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The purpose of this study was to describe nurses' experiences of interactions with family members in intensive care units. Ten experienced Registered Nurses were interviewed, and the interview text was qualitatively analysed by its content. Nursing of families was experienced as an essential, necessary and demanding task, and no systematic assessment and intervention with families were talked about. Two categories emerged from nurses' descriptions: inviting and noninviting interactions between nurses and family members. Inviting interactions were considered when family members were seen as important in the nursing care. The nurses used themselves as instruments to create contact and felt confident working with the family members. Thereby the nurses were forced to reflect on their way of caring and received positive responses from family members. In noninviting interactions, medical and technical tasks were considered to be most important and the nurses considered themselves as experts. They expressed having little time for family members and described being afraid of coming too close to them and having problems with creating relationships. Further research, including direct observations of interactions between nurses and family members, is needed.

Keywords: family members, families, intensive care, interaction, nurses' experience, interview, content analysis.

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Introduction

In intensive care units (ICU) the traditional nurse–patient relationship is often replaced by a nurse–family member relationship, due to the critical state of the adult patient (1). ICU nurses are responsible for supporting family members in various ways, including being aware of the family members' uniqueness and different ways of coping (2), as family members suffer when the survival of the patient is uncertain. Because of the state of the patient, a positive relationship between nurses and family members is important and benefits patients, family members and nurses (1, 3). However, it can be difficult for nurses to support and interact with family members in such critical situations (4–6).

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Literature review

Based on a recent literature review (7) and our present review one might assume that studies concerning the relationships between nurses and family members in ICU are sparse. Previous studies in the context of ICU have focused, for example, on nurses' perceptions of families' needs (8–10) and the care of children (11). Studies relating to transplantation care are not included in this review.

Chesla and Stannard (5) have described negative or difficult situations related to the care of families from the perspective of ICU nurses, based on interviews and observations. The study showed that neither assessment nor intervention with a systematic family perspective was carried out, and some nurses had very little knowledge about the whole family as a caring unit. The same study showed that nurses judged the family members according to their actual behaviour, without reflecting on the situation for the family as a whole. Nurses tried to control family members and if they failed, or had difficult relationships with family members, nurses characterized family members as pathological and lacking knowledge

about the situation. Nurses sometimes distanced the family physically from the patient and distanced themselves from the patient and the patient's family (5). Similar results were presented by Hupcey (6), whose study showed that nurses often acted with inhibiting behaviours such as depersonalizing family members, for example by labelling the family members as difficult and by acting busily in performing medical and technical tasks. Nurses explained these behaviours in terms of being overwhelmed, tired or busy with unstable patients. The nurses' strategies for developing nurse–family relationships were to show interest in family members as people, provide explanations and to encourage family participation in care. However, nurses fail to understand the anxiety experienced by family members (12). They often intimidate family members (1, 5) and strongly focus on technological care (4, 5). Such behaviour may lead to episodic and infrequent nursing care of patients (5) as well as affecting family members, whose anxiety and grief are increased by the lack of support from nurses (1, 12). In a study where nurses rated obstacles and help in end-of-life care, most obstacles were related to family members, for example, that they did not accept that the patient was dying, that they asked for technical treatment and that they showed anger (13).

Hupcey (1) developed a model describing how nurses and family members interacted to increase or decrease families' involvement with nurses in ICU. Some nurses prepared the family members and made them comfortable, developed relationships with family members and watched out for them, while others stayed in control by preventing family interference. Plowright (14) showed that nurses have many negative beliefs and attitudes towards families and their visits in the ICU, and Fox and Jeffrey (15) found that most nurses restricted family visiting especially during various treatments and nursing actions. Another study (16) found that nurses varied in their opinions on families' roles in providing physical care and emotional support to the patients. The same study found that the most important factors for involving family members in care were related to the patients' death and to the nurses' feelings about the family.

Although this review of the literature described various aspects of interactions between nurses and family members, few of them specifically focused on nurses' experiences of interactions with family members. In order to improve nursing care of families, there is a need to gain knowledge about how nurses experience interactions with family members.

Aim

The aim of this study was to describe nurses' experiences of interactions with family members in ICU.

Method

Context

The contexts of the study were two general ICUs in Sweden where patients were cared for with various surgical, medical, cardiac and neurosurgical diseases. The Registered Nurses (RN) were accountable for two or three patients at a time with support at the bedside from Enrolled Nurses (EN). Each ICU had approximately 10 patient beds, with four to six nurses (RNs and ENs) present during each shift. Visits were allowed around the clock. No defined nursing theory or underpinning nursing philosophy was expressed in either of the two units.

