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Family health conversations create awareness of family functioning.

Mona Ahlberg^{a,b}, Gunilla Hollman Frisman^c, Carina Berterö^b, Susanna Ågren^{b,d}

^a Department of Anaesthesiology and Intensive Care, and Department of Medical and Health Sciences, Linköping University, Norrköping, Sweden.

^b Department of Medical and Health Sciences, Linköping University, Linköping, Sweden.

^c Anaesthetics, Operations and Speciality Surgery Centre, and Department of Medical and Health Sciences, Linköping University, Linköping, Sweden.

^d Department of Cardiothoracic Surgery and Department of Medical and Health Sciences Linköping University, Sweden.

mona.k.ahlberg@regionostergotland.se ; gunilla.hollman.frisman@regionostergotland.se ;
carina.bertero@liu.se; susanna.agren@liu.se

Corresponding author; Mona Ahlberg mona.k.ahlberg@regionostergotland.se

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Conflicts of Interest

The authors have no conflicts of interest to declare.

Abstract

Background: The whole family is affected if one family member is critically ill. The family health conversation intervention may give the family tools that support healthier family functioning.

Aim: The aim of this study was to identify which components of family function are affected when families participate in family health conversations.

Design: A secondary analysis was performed of existing qualitative interviews. The family health conversation is an intervention where nurses ask the family reflective questions, and reflection is made possible in three conversation sessions.

Material and Method: Transcribed data from 13 follow-up interviews from seven families attending family health conversations, after three and 12 months. Data were analysed with narrative analysis, focusing on family function.

Findings: Three themes were identified. The families' family functioning had been supported with: *improved understanding of each other*—there was an understanding of being in the same situation, but still having totally different experiences; *more concern for each other*—they talked about their different experiences and felt they had become closer to each other; *a process of working through*—they had experienced working through various experiences, standing by and supporting, and then being able to move on.

Conclusion: The family health conversation intervention is provided to families, accompanied by nurses. The families in this study gained an awareness of their family function that brought the family closer due to improved understanding of each other and the situation. The families experienced openness and the family members spoke more freely with each other, which facilitated the progress of working through the experience of critical illness and helped to maintain healthy family functioning.

Relevance to clinical practice: It is important to have an overall perspective, and to recognise the patient and the family as equally important within the family for awareness of family function.

Keywords: Family members • Family nursing • Intensive Care • Narrativism • Secondary Analysis

Introduction

The family has an important role in the care and rehabilitation of the critically ill patient (Wright and Leahey, 2013, Benzein et al., 2008a). A patient is a family member and the family functioning of a family experiencing critical illness can be affected in an unhealthy way by the illness (Newman, 1999). How the family copes with the critical illness and intensive care unit (ICU) stay regarding problem-solving, communication and the experience of connection and control is of importance for healthy family functioning (Epstein et al., 1978, McGoldrick et al., 2013). The Family Health Conversation (FamHC), a nursing intervention where family reflection is made possible in three conversational sessions, has been shown to put the family in focus. The family use their experiences as resources to identify and resolve issues that affect family function (Persson & Benzein, 2014).

This paper reports a secondary analysis, focusing on family function, of data collected from follow-up interviews with families attending FamHC.

Background

The family of ICU patients can experience negative psychological reactions, such as anxiety, complicated grief and/or depression (Davidson et al., 2012; von Beusekom et al. 2016; Davydow et al. 2008). ICU discharge patients and their families are likely to experience various difficulties, challenges and symptoms which will affect their family functioning. Follow-up for the whole family is important in order to address these negative reactions (Cuthbertson et al., 2009, Huggins et al., 2016, Stollings et al., 2016).

The definition of the family function is complex and focuses on the whole system rather than on the individuals, and includes roles (family structure), relationships, development, well-being and belonging (Epstein et al., 1978). McGoldrick et al. (2013) state that individual development of family functioning only takes place in the context of significant emotional relationships.

Essentially, healthy family functioning is related to positive adaption to changes; it is defined as a process of dynamically engaging with one another over time (Epstein et al., 1978, McGoldrick et al., 2013).

The follow-up on ICU patients is performed in a diversity of ways in different ICU clinics and countries, and may lack at some ICUs (Lasiter et al., 2016; Peskett & Gibb, 2009).

