
- e) Counselling has a broader perspective and scope than guidance. It is needed in all the fields.
- ii) Guidance and counselling
- a) is unique to individual
- b) is concerned with the 'Total' individual
- c) is always goal oriented and goal directed
- d) is a professional activity
- e) should be based on thorough knowledge of the stages of human growth and development
- iii) a) Establishing relationship
- b) Assessment
- c) Setting goals
- d) Interventions
- e) Termination and follow up
- iv) a) Listening and attending
- b) Using open questions
- c) Empathy building
- d) Reflection
- e) Checking for understanding
- f) Coping with feelings
- g) Exploring possible alternatives

Check Your Progress 2

- i) • Support
- Comfort
- Information
- Proximity
- Reassurance

- ii)
- clients to adjust with the environment of critical care unit.
 - patient and the family to overcome the stress of experiencing life-threatening illness.
 - maintain patient's cognitive integrity and the contact with reality.
 - enhance the individual coping mechanism of the patient.
 - caregiver to identify the family roles and responsibilities in the care of the patient.
 - family to cope with the situation of one as the family members being admitted in critical care unit with life-threatening condition.
 - ensures that quality care is provided to the critically ill patient by the caregiver and thereby the organization.
 - nurses to resolve their stress and prevent burnout syndrome.

3.7 REFERENCES

- 1) Burnard P and Miliar B. (1994) *Critical Care Nursing: Caring for the Critically Ill Adult* (1st.ed.). Paston Press Ltd.
- 2) Burnard Philip. *Counselling in Critical Care Nursing*. 331-343.
- 3) Grenvik Ake et.al. (2000) *Textbook of Critical Care* (4th ed.). New Delhi: Elsevier. 2038-2044.
- 4) Smith Sandra F., Karasik Darlene A. & Meyer Beverly J. (1984). *Review of Psychiatric and Psychosocial Nursing* (1st ed.) California: National Nursing Review.173-179.

UNIT 4 THERAPEUTIC COMMUNICATION AND INTERPERSONAL RELATIONSHIP (IPR)

Structure

- 4.0 Introduction
- 4.1 Objectives
- 4.2 Concept of Communication
 - 4.2.1 Components of Communication
 - 4.2.2 Factors Affecting Effective Communication
 - 4.2.3 Communication Problems Faced by Critically Ill Patients
 - 4.2.4 Points to Keep in Mind During Communication
 - 4.2.5 Importance of Involving Family Members in the Care of Critically Ill Patient
- 4.3 Concepts of Interpersonal Relationship
 - 4.3.1 Purposes of Interpersonal Relationship
 - 4.3.2 Importance of Interpersonal Relationship
 - 4.3.3 Factors Affecting Interpersonal Relationship
 - 4.3.4 Barriers of Nurse Patient Relationship
 - 4.3.5 Phases of Interpersonal Relationship
 - 4.3.6 Techniques to Improve Interpersonal Relationship
- 4.4 Therapeutic Communication
 - 4.4.1 Importance of Therapeutic Communication
 - 4.4.2 Therapeutic Communication Techniques
- 4.5 Nursing Process in Communication
 - 4.5.1 Assessment
 - 4.5.2 Nursing Diagnoses
 - 4.5.3 Planning
 - 4.5.4 Implementation
 - 4.5.5 Evaluation
- 4.6 Let Us Sum Up
- 4.7 Answers to Check Your Progress
- 4.8 References

4.0 INTRODUCTION

In the previous unit you have learnt about the guidance and counselling skills to be utilized by a critical care nurse in order to provide holistic care to the critically ill patients. You will appreciate that to be a good counsellor one has to establish effective communication with her clients. Communication is the dynamic, multisensory interaction in which a person shares thoughts and feelings with other people in his psychosocial environment. Critical illness has impact on the psychosocial health of the previously well-adjusted person and family who are now stressed by a situational crisis. Critical care nurse can appreciate the numerous and varied communication needs of a critically ill patient with focus on psychosocial aspects of critical care.

Through therapeutic communication nurse develops a relationship with the client to meet several purposes. Imogene King (1971), (a nurse theorist), call nurse-patient relationship as “learning experiences whereby two people interact to face an immediate health problem to share, if possible, in resolving it, and to discover ways to adapt to the situation”. In this unit you will learn about the concept and techniques of communication, therapeutic communication and interpersonal relationship in detail. We will also focus on nursing process in communication.

4.1 OBJECTIVES

After completing this unit you should be able to:

- explain the concept of communication;
- describe the factors affecting effective communication;
- relate the importance of involving family in communication and interpersonal relationship in critical care setting;
- differentiate the concept of therapeutic and social communication;
- discuss the importance and benefits of therapeutic relationship in critical care units;
- apply therapeutic communication in Critical care units;
- review the concepts of interpersonal relationship;
- discuss the purpose, importance and factors affecting interpersonal relationship, describe the phases of interpersonal relationship;
- apply the techniques to improve interpersonal relationship; and
- utilize nursing process in meeting the communication needs of the critically ill patients;

4.2 CONCEPTS OF COMMUNICATION

Communication as you have studied in your basic training is the exchange of ideas between two or more persons. It is actually a process more than just the simple art of conversation. It is important in nursing profession because it can make or break a nurse-patient relationship. Communication can be **verbal** and **non-verbal**. It can best be described as a **two way process** and can be broken down according to its essential components: the **encoder**, the **code** or **the message**, the **decoder** and the **response or feedback**. We shall discuss these components in following subsections:

4.2.1 Components of Communication

There are four components of communication as discussed below (Fig 4.1).