Participants

Ten RNs (hereafter called nurses) from two ICUs, trained and educated in intensive care nursing were asked by head nurses in two ICUs to participate in the study. All nurses received oral and written information and gave their consent to participate. The nurses were not known to have a special interest in families.

The mean age of the nurses was 41 years (range 31–51 years). They had worked as nurses between 10 and 28 years (mean = 19 years) and in ICU between 4 and 26 years (mean = 11 years).

Interviews

The interviews were conducted in a quiet room separate from the ICU, during the nurses' working time. The tape-recorded individual interviews started with an open question, where nurses were asked to tell about their interactions with family members in the ICU. The nurses were also asked to describe positive and negative interactions that had been of special significance to them. Supplementary questions about thoughts and feelings in the interactions with family members were posed.

The interviews lasted about 1 hour. After each interview the researcher made notes of both the explicit and implicit content in the interviews, which were transcribed verbatim.

Analysis

A content analysis was conducted, inspired by Burnard (17–19), in order to make sense of the textual interview data. This is accomplished by the researcher's interpretation of the text either on a surface or on a deeper level (19). The interpretation in this study goes beyond the surface level, i.e. reveals the unspoken, but is not on a deeper level, which, according to Burnard (18), requires, for example, a particular framework.

The analysis is described in a series of steps aiming at getting immersed in the data, and then searching for headings, known as open coding (17: 462). Then similar headings are grouped together into broader subcategories, trying to find as many explanations for the text as possible, while staying true to the text and to the meaning expressed by the participants. Further steps are to reduce the number of headings and subcategories into final categories, by increasing the level of abstraction and thus make sense of the text. Lastly, Burnard (17) proposes several actions to validate the findings, for example to check the appropriateness of the categories with some of the participants to ensure validity.

While reading the text several times to get a sense of the whole, plausible categories and notes about reflections were written down. Then open coding was performed, picking out as many headings as possible, which were written down and grouped into subcategories. The subcategories were reduced and brought into broader categories. The subcategories together with notes and the implicit message, i.e. feelings and tones in the communication were analysed, compared, reflected on and interpreted in a higher level of abstraction. Finally, two categories emerged in the analysis (Table 1). The first author made the analysis and the second and third authors also read some of the interviews and, after a few adjustments, all agreed on the emerging subcategories and categories.

A member check was performed with one of the participants who validated the appropriateness of the categories. The findings were also discussed with another nurse from one of the units who also recognized the experiences described. Related citations were extracted from the text to illustrate and validate the findings.

Ethical considerations

Confidentiality was promised and the nurses were told that they could terminate their participation whenever they wanted to. There was no dependency or personal relationship between the interviewer and the nurses. The chief physicians of the departments and the Chairman of the Research Ethics Committee at the Health University of Linköping approved the study.

Findings

All nurses described some common experiences. The nurses considered nursing care of family members as a necessary part of their work, but expressed the view that the creation of an open and trustful relationship with family members was one of the most essential and demanding parts of nursing care. When a patient's condition was critical, nurses were exclusively referred to interact with family members. Nurses further wished that there would be at least two family members present, so that they could support one another. Family members who were calm and well informed were acknowledged not only as an important link to a more normal life for patients, but also as a resource for the nurses themselves, as the family members contributed information about the patients and their families. The nurses did not actively assess families or involve them in planning, discussions or accomplishment of nursing care. Most nurses felt, however, that nursing of families, documentation and care planning with respect to the family could be improved and the ideal would be to have a more systematic, common way of working with families. More education, tools for assessing and intervening in families, professional supervision and support in

Table 1 Examples of the content analysis from text to categories

Text	Headings	Subcategories	Categories
Some sort of engagement (with family members) is needed when I get affected by a situation	Engagement is needed when nurses get affected	Nurses open themselves to family members	Inviting interactions
These questions are difficult for me too so I have to start working with them (questions that come up through the presence of family members)	Difficult questions must be dealt with	Nurses reflect about nursing care when family members are present	Inviting interactions
Often we are afraid to get close to family members, we are afraid of talking about sensitive issues.	Nurses are afraid to get close to family members	Nurses avoid interactions with family members	Noninviting interactions
I mean, perhaps I have to reveal who I am.	Nurses are afraid to talk about sensitive issues	Nurses avoid sensitive issues	Noninviting interactions
I mean this cool role, perhaps the professional shell breaks. I might reveal a slight weakness somewhere	Nurses are afraid of revealing who they are, of disclosing a small weakness somewhere	Nurses try to hide behind some mask, unwilling to show what is underneath	Noninviting interactions

relation to working with families were asked for. The nurses also desired more time and specific places to sit down with family members in order to talk in a confidential milieu.

