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Empathy of Nurses and Family Needs in the Intensive Care  
Unit

By

Jolene M. Tietz

A Thesis Submitted in Partial Fulfillment of the  
Requirements for the Degree of  
Master of Science  
In  
Nursing

Minnesota State University, Mankato

Mankato, Minnesota

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Empathy of Nurses and Family Needs in the Intensive Care  
Unit

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## Table of Contents

## Chapter

I.	INTRODUCTION.....	7
	Purpose of the Study.....	9
	Research Questions.....	10
	Significance of the Study.....	10
	Assumptions.....	10
	Limitations.....	11
	Conceptual/Theoretical Framework.....	11
II.	LITERATURE REVIEW.....	15
	Empathy.....	15
	Family.....	17
	Perceptions and Age.....	20
	Culture and Ethnicity.....	21
	Interventions.....	22
	Summary.....	24
III.	METHODOLOGY.....	25
	Setting.....	25
	Population and Sample.....	26
	Questionnaire.....	26
	Data Collection.....	27
IV.	FINDINGS.....	30
V.	DISCUSSION and RECOMMENDATIONS.....	35
	REFERENCES	

APPENDICES

**Abstract**

Introduction: Patients and patients' families are in crisis when the patient is in the Intensive Care Unit. There have been studies demonstrating the importance of recognizing patient and family needs, and meeting those needs. This study explored what needs families rank as important and if the nurse met their needs, and what effect nurse empathy had on meeting family needs.

Methods: Families in the Intensive Care Unit were given questionnaires to complete that addressed which needs they felt were important, if their needs were met, and the level of empathy they gauged their nurse to have. The tools utilized in this study included the Critical Care Family Needs Intervention (CCFNI), the Needs Met Inventory (NMI), and the Barrett-Lennard Relationship Inventory.

Results: A total of fifteen families participated in this study. There was no correlation between the empathy of the nurse and their ability to meet family needs. There was a negative correlation between the CCFNI, and the NMI.

Conclusions: This study validated the need for assurance as one of the most important family needs. More studies

should be performed to see the effect, if any, empathy has on the nurse's ability to identify and care for a family's needs.

## Chapter I

### Introduction

The Intensive Care Unit (ICU) in a hospital is often a stressful place for patients and families; and families in crisis are not an unusual phenomenon. Crisis is "an acute emotional upset stemming from any variety of sources that results in a temporary inability to cope" (Appleyard, Gavaghan, Gonzalez, & Ananian, 2000, p. 41).

Traditionally, patients have been the main focus of the nurse in the hospital setting. Nurses recognize that families of patients in the ICU are in need of support to work through the crisis, but "because of the serious, unstable nature of patients admitted to the ICU, the majority of staff members' efforts are directed at maintaining and preserving life at all costs" (Mendonca & Warren, 1998, p. 58). Families have not always been recognized as an essential component to the patient's well-being and recovery. This thinking may detract from a holistic plan of care for the patient and family in the intensive care setting. Holism is defined as "a dynamic condition or state of being, experienced in multiple realms by developing persons as they struggle with complex, dichotomous, and ambiguous phenomena to attain the



ephemeral state of well being" (Denham, 2003, p. 279).

Adding to the complexity of caring for the patient and family, nurses recognize that families are diverse, and are usually not the once typical nuclear family. Denham (2003) stated that "a family is a group of people, connected emotionally and/or by blood, who have lived together long enough to have developed patterns of interaction and stories that justify and explain these patterns of interaction" (Denham, 2003, p. 21). Simply stated, a family is defined by the members in that family. Denham (2003) described family health as "a process of multimember interactions and health-related behaviors that evolve over time that members use to attain, maintain, sustain, or regain the health of individual members and the family as a whole"(Denham, 2003, p. 32). This definition is indicative of the complexity involved in caring for families, in addition to responding to the patient's immediate medical needs. Nurses are regularly faced with families feeling despair, fear, anger, and helplessness, and nurses are challenged to respond therapeutically, often without formal education in family dynamics or intervention (Goodnell, 1999, p. 73).

Empathy is defined as "understanding a client's thoughts and feelings and the ability to communicate to the

patient this understanding of both the patient's feelings and reasons for those feelings" (Peterson & Bredow, 2004, p. 151). Peterson and Bredow (2004) continued that empathy is one of the most essential variables in establishing and maintaining the nurse-patient relationship. As families are an integral piece of the patient's experience and well-being, this statement could be generalized to the nurse-family relationship as well. The majority of studies related to empathy come from the psychotherapy and counseling literature (Olson & Hanchett, 1997). In a review of nursing research empathy studies, the focus was on the impact of empathy on patient care; specifically in relation to patient distress, anxiety, satisfaction, perceived needs, and how patients experience pain (Yu & Kirk, 2008).

#### Purpose of the Study

The purpose of this study was for family members of patients in the ICU to identify whether certain needs were important to them and to identify whether the nurse met those needs. An additional purpose of the study was to identify whether or not nurses' empathy had an impact on the families' perceptions of their needs being met. Family needs, whether or not the families' needs were met, and nurse empathy were the variables studied. Gender and age

of the patients and families, along with previous hospitalization history were specific demographic questions that were reviewed in relation to these variables.

#### Research Questions

The research questions in this study are:

1. Which needs are most important to the participants in this study?
2. Will an empathic nurse meet the needs of a patient's family more completely than a nurse with less empathy?
3. Does patient and/or family gender or age have any bearing on the results of the study?

