

A STUDY OF THE IMPACT CRISIS INTERVENTION HAS ON THE
LEVELS OF ANXIETY, DEPRESSION, AND HOSTILITY
OF FAMILY MEMBERS OF ACUTELY ILL PATIENTS

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DEDICATION

To my parents, whose aspirations for
my future became an incentive,
a goal, and a reality, and

To my husband, whose continuous support,
encouragement, and sacrifice has
made this reality possible

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CHAPTER I

INTRODUCTION

The family is an essential unit in society. It functions as an interacting and transacting organization which provides support and protection for its members. The provision of support and protection may be interrupted by a crisis or hazardous situation within the family unit. When a crisis occurs, the family members may have a decreased ability to cope because they have had no previous experience with the events they are facing. Their perceptions may be distorted by anxiety. The family unit may need assistance to cope with the crisis situation.

Nurses are accessible to many families in a crisis situation and are in a position to offer supportive and therapeutic intervention. This type of supportive and therapeutic intervention is needed in the Intensive Care Unit because each family unit is in a crisis or hazardous situation.

Teaching programs exist for Intensive Care nurses which provide specialized information on the physical skills and treatment modalities necessary to function in an acute

care area. However, few programs exist which provide in-depth information on the psychological and emotional care of the patient and family.

Crisis intervention is a supportive and therapeutic methodology which can be used to provide psychological care to the patient and his family. In the past, it has been used widely in mental health settings or crisis centers. Crisis intervention is now being used in acute care areas. The intent of this study is to implement crisis intervention in an acute care setting and determine its effect. Therefore, the following problem were studied.

Statement of the Problem

The problem of this study is: What impact, if any, does crisis intervention have on the levels of anxiety, depression, and hostility of family members of acutely ill patients?

Statement of the Purposes

The purposes of this study are:

1. To develop a protocol for the implementation of crisis intervention for families of acutely ill patients

2. To determine the family member's level of anxiety with and without crisis intervention
3. To determine the family member's level of depression with and without crisis intervention
4. To determine the family member's level of hostility with and without crisis intervention
5. To compare the family member's level of anxiety, depression, and hostility with and without crisis intervention.

Background and Significance

Crisis occurs when a person faces an obstacle to important goals. For a time, the person's usual methods of problem-solving render the obstacle unsurmountable. A period of disorganization ensues during which many attempts at solution are made (Caplan 1961, p. 18). The nurse, in dealing with persons in crises, has the opportunity to be influential in assisting the individual toward a resolution.

The minimum goal of crisis intervention is resolution of the individual's immediate crisis and restoration to at least the level of functioning that existed prior to the crisis period. A maximum goal is to improve functioning above the pre-crisis level by strengthening coping abilities

(Aguilera 1970, pp. 13-14).

It is possible to anticipate that people will experience crises centered around certain life occurrences. Reactions to accidental crises are also predictable. All stress-provoking events are identified as having the potential for precipitating crises. Since persons in crisis and their needs are readily identifiable, the nurse should direct her intervention toward this specific population. By understanding crisis theory and utilizing crisis intervention, the nurse can provide psychological support to a variety of persons during their times of stress (Grace 1974, p. 1).

Crisis intervention was utilized in this study to provide psychological support for families of acutely ill patients in an Intensive Care Unit. Some effects of crisis intervention were then measured. The main concept of crisis intervention which underlies the research problem has been discussed through use of available literature. Questions that resulted from the problem were as follows.

Questions

1. Can a protocol for implementation of crisis intervention for families of acutely ill patients be developed?
2. What is the family member's level of anxiety, with and without crisis intervention?

3. What is the family member's level of depression with and without crisis intervention?
4. What is the family member's level of hostility with and without crisis intervention?

The one hypothesis of the study tested at a .01 level of significance was:

There is no difference in levels of anxiety, depression, and hostility between families with crisis intervention and families without crisis intervention.

Definition of Terms

Acutely ill is a characteristic of all the patients admitted to the Intensive Care Unit whose diagnosis demands physical support and medical and nursing observation.

Anxiety is a feeling of apprehension which results from a threat to some value which the individual holds essential to his existence as a personality.

Crisis is the situation and the emotional response of having a family member as a patient in the Intensive Care Unit.

Crisis intervention is interaction between the clinical specialist and family members which provides support and assistance with coping.

Depression is a feeling of sadness, dejection, or melancholy.

Families are relatives who consistently visit the acutely ill patient in the Intensive Care Unit. The families have had no previous experience with an Intensive Care Unit (see sample selection).

Hostility is a feeling of antagonism, accompanied by a desire to hurt or humiliate others which may produce subsequent feelings of inadequacy and self rejection owing to a loss of self-esteem.

Limitations

The intervening variables jeopardizing the internal validity and which were not controlled included:

1. The population was limited to those who were willing to participate in the study
2. The study was limited to one hospital in the Central Texas area; therefore, the sample was small and cannot be generalized
3. The demographic variables not controlled were age, race, sex, education, and religion.
These demographic variables were collected and are described in Chapter IV
4. The Hawthorne effect may have influenced the response of family members

5. The variability of the role performance and the communication skills of the staff nurses and/or other health care providers employed in the study setting may have influenced the responses of the family members
6. The effect of the interviewer's voice and nonverbal communication may have influenced subject's answers to the Multiple Affect Adjective Check List

Delimitations

The intervening variables which were controlled in this study included:

1. The population was limited to families of acutely ill patients in the Intensive Care Unit
2. Family members were age eighteen or older and were able to speak and understand English
3. Family members had no previous experience with a mental health professional or the data collection tool
4. Family members consistently visited the acutely ill patient in the Intensive Care Unit

Assumptions

Assumptions made in this study included:

1. The participants gave honest answers
2. Families of acutely ill patients in the Intensive Care Unit were in a crisis situation

Summary

Crisis intervention is a communication methodology which can be used to deal with emotional reactions and the stress of illness. In this study, the independent variable, crisis intervention, was used to manipulate the dependent variables of anxiety, depression, and hostility. The problem, purposes, and definitions were listed. The controlled and uncontrolled variables were identified. The assumption was made that the families of acutely ill patients in the Intensive Care Unit were in a crisis situation.

Overview

The remaining chapters will be described briefly. Chapter II includes a review of current literature. The review will cover topics such as the psychological aspects of intensive care, family unit disruption, and the therapeutic communication of crisis intervention.

Chapter III describes the acute care setting, the population, and the implementation of crisis intervention. Included within this chapter is a description of the experimental and the control group methodology, the scheduled interview, the Multiple Affect Adjective Check List, and the treatment of the data collected.

Chapter IV contains the presentation and the analysis of the data collected. Chapter V includes the summary, conclusions, and recommendations for further study.

CHAPTER II

REVIEW OF LITERATURE

The review of literature encompasses the significant findings from studies reported during the past ten years. Unfortunately, there has been little published research done on families of acutely ill patients and on the use of crisis intervention in the Intensive Care Unit. However, the literature available on these topics is included. The related literature is presented in four parts: 1) Stresses in the Intensive Care Unit, 2) Individual reactions to stress in the Intensive Care Unit, 3) Severe illness as a crisis, and 4) The methodology of crisis intervention.

The Intensive Care Unit

Within the past fifteen years, there has been an immense growth of special care units for the critically ill patient. This has resulted in both improved lifesaving methodologies and the identification of the psychosocial aspects of illness (Kiely 1974, p. 139). Identification of these psychosocial aspects of illness has resulted from a

sharpened focus upon altered states of consciousness, emotional responsibility, and behavioral reactions of the patients being treated. For life-threatening illnesses, attention has also been directed toward the identification of those stressful situations which cause these behavioral responses.

Stresses Associated With the Intensive Care Unit

Stresses related to the Intensive Care Unit are grouped into three categories for this review. The categories included patient stresses, family stresses, and personnel stresses.

Patient Stresses in the Intensive Care Unit

Numerous stressful factors associated with an Intensive Care Unit were identified in the literature. External environmental stressors were frequently referred to. Kiely (1974, pp. 140-141) discussed the usual intensive care design and environment and found them to frequently be multi-bed units which were windowless and austere. A variety of monitors, respirators, and other equipment were located at the bedside. The meaning and purpose of this equipment were frequently ambiguous to the critically ill patients (Kiely 1974, p. 140). Frequently, patient cues for orientation such as day and night, time, date, and place were obscured.

Unfamiliar and bizarre sights, sounds, and smells were present. Expected rights to privacy, personal property, and individual choice were ignored at times. Interpersonal contacts for these persons were numerous with large numbers of unfamiliar hospital staff, and minimal with family and friends. Sleep, meals, and locomotion were absent or altered. The environmental stimulation in the Intensive Care Unit was excessive or deficient, disorganized or incomplete, and unfamiliar and threatening (Marion, Bryan-Brown, and Shoemaker 1963, p. 82).