In addition to common experiences, nurses described experiences of interactions that could be interpreted as inviting or noninviting. Both ways of interaction were found in descriptions from each nurse, depending on different situations or persons in the interaction. In spite of more text relating to the category inviting interaction, most nurses described experiences predominantly for one of the two categories.

Inviting interactions

The category 'Inviting Interactions' included descriptions by nurses who believed that family members are important and that having a good relationship with families is a prerequisite for providing good caring. The skill of interacting and creating contact with family members was something that the nurses had learnt over time and through professional and private experiences. These nurses said they used their intuition, skills and experiences to 'read' other people and create contact with patients and family members. Nurses stated how they 'offered' themselves several times to family members. This offering required courage and consisted of confirming patients and family members, by being present, listening, answering questions and offering comfort. The nurses stated that they simultaneously looked for some response from family members. This directed the subsequent behaviour of the nurses.

> It is important to be involved, and important to be touched. Then I feel a meeting too.

These nurses, who experienced confidence in their professional roles, showed an interest and a wish to know family members as persons and create relationships. They also described how they felt humble in the task of creating relationships as a basis for further interactions and that this task was the deepest meaning of caring. It took time to create trusting relationships, but when successful, it was ultimately timesaving.

> If you take those five minutes worth of time you'll get it back later. Shut out everything going on around you. It's just you and me. And it doesn't need to take very long. Just show that you care. Just listen to them.

According to the nurses, one prerequisite for being accepted by family members was that they perceived nurses as medically and technically competent, as well as being honest. If nurses felt that family members had confidence in the nurse, it strengthened the nurses' courage to pose delicate questions and initiate interactions with the family. A good relationship made it possible to support family members in emotionally charged situations by being close, comforting and using touch. Nurses stated that they

did not shelter themselves and were not afraid of showing their own feelings when the relationship was created. They even thought that it was important to show feelings instead of keeping a brave face. The more the nurses drew from their private experiences, the more difficult, and the more involving and engaging the nursing care became.

> To show that you are a human being. Daring to show that you have feelings. It also needs courage to cry when it is the only thing you want to do when everything is so terrible.

A trustful relationship influenced not only contact with family members, but also the nursing care for patients. When the described actions resulted in a good relationship, nurses were involved and more present in the patient's room, using every opportunity to create contact, even while nursing the patient. Families had free access to the patient, and having family members present around the patient forced nurses to reflect on their work, which, according to the nurses, could increase the quality of their nursing.

> Working with family members present makes you think, why did this happen? You have to think before you say anything, before you do anything and explain why you do things. That is positive.

The nurses described that it was their duty to inform everyone in the family who desired information. These nurses sat down to talk to individual family members, although there was no tradition of inviting the whole family to talk about emotional or spiritual needs. One exception might be when patients were dying or had died. In these situations the nurses seemed to open up the possibility for family members to be involved in working together with nurses to make the best out of a difficult situation. When the nurses worked together with family members, they considered the mutual effort to be helpful in lowering their own anxiety. One nurse said, after having dressed a dead mother together with a daughter:

> She [the daughter] explained so much, she was so open. I got the answers to so many questions and I did not feel so empty and strange inside as I usually do when someone dies so quickly.

Some family members were said to not show any feelings, and, according to the nurses, such situations were very difficult, requiring courage to go on trying to create contact. However, some nurses experienced difficult nursing relationships with family members as a personal challenge and went on trying to create a positive relationship with the family members.

> That person has barriers and defence mechanisms that you try to overcome. It is exciting. It is a challenge, not an impediment. If it does not work this time, you cannot manage in one conversation, one contact, you have to go on.

Some situations were especially demanding and the nurses initially experienced powerlessness, for example

when family members had unrealistic hope. This might happen when physicians and/or nurses, who did not know the family well, gave too much positive information about recovery of the patient. The nurses considered information to be a balancing act, where they were honest but still left the possibility for hope.

> I do not want to take hope away, but if you do not have contact you cannot talk openly, because they return to hope all the time. Hope becomes bigger than reality. Such situations are depressing, and they occur all the time.

When the nurses described experiencing problematic relationships in families, nursing care became more time consuming. The nurses were afraid of disturbing the integrity of the family and starting processes, which they could not handle. Another demanding situation was when families were disappointed with the health care system. These families were difficult to reach, and the nurses worked hard to regain both respect and a trusting relationship towards health care personnel.

> When you don't succeed – how do you deliver that message? If there is a problem, something has happened or something could have been dealt with in a better way – then you have to stand up as a representative of the health care system.