#### Significance of Study

There has been much research focused on families of patients in the intensive care unit and their needs. There has also been plentiful research on the concept of empathy and nursing. However, there is little research that connects these variables.

#### Assumptions

This study makes some basic assumptions about families with members undergoing acute and chronic issues that need to be treated in the ICU.

1. Families of the patients in ICU are undergoing stress and crisis.
2. Patients are influenced by their families.

3. Nurses who are more empathic will meet families' needs more successfully than nurses who are less empathic.

#### Limitations

The limitations of this study included the variability of patient census in the Intensive Care Unit; low census may have contributed to a small sample size.

#### Conceptual/Theoretical Framework

The theoretical framework for this paper is Joanne Olson's Theory of the Empathic Process (1997). Olson's middle range theory is based on Orlando's Model of Nursing (Orlando, 1961, 1972). Olson identified three relational statements from Orlando's model to further develop.

1. "There will be greater improvement in patient behavior and more effective nursing care when nurses use the disciplined professional response than when they use automatic personal response" (Peterson & Bredow, 2004, p. 155).
2. "When a nurse assesses a patient's immediate needs, immediate experiences, and immediate resultant behaviors, nursing care is more effective in decreasing distress and helplessness and increasing comfort" (Peterson & Bredow, 2004, p. 155).
3. "There will be greater improvement in patient outcomes when nurses have accurate perceptions of patient needs

and when these accurate perceptions are shared verbally with the patient" (Peterson & Bredow, 2004, p. 156).

Olson identified three key concepts that need definition before explanation of the theory's proposition statements. The concepts included nurse-expressed empathy, patient-perceived empathy, and patient distress.

Nurse-expressed empathy is defined as understanding what a patient is saying and feeling and communicating this understanding verbally to the patient. Patient-perceived empathy is described as the patient's feelings of being understood and accepted by the nurse. Patient distress is defined as the negative emotional state resulting from unmet needs; includes anger, anxiety and depression. (Peterson and Bredow, 2004, p. 151)

The three empathic propositions that provide the basis of Olson's theory are listed below:

Nurse expressed empathy (accurate perceptions verbally shared with patients) leads to decreased patient distress, and if accurate perceptions are verbally shared with patients (nurse-expressed empathy), the patient experiences greater perceived empathy (feelings of being understood and accepted by the

nurse), and patient-perceived empathy leads to lower patient distress (Peterson and Bredow, 2004, p. 156). Olson's theory provides a "structure from which to study the relationships among nurse-expressed empathy, patient-perceived empathy, and patient outcomes" (Peterson, 2004, p. 156). A nurse needs to review a patient's needs and experience, and then select the best intervention; this is part of the empathic process. While this study takes the above three concepts into account, it is most interested in the patient-perceived empathy, and how nurses can affect that concept.

Along with the above empathy theory, this study also expressed a component of family theory. Family Systems Theory is based on input from several disciplines including sociology, psychology, and the family sciences. The theory of family systems "emphasizes the whole of the family but focuses on member relationships and interactions and the functional status of the system to address needs, goals, and sustain its members" (Denham, 2003, p. 201). This statement relates to the nurse, in that there needs to be thoughtful consideration of not only what the patient requires, but also what the family as a whole needs. There is a circular theme here, the family influences the patient, and the patient influences the family.

The various concepts of empathy, patient, and family are related within this study. As previously described, families are an integral part of patient care within the Intensive Care Unit. The Family System's theory suggests that Olson's empathic propositions apply not only to the patient's needs, but also to the family's needs. Increased patient (family) perceived empathy should decrease the patient (family) distress.

## Chapter II

### Literature Review

The purpose of this study was for family members of patients in the ICU to identify whether certain needs were important to them, and to identify whether the nurse met those needs. An additional purpose of the study was to identify whether or not nurses' empathy had an impact on the families' perceptions of their needs being met. The literature review begins with the study's main concepts, empathy and family systems. The literature review then delves further into the themes that presented upon reviewing the literature.

#### Empathy

Three main concepts have driven the study of empathy; the interpersonal approach, the therapeutic communication approach, and the multidimensional or multiphasic approach (Peterson & Bredow, 2004). The interpersonal approach branches into two categories, cognitive and affective. Cognitive empathy is "the ability to understand another's viewpoint" (Peterson and Bredow, 2004, p. 152). Affective empathy is "the emotional experience that one has to another's feelings" (Peterson and Bredow, 2004, p. 152). Therapeutic empathy refers to "actively communicating an



accurate understanding of a person's feelings, to that person" (Peterson and Bredow, 2004, p. 154). The empathy scale constructed by Barrett-Lennard, utilized by this study, falls in the therapeutic empathy category. The multidimensional or multiphasic approach is any combination of the interpersonal and therapeutic approaches. In a systematic review of empathy in nursing research performed by Yu & Kirk (2008), thirty studies were reviewed that focused on a variety of empathy components including empathy levels, variation in empathy between health professionals, the effect of empathy on patient outcomes, and empathy evaluation studies. A finding their review highlighted is the large number of measures and tools available. They theorized that "a rigorous tool to demonstrate empathic skills could help to highlight the invisible work of nursing" (Yu & Kirk, 2008, p. 452). Debate also existed over whether empathy can be learned skill or if it is a natural trait. There were studies that support teaching empathy, however, the research has not supported that learned empathic skills are sustained. Yu and Kirk (2008) suggested that these findings identify the need for longitudinal studies that explore how empathy can be enhanced and sustained. Baillie (1995) summarized the differing viewpoints as "while behavioural aspects of

empathy can be learned and may be effective, it seems important to recognize and value nurses' natural empathic qualities" (Baillie, 1995, p. 31).

