THE EFFECT OF A COPING PROMOTION PROGRAM ON WELL-BEING OF RELATIVES OF PATIENTS IN THE INTENSIVE CARE UNIT

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF NURSING SCIENCE
(ADULT NURSING)
FACULTY OF GRADUATE STUDIES
MAHIDOL UNIVERSITY
2006

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entitled

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was submitted to the Faculty of Graduate Studies, Mahidol University
for the Degree of Master of Nursing Science (Adult Nursing)
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ACKNOWLEDGEMENT

I would like to take this opportunity to acknowledge my sincere thanks to these people. Without them, I would not have been able to complete my degree.

First, I would like to express my gratitude to Dr. Porntip Malathum, my major advisor and Associate Professor Orasa Panpakdee, my co-advisor for their encouragement, constructive guidance, and warm welcome throughout this study. Dr. Porntip Malatum is a wonderful supporter who always contributes herself and spends her valuable time with numerous comments on my thesis. Importantly, she has helped and guided me to complete my study, despite various struggles and frustrations.

My appreciation was also expressed to Associate Professor Johnphajong Phengjard and Associate Professor Titiwone Thumapiroj for their invaluable comments and wonderful guidance on my thesis.

I would like to express my deep gratitude to the experts who validated the research instrument. I would like to offer my sincere thanks to all participants and staff at the Medical Intensive Care Unit, Ramathibodi Hospital for their generous contributions through my research study. I owe a great deal to the nursing director and my colleagues, Department of Nursing, Faculty of Medicine, Ramathibodi Hospital, Mahidol University to give me an opportunity to complete the research study.

I am also thankful to all my best friends at the Ramathibodi Hospital, School of Nursing and my roommate for their encouragement, support, help, and love which have inspired me to reach the goal, especially Soontaree Sriaramanee who always motivates and helps me in anyway she can despite her backbreaking work. Finally, I am deeply indebted to my parents and all family members for their love, understanding, encouragement and support. Importantly, I would like to express my heartfelt thanks to Mr. Suthiporn La-orchan, my husband, for his understanding and support in order to help me succeed my academic goal. Panita La-orchan, my daughter, is my best inspiration to help me accomplish my academic goal.

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ABSTRACT

This study employed the one-group pretest posttest research design to investigate the effects of a Coping Promotion Program on well-being and to evaluate satisfaction with nursing care of relatives of patients admitted to a medical intensive care unit (ICU). Lazarus and Folkman's Stress, Appraisal, and Coping theory was used to guide the study. Purposive sampling was used to recruit the subjects who met the inclusion criteria, with one subject recruited from one family. The subjects were 30 relatives of patients who were admitted to the medical intensive care unit (ICU), Ramathibodi Hospital from June to December 2005. The subjects received usual nursing care plus nursing interventions according to the Coping Promotion Program provided by the researcher. The subjects were asked to rate their well-being using the General Well-Being Schedule and to answer the Relative Satisfaction Scale. Data were analyzed using descriptive statistics and paired t-test.

The analysis revealed that most subjects were female and were either son/daughter or spouses of the patients. The subjects' mean score of overall general well-being and of its subscales after receiving the Coping Promotion Program were higher than those before receiving the program, but not significantly different ($p > .05$), except for the mean score of the positive well-being subscale, which was significantly higher than that before receiving the coping promotion program ($p < .05$). Additionally, the subjects reported their satisfaction with nursing care as rather high.

Findings in this study provide information that can be used to improve nursing care for relatives of the patients admitted to the intensive care unit, promote their coping ability, maintain their well-being, and promote their satisfaction with nursing care.

KEY WORDS: COPING PROMOTION PROGRAM / LAZARUS AND FOLKMAN'S STRESS, APPRAISAL, AND COPING THEORY / MEDICAL INTENSIVE CARE UNIT / WELL-BEING / SATISFACTION WITH NURSING CARE

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ผลของโปรแกรมการส่งเสริมการเผชิญความเครียดต่อความผาสุกของญาติผู้ป่วยในหอผู้ป่วยวิกฤต
(THE EFFECT OF A COPING PROMOTION PROGRAM ON WELL-BEING OF RELATIVES OF PATIENTS IN THE INTENSIVE CARE UNIT)

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บทคัดย่อ

การศึกษาครั้งนี้เป็นการวิจัยกึ่งทดลองแบบ One-group pretest posttest เพื่อศึกษาผลของโปรแกรมการส่งเสริมการเผชิญความเครียดของญาติผู้ป่วยในหอผู้ป่วยวิกฤตต่อความผาสุก และประเมินความพึงพอใจต่อการพยาบาลที่ได้รับของญาติผู้ป่วยที่รับการรักษาในหอผู้ป่วยวิกฤต โดยใช้ทฤษฎีการเผชิญความเครียดของลาซารัสและโฟล์คแมนเป็นกรอบแนวคิดในการศึกษา กลุ่มตัวอย่างเป็นญาติของผู้ป่วยหนักที่รับการรักษาอยู่ในหอผู้ป่วยวิกฤตอายุรศาสตร์ แผนกอายุรกรรมโรงพยาบาลรามาธิบดี ระหว่างเดือนมิถุนายน ถึง ธันวาคม พ.ศ. 2548 เลือกกลุ่มตัวอย่างแบบเจาะจงตามคุณสมบัติที่กำหนด โดยกลุ่มตัวอย่างได้รับการพยาบาลตามปกติร่วมกับการพยาบาลตามโปรแกรมการส่งเสริมการเผชิญความเครียดของญาติผู้ป่วยในหอผู้ป่วยวิกฤตที่ผู้วิจัยพัฒนาขึ้น เครื่องมือในการเก็บรวบรวมข้อมูลคือ แบบวัดความผาสุกโดยทั่วไปและแบบวัดความพึงพอใจของญาติต่อการพยาบาลที่ได้รับ วิเคราะห์ข้อมูลโดยใช้โปรแกรมสำเร็จรูปทางสถิติ

ผลการศึกษาพบว่า กลุ่มตัวอย่างซึ่งเป็นญาติของผู้ป่วยส่วนมากเป็นเพศหญิง มีความสัมพันธ์เป็นบุตรและคู่สมรสของผู้ป่วย มีคะแนนเฉลี่ยความผาสุกทั้งโดยรวมและรายด้านในด้านความวิตกกังวล ความซึมเศร้า ภาวะสุขภาพทั่วไป การควบคุมตนเอง และความมีชีวิตชีวา หลังได้รับโปรแกรมฯ สูงกว่าคะแนนเฉลี่ยก่อนได้รับโปรแกรมฯ แต่ไม่แตกต่างกันอย่างมีนัยสำคัญทางสถิติที่ระดับ .05 ยกเว้น คะแนนเฉลี่ยด้านความผาสุกด้านบวกหลังได้รับโปรแกรมฯ ซึ่งสูงกว่าคะแนนเฉลี่ยก่อนได้รับโปรแกรมฯ อย่างมีนัยสำคัญทางสถิติที่ระดับ .05 ส่วนคะแนนความพึงพอใจของญาติผู้ป่วยต่อ การพยาบาลที่ได้รับหลังได้รับโปรแกรมฯ แสดงถึงความพึงพอใจค่อนข้างสูงต่อการพยาบาลที่ได้รับของญาติผู้ป่วย

ผลการศึกษาครั้งนี้สามารถนำไปใช้เป็นข้อมูลเพื่อการพัฒนาการพยาบาลแก่ญาติผู้ป่วยในหอผู้ป่วยวิกฤต เพื่อช่วยให้สามารถเผชิญสถานการณ์ความเครียดและภาวะวิกฤตในครอบครัว ช่วยให้ญาติดำรงความผาสุกในชีวิตได้ และเพื่อเพิ่มความพึงพอใจต่อบริการทางการพยาบาล

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CHAPTER I
INTRODUCTION

Background and Rationale

Being hospitalized and treated in the Intensive Care Unit (ICU) is regarded as a critical condition for individuals. This is because such condition tends to occur suddenly and unexpectedly, and it threatens the life of individuals who do not have a chance to prepare themselves for it. Not only does a critical illness have a great impact on the patients' life, but it also affects their family. While the patients are suffering from their critical condition, the remaining family members are also learning to cope with different changes that have taken place from the hospitalization (Hickey, 1996: 65; Hodovanic et al., 1984: 243; Jamerson et al., 1996: 467; Mendonca & Warren, 1998: 58).

Family is a basic social institute, which consists of at least two members who live together and share attachment and feelings (Bursch, 1982: 29). One important characteristic of a family is that the family members have a close relationship with one another, and they share love, attachment, and attention. They also have a responsibility and duty for one another based on their role in the family such as the husband, wife, mother, father, child, or sibling (Friedman, 1998: 5-6). Thus, when a family member has to be hospitalized, the balance of the family will be affected. Apart from having to visit and take care of the hospitalized member, other family members may have to take over the role and responsibilities of the hospitalized member (Cleveland, 1980: 558-565; Jonhson et al., 1995: 238-243; Titler et al., 1991: 174-182). In addition, they may have to deal with problems and be responsible for medical expenses, family expenses, and transportation fares for the patient's visits at the hospital (Hodovanic et al., 1984: 243). Also, they are concerned with the sickness and the danger the patient is facing. These changes can be a cause of stress among the relatives of the patient. It can also result in the crisis in the family, with the degree of the crisis varying depending on

each family's and family member's perception of the situation, assessment of the situation, and stress coping ability in each context (Epperson, 1977: 265-273).

In addition to changes in the family structure, the relatives of the patient have to cope with the sickness that threatens the life of their loved one, including the uncertainty of the pathology of the illness, especially when the illness is so severe that the treatment in the ICU is required. Both the patient and the relatives may perceive the danger or the threat of the sickness, and are likely to fear that disability or mortality may eventually result. This can be a cause of a great worry and concern among them. Moreover, the severity of the illness may affect the relatives psychologically. They may be worried about the patient's safety and well being. Moreover, an unfamiliar environment in the ICU, with the use of equipment and tools to monitor the patient's vital signs and to safe or sustain life, as well as the rush and hectic environment with emphases on the life of the patient (Mendonca & Warren, 1998: 58) may make the relatives feel that they are neglected by healthcare staff. Finally, restrictions in visitation and inconvenience when seeking information about the patient's conditions and treatments may contribute further to the family members' stress. Wanichapichat (2000) conducted a study and reported that the top five stressors of family members of the ICU patients were as follows: 1) perceived severity of the illness, 2) financial problems, 3) disruption of normal routines, 4) decreased stability of the family, and 5) lack of information about the patient's diagnosis and plan of treatment, respectively.

A critical illness of the patient is a cause of great stress among family members who are the patient's relatives (Leske & Hendrich, 1996: 91-102). Such severe stress can result in a critical condition in the family. This is because other family members have increased family responsibilities (Johnson et al., 1995: 238-243; Titler et al., 1991: 174-182) and they are concerned with the safety of the patient. As a result, they may become physically and psychologically exhausted, and their well-being in life may be adversely affected. Wanichapichat (2000) also pointed out that relatives of critical patients in the ICU felt that they lost their appetite and had decreased sleeping time. A variety of emotions that they are experiencing, together with the fear of the unexpected or uncontrollable situation, make relatives of critical patients in the ICU need more assistance and support from others to ensure that the patients will receive

the best of care and be safe. Nurses are the healthcare professionals who provide close care to both the patients and their relatives, so they are able to provide nursing cares to satisfy the family members' needs (Aree Boonbarwonrattanakul, B. E. 2538, B.E. 2538; Chuthamas Panchawisut, et al., B. E. 2535; Leske, 1998: 182; Niphawan Samartkit & Junporn Yodying, B. E. 2541; Woolley, 1990: 1405). It has also been reported that unsatisfied needs can be a cause of stress of relatives (Meisel, 1991: 20).

At present, based on the notion of holistic nursing care and the existing body of knowledge on needs of relatives of critical patients, the nursing care plan is designed to also respond to the needs of relatives of the patients in the form of family-centered care or family-focused care. Previous studies have shown that relatives acknowledge that their needs have been responded to and they have more satisfaction with the nursing care they have received (Cleveland, 1980: 558-565; Craft, Cohen, Titler, & DeHamer, 1993; Horn & Tesh, 2000: 40-49; Johnson et al., 1995: 238-243; Titler et al., 1991: 174-182, 41). Previous studies have attempted to develop different nursing programs to provide assistance and care to family members of critical patients (Aimin, 1999; Dracup & Breu, 1978 as cited in Meisel, 1991: 21; Hodovanic, et al., 1984: 243-249; Huckabay & Tilem-Kessler, 1999: 36-42; Lopez-Fagin, 1995: 21-25; O'Keeffe & Gillis, 1988: 191-198; Pikul Tantitham, B.E. 2533; Ward et al., 1990 cited in Clark, 1996: 54). However, few studies have been conducted regarding promotion of stress coping during a critical condition. Based on the problems of stress experienced by relatives of critical patients in the ICU and the needs that take place as a result, the researcher was interested in developing a nursing intervention to promote coping among relatives of critical patients admitted to the ICU and in assessing their satisfaction with nursing care. The intervention was developed based on the notion that nursing care is one of the resources that enables the relatives to cope with stress during a critical situation, which in turn, facilitates them to adjust themselves and handles their stress more effectively while maintaining normal routines and balance of the family. It was anticipated that findings of this study could assure whether a coping promotion program is workable and it can be useful in further developing a nursing care plan to more effectively help relatives of critical patients admitted to the ICU cope with stress and gain more satisfaction with the nursing care received.

Conceptual Framework

The conceptual framework of the present study was based on the Stress, Appraisal, and Coping Theory proposed by Lazarus and Folkman (1984). According to them, stress is seen as a transaction, stating “stress is a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (Lazarus & Folkman, 1984: 19). In order to judge whether a situation or a relationship between an individual and his or her environment is a stressor or not depends on individuals’ cognitive appraisal (Lazarus & Folkman, 1984: 21), which can further be divided into primary appraisal, secondary appraisal, and reappraisal (Lazarus & Folkman, 1984: 31-38).

Generally, when patients are treated in the ICU, their relatives use the cognitive appraisal to judge the situation with an emphasis on the sickness and the safety of their loved ones. They begin with primary appraisal to determine how severe or threatening the situation is toward their security and well-being. Primary appraisal can be categorized as three forms: 1) irrelevant, 2) benign-positive, and 3) stressful. Stressful appraisal can further be determined as 1) harm or loss, which the individuals will have to suffer; 2) threat, when individuals assess the damages that will take place in the future as a result of the situation; and 3) challenge, which refers to the benefits or controls of the situation that may result despite its damages (Lazarus & Folkman, 1984: 32-35). Besides, the relatives of the patients may assess the severity of the stressful situation based on two stimulating factors of personal factors and situational factors (Lazarus & Folkman, 1984: 55-116). Important personal factors include commitment and belief. If relatives appraise the situation as a commitment, they may interpret the situation as a threat or a loss for them. For instance, when a spouse is treated in the ICU, the partner will be deeply concerned that he or she may have to lose his or her loved one. In addition, when the head of the family is critically ill, the rest of the family will have to deal with changes in the roles and responsibilities of the family. These two incidents may be assessed as a threat or a loss by relatives. Moreover, family members may see the situation as a challenge if they believe that the situation is still somehow controllable—either by themselves or by outside power such as the healthcare team or supernatural beings (Lazarus & Folkman: 1984: 55-81).

In addition, hospitalization in the ICU tends to be sudden and unexpected. Both patients and their relatives do not prepare themselves for such situation. They may have to deal with a severe illness that threatens health and life of the patients, the conditions of the patients that may change all the time, and sometimes the doctors' inability to give a definite diagnosis during the initial phase of the hospitalization. These bring about the feeling of uncertainty among relatives. Other ambiguous events may also be present, and sometimes the relatives are required to make a major decision without sufficient information and within a very limited timeframe such as to opt for the operation or to discontinue the treatment. These are all factors that influence the relatives' appraisal of a stressful situation (Lazarus & Folkman, 1984: 82-116).

When the relatives of hospitalized patients assess the situation as a stress, they will then conduct a secondary appraisal to determine coping resources and options available to deal with the situation they are facing (Lazarus & Folkman, 1984: 35-37). At the same time, the appraisal of the relatives may be changed when they receive more information from the surrounding or from their past experiences. This process is called reappraisal, which is an assessment of the same situation the relatives are facing, but with a new appraising technique and coping strategy. For example, they may change their feelings about the situation and adopt a new appraisal technique. For this reason, the appraisal process and the reappraisal process are in fact similar (Lazarus & Folkman, 1984: 38).

When dealing with stress, individuals seek for ways and resources that would enable them to cope with the situation. According to Lazarus and Folkman (1984: 141), coping refers to individuals' "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person." Lazarus and Folkman further categorize coping into problem-focused form of coping and emotion-focused form of coping. In general, individuals tend to use both forms of coping while they are searching for the best way to cope with stress (Lazarus & Folkman, 1984: 150-153).

In addition, for individuals to cope with stress successfully, they need to make use of coping resources that are available in their context. Coping resources can be classified as two types. Firstly, individual resources, which primarily are properties of

the individuals including 1) physical resources: health and energy; 2) psychological resources: positive beliefs, and 3) competencies: problem-solving skills and social skills. Secondly, environmental resources including 1) social resources; and 2) material resources (Lazarus & Folkman, 1984: 59, 157-164). When they are in a stressful situation, if individuals feel that they are still able to control the outcomes and they are physically healthy, they will still be able to seek information, analyze the situations, evaluate different alternatives, and make use of the best option to appropriately deal with the situation (Janis & Mann, 1977, as cited in Lazarus & Folkman, 1984: 162). This involves effective communication and appropriate behaviors shared with other members in the society, which, together with social support and assistance, will enable individuals to cope with stress.

Previous studies conducted with family members of critical patients admitted to the ICU have pointed out that the family members have different needs and seek social support from others and that unmet needs are one of the factors that increase the family members' stress and hinder their efforts to cope with stress (Bozett & Gibbons, 1983: 22; Taylor et al., 1993: 137). At the same time, there have been reports that social support is a significant resource that enables family members to better cope with stress. Nurses are healthcare professionals who play a major role in providing assistance and serving the needs of family members of the critical patients in the ICU (Bowman, 1984, as cited in Meisel, 1991: 20; Daley, 1984: 231-237; Hampe, 1975: 113-120; Molter, 1979, as cited in Meisel, 1991: 21, Suparat Vaicheeta, B.E. 2542). Receiving the nursing care that specifically serves the needs arisen when the patients are admitted to the ICU will provide the family members with resources that enable them to adjust themselves and cope with stress.

When individuals cope with stress, adaptational outcomes occur. According to Lazarus and Folkman (1984), individuals' appraisal of the situation and coping results in three aspects of adaptational outcomes regarding social functioning, morale, and somatic health. Social functioning is the ability of individuals' to fulfill different roles and maintain the interpersonal relationship with others that they have, while morale refers to individuals' feelings toward themselves and the situations in their life, which tend to be long-term. The short-term effects are likely to be the emotions specific to certain situations that the individuals are facing at the moment. Finally, somatic health

is the changes in individuals' physical conditions while coping with stress, which can result in a sickness (Lazarus & Folkman, 1984: 181-225). Lazarus and Folkman emphasize the significance of assessment of adaptational outcomes, which cover individuals' physiological, social, and psychological well-being. In addition, they underline that assessment of adaptational outcomes, which is the result of stress coping, does not entail a single outcome, but multiple outcomes (Lazarus & Folkman, 1984: 2232-223).

Dupuy (1977, as cited in McDowell & Newell, 1996: 215) points out that when individuals face problems, their adaptation can be assessed by their own inner feelings and expressed behaviors including anxiety, depression, general health, positive well-being, self-control, and vitality, which are called general well-being. Dupuy (1977, as cited in McDowell, & Newell, 1996: 206-213) used the General Well-Being Schedule (GWB) to assess the inner feelings of individuals in six aspects as follows: anxiety, depression, general health, positive well-being, self-control, and vitality rather than external situations such as income or environment. In the present study, the well-being of relatives of critical patients admitted to the ICU is conceptualized as adaptational outcomes, by which well-being reflects an integration of somatic health, social functioning, and morale. This notion is based on the belief that the relatives of the critical patients in the ICU who are able to adapt themselves to cope with stress will be able to maintain their health, social functioning, and morale. On the other hand, those who are unable to effectively cope with stress are likely to experience adverse effects on their health, functioning, and role maintenance, as well as their emotional conditions while encountering such stressful situations.

Additionally, satisfaction with the nursing care received is one of the criteria used to assess nursing outcomes reflecting the quality of nursing care (Greeneich, 1993: 65; Mahon, 1996: 1243; Munro et al. 1994: 119). Also, it indicates the receivers' perception of how much the nursing practices have served their needs or met their expectation (Eriksen, 1995: 61; Oberst, 1984: 2367),. The researcher believed that the evaluation of the Coping Promotion Program would provide useful information to further develop interventions for improving nursing care.

Based on the aforementioned conceptualization, a Coping Promotion Program, was developed for relatives of patients admitted to the ICU based on the Stress Theory of Lazarus and Folkman (1984) and an extensive review of research literature regarding the needs of relatives of patients admitted to the ICU, conducted both in Thailand and abroad. The goal of the program was to enable the relatives of critical patients admitted to the ICU in coping with stress effectively and to provide nursing care satisfying their needs. In this study, the nurses and nursing care plan constructed in accordance with the conceptual framework previously discussed are regarded as coping resources for relatives of the patients with an aim at promoting their well-being and satisfaction with the nursing care. The conceptual framework of the present study is illustrated in Figure I.

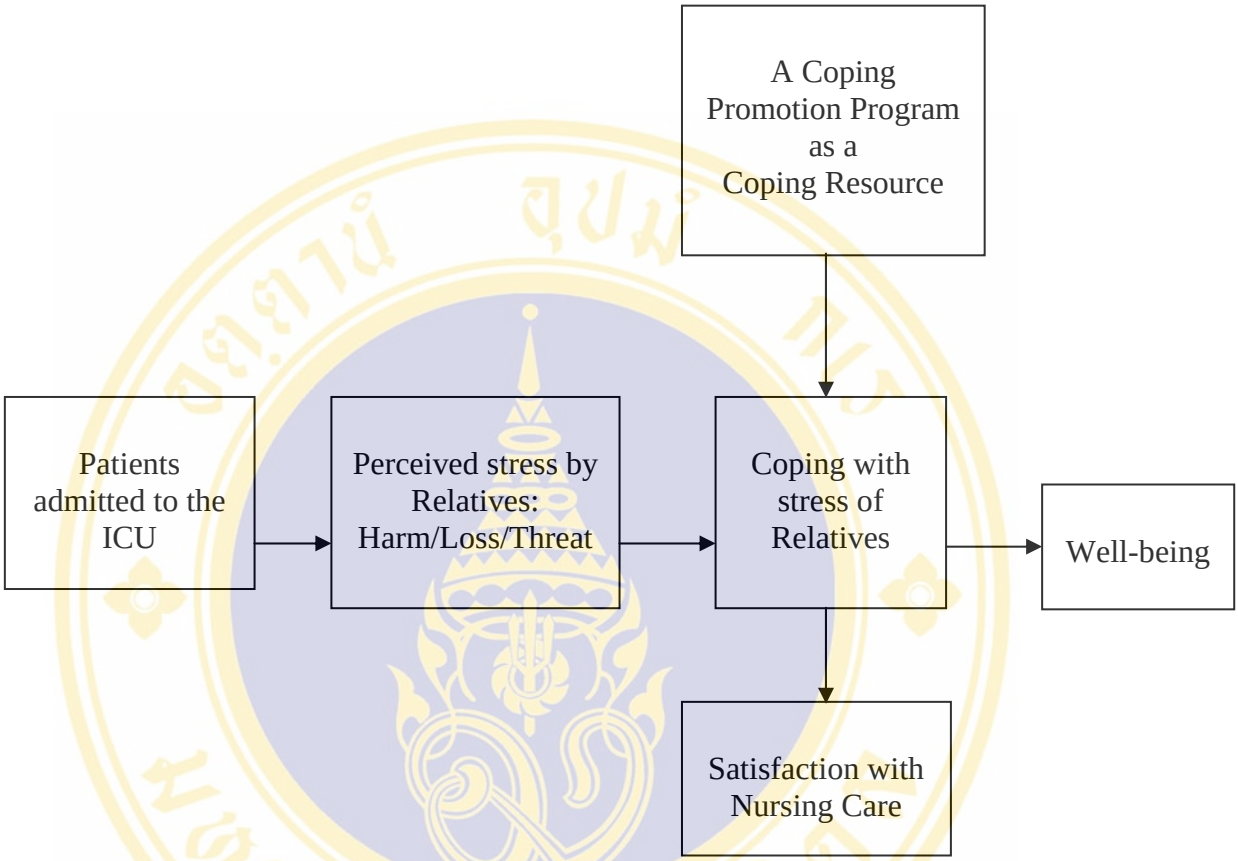

Figure I: Conceptual Framework for the Study

Research Questions

1. What is the effect of a Coping Promotion Program on well-being of relatives of the patients admitted to the ICU?

2. Are relatives of the patients admitted to the ICU satisfied with nursing care provided?

Research Objectives

1. To determine the effect of a Coping Promotion Program on well-being of relatives of the patients admitted to the ICU

2. To evaluate satisfaction with nursing care of relatives of the patients admitted to the ICU

Research Hypotheses

1. The mean score of overall well-being of relatives of the patients admitted to the ICU obtained after receiving the Coping Promotion Program was higher than that obtained before receiving the program.

