〔Research Report〕

Experiences on the Process of Supporting Patients' Families of Critical Care Nurses Who Feel Hesitant to Engage with Them

Tsuyako Nagata[1)]　Yasuko Irie[2)]　Kiyoko Tagawa[3)]

Introduction: Previous studies have identified the difficulty of forging relationships between patients' families and critical care nurses within a limited time. However, qualitative research on the process of supporting patients' families by nurses experiencing hesitation nurses to engage with patients' families remains unavailable and is a challenge for critical care nurses' practices in supporting families.

Aim: To identify the experiences of those critical care nurses who feel hesitant to engage with patients' families regarding the process of supporting these families.

Design: This was a qualitative descriptive study with semi-structured interviews.

Methods: The data were collected by face-to-face interviews with 11 critical care nurses in Japan and analysis was based on qualitative content analysis.

Results: The main theme was "noticing emotional changes or behavioral changes in patients' families even while feeling hesitant to engage with them." Three categories as follows: "building a mental barrier and feeling hesitant to engage with families," "engaging with families after noticing emotional or behavioral changes," and "experience that led to the favorable outcomes or unfavorable outcomes in terms of family support."

Relevance to clinical practice: First, observing the effect of direct care for patients by critical care nurses on the patients' families allows for noticing changes in the family. This allows nurses to determine a turning point in terms of changes in the family, which in turn, promotes engagement with the family. Second, the utilization of therapeutic family nursing therapeutic conversation skills by nurses and an improved institutional framework to support families should be developed.

Conclusions: As there is limited time available for critical care, the ability to discern the autonomy of family members by noticing their confusion and emotional or behavioral changes is an essential nursing competency for supporting families while feeling hesitant.

Key words: critical care nurses, experience, qualitative content analysis, family support, feeling hesitant to engage with patients' families

I. Introduction

In critical care, the impact of the sudden onset of symptoms or development of a life-threatening condition and the resulting confusion affects not only patients, but also their families (Davidson, Jones, Bienvenu, 2012). When patients are supported by their families, they feel more secure and comfortable (Mitchell, Aitken, 2017). Families thus play an important role in supporting patients in critical care even while experiencing stress themselves (Linnarsson, Bubini, Perseius, 2010).

Therefore, healthcare workers should communicate with family members, and the way in which families are included in care and decision-making may affect long-term outcomes (Needham, Davidson, Cohen et al., 2012).In the Guidelines for Family-Centered Care in the Neonatal, Pediatric, and Adult Intensive Care Unit (ICU), the ICU fami-

1) Faculty of Nursing, School of Medicine, Nara Medical University
2) Graduate School of Health Science, Kobe University
3) Nara Medical University Hospital

ly-centered care recommendations follow practices pertaining to: "family presence in the ICU," "family support," "communication with family members," "use of specific consultations and ICU team members," and "operational and environmental issues" (Davidson, Aslakson, Long et al., 2017).

In the critical care environment, the family's "open" presence at patients' bedsides (also called "open visiting") affects family satisfaction with hospitals. ICUs in hospitals with open visitations without restrictions on visiting hours have been reported to increase family satisfaction (Chapman, Collingridge, Mitchell et al., 2016). However, nurses working in critical care units (i.e., critical care nurses) do not necessarily hold a positive view of open visitation without restrictions, as the presence of families tends to prevent patients from resting making their care more difficult. Additionally, the nurses find it difficult to communicate with families who may subject them to emotional criticism (Garrouste-Orgeas, Philippart, Timsit et al., 2008). These realities mean that although critical care nurses recognize that supporting patients' families is essential, they may have difficulty in forming relationships with them. Consequently, family members may not receive adequate support for the stresses they face. Not only does this make it difficult for nurses and families to work collaboratively, but it may also affect the recovery of patients who require their families' emotional support (Olsen, Dysvik, Hansen, 2009). Therefore, family support is of the utmost importance for patients' recovery, and supporting families of critically ill patients is described as one of the responsibilities of healthcare teams.

It is the responsibility of healthcare teams to provide support for families of critically ill patients. However, qualitative studies of critical care family nursing in Japan have found that when families of patients in life-threatening conditions are anxious in the patients' presence, critical care nurses may also feel anxious in communicating with these family members. This is because such communication requires forging relationships with the family members within a short time, and many nurses hesitate to talk with them directly (Kinoshita, Hyakuta, 2012). Nurses may feel that they are being watched by family members, who are faced with a difficult reality, and perceive this as being psychologically painful (Inukai, Watanabe, Nomura, 2009). As a result, nurses are not only unable to build relationships with families in such a limited time, but are also unsure as to whether they should discuss with them their real feelings (Uesawa, Nakamura, 2013). Nurses also feel conflicted and guilty because of their own insecurity and inability to work well with other staff members (Yanagisawa, Kaneko, Kamiyama, 2012).