- i) **The encoder:** The encoder is the person who originates a message. He experiences a desire to share a thought or feeling with someone else (cognitive processing) and moulds this thought or feeling into a form suitable for transferring it from his mind to theirs.

- ii) **The code:** Code is the message that is conveyed and the medium or system used to convey it. Although this usually involves a simple spoken system, message can also be conveyed by a painting, poem or movie, Braille, computers, television, audio tape etc.
- iii) **The decoder:** The receiver of the message not only receives it (hears, reads, views) but interprets or decodes. People interpret messages in light of their store of knowledge. Message may be misinterpreted if a receiver's store of knowledge is so different from that of a sender that the message has a different meaning, or the person misses part of the transmission.
- iv) **The feedback or response:** Feedback is the reply that the decoder returns to the sender that acknowledges that the message has been received and interpreted. Communication can be ineffective if people do not offer feedback or if feedback is offered before the message is fully interpreted.

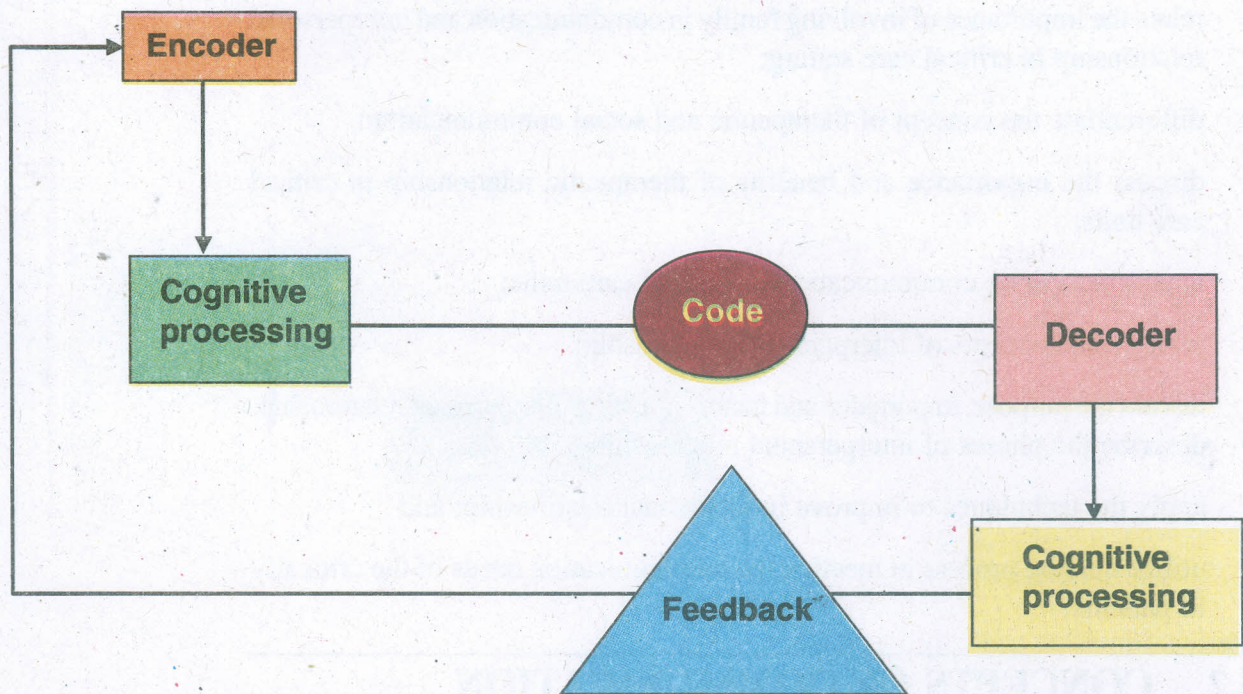


Fig. 4.1: Components of Communication (Communication Process)

Communication can be **verbal** (words or written language) or **nonverbal** (Behaviours, actions). Verbal communication includes both **spoken words** and **written words**. **Nonverbal** communication describes all behaviours that convey messages without the use of verbal language. This includes body movement, physical appearance, personal space and touch. "Actions speak louder than words" is an old saying but still true.

Non-verbal communication is expressed in a variety of ways. It gives a feeling of genuineness warmth and empathy. It includes following:

- Use of gesture.
- Body posture and gait.
- General appearance.
- Use of touch: Touch is the most intimate and meaningful non-verbal communication. Learn to use touch such as clasping a patient's shoulder or

squeezing a hand to accompany reassuring words or in place of words as a strong support signal. Assess people individuality for the technique appropriateness.

- Use of humor.
- Use of distance: Although it is affected by cultural and personal variables, the distance you place yourself away from a person may indicate your feelings toward him or the type of conversation you want to engage in with him.

4.2.2 Factors Affecting Effective Communication

The factors which influence the effective communicative can be classified in general factors and the factors that block the communication.