To give the whole family support after critical illness, a nurse-led intervention, the FamHC can be used. The FamHC is based on the so-called Calgary model, which is theoretically built on the Calgary Family Assessment and Intervention Models (Wright & Leahey, 2013) and particularly the Illness Beliefs Model (Wright & Bell, 2009). The FamHC was developed and adjusted for the Swedish culture, representing family-centred care based on a systematic, non-hierarchical relationship that is characterised by reciprocity (Benzein et al., 2008b). The FamHC intervention involves a nurse putting reflective questions to the family, and reflection is made possible in three conversation sessions. The FamHC is about family members listening and learning from each other in order to facilitate the emergence of new meanings of family issues, and healthy family function may be enhanced (Benzein et al., 2008b). A randomised control pilot study by Agren et al. (2018) has shown that the FamHC may improve family well-being within the ICU context, promoting family functioning, reducing stress and improving mental health.

The aim of this study was to identify which components of family function are affected when families participate in FamHC.

Methods

Design

This study was designed as a secondary analysis. The original study (Hollman Frisman et al., 2018) aimed to describe the outcomes of the FamHC regarding family functioning and well-being in families with a member who was critically ill. Using conventional content analysis of follow-up family interviews the findings show that although the conversations brought up feelings that had been repressed, the families considered the FamHC to be healing, and that their well-being was increased through enabling them to share each other's experiences (Hollman Frisman et al., 2018). The primary findings did not identify what was affected in the family function.

Secondary analysis provides an opportunity for existing qualitative research data to reveal new, broader or deeper perspectives on existing data (Heaton, 2004). The original data seemed to contain more information on family function, and by using a narrative approach focusing on the families' experience of family function, both directly and indirectly expressed, we were able to find which components of family function are affected when families participate in a FamHC.

Setting and participants in the original study

The original data was collected purposefully from eight families that had a patient who was critically ill and being cared for at one of two ICUs in two different hospitals in Sweden. The

selection criteria were adult patients >18 years, cared for at the ICU for >72 hours. (Hollman Frisman et al., 2018).

In this study, the family is defined by the persons who consider themselves to belong to the family, i.e. the former ICU patient and the patient's self-reported family. The participants had all been recruited voluntarily to the FamHC. The families received information about the study, about its voluntary nature, a consent form, and prepaid envelopes to facilitate the return of the signed consent form (Hollman Frisman et al., 2018).

The secondary analysis included data from 13 interviews (seven families; overall, 17 participants). One family including just the patient was excluded from the analysis. The participants' mean age was 60 ± 19 years. The former critically ill patient had a mean stay in the ICU of 7.3 days.

Data collection in the original study

Data was collected using qualitative interviews. The families were telephoned to book the interviews three and 12 months after they had participated in the FamHC intervention. The interviews were performed family-wise (including the patient), at a time and place chosen by the families. Nine interviews were conducted in the families' homes, and four interviews in a consultation room at the hospital. Semi-structured interviews with open-ended questions focusing on family members' experience of the FamHC intervention were conducted. The families were asked to describe as freely as possible their reflections and the significance of the conversations for family functioning and well-being (Hollman Frisman et al., 2018).

The two interviewers were female registered nurses with ICU specialisation. They had experience and training in qualitative research methods, and did not have any previous connection to these families (Hollman Frisman et al., 2018).

Secondary Data Analysis

In this secondary analysis, narrative analysis using a holistic content was employed, with a focus on family function. Narrativism catches how the families make sense of and interpret their life-world, by discourse, or by exemplifying it presenting a connected succession of happenings (Lieblich et al., 1998). The analysis focused on wholeness as well as the content of the interviews in order to interpret what the families said about family function directly and indirectly. The holistic analysis is a narrative approach that gives the opportunity to learn about variations in the data structure and content and thereby understand the interviewee's revolutionary life experiences (Lieblich et al., 1998).

Five steps are suggested by Lieblich et al. (1998) for the analysis, and these were followed. First, the transcribed data was read multiple times, then, separately, the authors wrote down a resume. Strophes in the interviews were marked in different colours and read separately and repeatedly. Words that had close associations in meaning were grouped. After this was done, these words were grouped to form a label. Later the labels were combined to form a theme. This was done by the authors separately, and then two of the authors (MA, CB) discussed their analysis several times and came to a consensus (Fig. 1).