#### Family

Most of the current research that involves families in the ICU attempts to identify what elements, or needs, are important to families. Holden, Harrison, and Johnson (2002) stated that early research in intensive care "focused on the critically ill patient, and little emphasis was placed on responding to the needs of the family members" (Holden, Harrison, & Johnson, 2002, p. 141). In the recent research on the family, one tool that is consistently used across studies is the Critical Care Family Needs Intervention (CCFNI) tool. Leske (1991) identified five categories of needs that are universally experienced by different types of families: needing to receive assurance, needing to remain by the patient, needing to receive information, needing to be comfortable in the setting, and needing support that is readily available (Leske, 1991). Family needs are a very common theme that is present in most, if not all, of the current research.

Families often feel scared, intimidated, or bothersome in the ICU environment. Auerbach, Kiesler, Wartella, and

Rausch (2005) stated "family members who are exposed to the trauma experience may have an emotional distress level almost as great as that of the patients" (p. 203). Curry (1995) listed three main areas of psychosocial stress that families in the ICU experience: 1) disruption of community life, 2) potential/actual loss of a loved one, and 3) uncertainty of control over one's environment in the ICU.

Appleyard, Gavaghan, Gonzalez, & Ananian (2000) found that families in the ICU felt frustrated and distressed about the lack of information and support from the ICU staff. The families felt like they were a hindrance to the nurses. This study used the CCFNI, which identified the most important family needs as support, comfort, information about the patient, proximity to their loved one, and assurance. This study incorporated nurse-coached volunteer staff to act as a bridge between the family and staff, providing access and support to the family. One finding that came from this study was the large amount of time that family members spent in the hospital visiting their loved ones. The majority of families spent greater than six hours a day in waiting rooms or at the bedside (Appleyard et al., 2000). This finding is especially important when you consider the families' need for comfortable surroundings. Another finding from this study

was the families' wish to collaborate with the healthcare team. The family does not want to feel like an outsider, they want to "belong" in the environment.

Auerbach et al. (2005) performed a study that dealt with the optimism of family members in the ICU and if optimism influenced the families' perception of whether their needs were being met by the nurses. The researchers measured the levels of stress and anxiety at the beginning of the stay in ICU and again once the patient was discharged from ICU. This study determined that lack of information and lack of comfortable surroundings was the main cause of stress for the family at the beginning of the ICU stay. The authors of this study discovered that families who were determined to be optimistic did have greater satisfaction that their needs were being met. These findings suggested that nurses should develop interpersonal contact and encourage the family to participate in the patient's care as a way to foster optimism and meet the information needs of the family.

Engstrom and Soderberg (2007) studied family presence in the ICU and found that family presence was expected in the ICU. "Information from close relatives made it possible for the critical care nurses to create individual care for the critically ill person" (Engstrom & Soderberg,

2007, p. 1651). The study discussed the time, effort, and stressors to build a relationship between the nurses and family, in order to improve the care of the patient.

#### Perceptions and Age

Kosco and Warren (2000) performed a study that looked at both family and nursing needs. They measured whether or not nurses' perceptions of meeting needs of the family correlated with the families' perceptions of their needs being met. This study used the CCFNI and found that families ranked assurance, information about the patient, and proximity to patient as the most important needs. This study found a difference between the experience and age of the nurses and what they thought was important. Less experienced nurses thought it was more important for there to be a concerned relative at the hospital. More experienced nurses thought that information, giving the best care possible to the patient, and good food was important to the family. This study did not analyze whether the ages of the families had a bearing on their perceptions. Two important problems were identified by this study; the importance of having interpreters available as needed and increasing compassion and attention paid to the family by the nurses. FoxWasylyshyn, ElMasri, and Williamson (2005) studied the needs of the family in

critical care, and whether or not the nurses met those needs. They studied the perceptions of the family regarding what the nurses should be doing versus their perception of what they were actually doing. They examined whether there was a difference in satisfaction with care depending on families' expectations being met or not. FoxWasylyshyn et al. (2005) found that nurses generally did well meeting family needs and stressed the need to evaluate families on a "case by case" basis (2005).

#### Culture and Ethnicity

Mendonca and Warren (1998) conducted a study that measured families' needs in critical care, and how those needs were met or unmet over a period of three to four days. This study found that ethnicity and culture were important variables that should not be overlooked. The study also stressed that all families were different and may have different needs. Along with culture, this study discussed the education levels of families and that less educated families needed information delivered in a way that pertained to their level of understanding.