General factors include following:

- **Personal Factors:** If you relate well with another person, it is easier to communicate clearly. Similarities between the sender and receiver as far as their age, cultural background, intellectual levels are concerned, fosters effective communication.
- **Physical factors:** Such as speech defects and hearing impairment can interfere with the transmission and reception of message.
- **Emotional factors:** Anxiety, anger, grief, and excitement interfere with communication. Good communication in emergency situations calls for extra concern and effort.
- **Social factors:** A person's cultural or ethnic background may interfere with communication.
- **Environment factors:** Extreme temperatures, excessive noise, special environment of a critical care unit can affect communication and may require special technique to follow.

Factors Blocking the communication

- Changing the subject
- Offering false reassurance
- Giving your personal opinion
- Telling people how they should feel
- Technical jargon
- Inattentive listening
- Showing disapproval
- Not showing approval when warranted
- Being defensive

4.2.3 Communication Problems Experienced By Critically Ill Patients

Critically ill patients experience intense communication problems caused by following deficits:

- Cognitive, sensory or language deficits that distance the patients from caregivers and loved ones.
- Mechanical ventilation and use of sedative agents impair communication between patients and others.
- Physical restraints used to prevent disruption of medical devices further limits ability of client's ability to gesture or use alternative communication techniques.
- Patients in critical care units are subjected to a distressing amalgamation of unit noise: beeping sounds from cardiac monitors; whooshing sounds from ventilators; ear-piercing alarm etc.
- Patients are in unfamiliar beds in unfamiliar rooms that are lit constantly and may have no windows out of which they can look.
- Patients are connected by myriad tubes and wires to strange machines, which they sometimes perceive as frightening.
- Critically ill patients are regressed to being bathed, fed and toileted by strangers.
- Patients are deprived of undisturbed sleep. Their minds may be clouded by their diseases, fluid and electrolytes imbalances and drugs.

All the situations mentioned above may complicate the situation at a time when the patients are trying to cope with life-threatening illnesses.

4.2.4 Points to keep in mind during communication

- Avoid giving false or ineffective reassurance.
- Avoid giving advice.
- Avoid jumping from one topic to another.
- Use non-judgemental attitude.
- Consider age, intelligence and degree of illness.
- Avoid probing.
- Maintain confidentiality.
- Learn how to overcome the barrier.
- Avoid challenging the client.

4.2.5 Importance of Involving Family Members in the Care of Critically Ill Patients

Patients are members of a family long before they become participants in the environment of critical care. The experience of life-threatening illness is one of the most difficult situations that individuals and their families have to face. Through the mounting suspicions about dangerous symptoms, through the crisis of diagnosis and long periods of chronic illness, whether the result is recovery or death, may encounter with life-threatening illness which leaves an indelible mark on all individuals, their families and even the people who care for them. Families of critically ill patients have discrete needs for support because of the uncertainty, anxiety, and stress of having a critically ill family member. The caregivers should

be sensitive to the needs of the family of the critically ill patient and involve them in the communication process as well as put efforts to maintain interpersonal relationship with them. On many occasions, the critical illness of the patients demands that the nurses should involve the family members in the care of the patients and they should proceed to plan fully to provide family-focused care.

Check Your Progress 1

- i) State the ways of expressing nonverbal communication.
 - a)
 - b)
 - c)
 - d)
- ii) List five general factors that can interfere with effective communication.
 - a)
 - b)
 - c)
 - d)
 - e)

4.3 CONCEPTS OF INTERPERSONAL RELATIONSHIP

Interpersonal relationship (IPR) can be defined as a relationship (state of being related) that exists between two people. It depends on the kind of connection or correspondence that prevails between persons. A series of planned purposeful interactions between two individuals can be undertaken to develop interpersonal relationship. It may be between a **nurse and a client**, **nurse and other members of health team**, **a leader and a follower** or **a boss and subordinate**.

Let us focus on Nurse-patient relationship/Helping relationship/Therapeutic relationship.

Helping relationship is a bond between nurse and client that allows the nurse to be more objective in carrying out the nursing process. The nurse-client relationship is more than a mutual partnership. Travelbee (1971) calls it a human-to-human relationship. The nurse uses the skills of interpersonal communication to develop helping relationship with the client that allows her to understand the client as a total person. The relationship is therapeutic, promoting a psychological climate that facilitates positive change and growth in the client. You will learn about therapeutic communication in section 4.4 of this unit.

4.3.1 Purposes of Interpersonal Relationship

The main purposes of Interpersonal relationship are as follows:

- Develop interpersonal trust.

- Bring desirable change in behaviour.
- Reduce anxiety.
- Help to increase self-esteem and autonomous functioning.
- Provide support and encouragement.
- Utilize full potentialities.
- Create a smooth and healthy emotional environment.

4.3.2 Importance of Interpersonal Relationship

The IPR is important for both nurse and patient as discussed below:

Benefits to nurses

- Understanding interpersonal process helps a nurse in her daily association with clients and their relatives, hospital co-workers and with their family members and neighbours.
- It helps to function co-operatively with other human beings that make health care accessible for individual in community.
- It helps to create a therapeutic relationship, which has a great influence on client's recovery.
- It helps nursing personnel to provide effective care by using nursing process.
- It improves communication, co-ordination and co-operation.
- It helps to take right decision and solve problems effectively both in client care and in administration.
- Self-awareness, self-understanding and insight can be improved by continuous use of interpersonal process.
- It enables us to become interpersonally effective.

