

## Factors that Influence the Counselling of Family Members in Out-of-Hospital Emergency Medical Care

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### Abstract

**Background:** Counselling family members of acutely ill patients has not been studied from the perspective of out-of-hospital emergency care. The purpose of this study was to fill the research gap by describing care providers' experiences of factors that influence counselling and supporting family members in out-of-hospital emergency care.

**Methods:** The data were collected by semi-structured interviews of emergency care providers (N=15) in Finland in 2014 and analysed using content analysis.

**Results:** Factors that influence the counselling aimed at family members in out-of-hospital emergency care can depend on the patient, family member, emergency care provider or context. Patient-dependent factors involve the patient's personality, severity of physical and psychological symptoms, criticality of the situation, the patient's memory, responses, behaviour and cognitive abilities and emotional resources. Family member-dependent factors include the family members' needs and responses, fears, anxiety, feelings of not having control, needs for support, cognitive and emotional preparedness to commit themselves to help and support the patient and willingness to engage in supporting the patient. Care provider-dependent factors include the care provider's personality, clinical expertise, theoretical and practical competence, work and life experience and attitudes. Context-dependent factors include time, degree of urgency, safety of the environment and the circumstances.

**Conclusions:** Care providers must gain an overall idea of the family's function and their ability to endure stress in acute situations, so that counselling can be founded on the family's strengths and limitations regarding the patient's follow-up care and coping at home. Ability to differentiate between various factors in counselling situations helps care providers concentrate on factors that they can affect. The results can be used in the education of health care students and professionals and in developing the quality of counselling.

**Keywords:** Acute care; Counseling; Family member; Out-of-hospital emergency care; Qualitative research

### Introduction

Emergency medical services and out-of-hospital care are important areas in health services, providing urgent care for acutely ill patients and supporting their family members on site. In previous studies, the quality of emergency care has been mainly approached from the patient perspective [1-5] and some studies have discussed the counselling provided for family members of acutely ill patients in emergency departments as an important contributor to quality [6-8]. The perspective of care providers working in out-of-hospital care, however, has not been studied much, so this paper will contribute to filling this research gap by a qualitative approach based on semi-structured interviews.

The purpose of this study is to describe emergency care providers' experiences of factors that affect counselling and support for family members in out-of-hospital emergency medical care. The study aims at producing new research knowledge that can be used to develop the counselling and support for family members in out-of-hospital emergency medical care. This study is a part of larger project on the quality and safety of emergency medical services in one hospital district serving 200,000 inhabitants in Finland. Counselling is defined as goal-oriented, research and evidence-based support and advice, whose purpose is to enhance the coping of patients and their family members during follow-up care at home [9,10].

Earlier studies have primarily focused on family counselling interventions for chronic illness [11-14]. Three general goals that family-focused interventions have been found to involve are: helping families cope with the challenges of chronic illness management, mobilizing family support and reducing intrafamilial suffering [15]. A number of studies have also discussed the usefulness of family interventions that

examine the influence of each family member's illness experiences on other family members [16-18]. Besides the usefulness of the family interventions, their effectiveness in the treatment of physical illness has been examined in 2 integrative reviews [19,20]. Support was found for the effectiveness of interventions directed to the family rather than just the individual diagnosed with the illness.

Support from care providers has been found to be a significant contributor to the coping of patient and families [21,22]. However, a study revealed that family members received very little support in how to become involved in the patient's care [23]. Counselling and support are required to strengthen the family's resources, so that they can trust their ability to care for patients at home [24]. This is especially important in acute home care situations, which do not require hospitalization.

According to some previous studies, the most important needs in family members of patients experiencing a critical illness involve assurance, information, communication, proximity, support and comfort [25-27]. Good communication between care providers and families can reduce the family members' experience of stress [28,29].

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Successful counselling can also promote family members' management of the situation, as regards both information and action, and this, in turn, can help the acutely ill patient to better manage the new life situation [7,30].

## Materials and Methods

### Participants and data collection

The data for this study were collected by semi-structured interviews (N=15) within a single hospital district in Finland in October 2014. The voluntary participants were 5 paramedics, 5 nurses, 5 emergency medical technicians and 2 practical nurses, selected by discretionary sampling. To be eligible, participants had to have a minimum of two years' work experience of out-of-hospital emergency care. The emergency medical services of the hospital district operate in five areas, with a total of 280 employees. Three participants were recruited from each area. Ten participants worked in advanced life support, whereas five were qualified to administer basic life support, that is simple life-saving procedures and prevention of patient's deterioration during care and transport [31]. As there is little previous knowledge of the challenges in counselling family members of acutely ill patients, a qualitative approach with semi-structured interviews was selected as a data collection method [32].