Such difficulties faced by nurses in supporting families of patients in critical care within the context of the nurses' unsteady relationship with the family members tends to result in a negative attitude of disinclination to engage with families, rather than in a positive attitude that seeks to proactively engage with them (Nagata, Irie, Tagawa, 2018). Hence, critical care nurses distance themselves psychologically from patients' families, meaning that in addition to the latter's needs being unmet, the patients themselves are less likely to receive support from their families. Ambivalence over supporting families means that nurses may experience internal conflicts, wanting to engage with families but also simultaneously hoping to avoid such experiences. As found in a study by Bell (2013), critical care nurses harbor thoughts such as, "I have no time to involve families" or "If

I talk to families and patients about things that matter to them, I might open a can of worms." There is some distinction between family centered care and family nursing, and family nursing is more than family centered care, which warrants that critical care nurses approach the families as an integral part of the family unit.

These can constrain the establishment of relationships between patients' families and critical care nurses who feel hesitant of ways to engage with families, which implies possibilities for critical care nurses to pause before engaging in family care. Previous studies have identified the difficulty of forging relationships between patients' families and critical care nurses within a limited time (Inukai et al., 2009; Uesawa, Nakamura, 2013). However, qualitative research on the process of supporting patients' families by nurses experiencing hesitation to so do remains unavailable. Therefore, we attempted to identify the experiences of those critical care nurses who felt hesitant to engage with patients' families regarding the process of supporting these families. This analysis was expected to lead to insights that would be useful for critical care nurses' practices in supporting families of critically ill patients.

II. Methods

1. Study design

This study was conducted as a qualitative descriptive study, which is the method of choice when clear descriptions of a phenomena are desired (Sandelowski, 2000).

2. Operational Definitions

1) Support for families in critical care nursing

According to a report on the Guidelines for Family-Centered Care in the Neonatal, Pediatric, and Adult ICU (Davidson et al., 2017), this refers to the support by critical care nurses intended to reduce family members' anxiety and stress, by enabling the families of patients in life-threatening conditions to deal with the various problems resulting from the critical illness. This support includes several components, such as providing information about the ICU setting, teaching ways to assist in the care of the critically ill patient, and offering valid decision support tools.

2) Hesitation

This refers to feelings of confusion or ambivalence among critical care nurses regarding engaging with patients' families. It is also characterized by vacillating between acknowledging the need for engaging with family members and being unwilling to do so.

3. Recruitment

Japanese critical care nurses were invited to participate if they had at least 3 years of nursing experience, at least 2 years of experience in their current position, and were able to practice critical care independently, but experienced hesitation about engaging with and supporting the patients' families. They were recruited through purposive sampling. The criterion of at least 3 years of nursing experience corresponds to the "competent" stage in Benner's (2005) model of clinical competence; at this point, nurses have the ability to deal with and manage unpredictable situations in clinical practice.

Recruitment was conducted by approaching three units in two hospitals that were known to the researchers. Eleven critical care nurses responded within the first 2 weeks of recruitment; however, four of them could not be re-contacted. Prior to being interviewed, each critical care nurse was emailed the date and place of the interview.

During the interview, the aims and methods of the study as well as the ethical considerations were explained orally and in writing, and written informed consent was obtained. Participants were recruited until saturation was reached.

Sampling was guided by the principle of saturation. This concept has been presented as an element of the constant comparative method in grounded theory. Saturation is important as when it is not achieved, it is often difficult to group the data and create concepts. The saturation of data helps indicate the optimal sample size in qualitative content analysis (Elo, Kääriäinen, Kanste et al., 2014).

4. Data collection

Data were collected through semi-structured interviews using an interview guide prepared in advance. The participants were requested to think of an instance in which they had experienced hesitation regarding supporting families. The interview guide was based on previous literature and pilot tested with one critical care nurse.

The interview started with the question "*Would you summarize a personal experience wherein you hesitated to provide support to patients' families?*" This was followed by the questions: "*What opportunity are your thoughts about engaging with patients' families?*," "*What did you think and do for families through the process of supporting patients' family?*," "*What kind of experiences did you have in the process of supporting patients?*" and "*How did you feel this experiences when supporting patients' family over?*," "*What is the reason?*"

Data were collected through face-to-face open-ended interviews. This approach was using the interviews covered the corresponding situation. Most of the interviews occurred in a private room at the university. With the participants' consent, a digital recorder was used for audio recordings. Field notes were made by the researchers detailing observations during the interview, such as the participants' expression and tone of voice. A personal information form was used to record summary information comprising the nurses' age, sex, and years of experience in their current position. Data were collected by two researchers: one to head the interview proper and the other tasked to observe. Data collection occurred from September 2016 to March 2018.

5. Data analysis

The data were analyzed using qualitative content analysis, which has been developed to provide in-depth knowledge and understanding of the phenomena under research. Qualitative content analysis is specifically suited for open and semi-structured interview data (Graneheim, Lundman, 2004; Hsieh, Shannon, 2005).