Benefits to patients

The IPR helps the patient in —

- Understanding and coping with present problems through clear explanation of illness.
- Finding out a new alternative solution for a problem.
- Trying out new patterns of behaviour.
- Understanding his participation in a therapeutic experience.
- Communicating with other members.
- Socializing among group members.
- Talking in terms of other person's interest.
- Preparing one-self mentally to accept the worst if necessary.
- Always having a smiling face.

Check Your Progress 2

- i) Briefly explain the concept of interpersonal relationship.

.....
.....
.....
.....
.....

- ii) Explain importance of Interpersonal relationship for patient.

.....
.....
.....
.....
.....
.....
.....

4.3.3 Factors Affecting Interpersonal Relationship

The relationships between nurse and patient / nurse and other health team members or among the persons in administration do not just 'happen'. It is built with care as the persons involved in the process are having their own beliefs, values, attitudes and behaviours. The factors facilitating interpersonal relationship are explained below: .

Self awareness and Knowledge of Others

It is an important aspect, which a person must identify in him/her. Self-awareness includes self-concept, beliefs and values and life experiences. If the person has developed positive self-concept, the person values the human life and believes in respecting the person as a human being and has the positive life-experiences, the person will be able to develop good inter-personal relationship.

Communication

It is a major tool to develop interpersonal relationship. It refers to the reciprocal exchange of information, ideas, beliefs, feelings and attitudes between persons or among a group of persons. It is a goal-directed process in which people use a system of symbols and signs to convey a message. We communicate when we talk (verbal), and also when we don't talk (non-verbal). We communicate when we move and when we are still. We communicate within ourselves and with others.

Empathy

It is a fair, sensitive and objective look at what another person experiences, it tends to depend on similarities of experiences between the persons communicating. In contrast, sympathy is the inclination to think or feel as the other person does. Sympathy is a subjective look at another person's world that prevents a clear perspective of all sides of the issues confronting that person. A

person can empathize more easily with another person in pain, if the former has experienced pain. Empathy can be expressed in many ways, such as being available when needed, showing awareness. A person who empathizes with another person avoids impulsive judgements about that person and is more likely to be sensitive and genuine.

Trust

It refers to the feeling of confidence in the reliability of another that makes the individual to feel safe in the other's company which in turn helps to more openly share concern, feelings and hope. Basic feeling of trust develops from the way an individual's basic needs have been met in the past through significant people in his life.

Genuineness

It is actual interest or feeling with which a nurse cares for the patient or a person shows interest in others.

Warmth

Is acceptance of the client/person. A warm, permissive, non-threatening atmosphere demonstrates the acceptance. Warmth can also be communicated nonverbally by a calm, reassuring tone of voice, a facial expression displaying concern and gentle grasp of one's hand.

Caring and Loving

A nurse who is efficient and skillful uses the compassionate component of care and loving approach, while providing care to the patient. She shows concern for the patient.

Regard and Respect

A skillful efficient nurse shows regard and respect for the feelings expressed by the patient while providing nursing care and solves the problems.

Concreteness involves the use of specific terminology rather than abstractions to avoid vagueness and ambiguity.

Listening is an active process of receiving information and examining one's reaction to the message received.

4.3.4 Barriers of Nurse-patient Relationship

Following are the barriers of nurse patient relationship:

- Social class of client.
- Status of client.
- Language.
- Anxiety of nurse and client.
- Feeling of closeness for the client.
- Defective knowledge and skill.
- When the nurse thinks that patient's progress is slow.

4.3.5 Phases of Inter Personal Relationship

The nurse-Patient relationship/human relationship consists of four overlapping phases as shown in the Table 4.2. below:

Table 4.2: Phases of Nurse patient relationship

Phases	Time period
Pre-interaction phase	Before seeing the patient
Introductory or orientation phase	As soon as the nurse meets the patient
Working phase	Through out hospitalisation
Termination phase	Usually during discharge of the patient

Pre-interaction phase

In this phase a nurse has actual interaction with the client. This phase begins when the nurse is assigned a client to develop therapeutic relation with him till she goes to him for interaction. Reactions of the nurse in this phase can be fear and anxiety.

Tasks of this phase including following:

- Obtaining some information about the client before they meet.
- Setting the objectives for the interaction phase.
- Exploring sources of her fear and anxiety.
- Taking the help of the supervisor to overcome her fear and anxiety.

Introductory phase or Orientation phase

In this phase the nurse goes to the patient, introduces herself and gets introduction about him. The nurse and the patient who are strangers meet for the first time and become acquaintances. Orientation phase ends when the nurse and the patient begin to accept each other as a unique human being. Tasks of this phase include following:

- Establishment of contact with the client.
- Development of mutual agreement
- Talking with the client.

Working phase

It starts when the nurse and the patient are able to overcome the barrier of orientation or introductory phase. During this phase the nurse and the patient actively work on meeting the goals, which they had established during the orientation phase. The nurse is able to overcome anxiety and the patient's fear of unknown is also decreased.

Tasks of the nurse during working phase are given below:

- collects data in detail from primary and secondary sources and identifies the needs of the patient.
- assists the client to identify his/her problem.

- helps the patient to communicate.
- encourages the patient to socialize.
- helps the client to find an alternative solution to his/her problem.
- encourages the patient to use new patterns of behaviour.
- helps the client to understand that he has a significant role in his treatment.
- Prepares the patient for termination of relationship.

