



# The Impact of Social Support Networks on Family Resilience in an Australian Intensive Care Unit: A Constructivist Grounded Theory

Pauline Wong, PhD, BN(Hons), RN, GradCertHealthInf, GradDipAdvNurs(ClinNursEd)<sup>1</sup> ,  
Pranee Liamputtong, PhD<sup>2</sup>, Susan Koch, PhD<sup>3</sup>, & Helen Rawson, PhD, MSc, BSc(Hons), RN<sup>4</sup> 

1 Lecturer in Nursing, Deakin University, School of Nursing and Midwifery, Faculty of Health, Geelong, Australia

2 Professor of Public Health, School of Science and Health, Western Sydney University, Penrith, New South Wales, Australia

3 Conjoint Professor of Practice, Faculty of Health and Medicine, University of Newcastle, New South Wales, Australia; Adjunct Associate Professor, University of Sydney Medical School, Hornsby Ku-ring-gai Hospital, New South Wales, Australia

4 Research Fellow, Deakin University, School of Nursing & Midwifery, Faculty of Health, Geelong, Australia

## Key words

Critical care nursing, families, grounded theory, qualitative studies, social support

## Correspondence

Dr. Pauline Wong, Deakin University, School of Nursing & Midwifery, Faculty of Health, 75 Pigdons Road, Geelong, Australia, 3216. E-mail: p.wong@deakin.edu.au

Accepted July 2, 2018

doi:10.1111/jnu.12443

## Abstract

**Purpose:** This article discusses the findings of a grounded theory of family resilience in an Australian intensive care unit (ICU) with a specific focus on families' experiences of their interactions with other members within their own family, and the families of other patients in the ICU.

**Design:** A constructivist grounded theory methodology was adopted. Data were collected using in-depth interviews with 25 family members of 21 critically ill patients admitted to a tertiary-level ICU in Australia.

**Findings:** The core category regaining control represents the families' journey toward resilience when in ICU. The major categories represent facilitators for, and barriers to, regaining control. One of the main facilitators is drawing strength, and it explains the manner with which families receive social support from their own and other family members to help them cope.

**Conclusions:** This study offers a framework to improve patient- and family-centered care in the ICU by facilitating families' ability to manage their situation more effectively. Social support offered by family members facilitates the families' ability to regain control. An ICU family resilience theoretical framework, situated within the context of the Australian health-care system, adds to what is currently known about the families' experiences in the ICU.

**Clinical Relevance:** The relationships that develop between families in the ICU may provide a source of social support; however, not all families welcome interactions with other ICU families, and it may cause further emotional distress. Further research is warranted to determine whether families suffer a secondary stress reaction from incidental interactions with other patients' families in the ICU. Furthermore, when family members pull together and offer social support to each other, they are better able to regain control. This process contributes to an ICU family resilience framework.

The unexpected admission of a relative to an intensive care unit (ICU) in a life-threatening condition is associated with intense emotions and may cause overwhelming fear, stress and anxiety for families (Davidson, Aslakson, Long, Puntillo, et al., 2017; McAdam, Fontaine, White, Dracup, & Puntillo, 2012; Vandall-Walker &

Clark, 2011). Families in the ICU are often unable to rely on their everyday coping mechanisms; therefore, the patient's social support structure is most often in a state of crisis (Leon & Knapp, 2008).

The effect of social support on reducing an individual's distress during times of stress, such as illness, is well

documented in the literature (Iverson et al., 2014; Morrison, Bennett, Butow, Mullan, & White, 2012). Additionally, the beneficial effects of social support on mental and physical health outcomes are well recognized (Barley & Lawson, 2016; Paul & Rattray, 2008). The physiological benefits of social support to health include a reduction in the risk for illness, reducing the time for recovery when individuals experience illness and decreasing mortality due to serious illness (Uchino, 2006).

Social support is considered a significant resource that may influence families' ability to manage their stress and cope effectively (Iverson et al., 2014; Olsen, Dysvik, & Hansen, 2009). Seminal work by McCubbin, Cauble, and Patterson (1982) on family stress theory explains how families cope with a stressful or traumatic situation by appraising the stressor event, then seeking resources to manage it. The more resources available, the better families are able to cope.

Social support is defined as "A social network's provision of psychological and material resources intended to benefit an individual's ability to cope with stress" (Cohen, 2004, p. 676). It is a multidimensional construct that can be actual or perceived (Morrison et al., 2012) and is conceptualized in terms of its structure (e.g., type of supports, the size of a person's social network, and the number of available resources) or its function (e.g., what is provided and received) (Hogan, Wolfgang, & Bahman, 2002). The main types of social support described in the literature are emotional, informational, and instrumental (Arora, Finney Rutten, Gustafson, Moser, & Hawkins, 2007; Cohen, 2004; Roy, 2011).

Families have a vital role to play in ICU patients' recovery and outcomes (Vandall-Walker & Clark, 2011). There exists a potential risk to the critically ill families' psychological well-being, and there is an ongoing need for an evidence base to support family-centered care that informs and drives change in practice (Davidson, Aslakson, Long, Puntillo, et al., 2017; Gries et al., 2010). A small number of studies have noted the support families receive by interacting with families of other patients in the ICU (Engström & Söderberg, 2004; Hupcey, 1998b, 1999; Vandall-Walker & Clark, 2011). Respondents in a nonexperimental, cross-sectional descriptive study reported that emotional support was provided most often by friends and family (84%); however, other ICU visitors offered support to each other (38%) by sharing information. It was suggested that such support was due to the common experience shared with others in close proximity over time (Van Horn & Tesh, 2000). Partners found strength in knowing there were others in the same situation as themselves. It is suggested that when families are able to share their stories, as well as emotions such

as grief, loss, and suffering, rapport is built and friendship develops based on mutual understanding and empathy (Engström & Söderberg, 2004).