2. The mean score of each subscale of well-being of relatives of the patients admitted to the ICU obtained after receiving the Coping Promotion Program was higher than that obtained before receiving the program.

Scope of the Study

The present study was a quasi-experimental research design, which aimed to investigate the effect of a Coping Promotion Program on well-being of relatives of patients admitted to the ICU and to evaluate satisfaction with nursing care at the relatives. The study was conducted at Department of Medicine, Ramathibodi Hospital, from June to December 2005.

Expected Outcomes and Benefits

1. This study provides a coping promotion program, by which nurses can use interventions in the program based on Lazarus and Folkman's theory to assist relatives of patients admitted to the ICU to effectively cope with stress. Nurses can enable them to maintain their health and energy, to develop stress coping skills, and to make use of available resources to appropriately deal with stress, thus, increased ability to maintain their roles, general well-being, and family balance. In addition, the relatives themselves can become important resources who offer hope and encouragement necessary for the critical patients' recovery.

2. Findings in this study could also be utilized to prevent a psychologically critical condition that may take place among relatives of patients in the ICU who have to cope with a considerable amount of stress.

3. Findings regarding satisfaction with nursing care of this study could raise the nurses' awareness of provision of good care to the relatives of the patients, which are regarded as fundamental care providers to the patients under the family context according to the holistic nursing care concept. Satisfaction with service is presently used as an important indicator for care quality, thus, results from this study can help nurses to develop interventions to increase satisfaction of the clients.

Definition of Terms

A Coping Promotion Program. A Coping Promotion Program refers to nursing interventions designed specifically for relatives of critical patients admitted to the ICU developed by the researcher to enable them to cope with stress and to appropriately serve their needs. The program was developed based the Stress, Appraisal, and Coping Theory proposed by Lazarus and Folkman (1984) together with an extensive review of research literature on needs of family members of critical patients. According to this program, nursing interventions are provided four times in three days, including an establishment of relationships, assessment of responses to the situation and needs, promotion of stress coping skills of relatives of the patients admitted to the ICU.

Well-being. Well-being refers to the summing up of emotional states that repeatedly takes place during a certain period of time or the feeling about personal state of persons (Dupuy, 1977, as cited in McDowell & Newell, 1996: 215; Lazarus, 1991: 406-407). In this study, well-being is assessed using the General Well-Being Schedule developed by Dupuy (1977 as cited in McDowell, & Newell, 1996: 206-213), which evaluates individuals' well-being in six aspects as follows: 1) anxiety, 2) depression, 3) positive well-being, 4) self-control, 5) general health, and 6) vitality. The total scores ranged from 0 to 110, with higher scores indicating a higher level of well-being.

Satisfaction with nursing care. Satisfaction with nursing care refers to pleasurable feelings of the relatives of critical patients admitted to the ICU toward the nursing care they received. It reflects the compatibility between the expectation of the nursing care and the nursing care actually received. In this study, satisfaction with nursing care was assessed with "the Relative Satisfaction Scale", which was firstly developed to assess satisfaction of hospitalized patients by La Monica, Oberst, Madea,

and Wolf (1986) and was called as “the La Monica-Oberst Patient Satisfaction Scale (LOPSS)”. In 1994, Munro, Jacobsen, and Brooten (1994: 119-125) revised the LOPSS. The revised LOPSS was translated and adjusted in Thai by Chavalee Yamvong (B.E.2538). The total scores ranged from 28 to 140, with higher scores indicating a higher level of satisfaction.

Relatives of critical patients. Relatives of critical patients refer to members in the family of patients admitted to the ICU. They could be those who were related to the patients by blood such as father, mother, children, or siblings, or they can be those who were related to the patients by law such as a spouse, adoptive father, adoptive mother, or adopted child. Family members in this study were selected by the researcher on the criteria that they had a close relationship with the patients who were the main caregiver, able to make a decision on behalf of the patients and/or responsible for the medical expenses during the patients’ hospitalization. They may or may not live in the same house with the patients. Relatives do not refer to paid caregivers.

CHAPTER II
LITERATURE REVIEW

The present study was quasi-experimental research, which aimed to investigate the effect of a Coping Promotion Program on well-being and to evaluate satisfaction with nursing care of relatives of the patients who were admitted to the ICU. In this chapter, the related literature and research are reviewed in the following topics:

1. Stressful situations of relatives of the patients admitted to the ICU
   - Stress of relatives of the patients admitted to the ICU
   - Stress coping of relatives of the patients admitted to the ICU
2. Well-being of relatives of the patients admitted to the ICU
3. Needs of relatives of the patients admitted to the ICU
4. Nursing care to promote stress coping of relatives of the patients admitted to the ICU
5. Satisfaction with nursing care of relatives of the patients admitted to the ICU

Stressful Situations of Relatives of the Patients Admitted to the ICU

Stress of Relatives of the Patients Admitted to the ICU

According to Lazarus and Folkman (1984: 19), stress is an interaction between individuals and their environment. It is a situation about which individuals need to assess how much available resources they need to utilize, and it is also a situation, which may pose harms or threaten their well-being or security. Assessing a situation as a stress, therefore, means individuals' assessment of the interaction of such an event and its effect on them and interpretation of the significance of the stress and its effect on their well-being. After that, individuals may manage or cope with stress or adjust themselves to such situation. In general, the effects of the same arousal can vary among individuals. This is because stress is assessed by individuals' perceptions rather than the stimulation of such stressful situation (Meisel, 1991: 15).

An illness of a family member is one of the situations, which can cause stress to other family members, especially when the illness is so severe that admission in the ICU is required. However, not all illnesses or hospitalizations are seen as stress, but whenever the family perceive such illness as a threat to the family's well-being, a critical condition can result (Leske & Heidrich, 1996: 91-102; Meisel, 1991: 20). Bedsworth and Molen (1982: 450-453) conducted a study to examine psychological stress in 20 subjects who were the wives of first-time patients with myocardial infarction within 72 hours after the treatment in the hospital. The findings indicated that the subjects' highest level of perceived threat was the threat of loss, especially the loss of the mate and the loss of a healthy mate, followed by anxiety and fear, all of which were dominant emotions expressed by the subjects.

Wanichapichat (2000) studied stress, coping resources, and constraints against utilizing coping resources of 64 relatives of the patients admitted to the medical and surgical ICU in the Thai context. All subjects paid a daily visit to the patients during the first four – five days after admission in the ICU. According to the findings, 100% of the subjects assessed the patients' treatment in the ICU as a stressful situation, and the top five stressful situations included perception of the severity of the illness, financial problems, disruption of normal routines, decreased stability of the family, and lack of information about the patients' diagnosis and plan of treatment, respectively. As for the perception of the severity of the illness, it was composed of the following five factors: 1) the image of the patients, which reflected the severity of their illness, 2) the perception that the ICU symbolized critical illness, 3) lack of experience and the sudden occurrence of the situation, 4) reception of information regarding the symptoms and diagnosis (related to chances of mortality obtained from both the physicians and previous experience), and 5) uncertainty about the survival of the patients.

When facing a situation in which a family member is critically ill, Lazarus has pointed out three factors which cause psychological stress as follows: 1) disruption of community life resulting from visitation constraints and inability to communicate with the patients, 2) loss of loved ones resulting from worries about the chances of morbidity and mortality of the patients, and 3) uncertainty over the ability to control one's environment resulting from lack of familiarity which high-tech medical

equipment used in the ICU (Lazarus, 1996, as cited in Curry, 1995: 15-19). Moreover, Hodovanic et al. (1984: 243) contend that the stressors that family members have to face include role changes, isolation from other family members, financial problems, and problems related to having to commute between the hospital and home. Besides, the family members may have a number of needs that arise during the patients' hospitalization.

In brief, the stressful situation of relatives of the patients admitted to the ICU can be summarized as follows (Hodovanic et al., 1984: 243; Meisel, 1991: 20-21; Wanichapichat, 2000).

1. Sick Condition of the Patients

This consists of the following:

1.1 Severity of the illness

When the patients are treated in the ICU, the images that the relatives are likely to see are the patients being attached to or inserted with a large number of tools and equipment. Such images make relatives feel that the illness is very critical and causes the patients a great deal of pains and sufferings as well as threatens the patients' life and well-being. As such, the relatives may assess the situation as a stressful situation for themselves as it puts their loved ones under a great threat (Rukholm et al., 1991: 920-922).

1.2 Inability to communicate with the patients

Generally, the patients in the ICU are inserted with breathing tubes or undergo changes in terms of consciousness due to confusion caused by the illness or by the medication given to them. As a consequence, they are not able to communicate normally to their relatives. The relatives, at the same time, are unable to ask if the patients are comfortable or in pain, and they have to make assessment of the patients' well-being by themselves. This can become a stressor for the relatives. Furthermore, some relatives may not dare to touch the patients for fear of causing the equipment to come off or to disturb the patients, and this can also increase their level of stress.

1.3 Uncertainty of the situation

The conditions of critical patients are likely to fluctuate, and changes or complications, which may harm their health or life, can occur at any time. In addition, the physician may not be able to provide a definite prognosis or confirmation,

especially during the initial stay in the ICU. This causes ambiguity and uncertainty, which becomes a situational factor that can affect the relatives' level of stress.

2. Environment in the ICU

The environment in the ICU can cause stress to both the patients and the relatives for different reasons as follows:

2.1 unfamiliarity with different equipment attached to or inserted into the patients' body, especially when the alarm goes off without reasons

2.2 perception that the ICU is a place where treatment is provided to critical patients in a life-threatening situation

2.3 hectic working environment with emphasis on the care given to the patients, which prevents doctors and nurses to pay much attention to the relatives or to answer their questions, hence a possible feeling of being unwelcome on part of the relatives.

2.4 having to give trust to strangers—the relatives have no choice but to give absolute trust in the doctors and nurses' hands when it comes to the patients' safety and survival. Moreover, as the visitation of the patients in the ICU is restricted, the relatives are unable to provide care to the patients as much as they want. Besides, they may not have a chance to see what is going on with the patients, causing them anxiety and concern about the patients' well-being. Gardner & Stewart (1978, as cited in Hickey, 1993: 94) point out that such situation can easily make relatives feel helpless and powerless and unable to help the patients.

3. Unsatisfied Needs

According to Molter (1979, as cited in Thitima Wataneeyavej et al., B.E.2541), when the patients are treated in the ICU, the family members who are the patient's relatives develop special and different needs from those of family members of the patients who are treated in a general ward. The family members' needs have an effect on their stress and anxiety (Rukholm et al., 1991: 920-922).

Hupcey and Penrod (2000: 44-49) studied the experience of family members who spouse was treated in the ICU. The subjects of the study reported that having their needs responded to could reduce their stress and enable them to continue their support and care for the patients. Thus, family members' needs should be satisfied to reduce stress. If the family members' needs are not satisfied, they may experience stress and

become unable to maintain their system in the society or provide support needed for the patients' recovery and rehabilitation (Nuananong Boonjaroonsil, B.E.2537; Taylor et al., 1993: 137).

4. Changes in Family Roles and Responsibilities

When the patients are treated in the ICU, their roles and responsibilities become roles and responsibilities of the remaining family members, whose activities and schedules would then become disrupted. The patients' former roles such as giving others' encouragement, taking care of other members' comfort, and scheduling other members' activities would disappear. This, coupled with the new roles and responsibilities the family members have to undertake, make family members feel that something is missing from their lives (Hudak et al., 1998: 21-29; Hupcey & Penrod, 2000: 44-49; Johnson et al., 1995: 238-243; Meisel, 1991: 20-21; Nymathi et al., 1992: 160-166; Wanichapichat, 2000).

Stress coping of relatives of the patients admitted to the ICU

Lazarus and Folkman (1984: 150-153) contend that stress is individuals' feeling, which results from the imbalance of individuals and their environment. Therefore, stress coping is a process, which individuals use to create and maintain balance with the environment. The stress coping strategies employed, however, depend on individuals' assessment of the stress situations.

In addition, family coping refers to strategies, patterns, or behaviors, which are developed for the following purposes: 1) to maintain or strengthen the family structure or both, 2) to maintain stable emotional conditions, 3) to utilize available resources to deal with the situation, and 4) to create driving forces to solve problems caused by stressful situations. The resource the family has is one of the strengths the family can make use of to cope with stress by preventing the disruption to patterns of duties and roles (Leske, 2000: 239). Critical illness results in tremendous changes in roles and responsibilities of family members who are the patients' relatives. They have to face with sufferings from the critical condition that has taken place. Their ability to perform family roles and functions, therefore, depend on whether and how much they are able to make use of available resources (Hickey, 1996: 65).

There are two coping strategies. First, problem-focused coping is a coping strategy, which changes or improves the environment by dealing with the stressor or with oneself. Second, emotional-focused coping is an adjustment of emotions and feelings to prevent the stress from destroying morale (Lazarus & Folkman, 1984: 150-153). Stress caused by having a family member admitted to the ICU requires the relatives to maintain the family balance using coping mechanisms to deal with the situation. The pattern of the responses may be difficult to clearly differentiate as different individuals may use different techniques and strategies to deal with stress and anxiety (Hudak et al., 1998: 21-29; Twibell, 1998: 100-144). In addition, the ways relatives interact with the situation have an influence on the patients' recovery. They also indicate relatives' need for help to deal with the situation (Lopez-Fagin, 1995: 21).

In general, relatives tend to have the most serious reactions to the critical situation within the first 24-48 hours after it has happened. They tend to experience denial, fear, and loss of control. For this reason, receiving assistance and preparation enables them to maintain their hope and empowers them to better cope with the situation (Wallace-Barnhill, 1992: 77). Besides, trying to maintain hope is one of the factors, which help maintain coping ability (Kleeman, 1994: 207). If relatives are unable to deal with the situation, their well-being, functioning, and psychological health can be affected (Leske, 2000: 239).

Epperson (1977: 265-273) conducted a study to investigate coping of family members during a critical condition. The findings showed that the coping process could be divided into six phases as follows: 1) high anxiety, 2) denial, 3) anger, 4) remorse, 5) grief, and 6) reconciliation. Furthermore, such coping varied in terms of pattern depending on individuals, which may have different reactions in different sequences. Such differences result in different needs for assistance during different times along the coping process.

Moreover, Nyamthi (1987: 86-92) found that during hospitalization, the spouses of the patients handled stress by using behavioral, cognitive, and intrapsychic coping to prevent or reduce the stress caused by the illness of the patients. The techniques used included assessment of the spouse' conditions, communication with the doctor, and search for assistance and spiritual support from family and friends. Later on,

Nymathi et al. (1992: 160-166) studied coping and adjustment of spouses of patients with heart diseases. The findings indicated that individuals with a high level of negative personalities (such as a high level of dependence, anger, restlessness, and moodiness) tended to use more emotion-focused coping and experienced a higher level of both physical and mental distresses. On the other hand, individuals with more positive personalities were more likely to use problem-focused coping.

LaMontagne and Pawlak (1990: 416-421) explored stress and coping of parents of children admitted to the pediatric intensive care unit and found that the subjects of the study used different strategies to cope with stress according to the causes of stress. Even though both problem-focused coping and emotion-focused coping were generally used by this group of subjects, the most frequently employed techniques were seeking social support and making positive reappraisal.

In summary, when a family member is sick and has to be treated in the ICU, the other family members who are the patient's relatives can experience stress depending on their appraisal of the threat or loss caused by such illness as well as on other situational and environmental factors, which cause the stress. When experiencing stress, relatives tend to make use of available resources to cope with stress in their attempt to maintain happiness in life and balance of the family. Individuals' coping ability varies according to personal factors such as perception and assessment of the severity of the situation, personalities and characteristics, selected strategies, and available resources.

Well-Being of Relatives of the Patients Admitted to the ICU

According to Lazarus (1991: 406-407), subjective well-being is an old and important criterion in quality adaptation. In other words, subjective well-being refers to expression of happiness, morale, encouragement, and satisfaction with life. This can be assessed through a combination of emotional outcomes, which take place repeatedly during a certain time. Dupuy (1977, as cited in McDowell & Newell, 1996: 215) believes that individuals' feeling toward their personal state is more important than outer conditions including work environment or neighborhood. When individuals have to face with stress or problems, their adaptation can be assessed from internal feelings and expressed behaviors such as anxiety, depression, general health status,

positive well-being, self-control, and vitality, all of which are categorized under general well-being. The General Well-Being Schedule (GWB) can be used to assess six aspects of individuals' well-being including anxiety, depression, positive well-being, self-control, and vitality, rather than being assessed by external situations such as income or environment.

Campbell (1976: 117-124) contends that subjective well-being refers to individuals' experience, learning, and perception of a situation that has actually taken place compared with those of the situation, which individuals hope for or desire. The conflict between perception of real life events and what ones expect may become satisfaction or dissatisfaction of individuals.

Kaplan et al. (1984: 85) recommends that individuals' well-being should be assessed in the form of assessment of individuals' personal responsibilities in carrying out daily life activities and social functioning, both of which result from stress coping.

Orem (1995: 101) explains that well-being is a state characterized by experiences of contentment, pleasure, and kinds of happiness; by spiritual experiences; by movement toward fulfillment of one's self-ideal; and by continuing personalization. Well-being is associated with health, success in personal endeavors, and sufficiency of resources.

The effects of a stressful situation that occurs to relatives of critical patients admitted to the ICU clearly reflect that stress and stress coping lead to changes in relatives' lives. When a family member is sick, roles and functions in the family will be affected. Critical illness can cause a stable family to lose balance and result in a critical condition (Hartshorn et al., 1993: 114-119). This is because whiles the patients are dealing with their own illness, their relatives are facing with stress caused by the patients' illness (Hodovanic, 1984: 243; Jamerson et al, 1996: 467-474). Normal family functions will be disrupted, and remaining family members have to take care of increased responsibilities (Cleveland, 1980: 558-565; Johnson et al., 1995: 238-243; Titler et al., 1991: 174-182).

There have been reports on different changes in behaviors of relatives of critical patients including sleep pattern, food intake, performance of activities, smoking, alcohol drinking, and use of medications (Halm et al., 1993, as cited in Horn & Tesh, 2000: 41). Some relatives of critical patients may have physical symptoms and

expressions such as listlessness, disrupted sleep pattern, loss of appetite, or other expressions of reactions such as asking for help from others including friends, relatives, and medical staff in the ICU.

Titler et al. (1991: 174-182) found that the impact of having a family member admitted to the ICU included 1) lack of family communication, 2) protection of children from anxiety-provoking information, 3) overriding threat, exemplified by feeling of vulnerability, uncertainty, intense emotion, and physical illness in children such as influenza, headache, and stomach ache, 4) difficulty caused by household chores, 5) changes in family relationships, and 6) role conflicts.

Craft et al. (1993: 64-71) conducted a study and discovered that children aged 5 – 18 years whose parents were critical patients had perception of the impact of a stressful family situation consisting of the following: 1) emotional difficulty and confusion which varied in form. The symptoms or expressions manifested in the form of shock, anxiety, and fear, which resulted from confusion, difficulty, and uncertainty of the situation; 2) separation of the family. Some children felt that they had increased family responsibilities and the family lacked unity and communication. The relationship with their well parents also changed as they became noticeably moody or irritable or depressed. Thus, some children felt that they had lost both of their parents; 3) need for assistance. Some needed mental and emotional support from family and friends; 4) illness. It was found that some children developed the symptoms of a common cold.

Huckabay and Tilem-Kessler (1999: 36-42) studied stress reactions of parents of children hospitalized in the pediatric ICU during the first five days after hospitalization. According to the findings, most of the parents had the highest level of stress on the first day, which was close to a panic level, and this graduated reduced on the following days, even though it remained at a high level.

Horn and Tesh (2000: 40-49) investigated the impact of having a family member admitted to the ICU. They found that family members of critical patients encountered a large number of stressors, which affected their personal health and family stability. Their behaviors, which were changed to respond to the situation, included those involving food intake, performance of activities, and family roles and responsibilities. To be more exact, they discovered that 1) the subjects had less time to sleep and had

decreased quality of sleep as they lacked sleep and could sleep or nap for only a short period of time, sometimes while they were waiting to visit the patients; 2) they lost their appetite and changed to eat more snacks or instant food. They also experienced problems with their digestion system; 3) they had fewer activities in life including spending time with other family members, exercising, or doing recreational activities as they had to spend most of their time visiting and taking care of the patients. They also spent their time worrying about the patients' condition, and most experienced a high to an extremely high level of exhaustion. They also reported changes in roles and responsibilities of the family including childcare, resignation from work, or reduced workload, as well as increased financial burdens. The factors, which caused and increased stress, included emotional distress, distance between the hospital and home, employment, and financial status. Other factors were uncertainty of the situation, the patients' complications, lack of attention from the medical staff, and feeling of isolation.

In addition, Wanichapichat (2000) studied stress, resources, and constraints in utilizing resources in coping with stress in the Thai context. It was found that the patients' relatives perceived loss of appetite, loss of sleep and rest, and deteriorating health, as well as loss of income (most were wage earners on a daily basis) due to the fact that they had to take leaves to visit and care for the patients.

Lazarus and Folkman (1984: 181-225) point out that individuals' appraisal of a stressful situation and stress coping lead to three adaptation outcomes of social functioning, morale, and somatic health. As regards the effect of stress on relatives of critical patients, it could be concluded that while the relatives want the patients to receive the help they need, the relatives themselves also need help because of the stress caused by the critical situation of the patients which affected the relatives' both physical and psychosocial well-being.

However, despite lack of a clear-cut assessment of stress coping, the aforementioned studies clearly reflected the effects of stress on relatives' physical and psychosocial well-being. The assessment of overall effects may help reflect the severity of the situation that affects the patients. This is because Lazarus and Folkman (1984) do not consider stress as a measurable variable, but an outcome of the interaction between individuals and their environment under each individual's

perception and appraisal. The outcomes then indicate the impact of individuals' attempt to cope with stress.