#### Interventions

Nurses can make a difference in family care. "A myriad of interventions is possible, but nurses need to tailor their interventions to each family" (Wright &

Leahey, 2005, p. 155). This statement is important to remember. Each family is unique and requires interventions appropriate to their expressed and unexpressed needs. Wright & Leahy (2005) define a nursing intervention as "any treatment, based on clinical judgment, that a nurse performs to enhance patient/client outcomes" (Wright & Leahy, 2005, p. 14). Leske (2002) identified many family interventions from a variety of research. Some of these interventions included identifying a family spokesperson and a primary nurse contact for the family. Promoting access to the patient, and keeping in contact with the family were also identified as important interventions. Leske (2002) went on to explain the importance of initiating these interventions on first contact with the family, continuing the interventions throughout the critical care period, and even past discharge from the intensive care unit. Pearce (2005) suggested interventions such as implementing liaison nurses in the intensive care unit. The nurses in the intensive care unit rotated into the liaison nurse position for two months at a time. The liaison nurses were solely responsible for the family; they were present with the family during doctor and family meetings, they answered questions, and they arranged visiting times. These liaison nurses did everything from

helping the family at the bedside to arranging child and pet care (Pearce, 2005). Nurses and families involved with this project were pleased at the results of this trial.

De Jong and Beatty's (2000) study involved the specific interventions that met families' needs in the intensive care unit. This study proposed that there were differences in the interventions family members found helpful depending on the ages of the family members. The study examined areas of support provided to the family, including emotional support, appraisal support, informational support, and instrumental support. The spouses and adult children ranked specific interventions that were contained within the areas of support. The study determined that the four most important interventions for families related to informational support: 1) notifying appropriate persons if the patient condition changed, 2) explaining what was being done to the patient, 3) allowing time to visit the patient, 4) and answering questions. Both age groups, spouses and adult children, ranked their needs for support similarly in this study, suggesting that family members have the same needs, regardless of age.

#### Summary

Many different themes have been identified throughout the literature review. One overarching idea or conclusion



is the fact that all families are different. Nurses need to assess what is important to an individual family and meet that need. Each of the studies identified different family needs. Therefore, it is hard to generalize that what works for one family will be applicable to another.

### Chapter III

#### Methodology

The purpose of this study was for family members of patients in the ICU to identify whether certain needs were important to them and to identify whether the nurse met those needs. An additional purpose of the study was to identify whether or not nurses' empathy had an impact on the families' perceptions of their needs being met. The subjects were asked several demographic questions. They then completed a two-part questionnaire. The first section of the questionnaire asked the participant to rank the empathy of the nurse caring for their family member. The next section asked the participant to identify which needs were important to them and if those needs were met. Relationships between the variables were then analyzed utilizing the Statistical Package for the Social Sciences (SPSS).

#### Setting

The setting for this sample population was an adult Intensive Care Unit in a Midwestern hospital. This hospital is the largest hospital in the area, with an average inpatient population of approximately 130 patients and an average ICU population of five to eight patients.

This ICU's patient population is medical-surgical focused, although patients with a variety of diagnoses are seen.

#### Population and Sample

The participants in this study were at least eighteen years old, with an ability to read and write English. Only one family member per ICU patient completed the questionnaire.

#### Questionnaire

The instruments utilized in this study were the CCFNI, the Needs Med Inventory (NMI), and the Barrett-Lennard Relationship Inventory (BLRI).

The CCFNI was developed by Leske in 1983. Leske based the CCFNI on a 45-item questionnaire developed by Molter in 1979 to identify which needs the family perceived as important. The CCFNI consists of 45 need statements that the family ranks on a four point Likert-type scale of "not important at all" to "very important".

In 1998, Mendonca and Warren adapted the original CCFNI and added a column that addressed whether or not the needs identified in the CCFNI were met or unmet. The revised form of the CCFNI was used in data collection for this study.

The BLRI was developed in 1962, and contains 64 items that are scored on a six point Likert-type scale. The BLRI

measures four dimensions of interpersonal relationships. One subset of the BLRI contains 16 items that measure empathy. The 16-item tool was utilized in this study. Layton & Wykle (1990) have reported that the BLRI is frequently used and has been found to be reliable and valid in a number of empathy and counseling studies (Layton & Wykle, 1990).

The participant also completed seven demographic questions. Four questions relate to the ages and gender of the patient and family member. One question determined relationship between the patient and participant, and the final questions related to the patient's condition and prior hospitalization history (see Appendix A for a copy of the questionnaire). Approval to conduct the study was given by the Institutional Review Board (IRB) of the College of Graduate Studies and Research at Minnesota State University, Mankato and the IRB at Immanuel St. Joseph's Hospital - Mayo Health System prior to the initiation of data collection.

#### Data Collection

The questionnaires were distributed to family members in the Intensive Care Unit. One questionnaire was given per patient family.

An Information Sheet accompanied the questionnaire (see Appendix B). The sheet requested participation in the research, described the purpose of the research, confirmed that IRB approval had been obtained, and indicated how confidentiality would be preserved. The Information Sheet also provided information regarding the purpose and use of the questionnaire. The potential participants were approached by the graduate student, taking into account the patient's needs and condition. The questionnaires were also mailed to family members at their homes if they were not available to be contacted at the hospital. The participants had the option of returning the questionnaires through the mail or into a locked box located directly outside the Intensive Care Unit. Return of the questionnaire served as informed consent to participate in the research study. Participants' confidentiality was maintained by using numbers to code the questionnaires. The numbers were used in the computer analysis of the data.

Approximately 100 questionnaires were distributed between March 2008 and July 2008, resulting in 15 participants.

## Chapter IV

### Findings

The data were analyzed using the SPSS. The product-moment correlation coefficient (Pearson's  $r$ ) was used to correlate the participants' answers to the different scales and demographic data.

