

# Family Members Involvement in Patient Care: Are They Invited?

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## Abstract

**Introduction:** Health care providers are expected to gain vital information regarding the patient, illness, and relationships from family members and the social network through therapeutic conversation, particularly when a patient is in a position where he/she cannot provide reliable or complete information.

This review aimed to provide simple advice and tips for healthcare providers regarding the engagement of family members in developing an optimal nursing and medical healthcare plans for their relative patients during hospitalization and after being discharged

**Conclusions:** The involvement of family members within a patient's social network is essential for the development of an appropriate medical and nursing care plan. There is a pressing need to effectively use information obtained from family therapy interviews. Keeping an open communication channel with close family members during patient hospitalization is beneficial to the patient, family members and to healthcare providers. This will also offer a mutual understanding and a better adherence to the agreed healthcare plan. Furthermore, many aspects of medicine, including primary healthcare can be improved by family therapy.

**Key Words:** Family-Oriented Patient Care, Healthcare Providers, Communication Skills, Family Therapy

## Introduction

Research has shown that family members and close individuals within the social network can provide an improved understanding of the patient, which is critical in optimal treatment planning and delivery. Health care providers (e.g., physicians, nurses, respiratory therapists, etc.) are expected to gain vital information regarding the patient, illness, and relationships from family members and the social network through therapeutic conversation (Haine-Schlagel & Walsh, 2015).

This review aims to provide simple advice and tips for healthcare providers regarding the engagement of family members in developing an optimal nursing and medical healthcare plans for their relative patients.

## Healing Elements of Therapeutic Conversation

The healing elements of therapeutic conversation are imperative to the success of therapy interviews. Seikkula & Trimble (2005) outlined “actions that support dialogue in conversation, shared emotional experience, creation of community, and creation of new shared language” among the vital elements of therapeutic conversation. Each of the stated elements is essential as conversations enable therapists to understand the “reciprocal relationships” between patients and the rest of nature, including social networks (Clayton & Saunders, 2012).

An in-depth understanding of the nature of patients’ relationships with outer elements helps in the development of a suitable care plan. To facilitate conversation, therapists are required to perform the stated actions that support dialogue. The first action concerns the creation of a shared language. Therapists should seek information using techniques that make the telling of relevant stories an easy task. Also, healthcare professionals should listen “compassionately and intently,” and engage in reflective dialogue connecting the collective contributions of participants as opposed to focusing on single utterances. The stated strategies facilitate a shared language that increases understanding of the illness among all participants, particularly the patient and health care provider (Seikkula & Trimble, 2005).

Moreover, Seikkula & Trimble (2005) noted that a shared language generates communal feelings as each participant is vested in the recovery of the patient following participation in open dialogue. Further, when participants experience feelings of togetherness, the resulting familiarity enables the sharing of the “not-yet-said”. Creating communities encourages the sharing of experiences that participants otherwise cannot share with unfamiliar therapists. To enrich conversation, the attention of therapists is drawn to the role of “shared experience of emotion” that can be created by responding to “odd or frightening psychotic” utterances from patients with similar manner and disposition as comments from family members. In addition, healthcare providers should inform

family members that all contributions of the team will be utilized in the improvement of the care process to inspire in-depth conversation.

The emotions of participants also impact the interview process as clues to the nature of relationships within the social network. A healthcare provider can establish the emotions of participants by remaining vigilant of changes in body language, including “tears in the eye, constriction in the throat, changes in posture, and facial expression”. Shared language, feelings of togetherness, and a common experience of emotion help care professionals to gain an improved understanding of the medical conditions ailing patients (Seikkula & Trimble, 2005).

## The Therapist’s Inner Conversation

In family therapy, the therapist’s inner conversation is a challenging practice that can be identified as a “negotiation between the self of the therapist and his role.” (Rober, 1999). This definition is based on a recognition of the influence of therapist’s ideas, thoughts, and imagination on therapy processes.

Notably, Rober (1999) argued that the outer and inner conversations of a therapist are influenced by the utterances of patients and family members. Given the influence of both the internal and external environments, attaining a balance between the inner and outer conversations is a challenging task for professionals in care settings, intensive care units (ICU) included.