Fig.1. Analytical Process; coding in different colours for identifying labels, such as understanding, insight (yellow), good feeling (green), acceptance, new perspectives (blue), supporting (green). The labels were formed through clustering themes.

Ethical Considerations

The study was approved by the Ethics Review Board in Linköping (record no. 2013/228-31, 2016/292-32 and 2017/164-32). The data were treated confidentially. All participants in the original study (Hollman Frisman et al., 2018), gave oral and written informed consent, in line with the declaration of Helsinki (World Medical Association, 2013). Since, the aim of this secondary analysis was covered by the ethical approval, no direct approval for this analysis was requested from the participants. The data from the transcripts were saved and stored under current rules. The transcribed interviews were coded with a number to ensure no personal information could be identified (World Medical Association, 2013).

Findings

Three themes were identified in this analysis; *improved understanding of each other, more concern for each other*, and *a process of working through*. These themes answer the study's aim concerning which components of family function are affected when families participate in FamHC (Fig. 2).

Fig.2. The three themes identified as the components in family function affected by family health conversations.

Improved understanding of each other

The families said that the communication helped the family members (including the patient) to understand each other. The former critically ill patient gained an insight into what it was like to be a family member standing at the bedside —standing there and experiencing everything from another point of view.

“For me, I have been able to understand, better understand, how the others in the family have experienced what I have been through.” (8).

The families talked about how the conversations also gave insights to the family about being a critically ill patient staying at the ICU, losing some days of one’s life, and how it affected the whole family. They discussed how well-being was affected by being a critically ill patient and experiencing hallucinations and having nightmares about the ICU stay.

An understanding was given; the family members were in the same situation, but still had totally different experiences. While the ICU patient did not remember anything or had hallucinations, the family members were there and experienced every frightening thought of being unable to help and comfort the patient. The families pointed out different perspectives and different experiences.

The understanding was easier for the family members when they could talk about different issues regarding the ICU stay and how these had affected them. The family dared to ask questions about how the other members of the family felt and to face the answers that were given. The conversations about different issues continued at home, within the family.

“Yes, it was easier to talk within the family about this after taking part in these conversations”
(6).

The former critically ill patient valued the conversations and hearing the family member’s stories about their thoughts and experiences concerning the ICU stay. The stories about how the family members reacted and acted during ICU care were meaningful for the former critically ill patient.

“We as a family stayed together and our eldest son took charge and made a visiting schedule. He also decided that I wouldn't have to be alone” (5).

Questions were answered, and all family members were encouraged to talk about their own experiences and feelings. No feelings were said to be normal or abnormal, all were accepted. Different reactions or feelings were talked about, and this strengthened the family members in their family function, although they did not use the term ‘family function’. The families talked about understanding that relationships could be strengthened, roles could be changed, and there could be well-being within the family although the family structure was changing.

The understanding the families talked about also involved the recovery of the family members, which was experienced differently. Recovery may vary, and the former critically ill patient may not be the one that needs the most time for psychological recovery. As the former critically ill patient gets better and no longer needs to be cared for, the family members suddenly have the

time to think about what happened. Feelings arise and now the family members need time for recovery.

“It has helped us to better understand each other. ...// when I started to feel healthy, now we can put this behind us and start again. But now she felt low and had health issues. But the conversations have helped me better understand that she has another process” (8).

More concern for each other

The family members stated that they had become closer. Some had always been close, and others found that the ICU stay and the conversations with the ICU nurses brought them together. Families talked about their different experiences and this brought them even closer.

The family members showed their feelings, revealed their weaknesses, and it was shown that a family member can be strong even though feeling sad and crying. Having the grown-up children as well as the partner at the former critically ill patient’s bedside, was experienced as support: *“everybody supported each other” (5).*

“The feelings came up and we cried a lot even at home when we talked about what had happened, how we stayed together and helped each other” (5).

On the other hand, there were also some families that were not so close, and who did not communicate with each other in a friendly manner. Even these families experienced supporting each other. The fact that they had more concern for each other was not something they talked about, but they stated that they were kinder and were more supportive of each other. The families stated that the family’s relationships were calmer and more peaceful nowadays.