The analytical procedures that preliminary analysis should start, for example, after first interview (Elo et al., 2014) and were as follows: (1) The first interview was transcribed verbatim in Japanese. Interview transcripts were read closely, and sections relating to the theme (i.e., the experiences of the process of supporting patients' family by critical care nurses who feel hesitant to engage with them) were extracted with consideration of the context. (2) The meanings of these extracted sections were interpreted, an analysis was produced, and codes and categories were constructed. (3) After the analysis of the first interview transcript, the transcript of the next interview was analyzed. (4) The extracted codes were classified in terms of similarities and differences. (5) Interrelationships between categories and sub-categories were considered, categories and main theme formed by concepts were generated, and a diagram based on

the results was produced. (6) The data were further examined to identify variations, check for new categories, and determine that saturation has been reached. (7) The data and the results of the data analysis were checked by three study participants to improve the credibility of the analysis.

6. Rigor

Graneheim and Lundman (2004) developed three criteria for achieving trustworthiness of qualitative content analysis: (1) credibility, (2) dependability, and (3) transferability. The details regarding how each criteria was achieved in the present study are as follows:

Credibility: The credibility criterion was achieved through various data collection and ensuring saturation of data. In this research, interviewees' different genders, ages, and units or hospitals facilitated to variation of data. The main theme was identified around the time interviews with nine participants were completed. At this point, this research term was related to ICUs' environment issues (e.g., ICU team consultation). We wanted to identify the any differences in the categories in order to identify as much variation as possible. Therefore, we requested critical care nurses working in different ICUs to participate in the study. When no new categories were extracted, we judged that saturation had been reached.

Dependability: The dependability criterion was achieved through the research members' characteristics. Our research members consisted of a qualitative researcher, a critical care nursing researcher, and a critical care nurse.

Transferability: The transferability criterion of the analysis was achieved through discussions among research members and checking of data by the participants. Our research members reviewed the data analysis process and discussions were conducted to ensure agreement in the way data was labeled. Moreover, three of the participants checked the data to determine whether the results of the analysis reflected their actual experiences.

7. Ethical considerations

Since our study involved human participants, we obtained approval from the Institutional Review Board of Nara Medical University Ethics Committee (1358). The study objectives, methods, reasons for audio recording during interviews, right to withdraw, and protection of personal data were explained to the participants in both verbal and written form.

III. Results

1. Participant characteristics

The participants were 11 critical care nurses (4 men, 7 women). The length of their overall nursing experience ranged from 4.1 years to 22 years, and their critical care experience ranged from 3.6 to 13.6 years. The mean interview duration was 44.4±8.3 minutes (range, 31–58 minutes) (Table 1).

A main theme, 3 categories, and 8 subcategories were extracted in our comprehensive analysis of data.

2. Main theme

The main theme that emerged from the data analysis was "noticing emotional changes or behavioral changes in patients' families even while feeling hesitant to engage with them."

As mentioned by all participants, critical nurses created a mental barrier and subsequently became hesitant to engage with patients' families. However, after noticing emotional or behavioral changes, they finally engaged with the family

Table 1. Overview of study participants characteristics and case studies covered in interviews

	Sex	Age	Length of nursing experience	Length of critical care nursing experience	Interview duration (minutes)	Case study covered in interview
A	Male	30s	9 years 6 months	3 years 6 months	49	Family of a patient who did not want life-extending treatment
B	Male	30s	13 years 6 months	13 years 6 months	58	Family of a pediatric patient who asked about the positives and negatives of visiting
C	Female	40s	22 years	5 years 6 months	53	Family of a child whose life could not be saved
D	Female	40s	4 years 11 months	4 years 11 months	52	Family who were unhappy about restrictions on visting
E	Female	30s	8 years 6 months	8 years 6 months	33	Family who watched a patient from outside their room
F	Female	30s	11 years 8 months	3 years 11 months	31	Family who refused to allow the patient's transfer to another hospital
G	Female	30s	16 years	5 years 8 months	40	Family who visited alone
H	Female	30s	7 years 11 months	7 years 11 months	40	Family complaining that they were unable to eat or sleep
I	Male	20s	6 years 7 months	6 years 7 months	45	Family who suffered mental distress as a result of restrictions on visiting
J	Male	30s	13 years	5 years 6 months	44	Family members with different opinions on surrogate decision-making
K	Female	30s	13 years	7 years	43	Family members who were psychologically disturbed

members. They also realized that their skills were adequate when they experienced favorable outcome in terms of family support; alternatively, they recognized a sense of inadequacy when they experienced unfavorable outcome in terms of family support. The main theme included the three categories of "building a mental barrier and feeling hesitant to engage with families," "engaging with families after noticing emotional or behavioral changes," and "experience that led to the favorable outcomes or unfavorable outcomes in terms of family support" (Table 2).