Rober (1999) noted that patients often seek therapy with a story to tell. The therapist’s role involves gaining insight into the story to improve understanding of the medical condition. Patients can engage in ‘selectivity,’ whereby particular aspects of the story are shared, and others are left in obscurity. The questions a therapist asks to generate information about the story originate from inner conversations within him or herself. Put differently, the content of the outer talk with family members informs the therapist’s inner conversation. Therefore, inner conversations should generate as many ideas as are discussed in the outer conversation. Consequently, therapists are cautioned against prioritizing particular ideas, as a result of inherent ideologies, to generalize the patient’s condition.

Therapists ought to be flexible and entertain “multiple views” while conversing internally. Further teachings regarding the utilization of inner conversations included that a therapist should refrain from acting unless inner conversation aligns with the context of each session (Rober, 1999).

Essentially, the inner conversations should be used to develop techniques through which a therapist can promote healing in spite of contrasting agendas and realities. The primary challenge concerns striking a balance between the inner and outer conversations such that inner processes facilitate rather than inhibit healing conversations. Also,

therapists should maintain flexibility and deliberate on multiple ideas as presented in outer conversations as opposed to selective prioritization of concepts based on personal ideas, thoughts, emotions, and imaginations (Rober, 2017).

### Hypothesizing, Circularity, and Neutrality

Hypothesizing, circularity, and neutrality are inspiring concepts for family therapy. Healthcare providers are inspired to continually evaluate therapy processes for bias and apply corrective measures given the subjective nature of humans. Hypothesizing involves the formulation of a supposition regarding the family being interviewed, based on information available at any particular point during therapy. For instance, a healthcare provider can form a hypothesis using the information provided before initial contact with a family. The initial hypothesis, such as a child's mental illness occurring due to an ineffective relationship with parents, can be redefined as a healthcare provider acquires additional information through interactions with the family (Cecchin, 1987).

Selvini et al. (1980) wrote that a valid hypothesis should be systemic, which implies the inclusion of all components of a family and the "total relational function". A hypothesis forms the basis of an effective family interview session. After generating a hypothesis, a healthcare provider should engage in circularity.

Selvini et al. (1980) defined circularity as the ability to seek complete information regarding the patient and illness based only on feedback from the family rather than personal thoughts or ideas. Health care providers should remain free of cultural and linguistic frameworks that can inhibit the objective consideration of information generated by the family interview. Therefore, one should refrain from judgement, from prioritizing one ideology or conclusion as more correct than others to achieve neutrality. Instead, therapy should invoke the curiosity and inventiveness of a therapist to support the evaluation of alternatives without particular attachment to any one ideology. Through effective hypothesizing, circularity, and neutrality, therapists can develop an appropriate treatment approach suited to the unique needs of the patient and family members involved.

### Open Dialogue

Seikkula (2011) stated that the open dialogue approach to treating severe mental illnesses, such as schizophrenia, is both a challenging and troublesome concept. Open dialogue concerns the involvement of the patient and other significant persons within the social circle in therapy. The individuals help both the patient and healthcare providers to have an in-depth understanding of the causes, effects, and potential treatment options for the medical condition in question. Open dialogue mobilizes the "psychological resources of both the patient and the family members".

Seikkula (2011) explained that the initial meeting is arranged within 24 hours of contact with a psychotherapist or care facility. The patient is invited to the meeting alongside other significant persons from the social circle, including friends and family members. The primary challenge concerns moderating the meeting by initiating the conversation. The healthcare provider in charge is expected to ask a question, to which other participants are required to provide answers, ask other questions, and contribute without straying from the content being discussed.

Healthcare providers must ensure that answers are adapted to what other participants say so as not to interrupt dialogue. The exchange can discuss multiple issues but should end within the recommended length of "90 minutes". Markedly, the therapy meeting can generate critical insights for health care providers to understand the patient and aid in the development of a family-centred treatment. However, open dialogue approaches can be perceived as troublesome for failing to establish the appropriate number of individuals, family, and friends that should be involved in the therapy meetings to assure success (Pavlovic et al., 2016).