#### Sample Description

There were fifteen participants in the study; eleven of them (73.3%) were female. The patients consisted of nine (60%) males and six (40%) females. The participants were related to the patients in the following ways: five (33.3%) spouses/significant others, four (26.7%) parents, four (26.7%) sons or daughters, one (6.7%) niece (N=1), and one (6.7%) grandchild. The mean age of patients was 65; the range 18 to 90 years of age. The participants' mean age was 52.2 and ranged from 28 to 77. Thirteen of the patients had been hospitalized in a prior instance.

#### Findings

The data was analyzed to determine the top ten family needs while the patient was hospitalized in the intensive care unit. Tables 1 and 2 represent the data obtained from the CCFNI.

Table 1 - CCFNI Most Important Needs

	<b>Mean</b>	<b>Needs Met</b>
1. To have questions answered honestly	4.00	93.3%
2. To be assured that the best care possible is being given to the patient	4.00	86.7%
3. To feel that hospital personnel care about the patient	3.93	93.3%
4. To have explanations given in terms that are understandable	3.93	100%
5. To know the prognosis	3.87	86.7%
6. To know how the patient is being treated medically	3.87	93.3%
7. To feel there is hope	3.80	93.3%
8. To know the specific facts concerning the patients progress	3.80	93.3%
9. To be called at home about changes in the condition of the patient	3.73	73.3%
10. To visit at any time	3.73	73.3%



Table 2 - CCFNI Least Important Needs

	<b>Mean</b>	<b>Needs Met</b>
1. To be encouraged to cry	1.92	50%
2. To have another person with the relative when visiting in the ICU	2.08	50%
3. To be alone at any time	2.31	61.5%
4. To have a telephone near the waiting room	2.36	57.1%
5. To talk about negative feelings such as guilt or anger	2.36	45.5%
6. To have a place to be alone at the hospital	2.38	61.5%
7. To have someone help with financial problems	2.64	54.5%
8. To be told about someone to help with family problems	2.67	41.7%
9. To have directions as to what to do at the bedside.	2.67	46.7%
10. To help with the patients physical care	2.73	73.3%

Participants also rated how empathic the nurses were on the Barrett-Lennard Relationship Inventory. Table 3 represents the results from the study.

Table 3: BLRI Subset - Barrett-Lennard Empathy Scale

	<b>Mean</b>
1. The nurse wants to understand how I see things	2.1
2. The nurse nearly always knows exactly what I mean	1.9
3. The nurse usually senses or realizes what I am feeling	1.8
4. The nurse understands me	1.8
5. The nurse usually understands the whole of what I mean	1.7
6. The nurse does not realize how sensitive I am about some of the things we discuss	-1.7
7. When I am hurt or upset, the nurse can recognize my feelings exactly, without becoming upset themselves	1.7
8. The nurse's response to me is usually so fixed and automatic that I don't really get through to him or her	-1.6
9. The nurse realizes what I mean even when I have difficulty saying it.	1.5
10. The nurse appreciates exactly how the things I experience feel to me.	1.5
11. The nurse's own attitudes toward some of the things I do or say prevent him/her from understanding me	-1.3
12. The nurse takes no notice of the some things that I think or feel	-1.3
13. Sometimes the nurse thinks that I feel a certain way, because that is the way he/she feels	-1.1
14. At times the nurse thinks I feel a lot more strongly about a particular thing than I really do	-1.0
15. The nurse may understand my words, but does not see the way I feel	0.3
16. The nurse looks at what I do from his/her own point of view	0.1

When comparing the different scales, it was determined that there was no significant correlation between the BLES and the NMI. The BLES did not correlate to the CCFNI. Table 4 shows a significant negative correlation between the CCCFNI and the NMI.

Table 4 - Correlations

		BLES	CCF	NMI
BLES	Pearson Correlation	1	-.153	.276
	Sig. (2-tailed)	.	.587	.320
	N	15	15	15
CCF	Pearson Correlation	-.153	1	-.560(*)
	Sig. (2-tailed)	.587	.	.030
	N	15	15	15
NMI	Pearson Correlation	.276	-.560(*)	1
	Sig. (2-tailed)	.320	.030	.
	N	15	15	15

- Correlation is significant at the 0.05 level (2-tailed).

## Chapter V

### Discussion and Recommendations

The purpose of this study was for family members of patients in the ICU to identify whether certain needs were important to them and to identify whether the nurse met those needs. An additional purpose of the study was to identify whether or not nurses' empathy had an impact on the families' perceptions of their needs being met. Five of the most important needs that were reported in this study were also found by Molter (1979), Leske (1986), and Mendonca and Warren (1998). These needs were: 1) to have questions answered honestly, 2) to feel that hospital personnel cared about the patient, 3) to know the prognosis, 4) to know the specific facts concerning the patient's progress, and 5) to be called at home about changes in the condition of the patient. One need in the top ten of this study did not feature in the other studies' most important needs: to visit at any time. Of the top ten needs identified, seven of those needs fell into the need for assurance category. The remaining three needs were grouped under the proximity and information needs. Eight out of the ten least important needs fell under the support

category, with information and comfort making up the rest of the least important needs. All of the top ten needs identified within the study were met more than 70% of the time. This finding was also true in the study performed by Molter (1979). There were very few needs that were influenced by age or gender. One need that did appear in the 18 to 34 year old top ten needs was the need to have the waiting room near the patient. This did not end up as one of the most important needs in the overall analysis. Other factors did not seem to play a role, although the small sample size may have influenced these findings.