1) "Building a mental barrier and feeling hesitant to engage with families"

(a) Mental barriers between nurses and patients' families

This subcategory referred to critical care nurses building mental barriers between themselves and patients' families because they believed that engaging with the family members might be difficult, despite being conscious of the necessity of supporting the family. The nurses experienced fear and anxiety about being blamed, based on their past experience of criticism from patients' families, and believed that engaging with family members would be hard, stemming from the idea that families would not accept anything they might say. The nurses felt that they were unable to ask about family members' feelings but had to discern them based solely on the family members' facial expressions and other non-verbal clues. The nurses supported surrogate decision-making for families, and evaluated surrogate decision-making statues as the gap between patient values and family values, which reinforced each other in creating mental barriers against patients' families.

K participant said, "The past experience of facing trouble with family becomes a post-traumatic experience for critical care nurses… When I would initiate communication with family members of critically ill patients, I would remember the past experience of facing trouble with fami-

Table 2.　Critical care nurses' hesitation about supporting patients' families

Example of codes	Subcategories	Category	Main theme
Fear and anxiety that they might be blamed	Mental barriers between nurses and patients' families	Building a mental barrier and feeling hesitant to engage with families	Noticing emotional changes or behavioral changes in patients' families even while feeling hesitant to engage with them
Awareness that engaging with family members would be hard			
Unable to ask about family members' feelings			
Doubts about making decisions on the patient's behalf.			
Hardship of having to deal with families' bewilderment	The hardship of having to deal with families' conflicts		
Difficulty of choosing the right time to say something			
Caught between families' wishes and institutional management	Feeling overwhelmed from engaging with patients' families because of challenges with the management system		
Fear and anxiety about possible discrepancies with doctors' explanations			
Feeling uncertainty at the stage at which relationships with families were still tenuous	Feeling hesitant to engage with patients' families		
Feelings of uncertainty after having understood the family's wishes			
Observed families without overlooking changes in their emotions	Engagement with families after noticing changes in them	Engaging with families after noticing emotional or behavioral changes	
Decisions on timing			
Choosing the best time to say something			
Measures to encourage closeness with the family during visiting hours			
Take care of families' safety at every moment			
Predicted what was going to happen to the family	Consideration of what would happen to the family relationships after the patient's discharge from ICU		
Encouraged families to keep control of emotions and remain calm			
Somewhat trusted by the family	Sense of adequacy about their own skills	Experience that led to the favorable outcomes or unfavorable outcomes in terms of family support	
Trust relationship in which the patient's family remembers family name of the nurse			
Residual feelings of gloom	Sense of inadequacy about their own skills		
Unable to talk sufficiently with other members of the medical team			

lies," and "the past experience of the trouble with families triggered the mental barriers between critical care nurse and patients' families."

(b) The hardship of having to deal with families' conflicts

This subcategory referred to the difficulties experienced by critical care nurses in having to deal with families confused by the patient's severe condition. Critical care nurses experienced the challenge of having to deal with families' bewilderment when the family members expressed the hope that the patient would recover consciousness despite having been told by doctors that there was no prospect of any improvement in the patient's level of consciousness. Nurses also felt at a loss in the face of the anger and tears of family members bewildered by the severity of the patient's condition and the suddenness of events, and experienced difficulty in choosing the right time to say something, which led to the hardship of having to deal with families' conflicts.

E participant noted, "I wanted to communicate with the family member (such as through active listening and expressing empathy), but I felt that they were still a little bewildered," and "I couldn't communicate with the family member. I faced hardship in engaging with patients' families."

(c) Feeling overwhelmed from engaging with patients' families because of challenges with the management system

This subcategory was based on critical care nurses' fear of engaging with family members because they were expected to fulfill family members' wishes when their wishes were impossible to achieve. It also included the nurses' fear or anxiety about possible discrepancies with doctors' explanations. Though the nurses wanted to fulfill families' requests, there might be differences not only between them and doctors, but also among nurses themselves concerning the implementation of the families' requests. Their fear and anxiety about possible discrepancies with doctors' explanations should they say something thoughtless led them to avoid engaging with patients' families in the face of challenges with the management system.

D participant noted, "Family members tell me that the visiting policy should be more open. I understood that an open visiting policy was important for the family member, but the hospital's policy did not support open visiting." The critical care nurse wished to implement the hospital policies. ICUs protect hospital policies. I was caught in a dilemma between the family members' needs about the patient and hospital policies, and experienced hesitation in engaging with patients' families."

(d) Feeling hesitant to engage with patients' families

This subcategory was formed when critical care nurses had to engage with family members when the relationships between the two were still tense, or as a result of the difficulty of implementing families' requests. The nurses were confused about the best timing to say something to families who were upset and regarding what to say when the family members were silent. This left them feeling uncertain when relationships with families were still tense, such as after having understood the family's wishes about aspects of the burden of long-term treatment on the patient and the resulting hardship to the family.