### The theme of the interview and research problem

What kind of factors affect the scope and contents of counselling aimed at family members of acutely ill patients, as experienced by out-of-hospital emergency care providers? Before the interviews, participants studied an information sheet and signed a consent form. The interviews were conducted individually in a peaceful setting and they were taped with the participants' permission. The length of the interviews varied between 60 and 80 minutes.

### Analysis

The data were analysed using inductive content analysis [33]. The transcribed material amounted to 124 pages (Times New Roman, single spacing). First, the material was read through several times. Sentences, expressions and any units of thought that seemed to represent an answer to the research problem were picked out and saved into separate Word files as reduced expression, retaining as much of the original form as possible. Expressions representing the same or similar contents were grouped under sub-categories, which were classified into generic categories and further combined to form main categories with similar contents. The original data was consulted repeatedly to ensure plausible interpretation. The results of the analysis were evaluated by a group of researchers [31].

## Results

In the experience of care providers, factors that affect the scope and contents of counselling contents aimed at family members of acutely ill patients in out-of-hospital emergency care can depend on the patient, family member, emergency care provider or the context (Table 1).

### Patient-dependent factors

The patient-dependent factors were found to involve the following: the patient's personality, severity of the physical symptoms, severity of the psychological symptoms, criticality of the situation, the patient's memory status, the patient's responses and behaviour and the patient's cognitive abilities and emotional resources.

In the experience of care providers, the patient's personality had an

important role in the counselling provided. For example, it could occur that a patient with an extremely introverted personality did not discuss his or her physical and psychological symptoms openly, not even with family members. Patients had emotional blocks and were unable to share their feelings, or they were ashamed of being ill and having symptoms. Some patients tried to avoid hospitalization by hiding their symptoms, whereas others were so loquacious that the care providers found it impossible to give them adequate attention.

"The family member did not have any room to talk, the patient was manic, talking volubly. I guess the family member did not get enough attention and counselling."

The second patient-dependent factor, severity of the physical symptoms, was found to complicate counselling of family members, because attending to the symptoms required all the care providers' attention. They were unable to deal with the family member's needs.

"So many problems, the patient's life was at risk, we both had our hands on the patient, no time to pay attention to the family member."

The severity of psychological symptoms, too, sometimes required care providers' full attention. Some patients suffered from mental health problems or they abused alcohol or illicit or prescription drugs. Some had delusions or a distorted view of the world or acted in a threatening or aggressive manner. In case of very aggressive patients, assistance was requested from the police, which resulted in postponing the counselling of family members or in inadequate support for the family.

"We were fully occupied trying to get the aggressive patient into the ambulance, watching out for those flinging arms. There was just no time for the family member."

Generic category	Main category
The patient's personality	Patient-dependent factors
Severity of the physical symptoms	
Severity of the psychological symptoms	
Criticality of the situation	
The patient's memory status	
The patient's responses and behavior	
The patient's cognitive abilities and emotional resources	Family member-dependent factors
The family members' needs and responses	
The family members' fears, anxiety and feelings of not having control	
The family members' needs for support	
The family members' cognitive and emotional preparedness to commit themselves to help and support the patient in coping with the acute illness	
The family members' willingness to engage in supporting the patient	Care provider-dependent factors
The care provider's personality	
The care provider's clinical expertise	
The care providers' theoretical and practical competence	
The care provider's work experience	
The care provider's life experience	
The care provider's attitudes	Context-dependent factors
Time	
Degree of urgency	
Safety of the environment	Context-dependent factors
The circumstances	

**Table 1:** Factors that affect the counseling of family members.

The criticality of the situation, for example in case of cardiac resuscitation or rapid transfer of a trauma patient, was another patient-dependent factor which sometimes left family members fending for themselves without proper counselling and attention.

"You just have to get the patient to hospital fast, no time for the family at that moment."

It was mentioned by the care providers interviewed that some patients may have had memory problems; they answered and agreed with the instructions without actually understanding them. In such cases, to ensure later coping with self-care at home, all counselling needed to be directed at the patient's family member. The care providers stressed the importance of assessing the patient's and family's entire life situation and factors that might affect it, including potential need for assistance at home.

In the experience of care providers, counselling became challenging at times because of the patient's responses or behaviour. The family member might have contacted the emergency centre against the patient's wishes; the patient and family member had a different understanding and opinion of the severity of the situation. It seemed sometimes that there were as many truths or realities as there were family members. Their anxiety and concern prevented them from appraising the situation realistically. The care providers were compelled to ask themselves who they should primarily believe.