Seikkula (2011) failed to provide an estimation of the number of participants that should be involved to generate adequate data for use in developing a treatment approach. The open dialogue method is troublesome for assuming that the family members and friends of patients are naturally willing to participate in care processes for the sake of the patient. The possibility that a health care provider and patient can fail to interest family members or friends to attending therapy meetings exists. Further, a patient can have one family member or friend in the social network, in which case, the resources available for the health care provider to formulate appropriate care methods are limited. While open dialogue approaches to therapy are critical in developing appropriate care plans by providing immediate help, involving social networks, and ensuring care continuity, the assumption regarding the willingness of social networks to participate in care can be troublesome.

### Engaging Families in Intensive Care Units

Each of the concepts discussed above by the authors of this review demonstrate effective techniques for involving families in the development and execution of suitable nursing care plans during the authors' practice. The importance of utilizing open dialogue and applying the healing elements of therapeutic conversations have been learned by the authors. The information is imperative considering the need to provide constant support for patients throughout recovery in ICU. Open dialogue is characterized by the scheduling of the first therapy meeting 24 hours after a patient seeks help. In the case of ICU, the family members of a patient can be involved immediately after the patient's arrival in the hospital. The primary concern is ensuring that the family receives adequate information regarding the patient's condition

as well as addressing any emerging issues. The initial meeting incorporates the opinions, ideas, and thoughts of close associates from family and friends.

According to Seikkula (2011) and Pavlovic et al. (2016), healthcare providers can use the information generated from the initial interaction to understand the illness by examining relationships between the patient and the social networks. The conversation should be steered in such a way that all contributions build on the utterances of other participants progressively. However, a primary challenge lies in the failure of research to define who is the proper family member to be engaged, their own views and understanding of the illness, in addition to the appropriate number of individuals that can participate in the initial meeting.

Therefore, healthcare providers are challenged with ensuring that family members attend the meeting with the help of patients where possible. Obstacles can emerge if the identified family members are unavailable. Furthermore, ICU nurses should apply the healing elements of therapeutic conversation while engaging families. The components include "steering effective dialogue in conversation, creating shared emotional experience, cultivating feelings of togetherness, and establishing a new shared language" (Seikkula & Trimble, 2005).

The healing elements of therapeutic conversation are essential when addressing the mental health of patients and family members within ICU settings. The stated elements enable an in-depth analysis of "reciprocal relationships" between patients and the rest of nature, including social networks. Key lessons for family therapy in an ICU situation concern the creation of the experience of emotion by encouraging sharing while remaining aware of the feelings that utterances evoke in participants. Shared language is also necessary for cultivating feelings of togetherness among health care providers and family members, towards the complete recovery of the patient. Togetherness and emotional experience are especially vital when providing updates to family members, whether the information contains encouraging or discouraging content (Clayton & Saunders, 2012).

Besides delivering information, healthcare providers ought to consider the thoughts of family members as well. Each participant needs to perceive the commitment of health care providers and other concerned persons to the patient's healing. As a result of shared emotions, language, and togetherness, healthcare providers can create collaboration as family members will be willing to share information regarding the illness that they would otherwise not share.

Hypothesizing, circularity, and neutrality also significantly influence ICU nursing roles. Teachings on the stated ideologies establish the importance of addressing personal ideas, thoughts, and imaginations that can influence care processes by relying primarily on information generated from family interviews. Selvini et al. (1980) confirmed that

therapists form hypotheses consciously or unconsciously regarding patients and related illnesses. Suppositions are formulated using available information at any given point in the care process. Hypotheses can be utilized to facilitate rather than inhibit care processes. To ensure success, it is important to formulate hypotheses that incorporate all components of a family. Next, circularity should be engaged, whereby inner conversations (Rober, 1999) and actions (Selvini et al., 1980) are informed by information from the family interview as opposed to personal thoughts. Moreover, therapists should separate themselves from cultural and language models that inhibit the utilization of information from family interviews in the development and execution of care plans for critically ill patients. Circularity helps in the achievement of neutrality. ICU nurses should recognize the incapacity to always act and reason objectively. Their commitment concerns refraining from the prioritization of one ideology or conclusion as more correct than others. Instead, curiosity and a need to invent should prompt one to evaluate alternatives without particular attachment to one belief or action. Neutrality is critical while working with inter-professional teams to develop and execute optimal care plans. Andersen (1987) stated that ICU nurses should work with a reflective team to evaluate conversations with family members and establish relationships with the environment and patterns of behaviour and develop an effective care plan.