Stress also resulted from alterations in the patient's sensory system within the Intensive Care setting. The patient frequently found himself uncomfortably hooked up to machines and tubes. Busy people constantly turned and poked him. He felt half naked and almost like a thing instead of a person. When his family was allowed to visit, he saw the fear in their eyes and was reminded of his own fear (Benoliel and Van de Velde 1975, p. 261). These sensory deficits may be heightened by drugs, coma, obtundation, fever, and pain. The sensory systems may also be directly blocked by drug-induced deafness, edematous eyelids, bandages, and restraints. Other examples which were frequently overlooked included a decreased cardiac output, liver disease, renal failure, respiratory insufficiency, blood pressure disturbances, and electrolyte imbalance (Marion, Bryan-Brown, and Shoemaker 1963, pp. 82-83).

The stress produced by the Intensive Care environment and by the patient's illness is heightened by the patient's perception of himself. He may feel "damaged, helpless, and hence childlike, with a tendency to look for omnipotence and infallibility in those who are providing care" (Benoliel and Van De Velde 1975, p. 261). The patient may also ". . . tend to read messages into the behaviors of the staff--although their interpretations may not always be correct" (Benoliel and Van De Velde 1975, p. 261). Thus, the behavioral reactions manifest an alteration in the patient's sensory system and in his external environment.

Family Stresses in the Intensive Care Unit

Little information was available in the literature on families of patients in the Intensive Care Unit. It was noted, however, that these families did experience psychological stress (McClellan 1972, p. 363). The fact that their family member was admitted to the Intensive Care Unit was, in itself, a stress. This meant that their relative was seriously ill, and that his life was threatened. This stress resulted in a family feeling of gratefulness, as they interpreted this to mean that their relative was receiving the best care medical science could offer (Roberts 1976, p. 356).

A great source of stress for families was the Intensive Care Unit's visiting privileges. This privilege was usually very limited for the family, or nonexistent, and thus conflicted with the family's need to be close to their relative during the critical illness (West 1975, p. 63). Furthermore, when the families were allowed to visit in the Intensive Care Unit, another stress was experienced. Familiarity with the internal environment resulted in feelings of discomfort and sympathy for the other patients. This experience added to their concern for their own relative (West 1975, p. 63).

Another stress for the family was communication with the staff. Families needed to be informed on a continuing basis about the general course of the patient's illness, prognosis, and treatment response. Family members felt more comfortable and better able to deal with the situation when they knew the details about their relative's illness (Kiely 1974, p. 142).

Other stresses identified by Kuenzi (1975, pp. 832-833) included lack of privacy and disrupted sleeping and eating habits. She also discussed the stress of a family's newfound friend who loses his family member in the Intensive Care Unit.

Personnel Stresses in the Intensive Care Unit

West (1975, p. 63) suggested that the personnel who care for the critically ill patient in the Intensive Care Unit experienced stress in three areas. These areas included the repetitive exposure to suffering and death; the constant threat of object loss; and feelings of personal failure. The threat of object loss was the main reason that the personnel avoided closeness with patients. It was easier to accept the death of a stranger instead of a friend (West 1975, p. 63). These stresses are compounded by:

. . . work overload; lack of gratification from obtunded patients; and communication problems with physicians, families of the patients, and hospital administrators (West 1975, p. 63).

Additional stress factors on the Intensive Care Unit personnel were described by Cassem and Hackett (1975, p. 253) in their study of sixteen nurses in a Coronary Care Unit. In a questionnaire, the nurses were asked to rate the most difficult stresses associated with their job. Three of the stresses identified included heavy lifting, unpredictable scheduling, and being annoyed by anxious families.

Reactions to Stress in the Intensive Care Unit

It was found that the patient's reaction to the stresses in the Intensive Care Unit is dependent upon many factors. Some of these included the patient's age, level of cerebral competence, characteristic personality style, emotional state, and the nature of previous interpersonal relationships (Lipowski 1970, p. 91).

In his article, Kiely (1974, p. 141) documented some extreme reactions to stress in the Intensive Care Unit. Some of these included diminished meaningfulness of perceptual input, detachment and disengagement of attention to environmental surroundings, and dream-like uprooting from centered time and place which may lead toward delusional and hallucinatory misinterpretation of reality. Visceral changes noted during this study included alteration in cardiac rate, rhythm, blood pressure, and muscle tone. This collection of symptoms has been referred to as the "ICU Syndrome" (Marion 1973, p. 84). Marion, Bryan-Brown, and Shoemaker (1973, p. 84) reported that early recognition of these psychological disturbances and appropriate intervention have resulted in a decreased incidence of the syndrome. Previously, it was considered a major complication of Intensive Care patients.

More common reactions to the stresses of the Intensive Care setting included in the literature were denial, anxiety, depression, hostility, and agitation. These reactions resulted from the environment, the stress of the illness, sensory deprivation, and transfer out of the unit (Hudak 1973, p. 14; West 1975, p. 62). In a study on patient reactions to the stress of illness, it was noted that the stress of illness produces severe anxiety in 80 percent of the patients, depression in 58 percent, overt hostility in 21 percent, and acute agitation in 16 percent. These symptoms tended to overlap, but usually were seen at one time or another in all patients involved (West 1975, p. 62).

Cassem and Hackett (1975, p. 252) reported a similar study on nurses. The study compared Intensive Care nurses with non-Intensive Care nurses. It was determined that Intensive Care nurses, although they do not show any distinctive personality patterns on psychological tests, reported more depression, hostility, and anxiety than non-Intensive Care nurses (Cassem and Hackett 1975, p. 252).

At the time the review of literature was done no similar study had been done on families of patients in Intensive Care. Roberts (1976, p. 353) identified that in some instances, we can only speculate through clinical experiences about the family's inner feelings and reactions. It was also reported that there is a need for more research to

be done in this area. These findings established the need and basis for this study.

Severe Illness as a Crisis

Whenever stressful events occur in a person's life that threaten the sense of biological, psychological, or social integrity, there is some degree of disequilibrium resulting and the possibility of a crisis (Rapoport 1965, p. 22). A crisis has been defined as a:

. . . period of disequilibrium overpowering the individual's homeostatic mechanisms. During a crisis, a person is faced by a problem which, on the one hand, is of basic importance to him because it is linked with his fundamental instinctual needs, and on the other hand, cannot be solved quickly by means of normal range of problem-solving mechanisms (Parad 1965, p. 56).

Rapoport (1965, pp. 24-25) stated that the ego usually responds characteristically with anxiety when an instinctual need or sense of integrity is threatened, and with depression to a loss or deprivation.

According to the general system theory it was determined that crisis, as described above, was not an isolated event. What affected one individual also affected the system of which that individual was a part (Bertalanffy 1968, p. 55). The family has been viewed as a system, small group, or transacting organization (Hill 1965, p. 32). The patient was considered a member of this family system. The need to respond

to illness immediately included the family members within the larger system of medical administration (Hill 1965, p. 32).

When a system responds to a crisis, certain behaviors have been exhibited:

1. A change occurs to a system in dynamic equilibrium
2. The system perceives the change as a disruption of intersystem balance of internal needs and external demands
3. The system mobilizes its habitual problem-solving energies (internal resources) and desires situational support (external resources) to attempt to resolve the imbalance
4. The internal and external resources fail to resolve the problem demands
5. Feelings of helplessness and ineffectiveness result in behavior disorganization (Walkup 1974, pp. 152-153).

This behavior disorganization was exhibited in several ways. The patient as a member of the family, displayed anxiety, depression, and distress in response to the crisis (Kales 1975, p. 110). More specifically, the patient exhibited behaviors such as refusing treatment, anger, confusion, crying, refusal to do things for himself, demanding or sexual behavior toward the staff (Williams 1974, p. 124).

The patient's exhibited behaviors were dependent on his general personality and his previous coping style.

From this background

. . . the patient brings to a crisis situation his habitual attitudes toward and his modes of dealing with novelty and the unfamiliar, dependency, authority figures, and passivity--hallmarks of the sick role in critical care facilities (Kiely 1974, p. 140).

Families also respond to critical illness because it threatens their family integrity. Development of a crisis depended on the family member's interpretation of the critical illness and on their existing coping mechanisms (Williams 1974, p. 38).