As a result, the outcomes that could be expected from stress coping are maintenance of life, health, and well-being. Thus, an assessment of the effects on relatives of critical patients in the ICU may shed light on individuals' ability to effectively cope with stress. This can be done by assessing perceived general well-being at a certain point in time (Somchit Hanucharurnkul, B.E.2534: 107-108). The researcher selected the General Well-Being Schedule (GWB) of Dupuy (1977, as cited in McDowell & Newell, 1996: 206-213) to assess the effects of stress coping in relatives of critical patients. It was believed that the instrument could reflect general well-being in life, which consisted of physical health, emotional status, and maintenance of perceived social roles during the situation.

In conclusion, well-being reflects the normality and happiness in daily living of individuals. It can reflect individuals' ability to perform their roles and duties according to their potential, balance in expected needs, and happiness and satisfaction in life. A stressful situation of having a family member admitted to the ICU can tremendously affect the relatives of the patients, which may result from the situation itself or from the individuals' attempt to use different strategies to cope with the situation and reduce the resulting stress to maintain health, self-esteem, emotional stability, and general well-being in life. The assessment of the general well-being of the relatives would help reflect the outcomes of their struggle to cope with stress, as a high level of general well-being would reflect a higher level of ability to adapt and cope with stress and vice versa.

Needs of Relatives of the Patients Admitted to the ICU

A stressful situation caused by having a family member admitted to the ICU makes the relatives of the patients develop special needs different from the needs of relatives of other patients treated in a general ward. A large number of researchers have conducted studies to investigate the needs of family members of critical patients, some of which are reviewed below.

Hampe (1975, as cited in Norris, 1986: 191-199) carried out a retrospective study of the needs of spouses of terminal patients or deceased patients. The findings

showed that there were eight aspects specified by the subjects of the study as follows: 1) the need to be with the dying person, 2) the need to be helpful with the dying person, 3) the need to be informed of the spouse's condition, 4) the need to receive assurance about the comfort of the dying person, 5) the need to be informed of impending death, 6) the need to ventilate one's emotions, 7) the need to receive comfort and support from family members, and 8) the need to receive acceptance, support, and comfort from health professionals. Later on, Breu and Dracup (1978, as cited in Norris, 1986: 191-199) interviewed spouses of the patients treated in the coronary care unit (CCU) and found that the needs indicated by the subjects were similar to those reported by Hampe. One additional need reported in the latter study was the need for initial anxiety.

Molter (1976, as cited in Norris, 1986: 191-199; Molter, 1979, as cited in Daley, 1984: 231-237) examined the needs of 40 relatives of critical patients treated in the ICU to identify the needs according to their perception, the importance of such needs, and whether those needs were satisfied. A 45-item structured interview was employed after the patients had been discharged to the general care unit. The findings showed that the most important needs were hopefulness, the patients' reception of needed care from health professionals, availability of waiting rooms nearby, immediate reception of information regarding changes in the patients' condition, and perception of the prognosis of the diseases. It was also found that most of these needs were responded to by nurses more than other healthcare team members.

Daley (1984: 23-237) explored perceived immediate needs of families with relatives in the intensive care setting within 72 hours after admissions into the ICU. The subjects were 40 relatives who first experienced having a family member treated in the ICU. The 46-item questionnaire divided the needs of relatives into six categories as follows: the need for relief of anxiety, the need for information, the need to be with the patient, the need to be helpful with the patient, the need for support and ventilation, and personal needs. According to the findings, the most important need was the need for relief of anxiety consisting of the need to receive information about the patients' conditions and treatment outcomes, the need to be informed of the patients' changing conditions, the need to receive explanations about different equipment used with the patients, the need to be reassured that the patients were receiving the best possible

nursing care, and the need to be told that there was hope. Second came the need for information, and the item which received the highest score under this category was the need to know what is wrong with the patient.

Moreover, in 1983 Leske and Molter improved and revised the questionnaire previously used by Molter. The derived instrument was a 45-item questionnaire called Critical Care Family Needs Inventory (CCFNI). The responses were arranged in a four-point Likert-type scale of (1) not important, (2) slightly important, (3) important, and (4) very important. A panel of experts validated the instrument to ensure content validity and Cronbach's alpha coefficient was calculated, with the resulting reliability of 0.98. In 1986, Leske used the CCFNI to investigate the needs of 20 relatives of critical patients and discovered that the most important needs were to feel there was hope, to have questions answered honestly, to know the prognosis, to know specific facts about the patients' prognosis, and to have explanations given in terms that were understandable (Leske, 1986: 189-193). Finally, Leske (1991: 236-244) examined the construct validity and estimated the reliability of the CCFNI and re-categorized the items into five dimensions as follows (Hickey, 1996: 65-73; Titler et al., 1995: 376):

1. Assurance needs are relatives' need for the assurance that the patients are under the best care possible by the healthcare team, including hopefulness about the symptoms and prognosis of the patients, as well as the progress and possible treatment outcomes, all of which should be explained with easy to understand terms.

2. Informational needs refer to the needs to receive different information about the patients including symptoms, procedures, and treatment outcomes, as well as about the medical team members who provide care and from whom information could be sought.

3. Proximity needs refer to the need to be close to the patients, to visit the patients frequently, and to receive flexibility to visit the patients during a special occasion, as well as the needs to receive different information about the patients on a daily basis and every time there is some change.

4. Support needs refer to the need to have someone who can accompany the relatives to provide spiritual support and to listen to the relatives' ventilation. This also includes the needs for a quiet place where relatives can be by themselves or to meet with someone who can offer spiritual boosts such as a religious representative. The

relatives need someone to show concern about their health and to give advice in time of need as well.

5. Comfort needs refer to the needs for convenience and facilities including acceptance from the staff and the confidence that they could leave the hospital with no serious situations to happen during their absence.

Norris (1986: 194-199) conducted a study to compare the needs of family members of critical patients as perceived by the family members themselves and by the nurses. The subjects were 20 family members of the patients who had been treated in the ICU for at least 48 hours and 20 nurses. The findings suggested that the four most important needs of the family members were the needs to feel there was hope, to have questions answered honestly, to feel that hospital personnel cared about the patient, and to be assured that the best possible care was being given to the patient. The least important need of family members was to talk about feelings. It was also found that the needs of family members of critical patients as perceived by family members themselves and as perceived by the nurses were different.

Bouman (1984, as cited in Freichels, 1991: 16-29) conducted a study to examine the needs of 34 relatives of critical patients after 36 hours and 96 hours of admissions into the ICU. The findings showed that the importance of the needs of relatives changed with no statistical significance. Friechels (1991: 16-29) extended the duration of data collection to the first 72 hours after admission into the ICU and after seven to ten days after admission. There were 41 subjects who participated in the study, and the CCFNI was used to collect data. It was found that there were five needs, which were changed with statistical significance, as they became less important as time passed, while the perception of majorities of needs changed with no statistical significance despite the tendency to decrease in importance. At the second data collection, there were 32 items, which the subjects indicated as becoming less important. Finally, seven out of the ten most important needs were under the category of assurance needs, whereas the ten least important needs were ‘support’ and ‘comfort’ needs.

Hickey (1990: 401-415) reviewed 87 articles reporting on the needs of family members of critical patients published from 1976 to 1988. Eight articles, which reported on replicable primary research on the needs of families of critically ill patients, were selected. It was found that the families gave most importance to the

needs for information, followed by reassurance that the patients were receiving the best of care. In addition, other numerous studies on needs of families of patients in the ICU revealed similar findings. In general, family members needed information about the symptoms and treatment of the patients and needed reassurance that the patients were receiving the best of care. In other words, the needs for the patients to be well taken care of came first or seemed to be the most important, while the needs for families' comfort and care came later. Also, the persons who mostly responded to important or major needs of the families were nurses (Davis-Martin, 1994: 515-518; Lynn-McHale & Bellinger, 1988: 447-453; Mendonca & Warren, 1998: 58-67; Norris & Grove, 1986: 194-199; Price et al., 1991: 183-188; Stillwell, 1984: 238-242; Warren, 1993: 56-63).

In Thailand, Uraiporn Phongpatanawut (B.E.2532) studied the needs of relatives of critically ill patients in medical and surgical ICUs and found that the need to reduce stress came first, followed by the need for information about the prognosis and treatment activities provided to the patients. Aree Boonbarwonrattanakul (B.E.2538) investigated anxiety, needs, and received responses to needs of relatives of critically ill patients in the ICU. The findings showed that the relatives needed to reduce their stress and anxiety most, followed by the need for information. The least important need was the need for moral support and ventilation. It was also found that the needs of parents, spouses, or children of the patients were similar.

Thitima Wataneeyavej et al. (B.E.2541) carried out a study to examine the needs of families of critically ill patients as perceived by family members themselves and by nurses. The instrument used in data collection was a questionnaire adapted from the instrument developed by Molter (1979) which divided the needs into four categories based on the concept of Gaglione (1984)—informational need, physical need, emotional need, and spiritual need. The findings indicated that family members of the critical patients needed information most, followed by emotional needs, physical needs, and spiritual needs, respectively. The findings also showed that the needs of the families as perceived by the family members and by nurses in terms of informational need, physical need, emotional need, and spiritual need were not different.

Ubolwan Kitirattragarn (B.E.2541) investigated the needs of families of critically ill patients with acute brain injuries. The instrument used in data collection was

adapted from that developed by Molter (1979) and divided the needs into six aspects based on the concept of Daley (1984). According to the study findings, family members had the need for relief of anxiety most, followed by need for information, need to be with the patients, need to be helpful with the patients, personal needs, and need for support and ventilation. It was also suggested that the needs as perceived by the families were greater than those perceived by nurses. Pornthip Kosalwat (B.E.2541) explored the needs of families of the patients being treated in the ICU due to accidents. The instrument used was adapted from the one designed by Molter (1979). It was discovered that the most important need of the families was the need to reduce anxiety. Second came the need for information, and the need for support and ventilation ranked last. The family members of the patients also had similar needs in each of the aspects regardless of their relationship with the patients—parents, spouses, or children.

Suparat Vaicheeta et al. (B.E.2542) researched the needs and needs' responses of families of critically ill patients treated in the surgical, medical, and pediatric ICUs. The sample consisted of 100 family members of critical patients, and the questionnaire adapted from Molter (1979) was used to collect data. The findings revealed that the five most important needs of the subjects were 1) the need to know that the patients were receiving the best of care possible, 2) the need to have hope, 3) the need to be informed of the prognosis, 4) the need to be informed of the treatment plan, and 5) the need to be confident that everything would be all right while they temporarily left the patients alone in the ICU. Moreover, the five needs of the families which were mostly responded to were 1) the need to be ensured that the patients were provided with the best of care, 2) the need to be accepted by the healthcare team members, 3) the need to be taken care of by the healthcare team members, 4) the need to be informed of the advice on how to take care of the patients, and 5) the need for the explanation or information which was easy to understand. Finally, it was found that the needs of the families were higher than the responses they received.

Patitas (2000) investigated the needs and responses to needs of family members of critically ill patients using the questionnaire adapted from Molter (1979). It was found that the most important need of the family members was the need to reduce

anxiety. This was followed by the need for information and the need to be close to the patients in providing help. The lowest level of need was personal needs.

In brief, most of the studies conducted in Thailand yielded rather similar findings that the persons who most responded to the families' needs were nurses, followed by doctors.

Furthermore, studies have also been conducted to investigate the needs of families of critically ill patients to compare the perceived significance of the needs between families and nurses including the responses to needs of families as follows:

Lynn-McHale and Bellinger (1988: 447-453) studied the perceived satisfaction with the responses to needs of 52 family members of critically ill patients treated in the ICU and 92 critical care nurses. The findings showed that the needs which were rated as highly satisfactory were needs for personal support system, visitation, and information. On the contrary, the needs which were rated as only slightly satisfactory were psychologic aspect, environmental aspect, and institutional support services. Finally, the comparison of nurses' assessment of the perceived satisfaction with the responses to needs of family members and family members' assessment was only moderately accurate.

Mendonca and Warren (1998: 58-67) studied the needs which were served and which were not served of relatives of critically ill patients treated in the ICU. It was discovered that the most important need as perceived by family relatives of critically ill patients was assurance needs, which the relatives perceived that they were met. On the other hand, the need, which was perceived as least significant, was comfort needs. Finally, relatives perceived that the needs, which were not served, were comfort and support needs.

Forrester et al. (1990: 655-661) studied the perceived needs of relatives of critically ill patients treated in the ICU and compared them with perception of nurses. The sample was composed of 92 relatives and 49 critical care nurses. The findings revealed that the perception of the nurses was not in congruence with the perception of relatives.

In summary, the aforementioned research literature has shown that the needs of relatives of critically ill patients treated in the ICU are rather specific and homogeneous. The more important needs are the needs for information about the

patients and assurance that the patients are provided with the best of care. Nurses are healthcare team members who relatives perceive as best serve their needs. However, nurses' perception of the significant needs of the families is not consistent with the real needs of relatives.

Nursing Care to Promote Stress Coping of Relatives of the Patients Admitted to the ICU

Family is the oldest institution and is the most important institution in society. It is generally different from other social organizations. According to Friedman (1998: 5-6), family is a basic social unit, and it is a social institute which has a great impact on its members. The family institute exists in between society and individuals, and its fundamental goal is to serve the needs of society and family members, including affecting development of personality, behavior, and thinking of family members. For this reason, family is an important context with a great influence on growth and health development of individuals. It provides both physical and psycho-emotional care, and enhances individuals' sense of self-esteem.

At present, the pattern of living in society has greatly changed. Flexible living patterns and more open and extensive relationships have expanded the scope of the definition of family (Doherty et al., 1999: 55; Hickey, 1996: 65). The definition may not longer limit to the cohabitation of a married couple of opposite sexes who may have children, biological ones or adoptive ones. However, the definition now covers a group of two or more individuals who share love, attachment, and codependence (McCool et al., 1992, as cited in Hickey, 1996: 65). The codependence may be in the form of emotional, physical, or financial dependence, and it is up to the family members to provide the definition of their own family (Doherty et al., 1999: 55).

In addition, family may refer to individuals who are close to one another who take part in daily living of critically ill patients. Put another way, families are individuals whose social balance is affected by the critical condition of the patients. Any individuals who are important to the daily living of the patients can also be considered family members (Bursch, 1982: 29).

Family is important for the patients. This is because family provides mental and spiritual support and encouragement, which promote recovery of the patients as well as material support (Kleeman, 1994: 200). Furthermore, families provide familiar images and voices, which helps reduce the overstimulation and enables the patients to be calmer (Kirchhoff et al., 1985: 296-304). Thus, families act like a link between the world of illness and environment in the ICU and the outside world (Hupcey & Morse, 1995: 257-280). Besides, families act as a resource for nurses by offering information, which makes the nurses get to know the patients better, hence a more accurate assessment of the patients. In addition, families help nurses communicate with the patients and stimulate the patients to be cooperative with the treatment plan. Finally, families are sources of information about the patients' history, and they help the patients to receive care under the normal family structure, thus providing support to the holistic nursing approach.

Having a family member admitted to the ICU constitutes a great deal of stress on part of the family. The remaining family members or relatives of the patients may not be able to help one another (Jong & Beatty, 2000: 40). If relatives are not able to deal with the situation, well-being, functioning, and psychological health of the families may adversely be affected (Leske, 2000: 239). The stress of families can result in loss of balance of the family and family crises. Also, stress and anxiety of families may be contagious to the patients, thus increasing the level of stress of the patients (Bowman, 1984, as cited in Meisel, 1991: 20; O'Keeffe & Gillis, 1988: 191). Thus, when families difficultly encounter stress caused by the illness of the patients, the patients may experience difficulty adjusting themselves physically and psychologically to their illness (Jong & Beatty, 2000: 40; Horn & Tesh, 2000: 40-49). Family members who are unable to effectively cope with stress may cause the family to lose balance, and they may not be able to efficiently provide support to the patients or may disrupt the recovery and rehabilitation of the patients. Negative effects include distortion of the patients' actual condition, ineffective communication with the patients, decision making leading to negative outcomes on the patients, unrealistic expectation, and expression of negative emotions affecting the patients' physical and mental stability (Twibell, 1998: 100-114).

Critical patients can receive strengths transferred by relatives to overcome their biological crisis (Robert, 1976: 352, as cited in Meisel, 1991: 16). As a consequence, if the level of stress of relatives is reduced, families will be better able to offer care to the patients (Bozett & Gibbons, 1983: 22). For this reason, family support plays a very significant role in the patients' recovery. It also increases the patients' ability to cope with stress and develops their sense of self-esteem (Cobb, 1976, as cited in Meisel, 1991: 20).

Muenphun Maneechai (B.E.2542) studied the relationship between personal factors, uncertainty of illness, and social support from healthcare personnel and problem coping of family members of critically ill patients treated in the ICU. The findings revealed that support from healthcare personnel was positively related to coping of families, especially problem-focused coping. In addition, the healthcare team members who best responded to the families' needs were nurses. These findings indicated that assisting families to effectively cope with stress is extremely important and nurses should carefully plan for nursing intervention to offer help to family members of critically ill patients treated in the ICU (Caplan, 1961: 10-15; Dracup, 1993: 5; Olson, 1970: 31-36; Woolley, 1990: 1402). Nurses should be aware of the significance of the families and include families as part of the nursing care plan for the patients. This is provision of care which regards the patients as one dimension of family, and it clearly reflects holistic nursing care which aims at enabling families to maintain balance and functioning and to promote recovery of the patients.

Families have different patterns to deal with the situation. This is because they aim to cope with stress as best they can. In addition to realizing the stressful situation the families are facing and coping with, nurses need to assess how effectively they try to cope and to provide assistance to stimulate and promote their ability to cope (Meisel, 1991: 22). In fact, during a critical period, individuals tend to be more open to advice and assistance offered by others. Consequently, it is an opportunity for development of nursing care to assist families (Brose, 1979, as cited in Meisel, 1991: 20). When the stress of families is reduced, family members are then better able to support the patients (Bozett & Gibbons, 1983: 22). Successful nursing which enables the families to appropriately cope with stress may also enable the families to return to their former functioning and may possibly increase their coping ability.

A number of researchers have attempted to study nursing care to provide assistance to families of critically ill patients. Some of the studies are reviewed below.

Dracup and Breu (1978, as cited in Meisel, 1991: 20) investigated the effects of special care on spouses of critically ill patients in the Coronary Care Unit (CCU). The nursing intervention was developed from the findings of the needs of spouses of terminal patients reported by Hampe (1975). The nursing intervention included flexibility in visitation, phone calls to inform of the patients' conditions at home twice a day, and a 15-minute consultation session with nurses for questioning and emotional support. The findings indicated that the spouses of terminally ill patients who received special care felt that their needs were served by nurses more than the spouses who received only routine nursing care.

Ward et al. (1990, as cited in Clark, 1996: 54) developed a nursing intervention for families of the patients undergoing heart surgery. The intervention was composed of dissemination of knowledge to nurses and provision of information and assistance to family members who paid the patients a visit in the ICU. In the study, nurses followed the requirements regarding the pattern of each aspect of assistance. According to the findings, family members who received assistance reported a higher level of satisfaction and a lower level of anxiety than those who did not receive such nursing intervention.

Pikul Tantitham (B.E.2533) investigated the effects of a preparation program of families before visiting the patients in the ICU. The study aimed at determining the effectiveness of the preparation, which included systematic provision of information on the level of anxiety of 52 relatives of critically ill patients treated in the ICU, with 26 subjects in the experimental group and 26 in the control group. Both groups of subjects received similar usual nursing care from the staff, but those in the experimental group received systematic information before visitation. The level of anxiety of both groups of subjects was assessed before and after visiting the patients. The study findings showed that the mean scores of anxiety of both groups of subjects were not statistically significantly different ($p > .05$). However, the mean scores of anxiety of both groups after visiting the patients reduced with statistical significance ($p < .01$).

Lopez-Fagin (1995: 21-25) constructed a family guideline under the concept of needs of families of critically ill patients based on the CCFNI. In the study, the operating room nurses prepared the information about the surgery of the patients, and the hospital volunteers gave the information to the families. Moreover, the waiting room was redecorated to make it beautiful, tidy, and peaceful, and magazines and games such as puzzles were made available. Moreover, the in-service program was organized for surgical ICU nurses and medical and surgical healthcare teams to equip them with knowledge about assessment of needs of families based on the CCFNI, making them aware that the families need to be taken care of just like the patients. The assessment was carried out three months after the guideline was implemented by two nursing managers and nurse team members. It was found that the families received more information and the information received was accurate. Also, the number of complaints and reports filed to show dissatisfaction with the nursing care reduced, and visitation went more smoothly. Besides, the family members and relatives who came from out of town received assistance from social workers who helped them find a place to stay, thus no more sleeping over in the waiting room. The visiting environment was improved, with more quietness and peacefulness, and games effectively helped families kill time. Finally, having volunteers who coordinated between nursing from different units and families made the nurses feel that some of their burdens had been relieved or lifted.

Aimin (1999) studied the effects of information support on anxiety of 30 family members of critically ill patients treated in the ICU at Peking Union Medical College Hospital in Beijing, China. The findings indicated that the mean scores of anxiety after receiving information support of the control group and the experimental group were not different. However, the mean score obtained after receiving information support of the experimental group was lower than that obtained before the experiment with statistical significance ($p < .001$).

Panprasert (2004) carried out a study to determine the effects of informational and emotional support on the anxiety and satisfaction of accidental patients' relatives during the waiting period at the accident and emergency department. There were 30 subjects in the experimental group and 30 in the control group. It was reported that after the experiment the anxiety mean score of the subjects in the experimental group

who received usual nursing care together with nursing intervention to provide informational and emotional support and the mean score of the subjects who received only usual nursing care were not different with statistical significance ($p > .05$). However, the anxiety level of both groups of subjects after the experiment was lower than that before the experiment with statistical significance (control group: $p < .01$; experimental group: $p < .001$).

In addition to studies that investigated the effects of nursing intervention to provide assistance to families of critically ill patients, survey research or descriptive research was also conducted to shed light on stress and needs of families. Such research has yielded useful recommendations and guidelines which could be used to develop different nursing interventions to offer care to relatives of critically ill patients treated in the ICU as follows:

Epperson (1977: 265-273) studied the families of critical patients, their coping in a crisis caused by illness of family members, and assessment of assistance. It was found that families coped with the situation in six phases, and the coping lacked definite patterns as it varied among individuals. Different reactions of individuals meant that different forms of assistance were needed depending on individuals' specific needs when facing the situation. The six phases were as follows:

1. High anxiety phase: families should receive information about symptoms and treatment of the patients to serve their needs for information and reassurance that the patients were given the help they needed. The need for ventilation should also be met.
2. Denial phase: families should receive realistic information periodically.
3. Anger phase: families may put blames on others, so they should be given the opportunity to contemplate on and assess their feelings. Open communication may be needed as well.
4. Remorse phase: families should be assisted to confirm their sense of self-esteem.
5. Grief phase: families should be given the opportunity to express their emotions and feelings, to have a private time for themselves, and to realize the care and concern others had for them. Sometimes, understanding and compassion may be expressed through silence.

6. Reconciliation phase: sometimes it did not mean individuals' acceptance of the situation, but it referred to the time when families assessed how they should deal with the situation. Thus, assistance should be provided to enable them to make use of available resources or to search for beneficial resources to cope with stress and to get ready for the situation.

Hodovanic et al. (1984: 243-249) examined the effects of a nursing intervention on family members of critically ill patients treated in the ICU. It was observed that if nurses and families had contact as soon as the patients were admitted toto the ICU, the stress and anxiety of families could be reduced. Moreover, when the patients were treated in the ICU, assessment of families enabled nurses to receive information necessary for the nursing care plan. An assessment of family structure would also help nurses to plan for the nursing intervention more specific to each family's needs (Hartshorn et al., 1993: 14-19). For instance, nurses would be able to observe which family member had the authority to make decisions or coordinate among family members. In addition, it enabled nurses to assess valuables, goals, and expectations of the families, as well as family relationships, mutual assistance in coping, and problems and resources for problem solving of the families to deal with the stressful situation they were facing.