“No, the conversations have not affected me personally, but my relationship. I mean I have a calmer wife and she does not have any questions about her ICU stay and nightmares anymore, so it has kind of affected me” (6).

It was stated that the families were struggling to manage this new situation together, as a family. As one family member stated in the interview: *“as long as we have each other, everything is fine” (7).*

A process of working through

The conversations brought insight into differences that appeared among the families. There were a variety of ways of working through or adapting to the situation, and an understanding of the need to respect these differences, due to different experiences and different personalities. The families realised that there were no standard solutions to be used. Working through these experiences and managing them took time. The only thing they could do was to stand at the side and give support. This was something that both the former critically ill patient and their family stated.

The family talked about how the conversations between the ICU nurses and the family encouraged the family and provided more information about what had happened during the ICU stay. This was valuable for the former critically ill patient if he/she could not remember what had happened. The former critically ill patient wanted to process what had happened during the ICU stay. Being given this information was important for the process of working through and being able to move on. The family had been in the situation together but still had different experiences. They reflected in-depth and received some explanations by talking things through with each other, which facilitated their process of working through.

“ otherwise it might show up later, the feelings about the critical illness and ICU stay might show up; what did we go through and what did we feel and experience. We had the opportunity to talk it through, in the conversations, and we could put it behind us” (3).

The FamHC was seen as a good starting point for the process of ‘working it through’. All persons involved in this study had the chance to respond to questions and explain what had happened in their own words. Some of the family members were convinced that otherwise the issues would come up at another time, perhaps an unsuitable time, when there were no answers to be given.

Talking about experiences over and over again, remembering and trying to understand was characteristic of the process of ‘working it through’. As one family member said: *“You have now discussed the issue, so it is easier to put it behind you, and to move on” (4).*

Discussion

The findings following secondary analysis of data show that the families gained awareness of family functioning through their improved understanding of each other, and by family members having more concern for each other due to this process of working through.

There was an *improved understanding of each other*. Although the family members were in the same situation of experiencing critical illness, they still had totally different experiences.

Reflective questions asked in the FamHC made it easier for the family members to talk about different issues regarding the ICU stay and the effects on the family members.

Understanding and information about critical illness within the family was important for the patient’s recovery and for maintaining healthy family functioning (Dinglas et al., 2018, Ohtake et

al., 2017). To reveal the feelings that were exposed during the FamHC within the family improves the understanding of what each family member experiences during the ICU stay. The family members have concern for the critically ill, and thoughts about how the roles and responsibilities within the family can change after returning home. So the findings about improved understanding are important for family functioning as an engaging process within the family over time. With communication among the family members, they can experience better connection (Epstein et al., 1978, McGoldrick et al., 2013)

The FamHC conducted in families living with chronic illness (Benzein et al., 2015) as well as critical illness (Agren et al., 2018) has been shown to increase the family's capacity for mutual understanding; relationships within the family can develop and improve. Creating a complete picture of the situation with critical illness and ICU, being given the opportunity to listen to and fill in potential memory gaps helps to make the situation manageable. Receiving support in order to handle problems and gain control also facilitates healing (Agren et al., 2018, Benzein et al., 2015).

The family members have more concern for each other. By participating in the FamHC the families experienced feelings of weaknesses, which may have been related to their reflections on the family's entire life and related to the developed theory of the FamHC (Benzein et al. 2008 b). Similar findings are presented in a study by Terp and Sjöström-Strand (2017) where tightening the family relationship entailed being completely open and honest with each other, acting naturally without judging one another (Terp and Sjöström-Strand, 2017). Family members' ability to tell their story about their experiences of the ICU, their feelings of hope and despair, and the uncertainty of what the future held, were important. The stories while gathering the family together as well as supporting each other led to emotional comfort. The FamHC is

intended to make the family feel safe through providing support and facilitating reflection about their family functioning.

Talking about difficult issues with each other in the family within an intervention is supportive of the family function and therefore good for the individual family members (Goldfarb et al., 2017).