The engagement of families within ICU settings also requires consideration of inner conversations. Inner conversations are identified as a compromise between the self of health care providers and their roles in the interview process (Rober, 1999). It has been observed that negotiations between the self and professional role are a challenging task. Limiting personal ideas, thoughts, and imaginations from an intensive interview requires deliberate efforts. Since ICU nurses are involved in the care of patients and their families, they are required to seek adequate information about the patient and relations with social networks and make objective decisions regarding an appropriate care approach. Rober (1999) cautioned that barriers, such as lack of a shared language, can cause family members to withhold information selectively and inhibit information seeking. The creation of a shared language and emotions, as taught by Seikkula and Trimble (2005), is, thus, critical.

Also, Rober (1999) cautioned against the prioritization of particular ideas and issues. Instead, ICU nurses are expected to investigate and consider multiple ideas as presented during the interviews. Before making a decision, the ICU nurses should be sensitized to make sure that inner conversations align with the context of each session. Inner conversations are instrumental in handling patients and family members with heightened distress levels as a result of critical illness. Research had indicated the need to provide emotional support for family members as a means of reducing distress and increasing care satisfaction levels (Carlson et al., 2015). By using the strategies outlined above to align inner conversations with care processes, the quality and safety of care can be improved.

## Learning Priorities

Inner conversations appear as a key priority area considering the need to maintain a balance between inner deliberations and personal ideologies and perceptions with the context of external conversations with families (Rober, 1999; Rober, 2017). Further readings and research in therapeutic conversations involving both patients and their families are likely to enhance the ability to recognize and address the influences of personal thoughts on inner conversations. Key areas of focus will embrace attending to patient process, processing patient's story, addressing personal experience (thoughts and emotions), and managing the therapeutic process (Rober et al., 2008). Consequently, confidence in holding objective inner conversations will increase.

Open dialogue seems like a troublesome idea particularly, when family members are unavailable or are unwilling to participate in care processes. The authors of this review need additional information that can be acquired through interactions with colleagues, and inter-professional teams. The key concern is to achieve the knowledge and skills necessary to interest family members to attend the first therapy meeting with the help of the patient whenever possible. Engaging a substantial number of relevant family members is likely to generate adequate information to inform care processes.

Furthermore, personal communication and inter-professional team management skills should be improved. Communication is key in the effective execution of each of the family engagement concepts discussed above. For instance, organizing and managing an open dialogue session with family members and other key individuals within the patients' social circles imply the need to utilize essential communication skills such as active listening, cultural awareness, non-verbal cues, written communication, relaying and developing ideas, as well as inspiring trust (Boyle & Anderson, 2015; Dithole et al., 2017).

Slatore et al. (2012) emphasized the need for the stated communication skills. As ICU nurses interact with patients and family members in biopsychosocial information exchange, the sharing of power and responsibility occurs. Therapeutic alliances emerge to enhance the recovery of the patient. Their commitment toward improving personal communication skills to develop the ability to execute therapeutic conversation, thus, is validated. Further, communication skills will be instrumental in advancing inter-professional team management skills.

Researchers have confirmed the need for inter-professional collaborations to effectively execute and utilize information from family therapy interviews (Andersen, 1987; Rober, 1999; Seikkula & Trimble, 2005). By improving personal skills in the areas outlined in this section, the ability to engage families will increase significantly.

## Conclusions

The involvement of family members within a patient's social network is essential for the development of an appropriate medical and nursing care plan. There is a pressing need to effectively use information obtained from family therapy interviews. Keeping an open communication channel with close family members during patient hospitalization is beneficial to the patient, family members and to healthcare providers. This will also offer mutual understandings and a better adherence to the agreed healthcare plan.

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