Families of critically ill patients were confronted with many types of stress which could have developed into a crisis situation. The first stress experienced by the family was the Intensive Care environment, with its strange machines, sounds, and the dissatisfaction of being forced to remain outside the unit. A second stress was the inability to completely comprehend the medical diagnosis (Roberts 1976, pp. 356-357). The third stress included the crisis of dismemberment. In this situation, a family role was involuntarily vacated through illness. Reallocation of the patient's role to others in the family occurred (Hill 1965, pp. 37-38). Redirecting family energies and restructuring the system was stressful for all family members (Hill 1965, p. 38). The fourth stress was that of financial alteration or loss. This crisis was possible even if the family had health insurance (Roberts 1976, p. 364). When family members were unable to deal with the stresses of the illness previously mentioned, various behaviors indicating crisis were noted. Children in the family frequently began to misbehave in school or be truant. The patient's spouse became belligerent to the

hospital staff and demanding of their time (Roberts 1976, p. 35). No other responses were noted in the literature. According to Croog (1965, p. 136) there is a "lack of any systematic, widely accepted theory which presents an integrated concept of family responses to the crisis of illness."

Personnel in the Intensive Care Unit also experienced crises. If the hospital staff saw the family members as suspicious of their care of the patient, they felt as if they were giving inadequate care. This led to a crisis in the hospital staff. The staff symptoms of crisis included ignoring, yelling at, avoiding, or labeling the patient (Roberts 1976, p. 125).

Thus, crisis is not an isolated event. Davidites (1971, pp. 1588-1589) emphasized the need for a social systems approach in dealing with this type of crisis, thereby implementing a psychosocial intervention in such a way that a more constructive equilibrium could be obtained for the entire system. The use of crisis intervention to achieve equilibrium is reviewed below.

Crisis Intervention

The previous section reviewed the concept of severe illness as a situational crisis for patients, families, and medical personnel. A crisis such as this was formerly viewed as a catastrophic, disorganizing, and destructive

event in your life. The work of Lindemann (1965, pp. 7-21) and Caplan (1961, pp. 34-37) reversed this thinking during their research and development of crisis intervention techniques. Crisis intervention was found to offer immediate help that a person in crisis needed in order to re-establish equilibrium.

The minimum therapeutic goals of crisis intervention was psychological resolution of the individual's immediate crisis and restoration to at least the level of functioning that existed prior to the crisis period. The maximum goal was improvement in functioning above the pre-crisis level (Aguilera, Messick, Farrell 1970, pp. 13-14).

The crisis intervention approach used more frequently in the hospital setting was termed "generic." The proposition of this approach was that there were certain recognized patterns of behavior in most crises (Kuenzi and Fenton 1975, p. 830). Lindemann's studies (1965, pp. 7-12) of bereavement and grief work substantiated this proposition. His work in addition to that of Kubler-Ross (1969, pp. 38-138) formulated the key to crisis intervention in the hospital setting. This key was understanding the five emotional responses which an individual must experience to resolve a situation healthfully. Other authors (Kuenzi and Fenton 1975, p. 83) compress these stages into four responses. These responses included:

1. Shock, disbelief, and denial
2. Anger
3. Depression, and
4. Resolution or acceptance (Kuenzi and Fenton 1975, p. 836).

The generic approach focused on the psychodynamics of each individual in crisis. Specific intervention was designed to be effective for all members of a given group rather than for the individual differences of one person.

This approach has been found to be a feasible mode of intervention that can be learned and implemented by non-psychiatric physicians, nurses, social workers, etc. It does not require a mastery of knowledge of the intrapsychic and interpersonal processes of an individual in crisis (Aguilera, Messick and Farrell 1970, p. 15).

Aguilera (1970, pp. 16-17) and Kuenzi (1975, p. 830) both identified the steps of crisis intervention.

These included:

1. Assessment of the individual and his problem
2. Planning and implementing therapeutic intervention
 - a. Helping the individual gain an understanding of his crisis
 - b. Helping the individual identify his present feelings
 - c. Exploring coping mechanisms
 - d. Resocializing the individual

3. Resolution of the crisis (Aguilera 1970, pp. 16-17; Kuenzi 1975, p. 830).

Aguilera (1975, pp. 54-56) also identified and elaborated upon the three balancing factors which effect a return to equilibrium. These factors included perception of the event, available situational supports, and coping mechanisms (Aguilera 1975, pp. 54-56).

If the event was realistically perceived, there was recognition of the relationship between the event and feelings of stress. If this perception of the event was distorted, there would be no recognition of a relationship and resultant feelings of stress (Aguilera 1975, p. 54).

Situational supports included those persons available in the environment who were depended upon to help solve the problem. Lack of situational support led to a state of disequilibrium and crisis.

Coping mechanisms were patterns of behavioral response established to cope with stressful situations. Examples of behavioral responses included aggression, regression, withdrawal, and repression (Aguilera 1975, p. 56). When a new stress-producing event arose and learned coping mechanisms were ineffectual, discomfort was experienced (Aguilera 1975, p. 56).

An absolute time frame for crisis intervention was not scientifically validated in the literature. Waltzer (1975, p. 551) noted in his article that some people feel uncomfortable with anything less than the traditional "analytic hour" (Waltzer 1975, p. 55). The 45-minute or 50-minute sessions utilized had been arbitrarily determined. The 30-minute session had also been readily accepted by the psychiatric staff as meaningful and appropriate. When crisis intervention was proposed for use in the Intensive Care setting, the time frame was modified even more drastically. It was suggested that "the nurse in the acute care setting has eight hours of daily contact with patients and at least daily contact with family members" (Kuenzi and Fenton 1975, p. 83). Under these circumstances ". . . interventions may take place several times in an eight-hour shift, and each may last only a few minutes" (Kuenzi and Fenton 1975, p. 83). Another modification noted was that the nurse does not see the patient through to resolution of the crisis due to transfer out of the unit (Kuenzi and Fenton 1975, p. 831).

The literature gave a few examples of actual use of crisis intervention in the acute care areas. McClellan (1972, pp. 363-370) reported the use of a crisis group for nurses, patients, and families in renal dialysis units. The goal was to assist the nursing staff in their ability to intervene in the crisis of dialysis. Outcomes as reported by the patient,

families, and nursing staff were beneficial and included support, practical suggestions, and a general reduction of tension and anxiety (McClellan 1972, p. 370).

Cassem and Hackett (1971, pp. 9-14) reported a fifteen-month study of psychiatric consultation in a coronary care unit. The psychiatrist was called for consultation as deemed necessary by the nurses. One third of the admissions to the unit in the time-frame had a psychiatric consultation. This 33 1/3 percent rate of consultation provided probably indicated that the staff found the intervention helpful (Cassem and Hackett 1971, p. 11). Psychological needs of the patients in the study were analyzed. The most common reasons for consultation included anxiety, depression, management of behavior, hostility, and delirium (Cassem and Hackett 1971, p. 11).

Beagle (1974, pp. 135-138) discussed the use of social service to support cardiac patients. In this case, crisis intervention was utilized to prevent a major crisis from occurring with patients having open-heart surgery and their families. The goal was to assist the rehabilitation of the patient and family by making the situation as positive an experience as possible. According to the crisis theory, this kind of a stressful experience can be a period of growth if a person's strength is mobilized and appropriate emotional support is provided (Beagle 1974, p. 136). In this situation

a social worker was assigned to a patient and family. He dealt daily with both the patient and family from two to four days before surgery to the day of dismissal. During this time, he worked with their attitude toward illness, the family relationship, the social-economic situation, the fear of surgery, a visit to the Intensive Care Unit, reinforcement of pre-operative teaching, anticipation of home care and activities. An evaluation of the process was done on the first post-operative outpatient visit to the surgeon. In general, patients and families were pleased with the service.

Zahourek and Morrison (1974, pp. 2034-2063) discussed the use of mental health nurses as consultants to the staff nurses. Crisis intervention theory was also utilized in this setting. However, no specific mention of its use in the Intensive Care setting was made.

Summary

During the past fifteen years, the tremendous growth of special care units for the critically ill patient has also resulted in improved technological support systems and a sharpened focus on behavioral reactions within these units. Many stresses associated with the Intensive Care Unit which may precipitate behavioral reactions were identified. Stress-es specifically experienced by the patient in the Intensive Care Unit were related to his external environment, sensory

systems, and internal environment.

Little information was available in the literature on families of patients in the Intensive Care Unit. However, some environmental stresses were identified which related to limited visiting privileges and communication with the staff.

The Intensive Care Unit personnel also experienced stress. Some of these stresses included work overload, constant exposure to suffering and death, lack of gratification, and communication problems. Different reactions to the stresses of the Intensive Care Unit were listed. Two different studies identified the emotional reactions of anxiety, depression, and hostility. These three reactions were characteristic of both the sample of patients and the sample of nurses which were studied. A similar study was not found on the families of acutely ill patients in the Intensive Care Unit.

Whenever stressful events occur that threaten a person's sense of biological, psychological, or social integrity, there is some degree of disequilibrium resulting and the possibility of a crisis. A person responding to a crisis has feelings of helplessness and ineffectiveness which result in behavior disorganization.