F participant noted, "At the start you do not know anything, and so you are often silent," indicating that the nurses felt at a loss about whether to say something to families when they had not

yet forged a strong relationship with them.

2) "Engaging with families after noticing emotional or behavioral changes"

(a) Engagement with families after noticing changes in them

This subcategory referred to critical care nurses observing emotional changes or behavioral changes in the families in the limited time available and choosing the right time to say something to them. During their daily care for patients, critical care nurses observed families without overlooking changes in their emotions or behaviors. For example, family members may have had a slightly different look on their face on a certain day, based on which the nurse decided the best time to say something. They were also careful to not perform treatment while the families were visiting, and took measures to encourage patients' closeness with the family during visiting hours, such as by actively speaking to patients to encourage them to engage with their families.

B participant noted, "Just because I was responsible for communicating with them, I thought 'They have a slightly different look on their face today'." Within a limited time, critical care nurse B, thus, understood changes in family members' facial and verbal expressions, and consequently made a decision regarding the best time to say something.

(b) Consideration of what would happen to the family relationships after the patient's discharge from ICU

This subcategory comprised critical care nurses' conjecture on what life would subsequently be like for families, judging and being sensitive to what was required at that particular moment. The nurses predicted what was going to happen to the family after the patient's discharge or death by observing changes in family relationships and roles, thinking about what could be done at the present time, and acting accordingly. For instance, one nurse hugged the mother of a patient who had reached the hospital after her child—who was brought to hospital by ambulance—had died. The nurses encouraged the mother to touch her deceased child.

C participant said, "After a doctor had explained the situation to the mother whose child had died, I had waited for the mother to touch the child, but the mother said 'It can't be true!' and made no attempt to approach the body. I had felt at a loss about responding to the mother, but gradually, thinking about what the atmosphere would be like when the next emergency patient was brought in, and about how the mother would have to start making preparations for the funeral immediately after she returned home, I thought, out of some sort of human warmth, some idea of touching her heart, on the spur of the moment I hugged the mother from behind and said, 'Go on, touch him,' because I wanted her to remember her child through the sense of touch."

3) "Experience that led to the favorable outcomes or unfavorable outcomes in terms of family support"

(a) Sense of adequacy about their own skills

This subcategory was based on critical care nurses' sense of adequacy about their own skill. These nurses shared that they had succeeded in building relationships with families on the basis of what the latter said. When family members conversed with the nurses, these nurses deemed that they had successfully built relationships with the family and that they were somewhat trusted, inferring that family members were thankful and that a relationship had been successfully built between them. These experiences resulted in favour-

able outcome.

A participant stated, "Maybe by getting them to talk about themselves, I was somewhat trusted and had built a relationship with them."

(b) Sense of inadequacy about their own skills

This subcategory was formed based on critical care nurses' inability to determine from family members' narratives whether they had been successful in forging relationships with them, leaving them feeling that their relationships with the family were incomplete. If the nurses lost touch with families without having ever been able to speak their mind to them or knowing whether they had been successful in creating relationships with them, they had residual feelings of sadness. They also felt that they were unable to talk sufficiently with other members of the medical team about whether they had been able to provide the treatment preferred by the family, and were aware of the need for opportunities to review their treatment and nursing with other members of the medical team regarding how to act in the future. These experiences resulted in unfavourable outcome.

J participant stated, "I experienced residual feelings of inadequacy about my own skills as a result of not having any evidence from family members that I had successfully forged relationships with them, and being unable to talk sufficiently with other members of the medical team."

IV. Discussion

1. Characteristics of family support provided by hesitant nurses

Support to families provided by nurses who harbor feelings of uncertainty ranged from feeling hesitant to engage with patients' families to engagement after having noticed changes in the family; these changes were related to observing family members without overlooking changes in their emotions or behavior.

However, regarding engagement after having noticed changes in the family, within a limited time, nurses understood changes in family members' facial and verbal expressions, and consequently made decisions on the best time to say something. Noticing changes in the family (i.e., having a slightly different look on their face that day) helped nurses to transition from being hesitant to engage with patients' families to actively supporting them. This suggests that critical care nurses recognize "a slightly different look on their face" as a turning point in terms of changes in the family.

Such changes in families are affected by the patient care provided by critical care nurses. Unspoken communication with the patient's direct care providers, such as through eye contact and facial expressions, is considered a resource by families, strengthening their spirits (American Association of Critical-Care Nurses, Carlson, 2008). Such changes in family members also involve changes in their autonomy. Autonomy refers to the capacity of family members to control their own lives by making choices for their own selves and directing their own course in life (Jacobs, 2019). This transition to autonomy is a process in which families become aware of their own power and then stand up for themselves, with the family being viewed by critical care nurses not as the recipient of support from medical professionals, but as partners working together with the medical team. For this reason alone, changes in the situation of families are important in terms of the timing of support for them.