The aforementioned studies document the support families are able to receive from other families in the ICU. However, most are limited to thematic descriptions of families' experiences and do not attempt to incorporate findings that specifically relate to support from other families in a wider explanatory, theoretical framework. Furthermore, some of the research was conducted over one to two decades ago, and it can be argued that contemporary practice in the ICU is now very different. To date, there appears to be a gap in the existing ICU literature relating to the use of the grounded theory method to explore families' perspectives about their experiences interacting with their own and other family members in an Australian context. Notwithstanding the significant part families play in the ICU, the argument for research into families' experiences of their interactions, such as the current study has reported, is irrefutable.

We present some of the findings related to a grounded theory of family resilience in an Australian ICU. Regaining control was the identified core category of the wider grounded theory study. Five major categories comprise the grounded theory, with two published elsewhere (Wong, Liamputtong, Koch, & Rawson, 2017, 2018). In this article we focus on another major category—a facilitator of regaining control, Drawing strength. Its main focus is on families' experiences of their interactions with other members within their own family, and the families of other patients in the ICU. The subcategories and themes of Drawing strength (Pulling together and Experiencing vicariously) will also be discussed. See Figure 1 for a graphical representation of the facilitators of regaining control, of which Drawing strength is one.

## Methods

### Design

A constructivist grounded theory method was used to explore the families' perspectives of their interactions in the ICU. It is an appropriate method that aligns with the aim of this study. A constructivist approach is derived from an interpretive position, which claims to focus on the meanings and co-construction of knowledge with multiple views of a situation (Wong, Liamputtong, & Rawson, 2017). Grounded theory is a qualitative method used to explain human behavior and explore social processes, with the main purpose of developing a theory derived from the data (Wong, Liamputtong, & Rawson, 2017). According to Charmaz (2014), constructivist

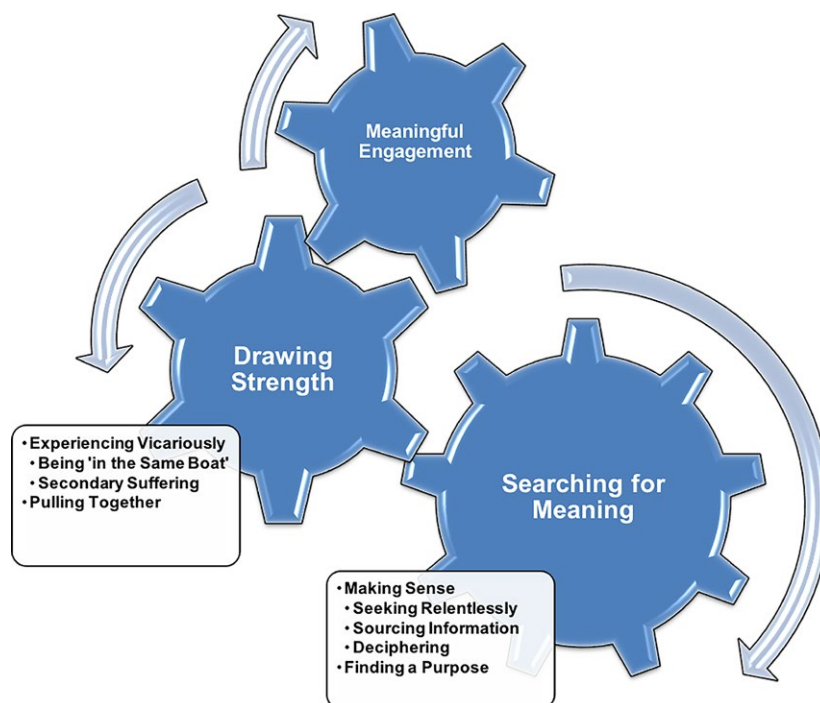


Figure 1. Facilitators of regaining control. [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]

grounded theory researchers use a set of processes and flexible guidelines to collect and analyze their data. Consequently, the resulting theory is “grounded in their data” (p. 1).

### Recruitment and Sample

Potential participants were recruited using a third-party recruitment strategy. This process was used to protect the privacy of the families and their critically ill relatives (Minichiello, Sullivan, Greenwood, & Axford, 2004). As per ethical and organizational requirements, the social workers and registered nurses were assigned the role of third party for recruitment purposes. The social worker excluded families from the study if they were found to be overtly distressed or if their social circumstances were too complex. If they were deemed suitable, the bedside registered nurse sought permission from the family to pass on their contact details to the researcher. We recruited 25 participants related to 21 critically ill patients for this study. The participant demographics and the study setting have been described elsewhere (Wong, 2016).

### Ethical Considerations

This study was approved by the relevant University Human Research Ethics Committee and Institutional

Ethics Committee. The transcripts were coded without the participants’ names, and pseudonyms were used in all publications and dissemination of findings.

### Data Collection and Analysis

Data were collected using in-depth interviews, as this was deemed the most suitable method to capture the families’ interpretation of their interactions in the ICU (Serry & Liamputtong, 2017). An interview guide (Table 1) with broad topics derived from the relevant literature and research objectives was used to guide the interviews. However, participants were encouraged to discuss in detail any aspects of their interactions in the ICU that they felt were significant to them. Each interview commenced with a general question such as, “Can you tell me about the experience you had when you interacted with the nursing staff in the ICU?” Interviews were conducted on the hospital site, but in an office remote from the ICU, as per ethical requirements. Each audio-recorded interview lasted between 30 and 90 min, and was then transcribed verbatim.

Initial, focused, and theoretical coding techniques characteristic of grounded theory were used to analyze the data (Charmaz, 2006, 2014). Additionally, data collection and analysis were iterative processes (Liamputtong & Serry, 2017). Therefore, following analysis of the