Crisis intervention was a methodology found to offer immediate help that the person in crisis needs in order to re-establish equilibrium. It was noted that this methodology can

be implemented by non-psychiatric persons.

The greatest need identified in the review of literature was the need for more research on families of acutely ill patients. Reviewing the information presented and the needs identified, it seemed feasible to investigate the impact of crisis intervention on families of acutely ill patients in the Intensive Care Unit.

The following chapter presents the methodology for collection of data. A description of the setting, population, and tools is included.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

A quasi-experimental design was the chosen method of research for this study. This approach is specifically for experiments such as this which are carried on under conditions where it is not possible to insure random sample selection.

The Solomon Four-Group design is similar to an experimental approach in that it deals with the phenomenon of cause and effect. The impact of crisis intervention on an experimental sample group was measured and then contrasted with an isolated group. The evaluation of the impact was done by statistical analysis of pretest and posttest Multiple Affect Adjective Check List scores. Both the main effects of testing and the interaction of testing were determined.

Setting

This research project was conducted in the 28-bed Intensive Care Unit of a 499-bed private hospital. The hospital was located in a Central Texas community with a population of 45,000. A waiting area adjacent to the Intensive Care Unit

was available for family members. A small, private conference room was utilized for interaction and data collection.

Population

The population for this study consisted of those families of acutely ill patients in the previously described setting that met the following criteria. These individuals must:

1. Be related to the acutely ill patient by marriage, blood, birth, or adoption
2. Visit the acutely ill patient for two consecutive days after the admission to the unit
3. Have had no previous experience with the data collection tool
4. Have had no previous experience with a mental health professional
5. Speak and understand the English language
6. Be age eighteen years or older

Tools

Two tools were used for collection of the data. Both instruments were administered by the investigator to insure intraobservational reliability. The tools are presented below.

Multiple Affect Adjective Check List

The Multiple Affect Adjective Check List is a test designed to measure the negative affective conditions of anxiety, depression, and hostility. It contains 132 adjectives, alphabetically arranged in three columns (Appendix B). In the administration of this tool, the subject was asked to indicate which word describes how he feels today.

Within the Multiple Affect Adjective Check List, the Anxiety and Depression scales were originally derived empirically by contrasting samples of anxious and depressed psychiatric patients with normal individuals. The Hostility scale was derived by selecting the adjectives endorsed significantly more often by women placed in a hypnotically-induced state of hostility than by women not in a hostile state. No adjectives were included that required more than an eighth grade reading ability. No item was included on more than one scale (Buros 1974, p. 112).

Reliability was established by the split half and retest method. The reliability median was .72 for different groups of subjects (Buros 1974, p. 112). Zuckerman and Lubin (1965, p. 17) reported a mean internal reliability of .71 at a $p \leq .01$ for different sample groups. The test - retest reliability of the total Hostility scale, as well as the reliability of the Anxiety and Depression scales were also

high and significant (Buros 1974, p. 112).

Validity was established by administering the instrument in conjunction with other measures of the three affects. Correlations of the Multiple Affect Adjective Check List with the Taylor Manifest Anxiety Scale, the IPAT Anxiety Scale, and the Welsh Anxiety Index range between .53 and .79. Correlations of the Multiple Affect Adjective Check List with the Gough Adjective Checklist scales range between .46 and .70. Correlations of the Multiple Affect Adjective Check List with the Anxiety, Depression, and Hostility levels of the MMPI range between .01 and .49 (Zuckerman and Lubin 1965, pp. 15-16).

The Multiple Affect Adjective Check List was administered by the investigator. Each adjective was read to the subject and followed by a short pause. During this time, the subject indicated if the word described how he felt that day. A continuing, constant effort was made by the investigator to keep the investigator's position, nonverbal communication, voice tone, and fluctuation consistent throughout each administration of the tool. This was done to control the uniformity of the administration and the influence on the subject's answers.

Scheduled Interview

A scheduled interview was developed (Appendix C). The questions were related to two parameters: 1) demographic data, and 2) stress factors which may have influenced the results of the Multiple Affect Adjective Check List. Content and face validity of the questionnaire was established by an expert panel composed of three members. The educational backgrounds of the panel members included a Master's degree in Medical-Surgical Nursing, a Master's degree in Psychology, and a Master's degree in Sociology. All panel members met the following criteria:

1. Expressed an interest in the subject under study
2. Had previous experience working with crisis intervention
3. Demonstrated a willingness to evaluate the factors to be included in the tool

Panel members were asked for suggestions which related to the previously identified parameters. A questionnaire was formulated from these suggestions and resubmitted to panel members for further evaluation of the content and for semantics. The questionnaire was then finalized.

The questionnaire was pretested on ten graduate nursing students at The Texas Woman's University. These students have had daily contact with patients and family members

in their own working environment. Suggestions were made to simplify the semantics and to improve the understanding. Revisions were made accordingly.

Data Collection

Prior to the period of data collection, the investigator obtained written permission from the study institution and from the Human Rights Committee of the Texas Woman's University (Appendix A). Subjects were also asked to sign an informed consent form affirming their permission to participate in the study (Appendix A). Before this consent form was signed, participants were given the following information:

1. Intent of the study
2. Explanation of the procedures to be followed
3. Description of benefits to be expected
4. Instruction that the subject was free to discontinue participation any time
5. Assurance of confidentiality and security of data obtained

The data were collected for a six-week period until N equalled 40. This collection took place during the peak visitation period between the hours of one p.m. and ten p.m. Tools utilized in the collection of the data included the Multiple Affect Adjective Check List and the scheduled inter-

view. A staff psychologist was available if an unanticipated serious psychological reaction had occurred. The sample was evenly divided into an experimental and control group. The experimental group was manipulated by utilizing two 30-minute sessions of crisis intervention per family member.

A protocol for implementation of crisis intervention was established (Appendix D). Information regarding the steps of crisis intervention and the criteria for implementing these steps was obtained in review of literature. The expert panel, as previously described, was then consulted for suggestions. Revisions were made as recommended.

According to the Solomon Four-Group design, the sample was divided into four subgroups of ten members each. The control group included Group A and Group B. The experimental group included Group C and Group D. Subjects were assigned to one of the four sample groups.

Protocols for the four sample groups are listed below. The protocols were arranged in order that both the main effects of testing and the interaction of testing could be determined.

The Multiple Affect Adjective Check List was administered uniformly as a pretest and as a posttest to the experimental and the control groups (Table 1). This was done to control the influence of predictable environmental stress on the subject's answers to the Multiple Affect

Adjective Check List. The predictable environmental stressors included the patient visits to the Intensive Care Unit and the crisis intervention sessions.

Table 1. Time Frame for Administration of the Multiple Affect Adjective Check List

MAACL	Time	Group
Pretest	1 hour post patient visit	Control and Experimental
Posttest	1 hour post patient visit	Control
Posttest	1 hour post crisis intervention	Experimental

Control Group A Protocol

1. A scheduled interview was given to the family member within the first twenty-four hours after the patient's admission to the Intensive Care Unit. This occurred one hour after the family member visited the patient in the Intensive Care Unit.

2. The Multiple Affect Adjective Check List was given as a pretest to the family member following the scheduled interview.

3. The Multiple Affect Adjective Check List was given as a posttest to the family member on the second day of the patient's hospitalization in the Intensive Care Unit.

This occurred one hour after the family member visited the patient in the Intensive Care Unit.

Control Group B Protocol

1. A scheduled interview was given to the family member on the second day of the patient's hospitalization in the Intensive Care Unit. This occurred one hour after the family member visited the patient in the Intensive Care Unit.

2. The Multiple Affect Adjective Check List was given as a posttest to the family member following the scheduled interview.

Experimental Group C Protocol

1. A scheduled interview was given to the family member within the first twenty-four hours after the patient's admission to the Intensive Care Unit. This occurred one hour after the family member visited the patient in the Intensive Care Unit.

2. The Multiple Affect Adjective Check List was given as a pretest to the family member following the scheduled interview.

3. A thirty-minute session of crisis intervention with the family member followed the administration of the Multiple Affect Adjective Check List.

4. A thirty-minute session of crisis intervention with the family member was done on the second day of the patient's hospitalization in the Intensive Care Unit. This occurred one hour after the family member visited the patient in the Intensive Care Unit.

5. The Multiple Affect Adjective Check List was given as a posttest to the family member on the second day one hour after the crisis intervention session concluded.

Experimental Group D Protocol

1. A scheduled interview was given to the family member within the first twenty-four hours after the patient's admission to the Intensive Care Unit. This occurred one hour after the family member visited the patient in the Intensive Care Unit.

2. A thirty-minute session of crisis intervention with the family member followed the scheduled interview.

3. A thirty-minute session of crisis intervention with the family member was done on the second day of the patient's hospitalization in the Intensive Care Unit. This occurred one hour after the family member visited the patient in the Intensive Care Unit.