Thus, turning points can be said to exist in the critical care process, and critical care nurses can be said to discern changes in families. These

changes serve as turning points and thereby provide optimal moments to offer support. This suggests alignment between the critical care nurse, the patient, and the family members in the ICU setting.

According to Goldfarb, Bibas, Bartlett et al. (2017), a lack of alignment between the critical care nurse, the patient, and the family members can lead to tension, dissatisfaction, and a potentially poor outcome. Family-centered care often enlists family members as decision makers for the patient and acknowledges their contribution to the patient's healthcare. Family support with relationship between the critical care nurse, the patient, and the family members has been introduced to help families meet their communication needs (Mol, Boeter, Verharen et al., 2016).

By noticing the confusion of the patients' families and the changes they were undergoing in the time-limited process of critical care, nurses engaged with them without overlooking changes and considered what would happen to the family relationships after the patient's discharge from ICU. Therefore, the nurses expanded the intervention to becomes more family nursing directed despite being hesitant to engage with the patients' families. Family nursing provides a wider lens to view the family dynamics which family and patients experiencing (Bell, 2016).

Feeling hesitant generally means failing to engage in an action despite intending to perform it. However, the critical care nurses in this study did not go so far as deciding not to perform the actions required for supporting the family. Thus, supporting the family given the limited time available in spite of feeling hesitant requires critical care nurses to dynamically understand family units as they are undergoing changes.

2. A sense of inadequacy about their own skills

Participants described the experience of having residual feelings of inadequacy about their own skills as a result of not having any evidence from families that they had successfully forged relationships with them, and an inability to sufficiently talk to other members of the medical team. This shows that critical care nurses want to know how their support for families contributes to family outcomes. If a nurse's relationships with families are ambiguous, evidence from the family that relationships have been forged is required when evaluating the outcome. However, if this cannot be established, nurses are left with feelings of inadequacy about their own skills. The relationship between the institutional framework for supporting families in critical care and the communication skills of critical care nurses underlies their residual sadness due to the ambiguity of their relationships with patients' families. These communication skills are different from usual communication and are helpful for the development of nurse-family relationships. Family nursing therapeutic conversations are helpful to them (Bell, 2016). Therapeutic family nursing conversations based on the Calgary Family Assessment Model and the Calgary Family Intervention Model (Wright, Leahey, 2012) are beneficial and appear to result in better outcome for the patients and their family (Svavarsdottir, Kamban, Konradsdottir et al., 2020; Gisladottir, Treasure, Svavarsdottir, 2017).

In terms of feeling overwhelmed to engage with patients' families due to challenges with the management system, the nurses are conflicted between wanting to fulfill the needs of family members who want to see the patients and their obligation to enforce the restrictions on visiting times. This internal conflict caused them to hesitate in supporting the family. Frost, Abram, and

Burgess (2014) reported that supporting roles (nurses) develop a partnership with families; hence, they find themselves in a difficult position because they take up a coordinator's role wherein they communicate the policies of the management system. Sometimes, even if nurses have already previously explained the visiting time restrictions, the situation can still lead to "blame culture" and increase the power imbalances in the relationship between the nurses and the patients' families. Therefore, the nurse's supporting role should be independent from the management system.

Hunter, Goddard, Rothwell et al. (2010) found that an institutional support system of conferences with doctors and family members was important for building relationships between critical care nurses and family members. Further, sharing of matters, such as family information and the nature of support between staff in conferences, provided a foundation for nurses to engage with patients' families, which was important for building relationships between these groups. Critical care nurses are in a prime position institutional frameworks for supporting families.

The Coping and Need Scale for Family Assessment in Critical and Emergency Care settings (Yamase, Yamase, Project members for development of CNS-FACE, 2003), which includes an assessment of family needs, is used in critical care nursing. However, as shown by the category of "mental barriers between themselves and patients' families," differences in how the nurses and patients' families think and feel may become evident when relationships are being developed between them, making it hard for nurses to engage with family members and causing them anxiety. Fukuda, Kuroda (2007) found that this mismatch may affect the assessment of the families' needs. Miyamoto (2003) also found that nurses experienced unpleasant emotions of discomfort due to incongruities with the families, but when they perceived any incongruity in an expression, they resolved it. In this study, we found that although the nurses' hesitant feelings about engaging with patients' families changed in accordance with the changes seen in the families, we did not observe any nurses targeting their own mental barriers and reflecting on the reasons behind these barriers. The utilization of therapeutic family nursing conversation skills by nurses in a way that enables their incongruity to elicit an understanding on the part of patients' families would also help in the development of relationships between critical care nurses and patients' families.