Huckabay and Tilem-Kessler (1999: 36-42) studied reactions to stress of parents of the children admitted to the pediatric ICU. The findings were then used as a guideline in developing context-specific nursing intervention. On the first day after admission into the ICU, families had the highest level of stress and anxiety, and this reduced their ability to accept information and to concentrate. Thus, the nursing care provided during the first 24 hours should include assessment of the response level of the families. Families should be encouraged to have realistic perception of the situation by giving important information about the symptoms and threats to life of the patients, as well as information on treatment and safety. The information provided should be concise, clear, and easily comprehensible. It should not be too detailed or too overwhelming for the families to process. Furthermore, families should be provided with the opportunity to express their feelings and vent their emotions. Meanwhile, reassurance was needed to make the families be contented that the patients were given the best of care. Resources should be sought after, and families'

needs should be satisfied as much as possible including observing the patients, monitoring the patients' conditions and responsiveness, etc. On the following days, the families should receive more comprehensive information and be given the chance to care for the patients. Information which needed to be disseminated included attitudes and capacity of the staff, progress of the patients, treatment plans and chances of discharge from the ICU to prepare families for different nursing care which can vary depending on the condition of the patients. Explanation of capacity and efficiency of nurses in general wards should be given to ensure that necessary care could be given to the patients in case of emergency.

Even though the study of Huckabay and Tilem-Kessler (1999: 36-42) was conducted with pediatric patients, the findings were consistent with those of the studies conducted with adults. For instance, Wanichapchat (2000) found that all 100% of adults who were relatives of critically ill patients treated in the ICU perceived the situation as stressful. Also, Bedsworth and Molen (1982: 450-456) found that spouses of patients with myocardial infarction developed anxiety and fear in the initial phase of the event.

In fact, knowledge about needs of family members of critically ill patients treated in the ICU makes nurses become more sensitive to families of critical patients. As families' reactions to the situation has an effect on the patients' recovery, nurses should provide assistance by conducting early detection of their needs and responding to the needs identified (Leske, 1986: 189-193).

Molter (1979, as cited in Lopez-Fagin, 1995: 21-25) found that needs for hopefulness and information about the patients' symptoms were very important. Families needed to be confident that the patients were well taken care of. In addition, the responses to comfort needs such as a comfortable waiting room, a telephone or a toilet nearby, etc. enable families to more effectively endure stress. On the other hand, responses to support needs foster their emotional well-being and coping mechanisms until the critical condition improves (Leske, 1991: 236-244).

Daley (1984: 231-237) studied the perceived immediate needs of families with relatives in the intensive care setting and proposed the nursing intervention plan that nurses should be enthusiastic to assist and serve the needs of families, especially during the first phase of the treatment. Initially, families are concerned with the

condition and safety of the patients, and they needed information about the patients more than other personal needs. During this phase, nurses may have to response to relatives' personal needs, as the family members themselves are more concerned with the patients rather than themselves. Nurses should make families realize that they are part of the nursing care plan offered to the patients, and provision of assistance to families does not cause difficulty or burden to nurses. Besides, nurses should prepare information fir families and offer their assistances before being asked. Care should also be given on a regular basis to create a more trusting relationship with families. Moreover, nurses should be present when the doctors and family members are discussing the symptoms or the treatment plans of the patients so as to assess the perception and estimation of the situation of the families. Also, nurses would then be able to give repeated information or further explanations when family members have doubts, misunderstanding, or desire to have repeated explanations later on. Nurses may also need to arrange for the meeting between the doctors and the family members. These nursing interventions can reduce stress and anxiety of the family members, and they enable doctors to better understand the needs and reactions of families. At the same time, family members have more chance to learn about the potential of nurses. Finally, nurses need to familiarize themselves with different cultures to be able to more accurately and appropriately assess the needs for nursing care of individuals with different cultures and attitudes.

The effects of the perception of the significance of the needs of family members of critically ill patients treated in the ICU during different phases as reported by Friechels (1991: 16-29) shed light on the guidelines to provide nursing care to satisfy the needs of relatives of critically ill patients treated in the ICU. Nurses should assess the responsiveness and needs of the relatives. As initially relatives have a high level of anxiety about the patients, the information provided to them should be important and not too overwhelming, as too much or too detailed information can increase relatives' stress and anxiety. The study findings also suggested that assurance needs and informational needs are always important even after some time has passed. Thus, these needs should be served on a regular basis. As for other information which is not urgent, it can be kept for a later occasion when relatives are more ready to take in more information, or it can be prepared and given in the form of a document which

can be reviewed anytime including visiting hours, available resources, etc. Moreover, as relatives' personal needs including support needs and comfort needs tend to receive less priority, nurses should prepare to serve these needs when the relatives are still more concerned about the patients rather than their own well-being.

Jong and Beatty (2000: 40-47) examined acceptance of support of family members of critically ill patients treated in the ICU. They found that the most important support as perceived by family members was information/communication support. This was followed by appraisal support, emotional support, and instrumental support, respectively.

Most of the nursing interventions provided to relatives of critically ill patients treated in the ICU tend to respond to the needs of relatives while the patients are still admitted to the ICU. Such needs are characteristically different from the needs of relatives of the patients admitted to the general ward. It is generally expected that the responses to those needs will help reduce the relatives' anxiety and promote their capability to cope with stress. However, in addition to acknowledgement of the assistance provided, relatives' coping potential should also be promoted. This is to enable them to carry out reappraisal and appropriately select and utilize available resources when the situations have changed or new situations have arisen such as the worsened condition of the patients due to acute complications or changes in the treatment plan of the doctor. The researcher was interested in developing a nursing intervention, which could help families cope with stress and promote their coping capability to achieve sustainable outcomes during the patients' stay in the ICU.

In 1988, O'Keeffe and Gillis investigated the effects of nursing care provided by critical nurse specialists (CNS) on family members of critically ill patients based on Lazarus' theory of individual psychological stress. According to Lazarus & Folkman (1984), different resources including health and energy, positive beliefs, self-esteem, problem-solving skills, social skills, social resources, and instrumental support are important and necessary for successful coping. These resources will be assessed in the secondary appraisal step to suit the needs that arise from the stressful situation and to provide nursing intervention to promote stress coping as they are also considered stress coping resources. The pattern of nursing assistance consists of the following: 1) assessment of the families starting from creating a relationship with the families since

gathering data about the families and evaluating responses to the situation of the families; 2) provision of nursing care by developing a nursing plan that is suitable for each individual patient and using the primary nursing system to prepare the patients for the discharge from the ICU, to plan for discharge from the hospital, and to follow-up after returning home; and 3) assessment of nursing care outcomes on the stress of family members of critically ill patients as follows: families are able to identify coping options and seek help from available resources, they are able to develop decision-making abilities, the level of perceived threat is decreased due to realistic expectation about the mortality of the patients, and there is development of family resources to cope with stress of family member's illness and death (O'Keeffe & Gillis, 1988: 191-198). The findings of O'Keeffe and Gillis' study revealed stress coping situations and adaptation of family members of critically ill patients. The nursing outcomes also reflected the development of increased coping ability and skills of family members of critically ill patients.

In the Thai context, Wanichapichat (2000) studied stress, coping resources, and constraints against utilizing coping resources of relatives of critically ill patients admitted to the ICU. The findings led to the following useful recommendations on provision of assistance to relatives of critically ill patients:

1. As relatives of critically ill patients tend to perceive stress during the first two to five days after the patients' admission into the ICU, nurses should appraise their perception, resources, and possible obstacles in coping since the beginning. Giving an opportunity for relatives of critically ill patients to vent their feelings or discussing problems enables nurses to gather such needed information and to understand each relatives's stress situation, hence an establishment of rapport which helps ease the relatives' difficulty in seeking needed information since the initial phase of the situation. Nurses can also use such information to properly plan for nursing care and assistance to be provided to them

2. The study findings indicated that the most stressful situation as perceived by relatives of critically ill patients is the perceived severity of the patients' condition. Thus, nurses should help relatives to have accurate and realistic appraisal to reduce the feeling of uncertainty of the situation. This can be done by giving information about symptoms and treatment plans of the patients and by coordinating between relatives

and doctors so that relatives can search for information from the doctors that can help ease the difficulty of information search. Wanichapichat found that one of the obstacles for the adaptation of relatives of critically ill patients in the ICU was inconvenience in searching for information about the symptoms of the patients.

3. Nurses should promote maintenance of health and energy level among relatives of critically ill patients. For instance, they can help them perform self-care regarding food consumption, rest and relaxation, and stress reduction. Nurses can help relatives of critically ill patients find ways to reduce anxiety and worry as well.

Based on the theory of Stress, Appraisal, and Coping proposed by Lazarus and Folkman (1984) and an extensive review of literature on stress situations and needs of family members of critically ill patients in the ICU, the researcher developed a nursing intervention to satisfy the needs and to provide assistance to relatives of critically ill patients to cope with stress. Put another way, the Coping Promotion Program developed by the researcher was constructed based on the following concepts:

Concept 1: Establishment of relationship between nurses and families

A good relationship between nurses and families make family members who are the patient's relatives feel that they are accepted and that they are not an unwanted part in the provision of care. Nurses' enthusiasm to help and respond to the needs of relatives of critically ill patients makes them understand that they are part of the treatment plan offered to the patients and the help provided to them does not cause difficulty or burden to nurses. Moreover, offering help to the relatives of critically ill patients before they ask for it and giving help regularly help establish a more trusting relationship (Daley, 1984: 231-237). This can reduce stress and anxiety of relatives of critically ill patients and enable them to better understand nursing potentials and attitudes.

Concept 2: Assessment of perception and decision of relatives of critically ill patients

Nurses should observe and assess the reactions and coping strategies selected by each of the relatives of critically ill patients to more appropriately and effectively provide nursing assistance. However, nurses should always keep in mind that relatives of critically ill patients tend to be open for assistance, and their strengths or weaknesses depend on the assistance they receive. In addition, they tend to make use

of previous experiences or familiar methods to cope with stress even though they may not have been successful in the past. One way to help them more effectively cope with stress and a critical condition is to make them develop thorough understanding (Hudak et al., 1998: 21-29).

Concept 3: Assistance in coping

During the first days after the patients' admission into the ICU when the level of stress and anxiety is very high, the ability of relatives to perceive or to concentrate will greatly be reduced. Nursing care provided in the first 24 hours should assess the level of responses of the families and promote realistic and accurate perception. The information provided to them should be important and not too overwhelming. In other words, only important information about the symptoms, treatment, and safety of the patients should be offered, and families should be given the opportunity to vent their feelings and emotions as much as they want. Nurses should also help them search for available resources and respond to their needs (Huckabay & Tilem-Kessler, 1999: 36-42). Even though some relatives of critically ill patients may not be familiar with the environment in the ICU, they should have a chance to see the patients in the ICU as soon as possible to reduce their anxiety about the patients' conditions. Thus, nurses should give them advice or explanation about the environment in the ICU (Pikul Tantitham, B.E.2533). After that, nurses can give further information or answer questions the relatives of critically ill patients may have. Nurses should offer other useful information to relatives of critically ill patients later on when they are more ready including assistance with stress coping.

Concept 4: Assessment of Coping Resources

According to Hodovanic et al. (1984: 243-249), the contact between nurses and families since the beginning can reduce some stresses and anxieties of the families. Furthermore, after the patients are admitted toto the ICU, assessment of the families enables nurses to receive information necessary for the nursing care plan. Also, the assessment of the family structure will help nurses make specific intervention plans for each of the families (Hartshorn et al., 1993: 14-19). For example, nurses can observe which relative has the authority to make decisions or coordinate among family members. They should also assess values, goals, and expectations of the families, as well as their relationships to help them determine

resources and stress coping strategies most suitable to the situation they are encountering.

Concept 5: Responses to needs of relatives of critically ill patients

The researcher adapted the categorization of needs of the CCFNI, which divides needs into five categories as follows (Hickey, 1996: 65-73; Leske, 1991: 236-244; Titler et al., 1995: 376):

1. Assurance needs are relatives' need for the assurance that the patients are under the best care possible by the healthcare team, including hopefulness about the symptoms and prognosis of the patients. According to Motler (1979, as cited in Lopez-Fagin, 1995: 21-25), the needs for hope and information about the symptoms of the patients are very important. The relatives need to be confident that the patients are well taken care of. During hospitalization in the ICU, relatives do not have a chance to provide care to the patients as much as they want, and the caring responsibility is turned to doctors, nurses, and healthcare team members who are like strangers to them. During the critical period, the need of relatives regarding hope about the condition and safety of the patients is very high (Freichels, 1991: 16-29). Thus, nurses need to help them develop hope, which is realistic and possible. Responses to such needs are in the form of reassurance of the potential and ability of the healthcare team to take care of the patients to make relatives understand the expertise of staff, the nature of work with close care, and the speed of provision of care. Nurses should also let relatives know their attitudes and acceptance of the patients as individuals with integrity and rights.

2. Informational needs refer to the needs to receive different information about the patients including symptoms, procedures, and treatment outcomes, as well as about the medical team members who provide care and from whom information could be sought. The information the relatives need has to be realistic, accurate, and current (Hickey, 1990: 401-415), which can reduce anxiety and stress of relatives of critically ill patients (Leske, 1991: 236-244). The information during the first phase should be short, concise, straight to the point, and easy to understand, and it should not be so overwhelming that it causes confusion to the relatives. However, the need for information may remain even if the condition of the patients has become stable (Freichels, 1991: 16-29). Other information to be given at a

later occasion should wait until the relatives are more ready to accept it (Huckabay & Tilem-Kessler, 1999: 36-42). The information provided should be clear, concise, and easy to understand, with avoidance of technical terms that may be beyond the relatives' comprehension. Written information is another option, which can be employed to give information about rules and regulations, which can be reviewed by the relatives when they are confused, or forget it.

3. Proximity needs refer to the need to be close to the patients, especially when the condition is severe and unstable (Hickey, 1990: 401-405). In addition, seeing the patients with their own eyes make relatives feel more comfortable than receiving only information about the patients from others. Also, seeing the patients may make it easier for relatives to accept their conditions and to have accurate perception of the conditions. Being close to the patients enables families to give care to the patients as much as possible, and this responds to their needs for caregiving and reduces their feeling of helplessness and worthlessness while increasing their sense of empowerment and control of the situation. Finally, having a relative close by helps create a familiar atmosphere to the patients, hence a reduction in fear and a rise in morale to endure the sufferings and pains caused by the illness.

4. Support needs refer to the need to have someone who can accompany the relatives to provide spiritual support and to listen to their ventilation. During the critical condition, relatives are concerned and anxious about the patients' symptoms and safety. They tend to overlook their own needs even though they themselves need to be emotionally taken care of as well. The relatives of critically ill patients tend to believe that healthcare team members should devote all their time and attention to the patients and that they have no responsibility to care for relatives of the patients (Kleinpell & Powers, 1992, as cited in Hickey, 1996: 71). However, during the time of sufferings, individuals are more open for the assistance from others. Providing assistance to respond to personal needs of relatives during the initial phase when the families are more concerned with the patients rather than themselves, therefore, should be taken into serious consideration by nurses (Freichels, 1991: 16-29). Apart from giving assistance and responding to their needs, nurses should provide them with the opportunity to vent their feelings or ask for advice. The responses to

support needs promote relatives' emotional well-being and coping mechanisms until the critical condition has improved (Leske, 1991: 236-244).

5. Comfort needs refer to the needs for convenience and facilities including acceptance from the staff and the easy feeling to leave the hospital with the confidence that the situation would remain the same and nothing serious would happen to the patients during the absence. Even though comfort needs are not the needs that receive priority, relatives still have comfort needs including waiting rooms, cafeterias, toilets, and telephones, which can help reduce their fatigue and exhaustion and increase their ability to withstand stress (Molter, 1979, as cited in Lopez-Fagin, 1995: 21-25). Responses to comfort needs can reduce the likelihood of crises in the families.

In short, family members who are the relatives of critically ill patients are important resources, which offer encouragement and moral support and promote recovery and rehabilitation of the patients. When family members are unable to effectively cope with stress, the family balance as well as the patients will be affected. Providing assistance to family members, therefore, enables them to cope with the situation and continue their family responsibilities to maintain their well-being. Thus, the family will not lose balance or face with a crisis. As nurses are healthcare team members who are close to both the patients and the family members of the patients, including family members in the nursing care plan can help them better cope with the stressful situation, adjust themselves to stress, maintain their well-being in life, and sustain family balance. As a result, family members are enabled to continue to be a helpful resource necessary for successful recovery of the patients.

Satisfaction with Nursing Care of Relatives of the Patients Admitted to the ICU

In developing nursing care for clients, satisfaction of clients is an important criterion used to evaluate the nursing care outcomes to reflect the quality of the services in addition to use of mortality and morbidity (Greeneich, 1993: 65; Mahon, 1996: 1243; Munro et al., 1994: 119), especially when a new nursing care plan is developed or created. Satisfaction with nursing care is defined as the equal levels of expectation of nursing care and the actual nursing care received. The level of expectation of individuals depends on the individuals' consideration of the situation

and their perception of their own needs (La Monica et al., 1986: 43-50). The level of satisfaction results from the congruence between the expectation and the actual nursing care the patients and families receive (Obserst, 1984: 2367). Similarly, Eriksen (1995: 61) defines clients' satisfaction with services as the outcomes of the responses provided by nurses. In short, the overall definition of satisfaction with nursing care refers to clients' feelings and perceptions of the nursing care they receive which responds to their needs or the expectation of the nursing care they have. It reflects a feeling of reception of quality and effective care which results in positive assessment of the nursing care outcome.

Erikson (1987: 31-37) studied the relationship between quality of nursing care and satisfaction with nursing care. The findings showed that nursing care which caused dissatisfaction involved nursing care which did not take the patients' problems and needs into account, which too strictly adhered to rules and regulations, and which made the patients feel that they were dependent on others. When the reports on dissatisfaction with nursing care were analyzed, it was found that nurses should increase their interest in and pay more attention to gestures and expressions of the patients. This is because the provision of care with strict adherence to standards and policies without taking individuality and individual needs into consideration could easily cause dissatisfaction with the nursing care.

Naylor (1991: 210-214) points out that the factors, which are related to satisfaction, include attitudes, expectations, economic status, and nursing care outcomes. However, the increase in the level of satisfaction is associated with specific qualifications and characteristics of nurses such as communication skills, compassion, understanding, and nursing techniques. It has been reported that using primary nurses results in a higher level of satisfaction with nursing care than other systems.

In 1992, Greeneich et al. (1993: 64) constructed a theoretic model of patient satisfaction specific to nursing and defined satisfaction with nursing care as a result of a perfect balance between expectation of nursing care and actual nursing care received. The consideration is divided into three tracts: nurses, patients, and organizations. The nurse tract involves inherent personality, nursing care characteristic, and proficiency, while the patient aspect is composed of expectation. Finally, the organization aspect consists of the nursing milieu including the nursing

environment and service policies such as cleanliness, quiet environment, and visitation regulations.

Provision of nursing care, therefore, should be developed under the needs of clients. Even though the basic needs of human beings are generally similar, under different or critical circumstances, which reduce their ability to acquire or respond to their needs, individuals may not be able to satisfy all the needs they have. Individuality also makes individuals under the same situation have different levels of needs including expectation of nursing care. Under different cultures, beliefs, and values, provision of nursing care has to include assessment of expectation and needs of individuals in such situations as well.

At present, nursing care covers the care given to family members or relatives of the patients. Nursing care has been developed to include care and assistance provided to family members of the patients who are clients or customers together with the care provided to the patients. Thus, family members' satisfaction with nursing care reflects the quality of nursing care as well. The patterns of nursing care have been developed to offer care to families of the patients in different aspects, and the quality of such nursing care is assessed based on the clients' satisfaction with the nursing care.

Chavalee Yamvong (B.E.2538) examined the effects of the implementation of a nursing care developed based on Orem's theory on satisfaction with nursing care of patients and relatives. The subjects were 60 pairs of patients and relatives. The 30 pairs in the control group received only usual nursing care, while the other 30 pairs in the experimental group received the nursing care developed based on Orem's theory. The nursing care, which was provided based on Orem's theory, included collaborative establishment of relationships with a mutual agreement to assess the problems and needs for care, planning and provision of nursing care, and mutual assessment of the nursing care outcomes. Nurses' ability to provide care to both the patients and their families was developed and promoted to completely serve the needs for care. The study findings revealed that the level of satisfaction with nursing care of the patients and relatives in the experiment group was higher than that of the subjects in the control group with statistical significance.

Phongphanngam (2003) investigated the effects of a home-based management intervention program for family caregivers of elderly undergoing hip artroplasty on

caregivers' adaptation and satisfaction. The total number of subjects was 54 pairs, with 27 pairs in each of the control and experimental groups. In the study, the control subjects received usual nursing care, whereas the experimental subjects received usual nursing care together with the program developed by the researcher. According to the findings, the mean score of satisfaction with nursing care of families of the patients in the experimental group was higher than that of the subjects in the control group with statistical significance.

Panprasert (2004) carried out a study to determine the effects of informational and emotional support on the anxiety and satisfaction of accidental patients' relatives during the waiting period at the accident and emergency department. There were 30 subjects in the experimental group and 30 in the control group. The findings showed that after the experiment the mean score of satisfaction with nursing care of the subjects in the experimental group who received usual nursing care together with nursing intervention to provide informational and emotional support was higher than that of the control subjects who received only usual nursing care.

Studies of the nursing intervention, which was developed to offer assistance and respond to the needs of families of the patients in different contexts, involved the assessment of satisfaction with nursing care to assess the families' attitudes toward the newly developed nursing intervention. In the present study, the researcher developed a stress coping program to provide nursing care to relatives to determine their satisfaction with the nursing care they received. The responses to the needs or expectations of relatives were also investigated, as they constituted a criterion that could effectively be used to assess the quality of nursing care.

In conclusion, when patients are admitted to the ICU, the family members who are their relatives have to live with stress and other impacts of the unexpected situation. They have to adapt themselves to cope with stress, while they develop the needs in other aspects. Thus, nursing care, which enables relatives to cope with stress and responds to their needs, will help them effectively live and deal with the situation. It is considered a provision of comprehensive nursing care under membership of the family, resulting in satisfaction with nursing care of relatives. In the present study, the researcher has developed a nursing intervention to help relatives of critically ill patients cope with stress, with nurses becoming a stress coping resource for relatives

of the patients. This is because nurses are the healthcare team members who are closest to the patients, and they are able to offer assistance to the patients and their relatives in many aspects as well as to respond to the needs that have arisen. In short, nurses are able to help not only the patients, but also the families to effectively cope with stress and adapt themselves to maintain well-being and to promote satisfaction with the nursing care.

CHAPTER III
MATERIALS AND METHODS

The present study was quasi-experimental research design, which employed the one-group pretest posttest design to investigate the effect of a Coping Promotion Program on well-being of relatives of the patients who were admitted to the ICU. Also, satisfaction with nursing care of the relatives of the patients was evaluated. The conceptual framework of the study was based on the Stress, Appraisal, and Coping Theory of Lazarus and Folkman (1984). This chapter discusses the research methodology used in the study.

Population and Sampling

The population of the study was relatives of critical patients who were admitted to the intensive care unit (ICU). Purposive sampling was used to recruit the subjects at the Medical Department, Faculty of Medicine, Ramathibodi Hospital from June to December 2005. One subject was selected by the researcher from each patient's family according to the inclusion criteria.