Termination phase

It is also called a resolution phase or end phase. The main objective of the terminating phase is to bring a therapeutic end to nurse-client relationship. Causes of termination may be discharge of patient, change in the posting of nurse.

Tasks of termination phase include following:

- Bring therapeutic end to the relationship.
- Reviewing feelings about the relationship.
- Evaluating progress towards goals.
- Establishing mechanism for meeting future therapy needs.

4.3.6 Techniques to improve Interpersonal Relationship

You can improve interpersonal relationship by focussing on following techniques:

- Recognize clients need to express his feelings. This will help to provide an atmosphere of freedom from fear and stress.
- Communicate verbally and non-verbally the willingness to listen.
- Recognize client's need to proceed at his own pace.
- Provide a safe, secure and nurturing environment, which communicates care so that they feel safe and cared.
- Improve the feeling of hope in the clients. Allow them to make choices and invite their participation in decision regarding the care.
- Reassure the client in feeling of dependency.
- Show empathy and make him feel that he is being understood and accepted.
- Nurse must be relatively free from internal and external stress.
- Helping client to be open and try to reduce his stress.
- Meet the needs of client for emotional support, interpersonal interaction, and expectation.
- Listen to the other and give undivided attention.
- Use of non-verbal signal is helpful.
- Don't express strong emotions like anger and sorrow.

Check Your Progress 3

i) List five factors of effective Interpersonal Relationship.

a)

b)

c)

d)

e)

ii) State the techniques of improving Interpersonal Relationship.

.....

.....

.....

.....

.....

.....

4.4 THERAPEUTIC COMMUNICATION

Communication as a process can be divided into two major categories; **therapeutic** and **non-therapeutic**. **Non-therapeutic communication** is identified by its lack of structure or planning and lack of deliberate purpose other than as a social activity. The average person, not in a helping profession, communicates in this way most of the time.

Therapeutic communication is an interaction between two people that is planned, has structure, and is helpful and constructive. It is an application of the process of communication to promote the well-being of the client. Through therapeutic communication nurse develops a relationship with the patient to meet several purposes. In many instances there is no cure for the people you care for: no surgery, no medication, no physical remedy available to help them. In these instances you still have something to offer them; support through therapeutic communication by your words or non-verbal communication technique such as touching gently, you can provide care to them. Assessment, planning, implementation and evaluation of a patient, which constitute the basis of nursing process, cannot be carried out without effective communication ability. The difference between therapeutic and non-therapeutic social relationship is given below (Table 4.1).

Table 4.1: Differences between therapeutic and social relationship

Areas of Focus	Therapeutic relationship	Social relationship
Technique	It is a planned therapeutic relationship	It just happens with mutual interest.
Objective	Helping the patient.	Having fun together or satisfying needs of each other
Interaction time	Interactions are planned for specific time and place	It may be planned, unplanned and by chance when two people meet.
Duration	The length of relationship will depend on the goal. This is limited.	This varies and may last for years.
Accountability	The nurse focuses on goals during her relationship.	It is shared. Both are responsible or accountable in this relationship.
Acceptance	The nurse accepts the patient as "here and now" without attaching, judgement and interest.	Acceptance of relationship is based on unshared values and beliefs.
Termination	It is considered as an important part of relationship. It is planned and discussed with the patient.	The relationship may exist life long. May terminate gradually. There may be environmental factor like shifting away to another place.

4.4.1 Importance of Therapeutic Communication

- helps in building nurse-patient/therapeutic relationship.
- assists the nurse to apply every element of nursing process objectively.
- helps the patient to develop a sense of trust in the caregiver.
- increases patient's satisfaction.
- helps the patient to be aware of the self.
- provides a supportive environment for the patient.
- brings about positive change in the client.

4.4.2 Techniques of Therapeutic Communication

The nurse needs to have an ability to read, write, speak and listen to the patient. To interpret accurately the effective therapeutic communication you need to develop special abilities and skills.

Therapeutic communication techniques used are discussed below:

(Adopted from text book of psychiatric nursing vol-II by Bimla Kapoor (2009) pg 37-40).

- 1) **Observation** : Observation is made by the nurse of wringing of hands, wiping perspiration, dry lips, speaking in a very low tone.

- 2) **Listening** : As the patient is talking, the nurse responds by nodding her head, or by saying. "Yes, I follow what you told me". The active listening.
- 3) **Restating** : The nurse restates or repeats what the patient has been saying. It can be in the form of a question or a statement.
- 4) For example **Patient** : My children are going through a financial problem because I am sick.

Nurse : Your children are going through a financial problem because you are sick.

The nurse is restating the statement to increase the patient's awareness of his children's suffering due to his sickness.

- 5) **Validating** is a technique which the nurse uses to confirm the accuracy of data or information given by the patient.

Patient : I get very upset when my husband beats me if I talk anything against my mother-in-law.

Nurse : Yes, it makes sense that you get upset when your husband beats you while complaining against your mother-in-law. I wonder if you would like to explain further. The nurse is validating the appropriateness of the feeling of being upset about the patient's husband, beating her.

- 6) **Reflecting** : In reflection, the nurse highlights the affective content of the patient's communication that is the feeling or attitude which is implicitly expressed.

Patient : I am very angry with my wife.

Nurse : It sounds that you are really angry with your wife. The nurse's use of reflection helps the patient to make further or additional clarification about the statement.