The study's results suggest that in providing support for patients' families by critical care nurses who feel hesitant of how to build relationships with them, the relationship between families and nurses may be ambiguous, leading to feelings of sadness in the nurses. Therefore, improving institutional frameworks regarding the support of families of patients in critical care as well as developing therapeutic family nursing conversation skills so that nurses can reflect on their incongruity with the thoughts and emotions of families of critical care patients may be crucial for dealing with the nurses' hesitancy regarding developing relationships with patients' families.

3. Limitations

With regard to engaging in the process of family support by critical care nurses hesitant to engage with patients' families, there are cultural differences in critical care nurses' practices and critical care environments. In Japan, there are only a few hospitals with open visiting systems (Hyakuta, Kimura, and Nakayama, 2014). There-

fore, other important issues or themes may be identified in other countries. Thus, the findings of the present study may not be applicable to other countries with different family cultures.

V. Relevance to clinical practice

Critical care nurses experience moral distress and this is disruptive to the engagement between nurses and families (McAndrew, Leske, 2015; McAndrew, Schiffman, Leske, 2019). Therefore, the practice of family engagement is important in ICU. In this research, the data analysis findings showed that nurses were capable of "noticing emotional changes or behavioral changes in patients' families even while feeling unsure of how to engage with them."

Our results provide important suggestions for nursing practice. First, observing the effect of direct care for patients by critical care nurses on the patients' families allows for noticing changes in the family. This allows nurses to determine a turning point in terms of changes in the family, which in turn, promotes engagement with the family. Second, the utilization of therapeutic family nursing conversation skills by nurses and an institutional framework for supporting families would also help in the development of relationships between critical care nurses and patients' families.

VI. Conclusion

As there is only a limited time available for critical care, the ability to discern the autonomy of family members by noticing their confusion and emotional or behavioral changes is an essential nursing competency for supporting families despite any feelings of hesitation. Our results suggest the need for developing therapeutic family nursing conversation skills of nurses and an institutional framework for supporting families to enable nurses to reflect upon any incongruities arising from the family members' attitudes.

(Received February, 10. 2020
Accepted April, 16. 2021)

Acknowledgments

We would like to acknowledge the critical nurses who shared their experiences about hesitation regarding supporting families. We would like to thank Editage (www.editage.com) for English language editing. This study was supported by a grant from the Nursing Career Support Center at Nara Medical University.

Author Contributions

TN and YI made contribution to research conception and design, acquisition of data, analysis and interpretation of data, and involved in drafting the manuscript. KT made contribution to analysis and interpretation of data. All authors read and approved the final manuscript.

References

American Association of Critical-Care Nurses, Carlson, K. K. (Ed.): AACN advanced critical care nursing (1st ed.), 145–156, Saunders, Washington, DC, 2008

Bell, J. M.: Family nursing is more than family centered care, Journal of Family Nursing, 19(4): 411–417, 2013

Bell, J. M.: The central importance of therapeutic conversations in family nursing: Can talking be healing?, Journal of Family Nursing, 22(4): 439–449, 2016

Benner, P./Ibe, T. et al. (Translator), From Novice to Expert: Excellence and Power in Clinical Nursing Practice (1st ed.): 11–32, Igaku Shoin, Tokyo, (Original work published 2001), 2005 [In Japanese]

Chapman, D. K., Collingridge, D. S., Mitchell, L. A. et al.: Satisfaction with elimination of all visitation restrictions in a mixed-profile intensive care unit, American Journal of Critical Care, 25(1): 46–50, 2016

Davidson, J. E., Jones, C., Bienvenu, O. J.: Family response to critical illness: Postintensive care syndrome-family, Critical Care Medicine, 40(2): 618–624, 2012

Davidson, J. E., Aslakson R. A., Long, A. C. et al.: Guidelines for family-centered care in the neonatal, pediatric, and adult ICU, Critical Care Medicine, 45(1): 103–128, 2017

Elo, S., Kääriäinen, M., Kannste, O. et al.: Qualitative content analysis: A focus on trustworthiness, SAGE Open, 4

(1): 1–10, 2014

Frost, N., Abram, F., Burgess, H.: Family group conferences: context, process and ways forward, Child and Family Social Work, 19(4): 480–490, 2014

Fukuda, K., Kuroda, Y.: Perceptions of nurses about the family needs of critically ill patients and the investigation of relating factors, Journal of Japan Academy of Critical Care Nursing, 3(2): 55–66, 2007 [In Japanese]

Garrouste-Orgeas, M., Philippart, F., Timsit, J. F. et al.: Perceptions of a 24-hour visiting policy in the intensive care unit, Critical Care Medicine, 36(1): 30–35, 2008

Gisladottir, M., Treasure, J., Svavarsdottir, E. K.: Effectiveness of therapeutic conversation intervention among caregivers of people with eating disorders, quasi-experimental design, Journal of Clinical Nursing, Mar; 26(5–6): 735–750, 2017