4. The Multiple Affect Adjective Check List was given as a posttest to the family member on the second day. This occurred one hour after the crisis intervention session concluded.

Treatment of the Data

Results from the data collection are displayed in tables. Information from the scheduled interviews is categorized in tables to describe and to observe differences in the experimental and the control groups. Multiple Affect Adjective Check List pretest and posttest scores are listed for control and experimental groups. The scores are arranged according to anxiety, depression, and hostility.

The Multiple Affect Adjective Check List scores were analyzed using the One-Way Analysis of Variance. The analysis of variance tests the hypothesis that several means are equal. The test examines the ratio of two or more numbers. The ratio in the analysis of variance has the F distribution. The numerator of the ratio is the average of the squared differences between the group means and the mean of all of the scores. The denominator of the ratio is an estimate of the variance of all scores (Terrace and Parker 1971, p. 15).

The analysis of variance was used to test the hypothesis of the study:

- H_0 There is no difference in the pretest and posttest levels of anxiety, depression, and hostility between families with crisis intervention and families without crisis intervention

The sum of the scores, the F score, the degrees of freedom, and the level of significance are listed for each computation performed. The frequencies of the dependent variables were then analyzed according to the table below. The intervening variables which differed between the experimental and the control groups were further analyzed utilizing the one-way analysis of variance.

Table 2. Identification of Independent and Dependent Variables by Groups

Independent Variables	Dependent Variables	
	Pre- and Post-test	Posttest Only
No Crisis Intervention	A	B
Crisis Intervention	C	D

Summary

A sample of forty participants was chosen from family members of acutely ill patients in one hospital setting. The independent variable, crisis intervention, was used to manipulate the experimental group. The Multiple Affect Adjective Check List was used to measure the effect of crisis intervention. Scores were then compared utilizing a one-way

analysis of variance. The following chapter describes the statistical analysis of the data obtained.

CHAPTER IV

ANALYSIS OF DATA

The purpose of this study was to determine and compare the family member's level of anxiety, depression, and hostility with and without crisis intervention. The data obtained by the methods previously described were analyzed by utilization of the one-way analysis of variance. The presentation will include demographic data, intervening variables, and dependent variables.

The sample consisted of forty family members evenly divided into a control and an experimental section. Group A and Group B formulated the control section with no crisis intervention. Group C and Group D formulated the experimental section and received crisis intervention.

Demographic Data

Demographic information obtained from all subjects included race, age, sex, education, and religion. The race identified in 100 percent of the sample was Caucasian. Other demographic information is described in Tables 3 through 6.

Table 3 describes the ages of the subjects. The greatest percentage of the control group fell into the 55 to 59 year old category. The greatest percentage of the experimental group fell into the 60 to 64 year old category.

Table 3. Comparison of Experimental and Control Groups By Age

Years Old	Control (A&B)		Experimental (C&D)	
	Number	Percent	Number	Percent
20 - 24	1	(5)	2	(10)
25 - 29	1	(5)	3	(15)
30 - 34	1	(5)	2	(10)
35 - 39	1	(5)	1	(5)
40 - 44	1	(5)	0	(0)
45 - 49	3	(15)	3	(15)
50 - 54	2	(10)	2	(10)
55 - 59	5	(25)	1	(5)
60 - 64	3	(15)	5	(25)
65 - 69	1	(5)	1	(5)
70 - 74	1	(5)	0	(0)

Range 22-74 years

Mean 50.7

Median 54.5

Range 21-66 years

Mean 42.65

Median 46

The sex of the family members is described in Table 4. The majority of the participants were females.

Table 4. Comparison of Experimental and Control Groups by Sex

	Control (A&B)		Experimental (C&D)	
	Number	Percent	Number	Percent
Female	17	(85)	13	(65)
Male	3	(15)	7	(35)

The educational levels attained by the study subjects is shown in Table 5. The greatest percentage of the control group had acquired a high school education, while the greatest percentage of the experimental group had completed one to three years of college.

Table 5. Comparison of Experimental and Control Groups by Highest Educational Level

	Control (A&B)		Experimental (C&D)	
	Number	Percent	Number	Percent
6 - 8th grade	1	(5)	3	(15)
9 - 11th grade	2	(10)	4	(20)
High school graduate	11	(55)	4	(20)
1 - 3 years of college	5	(25)	5	(25)
Bachelor's degree	0	(0)	1	(5)
Master's degree	1	(5)	2	(10)
Doctorate degree	0	(0)	1	(5)

Range: 6th grade -
masters
degree
Mean: 11.76 years
Median: 12

Range: 8th grade -
doctorate
degree
Mean: 13.45 years
Median: 12

Table 6 describes the religious preference of the family members. The greatest percentage of both the experimental and the control groups was Protestant.

Table 6. Comparison of Experimental and Control Groups by Religion

	Control (A&B)		Experimental (C&D)	
	Number	Percent	Number	Percent
Protestant	19	(95)	17	(85)
Catholic	1	(5)	1	(5)
Atheist	0	(0)	1	(5)
None	0	(0)	1	(5)

Intervening Variables

Intervening variables are described and analyzed. These are variables which were not controlled, but which may have influenced the dependent variables. This information was obtained by utilizing the scheduled interview previously described. These data have been categorized and then displayed in tables 7 through 11 to compare the control and the experimental groups. The first intervening variable described is the patient's relationship with the visiting family member. The data are presented in Table 7. The patient's relationship identified most frequently in both the control and the experimental group was that of a husband.

Table 7. Patient's Relationship with the Visiting Family Member

	Control (A&B)		Experimental (C&D)	
	Number	Percent	Number	Percent
Wife	2	(10)	6	(30)
Husband	10	(50)	8	(40)
Mother	3	(15)	2	(10)
Father	2	(10)	0	(0)
Daughter	0	(0)	2	(10)
Son	1	(5)	1	(5)
Sister	0	(0)	1	(5)
Brother	2	(10)	0	(0)

Table 8 describes the time interval between the patient's admission and the initial family contact made by the investigator. This time was recorded in terms of the number of hours after the patient's admission to the Intensive Care Unit. The largest percentage of initial contacts in both the control and the experimental group was one to four hours after the patient's admission. The mean number of hours for the control group was 7.8 hours. The mean for the experimental group was 6.7 hours.

Table 8. Time Interval Between the Patient's Admission and the Family Contact by the Investigator

Number of hours after patient admission	Control (A&B)		Experimental (C&D)	
	Number	Percent	Number	Percent
1 - 4	5	(25)	12	(60)
5 - 9	2	(10)	5	(25)
10 - 14	1	(5)	00	(0)
15 - 19	2	(10)	2	(10)
20 - 24	0	(0)	1	(5)
Range: 2-19 hours		Range: 1-20 hours		
Mean: 7.8		Mean: 6.7		
Median: 6		Median: 5.5		

Family members were asked to identify the reason for their relative's hospitalization and their responses are described in Table 9. The most frequent cause for hospitalization listed for both groups was a heart problem. The specific diagnosis for this category includes seven myocardial infarctions, one cardiac arrhythmia, and one coronary arteritis.

Table 9. Identified Reasons for Patient's Hospitalization

	Control (A&B)		Experimental (C&D)	
	Number	Percent	Number	Percent
Operation	3	(15)	3	(15)
Heart problem	5	(25)	4	(20)
Difficulty breathing	1	(5)	2	(10)
Other	11		11	
Brain tumor	2	(10)	2	(10)
Cerebral vascular disease	2	(10)	0	(0)
Cancer	1	(5)	3	(15)
Eclampsia	0	(0)	1	(5)
Gastrointestinal bleeding	1	(5)	0	(0)
Head and multiple injuries	4	(25)	2	(10)
Occlusive vascular disease	1	(5)	2	(10)
Renal failure	0	(0)	1	(5)

Table 10 describes the individual who makes the majority of the decisions in the patient/family member relationship. In the experimental group, the largest percentage of decision making was done by both the family member and the patient. In the control group, the largest percentage of subjects marked the "not applicable" answer, indicating that the visitor's family member was not directly involved in the patient's decision-making or the outcome of this process.

Table 10. Identified Decision-Making in the Patient/Family Member Relationship

	Control (A&B)		Experimental (C&D)	
	Number	Percent	Number	Percent
Family member	0	(0)	4	(20)
Patient	6	(30)	0	(0)
Both	6	(30)	13	(65)
Not applicable	8	(35)	3	(15)

Additional questions and responses obtained during the scheduled interview are described in Table 11. A positive or negative answer was elicited from the subjects. In answer to Question Number 1, "Has the diagnosis been explained to you?", 80 percent of both the control and experimental groups indicated that the diagnosis had been explained to them. The majority of the subjects had no questions. Sixty-five percent of the control group, and 55 percent of the experimental group had no additional questions regarding the patient diagnosis.