Nursing was perceived as positive and family members seemed to be satisfied if the nurses felt that they succeeded in creating a trusting relationship despite problems. The nurses who acted in a seemingly inviting way described how they received positive feedback from patients and their family members, and had feelings of satisfaction with the nursing care.

> If the condition is getting better, I share their joy. Then I get something in return. I seldom get anything as a nurse. I get something from them.

Noninviting interactions

The category 'Noninviting Interactions' included descriptions by nurses who seemed to have the belief that medical and technical tasks with patients were the most important nursing duties. These nurses described themselves as experts in nursing and wanted to have a professional relationship with family members, and seemed to perceive themselves as authorities. They also stated that they did not want any interference in their work from family members, and these nurses were disturbed if family members started to question their nursing activities. When this happened the nurses clearly stated who was responsible for patient care.

> Sometimes I need to point out, that I am the one that knows best. I need to tell them that this is my area.

Noninviting interactions seemed to be formal. The nurses informed family members thoroughly about the patient and his condition. When one or two family members were informed, these family members were expected to communicate with the rest of the family, because of limited nursing time. When family members were present while the nurses worked with the patient, nurses described a feeling of being observed and sometimes adopted a defensive position. Family members were often asked to leave the room while patients were cared for, especially in acute situations.

> I get stiff, I cannot be natural when I feel observed from all angles and corners. The work is not smooth and easy when you feel you have to weigh each word on a gold scale. Then it is not natural to talk either, it becomes forced, strange.

These nurses wished to keep a distinct border between their professional and private roles. The nurses did not want to show any feelings or give too much of themselves in the interactions. In emotionally demanding situations for family members, such as when patients' condition got worse, the nurses said that they felt ineffective and had difficulties in supporting or providing comfort to the family members. As a consequence, nurses tried to protect themselves through distancing themselves and avoiding personal involvement. Some nurses said that they felt they had become hard and had lost their compassion. These nurses withdrew, having nothing more to provide, leaving them with feelings of loneliness.

> You can withdraw and go in there [into the patient's room] as little as possible. Then you don't feel so much. But the closer you come to people, the more you get involved and feel for them.

Some of the nurses said that family members sometimes showed mistrust in their professional competence, or disliked the nurse as a person and therefore did not want to leave the patient. Then the nurses described fear of being attacked and took a defensive position. In these situations, the nurses did not become involved any more than necessary with the patients and/or the family members.

> It is just that situation when you don't get a good relationship with the family members, that aggressiveness – then it's easy to turn your back, and remove yourself from the situation, to not dare because you're scared of being assaulted, always to be in a defensive position. It's unbelievably tiring. Then you're totally drained when you go home.

Discussion

The purpose of this study was to describe nurses' experiences of interactions with family members in ICUs. The findings revealed two categories of how nurses described their experiences: inviting and noninviting. Inviting interactions were considered when family members were seen as important in nursing care and also the importance to create contact with them. In noninviting interactions medical and technical tasks were considered to be most

important and the nurses saw themselves as experts, having little time for family members and having problems with creating relationships.

All nurses said that family members are important, although some nurses described how they carried on in a noninviting manner. There seems to be an underlying difference in nurses' beliefs about family members and caring for family members, as well as ways of interpreting nursing roles. Beliefs can be both facilitating and constraining, and it is argued that individuals are only slightly aware or unaware of their own beliefs (20). In the present study it appeared as though nurses, whose descriptions of their thoughts, feelings and actions were interpreted as inviting interactions, acknowledged family members as a resource and had facilitating beliefs about families. Nurses, who believed that family members are important and having a good relationship with family members is a prerequisite for good caring, also acted as if this belief was internalized and considered as a natural part of nursing. These nurses also tried to see possibilities in nursing of family members and did not complain about lack of time. Further, the nurses seemed to use themselves as instruments to encourage interactions in every contact with family members. These nurses appeared to have a less hierarchical point of view than the nurses whose descriptions were categorized as noninviting interactions. These descriptions are consistent with Hupcey (6) who described how nurses develop relationships by treating the patient and family as persons, by spending time with the family members, and by sharing personal information.

The nurses whose descriptions were categorized as noninviting interactions seemed to have constraining beliefs, which hindered the nurse–family relationship and also the solutions to the problems in the interactions (*c.f.* 20). Nurses with these beliefs seemed to have a more hierarchical point of view than nurses with more facilitating beliefs about families. The nurses, whose descriptions were categorized as noninviting interactions, verbalized experiencing a threat to their professional roles from family members and therefore sometimes avoided contact, hiding behind lack of time. Other studies (4–6) described nurses as having inhibiting relationships by depersonalizing patients and family members and maintaining an efficient attitude by acting busily. Hupcey (1) showed that it could be an unconscious or even a conscious wish to use power or inhibit families and assert their professionalism. Nurses use various tactics to maintain control, for example 'putting the family in their ''place'' when the family members tried to interfere with their work' (1: 257).