**Table 1.** Interview Guide

- 
1. How was the interaction between you and the first person you met in the intensive care unit (ICU)?
  2. Can you tell me about the experience you had when you interacted with the following staff caring for your relative?
    - a. Nurse
    - b. Doctor
    - c. Other healthcare professionals caring for your relative (e.g., physiotherapists, dieticians, social workers, chaplain/pastoral care, etc.)
    - d. Other staff in the ICU (e.g., receptionist/ward clerks, cleaners, ward support/orderlies)
  3. Can you discuss the experience you had when you interacted with family members of other patients in the ICU?
  4. Could you please tell me about the experience you had when you interacted with your relative?
    - a. The first time you saw him/her in the ICU
    - b. After the first time you saw him/her in the ICU
  5. I would like to know about the experiences you have had interacting:
    - a. with the ICU environment.
    - b. with the equipment.
    - c. in the waiting room.
    - d. in your relative's cubicle.
  6. Other prompts:
    - a. How did that make you feel?
    - b. Can you tell me more about that?
    - c. What happened next?
    - d. Can you give me an example?
    - e. Can you tell me about the positive and negative interactions that had special significance for you?
- 

interview transcript, the researchers returned to the field to collect further data, guided by questions and themes that arose from the analysis. In this way, constant comparative analysis and theoretical sampling were strategies used to build a conceptually dense theory from the data. For example, one family member talked about how distressing it was to witness other distressed relatives in the waiting room. This was an early example of the theme Experiencing vicariously, and it provided the prompt for the researchers to question subsequent families about their experiences and the observations they made in the waiting room. As theoretical sampling was used to inform subsequent interviews, it provided a mechanism for researchers to reach conceptual saturation. Researchers continued to explore emerging concepts with subsequent participants until it was apparent that no new data were being generated and the data generated from the final interview could be represented by the categories already developed. This was apparent by interview 25. Theoretical sensitivity is acknowledged as another analytical technique used in this study. According to Corbin and Strauss (2015), professional background and experience, as well as knowledge of the extant literature on a topic, can help the researcher to understand the significance in the data more quickly and become more sensitive to relationships between concepts.

Strategies to ensure rigor and trustworthiness included audit trails and member checking (Creswell, 2013). A methodological log of the research activity and theoretical memos, which described the rationale for coding a piece of data in a particular way, provided the

necessary documentation for an audit trail. Member checking involved going back to participants and asking them to check and comment on the interpretive analysis with the aim of validating our findings.

## Findings

Families that had access to social support networks and others on whom they could depend were more readily able to regain control of their situation. Drawing strength represents the ability to access resources, other than ICU staff, which helped families cope during their relative's unexpected admission to the ICU. Families identified two main sources of strength to which they had access. First, interactions with members of their own families provided support that helped them cope and regain control. Second, they experienced interactions with families of other critically ill patients. Pulling together and Experiencing vicariously represent the processes through which they were strengthened (Table 2).

## Pulling Together

Having a critically ill relative in the ICU was an undeniably stressful situation and a challenge for most families. However, it is evident that their own families were a source of strength that influenced their stress levels and helped them regain control of their situation. Pulling together exemplifies a concept in which family members within their own families drew strength from each other by providing a source of emotional and social support. As a consequence, they are better

**Table 2.** Categories and Subcategories That Constitute Drawing Strength

Participant quotes	Category/subcategory	Major category
I'd ring my mum and let her know or ring the one that wasn't there. I'll go and ring [name] and let her know or [name] or whoever wasn't there, and then, you know, or I'll ring [patient's] friend or uncle [name] or whoever. (Robyn)	Pulling together	Drawing strength
I think until you're in the same situation or been through what we've been through, I suppose no one else would understand. (Linda)	Experiencing vicariously/being "in the same boat"	
People burst into tears and you go, "Oh no, somebody else has passed away" or something like that ... you see people go to the meeting room, you go, "Oh my god, I'm getting out of here," 'cause often, you know, next minute somebody's burst into tears and they all come out crying and you can guess what's gone on there, you know. (David)	Experiencing vicariously/secondary suffering	

able to regain control and cope with the unexpected admission of their relative to the ICU.

Families supported each other in several ways, depending on the context of their circumstances and their family structure. When children were involved (e.g., when the parent of the child was critically ill or the child was a sibling of the critically ill patient), support centered on prioritizing the stability of the children's lives and their environment. The wider family members supported each other to ensure the child was cared for: Helen said, "My daughter was with the kids in [town] and they were stable and that was my main concern too. She got them on that night and she had them, so I knew that they would be alright."

A significant outcome of exploring intrafamily interactions in the ICU was prioritizing the welfare of children related to the critically ill relative. Furthermore, families carefully considered the optimal time to bring children to see their relative, and it was also important to prepare them for the unfamiliar and foreign environment as the following excerpt illustrates:

I think I could do it easier like a couple of weeks down the track, 'cause I wasn't going to push [sibling] at the beginning ... a couple of weeks down the track when we knew that [daughter] was going to be okay, it was certainly a lot easier to talk about then. (Linda)

It is understood that children of critically ill parents experience anxiety and they fear their parent's death. Findings in the current study reinforce previous research that identifies the importance of advanced preparation for children to minimize fears related to what they may experience and to facilitate coping (Hanley & Piazza, 2012; Kean, 2010). Supported visitation is reported to help children understand and

give meaning to their circumstances (Kean, 2010). However, as Kean (2010) suggests, there is currently a lack of informational support materials to assist staff and parents in preparing children before they come to the ICU.

Families looked out for the well-being of other family members. They checked up on each other by asking how the others were coping, rather than assuming everything was okay. They identified times when family members appeared more stressed than usual, then intervened to help them deal with the problem: Frank said, "Oh yeah, it's stressful but we cope, you know ... [son] always asking me am I right, you know, 'How you going, Dad, are you sure you're right, you won't tell us any different?'"

In some instances, family members took over the bedside vigil so others could rest, and this was one strategy that helped families manage the ongoing stress of their situation. Removing themselves from the source of stress helped families cope at certain times. Laura described being away from the ICU as a helpful solution when she felt overwhelmed: "We're all tired ... so it's just handling that and ... if someone needs a bit of space ... you give them a bit of time and things like that."

Tighter bonds and closer relationships were established between some family members due to the shared experience of having their relative in the ICU: Laura said, "I guess it brings us sort of tighter together, closer together as a family, sort of thing, because we just have to support each other through it all."

It was difficult for those family members who were in the ICU by themselves without other family support present. Several families told of their struggle in the early days because they were on their own, as Helen explained: "I know the first week I was home without the kids I struggled, but then I've got a good husband and a daughter and we all sort of banded together."