Responses to Question Number 2, "Has the treatment been explained to you?", showed that 60 percent of both the control and experimental groups felt that the treatment plan had been explained. Fifty-five percent of the experimental group had no questions regarding the patient's treatment plan. Forty-five percent of the control group had no questions. The control group was further analyzed by comparing the data from

Group A with the data from Group B. Group A provided an answer to this question on the day of the patient's admission to the unit. Group B provided an answer to the question on the second day of the patient's admission to the unit. Forty percent of Group A had questions regarding the patient's treatment plan on the day of the patient's admission to the unit. Seventy percent of Group B had questions regarding the patient's treatment plan on the second day of the patient's admission to the unit.

The answers to the third question, "Is the visiting time in the Intensive Care Unit Adequate?", indicated that the majority of the family members found the Intensive Care Unit's visiting privileges adequate for their needs. Ninety percent of the control group, and eighty percent of the experimental group felt they had enough time to visit their relative in the unit.

Responses to Question Number 4, "Do you have dependents at home?", demonstrated that the largest percentage of the subjects had no dependents at home. Sixty-five percent of the control group, and 55 percent of the experimental group, had no dependents at home. The control group had a mean number of 2.4 dependents at home. The range was one to four persons. The experimental group had a mean number of 1.4 dependents at home. The number of dependents at home was either one or two persons.

The responses to Question Number 5, "Is it easy for you to get to the hospital?", indicates that 50 percent of the control group found it easy to get to the hospital. Ninety percent of this group traveled by car a mean distance of 158 miles. Sixty percent of the experimental group found it easy to get to the hospital. One hundred percent traveled by car. A mean distance of 137 miles was traveled.

The majority of the patients had health insurance, as documented in the responses to Question Number 6, "Does the patient have health insurance?". Ninety percent of the control group, and 75 percent of the experimental group had health insurance.

The answers to the seventh question, "Have you had any previous experience with illness or death?", showed that 85 percent of both the control and the experimental group had previous experience with illness or death. The control group's range of years since the experience with illness or death was 1 to 20 years. The mean number was 6 years. The experimental group's range of years since the experience with illness or death was 1 to 30 years. The mean number was 5 years.

Table 11. A Description of Uncontrolled Intervening Variables

Question Number	Control (A&B)		Experimental (C&D)	
	Yes	No	Yes	No
1. Has the diagnosis been explained to you?	16	4	16	4
2. Has the treatment plan been explained to you?	12	8	12	8
3. Is the visiting time in the Intensive Care Unit adequate?	18	2	16	4
4. Do you have dependents at home?	7	13	9	11
5. Is it easy for you to get to the hospital?	10	10	12	8
6. Does the patient have health insurance?	18	2	15	5
7. Have you had any previous experience with illness or death?	17	3	17	3

The data demonstrating similarities in the control and the experimental groups were described in Tables 7 through 11. The data representing differences in the control and the experimental groups are listed and described in Tables 12 through 16. Information for these tables was obtained from

from the scheduled interview. The analysis of variance was utilized to determine if there was a statistically significant difference between the dependent variable scores. If significantly different, did a relation exist between the intervening variable and the dependent variables?

Table 12 presents an analysis of the relation between Intensive Care experience and the dependent variables of anxiety, depression, and hostility. Intensive Care experience represents sample subjects who had previous experience in an Intensive Care Unit as a patient or as a visitor. The analysis of variance demonstrated that there was no statistically significant difference between the subject's scores with Intensive Care experience and the subject's scores who had no previous Intensive Care experience, at a .01 level of significance. Therefore, the intervening variable and the dependent variables were not related.

Table 12. Analysis of the Relationship Between
Intensive Care Experience and the
Dependent Variables

	Intensive Care Experience	No Intensive Care Experience	
Anxiety scores	$\Sigma = 825$	$\Sigma = 1470$	F=4.64
Depression scores	$\Sigma = 823$	$\Sigma = 1380$	F=1.24
Hostility scores	$\Sigma = 731$	$\Sigma = 942$	F=2.35

df = 1/38 a=.01

Table 13 describes an analysis of the relation between present employment and the dependent variables. Present employment represents family members who are currently working. The analysis of variance demonstrated that there was no statistically significant difference between the subject's scores with present employment and the subject's scores without present employment at a .01 level of significance. Therefore, the intervening variable and the dependent variables were not related.

Table 13. Analysis of the Relationship Between Present Employment and the Dependent Variables

	Present Employment	No Present Employment	
Anxiety scores	$\Sigma = 1059$	$\Sigma = 1201$	F= 1.63
Depression scores	$\Sigma = 1067$	$\Sigma = 1136$	F= .41
Hostility scores	$\Sigma = 836$	$\Sigma = 837$	F= 0.00

df = 1/38 a=.01

Table 14 presents the analysis of the relation between providing the main financial support and the dependent variables. Providing the main financial support represents the patients who provide the main financial support for the family. The analysis of variance demonstrated that there was no statistically significant difference between the subject's scores whose family member provided the main financial support and whose family member did not provide the main financial support, and whose main financial support was provided jointly. This was true at a .01 level of significance. Therefore, the intervening variable and the dependent variables were not related.

Table 14. Analysis of the Relationship Between
Provision of the Main Financial
Support and the Dependent Variables

	Patient Provides Main Support	Patient Does not Provide Main Support	Joint Provision	
Anxiety scores	$\Sigma = 1126$	$\Sigma = 606$	$\Sigma = 528$	$F = 3.54$
Depression scores	$\Sigma = 1074$	$\Sigma = 619$	$\Sigma = 510$	$F = 2.07$
Hostility scores	$\Sigma = 787$	$\Sigma = 515$	$\Sigma = 371$	$F = .36$

df = 2/37 $\alpha = .01$

Table 15 shows an analysis of the relationship between the type of admission and the dependent variables. The type of admission refers to a classification of expected versus unexpected patient admissions. The analysis of variance demonstrated that there was no statistically significant difference between the subject's scores whose family member's admission was expected and the subject's scores whose family member's admission was unexpected. This was true at a .01 level of significance. Therefore, the intervening variable and the dependent variables were not related.

Table 15. Analysis of the Relationship Between
Type of Admission and the
Dependent Variables

	Expected Admission	Unexpected Admission	
Anxiety Scores	$\Sigma = 366$	$\Sigma = 1894$	F= .47
Depression Scores	$\Sigma = 357$	$\Sigma = 1846$	F= .49
Hostility Scores	$\Sigma = 240$	$\Sigma = 1433$	F= 2.89

df = 1/38 a=.01

Table 16 describes the analysis of the relation between patient condition and the dependent variables. The patient condition represents the family member's interpretation of the patient's condition on the second day. The analysis of variance demonstrated that there was a statistically significant difference between the subject's scores when the patient's condition improved and the subject's scores when the patient's condition remained the same on the second day. This was supported at a .01 level of significance. Therefore, the intervening variable and the dependent variables were related.

Table 16. Analysis of the Relationship Between Patient Condition and the Dependent Variables

	Condition Improved	Condition Same	
Anxiety Scores	$\Sigma = 1108$	$\Sigma = 1091$	F=16.51
Depression Scores	$\Sigma = 1073$	$\Sigma = 1083$	F=22.28
Hostility Scores	$\Sigma = 841$	$\Sigma = 796$	F=11.77

df = 1/37 a=.01

Thus, one intervening variable analyzed was shown to be statistically significant, and therefore related in some way to the dependent variables. This intervening variable, patient condition, was not controlled and may therefore have influenced the data presented below.

Dependent Variables

In the following analysis, a description of the dependent variables is given. The hypothesis of the study was then tested utilizing the analysis of variance.

The dependent variables are presented in Table 17 as anxiety, depression, and hostility scores. This information was obtained from the Multiple Affect Adjective Check List. Mean scores for the groups are displayed in their pretest and posttest category.

Table 17. Mean Scores for the Dependent Variables
Anxiety, Depression and Hostility

Groups	PRETEST SCORES			POSTTEST SCORES		
	Anxiety	Depression	Hostility	Anxiety	Depression	Hostility
Control						
A	76.2	71.9	51.5	70.5	69.2	51.2
B				68	63.4	41.2
Experi- mental						
C	71.1	70.1	50.3	44.5	46.5	41.6
D				43	41.2	33.3

The hypothesis of the study was:

H_0 There is no difference in levels of anxiety, depression, and hostility between families with crisis intervention and families without crisis intervention

The hypothesis was clarified for the purposes of analysis and tested as:

H_{01} There is no difference in pretest levels of anxiety, depression, and hostility between families with crisis intervention and families without crisis intervention

H_{02} There is no difference in posttest levels of anxiety, depression, and hostility between families with crisis intervention and families without crisis intervention

The one-way analysis of variance was utilized to determine whether there was a significant statistical difference in the levels of anxiety, depression, and hostility. Pretest scores were compared by performing an analysis of variance on the pretest scores of Groups A and C. Posttest scores were compared by performing an analysis of variance on the posttest scores of Groups A and B, C and D, A and C,

B and D, A and D, and B and C. The analysis is presented in Table 18.