Goldfarb, M, J., Bibas, L., Bartlett,V. et al.: Outcomes of patient- and family-centered care interventions in the ICU: A systematic review and meta-analysis, Critical Care Medicine, 45(10): 1751–1761, 2017

Graneheim, U. H., Lundman, B.: Qualitative content analysis in nursing research:concepts, procedures and measures to achieve trustworthiness, Nurse Education Today, 24(2): 105–112, 2004

Hsieh, H. F., Shannon, S. E.: Three approaches to qualitative content analysis, Qualitative Health Research, 15(9): 1277–1288, 2005

Hunter, J. D., Goddard, C., Rothwell, M. et al.: A survey of intensive care unit visiting policies in the United Kingdom, Anaesthesia, 65(11): 1101–1105, 2010

Hyakuta, T., Kimura, Y., Nakayama, S.: A survey of intensive care unit visitations in Japan (first report): Considerations surrounding the expansion of visitation opportunities, Japanese Red Cross Hiroshima College of Nursing, 14: 19–27, 2014 [In Japanese]

Inukai, T., Watanabe, K., Nomura, K.: "Difficulties in building relationships that fail to pass patients with cranial neurological diseases" between nurses and families of patients: Analysis based on interview data with nurses in the acute stage, Journal of Japanese Society of Nursing Research, 32(5): 75–81, 2009 [In Japanese]

Jacobs, G.: Patient autonomy in home care: Nurses' relational practices of responsibility, Nursing Ethics, 26(6): 1638–1653, 2019

Kinoshita, S., Hyakuta, T.: Factors causing difficulty in the care of patients with acute neurological disease, Journal of Japanese Association of Neuroscience Nurses, 34(2): 145–152, 2012 [In Japanese]

Linnarsson, J. R., Bubini, J., Perseius, K. I.: A meta-synthesis of qualitative research into need and experiences of significant others to critically ill or injured patients, Journal of Clinical Nursing, 19(21–22): 3102–3111, 2010

McAndrew, N. S., Leske, J. S.: A balancing act: Experiences of nurses and physicians when making end-of-life decisions in intensive care units, Clinical Nursing Research, 24(4): 357–374, 2015

McAndrew, N. S., Schiffman, R., Leske, J.: Relationships among climate of care, nursing family care and family well-being in ICUs, Nursing Ethics, 26(7–8): 2494–2510, 2019

Mitchell, M. L., Aitken, L. M.: Flexible visiting positively impacted on patients, families and staff in an Australian intensive care unit: A before-after mixed method study, Australian Critical Care, 30(2): 91–97, 2017

Miyamoto, M.: Process records as an assistive technique: From self-congruence to empowerment, 12–24, Seishin Kango Shuppan, Tokyo, 2003 [In Japanese]

Mol, M. M. V., Boeter, T. G., Verharen, L. et al.: Patient- and family-centred care in the intensive care unit: A challenges in the daily practice of healthcare professionals, Journal of Clinical Nursing, 26: 3213–3223, 2016

Nagata, T., Irie, Y., Tagawa, K.: A meta-synthesis of qualitative research into the aspect of difficulties of critical nursing care of family members, Japan Journal of Family Nursing Research, 24(1): 3–13, 2018 [In Japanese]

Needham, D. M., Davidson, J., Cohen, H. et al.: Improving long-term outcomes after discharge from intensive care unit: Report from a stakeholders' conference, Critical Care Medicine, 40(2): 502–509, 2012

Olsen, K. D., Dysvik, E., Hansen, B. S.: The meaning of family members' presence during intensive care stay: A qualitative study, Intensive and Critical Care Nursing, 25(4): 190–198, 2009

Sandelowski, M.: Whatever happened to qualitative description?, Research in Nursing & Health, 23(4): 334–340, 2000

Svavarsdottir, E. K., Kamban, S. W., Konradsdottir, E. et al.: The impact of family strengths oriented therapeutic conversations on parents of children with a new chronic illness diagnosis, Journal of Family Nursing, Aug; 26(3): 269–281, 2020

Uesawa, H., Nakamura, M.: Difficulties of nurses who are involved in a family's surrogate decision-making for an emergency patient and their reasons, Journal of Japan Academy of Critical Care Nursing, 9(1): 6–18, 2013 [In Japanese]

Wright, L. M, Leahey, M.: Nurses and families: A guide to family assessment and intervention (6th ed.), 23–178, F. A. Davis, Philadelphia, 2012

Yamase, H., Yamase, Y., Project members for development of CNS-FACE: Family assessment tool for critical and emergency care settings: Developing a complete version of CNS-FACE, Journal of the Japanese Society of Intensive Care Medicine 10(1): 9–16, 2003 [In Japanese]

Yanagisawa, E., Kaneko, S., Kamiyama, S.: Conflict for nurses regarding terminal patients and their families: A literature review, Bulletin of Kansai University of Nursing and Health Sciences, 4(1): 23–29, 2012 [In Japanese]