Other family members could not be present because they lived a long distance away, either interstate, regionally or overseas. Families that had their immediate support systems living a distance away found strength from others. Although David's nuclear family members were overseas, he received and provided support to his siblings and father: "I think it's really good that we just all stick together anyway because, you know, it's not like we had wives or husbands there, children, so it was okay. Yeah, so we've been supporting each other."

A few participants discussed strained relationships with other family members both prior to and during the admission of their relative to the ICU. Some overcame their differences so that they could support each other and their critically ill relative. The recovery and well-being of their relative was prioritized for these families, and any past conflicts were put aside:

We both agreed right at the very start that it wasn't about me and her, and we don't want none of this stupid, petty fighting that goes on between exes and all that sort of rubbish. We were there for [son]. (John)

Individuals within a family may have divergent views that lead to family friction or disagreements (Eggenberger & Nelms, 2007). As previous studies have highlighted, latent family disputes have the potential to resurface during a critical illness, and family relationships may strengthen or weaken as a result (Baumhover & May, 2013). Nevertheless, most families in the current study were able to move beyond past conflicts and get along for the benefit of the patient.

Families were able to draw strength and therefore support one another by maintaining normal family functioning. Families in this study ensured a degree of normality by continuing usual daily routines as much as possible. Once again, this was especially important where younger siblings and children were concerned:

We've still got to be positive for those guys, you know, that's why we try to get home at a reasonable hour and still spend some time with them and ask them how their day was and all that sort of stuff. (Michael)

Maintaining a degree of normality strengthened families by allowing them to regain some control of their situation. Eating together as a family and continuing with their normal daily routines helped families to feel in control and therefore supported:

I'd actually sat down with the kids and my daughter's husband and we had a meal and I had something to eat and, yeah, I felt not better, but like I could handle or I could control what was going on. (Donna)

Families in the ICU provided significant instrumental, informational, and emotional social support, as similarly documented by Iverson et al. (2014). Informational support can help a person understand their stressful situation by providing advice and guidance. In addition, it facilitates a perception of control by minimizing confusion and suggesting strategies to help cope with problematic situations (Olsen et al., 2009). Instrumental support comprises resources such as financial, material, or practical assistance. Several families in the current study spoke of their role in providing informational support, whereas others offered instrumental support by providing transportation to hospital, preparing meals, or sharing the financial burden for such matters as hospital parking fees. In the process of providing emotional support, families looked out for one another and were perceptive to signs of increased emotional burden. This supported families to maintain tolerable stress levels. The need to watch out for one another and protect other family members from additional threats while in the ICU has been described previously as "intensified family connections and communications" (Eggenberger & Nelms, 2007, p. 1623).

Promoting flexible and open visitation, as recommended by several researchers previously (Coombs, Mitchell, James, & Wetzig, 2016; Cypress, 2010; Kean & Mitchell, 2013; Vandall-Walker & Clark, 2011), is supported by findings from the current study, as it allows family members the opportunities to provide emotional and informational support that is characteristic of Pulling together. The current study also extends previous findings by incorporating strengthened family ties within a conceptual framework. Pulling together represents a significant strategy families can employ to help them move beyond their emotional vulnerability to regain control. Resilience in families that experience critical illness can be promoted by understanding the impact family members have on each other.

Pulling together represents the way in which families were strengthened to support one another to overcome their emotional vulnerability. Strength as a positive consequence of vulnerability in families of the critically ill has been recognized (Baumhover & May, 2013). Maintaining normal family functioning and routines was especially important to help children cope. Families

offered a significant source of social support that buffered the effects of their stressful situation.

### Experiencing Vicariously

Experiencing vicariously represents the incidental interactions and emotional responses that families shared with families of other ICU patients (who were essentially strangers). Families viewed this in both a positive and negative light. It was seen as an opportunity by many who received social and emotional support from other families going through a similar situation. However, there were some families that felt it was an added emotional burden to have no choice but to witness the emotional suffering of others.

Families were compelled to share a communal space with other families due to the physical layout of the waiting room. The open-plan configuration meant families often had to interact with other families unintentionally. Most families felt positive about the organization of seating in the waiting room area. However, others commented on the distress of overhearing other families receive bad news about their relative. Being in the same boat represents the strength families received by sharing a common experience. It was seen as an opportunity and a positive situation. In contrast, Secondary suffering was seen as a negative consequence of being a relative in the ICU and exemplifies the additional emotional burden families experienced incidentally as a consequence of being in the same environment as families of other patients in the ICU.

### Being in the Same Boat

Families shared common experiences with other families in the ICU; as a result, a close and supportive relationship sometimes developed between them. Relationships that developed between families varied in depth and significance. Some relationships were more casual, while others were based on stronger and deeper connections. Participants used the term Being in the same boat to exemplify how they experienced a similar course of events as other families they had met in the ICU. Families were supported in the knowledge that other families understood their situation as a result of similar circumstances. Linda's statement illustrates this: "It's helpful and supportive because you know that they were in the same boat as you and they can relate to what you're talking to, for sure, you know."

Several participants spoke about their friends and more distant relatives outside the ICU whom they considered less empathic because they had not

experienced what the families were enduring. From the families' perspective, their external networks were unable to appreciate what they were experiencing: Donna said, "Whereas if you talk to outside people, they just say, 'Oh yeah, he'll be right', like they just have no comprehension of what's going on."

Sharing common experiences was also supportive for several families because they could gather further information that helped them prepare for future treatments or procedures, as a result of the other family having already gone through the experience. This participant described her interactions with another mother in the ICU:

Her son's fairly young too and been through a lot and had the trachy[ostomy], like we were talking about trachys the other day ... she's pretty good and ... very informative and what to expect.... If I wasn't sure, you know, I'd say, "Well, what happened to [her son]?" and, you know, no problems, wouldn't hold back, she'd tell me, and she knew that we were in the same sort of situation so, yeah, she was great. (Linda)

As well as receiving support and comfort from other families in the ICU, participants also told of their experience of providing support to other families. Some could offer hope, given they had already been through a similar situation with their relative and were progressing towards a positive outcome. John explained how he supported the family of another patient in the ICU in this way:

When [son] started coming through, I was able to try and tell her "Keep hanging on' ... 'cause like, we thought [it's] not looking good for [son] but you know, we didn't give up and ... just [to be] able to explain ... empathize with her that "I know where you're at, I know what stage you're at and don't give up because it can or will come good," so that sort of thing.