The participants ranked their nurses on the differing empathy statements. The negative numbers in the BLRI table resulted from the scoring system used to analyze the results.

Positively expressed items are questions to which affirmative answers score in a positive direction and 'no' answers in a negative direction. Negatively stated items are questions to which affirmative answers score in a negative direction and 'no' answers in a positive direction (Barrett-Lennard, 1978. p. 2). There was a maximum possible score of 3 for the positively expressed items, and a possible score of -3 for the negatively expressed items. The table above illustrated

the mean scores the nurses received on each question. The two questions the nurses scored the highest on were 1) the nurse wants to understand how I see things and 2) the nurse nearly always knows exactly what I mean. The nurses scored the lowest on 1) the nurse may understand my words, but does not see the way I feel, and 2) the nurse looks at what I do from his/her own point of view.

According to the analysis of the relationship, there was no correlation between the empathy of the nurse, and how the participants felt their needs were met. The absence of correlation between the BLES and the CCF may be because the empathy of the nurse was gauged by the family, instead of the nurse. This study examined nurse empathy from the viewpoint of the family and there may have been different results if the nurse had rated their own empathy. The absence of correlation between the BLES and NMI may also be due to this reason. However, even though empathy did not correlate with the other scales in this study, the nurses met the needs of the patients a high percentage of the time. Most of the least important needs were met more than 50% of the time.

There was an overall significant negative relationship between the NMI and the CCF. This finding illustrated that as one variable decreased (the family's ranking of the need

importance), the other variable increased (the percentage of time the nurse met the need). This finding indicated that nurses were able to meet the needs of the family, even if the family did not identify the need as important to them. There were some differences in this study as compared to the study performed by Mendonca and Warren (1998). They discovered a significant positive relationship between the support and comfort scales on the CCFNI and the NMI, however these were the only scales that evidenced this finding.

#### Recommendations

The ICU can be a stressful place, and families are often experiencing crisis. Most of the research to date has used the CCFNI to rank family needs. Recommendations for nursing practice include recognizing that families have important needs and knowing how to respond to those needs. Families with a patient in the Intensive Care Unit need assurance about their loved one. Even though this study did not identify empathy as correlating with meeting patient's needs, many research studies and theories support empathy as "integral to therapeutic relationships and related positively to client and nurse outcomes" (Alligood & May, 2000, p. 243). A study performed by Murphy, Price, Forrester, and Monaghan (1992) did validate that "higher

levels of empathy do permit nurses to gauge more accurately at least some of the needs of their critical care patients' family members" (Murphy, Forrester, Price, & Monaghan, 1992, p. 29). The families in this study rated the nurses the lowest on the following empathy statements, 1) the nurse may understand my words, but does not see the way I feel, and 2) the nurse looks at what I do from his/her own point of view. These findings suggest that nurses could potentially benefit from some empathy training focusing on the family's perspective.

Recommendations for nursing research include studying the use of technology in caring for and communicating with families. The CCFNI tool was created in the 1970s, with updates in the 1980s. Some elements of the information needs may be outdated, such as the need to have a telephone near the waiting room. Many people now have cell phones, so having a hospital provided phone available may not be a significant need any longer.

Gaps identified in the literature are the limited studies involving cultural diversity. There is little mention about different races and cultures, and whether their perceived needs are the same as others. Also, there may be a difference among families and/or nurses from rural



or urban settings. Not many studies addressed these demographics.

Recommendations for nursing education include teaching about the five categories of family needs identified from the CCFNI: assurance, support, information, comfort, and proximity. Nurses should consider these areas when they are caring for families. Relationship building with the family, using empathy and communication skills allows for better family and patient care.

The research has shown that families want basic things; to be near their loved one and to know what is going on with them. This study validated the need for assurance as one of the most important needs. More studies should be performed to see the effect, if any, empathy has on the nurse's ability to identify and care for a family's needs.

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## Appendix A

**Section I**

1. What is the gender of the patient?
  - a. Male
  - b. Female
2. What is your gender?
  - a. Male
  - b. Female
3. What is your relationship to the patient?
  - a. Parent
  - b. Spouse
  - c. Child
  - d. Other \_\_\_\_\_
4. What is the age of the patient? \_\_\_\_\_
5. What is your age? \_\_\_\_\_
6. Has the patient been hospitalized before?
  - a. Yes
  - b. No
7. What is the patient's condition?
  - a. Stable
  - b. Critical