- 7) **Providing information** : Providing, personal, social and therapeutic information increases the patient's resources. For example, the nurse informs her patient that a social worker will be here from 10 a.m. to 1 p.m. today. Group therapy will be from 2 p.m. to 3 p.m. tomorrow. The patient may ask for more information and utilize the opportunity to clarify doubts.

- 8) **Clarifying** : The nurse's formulation of patient's statement or expression of feelings in clearer terms without indicating approval or disapproval.

Patient : I am very sad today.

Nurse : You say you are feeling very sad today. Would you elaborate what is happening? Explanation given by the patient will clarify further what is making him feel sad.

- 9) **Paraphrasing** : In paraphrasing the nurse restates whatever she has heard from the patient.

Patient : Sister, all my friends and relatives point out that I will never be able to look after my family members. That makes me depressed.

Nurse : I hear you saying that whenever you need anyone, your friends and relatives point out that you will always remain sick and will be of no use to your family. This makes you feel more sad.

The nurse's paraphrasing gives a feelings to the patient, whether she has understood what he wanted to communicate.

- 10) **Pinpointing :** The nurse pays attention to certain consistent statements, made by the patient. She pinpoints the difference in what the patient says and what he does.

Nurse : So, you and your father does not agree to the girl you want to marry. (makes observation of the patient's behaviour). The **nurse** may point out, "you say you are feeling sad, but you are smiling.")

- 11) **Linking :** The nurse tries to link the patient's two events, feelings or persons together.

Nurse : You fight with your wife because her friends visit her too frequently and you feel neglected.

- 12) **Questioning :** Questioning in Communication is used when the nurse wants clear information. Too many questions should be avoided. The nurse can use open-ended or close-ended questions. Close-ended questions are with the answer of 'yes' or 'no', right or 'wrong'. Open ended questions gives more chance for patient to speak.

Nurse : Do you feel sad when your mother does not come to visit you. This is an example of a close-ended question.

- 13) **Focussing :** Concentrating on one single point.

Nurse ; Since when did you start taking alcohol?

Patient : 20 years.

Nurse : How did you start taking it?

- 14) **Sharing :** The nurse thinks about the patient other than the time she looks after him. She may evaluate whether their interactions are helping the patient. She may say: "I was thinking of you yesterday." This is definitely a gesture of warmth and thinking caring according to Indian Culture. The patient may also feel that the nurse is caring for him.

- 15) **Summarizing :** In summarizing the nurse highlights the main theme of what has been discussed. Summarizing is useful in focusing the patient's attention on what he has discussed: if he would like to add or delete anything.

Nurse : Yesterday, we were discussing about the various carrier lines your son could choose. Today, we have discussed two main points.

Some of the other techniques like structuring, confronting processing checking perceptions, asking for demonstration and illustration are also used in communication.

Non-therapeutic communication techniques

These are reassuring, rejecting, giving approval, advising, defending, requesting, belittling the feeling of the patient etc. are some of the examples. These non-therapeutic techniques should be avoided.

Check Your Progress 4

i) List the importance of therapeutic communication.

.....

.....

.....

.....

.....

ii) State the techniques of therapeutic communication.

.....

.....

.....

.....

.....

.....

.....

.....

4.5 NURSING PROCESS IN COMMUNICATION

In the previous section you have learnt about therapeutic communication, techniques of communication and now you will learn the nursing process in therapeutic communication. We shall follow the steps of nursing process as discussed below :

4.5.1 Assessment

- Assess the client's total condition as well as his ability to communicate and his communication patterns.
- Observe client's pattern of communication and verbal or nonverbal behaviour (gestures, tone of voice, eye contact).
- Evaluate environmental conditions as that will have an impact on the communication process.
- Be aware of general life situation of the client and the way it will influence the communication process.
- Assess specific communication characteristics - client's language and ability to speak.
 - Ability to receive and assimilate feedback.
 - Ability to communicate wants, needs, feelings and thoughts.
 - Ability to be congruent with verbal and nonverbal communication.

4.5.2 Possible Nursing Diagnoses

- Anxiety
- Impaired verbal communication
- Ineffective individual coping
- Ineffective family coping
- Sensory-perceptual alteration
- Knowledge deficit
- Impaired social interaction.

4.5.3 Planning

- Prepare for therapeutic communication by formulating individualized client goals.
- Prepare client and environment physically by providing a quiet environment conducive to interaction, maintaining privacy, reducing distractions and taking care of client's physical needs before beginning discussion.

4.5.4 Implementation (Nursing Interventions)

- Create a climate of warmth and acceptance.
- Introduce yourself by addressing the client appropriately and briefly explain what you will be doing each time you care for a new, confused or comatose patient. Touch the patient to express warmth and caring and to provide tactile stimulation.
- Use appropriate nonverbal behaviours (good eye contact, open relaxed position, sitting eye level with the client).
- Observe client's nonverbal behaviours. Actively listen to the client.
- Explain purpose of interaction when information is to be shared.
- Encourage the client to ask for clarification.
- Avoid communication barriers.
- Take a nursing history from the patient and/or family. Ask the patient to describe his/her normal pattern of activities and how s/he reacts when it is disrupted significantly. Use this information to duplicate as closely as possible the normal pattern of eating, sleeping, bathing, and toileting.
- Orient the patient and family to the unit. Explain the purpose of equipment used. Describe the visiting policies, location of nearby telephones etc.
- Encourage family and friends to visit patient.
- Help the patient remain oriented to time. Place a calendar and clock in the room. Try to perform activities at a consistent time each day.
- Reduce unnecessary stimuli. Measures include dimming overhead lights for those patients who do not need continuous observation, placing standby equipment out of the patient's immediate environment, promptly answering the telephones.