A notable gap exists in the literature regarding the experience of families interacting with families of other patients in the ICU. The interactions and relationship that developed between families from different ICU patients is a major finding in the current study. A few studies mention similar interactions briefly; however, this is not a salient theme of previous research, nor has it been comprehensively explored in the literature (Blom, Gustavsson, & Sundler, 2013; Engström & Söderberg, 2004).

Drawing from social support theory (Roy, 2011), it is evident that other families in the ICU offered social support in the form of emotional and informational support. Families that could advise other families when their critically ill relatives went through similar procedures provided informational support. Such support networks provided a buffer against the effects of families' stressful experience in the ICU because they received information that reduced their uncertainty. The availability of social support from other families altered the families' appraisal of their situation and their perceived ability to cope. Consequently, moderating their stress helped families regain control and move beyond their emotional vulnerability.

The positive impact of social support provided by families, friends, and relatives of other ICU patients has been previously documented, and the "same boat" phenomenon was proposed to explain this occurrence (Van Horn & Tesh, 2000, p. 46). Engström and Söderberg (2004) concurred that partners of critically ill patients were strengthened by being able to talk to other relatives. They were supported by the knowledge that relatives of other patients were in a similar situation. Developing "new or stronger social support networks... such as [with] waiting room families... [and] strengthening existing networks with friends and family" reinforced the idea that social supports were a source of strength and an activity in which families sustained energy in their work to get through critical illness (Vandall-Walker & Clark, 2011, p. 167).

Although the value of support groups in the adult ICU has not been rigorously explored, findings from the current study suggest families may receive several benefits from attending support groups in the ICU. Participants in the current study received informational and emotional support when they shared experiences with families of other patients. It is thought nurse-led support groups may encourage feelings of empowerment and control by creating "a safe atmosphere for dialogue and empathy while stimulating cohesion among families during the ICU crisis" (Benbenishty, 2015, p. 282). More broadly, support groups are believed to reduce feelings of isolation, loneliness, distress, and anxiety, and to facilitate the ability to clarify expectations and acquire information and practical advice about treatments (Mayo Clinic, 2015).

Being in the same boat represents the emotional support families provided to each other by developing a relationship that was based on common family experiences. However, not all families had a desire to interact with families of other patients in the ICU. Some families preferred to limit access and support within their own family and felt interactions with other

families would increase their emotional vulnerability, which has been recognized in this study as secondary suffering.

### Secondary Suffering

Despite the supportive role of other families, some participants denied finding comfort or support in this way and did not welcome interactions with them. There were different reasons for this. Some families were so consumed by the emotions of their own situation and providing support within their own family unit that interaction with other families was considered an additional burden:

You're going through your own grief so you just stick to yourselves, you know, and we're this tight little unit and we're okay, we're all looking after each other and we don't need anyone else's dramas as well, which is not very nice, but then they're probably thinking the same thing, and I don't really want to talk about it is the other thing. (Robyn)

Other families felt it was inappropriate or that the environment was not conducive to initiating a social interaction due to the solemn nature of the ICU waiting room: Richard said, "I didn't feel... like the environment to be going up and just starting a conversation with people, there was a lot of sadness in that area."

The waiting room environment and the open-plan layout of the ICU provided a context in which families witnessed others' plights and became aware of other families' suffering. Families spent prolonged periods of time in close proximity to other families while in the waiting room in the ICU and it was almost impossible to have private conversations.

Robyn's statement exemplifies how the nature of the waiting room was not an environment conducive to privacy for families: "I mean, you sort of get to know, you get an idea what's happening 'cause you overhear conversations, not that you're listening in, but they're sitting right there and it's not a very big space."

Similarly, Sharon's experience in the waiting room demonstrated the context in which families endured others' despair:

It's the most depressing place ever ... and people are so sad, they can't make it un-depressing ... and people are crying and



people are in shock and people are ringing up people on phones ... and everyone's sitting there in shock or sad or scared ... it's the most depressing room I've ever been in, in my whole life.

Several participants experienced further emotional distress when they became aware that others were going to lose a loved one. One participant, Robyn, described how this made them feel: "They've got loved ones in serious situations and some of them you knew were worse than [mother-in-law], you know, and we saw people, families having to go in and say goodbye to their family member and that's heartbreaking."

Although the thought of others suffering more severely than themselves caused some distress, a few families drew strength from the knowledge that there were other families in a worse position than their own:

I suppose [I] get some comfort because obviously there are other people that [are] enduring a lot more suffering than us, which actually then, I suppose in a selfish way, makes us feel a little bit better, saying well look, you know, our child hasn't got these amount of injuries. (George)

George also viewed other families that were in a more favorable situation than him as being a positive, as it gave them a goal to progress towards: "You have other ones that have less amount of injuries which then gives you something to strive for, but I think it's good."

Families endured Secondary suffering due to the nature of the waiting room and ICU layout. Even if families did not proactively seek to interact with families of other patients, the waiting room space to which they were confined allowed them to witness the emotional distress of others. Families experienced emotional vulnerability by enduring other families' plights. However, a few participants compared the situation with their own and could draw strength from it by viewing it in a more positive light. There is some evidence in previous clinical guidelines that suggest an increase in social interactions in a waiting room where furniture is organized in smaller, flexible sections (Davidson et al., 2007). More recent evidence-based guidelines for family-centered care suggest the ICU environment should be conducive to confidentiality and privacy by designing units with single rooms that accommodate enough space for families. However, the evidence is low level and the recommendation is based mostly on studies in the neonatal ICU with a focus on the environmental context

within the unit, not in the waiting room area (Davidson, Aslakson, Long, Kross, et al., 2017).

A similar phenomenon characterized by individuals who experienced symptoms not unlike those suffering post-traumatic stress disorder (PTSD) due to exposure to the trauma of others has been reported in the literature (Figley, 2013). It has been identified by various terms such as "secondary traumatic stress," "compassion fatigue," and "vicarious traumatization" (Figley & Ludick, 2017). The condition is most commonly described in the context of specific types of people at risk, such as emergency and rescue workers, or families of victims who experience catastrophic and other traumatic events (Moran, 2013).