## Section II – Barret-Lennard Empathy Scale

	How do you feel about this statement? 1= No, I strongly feel that it is not true 2= No, I feel that it is not true 3= No, I feel that it is probably untrue, or more untrue than true 4= Yes, I feel that it is probably true, or more true than untrue 5= Yes, I feel it is true 6= Yes, I strongly feel that it is true (Circle number to answer)
1. The nurse wants to understand how I see things.	1    2    3    4    5    6
2. The nurse may understand my words, but does not see the way I feel.	1    2    3    4    5    6
3. The nurse nearly always knows exactly what I mean.	1    2    3    4    5    6
4. The nurse looks at what I do from his/her own point of view.	1    2    3    4    5    6
5. The nurse usually senses or realizes what I am feeling.	1    2    3    4    5    6
6. The nurse's own attitudes toward some of the things I do or say prevent him/her from understanding me.	1    2    3    4    5    6
7. Sometimes the nurse thinks that I feel a certain way, because that is the way he/she feels.	1    2    3    4    5    6
8. The nurse realizes what I mean even when I have difficulty saying it.	1    2    3    4    5    6
9. The nurse usually understands the whole of what I mean.	1    2    3    4    5    6
10. The nurse takes no notice of some things that I think or feel.	1    2    3    4    5    6
11. The nurse appreciates exactly how the things I experience feel to me.	1    2    3    4    5    6
12. At times the nurse thinks I feel a lot more strongly about a particular thing than I really do.	1    2    3    4    5    6
13. The nurse does not realize how sensitive I am about some of the things we discuss.	1    2    3    4    5    6
14. The nurse understands me.	1    2    3    4    5    6
15. The nurse's response to me is usually so fixed and automatic that I don't really get through to him/her.	1    2    3    4    5    6
16. When I am hurt or upset, the nurse can recognize my feelings exactly, without becoming upset themselves.	1    2    3    4    5    6



## Section III – Critical Care Family Needs Intervention/Needs Met Inventory

Needs	How Important is This Need? (Circle Number) 1=Not Important 2=Slightly Important 3=Important 4=Very Important	Do you feel that your nurse met this need? (Circle Answer) No Yes Not Applicable (NA)
1. To feel there is hope.	1    2    3    4	No    Yes    NA
2. To feel that hospital personnel care about the patient.	1    2    3    4	No    Yes    NA
3. To have the waiting room near the patient.	1    2    3    4	No    Yes    NA
4. To be called at home about changes in the condition of the patient.	1    2    3    4	No    Yes    NA
5. To know the prognosis.	1    2    3    4	No    Yes    NA
6. To have questions answered honestly.	1    2    3    4	No    Yes    NA
7. To know specific facts concerning the patients progress.	1    2    3    4	No    Yes    NA
8. To receive information about the patient once a day.	1    2    3    4	No    Yes    NA
9. To have explanations given in terms that are understandable.	1    2    3    4	No    Yes    NA
10. To see the patient frequently.	1    2    3    4	No    Yes    NA
11. To feel accepted by hospital staff.	1    2    3    4	No    Yes    NA
12. To have a bathroom near the waiting room.	1    2    3    4	No    Yes    NA
13. To be assured that the best care possible is being given to the patient.	1    2    3    4	No    Yes    NA
14. To know why things were done for the patient.	1    2    3    4	No    Yes    NA
15. To know exactly what is being done for the patient.	1    2    3    4	No    Yes    NA
16. To have comfortable furniture in the waiting room.	1    2    3    4	No    Yes    NA
17. To know how the patient is being treated medically.	1    2    3    4	No    Yes    NA
(continued on next page)		

18. To have friends nearby for support.	1	2	3	4	No	Yes	NA
19. To be told about transfer plans as they are being made.	1	2	3	4	No	Yes	NA
20. To be assured it is alright to leave the hospital for a while.	1	2	3	4	No	Yes	NA
21. To visit at any time.	1	2	3	4	No	Yes	NA
22. To have a telephone near the waiting room.	1	2	3	4	No	Yes	NA
23. To have explanations of environment before going into the ICU the first time.	1	2	3	4	No	Yes	NA
24. To have good food available in the hospital.	1	2	3	4	No	Yes	NA
25. To have the pastor visit.	1	2	3	4	No	Yes	NA
26. To talk to the doctor every day.	1	2	3	4	No	Yes	NA
27. To have visiting hours start on time.	1	2	3	4	No	Yes	NA
28. To talk about the possibility of the patient's death.	1	2	3	4	No	Yes	NA
29. To help with the patient's physical care.	1	2	3	4	No	Yes	NA
30. To have directions as to what to do at the bedside.	1	2	3	4	No	Yes	NA
31. To know which staff members could give what type of information.	1	2	3	4	No	Yes	NA
32. To talk to the same nurse each day.	1	2	3	4	No	Yes	NA
33. To know about the types of staff members taking care of the patient.	1	2	3	4	No	Yes	NA
34. To have a specific person to call at the hospital when unable to visit.	1	2	3	4	No	Yes	NA
35. To be told about chaplain services.	1	2	3	4	No	Yes	NA
36. To be told about other people who could help with problems.	1	2	3	4	No	Yes	NA
37. To have someone be concerned with the relatives's health.	1	2	3	4	No	Yes	NA

38. To have a place to be alone at the hospital.	1	2	3	4	No	Yes	NA
39. To be alone at any time.	1	2	3	4	No	Yes	NA
40. To be told about someone to help with family problems.	1	2	3	4	No	Yes	NA
41. To be encouraged to cry.	1	2	3	4	No	Yes	NA
42. To have another person with the relative when visiting in the ICU.	1	2	3	4	No	Yes	NA
43. To have visiting hours changed for special conditions.	1	2	3	4	No	Yes	NA
44. To have someone help with financial problems.	1	2	3	4	No	Yes	NA
45. To talk about negative feelings such as guilt or anger.	1	2	3	4	No	Yes	NA

## Appendix B

**Consented Information Sheet**

You are invited to participate in a research project designed to explore the empathy of nurses and the needs of the family in the Intensive Care Unit (ICU). Participation is voluntary.