- Enhance the meaningfulness of necessary stimuli. Identify the noises of cardiac monitor, ventilators and other equipments the patient and family may hear. Clearly define their relatedness to the patient.
- Provide a pleasant auditory environment. Maintain a sensitive but cheerful attitude. Discuss with the patient about his/her hobbies, current events or other topics that may be of interest.
- Either involve your patients in conversations or hold them out of earshot. It is dehumanizing to tend to patient's physical needs while ignoring their spirit—particularly if you are chatting or joking with colleagues about personal matters, minimize conversations at the nurses' station.
- Alert patients to the possibility that they may experience unusual ideas or feelings because of illness, drugs, or the unfamiliar environment.
- Help the patient learn the patient roles. The patient and the family will look to you for clues to acceptable behaviour.
- Provide anticipatory guidance.
- Support the person's self-esteem. Avoid threats, confrontation, and criticism.
- When the patients are recovering, develop a plan together with them. If joint development is inappropriate for the patient's condition, at least share the care plan with family members.
- Encourage patients in performing their care, consistent with physical capabilities and emotional state.

4.5.5 Evaluation

- Observe the client's verbal and nonverbal responses towards your communication.
- Ask for feedback to evaluate if information obtained is accurate.
- The interview sessions remains goal-directed.
- The environment is supportive and conducive to the communication process.
- The specific established goals identified by nurse and client are achieved.
- Purpose of interview is accomplished.
- The problem-solving process is continually evaluated and modified as appropriate to the client's problems and needs.

Check Your Progress 5

- i) Write possible nursing diagnosis related to therapeutic communication in a critically ill patient.

.....

.....

.....

.....

.....

ii) List five nursing interventions related to communication in a critically ill patient.

.....
.....
.....
.....
.....

iii) Discuss the criteria of evaluation you will use to ascertain the effectiveness of your communication technique?

.....
.....
.....
.....
.....

4.6 LET US SUM UP

You have studied the concept and definition of therapeutic communication and Interpersonal Relationship (IPR). Communication is a powerful therapeutic tool and an essential nursing skill used to interact with others and achieve positive health outcomes. Any nurse who wishes to be an effective caregiver must first learn to communicate. Good communication skills enable nurses to get to know their patients and ultimately, to diagnose and meet their needs of nursing care. Communication skills are the building blocks of professional relationships between nurse and patient.

You have also learnt that both therapeutic communication and interpersonal relationship require some special techniques to be followed if they are to be used effectively.

We have discussed the special needs of the critically ill patients as they face intense communication problems. It is important to involve the family also in providing the care to these types of patients to achieve the goals of family-focused care.

4.7 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

- i) A feeling of genuineness.
 - a) A feeling of warmth by eye contact, using a gentle tone of voice, listening attentively, using touch appropriately.
 - b) A feeling of empathy: It is the ability to actually put you in another person's place and experience a feeling as he is experiencing. People who

are capable of empathy are the best support people in any circumstances.

- c) Use of gesture.
- d) Body posture and gait.

ii) General factors

- a) Personal Factors
- b) Physical factors
- c) Emotional factors
- d) Social factors
- e) Environment factors

Check Your Progress 2

- i) Interpersonal relationship can be defined as relationship that exists between two people. Helping relationship is a bond between nurse and client that allows the nurse to be more objective in carrying out nursing process.
- ii) IPR helps the patient in —
 - Understanding and coping with present problems through clear explanation of illness.
 - Finding out a new alternative solution for a problem.
 - Trying out new patterns of behaviour.
 - Understanding his participation in a therapeutic experience.
 - Communicating with other members.
 - Socializing among group members.
 - Talking in terms of other person's interest.
 - Preparing one-self mentally to accept the worst if necessary.
 - Always having a smiling face.

Check Your Progress 3

- i)
 - Self awareness and Knowledge of Others
 - Communication
 - Empathy
 - Trust
 - Genuineness.
- ii) Techniques to improve Interpersonal Relationship (IPR)
 - Recognize clients need to express his feelings. This will help to provide an atmosphere of freedom from fear and stress.
 - Communicate verbally and non-verbally the willingness to listen.
 - Recognize client's need to proceed at his own pace.

- Provide a safe, secure and nurturing environment, which communicates care so that they feel safe and cared.
- Improve the feeling of hope in the clients. Allow them to make choices and invite their participation in decision regarding the care.
- Reassure the client in feeling of dependency.

Check Your Progress 4

i) Importance of Therapeutic communication.

- helps in building nurse-patient/therapeutic relationship.
- assists the nurse to apply every element of nursing process objectively.
- helps the patient to develop a sense of trust in the caregiver.
- increases patient's satisfaction.
- helps the patient to be aware of the self.
- provides a supportive environment for the patient.
- brings about positive change in the client.