The inclusion criteria to select the patient's relative were as follows:

1. Being a family member of a critical patient admitted to the ICU. The relative could be one who was related to the patient by blood such as father, mother, children, or siblings, or one who was related to the patient by law such as a spouse, adoptive father, adoptive mother, or adopted child. The relative in this study had a close relationship with the patient who was the main caregiver, able to make a decision on behalf of the patient and/or responsible for the medical expenses incurred due to the patients' hospitalization. A paid caregiver was not regarded as a relative;

2. Being a family member who visited the patient at least once within 48 hours right after the patient was admitted to the ICU; and

3. Being 18 years old or older who was able to communicate in Thai, and had no seeing, hearing, or speaking impairments.

The exclusion criteria were as follows:

1. Being a family member of the patient who died or was discharged from the ICU before 96 hours (four days) after the admission to the ICU; and
2. One who needed to quit from the study.

Sample Size

The sample size was calculated using Cohen's (1988) power analysis table with a power of .80, an alpha of .05, and a medium effect size of 0.5. The sample size estimated was at least 50. In this study, data collection had been conducted for six months, from June to December 2005. Fifty subjects agreed to participate in the study; however, 20 subjects were excluded according to the exclusion criteria. Because of the time limited in this study, the number of recruited subjects was 30. According to Polit and Hungler (1999), at least 20 to 30 subjects are acceptable in an experimental study.

Setting

The research setting was a medical intensive care unit at Ramathibodi Hospital. The criteria for admission to this ICU were: 1) being critical patients who are 15 years old or older; and 2) having a severe respiratory failure or shock that requires intensive care for 24 hours a day. There were eight beds in the ICU, and the nurses work in shifts. There were three shifts a day; each lasted eight hours. There were about six or seven nurses and one nurse aid working in each shift. Each nurse was responsible for one to two patients depending on the severity of their conditions. There were also a head nurse and a nurse supervisor who served as nursing consultants. During office hours, resident physicians (those in the training program of specialty in internal medicine) provided treatment to the patients, while the fellow physicians (those training in the training program of subspecialty in medicine) and professors served as advisors and consultants. After office hours, the on-duty resident physician was responsible for the treatment of the patients.

As for the environment inside the ICU, there were single rooms with glass walls for each patient. There was a chair for the visitors in each room beside the patient's bed. When the patients were first admitted into the ICU, the physicians and nurses would performed physical examinations and gave immediate treatment as necessary.

During that time, the relatives had to wait nearby. One nurse would ask the relatives about the patient's demographic characteristics, illness history, and medical reimbursement scheme, as well as the relative's accessible phone number. After the physicians and nurses had completed initial treatment of the patients, the relatives would then be allowed to visit the patients. Visiting hours were divided into two periods: from 11:00 a.m. to 1:00 p.m. and 3:00 p.m. to 8:00 p.m. Only two visitors were allowed each time, and each visit should last no longer than ten minutes. Children under the age of 12 were not allowed at all in the ICU. The relatives might ask for information about the patients from the nurses who provided care in each shift or from the physicians. There was no toilet for the relatives in the ICU, and there was no waiting room inside. There was only a bench on the corridor outside the ICU where relatives could wait to visit the patients. There were altogether three ICUs on this floor, with one public telephone on the front of the ICU.

Research Instruments

The research instruments used in the present study could be divided into two parts:

1. **Instruments for intervention** consisted of the Coping Promotion Program for relatives of the patients who were admitted to in the ICU and a booklet for relatives of the patients who were admitted to the ICU entitled, "When the patient has to be in the ICU." Each instrument is described below.

1.1 **The Coping Promotion Program** was developed by the researcher based on the Stress, Appraisal, and Coping Theory proposed by Lazarus and Folkman (1984) together with an extensive review of literature on needs of relatives of the patients who were admitted to the ICU. The program consisted of nursing care, which could be further divided into three forms: 1) an establishment of relationship; 2) assessment of stress responses, stress coping skills, and needs of relatives; and 3) provision of nursing care to promote healthy coping with stress and to appropriately respond to needs of individual family members.

Validation of the Instrument

The Coping Promotion Program was examined to ensure content validity by a panel of three experts in critical nursing including one nursing instructor who was a

specialist in critical patients, one professional nurse who was specialized in critical patients, and one nurse who was the head of the ICU ward (see Appendix D). The instrument was revised and improved according to the experts' comments and suggestions before it was tried out with a group of three subjects who shared similar characteristics with the subjects of the main study.

The Coping Promotion Program was characterized as follows:

1 The nursing care was divided into three steps—Nursing Care Step 1, Nursing Care Step 2, and Nursing Care Step 3 (see Appendix B); each was selected based on the duration of the patients' stay in the ICU together with the assessment of symptoms of the patients and the needs of the relatives.

2. The duration of each step of nursing care provided varied depending on the patient's symptoms and the response of each relative.

3. The provision of nursing care could be divided as follows:

Nursing Care Step 1

This step of nursing care was provided within 24 hours after the patients were admitted to the ICU or when the nurses met the relatives at the first time. It consisted of three concepts: 1) an establishment of relationship, 2) assessment of stress responses, stress coping skills, and needs of family members, and 3) provision of nursing care to promote healthy coping and to appropriately respond to needs of individual relatives.

The nursing care provided began with an establishment of the relationship between nurses and relatives to elicit information regarding their responses to the situations and to assist relatives who tended to have a high level of stress and anxiety during the first phase of the hospitalization in the ICU. This type of nursing care was provided once when the nurse met the relatives at the first time.

Nursing Care Step 2

The nursing care was provided within the first 48 hours after the hospitalization in the ICU and after the relatives had received the nursing care in step 1 above. The nursing care was composed of four concepts—1) nursing care to maintain the relationship between the nurse and the family members, 2) assessment of perception and decision making of family members, 3) assessment of resources of

family members, and 4) promotion of healthy coping with stress. As regards the nature of the nursing care in this step, the nurse attempted to maintain the relationship with the relatives, assess their decision-making skills, and collect more data regarding their response strategies to the situation and the resources available for them. The nursing care also promoted hopefulness and responded to the relatives' needs to reduce their stress.

Nursing Care Step 3

The nursing care in this step was provided after the first 48 hours. The nursing care in this step was more complicated than those provided in the first two steps. It was better to let the relatives passed the most stressful time during the first 24–48 hours after the admission to the ICU. The nursing care in this step consisted of five concepts—1) maintenance of the relationship between nurse and relatives, 2) assessment of perception and decision making of relatives, 3) assessment of resources of relatives, 4) promotion of stress coping, and 5) preparation for the patients' discharge from the ICU.

The nature of the nursing care in this step was similar to that provided in Step 2. Moreover, nursing care to promote stress coping skills was given as well as the preparation to discharge the patients from the ICU (only in the cases that was planned or scheduled for discharge from the ICU). After that, the nursing care in this step would be continuously provided to develop relatives' ability and skills to cope with stress, as once should not be enough to ensure that the relatives would be able to memorize everything that they needed. Also, doubts that they might have were clarified.

4. The relatives should receive the nursing care as specified in the program, but the sequence may vary depending on the reactions or characteristics of the relatives as well as their ability to cope with stress and surrounding situations.

5. When the nurse was providing nursing care, if the relatives were highly stressed or lacked readiness to receive the planned nursing care as specified in the program, the care would be stopped and more appropriate nursing care would be offered instead. For instance, if the relatives had to make immediate decisions regarding the treatment of the patients, they should be helped with the decision-

making skills included in Step 3 even though they were still receiving Step 1 or Step 2 of the nursing care program.

1.2. **An ICU Booklet**

An ICU booklet (see Appendix B) was developed by the researcher based on the Stress, Appraisal, and Coping Theory of Lazarus and Folkman (1984) and a review of literature on needs of relatives of the patients in the ICU. The booklet contained information regarding the medical instruments used and the atmosphere in the ICU, characteristics of the critical patients in the ICU, rules, and advice for visiting the critical patients in the ICU, and available facilities in the hospital. The aim of the booklet was to provide important information that the family members could go over when they were less stressed and more ready to receive information.

Validation of the Instrument

The booklet was examined to ensure content validity by a panel of three experts in critical nursing including one nursing instructor who was a specialist in critical patients, one professional nurse who was specialized in critical patients, and one nurse who was the head of the ICU ward (see Appendix D). The instrument was revised and improved according to the experts' suggestions before it was tried out with a group of three subjects who shared similar characteristics with the subjects of the main study.

2. Instruments for data collection

2.1. **The Demographic Characteristic Questionnaire** (see Appendix C) consisted of two parts. The first part elicited information regarding the demographic characteristics of the subjects, including gender, age, chronic illness, history of hospitalization, history of admission to the ICU, diagnoses, level of consciousness, severity of the illness assessed with the APACHE II (Acute Physiologic and Chronic Health Evaluation version II) (see Appendix C) scores, medication used to stimulate heart rates and blood pressure, medical equipment used, and length of stay in the ICU. The second part elicited information regarding demographic characteristics of the relatives consisting of gender, age, religion, marital status, educational background,

occupation, income, relationship with the patients, experience with family members or close persons being treated in the ICU, and payment of medical treatments.

2.2. **The General Well-Being Schedule** (see Appendix C) was used to assess perceived well-being of relatives of the patients admitted to the ICU in this study. This instrument was developed by Dupuy (1977 as cited in McDowell, & Newell, 1996: 206-213) and was subsequently translated into Thai by Somchit Hanucharurnkul et al. (B.E.2532). This instrument consisted of 18 items, which were used to evaluate individuals' general well-being in six aspects as follows: 1. anxiety (4 items); 2. depression (3 items); 3. positive well-being (3 items); 4. self-control (3 items); 5. general health (2 items); and 6. vitality (3 items).

This instrument was a self-administered questionnaire, which consisted of two parts. In the first part, there were seven positive items and seven negative items, which were arranged in a six-point Likert scale ranging from 0 to 5 points. The second part was composed of four items: two positive items and two negative items arranged in a linear analog scale ranging from 0 to 10 points. As for the negative items, the scores would be reversed before the total scores of general well-being were summed up. The total scores ranged from 0 to 110, with higher scores indicating a higher level of general well-being as follows: the score of 0–60 meant severe distress; the score of 61–72 meant moderate distress; and the score of 73–110 meant positive well-being.

Validation of the Instrument

1.) As for validity, Dupuy (1977 as cited in McDowell, & Newell, 1996: 206-213) developed this instrument from the U.S. Health and Nutrition Examination Survey (HANES), which consisted of 68 items. Only 18 items were selected by Dupuy as they directly assessed general well-being. Factor analysis indicated that they elicited information regarding general well-being in three aspects and distress in three aspects. Edwards (1979) used the known-group technique to determine the construct validity of the instrument with a group of patients with mental health problems who sought treatment at a hospital on a daily basis and those who were normal. The result showed that the scores of the patients with mental health problems were lower than those of normal people.

2.) With regard to its reliability, Fazio (1977) tried out the instrument with 195 university students, whereas Edwards et al. (1979) used it with students in 98

universities. The alpha coefficients were .85 and .86, respectively. In addition, Monk (1981) used the test-retest method with two groups of subjects. The alpha coefficients were .68 and .85, respectively.

In Thailand, Somchit Hanucharurnkul et al. (B.E. 2532) translated the original instrument into the Thai language. A number of researchers then used this instrument with different groups of subjects. For example, Somchit Hanucharurnkul et al. (B.E. 2532) conducted a study with 30 nursing staffs of Ramathibodi Hospital. The alpha coefficient was .92. Moreover, (Sakul Kongpan , B.E.2533) used this instrument with 10 pilot mothers who had infants, toddlers, or preschoolers who were treated in the pediatric ward of Ramathibodi Hospital, and the alpha coefficient was .88. When the instrument was later used with 70 subjects of a main study, the alpha coefficient was .87. Also, Vimonwan Vloran (B.E. 2535). tried out the instrument with 20 pilot subjects who were parents whose children were treated in the special pediatric unit. The alpha coefficient was .95. When the instrument was subsequently used with 80 subjects of the main study, the alpha coefficient was .92. Finally, Wipawan Cha-um (B.E. 2536) used the instrument with 20 pilot subjects and 100 main subjects. The alpha coefficients were equal to .90 and .88, respectively.

In the present study, the researcher tried out the Thai version of the questionnaire with 16 family members of the critical patients in the ICU who shared similar characteristics with the subjects of the main study. After that, the questionnaire was used with 30 subjects of the main study. Cronbach's alpha Correlation Coefficients were equal to .91 and .92, respectively.

2.3. **The Relative Satisfaction Scale** (see Appendix C) was used to assess satisfaction with nursing care of relatives of the patients admitted to the ICU in this study. This instrument was adapted from the version of Rumphrada Intorn (B.E. 2539) using in relatives of patients, which was revised for language appropriateness by Chavalee Yamvong (B.E. 2538) to use in relatives of older patients. Munro et al. (1994: 119-125) adapted the instrument first developed to assess satisfaction of the hospitalized patients by La Monica et al. (1986); which was called as 'the La Monica-Oberst Patient Satisfaction Scale (LOPSS).' The questionnaire consisted of two dimensions: 1) Dissatisfaction and 2) Good Impression and Interpersonal Support,

with 14 items for each dimension, thereby, 28 items in total. This questionnaire was arranged in a five-point Likert scale: 1 = strongly disagree, 2 = disagree, 3 = undecided, 4 = agree, and 5 = strongly agree. The scores for negative items were reversed before they were summed up. The total scores ranged from 28 to 140, with higher scores indicating a higher level of satisfaction. However, the cut-off scores were not provided by Munro et al. (1994) to categorize the level of satisfaction.

Validation of the Instrument

Firstly, La Monica et al. (1986) developed the instrument to assess the hospitalized patients' satisfaction. Content validity was examined by a panel of nursing experts and studied in 75 hospitalized cancer patients. The instrument was then tried out with 100 hospitalized cancer patients, and the alpha correlation coefficient for the entire scale was .92. This version of the instrument consisted of 41 items, which were further divided into three aspects: 1) Dissatisfaction; 2) Interpersonal Support; and 3) Good Impression. There were 17 negative items on Dissatisfaction and 24 positive items on Interpersonal Support (13 items) and Good Impression (11 items). The items were arranged in a five-point Likert scale (La Monica et al., 1986: 45-49). After that, Munro et al. (1994) tried out the instrument with three groups of nononcologic patients: 120 women with unplanned cesarean birth, 78 childbearing diabetics, and 109 women post-nononcologic hysterectomy surgery. Cronbach's alpha correlation coefficient was .98 for the entire scale of the original 41 items. Then, the relationships between the items and total scores were analyzed and then, 13 items with low item-total correlations were deleted. The results of a factor analysis revealed two dimensions with 28 remaining items: 1) Dissatisfaction; and 2) Impression and Interpersonal Support, with 14 items in each dimension. The alpha correlation coefficient for the 28-items LOPSS was .97 (Munro et al., 1994: 119-125).

In Thailand, Vinya-Nguag, (1989). translated the La Monica-Oberst Patient Satisfaction Scale (LOPSS) into Thai. It was then tried out with 40 patients with kidney stones. Its alpha correlation coefficient was equal to .89. After that, Pornchan Pongprom (B.E. 2534) used this instrument with 66 patients with abdominal surgery, and the alpha correlation coefficient was equal to .94. Furthermore, Orachorn

Malahom (B.E. 2534) used this instrument with 48 patients with a surgery to remove kidney stones and found that its alpha correlation coefficient was equal to .92.

Tassanee Arnantapunpong (B.E. 2538) adapted the instrument and tried out with 10 family members of elderly patients in the pilot study and 60 subjects of the main study. The alpha correlation coefficient was equal to .95 and .96, respectively. Later on, Rumrada Intorn (B.E.2539) revised the instrument to ensure language appropriateness and reduced the number of items from 41 to 33, with 19 positive items and 14 negative items. The instrument was then examined for content validity by a panel of three nursing experts before it was used with 30 pilot subjects and 25 main subjects who were family members of patients with head injury. The alpha correlation coefficients were equal to .92 and .89, respectively. In addition, Chavalee Yamvong (B.E. 2539) adapted the original version of Munro et al. (1994) and the revised version of Rumphrada Intorn by adjusting the language used in some of the items. Then, the instrument was examined by a panel of five nursing instructors to ensure content validity before it was tried out with 12 pilot subjects and used with 60 subjects who were family members of elderly patients. The alpha correlation coefficients were equal to .91 and .92, respectively. Finally, Phongphanngam (2003) used this instrument with five caregivers of elderly patients undergoing hip arthroplasty in the pilot study and with 54 subjects in the main study. The Cronbach's alpha correlation coefficients were equal to .78 and .96, respectively.

In the present study, the researcher tried out the instrument with 16 relatives of critical patients in the ICU who shared similar characteristics with the subjects of the main study. Cronbach's alpha correlation coefficient was .95. When the questionnaire was used with 30 subjects of the main study, Cronbach's alpha correlation coefficient was .88.

Data Collection

Preparation of Research Assistant

In this study, a research assistant conducted the data collection. The research assistant was a professional nurse who did not work in the ICU. The reason of having a research assistant was to prevent the bias that might result from the fact that the researcher was the person who provided the Coping Promotion Program to the

relatives of the critical patients in the ICU. The researcher explained the research objectives, conceptual framework of the research, data collection methods, and data collection instruments to the research assistant. The research assistant practiced using the General Well-Being Schedule and the Relative Satisfaction Scale with five relatives of the patients before actually collecting data in the main study.

Protection of the Rights of Human Subjects

Before the data collection took place, approval was granted by the Committee on Human Rights Related to Human Experimentations of the Faculty of Medicine, Ramathibodi Hospital (see Appendix A). Before the data collection was conducted, the researcher met the relatives of the critical patients in the ICU who met the inclusion criteria previously set. The researcher introduced herself and explained the research objectives, data collection procedures, and expected benefits on the patients and their relatives. The researcher informed the potential subjects that they had the right to withdraw from the study at anytime with no negative effects on the treatment and care of the patients that they would receive. They were also assured that data collected from them would be kept strictly confidential and reported only as group data. If the subjects agreed to participate in the study, they were asked to sign the informed consent form (see Appendix A)..

Data Collection Procedures

1. The introductory letter was sent from the Graduate School, Mahidol University, to the Dean of the Faculty of Medicine, Ramathibodi Hospital, and the Director of Ramathibodi Hospital to explain the objectives and benefits of the research and to ask for cooperation in data collection. After the permission was granted (see Appendix A), the researcher introduced the plan of the study to the head of the Medical Nursing Division and the head of the ICU to explain the data collection process and to ask permission to collect data.

2. After permission to collect data was granted, the data collection conducted.

3. Everyday from 8:00 a.m. to 4:00 p.m., the researcher surveyed the name list of the patients and the records of admission of the patients into the ICU to select the

patients who had been treated in the ICU for less than 24 hours and compiled the name list of possible subjects.

4. The relatives of the patients whose names were recorded were contacted. On the first day of the data collection, the researcher introduced herself to the relatives, explained the research objectives to them, and asked for their participation in data collection. In addition, the researcher explained the protection of human rights to them. After the relatives agreed to take part in the study, they signed an informed consent form. Their names were recorded together with the patients' names and kept confidential.

5. Data collection began when the patients had been treated in the ICU for at least 24 hours, and the subjects had visited the patients at least once. This was to enable the subjects to experience the situation and the atmosphere in the ICU and to have enough information to fill out the general well-being schedule. The data collection procedure was done by the research assistant in a room of the critical medicine ward for privacy and quietness.

6. The research assistant collected data by distributing the questionnaires before the intervention, which had already been coded. The questionnaires consisted of the Demographic Characteristic Questionnaire and the General Well-Being Schedule. The research assistant distributed a pen and gave the subjects the opportunity to ask questions if they did not understand the procedure. The subjects had 15 to 20 minutes to complete the questionnaire, and the research assistant checked the questionnaires for completeness. If the subjects did not understand the questionnaire items, the research assistant clarified them. It is worth noting here that the researcher scheduled the time with the research assistant so that the researcher could proceed with the intervention after the subjects had completed the questionnaires.

7. During the experiment, all subjects received usual nursing care and an additional nursing intervention based on the Coping Promotion Program given by the researcher for three days. After the critical patients had been treated in the ICU for 96 hours and after the subjects had received the nursing intervention from the researcher for four times, the research assistant collected data before the patients were discharged from the ICU. The questionnaires consisted of the General Well-Being Schedule and the Relative Satisfaction Scale. If the patients were not discharged from the ICU after

the data collection procedure was completed, the researcher would continue providing nursing care to their relatives as seen appropriate.

The usual nursing care provided to the relative was characterized as follows:

When the patients were treated in the ICU, physicians and nurses would provide treatment to them. One nurse would elicit personal history of the patients and the data regarding health status according to functional health pattern. Information regarding methods of payment and contact information including a telephone number of one relative of the patients was also elicited. In addition, the nurse would inform the relatives about visiting hours and personal belongings needed and ask them to bring valuables or unnecessary things home. If the condition of the patients was under control, the physician informs the relatives regarding the patient's symptoms and initial treatment. The relatives may be allowed to visit the patients in the ICU. Additionally, the relatives may ask for information regarding the patients' symptoms and treatment from the nurses working in each shift or the physician on duty. When an invasive procedure was necessary to be undergone to the patient, the relatives were explained and asked to sign a consent form stating their decision to accept or refuse such procedures in case that the patients were unconscious or in a confusional state.

Nursing interventions according to the Coping Promotion Program, in addition to the usual nursing care, was characterized as follows:

1. There were four nursing interventions starting after the patients had been treated in the ICU for 24 hours and before 96 hours. The duration of the nursing intervention was three days.
2. The characteristics of the nursing intervention were as follows:

The first nursing intervention started after the patients had received treatment in the ICU for 24 hours. Data collection before the intervention had to wait until after 24 hours in the ICU to make sure that the subjects had enough experience with the situation and got a chance to complete the General Well-Being Schedule. After that, the researcher began the Nursing Care Step 1 according to the program (see Appendix B).

The second nursing intervention was provided between the first 24 and 48 hours after the hospitalization in the ICU and after the subjects had received the first

nursing intervention. The second nursing intervention provided the Nursing Care Step 2 according to the program (see Appendix B).

The third nursing intervention was provided between the first 48 and 96 hours after the hospitalization in the ICU and after the subjects had received the second nursing intervention. The third nursing intervention provided the Nursing Care Step 3 according to the program (see Appendix B).

The fourth nursing intervention was provided between the first 48 and 96 hours after the hospitalization in the ICU and after the subjects had received the third nursing intervention. The fourth nursing intervention was the repetition of the third nursing intervention to ensure development of ability and skills to cope with stress as only the third nursing intervention might not be enough to develop the subjects' potential to cope with stress and the subjects may not be able to memorize all the necessary information or they may have questions which needed additional explanations (see Appendix B).

Remarks of the Intervention Program:

1. Two nursing interventions might be provided in one day depending how progressive of the response of the relative to the situation. For example, the first and second interventions might be provided between 24 and 48 hours after the patients had been admitted to the ICU. The third and fourth interventions was conducted between 48 and 96 hours, after the researcher made an appointment with the subjects by choosing the time that was most convenient for them or when they planned to visit the patients. If it was necessary to provide two nursing interventions in one day, the second intervention of the day would take apart at least four hours after the first intervention as seen convenient to the subjects. This is because some relatives stayed at the hospital all day waiting for visiting hours, while other may come to the hospital more than once a day.

2. The nursing intervention was conducted in an appropriate place such as the consulting room, the patient's room, or a waiting area outside the ICU. The researcher would choose a spot, which was far away from other relatives depending on a particular situation. However, greeting and talking when the researcher came across the subjects did not count as nursing intervention.