Secondary traumatic stress reaction may be applicable to families that become mentally drained and vulnerable as a result of their emotional connection to the critically ill relative (Figley & Ludick, 2017). Some participants in this study reported they avoided interacting with other families in the ICU to avoid additional stress. It is already known that families of the critically ill are at risk for PTSD and acute stress disorder due to their experiences in the ICU (Gries et al., 2010; Kross et al., 2011; Petrinc, Mazanec, Burant, Hoffer, & Daly, 2015). Blom et al. (2013) have argued that families are faced with an ambiguous situation as a result of being close to their relative. Although they want to be with their relative, they experience "unintentional participation in the care of other patients" and their relatives (p. 6). Against their will, they are subject to hearing information about other patients in the waiting room, and this causes discomfort and vulnerability. Indeed, Azoulay et al. (2005) declared that a limitation to their study was a failure to consider "vicarious trauma," in which families may experience PTSD reactions due to their exposure to other families' trauma experiences in the waiting room (p. 992). Although this issue was briefly mentioned in these studies, a detailed exploration of secondary PTSD applied to the context of ICU families has not been identified in the literature. Further investigation is warranted to determine whether families suffer a secondary stress reaction from their incidental interactions with other patients and families in the ICU.

Although studies show overwhelming support for the beneficial effects of social support on mitigating distress during times of stress, there is evidence in the literature that social networks can be detrimental to families (Hupcey, 1998a; Taylor, Kelin, Gruenewald, Gurung, & Fernandes-Taylor, 2003). Families in our study experienced conflict among their networks when they had divergent views. This provided an additional source of tension and stress. Similar experiences are reported in the literature, and families limited contact with such relatives (Iverson et al.,

2014). Although Figley (2013) described secondary traumatic stress reactions in the literature, the notion of Secondary suffering that focuses specifically on the context of families' experiences in the ICU has received little attention in the research arena to date. Understanding this phenomenon may assist healthcare professionals in the ICU to provide improved family-centered care by acknowledging such implicit sources of stress that may not otherwise be considered.

## Limitations

The aim of the broader study on which these findings are based was to develop a grounded theory that can be used by staff to support improved family-centered care in the adult ICU. Whilst this study has added to current understanding of family-centered care in the adult ICU, specific limitations of this study are acknowledged. As this study involved families of critically ill patients admitted unexpectedly to the ICU, they (families) were deemed vulnerable and, as such, the healthcare institution and their ethics committee stipulated clear guidelines for recruitment and participation in this study. Consequently, there may be bias related to how participants were selected based on the required third-party recruitment strategy. Another limitation is that the participants were predominantly White, Anglo-Saxon. Although we attempted to theoretically sample family members from culturally diverse backgrounds, but English speaking, they were not available at the time. This study focused on family members 18 years of age and older; however, a limitation was the exclusion of family members under 18 years of age. The importance of children's experiences were recognized, and, through the process of theoretical sampling, the parents' perspectives on the interactions of their other children (i.e., the patient's siblings) in the ICU were included during data collection. Given there is a gap in the family experience in the ICU literature on the impact of an ICU admission on child family members, the specific experiences of children should be the focus of further research.

## Implications and Conclusions

Cohesiveness and flexibility are important characteristics of resilient families (Walsh, 2012), and they are also identified in the current study as salient influences on family resilience in the ICU context. Implications for practice are suggested here to support cohesive and flexible families in the ICU and direct staff in their clinical practice to help families regain control.

ICU visitation policies that govern family presence at the relative's bedside should reflect the optimal number of family members and the duration of their presence, in consideration of the need for family cohesion. Findings from this study demonstrate strengthened family relationships due to their ICU experience and the immense emotional and social support that family members provided to each other. Restrictive visitation policies that limit the number of family members to two at the bedside do not facilitate the emotionally supportive function families can provide for each other while in the ICU.

Staff need to support family flexibility and support processes that allow families to adapt to the challenge of being in the ICU. For example, families may need to alter their individual functions and responsibilities to maintain routines for other children and siblings.

Staff should also facilitate and support relationships that have developed with families of other patients in the ICU, so that families can offer emotional and informational support to each other. Support groups facilitated by an ICU staff member, such as an advanced practice ICU nurse or social worker, offer a strategy to promote such support for families. The aim of a support group in the ICU would be to introduce families to each other in order to initiate contact with families going through similar experiences. When individuals can share their experiences, it may help them feel that they are not alone during a crisis. Additionally, group members can share novel ways of coping with the critical illness event and gain new problem-solving skills from the crisis. This intended function aligns with the premise of the challenge model of family resilience (Walsh, 2006).

Consideration must be given for families that are not willing to engage with families of other patients in the ICU. An attempt to promote such relationships when they are not welcome may cause more emotional distress and heighten vulnerability. It is important for clinicians to acknowledge that some families may endure further emotional burden by witnessing other families' distress and suffering, identified in this study as secondary suffering. Therefore, family support groups in the ICU should only be offered in a voluntary capacity that does not obligate families to attend if they are uncomfortable with the idea.

The understanding of secondary suffering obtained from this study suggests that staff should optimize the use of private spaces to minimize potential vicarious traumatization as a result of witnessing the distress of other families and patients. It may be unrealistic to expect families to be completely protected from the distress of other families in the ICU. However, if staff

understand the potential impact of secondary suffering on families, they can be more proactive in limiting its occurrence. Staff should take families to private counseling rooms away from the viewing public when they communicate potentially distressing news or discuss the patient's condition and treatment.

This article has detailed a major category of a grounded theory of family resilience in the ICU—Drawing strength. Drawing strength explains the manner with which families are facilitated to move beyond their heightened emotional vulnerability to regain control by drawing on available social support networks. There are two main sources of social support for families in this context: their own family members and the families of other ICU patients. As a result of this study, staff working in these areas can provide improved patient- and family-centered care that integrates both the patient and family in all aspects of the patient's care where appropriate. By having an in-depth understanding of both the facilitators and barriers to the families' ability to regain control, staff can facilitate family resilience in the ICU.