Finally, the patient's cognitive abilities and emotional resources were also found to have a major effect on the situation. Patients with intellectual disability were unable to understand counselling contents, so it was essential for their survival that family members received adequate counselling. Similarly, when a patient's emotional resources were depleted, care providers found it important to support family members in their efforts to encourage the patient.

### Family member-dependent factors

Based on the interviews, family member-dependent factors that affected the counselling aimed at family members of acutely ill patients in out-of-hospital emergency care consisted of the following: the family members' needs and responses, their fears, anxiety and feelings of not having control, their needs for support, their cognitive and emotional preparedness to commit themselves to help and support the patient in coping with the acute illness and, last, their willingness to engage in supporting the patient.

Family members' needs and responses varied a great deal, so the care providers found it necessary to assess each family member's counselling needs individually. Some family members grasped the counselling contents rapidly, with a single attempt, while others required repetition. Especially those family members, who were severely shocked or insecure about their home care skills, were in need of extra attention.

"If the family member is in shock, they just do not get it."

According to the care providers, fears, anxiety and feelings of not having control prevented family members from appraising the situation realistically. Sometimes anxious family members interfered with the assessment, putting the care provider's concentration at risk by constantly offering their opinions. In some cases, family members were children or youngsters, who did not fully understand the seriousness of the situation or could not be left at home alone. Some family members experienced the patient's situation as so anxiety-inducing that they demanded transport to care, even though the patient objected to being taken to hospital.

Family members had different needs for support. Some of them were found to require only informational support, whereas others mainly needed emotional and social support. According to the care providers, the support to family members sometimes took very concrete forms, for example providing hands-on guidance in wound care.

"That is just the way it is, words are not enough for all family members, you have to draw it or give hands-on guidance."

The family members' cognitive and emotional preparedness to commit themselves to help and support the patient in coping with the acute illness was another factor that was found to influence the scope and contents of counselling. Again, there was great variation among family members. If they were facing a new situation, more thorough counselling was necessary, whereas only brief repetition was required for those family members, who had experienced similar incidents before and trusted their abilities to help. In other words, family problem solving was strongly influenced by the family members' previous experiences and beliefs about their abilities.

The last factor in this section, family members' willingness to engage in supporting the patient, was found to be strongly influenced by the family's shared history. It was also affected by the degree to which family members were engaged in work life or other activities in society. According to the care providers, not all family members were prepared to invest in the patient's home care; they did not want to give up other activities in order to care for the patient. This meant that they were not always interested in receiving counselling.

### Care provider-dependent factors

The care provider-dependent factors that had an influence on the scope and contents of counselling included the following: the emergency care provider's personality, clinical expertise, theoretical and practical competence, work experience, life experience and attitudes.

In the experience of the professionals interviewed for this study, the care provider's personality affected the counselling of family members significantly. It was maintained that a calm professional was capable of presenting instructions, even complicated ones, clearly and understandably. There was a risk that family members did not fully grasp instructions provided by professionals with a more abrupt communicative style. The care provider's emotional intelligence, empathy skills and situational sensitivity were mentioned as factors that promoted the quality of counselling.

"The emergency care provider's character and empathy are the key to good counselling. You must not rush."

Secondly, the care provider's clinical expertise was found to be of significance. According to the interviewees, optimal counselling of family members demands a correct analysis of the situation and a working diagnosis. An incorrect assessment due to lack of clinical experience may result in faulty counselling, even putting the patient's life at risk.

"If there is no clinical competence, it can happen that they do not know how to read the ECG and the patient is left at home and they tell the family member not to worry, whereas in reality the patient may have a life-threatening cardiac infarction."

Thirdly, emergency care providers' theoretical and practical competence was acknowledged as an important factor for the quality of counselling. Sound competence was found to mean that the care provider was able to give reasons for the instructions and to teach care techniques in concrete terms, thus inducing trust in family members.

“They grasp it better, if you can give the facts and the reasons why they should act in a certain way.”

Finally, work experience, life experience and attitudes were found to go hand in hand. Those who had several years’ experience of out-of-hospital emergency care were appreciated as having a humble attitude towards patients and families and as capable of approaching the clients individually, but also as having sufficient self-esteem and confidence to assume control over the situation. A positive, polite attitude was found to promote the acceptance of counselling. On the other hand, it was also mentioned that years of acting through habit might result in situations perceived as routine, which meant that individual counselling was compromised.

### Context-dependent factors

Patients’ and family members’ skills and resources are best understood within their own social context. The context-dependent factors discovered in this study were: time, degree of urgency, safety of the environment and the circumstances.