3. During data collection, the researcher might provide nursing intervention to more than one subject in one day. The researcher would inform the next subject and ask him or her to wait if possible. Otherwise, the researcher would make another appointment with him or her. The researcher also recorded the nursing intervention provided to each of the subjects to avoid confusion.

Data Analysis

After data collection was completed, the data were analyzed in the following procedures:

1. Data regarding demographic characteristics of the subjects and the patients were analyzed in terms of frequency distribution and percentage as follows:

1.1 Demographic characteristics of the patients consisted of gender, age, chronic illness, history of hospitalization, history of admission into the ICU, diagnoses, level of consciousness, the APACHE II scores, medications to stimulate heart rates and blood pressure, and medical equipments used.

1.2 Demographic characteristics of the subjects consisted of gender, age, religion, marital status, educational background, occupation, income, relationship with the patients, experience with family members or close persons being treated in the ICU, and payment of medical treatments.

2. The mean scores of well-being before and after receiving the Coping Promotion Program and the distribution of the scores of satisfaction with nursing care of relatives of critical patients in the ICU were examined to determine whether the distribution was normal using the Komogolov-Smirrnov Test.

3. The differences between the mean scores of overall general well-being and each aspect of general well-being before and after the Coping Promotion Program were compared using the paired t-test.

4. The overall score of satisfaction with nursing care was analyzed in terms of range, mean, standard deviation, and skewness.

CHAPTER IV
RESULTS

The present study aimed at investigating the effect of a Coping Promotion Program on well-being of relatives of the patients admitted to the intensive care unit (ICU) at Ramathibodi Hospital. In this chapter, the findings of the study are presented into three parts, as follows:

Part I: Demographic characteristics of the sample

1.1 Demographic characteristics of the relatives

1.2 Demographic characteristics of the patients

Part II: A comparison of well-being scores of relatives of the patients before and after receiving the Coping Promotion Program

Part III: Satisfaction with nursing care of the relatives of the patients admitted to the ICU

Part I: Demographic Characteristics of the Sample

1.1 Demographic Characteristics of the Relatives

Initially, the researcher approached 51 relatives of the patients admitted to the intensive care unit (ICU) to participate in this study. The data collection had been conducted for seven months from June to December 2005. However, only 30 subjects met the inclusion criteria in this study. The reasons why the potential subjects were excluded in the study were as follows: 1) 10 patients were dead; 2) 10 patients were admitted to the ICU shorter than 96 hours; and 3) one participant felt too stressed to participate in the study. Therefore, the sample consisted of 30 relatives of the patients admitted to the intensive care unit (ICU). The demographic characteristics of the subjects are illustrated in Table 1.

The analysis showed that most of the sample (83.3%) were female. Their mean age ranged from 22 to 70 years with a mean of 43.23 years (SD = 11.24). Almost all of them (93.3%) were Buddhists. Approximately, three-fourths (73.3%) were married. As

regards educational background, close to half of the subjects (43.3%) graduated with a Bachelor's degree or higher, and they worked as employees, traders, and government officers, respectively. A little more than half of the sample (53.3%) had sufficient income, but 20% of them did not earn enough income. However, almost all of them (90%) could reimburse the medical expenses of the patients. Three of the sample (10%) did not have any form of welfare, and they had to pay for the patients' medical expenses. Of these three subjects, one had to ask for assistance from the social welfare unit to pay for the medical expenses in installments. Moreover, with regard to the relationship with the patients, 43.3% of the sample were sons/daughters of the patients, whereas 36.7% were the patients' spouses. Finally, 76.7% of the sample refused having an experience with a family member admitted to the ICU.

Table 1: Demographic Characteristics of the Relatives of the Patients (N = 30)

Demographic Characteristics	Number	Percentage
Gender		
Female	25	83.3
Male	5	16.7
Age (years)		
18-40	12	40.0
41-60	16	53.3
> 60	2	6.7
Religion		
Buddhist	28	93.3
Christian	2	6.7
Marital status		
Married	22	73.3
Single	6	20.0
Widowed/Separated/Divorced	2	6.7

Table 1: Demographic Characteristics of the Relatives of the Patients (N = 30) (Cont.)

Demographic Characteristics	Number	Percentage
Level of education		
Elementary	8	26.7
Secondary school	4	13.3
High school	4	13.3
Certificate/Diploma	1	3.3
Bachelor's degree or higher	13	43.3
Occupation		
Employees	9	30.0
Traders	8	26.7
Government officers	7	23.3
Agriculturists	2	6.7
Other (retirees, housewives, students)	4	13.3
Income		
Sufficient with no saving	16	53.3
Sufficient with saving	8	26.7
Insufficient	6	20.0
Relationship with the patients		
Son/daughter	13	43.3
Spouse	11	36.7
Parents	4	13.3
Sibling	1	3.3
Other (aunt)	1	3.3
Having an experience with a family member admitted to the ICU		
Having	23	76.7
Not having	7	23.3

Table 1: Demographic Characteristics of the Relatives of the Patients (N = 30) (Cont.)

Demographic Characteristics	Number	Percentage
Payment for medical expenses		
Reimbursement from		
Workplace	18	60.0
Social security	7	23.3
30-Baht healthcare scheme	2	6.7
No reimbursement	3	10.0

1.2 Demographic Characteristics of the Patients

As regards the patients who were admitted to the ICU, close to three-fourths (73.3%) were male. Their ages ranged from 23 to 81 years, with a mean age of 53.03 years (SD = 19.23). Forty percent of the patients were older than 60 years. Furthermore, most of the patients (80%) had chronic illnesses. Of these, 26.7% had respiratory diseases, while another 26.7% had hematologic diseases, followed by diabetes mellitus, hypertension, ischemic heart disease, chronic kidney disease, and liver diseases at 13.3%. Besides, 80% of the patients had been admitted before, and 33.3% had previously been treated in the ICU. With regard to the severity of the illness measured by the Acute Physiologic and Chronic Health Evaluation (APACHE II), the scores ranged from 8 to 49 points out of 71, with a mean score of 26.13 (SD = 11.43). In addition, 66.6% of the patients were unconscious as some of them received sedatives, while others were comatose. Eighty percent of the patients were treated with inotropic drugs to increase their blood pressure, and 93.3% were intubated with an endotracheal tube and on a mechanical ventilator. Finally, 80% of them were in the shock state; 46.7% had respiratory failure; 20% had acute renal failure (see Table 2).

Table 2: Demographic characteristics of the patients (N = 30)

Demographic characteristics	Number	Percentage
Gender		
Male	22	73.3
Female	8	26.7
Age (years)		
15-40	9	30.0
41-60	9	30.0
> 60	12	40.0
Chronic illnesses*		
Not having	6	20.0
Having		
Chronic respiratory diseases	8	26.7
Hematologic diseases (leukemia, lymphoma)	8	26.7
Diabetes mellitus	4	13.3
Hypertension	4	13.3
Ischemic heart disease	4	13.3
Chronic kidney disease	4	13.3
Liver diseases	4	13.3
Mental retardation	1	3.3
Parkinson’s disease	1	3.3
History of hospitalization		
Yes	24	80.0
No	6	20.0
History of treatment in the ICU		
Yes	20	66.7
No	10	33.3

*One patient may have had more than one disease.

Table 2: Demographic characteristics of the patients (N = 30) (Cont.)

Demographic characteristics	Number	Percentage
Level of consciousness		
Unconscious (sedated, comatose)	20	66.6
Conscious—Alert	8	26.7
Conscious—Confused	2	6.7
Inotropic drug to increase blood pressure		
Receiving	24	80.0
Not receiving	6	20.0
Endotracheal intubation		
Yes	28	93.3
No	2	6.7
Mechanical ventilator use		
Yes	28	93.3
No	2	6.7
Medical diagnoses*		
Septic shock	24	80.0
Respiratory failure	14	46.7
Acute renal failure	6	20.0
Febrile neutropenia	3	10.0
Necrotizing Fasciitis	2	6.7
Symptomatic HIV	2	6.7
Cerebrovascular disease	1	3.3
Toxic epidermal necrolysis (TEN)	1	3.3
Status epilepticus	1	3.3
Leptospirosis	1	3.3

*One patient may have had more than one diagnosis.

Part II: A Comparison of Well-Being Scores of Relatives of the Patients Before and After Receiving the Coping Promotion Program

Table 3 showed the level of well-being scores of relatives of the patients admitted to the ICU. According to Dupuy (1977 as cited in McDowell & Newell, 1996:206-213), before receiving the Coping Promotion Program, 63.3% of the sample (n = 19) were categorized as severe distress; 20.0% (n = 6) were categorized as moderate distress, 16.7% (n = 5) were categorized as positive well-being. After receiving the Coping Promotion Program, 56.7% of the sample (n = 17) were categorized as severe distress; 23.3% (n = 7) were categorized as moderate distress; 20.0% (n = 6) were categorized as positive well-being.

Table 3: Well-Being Level Before and After Receiving the Coping Promotion Program (N = 30)

Well-Being Level	Before		After	
	Number	Percentage	Number	Percentage
Severe distress	19	63.3	17	56.7
Moderate distress	6	20.0	7	23.3
Positive well-being	5	16.7	6	20.0

To compare the mean well-being scores of relatives of patients admitted to the ICU before and after receiving the Coping Promotion Program, the paired t-test was used. The assumption of normality of differences between the before-and-after scores was tested. The non-significance ($p > .05$) was found, indicating the normal distribution of the differences of well-being scores. The results of comparison are illustrated in Table 4.

Hypothesis 1 stated, “The mean score of well-being of relatives of the patients admitted to the ICU after receiving the Coping Promotion Program higher than that before receiving the Coping Promotion Program.”

The findings revealed that the mean score of well-being of relatives of patients admitted to the ICU after receiving the Coping Promotion Program was higher than that before receiving the Coping Promotion Program, but no statistical significance (p > .05) was found, as shown in Table 4.

Table 4: A Comparison of the Mean Scores of Well-Being of Relatives of Patients Admitted to the ICU Before and After Receiving the Coping Promotion Program Using the Paired t-Test (N = 30)

Well-being	Before			After			t
	Min-Max	M	SD	Min-Max	M	SD	
Well-being	24-90	54.33	17.20	27-90	59.43	15.02	-1.53
Subscale of well-being							
Anxiety	2-23	12.70	5.29	6-22	13.77	4.24	-1.13
Depression	3-17	9.87	3.83	4-17	11.03	3.49	-1.70
Positive well-being	0-11	4.63	2.33	3-10	5.70	1.72	-2.35*
Self-control	4-15	9.77	2.94	5-13	9.83	2.46	-1.58
General health	4-16	9.67	3.10	5-16	10.57	2.93	-1.35
Vitality	1-14	7.70	3.48	1-15	8.53	3.63	-1.11
Well-being	24-90	54.33	17.20	27-90	59.43	15.02	-1.53

*P <.05

Hypothesis 2 stated, “The mean scores of well-being subscale of relatives of the patients admitted to the ICU after receiving the Coping Promotion Program higher than that before receiving the Coping Promotion Program.”

The analysis showed that the mean scores of well-being subscales (Anxiety, Depression, Positive well-being, Self-control, General health, and Vitality) of relatives of patients admitted to the ICU after receiving the Coping Promotion Program were higher than those before receiving the program. However, no statistical significance (p > .05) was found, except for the positive well-being subscale whose mean score after

receiving the Coping Promotion Program was significantly higher than that before receiving the program ($p < .05$) (see Table 4).

Part III: Satisfaction with Nursing Care of the Relatives of the Patients Admitted to the ICU

The total scores of the relatives' satisfaction with the nursing care after receiving the Coping Promotion Program ranged from 92–132 out of 140, with a mean of 115.93 (SD = 9.33). The skewness of the mean scores was negative (-.019), indicating that the total score of satisfaction with nursing care was rather high. Each item of the questionnaire had a 5-point response ranging from 1 (strongly disagree) to 5 (strongly agree). Further analyses revealed that the mean scores of each item ranged from 3.37-4.53 out of 5, indicating rather satisfaction with nursing care they received, which incorporated both usual nursing care and nursing intervention from the Coping Promotion Program (see Table 5).

The first three items that the relatives of the patients were most satisfied with were: 1) would use nursing care services again, if needed; 2) make the client feel secure when giving care; and 3) make the client feel better while talking with. On the other hand, the three items that the relatives of the patients were least satisfied with were: 1) be careful; 2) be attentive to the client's understanding about the medical explanation of the illness; and 3) consider the client's opinions and preferences regarding the care plan (see Table 5).

Table 5: The Rank Order of Satisfaction Scores with Nursing Care of Relatives of the Patients Admitted to the ICU from the Highest to the Least Mean Score of Each Item (N = 30)

Number of item	Item Contents of Satisfaction	Mean
# 28	Would use nursing care services again, if needed	4.53
# 26	Make the client feel secure when giving care	4.50
# 14	Make the client feel better while talking with	4.43
# 15	Care of the client is the top priority of the nurse	4.43
# 11	Make the client comfort	4.37
# 10	Be respected when talking with	4.33
# 1	Promptly respond to the client's call	4.30
# 16	Give directions at the right speed	4.30
# 4	Be patient	4.27
# 3	Be friendly	4.23
# 12	Enjoy caring for the client	4.23
# 18	Help the client understand the illness	4.23
# 23	Be gentle in caring	4.23
# 25	Understand the client's problems	4.17
# 2	Be responsive to the client's request	4.10
# 7	Acknowledge the client as persons	4.10
# 17	Keep promise	4.10
# 19	Be attentive to the client's understanding about the importance of treatment	4.10
# 21	Give thorough explanations	4.10
# 5	Listen to the client's concerns	4.00
# 6	Be alert to the client's need	4.00
# 13	Respond to the client's request promptly	4.00
# 20	Be available when the client needs support	4.00
# 27	Be attentive enough	4.00
# 9	Be trusty to share feeling with	3.97
# 22	Consider the client's opinions and preferences regarding the care plan	3.90
# 24	Be attentive to the client's understanding about the medical explanation of the illness	3.77
# 8	Be careful	3.70

In conclusion, this chapter presents: 1) demographic characteristics of the sample (relatives of the patients admitted to the intensive care unit) and those of the patients; 2) a comparison of well-being scores of the relatives before and after receiving the Coping Promotion Program; and 3) satisfaction with nursing care of the relatives. The analysis revealed that most subjects were female and were either son/daughter or spouses of the patients. The subjects' mean score of overall well-being and of its subscales after receiving the coping promotion program were higher than those before receiving the program, but not statistically significant, except for the mean score of the positive well-being subscale, which was significantly higher than that before receiving the Coping Promotion Program. Additionally, the subjects reported their satisfaction with nursing interventions. The relatives of the patients were most satisfied with: 1) would use nursing care services again, if needed; 2) make the client feel secure when giving care; and 3) make the client feel better while talking with, respectively.

CHAPTER V
DISCUSSION

The present study employed the one-group pretest posttest research design to investigate the effects of a Coping Promotion Program on well-being of relatives of the patients who were admitted to the intensive care unit (ICU) from June to December 2005 at Medical ICU at Ramathibodi Hospital. In this chapter, the research findings are discussed in the following topics: 1) demographic characteristics of the subjects; 2) demographic characteristics of the patients; 3) well-being before and after receiving the Coping Promotion Program; and 4) satisfaction with nursing care.

Demographic Characteristics of Relatives of the Patients Admitted to the ICU

The sample consisted of 30 relatives of critical patients who were admitted to the ICU, and they were recruited by purposive sampling according to the inclusion criteria. According to the findings as in Table 1, most of the subjects (83.3%) were female, and the majority were son/daughter or spouses of the patients. These findings were consistent with those of previous studies (Niphawan Samartkit & Junporn Yodying, B.E. 2541; Patitat, 2000; Porntip Kosalwat, B.E. 2541; Thitima Wataneeyavej et al., B.E. 2541; Ubonwan Kitirattrakarn, B.E. 2541; Wanichapichart, 2000). In general, spouses or daughters of the patients tend to have a close relationship with the patients. They better understand the patient's needs and reactions. In addition, they are usually eager to provide care to the patients by themselves, both at the hospital and at home after hospital discharge. In this study, the mean age of the relatives was 43.23 years, which is considered as adulthood. Adults are more ready to make decisions and to plan for care of the patients.

In addition, most of the subjects (80%) had sufficient income, which was similar to findings of previous studies (Niphawan Samartkit & Junporn Yodying, B.E. 2541,; Patitat, 2000; Porntip Kosalwat, B.E. 2541; Thitima Wataneeyavej et al., B.E. 2541;

Ubonwan Kitirattrakarn, B.E. 2541; Wanichapichart, 2000). A possible explanation why the subjects reported having sufficient income is that almost all of the sample (90.0%) did not have to be responsible for the patients' medical expenses; they could reimburse the medical expense either from their governmental welfare or employers or from social security and welfare service. This finding which the relatives in this study did not have to pay for the patients' medical expenses, was contradictory to that of previous studies on family members of critical patients. (Niphawan Samartkit & Junporn Yodying, B.E. 2541: 40-56; Patitat, 2000; Porntip Kosalwat, B.E. 2541: 54-64; Thitima Wataneeyavej et al., B.E. 2541: 30-40; Ubonwan Kitirattrakarn, B.E. 2541; Wanichapichart, 2000). This may be because at present, there is a healthcare insurance scheme, which enables those who have a low income, those who cannot ask for reimbursement (from their offices or social security), and those who are unemployed to receive free or almost free medical treatments. However, in this study, one subject did not have any coverage and received assistance from a nurse who coordinated with a social welfare office that allowed the family member to pay for medical expenses in installments. This family member expressed gratitude for the help received, stating "*I'm glad for the help that makes me able to pay for medical expenses in installments and I am able to manage for continuing the treatment. Otherwise, I wouldn't know what to do*."

Demographic Characteristics of the Patients

As the data in Table 2, the findings revealed that close to three quarters of the subjects, or 73.3%, were male. Their mean age was 53.03 years. In addition, most of them had a chronic illness, and 80.0% had been hospitalized and 33.3% had been treated in the ICU before. As regards their pathological conditions, it was discovered that 80% had shock or septic shock, and 46.7% had respiratory failure. Also, most of them 80.0% required medications to increase their blood pressure, while 93.3% required intubation or a mechanical ventilator. In general, the patients who are treated in the ICU are those who have a shock and their blood pressure needs to be controlled with medications to increase their blood pressure. Otherwise, they need to be the patients with respiratory failure and/or those who depend on mechanical ventilation. Furthermore, 26.7% of the patients were fully conscious and could communicate

normally, whereas the rest were unable to communicate as they were in a confused state (66.6%) due to sedative they received or a coma. Generally, patients with shock or respiratory failure tend to experience changes in their consciousness and alertness from an illness or sedative to reduce their level of consciousness to enable them to breathe on a mechanical ventilator during respiratory failure. Such a rather critical condition and lack of experience being treated in the ICU result in a new experience in their lives. Moreover, the patients were in their late adulthood on average. They used to have a certain level of quality of life, which enabled them to work and do activities normally. Thus, having to be treated in the ICU becomes a new and uncertain situation in life for both the patients and their relatives.

Well-being of the Relatives of the Patients Admitted to the ICU

When nursing interventions were implemented according to the Coping Promotion Program, the researcher asked the subjects about their feelings with the situation. All of them answered that it was a stressful situation. The result showed that before receiving the coping promotion program, approximately more than half of the subjects (63.3%) had the scores of well-being at a severe distress level and 20.0% at a moderate distress level. This is similar to the finding of Wanichapichart (2000) who conducted a study to explore levels of stress in relatives of critical patients and found that all of them appraised the situation as a stressful event. Wanichapichart also reported that perceived severity of the patients could cause the highest level of stress among their relatives, accounting for 93.5% of the total. It is similar to the study in family members of patients with cardiac disease (Artinian, 1989: 301-308; Bedsworth & Molen, 1982: 450-456). Stress could be appraised from the patients' appearance, which showed the severe condition such as edema, subcutaneous hematoma, subconjunctival hemorrhage, or cyanosis. In addition, the patients' condition such as unconsciousness, distress from hypoxia or dyspnea, or many kinds of tubes inserted in patients' body could cause their stress. The severity of patients' illness made relatives felt worried, frightened, shocked, upset, and sad (Wanichapichart, 2000); thus they appraised this situation as a stressful situation affecting their well-being.

In the present study, the mean score obtained from the Acute Physiologic and Health Evaluation (APACHE II) of the patients was 26.13 out of 71. (see Table 2),

which was not considered as very high, while most of the subjects had overall well-being scores at a severe or moderate distress level. This is because the scores were calculated from the laboratory results together with previous illnesses of the patients. When the patients were stricken with severe illnesses, and there were the use of medical equipment such as the breathing tube and changes in their level of consciousness, they were unlikely to communicate effectively with their relatives and make their feelings known to them. As a result, relatives assessed their feelings from the condition of the patients they were witnessing. Sometimes, the patients with different APACHE II scores had the same sickness and required the use of the same medical equipment. The assessment of the relatives then came from what they saw rather than the APACHE II scores that the healthcare personnel used to assess the severity of the patients' illness. Thus, the subjects appraised stress and reflected their altered well-being before received nursing intervention as the result.

Most of the subjects in this study were sons/daughters or spouses of the patients (see Table 1), who had a very strong attachment to the patients. According to Lazarus and Folkman (1984), when coping with a situation, individuals will make primary appraisal based on personal factors and environmental factors. Personal factors include comittment, which is attachment or the relationship between individuals. Lazarus and Folkman explain that commitment refers to anyone or anything that is meaningful and significant for individuals. The stronger the commitment, the more the individuals will suffer and become stressful because of such attachment (Lazarus & Folkman, 1984: 58). In the Thai society, children have a very strong attachment to their parents. Also, they have deep gratitude for their parents and are very likely to become caregivers when their parents are old and/or sick (Somrudee Sitthimongkol, B. E. 2541; Wipawan Cha-um, B.E. 2536). If the parents become severely sick, individuals tend to be very concerned and afraid of loss. As regards the relationship between the husband and wife, when one becomes sick, the other will inevitably feel worried about his or her well-being, as well as the well-being of the whole family. Furthermore, the spouse has to take over the duties of the sick partner, and they may feel that the welfare of the whole family is threatened. They may be afraid of having to lose financial security and/or the head of the family (Nyamthi, 1987: 86-92). Thus, family members may

perceive a sickness situation as a stressful situation, which avoidably affects their perceived well-being.

In addition, the environmental factor also played a role, as having a family member admitted to the ICU was a new situation that suddenly took place in the subjects' life. In this study, more than three-fourths of the subjects (76.7%) had no experience of having a close person who was treated in the ICU (see Table 1). This might have made them feel that they lost control of the situation when they had to leave the patients in the care of the healthcare team consisting of physicians and nurses, who were someone they were unfamiliar with nor unable to give definite information about the critical condition of the patients. Having to deal with a new and uncertain event, which could also be serious and ambiguous, could easily make the relatives appraise the situation as stressful (Lazarus & Folkman, 1984: 82-116). Therefore, it affected relatives' perception of well-being before received nursing intervention as shown in the result.

In addition to the personal and environmental factors that affected the family members' primary decision, other stimulating factors under the context of the ICU could also affect their perception of the situation as stressful. The critical care unit is generally perceived as the place for critical patients with a high chance of mortality, the hectic and confusing environment with unfamiliar equipments and sounds, lack of a chance to stay close to the patients all the time, as well as having to deal with doctors and nurses who were strangers. All of these images influence the relatives' assessment of the situation (Mendonca & Warren, 1998: 58). In this study, it might be that relatives' perception as stressful was caused by the situation that threatened both the patients' and their own security. For this reason, the mean score of overall well-being was rather high in this study.