The nurse needs to have an ability to read write and speak. Listen to the patient and interpret accurately for effective therapeutic communication special abilities are also required.

ii) Therapeutic communication techniques used are:

- Observation
- Listening
- Restarting
- Validating
- Reflecting
- Providing information
- Clarifying
- Paraphrasing
- Pinpointing
- Linking
- Questioning
- Focusing
- Sharing
- Summarizing

Check Your Progress 5

i) Possible nursing diagnoses

- Anxiety
- Impaired verbal communication
- Ineffective individual coping

- Ineffective family coping
 - Sensory-perceptual alteration
 - Knowledge deficit
 - Impaired social interaction
- ii) • Create a climate of warmth and acceptance.
- Introduce yourself by addressing the client appropriately and briefly explain what you will be doing each time you care for a new, confused or comatose patient. Touch the patient to express warmth and caring and to provide tactile stimulation.
 - Use appropriate nonverbal behaviors (good eye contact, open relaxed position, sitting eye level with the client).
 - Observe client's nonverbal behaviors. Actively listen to the client.
 - Explain purpose of interaction when information is to be shared.
- iii) **Evaluation**
- Observe the client's verbal and nonverbal responses toward your communication.
 - Ask for feedback to evaluate if information obtained is accurate.
 - The interview sessions remain goal-directed.
 - The environment is supportive and conducive to the communication process.
 - The specific established goals identified by nurse and client are achieved.
 - Purpose of interview is accomplished.
 - The problem solving process is continually evaluated and modified as appropriate to the client's problems and needs.

4.8 REFERENCES

- 1) Grenvik Ake et.al. (2000) Textbook of Critical Care (4th ed.). New Delhi: Elsevier. 2038-2044.
- 2) Hudak Carolyn M., Gallo Barbara M. & Morton Patricia Gonce (1998). Critical Care Nursing-A Holistic Approach (7th ed.). Philadelphia: Lippincott. 3-101.
- 3) Kapoor Bimla (2009). Text book of psychiatric nursing vol-II. New Delhi (Pg 37-40)
- 4) Kemp Brenda & Pillitteri Adele (1984). Fundamentals of Nursing-A Framework for Practice (1st ed.). Boston: Little, Brown And Company. 273-291.
- 5) Perry AG and Potter PA (1998). Clinical Nursing Skills and Techniques (4th ed). St. Louis: Mosby – Year book, Inc. P24-41.

- 6) Potter PA and Perry AG (2007). Basic Nursing – Essentials for Practice (6th ed). St. Louis: Mosby . P152-173.
- 7) Potter PA and Perry AG (2001). Fundamentals of Nursing (5th ed). St. Louis: Mosby. P444-469.
- 8) Potter PA. & Perry AG. (1985). Fundamentals of Nursing-Concepts, Process and Practice (1st ed.). St. Lois: The C.V. Company. 271-299.
- 9) Taylor Carol, Lillis Carol & LeMore Priscilla (2001). Fundamentals of Nursing- The Art & Science of Nursing Care (4th ed.). Philadelphia: Lippincott. 347-371.
- 10) Urden Linda D. & Stacy Kathleen M. Priorities in Critical Care Nursing (3rd ed.). St. Louis: Mosby. 15-35.

NOTES

BNS – 031 : Concepts and Principles in Critical Care Nursing

Block 1 Introduction to Critical Care Nursing

- Unit 1 - Concepts and Current Trends in Critical Care
- Unit 2 - Nursing Process in Critical Care Nursing
- Unit 3 - General Assessment of Patients in Critical Illnesses
- Unit 4 - Special consideration in management of Critically ill patients – Hydration, Oxygenation and Nutrition
- Unit 5 - Special consideration in management of Critically ill patients – Pain, Rest, Comfort and Sleep
- Unit 6 - Immunity and Dynamics of Healing

Block 2 - Psychological And Social Aspects In Care Of Critically Ill Patients

- Unit 1 - Individual and Family Response to Critical Illness
- Unit 2 - Stress and Crisis Management in Critical Care
- Unit 3 - Guidance and Counselling
- Unit 4 - Therapeutic Communication and Interpersonal Relationship (IPR)

Block 3 - Therapeutic Interventions

- Unit 1 - Pharmacological interventions
- Unit 2 - Fluid and electrolyte management
- Unit 3 - Acid base management
- Unit 4 - Blood and its component
- Unit 5 - Nutritional management
- Unit 6 - Hemodynamic monitoring

Block 4 - Infection Control In Critical Care Unit

- Unit 1 - Asepsis and Health Care Associated infection.
- Unit 2 - Infection Control Protocols
- Unit 3 - Biomedical Waste Management

Block 5 - Introduction to Management of Critical Care Unit

- Unit 1 - Organization and evolution of critical care unit
- Unit 2 - Role of Nurse in Transportation of Critically Ill Patient
- Unit 3 - Quality Assurance and Nursing Standards in Critical Care Unit
- Unit 4 - Supervision in Critical Care Unit
- Unit 5 - Staff Development and training
- Unit 6 - Ethical and medico-legal aspects in Critical Care Nursing

Block 6 - Teaching Learning Process, Research And Statistics

- Unit 1 - Teaching Learning In Clinical Setting
- Unit 2 - Nursing Research And Evidence Based Nursing Practice
- Unit 3 - Overview of Research Process
- Unit 4 - Research Methodology
- Unit 5 - Analysis and Interpretation of Data
- Unit 6 - Computers in Nursing