There was no statistically significant difference between pretest levels of anxiety, depression, and hostility at a .01 level of significance. Therefore, the first null hypothesis was not rejected.

There was a statistically significant difference between posttest levels of anxiety, depression, and hostility at a .01 level of significance. This was observed between Groups B and D and A and D. There was also a statistically significant difference between posttest levels of anxiety and depression, but not hostility, at a .01 level of significance between groups A and C and B and C. Therefore, the second null hypothesis was rejected for anxiety and depression, but not for hostility. This demonstrates that the independent variable, crisis intervention, was related in some way to the dependent variables.

There was no statistically significant difference between Groups A and B and Groups C and D. This indicated that the pretesting had no significant influence on the posttesting.

Table 18. Analysis of the Dependent Variables
Anxiety, Depression, and Hostility

	Sum of Scores			Analysis of Variance	Computed F Values		
	Anxiety	Depression	Hostility		Anxiety	Depression	Hostility
Pre- test							
A	762	719	515	A&C pretest	1.45	.06	.03
C	711	701	503				
Post- test							
				A&B posttest	.19	.79	2.79
A	705	692	512	C&B posttest	.07	1.26	3.13
B	680	634	412	A&C posttest	21.52	15.84	1.74
C	445	465	416	B&D posttest	19.41	15.30	12.17
D	430	412	333	A&D posttest	21.92	23.05	10.06
				B&C posttest	18.97	9.29	.01

Summary

The demographic data were categorized and displayed in tables. Intervening variables showing similarities between the experimental and the control groups were described. Intervening variables exhibiting differences included Intensive Care experience, present employment, provision of financial support, the type of admission, and the patient's condition. These intervening variables were investigated by utilizing the analysis of variance. The only intervening variable which was statistically significant at the .01 level was the patient's condition. Posttest levels of anxiety and depression were also statistically different at the .01 level for family members with crisis intervention and families without crisis intervention.

CHAPTER V

SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

The following chapter is a summary of the entire study. Conclusions are drawn from the data obtained in the study. Implications of the conclusions are then stated, followed by the recommendations.

Summary

This investigation was a quasi-experimental study of the impact of crisis intervention on the family members of acutely ill patients. It was conducted in a 28-bed Intensive Care Unit of a 499-bed private hospital in Central Texas.

The data were collected for a six-week period until N equalled 40. The sample was evenly divided into an experimental and control group. The experimental group was manipulated by utilizing two 30-minute sessions of crisis intervention.

The Multiple Affect Adjective Check List and a scheduled interview were used to collect data. Protocols for implementation of crisis intervention and for the collection of data were developed.

The dependent variables and the differences in intervening variables were compared by utilizing the analysis of variance. The intervening variable of patient condition was determined statistically significant, and therefore related to the dependent variables. The posttest levels of anxiety and depression were determined statistically significant for families with crisis intervention and families without crisis intervention. The independent variable is related in some way to the dependent variable.

Conclusions

The conclusions which resulted from this study were:

1. A protocol for crisis intervention (Appendix D) can be formulated and utilized to deal with family members' levels of anxiety, depression, and hostility
2. The Multiple Affect Adjective Check List can be utilized to determine family member's levels of anxiety, hostility, and depression
3. There is no statistically significant difference between the intervening variables (Intensive Care experience, present employment, provision

of financial support, the type of admission) and the dependent variables (anxiety, depression, and hostility).

4. There is a statistically significant difference between the subject's scores when the patient condition improved and the subjects' scores when the patient's condition remained the same.
5. There is no statistically significant difference between the subject's scores with Intensive Care experience and the subject's scores who had no previous Intensive Care experience.
6. There is no statistically significant difference between pretest levels of anxiety, depression, and hostility of families with crisis intervention and families without crisis intervention.
7. There is a statistically significant difference between posttest levels of anxiety and depression of families with crisis intervention and families without crisis intervention.

Implications

As a result of the findings of this study, several implications for nursing are presented. Crisis intervention was found to have a significant influence on the levels of anxiety, depression, and hostility of family members of acutely ill patients. Nursing educators in the hospital and nursing schools need to develop curriculums to facilitate understanding of crisis intervention protocols. These protocols should be utilized as a guide for nurses to assist individuals to resolve a crisis situation through appropriate coping mechanisms.

Recommendations

The recommendations resulting from this study are:

1. That the study should be replicated using a larger sample obtained from various populations
2. That similar studies be implemented in other areas of the hospital
3. That additional Intensive Care Units be utilized in a repeat study so that data could be compared or contrasted with the data derived from this study

4. That nurses serve as patient/family advocates
by implementing crisis intervention in the
hospital setting

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APPENDIX A

PERMISSION FOR THE STUDY

TEXAS WOMAN'S UNIVERSITY
DALLAS, TEXAS 75235



COLLEGE OF NURSING

February 4, 1977

Diana Twidwell
Texas Woman's University
College of Nursing
1522 Thornton Lane
Temple, Texas 76501

Dear Ms. Twidwell:

The Dallas Center Sub-Committee for Human Research has approved your proposal for "A Study of the Impact Crisis Intervention has on the Levels of Anxiety, Depression, and Hostility of Family Members of Acutely Ill Patients." Following acquisition of agency approval you may now proceed with your data collection as planned.

Sincerely,

A handwritten signature in cursive script that reads 'Geri Goosen'.

Geri Goosen
Chairman of Human Research Committee

cc: Dr. Phyllis Bridges
Graduate Dean

GG:js

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HOUSTON CENTER
1130 M.D. Anderson Blvd.
Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Scotland White Memorial Hospital
GRANTS TO Miana Fox Twidwell

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

What impact, if any, does crisis intervention have on the levels of anxiety, depression, and hostility of family members of acutely ill patients?

The conditions mutually agreed upon are as follows:

1. The agency (may) (~~may not~~) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (~~may not~~) be identified in the final report.
3. The agency (wants) (~~does not want~~) a conference with the student when the report is completed.
4. The agency is (~~willing~~) (unwilling) to allow the completed report to be circulated through interlibrary loan. *MAY BE ALTERED POSITION IN FUTURE*
5. Other: _____

Date January 18, 1977

Miana Fox Twidwell
Signature of student

William C. Archille
Signature of Agency Personnel

Mona M. Counts, R.N. M.D.
Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original -- Student; first copy -- agency; second copy -- T.W.U. College of Nursing.