The findings further revealed that the mean score of overall well-being of relatives of patients admitted to the ICU after receiving the Coping Promotion Program was higher than that obtained before receiving the Coping Promotion Program, but with no statistical significance. Moreover, the mean scores of subscales of well-being of relatives of patients admitted to the ICU after receiving the Coping Promotion Program were higher than those before receiving the program, but with no statistical significance, except for the positive well-being subscale. The mean score of

positive well-being subscale after the relatives had received the Coping Promotion Program was significantly higher than that before receiving the program. The plausible explanations for the non-significant difference of well-being at pretest and posttest are that the sample size of this study was rather small (N = 30), and the posttest score was collected after a short interval of three days after receiving the coping promotion program. Likewise, Wanichapichart (2000) found that within two to five days after the patients' admission into the ICU, 100% of the relatives found the situation stressful for them. The interval in Wanichapichart's study was rather similar to that used in the present study, which was four days. Moreover, it might because the nursing interventions by the researcher, which conducted four times within three days, were not enough to develop the relatives' coping ability. The posttest of well-being on the third day after received the fourth nursing intervention might be too soon for the intervention to be effective in coping ability, so the perception of well-being was not significantly changed. In the period of four days, most of the patients' conditions were not improved. They were still in critical conditions, had altered consciousness, and used inotropic drugs and the endotracheal tube with mechanical ventilator. At the same time, the staff, including the researcher, could not guarantee the relatives that the patients would, at the end, have a positive outcome as their hope. These might be the cause of anxiety and stress for the subjects. However, it might be possible that they have other problems related to patients' illness or their private problems. These were uncontrollable problems, which might caused the subject to continually reappraise them altogether as a stressful event affecting the well-being score.

However, the findings of this study reflected a more positive trend as the level of well-being tended to increase after the family members received the coping promotion program. In other words, provision of the Coping Promotion Program as a coping resource for family members of the ICU patients had a positive effect on them, especially in terms of positive well-being, as the score at posttest significantly higher than that at pretest (see Table 4). It might be because receiving support from nursing interventions according to the Coping Promotion Program stimulated the relatives' reappraisal toward the situation and themselves, so they might interpret the situation to be more positive and perceive their internal strength, which in turn, use it to cope with the situation. Therefore, it could be stated that both usual nursing care plus the Coping

Promotion Program promote positive well-being of relatives of the patients admitted to the ICU, while they were dealing with stress as shown in the findings of this study.

Satisfaction with the Nursing Care

According to the study findings, the mean scores of the relatives' satisfaction with the nursing care they received ranged from 96 to 132 out of 140 with a mean of 115.93 and the skewness was negative (-.019). Although the cut-off score to classify the level of satisfaction was not provided by the developer of the scale, the result showed a tendency of satisfaction with nursing care of the relatives. As the questionnaire is a five-point Likert scale, by which the score of 3 was undecided feeling; the score of 4 to 5 was satisfied feeling; and the score of 1 to 2 was unsatisfied feeling to nursing care they received. The finding in this study showed the mean score of each item ranged from 3.37-4.53 (see Table 5), meaning that the relatives were satisfied with nursing care they received. However, this study assessed the satisfaction of the relatives only once at posttest, thus, it is difficult to make a conclusion regarding the effect of the program.

In a study of Chavalee Yamvong (B.E. 2538), which investigated satisfaction of family members of elderly patients during hospitalization using the same instrument, the findings revealed that the subjects in the experimental group had a higher level of satisfaction with the nursing care than those in the control group with statistical significance, with the scores ranging from 98–135 with a mean of 115.50. Moreover, Phongphanngam (2003) examined levels of satisfaction of caregivers of elderly patients who had a hip joint replacement surgery and found that the satisfaction level in the experimental group was significantly higher than that of the control group, by which the mean score in the experimental group was 124.33. When comparing the scores obtained in the present study to those obtained in these two studies, the mean scores were similar, suggesting a somewhat high level of satisfaction of the family members in this study.

The findings found that the top five items reflected the family members' confidence in the nursing care that the patients and they received. The items were concerned with the satisfaction with the nursing care provided by the nurses and the feelings that they had been helped by the nurses. The item which had the highest mean

score was Item 28, stating, "*If you need more treatment, you will come back to this hospital*." On the other hand, the last five items of the satisfaction score were related to nursing behaviors, especially the attention that the nurses paid to the feelings and the needs of both patients and their relatives. This finding suggests that nurses pay more attention to caring behavior.

The top five items and the last five items were rather similar to those reported in the study of Chavalee Yamvong (B.E. 2538), particularly Item 28, which had the highest mean score, while Item 8, stating "*Be more careful*," which had the lowest mean score. In the study of Chavalee Yamvong (B.E. 2538), the nursing care program was developed based on the Self-Care Theory of Orem that emphasizes the provision of assistance to increase family members' awareness of necessary care and to enable them to respond to the needs in care of both the patients and themselves. It enables the family members to develop knowledge and potential to provide care to both the patients and themselves. A literature review on needs of family members of critical patients revealed that most family members generally need information about the condition of the patients, hopefulness, and assurance that the patients are receiving the best of care possible, while their own personal needs come later (Aree Boonbarwornrattanakul, B.E. 2538; Chuthamas Panchawisut, et al., B. E. 2535, Leske, 1998: 182; Phongphanngam, 2003; Uraiporn Phongpatanawut, B. E. 2532; Woolley, 1990: 1405).

A possible explanation of a rather high score of satisfaction in this study is that during the provision of the Coping Promotion Program, the researcher had a chance to meet and offer nursing care to the patients' relatives daily for three days, consisting of starting relationship by the researcher, giving information without their request, and offering help or support to them. These helped them away from being anxious while they did not know how and where to seek help and information. An establishment of a rapport between the nurses and the relatives who were representatives of the patients' family made the relatives understand assistance and responses to their needs they received from the nurses, both from the researcher and other nurses working in the ICU. This intervention promotes the relatives' pleasures and satisfaction with help and nursing care both from the researcher and usual nursing care.

The findings of the present study reflect the notion that the needs of the patients' relatives are responded to, and this is shown in the form of satisfaction with the nursing care they received. It could be explained that relatives require care quality that enables them to feel confident in the security and safety of the patients. Relatives also need assistance that makes them feel more comfortable with the situation as well as gives them a chance to vent their feelings. The subjects in this study received both routine nursing care and interventions in the Coping Promotion Program from the researcher who had planned for specific nursing care. The care provided also included the establishment of rapport between the researcher and the subjects, and provision of care taking place on a regular basis. The subjects were also assured that the nurse would be available to give nursing care and to meet other needs they may have. All of these may help relatives of the patients admitted to the ICU feel satisfied with the nursing care they received. As pointed out by Eriksen (1995:61), service receivers would feel satisfied with the nursing care when their wishes and their needs are responded to. Even though there was only one group of subjects in this study and the outcomes of the coping promotion program could not clearly be assessed as there was no other group for a comparison, the findings still shed light on ways to further develop nursing care of relatives of critical patients treated in the ICU.

CHAPTER VI
CONCLUSION

The present study employed the one-group, pretest posttest research design to investigate the effect of a coping promotion program on well-being of relatives of the patients who were admitted to the intensive care unit (ICU) and to evaluate satisfaction with nursing care of the relatives. The conceptual framework of the study was based on the Stress, Appraisal, and Coping Theory of Lazarus and Folkman (1984). The sample consisted of 30 relatives of patients who were admitted to the ICU at Medical Department, Faculty of Medicine, Ramathibodi Hospital from June to December 2005. Purposive sampling was used to recruit the subjects who met the inclusion criteria, by which one relative was selected by the researcher from each family of the patient.

Most subjects were female, with the mean age of 43.23 years. The majority of the subjects were employees, and most of them were son/daughter or spouses of the patients. Also, close to half held a Bachelor's degree or higher, and they had sufficient income. On the other hand, the majority of the patients were male, and their mean age was 53.03 years. Approximately, 80% of the patients had at least one chronic illness, with more than one-fourth having respiratory diseases and equally the same number having hematologic diseases. The most frequently found problems were shock and respiratory failure. Most of them were unconscious because they were given the medication to induce sleep or they were in a coma.

The instruments used in this study consisted of the research instruments and the data collection instruments. The research instruments were divided into 1) a Coping Promotion Program, which was developed by the researcher based on the Stress, Appraisal, and Coping Theory of Lazarus and Folkman (1984) and a review of literature on the needs of family members of critical patients; and 2) a booklet entitled, "When the patient has to be in the ICU," which was developed by the researcher to distribute information to relatives of the patients.

The data collection instruments consisted of: 1) the Demographic Characteristics Questionnaire, 2) the General Well-Being Schedule developed by Dupuy (1977) and translated into Thai by Somchit Hanucharurnkul et al. (B.E.2532), and 3) The Relative Satisfaction Scale. The General Well-Being Schedule consisted of 18 items, which had Cronbach's alpha correlation coefficient as .92 in this study. The Relative Satisfaction Scale was adapted from the La Monica-Obserst Patient Satisfaction Scale (LOPSS) revised by Munro et al. (1994) and translated into Thai by Chavalee Yamvong, (B.E. 2538) to use in relatives of the patients. In the present study, the Relative Satisfaction Scale was tried out with 16 relatives of critical patients in the ICU and then, with 30 subjects in the main study. Its Cronbach's Alpha Correlation Coefficients were .95 and .88, respectively.

Data collection was conducted by the researcher and a research assistant. The first round of data collection took place after the patients had admitted to the ICU for 24 hours and the relatives had visited the patients at least once. During this time, data regarding demographic characteristics and well-being of the subjects were elicited. After that, the researcher provided the subjects with nursing care according to the Coping Promotion Program and the booklet, "*When the patient has to be in the ICU*." After the patients had been treated in the ICU for 96 hours, the research assistant conducted the second round of data collection by eliciting data regarding the subjects' well-being and satisfaction with the nursing care they received. Data were analyzed using SPSS for Windows version 11.5.

The summary of the study findings is as follows:

1. Most of the sample (83.3%) were female. Their mean age ranged from 22 to 70 years with a mean of 43.23 years (SD = 11.24). Approximately, three-fourths (73.3%) were married; about half of the subjects (43.3%) graduated with a Bachelor's degree or higher, and they worked as employees, traders, and government officers, respectively. Nearly half of the sample (53.3%) had sufficient income, but 20% of them did not earn enough income. However, almost all of them (90%) could reimburse the medical expenses of the patients. Regarding the relationship with the patients, 43.3% of the subjects were sons/daughters of the patients, whereas 36.7% were the patients' spouses. Finally, 76.7% of the sample had never had an experience with their family member admitted to the ICU.

2. The subjects' mean score of overall well-being after receiving the Coping Promotion Program was higher than that before receiving the program with no statistical significance ($p > .05$).

3. The subjects' mean scores of different subscales of well-being after receiving the Coping Promotion Program were higher than those before receiving the program with no statistical significance ($p > .05$), except for the positive well-being subscale whose mean score after the relatives had received the Coping Promotion Program was statistically higher than that before receiving the program ($p < .05$).

4. The total scores of the relatives' satisfaction with the nursing care after receiving the usual nursing care plus the Coping Promotion Program ranged from 92–132 out of 140, with the mean of 115.93 (SD = 9.33).

The findings also yielded support to the concepts proposed in Stress, Appraisal, and Coping Theory of Lazarus and Folkman (1984) that when individuals encounter a situation, they will appraise such situation based on their perception and other related factors. When individuals assess a situation as a stressor, they will then try to cope with stress. Having a resource, which can offer support to individuals when they are coping with stress, enables them to manage it without exceeding their own limits of energy and effort. It also enables individuals to adapt themselves and handle the situation more effectively, hence the ability to maintain well-being. It reflects the quality of nursing care, which provides individuals with extensive and comprehensive care and assistance under the concept of holistic care.

Limitations

1. A one-group pretest-posttest design, rather than two groups, was used in this study because of the non-equivalent issue of the sample's characteristics, therefore, the conclusion regarding the effect of the program is limited.

2. The number of the subjects in this study was rather small and was recruited from one setting. Initially, the number of subjects was set at 50. However, as data were collected within a short period of three months, unexpected problems arose. For instance, some relatives were unable to visit the patients everyday due to various reasons such as living in another province or having to earn their living. In addition, some relatives were too stressed to participate in the study, and some patients did not

have a family member who came to visit them. The number of subjects at the beginning of the study was 50. Unfortunately, 20 of these were eventually excluded for different reasons. For example, some patients died, while others were admitted in the ICU shorter than 96 hours. Besides, there were only eight beds at the research setting, and some patients occupied the bed for longer than one week, therefore, the turn-over rate of the patients was rather slow. Thus, generalization of the results may be limited. Implications of the intervention in other intensive care departments should be concerned with the design and specific details, which may have to be modified according to each setting.

Recommendations

For Nursing Practices

1. The result showed the overall and all subscales of well-being after receiving the intervention were higher than those before receiving the intervention, even insignificantly different, use of this Coping Promotion Program should be useful in planning nursing care for patients and relatives in the ICU. Nursing care is a coping resource, which helps the relatives to cope with stress and maintain family equilibrium. In this study, the researcher found that the relatives are important social resource for the patients because they know the patient's needs, provide warm and gentle care of patients, and give useful information for nurses to plan the care for patients. Thus, nurses should provide care and assist relatives to deal with stress and let them participate in caring for patients.

2. From the finding, the relatives expressed their satisfaction with nursing care, especially, with nursing care that makes the client feel secured, comfort, and respected. Thus, nurses should consider nursing interventions in this program to make relationship with the relatives, and to give more time for listening and talking with them. This might consider decreasing the non-nursing jobs for nurses and having more time available for giving care to patients and their families. It was also found that the relatives feel comfort without anxious when the nurse used this intervention program to approach them or started making the relationship.

For Nursing Education

1. This study showed that while giving care to help the relatives coping with stress nurse should have the knowledge about stress theory and skills in helping persons under stress. The competency of nurses in helping patients and their family cope with stress could increase the quality of nursing care and satisfaction from the clients. Thus, the stress and coping theory should be included in all levels of nursing education.

2. The critical care nurses' knowledge and ability should be developed regarding assessment and care of individuals under stress so that they could provide nursing care with confidence as well as efficiency.

For Future Research

1. Further studies should be conducted with larger groups of subjects or replicated in other intensive care departments with more consideration of related factors to assure the effectiveness of this Coping Promotion Program.

2. The process of coping to the stress phenomenon can be seen in qualitative research. When an individual perceives stress, they may differ in appraisal coping types, adapting time, and adaptation outcomes. A qualitative study may elucidate the process of coping to stress, which is viewed as transaction between persons and situations. This may help nurses to better understand the stress phenomenon, which in turn, responds to the clients' needs effectively.

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APPENDIX

APPENDIX A

PROTECTION OF THE RIGHTS OF HUMAN SUBJECT

PART I: DOCUMENTARY PROOF OF ETHICAL CLEARANCE (English)

คณะแพทยศาสตร์ โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล
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Documentary Proof of Ethical Clearance Committee on Human Rights Related to Researches Involving Human Subjects
Faculty of Medicine, Ramathibodi Hospital, Mahidol University

No. 0479/2005

Title of Project	Effects of a Coping Promotion Program on Well – Being and Satisfaction with Nursing Care of the Relative of Patients in the Intensive Care Unit
Protocol Number	ID 03-48-27
Principal Investigator	Miss. Ruamporn Laopet
Official Address	Department of Medicine Faculty of Medicine, Ramathibodi Hospital Mahidol University

The aforementioned project has been reviewed and approved by Committee on Human Rights Related to Researches Involving Human Subjects, based on the Declaration of Helsinki.

Signature of Chairman
Committee on Human Rights Related to
Researches Involving Human Subjects ..... Prof. Krisada Ratana-olarn, M.D., FRCST, FICS.

Signature of Dean ..... Prof. Rajata Rajatanavin, M.D., F.A.C.E.

Date of Approval June 15, 2005

PART I: DOCUMENTARY PROOF OF ETHICAL CLEARANCE (Thai)

คณะแพทยศาสตร์ โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล
ถนนพระราม 6 กทม. 10400
โทร. (662) 354-7275, 201-1296 โทรสาร (662) 354-7233
Faculty of Medicine, Ramathibodi Hospital, Mahidol University
Rama VI Road, Bangkok 10400, Thailand
Tel. (662) 354-7275, 201-1296 Fax (662) 354-7233

เอกสารรับรองโดยคณะกรรมการจริยธรรมการวิจัยในคน
คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี
มหาวิทยาลัยมหิดล

เลขที่ ๐๔๗๕/๒๕๔๘

ชื่อโครงการ	ผลของโปรแกรมการส่งเสริมการเผชิญความเครียดต่อความผาสุกและความพึงพอใจต่อการพยาบาลของญาติผู้ป่วยในหอผู้ป่วยวิกฤต
เลขที่โครงการ/รหัส	ID ๐๓-๔๘-๒๗ ข
ชื่อหัวหน้าโครงการ	นางสาวรวมพร หลาวเพ็ชร์
ที่ทำงาน	ภาควิชาอายุรศาสตร์ คณะแพทยศาสตร์ โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล

ขอรับรองว่าโครงการดังกล่าวข้างต้นได้ผ่านการพิจารณาเห็นชอบโดยสอดคล้องกับแนวปฏิญญาเฮลซิงกิ จากคณะกรรมการจริยธรรมการวิจัยในคน คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี

ลงนาม _____
ประธานกรรมการจริยธรรมการวิจัยในคน (ศาสตราจารย์ นายแพทย์กฤษฎา รัตนโอฬาร)

ลงนาม _____
คณบดีคณะแพทยศาสตร์โรงพยาบาลรามาธิบดี (ศาสตราจารย์ นายแพทย์รัชตะ รัชตะนาวิน)

วันที่รับรอง ๑๕ มิถุนายน ๒๕๔๘

PART II: PERMISSION FOR DATA COLLECTION

บันทึกข้อความ

ส่วนราชการ คณะแพทยศาสตร์ โรงพยาบาลรามาธิบดี โทร. I+๖๘ ต่อ ๑๗๐๑, ๒๔๑๖

ที่ ศธ ๐๕๑๗.๐๖/๓๗๘๙ วันที่ ๑๒ กรกฎาคม ๒๕๔๘

เรื่อง อนุญาตให้เก็บข้อมูลเพื่อประกอบการทำวิทยานิพนธ์

เรียน คณบดีบัณฑิตวิทยาลัย

ตามหนังสือ งานบริการการศึกษา สำนักงานบัณฑิตวิทยาลัย สาขาศาลายา มหาวิทยาลัยมหิดล ที่ ศธ ๐๕๑๗.๐๒(ศย)/๐๑๖๑ ลงวันที่ ๑๑ มีนาคม ๒๕๔๘ แจ้งว่า นางสาวรวมพร หลาวเพ็ชร์ นักศึกษาบัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล หลักสูตรปริญญาโท สาขาการพยาบาลผู้ใหญ่ ขอความอนุเคราะห์เก็บข้อมูลในการทำวิทยานิพนธ์ เรื่อง "ผลของโปรแกรมการส่งเสริมการเผชิญความเครียดต่อความผาสุกและความพึงพอใจต่อการพยาบาลของญาติผู้ป่วยในหอผู้ป่วยวิกฤต" อยู่ในความควบคุมของ อ.ดร. พรทิพย์ มาลาธรรม ความละเอียดแจ้งแล้ว นั้น

คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี ได้พิจารณาแล้วไม่ขัดข้อง และยินดีอนุญาตให้เก็บข้อมูลและสามารถติดต่อขอข้อมูลได้ที่

- ภาควิชาพยาบาลศาสตร์ โทรศัพท์หมายเลข ๐-๒๒๐๑-๑๒๓๕, ๐-๒๒๐๑-๑๒๐๑
- ภาควิชาอายุรศาสตร์ โทรศัพท์หมายเลข ๐-๒๒๐๑-๑๗๑๔ , ๐-๒๒๐๑-๑๗๕๐

จึงเรียนมาเพื่อทราบ

(ศาสตราจารย์บุญส่ง องค์พิพัฒนกุล)
รองคณบดีฝ่ายวิจัย ปฏิบัติราชการแทน
คณบดีคณะแพทยศาสตร์โรงพยาบาลรามาธิบดี

หน่วยบริหารงานวิจัย
โทรศัพท์ ๐ ๒๒๐๑ ๑๗๐๑ , ๐ ๒๒๐๑ ๒๔๑๖
www.ra2.mahidol.ac.th rar

PART III: CONSENT TO PARTICIPATE IN RESEARCH STUDY

หนังสือยินยอมโดยได้รับการบอกกล่าวและเต็มใจ

(Informed Consent Form)

ชื่อโครงการวิจัยเรื่อง ผลของโปรแกรมการส่งเสริมการเผชิญความเครียดต่อความผาสุกและความพึงพอใจต่อการพยาบาลของญาติผู้ป่วยในหอผู้ป่วยวิกฤต

ชื่อผู้วิจัย นางสาวรวมพร หลาวเพ็ชร์

***ชื่อผู้เข้าร่วมการวิจัย**……**อายุ**……ปี

คำยินยอมของผู้เข้าร่วมการวิจัย

ข้าพเจ้านาย/นาง/นางสาว……..……ได้ทราบรายละเอียดของโครงการวิจัยตลอดจนประโยชน์และข้อเสี่ยงที่จะเกิดขึ้นต่อข้าพเจ้าจากผู้วิจัยแล้วอย่างชัดเจน ไม่มีสิ่งใดปิดบังซ่อนเร้นและยินยอมให้ทำการวิจัยในโครงการที่มีชื่อข้างต้น และข้าพเจ้ารู้ว่าถ้ามีปัญหาหรือข้อสงสัยเกิดขึ้นข้าพเจ้าสามารถสอบถามผู้วิจัยได้และข้าพเจ้าสามารถไม่เข้าร่วมโครงการวิจัยนี้เมื่อใดก็ได้โดยไม่มีผลกระทบต่อการรักษาที่ผู้ป่วยหรือข้าพเจ้าพึงได้รับ นอกจากนี้ผู้วิจัยจะเก็บข้อมูลเฉพาะเกี่ยวกับตัวข้าพเจ้าและผู้ป่วยเป็นความลับ และจะเปิดเผยได้เฉพาะในรูปที่เป็นสรุปผลการวิจัย การเปิดเผยข้อมูลเกี่ยวกับตัวข้าพเจ้าและผู้ป่วยต่อหน่วยงานต่างๆที่เกี่ยวข้องกระทำได้ เฉพาะกรณีจำเป็นด้วยเหตุผลทางวิชาการเท่านั้น

ลงชื่อ……(ผู้เข้าร่วมการวิจัย)

……....(พยาน)

……..(พยาน)

วันที่ ……..