The experiences described by nurses and interpreted as inviting interactions were more open to the suffering of family members if the suffering reminded these nurses of their private experiences, even hurtful ones. Wright et al. describe how nurses in tragic situations dared to share the suffering by 'giving up one's own tranquillity and becoming vulnerable' (21: 213). To face and respect one's own vulnerability can make it easier for nurses to respect patients' and family members' vulnerability. Oberle and Hughes (22) showed that nurses found the suffering of patients as the core ethical problem together with the decision of what interventions were the best for the patient and the family members.

The openness that evolved facilitated nursing care and helped the nurses in the present study to go on in the same way. Together with family members the nurses said that they worked through some of the most demanding situations, which helped both parties. Having family members present while working with the patient gave more time for contact and forced the nurses to reflect on nursing activities, which nurses verbalized as a way of improving nursing care of patients and family members.

Nurses in the present study verbalized that receiving positive feedback from patients and family members gave them confidence and satisfaction in their work, thus encouraging nurses to invite other family members as well. The thoughts, feelings and actions described by nurses in this study and interpreted as inviting interactions can be seen as positive circular relationships, in a sense that 'relationships may be viewed as feedback loops, since the behaviour of each person affects and is affected by the behaviour of each other person' (23: 31).

The medical and technical skills described by the nurses in the noninviting interaction category were not influential enough to create positive relationships with family members. The nurses described that they were aware of families' current behaviour, but not all nurses verbalized showing reflective and empathic response to families' emotional needs. Although nurses have good skills in assessing the total body system, many have poor skills in communicating with family systems (5, 6). Nurses said that they tried to connect with family members, but realized that this was difficult to achieve. They experienced difficulties in comforting and supporting family members, even if they could see the families' overt suffering. The inability to provide family care resulted in a sense of loneliness. Other researchers (21) describe how staff try to hide or repress their own emotions in order to be able to act in the right way. The tragic situations in ICUs evoked feelings of compassion and an intention to act, but some nurses were unable to turn these intentions into action. They experienced a disloyalty towards the families and themselves, which evoked feelings of despair (21). Nurses who are cut off from the emotion-filled sources of their work do not move on to become clinical experts (3).

In the category of noninviting interactions, nurses' descriptions revealed how fewer nursing activities were offered to patients and family members as a result of

feelings of insecurity in the interaction with family members. The nurses seemed to use power and at the same time verbalized experiencing insufficiency and loneliness. The experiences from nurses in this category concerned withdrawal, feelings of failure, looking for shortcomings in their own personality, and storing the experiences inside. In the described interactions with family members, the nurses stated that they did not have the courage to be open, to create relationships, but were formal and concentrated on the medical and technical tasks. These interactions can be seen as negative circular relationships (23).

The results of this study show that for some nurses it was natural to involve individual family members into the caring process. However, none of the nurses said it was a natural part of their work to include the whole family in nursing care, for example, inviting several family members to narrate their experiences during the care of a critically ill family member. It was obvious that all of the nurses felt insecure in communicating with the whole family at one time and talking about emotionally difficult problems. Nurses need to encourage not only individual family members but also the whole family to express feelings and thoughts, as families are influenced by the illness and vice versa (24, 25).

Strengths and limitations

The trustworthiness of the results are enhanced by the detailed descriptions of the nurses' experiences, by performing a member check, by having several researchers in the analysis process and by presenting the transparent analysis step-by-step, continuously returning to the text. It is important to emphasize that there is never only one right interpretation of the text but many interpretations with various levels of abstraction (17). During the interviews, the nurses showed verbal and nonverbal expressions of emotions, for example tears in their eyes, indicating that they took the interview seriously, which also enhances the trustworthiness of the study.

One limitation of this study is the small sample size. It is possible that interviews with an increased number of nurses or repeated interviews with the 10 interviewed nurses would have enriched the data. Another limitation of the study is its transferability, as the nurses were recruited from general ICUs in two small hospitals. The findings in this study may therefore be transferable only to nurses at general ICUs, although nurses at special or university ICUs may have the same experiences of interacting with families.

Conclusions

It would have been interesting to observe what really happened in the interactions described in this study. Only one study (5) has been found where observations of the interactions in the patient room in ICU have been con-

ducted. However, more research is needed about how caring interactions influence nurses, the individual family members as well as the whole family.

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