APPENDIX B

MULTIPLE AFFECT ADJECTIVE CHECK LIST

APPENDIX B

	A	D	H
1 <input type="checkbox"/> active	45 <input type="checkbox"/> fit	89 <input type="checkbox"/> peaceful	
2 <input type="checkbox"/> adventurous	46 <input type="checkbox"/> forlorn	90 <input type="checkbox"/> pleased	
3 <input type="checkbox"/> affectionate	47 <input type="checkbox"/> frank	91 <input type="checkbox"/> pleasant	
4 <input type="checkbox"/> afraid	48 <input type="checkbox"/> free	92 <input type="checkbox"/> polite	
5 <input type="checkbox"/> agitated	49 <input type="checkbox"/> friendly	93 <input type="checkbox"/> powerful	
6 <input type="checkbox"/> agreeable	50 <input type="checkbox"/> frightened	94 <input type="checkbox"/> quiet	
7 <input type="checkbox"/> aggressive	51 <input type="checkbox"/> furious	95 <input type="checkbox"/> reckless	
8 <input type="checkbox"/> alive	52 <input type="checkbox"/> gay	96 <input type="checkbox"/> rejected	
9 <input type="checkbox"/> alone	53 <input type="checkbox"/> gentle	97 <input type="checkbox"/> rough	
10 <input type="checkbox"/> amiable	54 <input type="checkbox"/> glad	98 <input type="checkbox"/> sad	
11 <input type="checkbox"/> amused	55 <input type="checkbox"/> gloomy	99 <input type="checkbox"/> safe	
12 <input type="checkbox"/> angry	56 <input type="checkbox"/> good	100 <input type="checkbox"/> satisfied	
13 <input type="checkbox"/> annoyed	57 <input type="checkbox"/> good-natured	101 <input type="checkbox"/> secure	
14 <input type="checkbox"/> awful	58 <input type="checkbox"/> grim	102 <input type="checkbox"/> shaky	
15 <input type="checkbox"/> bashful	59 <input type="checkbox"/> happy	103 <input type="checkbox"/> shy	
16 <input type="checkbox"/> bitter	60 <input type="checkbox"/> healthy	104 <input type="checkbox"/> soothed	
17 <input type="checkbox"/> blue	61 <input type="checkbox"/> hopeless	105 <input type="checkbox"/> steady	
18 <input type="checkbox"/> bored	62 <input type="checkbox"/> hostile	106 <input type="checkbox"/> stubborn	
19 <input type="checkbox"/> calm	63 <input type="checkbox"/> impatient	107 <input type="checkbox"/> stormy	
20 <input type="checkbox"/> cautious	64 <input type="checkbox"/> incensed	108 <input type="checkbox"/> strong	
21 <input type="checkbox"/> cheerful	65 <input type="checkbox"/> indignant	109 <input type="checkbox"/> suffering	
22 <input type="checkbox"/> clean	66 <input type="checkbox"/> inspired	110 <input type="checkbox"/> sullen	
23 <input type="checkbox"/> complaining	67 <input type="checkbox"/> interested	111 <input type="checkbox"/> sunk	
24 <input type="checkbox"/> contented	68 <input type="checkbox"/> irritated	112 <input type="checkbox"/> sympathetic	
25 <input type="checkbox"/> contrary	69 <input type="checkbox"/> jealous	113 <input type="checkbox"/> tame	
26 <input type="checkbox"/> cool	70 <input type="checkbox"/> joyful	114 <input type="checkbox"/> tender	
27 <input type="checkbox"/> cooperative	71 <input type="checkbox"/> kindly	115 <input type="checkbox"/> tense	
28 <input type="checkbox"/> critical	72 <input type="checkbox"/> lonely	116 <input type="checkbox"/> terrible	
29 <input type="checkbox"/> cross	73 <input type="checkbox"/> lost	117 <input type="checkbox"/> terrified	
30 <input type="checkbox"/> cruel	74 <input type="checkbox"/> loving	118 <input type="checkbox"/> thoughtful	
31 <input type="checkbox"/> daring	75 <input type="checkbox"/> low	119 <input type="checkbox"/> timid	
32 <input type="checkbox"/> desperate	76 <input type="checkbox"/> lucky	120 <input type="checkbox"/> tormented	
33 <input type="checkbox"/> destroyed	77 <input type="checkbox"/> mad	121 <input type="checkbox"/> understanding	
34 <input type="checkbox"/> devoted	78 <input type="checkbox"/> mean	122 <input type="checkbox"/> unhappy	
35 <input type="checkbox"/> disagreeable	79 <input type="checkbox"/> meek	123 <input type="checkbox"/> unsociable	
36 <input type="checkbox"/> discontented	80 <input type="checkbox"/> merry	124 <input type="checkbox"/> upset	
37 <input type="checkbox"/> discouraged	81 <input type="checkbox"/> mild	125 <input type="checkbox"/> vexed	
38 <input type="checkbox"/> disgusted	82 <input type="checkbox"/> miserable	126 <input type="checkbox"/> warm	
39 <input type="checkbox"/> displeased	83 <input type="checkbox"/> nervous	127 <input type="checkbox"/> whole	
40 <input type="checkbox"/> energetic	84 <input type="checkbox"/> obliging	128 <input type="checkbox"/> wild	
41 <input type="checkbox"/> enraged	85 <input type="checkbox"/> offended	129 <input type="checkbox"/> willful	
42 <input type="checkbox"/> enthusiastic	86 <input type="checkbox"/> outraged	130 <input type="checkbox"/> wilted	
43 <input type="checkbox"/> fearful	87 <input type="checkbox"/> panicky	131 <input type="checkbox"/> worrying	
44 <input type="checkbox"/> fine	88 <input type="checkbox"/> patient	132 <input type="checkbox"/> young	

APPENDIX C

SCHEDULED INTERVIEW

APPENDIX C - SCHEDULED INTERVIEW

Demographic Data:

Number	_____	Religion	_____
Age	_____	Patient age	_____
Sex	_____	Patient diagnosis	_____
Race	_____	Patient employment	_____
Education	_____	Patient condition	_____
		on second day	_____

1. What is the relationship between you and the patient?
 - a. wife
 - b. husband
 - c. mother
 - d. father
 - e. daughter
 - f. son
 - g. sister
 - h. brother
 - i. other _____

2. When was your _____ admitted:

(insert relationship)

 - a. to the hospital? _____
 - b. to the unit? _____

3. Was this hospital admission
 - a. unexpected
 - b. expected
 - c. length of time expected _____

4. What is your _____ being hospitalized

(insert relationship)

 for?
 - a. operation
 - b. heart problem
 - c. difficulty breathing
 - d. burns
 - e. other _____

5. Has the doctor or nurse explained to you what is wrong
 with your _____?

(insert relationship)

 - a. yes
 - b. no
 - c. explain _____
 - d. Do you have any other questions?

(1) yes (2) No

APPENDIX C - SCHEDULED INTERVIEW

6. Has the doctor or nurse explained the type of treatment that will be used?
- a. yes
 - b. no
 - c. explain _____
 - d. Do you have any other questions?
(1) yes (2) no
7. Do you feel you have enough time to visit with your _____ in the Intensive Care Unit?
(insert relationship)
- a. yes
 - b. no
8. Have you ever been in an Intensive Care Unit as a patient or a visitor?
- a. yes
 - b. no
 - c. how long ago _____
9. Do you have any people at home who depend on you?
- a. yes
 - b. no
 - c. number _____
 - d. ages _____
10. Is it easy for you to get to the hospital?
- a. yes
 - b. no
 - c. how _____
 - d. relationship to driver _____
11. How far do you live from the hospital? _____
12. Does your _____ have health insurance?
(insert relationship)
- a. yes
 - b. no
13. Are you presently employed?
- a. yes
 - b. no
 - c. where _____
 - d. full time
 - e. part time

APPENDIX C - SCHEDULED INTERVIEW

14. Have you had any experience with illness or death in your family or with a close friend?
- a. yes
 - b. no
 - c. whom _____
 - d. how long ago _____
15. Does your _____ provide the main financial support for the family?
(insert relationship)
- a. yes
 - b. no
16. Did you have any disagreement or argument with your _____ before the admission?
(insert relationship)
- a. yes
 - b. no
 - c. when _____
 - d. major _____
 - e. minor _____
17. Who makes more of the decisions in your relationship?
- a. you
 - b. your _____
(insert relationship)
 - c. both
 - d. not applicable
18. When you're upset what do you do to make yourself feel better?, e.g., cry, talk to friend, run, drink, etc.
19. Who has helped you the most during the times when you've been upset?

SCHEDULE D

PROTOCOL FOR CRISIS INTERVENTION

APPENDIX D - PROTOCOL FOR CRISIS INTERVENTION

Generic Approach

Steps:

1. Assessment - Determine what precipitating event caused the emotional disequilibrium. Assess the circumstances directly related to the immediate crisis situation. The following examples may be utilized:
 - a. Tell me what's been happening or what's been different in the last couple of weeks?
 - b. From our previous interview, I see (fill in pertinent information). Do you want to discuss this or do you see another problem area?In this situation, the immediate hazard is usually obvious, being whatever brought the patient to the Intensive Care Unit. Accomplish this step through use of the scheduled interview.
2. Intervention - Intervene appropriately by accomplishing the following measures:
 - a. Help the individual to gain an intellectual understanding of his crisis. Here, you may need to describe the relationship between the crisis and the event in his life.
 - b. Help the individual bring into the open his present feelings. Attempt to reduce tension to help the individual recognize his feelings.
 - c. Understand the four emotional responses which an individual must experience to resolve a situation healthfully. These include:
 - (1) shock, disbelief, and denial
 - (2) anger
 - (3) depression
 - (4) resolution or acceptanceEncourage the person to express his feelings. Inform the person that it's O.K. and normal to feel this way in this particular situation.
 - d. Explore coping mechanisms by utilizing the following measures:
 - (1) Determine how the crisis has disrupted the individual's life and environment
 - (2) Determine what coping skills may have been used successfully in the past. Will they work now?
 - (3) Determine what people in his life may be used for support.
 - (4) Determine alternative methods of coping.

APPENDIX D - PROTOCOL FOR CRISIS INTERVENTION

- (5) Encourage the person to get back in touch with family, friends, and/or work associates. This step must be individualized for each family member. Gather information necessary for the intervention from the scheduled interview.
- 3. Resolution of the Crisis and Anticipatory Guidance
Conclude the intervention by performing the following measures:
 - a. Summarize the entire crisis situation.
 - b. Reinforce the individual's strengths and healthy coping mechanisms.
 - c. Provide assistance, as needed, in making realistic plans for the future.
 - d. Discuss what the individual would do in similar circumstances in the future