คำอธิบายของแพทย์หรือผู้วิจัย

ข้าพเจ้าได้อธิบายรายละเอียดของโครงการตลอดจนประโยชน์ของการวิจัยรวมทั้งข้อเสี่ยงที่อาจจะเกิดขึ้นแก่ผู้เข้าร่วมการวิจัยทราบแล้วอย่างชัดเจนโดยไม่มีสิ่งใดปิดบังซ่อนเร้น

ลงชื่อ……...……(ผู้วิจัย)

วันที่……

หมายเหตุ : กรณีผู้เข้าร่วมการวิจัยไม่สามารถอ่านหนังสือได้ให้ผู้วิจัยอ่านข้อความในใบยินยอมฯนี้ให้แก่ผู้เข้าร่วมการวิจัยฟังจนเข้าใจดีแล้วและให้ผู้เข้าร่วมการวิจัยลงนามหรือพิมพ์ลายนิ้วหัวแม่มือรับทราบในการให้ความยินยอม ดังกล่าวข้างต้นไว้ด้วย

* ผู้เข้าร่วมการวิจัย หมายถึง ผู้ยินยอมตนให้ทำวิจัย

APPENDIX B
INSTRUMENTS FOR INTERVENTION

PART I : THE COPING PROMOTION PROGRAM

โปรแกรมการส่งเสริมการเผชิญความเครียดของญาติผู้ป่วยในหอผู้ป่วยวิกฤต

เมื่อผู้ป่วยเข้ารับการรักษาในหอผู้ป่วยวิกฤต เป็นสถานการณ์ที่ทำให้ญาติผู้ป่วยเกิดความเครียด ถ้าไม่สามารถปรับตัวเผชิญกับเหตุการณ์ความเครียดได้อย่างเหมาะสม ญาติจะไม่สามารถเป็นแหล่งประโยชน์ที่จะช่วยให้กำลังใจหรือสนับสนุนการฟื้นหายของผู้ป่วยได้ และอาจส่งผลให้เกิดภาวะวิกฤตในครอบครัว การพยาบาลผู้ป่วยที่รับการรักษาอยู่ในหอผู้ป่วยภาวะวิกฤตนอกจากจะดูแลรักษาให้ผู้ป่วยปลอดภัยพ้นจากภาวะวิกฤตแล้ว จึงควรรวมญาติของผู้ป่วยไว้ในแผนการพยาบาลของผู้ป่วยด้วย

โปรแกรมการส่งเสริมการเผชิญความเครียดของญาติผู้ป่วยในหอผู้ป่วยวิกฤตนี้ มีวัตถุประสงค์เพื่อเป็นหนึ่งในแหล่งประโยชน์ของการเผชิญความเครียดให้แก่ญาติผู้ป่วย ภายใต้กรอบแนวคิดทฤษฎีความเครียดของลาซารัส โดยมีการวางแผนการพยาบาลที่ช่วยส่งเสริมการเผชิญความเครียดและตอบสนองความต้องการให้แก่ญาติของผู้ป่วย โดยมุ่งหวังว่าเมื่อญาติผู้ป่วยสามารถปรับตัวเผชิญความเครียดได้จะทำให้ญาติสามารถดำรงความผาสุกของตนเอง รักษาความสมดุลในครอบครัว และสามารถเป็นแหล่งประโยชน์ที่ช่วยส่งเสริมการฟื้นหายของผู้ป่วยได้ โดยมีลักษณะดังนี้

1. การพยาบาลมี 3 ขั้นตอน ได้แก่การพยาบาลขั้นที่ 1 การพยาบาลขั้นที่ 2 และการพยาบาลขั้นที่ 3 เลือกให้การพยาบาลแต่ละขั้นตามระยะเวลาภายหลังการเข้ารับการรักษาในหอผู้ป่วยวิกฤตของผู้ป่วย ร่วมกับการประเมินอาการแสดงและความต้องการของญาติผู้ป่วย

2. ความยาวนานในการให้การพยาบาลแต่ละครั้ง ขึ้นกับอาการและปฏิกิริยาการตอบสนองต่อเหตุการณ์ของญาติผู้ป่วยแต่ละบุคคล ซึ่งอาจใช้เวลาในการให้การพยาบาลต่อญาติแต่ละคนไม่เท่ากัน

3. ลักษณะการให้การพยาบาลมีดังนี้

การพยาบาลขั้นที่ 1

ระยะเวลาการให้การพยาบาล ได้แก่ ภายใน 24 ชั่วโมงหลังการเข้ารับการรักษาของผู้ป่วย หรือเมื่อพยาบาลได้พบกับญาติผู้ป่วยเป็นครั้งแรก

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แนวคิด	วัตถุประสงค์	วิธีปฏิบัติ
1. การสร้างสัมพันธภาพระหว่างพยาบาลและญาติ	1. ญาติเกิดความไว้วางใจพยาบาล	1. ทักทายญาติ 2. แนะนำตัวต่อญาติ . . .
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3. การช่วยเหลือญาติในการเผชิญความเครียด	1. ลดความวิตกกังวล และ 2. ส่งเสริมการรับรู้อย่างถูกต้องตรงความเป็นจริงเกี่ยวกับอาการและความเจ็บป่วยของผู้ป่วย	1. ให้ข้อมูลเกี่ยวกับสภาวะความเจ็บป่วยของผู้ป่วยและการรักษาที่ผู้ป่วยได้รับ 2. ให้ญาติเข้าพบผู้ป่วยโดยเร็วที่สุดถ้าไม่มีข้อบ่งชี้ว่าผู้ป่วยอยู่ในสภาวะที่ญาติเข้าเยี่ยมในขณะนั้นไม่ได้ . . .

การพยาบาลขั้นที่ 2

ระยะเวลาการให้การพยาบาล ได้แก่ ภายใน 48 ชั่วโมงหลังการเข้ารับการรักษาของผู้ป่วย ภายหลังได้รับการพยาบาลขั้นที่ 1 แล้ว

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แนวคิด	วัตถุประสงค์	วิธีปฏิบัติ
1. การดำรงสัมพันธภาพระหว่างพยาบาลและญาติ	1. ญาติเกิดความไว้วางใจพยาบาล	1. ทักทายญาติ 2. เปิดโอกาสให้ญาติได้ซักถาม . . .
. . .	. . .	. . .
4. การช่วยเหลือญาติในการเผชิญความเครียด	1. ญาติมีความหวังในการฟื้นหายของผู้ป่วย	1. ประเมินความคาดหวังของญาติที่มีผลต่อการรักษาของผู้ป่วย 2. ให้ข้อมูลเกี่ยวกับอาการและการตอบสนองต่อการรักษาของผู้ป่วย โดยเฉพาะการตอบสนองในส่วนที่ดี ตามความเป็นจริง . . .

การพยาบาลขั้นที่ 3

ระยะเวลาการให้การพยาบาล ได้แก่ ภายหลัง 48 ชั่วโมงหลังการเข้ารับการรักษาของผู้ป่วย เนื่องจากมีลักษณะการพยาบาลที่มีความซับซ้อนมากขึ้นจึงต้องรอให้ญาติได้ผ่านพ้นช่วงเวลาที่มีภาวะความเครียดสูงคือ 24-48 ชั่วโมงหลังการเข้ารับการรักษาในหอผู้ป่วยวิกฤตของผู้ป่วยเสียก่อน

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แนวคิด	วัตถุประสงค์	วิธีปฏิบัติ
1. การดำรงสัมพันธภาพระหว่างพยาบาลและญาติ	1. ญาติเกิดความไว้วางใจพยาบาล	- ให้การพยาบาลเหมือนในขั้นที่ 2
. . .	. . .	. . .
5. เตรียมความพร้อมในการย้ายออกจากหอผู้ป่วยวิกฤต (เมื่อแพทย์วางแผนการหรือกำหนดวันการย้ายออกของผู้ป่วย) (ต่อเนื่อง)	1. ลดความวิตกกังวลเมื่อต้องย้ายออกจากหอผู้ป่วยวิกฤตและเตรียมความพร้อมในการเผชิญสถานการณ์ใหม่ (ต่อเนื่อง)	1. เปิดโอกาสให้ครอบครัวได้แสดงความรู้สึกและความต้องการ ให้การตอบคำถาม ให้คำอธิบายซ้ำ หรือคำอธิบายเพิ่มเติม และความช่วยเหลือที่เหมาะสมตามความต้องการของครอบครัว เช่น การช่วยเหลือประสานงานให้ได้คุยกับแพทย์

PART II: AN ICU BOOKLET

"When the patient has to be in the ICU."

เมื่อผู้ป่วยอยู่ไอ.ซี.ยู

เอกสารแนะนำสำหรับญาติของผู้ป่วยที่รับการรักษาในไอ.ซี.ยู.อายุรศาสตร์

โรงพยาบาลรามาธิบดี

จัดทำโดย

นางสาวรวมพร หลาวสิริ

นักศึกษาปริญญาโท สาขาการพยาบาลผู้ใหญ่

1

"เมื่อผู้ป่วยอยู่ในไอ.ซี.ยู."

เอกสารแนะนำสำหรับญาติของผู้ป่วยที่รับการรักษาในไอ.ซี.ยู.อายุรศาสตร์

สภาวะแวดล้อมของไอ.ซี.ยู.

ลักษณะของสถานที่

ตั้งอยู่ด้านทิศเหนือของอาคาร I ชั้นที่ 9 มี 8 เตียง โดยกั้นแยกเป็นห้องเพื่อความสะดวกในการให้การดูแลและการป้องกันการแพร่กระจายเชื้อโรคจากผู้ป่วยคนหนึ่งสู่อีกคนหนึ่ง

ลักษณะการทำงานของเจ้าหน้าที่

มีการดูแลรักษาอย่างใกล้ชิดโดยพยาบาลจำนวน 1คนให้การดูแลผู้ป่วยจำนวน 1-2 คน ตามระดับความรุนแรงและอันตรายของความเจ็บป่วย และมีแพทย์ประจำอยู่ที่หน่วยตลอดเวลา 24 ชั่วโมง สามารถให้การช่วยเหลือผู้ป่วยได้อย่างรวดเร็วถ้ามีอาการเปลี่ยนแปลง

2

ลักษณะของผู้ป่วยวิกฤตที่รับการรักษาในไอ.ซี.ยู.

ได้รับการติดตั้งอุปกรณ์ต่างๆบนร่างกาย ได้แก่

- **อุปกรณ์วัดสัญญาณชีพ :** ซึ่งติดไว้บนร่างกายของผู้ป่วย แล้วมีสายเชื่อมโยงสู่เครื่องแปรสัญญาณที่อยู่ในห้อง ประกอบด้วย อุปกรณ์ตรวจคลื่นหัวใจ วัดความดันโลหิต และวัดระดับออกซิเจนในเลือด เป็นต้น

- **อุปกรณ์ช่วยการหายใจ :** ผู้ป่วยอาจได้รับออกซิเจนลักษณะเป็นสายยางเล็กที่ปลายจมูกหรือลักษณะเป็นหน้ากาก หรืออาจได้รับการใส่ท่อช่วยหายใจผ่านจากปากหรือจมูกลงไปสู่ขั้วปอดและต่อปลายท่อด้วยสายออกซิเจนหรือเครื่องช่วยหายใจ ตามระดับความรุนแรงของอาการเจ็บป่วย ซึ่งการให้การรักษาในลักษณะนี้จะช่วยลดอาการเหนื่อยจากการหายใจเองไม่เพียงพอหรือการที่มีระดับออกซิเจนในเลือดต่ำ

3

- **อุปกรณ์ที่สวนเข้าส่วนต่างๆ ของร่างกาย :** อาจมีสายยางที่ผ่านเข้าส่วนต่างๆของร่างกาย เช่น สายยางผ่านเข้าจมูกลงสู่กระเพาะอาหารเพื่อให้อาหาร น้ำ และยารักษาโรค, สายยางสวนเข้าเส้นเลือดเพื่อให้น้ำเกลือ ให้ยา หรือให้อาหารชนิดเข้มข้น, สายยางสวนเข้าท่อปัสสาวะเพื่อช่วยขับถ่ายปัสสาวะ และผู้ป่วยที่มีอาการผิดปกติอื่นๆหรือได้รับการผ่าตัดอาจมีท่อสอดใส่เข้าไปที่อวัยวะต่างๆ เช่นผ่านหน้าอกสู่ปอด ผ่านบริเวณท้องเข้าสู่ภายในช่องท้อง ผ่านบริเวณลำคอเข้าสู่เส้นเลือดใหญ่ และผ่านบริเวณศีรษะเข้าสู่สมอง

APPENDIX C
INSTRUMENTS FOR DATA COLLECTION

PART I: THE DEMOGRAPHIC CHARACTERISTIC QUESTIONNAIRE

แบบบันทึกข้อมูลส่วนบุคคล

ส่วนที่ 1 ข้อมูลเกี่ยวกับผู้ป่วย

ข้อมูลลำดับที่.....

วัน เดือน ปี.....

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1. เพศ ☐ ชาย ☐ หญิง

2. อายุ……ปี

3. โรคประจำตัว ☐ ไม่มี ☐ มี ได้แก่

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.สำหรับเจ้าหน้าที่กรอก

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1. อาการสำคัญที่ต้องมาโรงพยาบาล.....

2. การเจ็บป่วยในครั้งนี้มีความผิดปกติของการทำงานในระบบใด (ตอบได้มากกว่า 1 ข้อ)

☐ ระบบหายใจล้มเหลว ☐ ระบบหลอดเลือดและหัวใจ

☐ ระบบทางเดินอาหาร ☐ ระบบไหลเวียนโลหิต (Shock & Septic shock)

☐ ระบบการทำงานของไต ☐ ระบบประสาท และความรู้สึกตัว

☐ อื่น ๆ ……..

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แบบบันทึกข้อมูลส่วนบุคคล

ส่วนที่ 2 ข้อมูลเกี่ยวกับญาติ

ข้อมูลลำดับที่.....

วัน เดือน ปี.....

จำนวนชั่วโมงหลังการ Admission ของผู้ป่วย .....ชั่วโมง

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1. เพศ ☐ชาย ☐ หญิง

2. อายุ……ปี

3. ศาสนา……

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10 ค่าใช้จ่ายในการรักษาครั้งนี้

☐ ไม่ต้องรับผิดชอบในการชำระค่ารักษา

☐ เป็นผู้รับผิดชอบค่ารักษาของผู้ป่วย

☐ อื่น ๆ……

SEVERITY MEASUREMENT OF ICU PATIENTS: The APACHEII severity of disease classification system

Physiologic variable	High abnormal range				Low abnormal range				
	+4	+3	+2	+1	0	+1	+2	+3	+4
Temperature-rectal (°C)	≥ 41°	39°-40.9°		38.5°-38.9°	36°-38.4°	34°-35.9°	32°-33.9°	30°-31.9°	≤29.9°
Mean arterial pressure-mmHg	≥ 160	130-159	110-129		70-109		50-69		≤49
Heart rate(ventricular response)	≥ 180	140-179	110-139		70-109		55-69	40-54	≤39
Respiratory rate: non-ventilated or ventilated	≥ 50	35-49		25-34	12-24	10-11	6-9		≤5
Oxyganation: A-aDO_2 or PaO2(mmHg) a. FiO2>0.5 record A-aDO_2	≥ 500	350-499	200-3499		<200				
b. FiO2<0.5 record only PaO_2					PO_2>70	PO_2 61-70		PO_2 55-60	PO_2<55
Arterial pH	≥ 7.7	7.6-7.69		7.5-7.59	7.33-7.49		7.25-7.32	7.15-7.24	<7.15
Serum sodium (mMol/l)	≥ 180	160-179	155-159	150-154	130-149		120-129	111-119	<110
Serum potassium (mMol/l)	≥ 7	6-6.9		5.5-5.9	3.5-5.4	3-3.4	2.5-2.9		<2.5
Serum creatinine (mg/100ml)(Double point score for acute renal failure)	≥ 3.5	2-3.4	1.5-1.9		0.6-1.4		<0.6		
Hematocrit (%)	≥ 60		50-59.9	46-49.9	30.45.9		20-29.9		<20
White blood count (total/mm^3)(in 1,000s)	≥ 40		20-39.9	15-19.9	3-14.9		1-2.9		<1
Glasgow coma score (GCS): Score=15 minus actual GCS									
❶Total Acute physiology score (APS): sum of the 12 individual variable points									
Serum HCO_3 (venous-mMol/L) (Not referred, use if no ABGs)	≥ 52	41-51.9		32-40.9	22.31.9		18-21.9	15-17.9	<15

❷Age points:
Assign points to age as follow:

Age(yrs)	points
≤44	0
45-54	2
55-64	3
65-74	5
≥75	6

❸Chronic health points
If the patient has a history of severe organ system insufficiency or is immuno-compromised assign points as follows:
a. for nonoperative or emergency postoperative patients - 5 points
b. for elective postoperative patients - 2 points

Definitions
Organ insufficiency or immuno-compromised state must have been evident prior to this hospital admission and conform to the follow criteria:
Liver: Biopsy proven cirrhosis and documented portal hypertension; episodes of past upper GI bleeding attributed to portal hypertension; or prior episodes of hepatic failure / encephalopathy / coma
Cardiovascular: New York Association Class IV
Respiratory: Chronic restrictive, obstructive, or vascular disease resulting in severe exercise restriction, i.e., unable to climb stairs or perform household duties; or documented chronic hypoxia, hypercapnia, secondary polycytemia, severe pulmonary hypertension (>40mmHg), or respirator dependency
Renal: Receiving chronic dialysis
Immuno-compromised: The patient has received therapy hat suppresses resistance to infection, e.g., immuno-suppression, chemotherapy, radiation, long term or recent high dose steroids, or has a disease that is sufficiently advanced to suppress resistance to infection e.g., leukemia, lymphoma, AIDS.

APACHE II score
Sum of ❶+❷+❸
❶APS points
❷Age points
❸Chronic health points

Total **APACHE II** _____

PART III: THE GENERAL WELL-BEING SCHEDULE

แบบประเมินความผาสุกโดยทั่วไป

ส่วนที่ 1

คำแนะนำในการตอบแบบสอบถามส่วนที่ 1

แบบสอบถามต่อไปนี้ เป็นคำถามเกี่ยวกับความรู้สึกและเหตุการณ์ต่างๆ ที่เกิดขึ้นกับตัวท่านในขณะนี้ ในแต่ละข้อคำถามกรุณาทำเครื่องหมาย ✓ ลงหน้าข้อความใน ( ) ที่ตรงกับความรู้สึกของท่านมากที่สุดเพียงคำตอบเดียว คำตอบของท่านไม่มีถูกผิด คำตอบที่ถูกมีเพียงข้อเดียว คือ คำตอบที่ตรงกับความรู้สึกหรือตรงกับความเป็นจริงในชีวิตของท่าน

1. โดยทั่วไป ท่านมีความรู้สึกอย่างไร (ในขณะนี้)

( ) รู้สึกเบิกบานใจอย่างที่สุด
( ) รู้สึกเบิกบานใจอย่างมาก
( ) รู้สึกเบิกบานใจเป็นส่วนใหญ่
( ) จิตใจห่อเหี่ยวและเบิกบานพอๆ กัน
( ) จิตใจห่อเหี่ยวเป็นส่วนใหญ่
( ) จิตใจห่อเหี่ยวอย่างมาก

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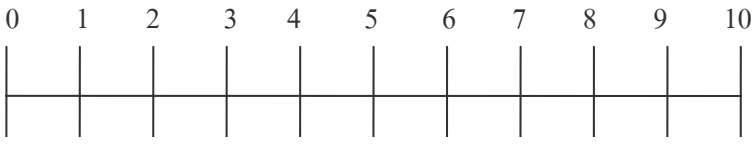
18. อารมณ์และความรู้สึกโดยทั่วไปของท่าน เป็นอย่างไร (ในขณะนี้)



ซึมเศร้า **สดชื่นร่าเริง**

PART IV: THE RELATIVE SATISFACTION SCALE

แบบวัดความพึงพอใจของญาติต่อการพยาบาลที่ได้รับ

คำชี้แจงวัตถุประสงค์

แบบวัดนี้ต้องการทราบความคิดเห็นและความพึงพอใจของท่านต่อการพยาบาลที่ท่านและผู้ป่วยได้รับขณะพักรักษาตัวอยู่ใน โรงพยาบาล เพื่อนำข้อมูลมาปรับปรุงคุณภาพการให้บริการพยาบาลต่อไป ข้อมูลที่ได้จากคำตอบของท่านจะถือว่าเป็นความลับ โดยถูกนำมารวมกับข้อมูลของญาติผู้ป่วยคนอื่นๆ และนำเสนอในภาพรวมพร้อมกับญาติผู้ป่วยคนอื่นๆ และคำตอบของท่านจะไม่มีผลต่อการบริการที่ท่านและผู้ป่วยได้รับแต่อย่างใด

วิธีการตอบแบบวัด

ข้อความทั้งหมดมี 28 ข้อ แต่ละข้อเป็นข้อความที่กล่าวถึงการกระทำของพยาบาลที่กระทำต่อท่านและผู้ป่วย ขอให้ท่านตอบคำถามทุกข้อโดยกาเครื่องหมาย ✓ ลงในช่องคำตอบด้านขวาที่ตรงกับความรู้สึกของท่านมากที่สุดเพียงช่องเดียว คำถามทุกข้อไม่มีคำตอบที่ถูกหรือผิด มีเพียงคำตอบที่ดีที่สุด คือคำตอบที่ตรงกับความรู้สึกของท่านมากที่สุดซึ่งมีเพียงข้อละ 1 คำตอบเท่านั้น

กาเครื่องหมาย ✓ ที่ช่อง 1 เมื่อท่านรู้สึกไม่เห็นด้วยอย่างยิ่งกับข้อความ
กาเครื่องหมาย ✓ ที่ช่อง 2 เมื่อท่านรู้สึกไม่เห็นด้วยกับข้อความ
กาเครื่องหมาย ✓ ที่ช่อง 3 เมื่อท่านรู้สึกเฉยๆ กับข้อความ
กาเครื่องหมาย ✓ ที่ช่อง 4 เมื่อท่านรู้สึกเห็นด้วยกับข้อความ
กาเครื่องหมาย ✓ ที่ช่อง 5 เมื่อท่านรู้สึกเห็นด้วยอย่างยิ่งกับข้อความ

ดังตัวอย่าง

ข้อความ	ไม่เห็นด้วยอย่างยิ่ง 1	ไม่เห็นด้วย 2	เฉยๆ 3	เห็นด้วย 4	เห็นด้วยอย่างยิ่ง 5
1. พยาบาลมีความนุ่มนวลขณะให้การดูแลผู้ป่วย				✓	

แสดงว่า ท่านเห็นด้วยกับข้อความที่กล่าวว่า พยาบาลมีความนุ่มนวลขณะให้การดูแลผู้ป่วย

ข้อความ	ไม่เห็นด้วยอย่างยิ่ง 1	ไม่เห็นด้วย 2	เฉยๆ 3	เห็นด้วย 4	เห็นด้วยอย่างยิ่ง 5
1. พยาบาลไม่สนใจเอาใจใส่ผู้ป่วยเท่าที่ควร					
2.พยาบาลไม่ทำอะไรเลยกับสิ่งที่ผู้ป่วยหรือท่านบอก					
3. พยาบาลไม่มีความเป็นกันเองกับผู้ป่วยและท่าน					
4.พยาบาลไม่มีความอดทน					
5.พยาบาลสนใจที่จะทำงานประจำให้เสร็จมากกว่าที่จะรับฟังเรื่องปัญหาของผู้ป่วยและท่าน					
6.พยาบาลคอยสอดส่องดูแลให้ผู้ป่วยได้รับความช่วยเหลือด้านร่างกายตามที่ผู้ป่วยต้องการ					
7.พยาบาลทำให้ผู้ป่วยและท่านรู้สึกว่าผู้ป่วยเป็นเพียงคนไข้ที่น่าศึกษาเท่านั้นไม่ใช่บุคคลที่มีความรู้สึกนึกคิด					
8.พยาบาลควรจะมีความละเอียดรอบคอบมากกว่านี้					
. . . .					
28.ถ้าจำเป็นต้องได้รับการดูแลรักษาพยาบาลอีก ท่านจะกลับมาที่โรงพยาบาลแห่งนี้					

APPENDIX D

LIST OF EXPERTS

The content of the instruments for intervention and the instruments for data collection in this study were validated by three consulting experts as follow:

1. Associate Professor Orasa Panpakdee, D.N.S.
   Chair of Master of Nursing Science
   Department of Nursing,
   Faculty of Medicine, Ramathibodi Hospital, Mahidol University.

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