### Clinical Resource

- Institute for Patient- and Family-Centered Care. Patient- and family-centered care. <http://www.ipfcc.org/about/pfcc.html>

### References

- Arora, N. K., Finney Rutten, L. J., Gustafson, D. H., Moser, R., & Hawkins, R. P. (2007). Perceived helpfulness and impact of social support provided by family, friends, and health care providers to women newly diagnosed with breast cancer. *Psycho-Oncology*, 16(5), 474–486. <https://doi.org/10.1002/pon.1084>
- Azoulay, E., Pochard, F., Kentish-Barnes, N., Chevret, S., Aboab, J., Adrie, C., & Schlemmer, B. (2005). Risk of post-traumatic stress symptoms in family members of intensive care unit patients. *American Journal of Respiratory and Critical Care Medicine*, 171(9), 987–994. <https://doi.org/10.1164/rccm.200409-1295OC>
- Barley, E., & Lawson, V. (2016). Health psychology: Supporting the self-management of long-term conditions. *British Journal of Nursing*, 25(20), 1102–1107.
- Baumhover, N. C., & May, K. M. (2013). A vulnerable population. *AACN Advanced Critical Care*, 24(2), 130–148. <https://doi.org/10.1097/NCI.0b013e318286489e>
- Benbenishty, J. (2015). Family support group: A tool for nurses. *Nursing in Critical Care*, 20(6), 282–283. <https://doi.org/10.1111/nicc.12228>
- Blom, H., Gustavsson, C., & Sundler, A. J. (2013). Participation and support in intensive care as experienced by close relatives of patients—A phenomenological study. *Intensive and Critical Care Nursing*, 29(1), 1–8. <https://doi.org/10.1016/j.iccn.2012.04.002>
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London, UK: Sage.
- Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). London, UK: Sage.
- Cohen, S. (2004). Social relationships and health. *American Psychologist*, 59(8), 676–684.
- Coombs, M., Mitchell, M., James, S., & Wetzig, K. (2016). Intensive care bereavement practices across New Zealand and Australian intensive care units: A qualitative content analysis. *Journal of Clinical Nursing*, 26(19–20), 2944–2952. <https://doi.org/10.1111/jocn.13624>
- Corbin, J., & Strauss, A. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory* [Kindle Edition]. Retrieved from <http://www.amazon.com/Kindle-eBooks/b?ie=UTF8&node=154606011>
- Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage.
- Cypress, B. S. (2010). The intensive care unit: Experiences of patients, families, and their nurses. *Dimensions of Critical Care Nursing*, 29(2), 94–101. <https://doi.org/10.1097/DCC.0b013e3181c9311a>
- Davidson, J. E., Aslakson, R. A., Long, A. C., Kross, E. K., Curtis, J. R., Puntillo, K. A., ... Levy, M. M. (2017). Guidelines for family-centered care in the neonatal, pediatric, and adult ICU. *Critical Care Medicine*, 45(1), 103–128. <https://doi.org/10.1097/CCM.0000000000002169>
- Davidson, J. E., Aslakson, R. A., Long, A. C., Puntillo, K. A., Kross, E. K., Hart, J., ... Curtis, J. R. (2017). Guidelines for family-centered care in the neonatal, pediatric, and adult ICU. *Critical Care Medicine*, 45(1), 103–128.
- Davidson, J. E., Powers, K., Hedayat, K. M., Tieszen, M., Kon, A. A., ... Shepard, E.,... American College of Critical Care Medicine Task Force 2004–2005, Society of Critical Care Medicine. (2007). Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American College of Critical Care Medicine