In a systematic review and meta-analysis of 46 studies, getting information and gathering the family for support was found to lead to improvements in many patient- and family-important outcomes for the family. The findings of this review showed improved satisfaction both in patients and the family, due to achievement of medical treatment goals, and improved satisfaction with communication and mental health sequelae (Goldfarb et al., 2017).

It was notable that not all participants found that the conversations within the FamHC were beneficial; some families did not communicate with each other in a friendly manner. This made it difficult for the members to give each other space to talk openly, even though they wanted to offer support and try to understand the difficulties experienced. The family members stated that they completed the FamHC intervention to give the family a chance of having a healthier family function. The families had their conflicts, and now seemed to be more tolerant. In agreement with Epstein et al. (1978) healthy family functioning does not mean avoiding conflicts, but entails family members interacting with each other and handling conflicts.

The family function was clarified and presented in the *process of working through*. There was variety in the ways the families worked through or adapted to the situation. The families realised that there were no standard solutions to be used. This finding is in agreement with Ahlberg et al.' (2015), findings in a study of support groups for family members of former ICU patients; that families try to adapt to the new family situation and find new strategies to cope with situations

that appear. The FamHC has been shown to improve family function, the family improves their ability to think differently about what bothers them, and they process the problem from a different angle (Agren et al., 2018). A nurse-led FamHC can help the family and the formerly critically ill patient to process their feelings. It can also ease their consciences, improve their emotional well-being, and change their beliefs about their own insufficiency and guilt. This is what ‘working it through’ is about, and this study’s findings are in total correspondence with the findings reported. Family members cope by using their personal resources and by receiving support from others (Dorell et al., 2017, Arestedt et al., 2016, Verhaeghe et al., 2005)

Families participating in the FamHC reported healthier family function than families just having regular follow-up (Agren et al., 2018).

A healthy family function may be facilitated by health professionals supporting the family during the ICU stay, while following proper guidelines (Haines et al., 2018, Lewis et al., 2018). There is a need to design strategies to support families throughout all stages of critical illness (Stayt & Venes, 2018). The intervention does not exclude individual support for the family members. The family and critically ill patient might still need individual consultations with health professionals and family-centred care services in the ICU, as well as follow-up.

Strengths and Limitations

A secondary analysis requires that the quality of data is good—informative and rich—and the analysis must be performed properly in regard to technical and ethical issues (Jack, 2008, Easton et al., 2000). The aim /research question of the secondary analysis may not go beyond the primary aim. A limitation of this study could be that a secondary analysis put the analysts in a situation of

not being present in the actual context, not performing the interviews, and not being able to ask follow-up questions. A secondary analysis demands knowledge about the context and the method of the primary data collection. In the present study the author of the primary study was a co-writer and the other researchers were experienced in primary and secondary analysis. The decision to exclude from the original data one interview that involved just the patient and no family member was taken because that this interview was not a family interview. In this secondary analysis the focus was on family functioning and not just the patient's experience of the ICU and critical illness.

Trustworthiness is reached by presenting the audit trail. By using quotes illustrating the themes, the reader is given the possibility to understand the interpretation and findings, which strengthens credibility. Transferability was achieved since the context, sample and quotes are presented, and the results could be applied to a similar group of people in a similar context (Lincoln and Guba, 1985).

Implications and recommendations for practice

Family functioning could be improved by the FamHC discussing their thoughts and experiences and by listening to each other's stories.

The FamHC can be a simple and effective standardised evidence-based intervention, resulting in family-centred care that leads to healthy family functioning.

Further studies are needed about how to involve the family members in the ICU follow-up clinic, clarifying which family members need the FamHC and also identifying at what point this intervention should take place.

Conclusion

The families attending a FamHC as a group, experienced improved awareness of family functioning, and their understanding of each other helped them to become closer. The awareness of family function ultimately led to better cooperation within the family, implementation of the 'working it through' process, and a greater sense of well-being.

Family members suggested these improvements were permanent and those who did not talk about how the FamHC had affected their view of family function still talked about how they were keen to participate in the FamHC for the sake of the family.

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What is known about this topic

The whole family is affected by having a family member who is critically ill and being cared for in an intensive care unit.

Healthier family functioning is gained when family patterns are made clear.

What this paper adds

Family health conversations help families to become aware of their family functioning.

The shared experience leads to better cooperation within the family and creates a sense of wellbeing.