According to the interviewees, time was often limited. Care providers often simply did not have the time for adequate oral counselling. In such situations, it became all the more important to have some written instructions available for the family. Most essentially, if the care provider was compelled to leave in order to attend to a more urgent case, the family member required information on where to contact and when, if necessary.

The degree of urgency also strongly affected the scope of counselling offered to family members by care providers. In critical situations, which involved rapid transport of patients following resuscitation, counselling family members often had to be kept to a minimum. If necessary, care providers contacted the family members later by telephone to ensure that they had understood the situation correctly and that support was available to them at home.

The two other context-dependent factors, safety of the environment and the circumstances, were also found to affect the quality of counselling family members significantly. If the situation involved serious risks, assistance from other local authorities was required and family members were removed from the area. The counselling remained rather general, although an effort was made to support the family’s psychological coping. The interviewees also reported that sometimes the presence of many people and noise in the patient’s home or at another site interfered with counselling. The people present were sometimes affected by alcohol or drugs, which made it more difficult to provide counselling for family members.

### Discussion

According to the care providers interviewed for this study, the scope and contents of counselling aimed at family members of patients in out-of-hospital emergency care depended on the patient, the family member, the emergency care provider and the context.

Some of the factors that affected the counselling situation were associated with the patient’s personality, physical illness and resources, all of which the care providers need to assess holistically before providing any counselling to the patient and family member. It is equally important to understand that the family member’s needs, emotions and resources affect the counselling situation. The family members’ previous experiences and beliefs about what they are able to achieve also have a strong role. Several studies have shown that various psychological stress factors may jeopardise family member’s management of the situation and family dynamics. These stress factors

can include feelings of shame and guilt, anxiety, insecurity, negative pre-conceptions, hopelessness and fear. Insecurity and experienced lack of support have been found to undermine both the patient’s and family member’s experience of coping [32,33]. Care providers could be advised to indicate that illness is a natural part of life that can be openly discussed. Studies have revealed that family members also appreciate information about the patient’s situation and about concrete opportunities to participate in the patient’s care at home [34,35].

One way to deal with the emergency situation at hand is to encourage family members to share their personal narratives concerning their experience in the acute situation. In this way, while fostering opportunities for family members to express feelings about the acute situation, care providers can enable them to draw forth their own strengths and resources to support one another. Earlier studies confirm that accurate, well-constructed family histories provide valuable information about the patient’s situation and family members’ need for support [36]. It has been reported that care providers do not always have the courage to face and address the family members’ needs [37,38]. Assessing family dynamics in the acute situation is in any case challenging; care providers lack information about the family history and family members’ roles – and there is very little time to gain an overall picture of the situation. Useful questions when approaching family members in counselling situations could include the following:

- Do family members share their fears, feelings and experiences?
- Do family members hide important issues from each other?
- Who in the family will identify and take responsibility for the acute situation?
- What is the role of illness in their lives and relationships?

The care provider has to observe multiple interactions and relationships simultaneously; the interaction among family members and the interaction between the care provider and the family. It is helpful to attempt to find out whether the acute illness is the patient’s problem alone or a challenge shared by the family. To sum up: As far as possible, it is useful to gain an overall idea of the family’s function in the acute situation and their ability to endure stress, so that the counselling can be founded on the family’s strengths and limitations regarding the patient’s follow-up care and coping at home.

As regards care providers themselves, their personality, clinical expertise and experience also constitute a factor that influences the counselling received by family members. These are qualities that emerge over time, as emotional intelligence and situation sensitivity develop. Earlier results have confirmed the importance of emotional intelligence and situation sensitivity to the quality and safety of emergency medical care [39]

Finally, contextual factors or time and environment also affect the scope and contents of counselling. Their role has been discussed earlier from the perspective of out-of-hospital care and counselling [40,41]. It has been discovered, for example, that proper maintenance of the equipment and vehicle and keeping all objects at their designated places promotes patient safety and counselling [40].

Emergency care providers reflecting on their work might benefit from the idea that the factors described above are of two types: those that can be affected and those that need to be taken into consideration but cannot be directly influenced. Ability to differentiate between the two sets of factors helps care providers concentrate on factors that they can affect and it might even relieve some of their professional stress. For example, it might be useful to ask oneself, which of the factors



discussed are associated with skills or competencies that can be learnt. Based on the results, at least assessment, encouragement and teaching skills seem to emerge, along with the practical skills related to the appropriate maintenance of the ambulance and equipment.

The results of this study can be used in the education of health care students and professionals. The results can also be useful in developing the quality of counselling targeted at family members in out-of-hospital emergency care.

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