- Task Force 2004–2005. *Critical Care Medicine*, 35(2), 605–622. <https://doi.org/10.1097/01.ccm.0000254067.14607.eb>
- Eggenberger, S. K., & Nelms, T. P. (2007). Being family: The family experience when an adult member is hospitalized with a critical illness. *Journal of Clinical Nursing*, 16(9), 1618–1628. <https://doi.org/10.1111/j.1365-2702.2006.01659.x>
- Engström, Å., & Söderberg, S. (2004). The experiences of partners of critically ill persons in an intensive care unit. *Intensive and Critical Care Nursing*, 20(5), 299–308. <https://doi.org/10.1016/j.iccn.2004.05.009>
- Figley, C. R. (2013). *Treating compassion fatigue*. Hoboken, NJ: Taylor and Francis.
- Figley, C. R., & Ludick, M. (2017). Secondary traumatization and compassion fatigue. In S. N. Gold & S. N. Gold (Eds.), *APA handbook of trauma psychology: Foundations in knowledge* (pp. 573–593). Washington, DC: American Psychological Association.
- Gries, C. J., Engelberg, R. A., Kross, E. K., Zatzick, D., Nielsen, E. L., Downey, L., & Curtis, J. R. (2010). Predictors of symptoms of posttraumatic stress and depression in family members after patient death in the ICU. *Chest*, 137(2), 280–287. <https://doi.org/10.1378/chest.09-1291>
- Hanley, J. B., & Piazza, J. M. (2012). A visit to the intensive care unit: A family-centered culture change to facilitate pediatric visitation in an adult intensive care unit. *Critical Care Nursing Quarterly*, 35(1), 113–122.
- Hogan, B. E., Wolfgang, L., & Bahman, N. (2002). Social support interventions: Do they work? *Clinical Psychology Review*, 22, 381–440.
- Hupcey, J. E. (1998a). Clarifying the social support theory-research linkage. *Journal of Advanced Nursing*, 27, 1231–1241.
- Hupcey, J. E. (1998b). Establishing the nurse–family relationship in the intensive care unit. *Western Journal of Nursing Research*, 20(2), 180–194. <https://doi.org/10.1177/019394599802000204>
- Hupcey, J. E. (1999). Looking out for the patient and ourselves—The process of family integration into the ICU. *Journal of Clinical Nursing*, 8(3), 253–262. <https://doi.org/10.1046/j.1365-2702.1999.00244.x>
- Iverson, E., Celious, A., Kennedy, C. R., Shehane, E., Eastman, A., Warren, V., & Freeman, B. D. (2014). Factors affecting stress experienced by surrogate decision makers for critically ill patients: Implications for nursing practice. *Intensive and Critical Care Nursing*, 30(2), 77–85. <https://doi.org/10.1016/j.iccn.2013.08.008>
- Kean, S. (2010). Children and young people visiting an adult intensive care unit. *Journal of Advanced Nursing*, 66(4), 868–877.
- Kean, S., & Mitchell, M. (2013). How do intensive care nurses perceive families in intensive care? Insights from the United Kingdom and Australia. *Journal of Clinical Nursing*, 23, 663–672. <https://doi.org/10.1111/jocn.12195>
- Kross, E. K., Engelberg, R. A., Gries, C. J., Nielsen, E. L., Zatzick, D., & Curtis, J. R. (2011). ICU care associated with symptoms of depression and posttraumatic stress disorder among family members of patients who die in the ICU. *Chest*, 139(4), 795–801. <https://doi.org/10.1378/chest.10-0652>
- Leon, A. M., & Knapp, S. (2008). Involving family systems in critical care nursing: Challenges and opportunities. *Dimensions of Critical Care Nursing*, 27(6), 255–262.
- Liamputtong, P., & Serry, T. (2017). Making sense of qualitative data. In P. Liamputtong (Ed.), *Research methods in health: Foundations for evidence-based practice*, (3rd ed., pp. 421–436). South Melbourne: Oxford University Press.
- Mayo Clinic. (2015). *Support groups: Make connections, get help*. Retrieved from <http://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/support-groups/art-20044655?reDate=15112015>
- McAdam, J. L., Fontaine, D. K., White, D. B., Dracup, K. A., & Puntillo, K. A. (2012). Psychological symptoms of family members of high-risk intensive care unit patients. *American Journal of Critical Care*, 21(6), 386–394. <https://doi.org/10.4037/ajcc2012582>
- McCubbin, H. I., Cauble, A. E., & Patterson, J. M. (1982). *Family stress, coping, and social support*. Springfield, IL: Charles C Thomas.
- Minichiello, V., Sullivan, G., Greenwood, K., & Axford, R. (Eds.). (2004). *Handbook of research methods for nursing and health science* (2nd ed.). Sydney, Australia: Pearson Education Australia.
- Moran, C. C. (2013). Humor as a moderator of compassion fatigue. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 139–154). Hoboken, NJ: Taylor and Francis.
- Morrison, V., Bennett, P., Butow, P., Mullan, B., & White, K. (2012). *Introduction to health psychology in Australia* (2nd ed.). Frenchs Forest, New South Wales, Australia: Pearson Australia.
- Olsen, K., Dysvik, E., & Hansen, B. S. (2009). The meaning of family members' presence during intensive care stay: A qualitative study. *Intensive and Critical Care Nursing*, 25(4), 190–198. <https://doi.org/10.1016/j.iccn.2009.04.004>

- Paul, F., & Rattray, J. (2008). Short- and long-term impact of critical illness on relatives: Literature review. *Journal of Advanced Nursing*, 62(3), 276–292. <https://doi.org/10.1111/j.1365-2648.2007.04568.x>
- Petrinec, A., Mazanec, P., Burant, C. J., Hoffer, A., & Daly, B. J. (2015). Coping strategies and posttraumatic stress symptoms in post-ICU family decision makers. *Critical Care Medicine*, 43(6), 1205–1212.
- Roy, R. (2011). Social support, health, and illness: A complicated relationship. Toronto: University of Toronto Press. Retrieved from <http://www.jstor.org/stable/10.3138/9781442685314>
- Serry, T., & Liamputtong, P. (2017). The in-depth interviewing method in health. In P. Liamputtong (Ed.), *Research methods in health: Foundations for evidence-based practice*, 3rd ed. (pp. 67–83). South Melbourne: Oxford University Press.
- Taylor, S. E., Kelin, L. C., Gruenewald, T. L., Gurung, R. A. R., & Fernandes-Taylor, S. (2003). Affiliation, social support, and biobehavioral responses to stress. In J. Suls & K. A. Wallston (Eds.), *Social psychological foundations of health and illness*, (pp. 314–331). Malden, MA: Blackwell.
- Uchino, B. N. (2006). Social support and health: A review of physiological processes potentially underlying links to disease outcomes. *Journal of Behavioral Medicine*, 29(4), 377–387. <https://doi.org/10.1007/s10865-006-9056-5>
- Van Horn, E. R., & Tesh, A. (2000). The effect of critical care hospitalization on family members: Stress and responses. *Dimensions of Critical Care Nursing*, 19(4), 40–49.
- Vandall-Walker, V., & Clark, A. M. (2011). It starts with access: A grounded theory of family members working to get through critical illness. *Journal of Family Nursing*, 17(2), 148–181. <https://doi.org/10.1177/1074840711406728>
- Walsh, F. (2006). *Strengthening family resilience* (2nd ed.). New York, NY: Guilford Press.
- Walsh, F. (Ed.). (2012). *Normal family processes: Growing diversity and complexity* (4th ed.). New York, NY: Guilford Press.
- Wong, P. (2016). Heightened emotional vulnerability and regaining control: *A grounded theory of family resilience in the intensive care unit* (doctoral thesis). College of Science, Health and Engineering, School of Psychology and Public Health. La Trobe University, Bundoora, Australia.
- Wong, P., Liamputtong, P., Koch, S., & Rawson, H. (2017). Barriers to regaining control within a constructivist grounded theory of family resilience in ICU: Living with uncertainty. *Journal of Clinical Nursing*, 26, 4390–4403. <https://doi.org/10.1111/jocn.13768>.
- Wong, P., Liamputtong, P., Koch, S., & Rawson, H. (2018). Barriers to families' regaining control in ICU: Disconnectedness. *Nursing in Critical Care*, 23(2), 95–101. <https://doi.org/10.1111/nicc.12310>.
- Wong, P., Liamputtong, P., & Rawson, H. (2017). Grounded theory in health research. In P. Liamputtong (Ed.), *Research methods in health: Foundations for evidence-based practice* (pp. 138–156). South Melbourne: Oxford University Press.