What do I need to do if I participate in the study?

The purpose of the study is to obtain information on family needs in the ICU and whether the empathy of the nurse has any impact on those needs. Results of this study may provide more information on ways to meet the family needs of patients who are critically ill. The typewritten survey consists of demographic questions, questions about empathy, and questions pertaining to the needs of the family in the ICU. You are asked to complete a short questionnaire and either mail (return envelope enclosed) or return it to a locked box located just outside the Intensive Care Unit.

Are there any risks to me?

No risks to you are anticipated from this study. However, you may experience feelings regarding your needs as a family. The hospital chaplain will be available should you wish to discuss your feelings. Please let your nurse know that you would like to speak to the chaplain. Your nurse will contact the chaplain for you.

Are there any benefits to me?

There are no direct personal benefits to you, but you will be providing valuable information in this study.

Who will have access to the study information?

The graduate student who is conducting this research will enter your responses to the questionnaire into a computer program. The results will be kept confidential, and no individual data will be identifiable in any communication, report, or publication that results from the study. The questionnaires will be shared with a research team consisting of the principal investigator, another faculty member, and the graduate student.

What if I change my mind?

You are free to withdraw from this study or to refuse permission for the use of your survey at any time. You have the right to not participate in this study. You may take as much time as you wish to think this over. Please feel free to ask any questions about this study. Contact information for the graduate student, the principal investigator, and the Minnesota State University, Mankato IRB Co-Chairs is attached. We will attempt to answer any questions you may have prior to, during, or following the study.

If you need further information about this study, please contact any of the following persons:

Jolene Tietz, RN  
Graduate Student at Minnesota State University, Mankato  
101 Lynx Court  
Mankato, MN 56001  
507-344-1455

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Associate Professor  
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Minnesota State University, Mankato

Anne E. Blackhurst – [anne.blackhurst@mnsu.edu](mailto:anne.blackhurst@mnsu.edu)  
Interim Dean  
Graduate Studies and Research

**Thank you for your participation in the study. You may write down this information for future reference.**

**Please mail or place your completed questionnaire in the locked box located just outside the Intensive Care Unit.**

- I want to participate
- I do not want to participate

Signature\_\_\_\_\_ Date\_\_\_\_\_

## Appendix C

**Immanuel St. Joseph's**  
*Mayo Health System*

February 14, 2008

Ms. Jolene Tietz, RN  
101 Lynx Court  
Mankato, MN. 56001

RE: "Empathy of Nurses and Family Needs in the Intensive Care Unit"

Dear Ms. Tietz:

The Institutional Review Board of Immanuel St. Joseph's—Mayo Health System reviewed and approved the Investigator Checklist, IRB Proposal, Consented Information Sheet, and Revised Participant Questionnaire for proposal "Empathy of Nurses and Family Needs in the Intensive Care Unit" at its meeting on February 13, 2008.

Approval is granted for one year and data for your proposal is to be gathered only by yourself and Dr. Sue Ellen Bell. (Human Subjects Protection Training certification is on file with the IRB.) You must seek IRB approval to continue past the one year granted.


A written Annual Report will be due prior to February 12, 2009 that, according to FDA regulations and IRB policy, should include the following:

- 1) The number of participants utilized in your survey
- 2) A summary description of the experience (benefits and adverse reactions)
- 3) Number of persons withdrawing from the study and the reasons for withdrawal
- 4) The results of the research thus far
- 5) A current risk-benefit assessment based on the results to date
- 6) Any new or unanticipated information found during the approved year

It is your responsibility to report the end of the survey to the Board. Also, any change in the consents or research protocol would need to be reported. Any adverse events that occur during the study should be reported to the Board as soon as possible.

The deadline for submission to the IRB agenda is usually the 3<sup>rd</sup> Friday of each month. Thank you for your cooperation in complying with these reporting requirements.

Sincerely,

  
S. David Li, M.D. - Chair  
Institutional Review Board

## Appendix D



Sue Ellen Bell, Ph.D.  
School of Nursing  
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Mankato, MN 56001

Jolene Tietz  
School of Nursing  
350 Wissink Hall  
Minnesota State University, Mankato  
Mankato, MN 56001

April 20, 2008

Dear Sue Ellen and Jolene:

Your proposed changes to your Institutional Review Board (IRB) approved research (Log #3249: *"Empathy of Nurses and Family Needs in the Intensive Care Unit"*) have been accepted as of April 20, 2008. Thank you for remembering to seek approval for any changes in your study.

If you make additional changes in the research design, funding source, consent process, or any part of the study that may affect participants in the study, you will have to reapply for approval. Should any of the participants in your study suffer a research-related injury or other harmful outcome, you are required to report them to the IRB as soon as possible.

The approval of your changes is attached to your original proposal; therefore, the original approval date has not changed. When you complete your data collection, or should you discontinue your study, you must notify the IRB. Please include your log number with any correspondence with the IRB.

This approval is considered final when the full IRB approves the monthly decisions and active log. The IRB reserves the right to review each study as part of its continuing review process. Continuing reviews are usually scheduled. However, under some conditions the IRB may choose not to announce a continuing review or a modification.

I wish you success in your research.

Cordially,

A handwritten signature in cursive script that reads "Patricia Hargrove".

Patricia M. Hargrove, Ph.D.  
IRB Coordinator  
CC: File