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Ways of Coping of Family Members in the Intensive Care Units of Selected Hospitals in Cavite

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Abstract

This study assessed the coping strategies of family members of patients in Intensive Care Units (ICUs) in selected hospitals in Cavite. A descriptive research design was utilized to examine family members' demographic profiles—such as age, gender, relationship to the patient, and duration of hospitalization—and their coping mechanisms, including acquiring social support, cognitive reframing, seeking spiritual support, mobilizing to obtain and accept help, and passive appraisal. The study also gathered respondents' suggested coping strategies and developed integrated clinical practice guidelines to support family members in ICUs. Most respondents were females aged 26–30 and 51–55 years, with family members hospitalized for less than one month, and included parents, siblings, and children of the patients. Among the coping strategies, seeking spiritual support was the most frequently employed, with a weighted mean of 4.28. Based on these findings, a clinical practice guideline was proposed to enhance support for family members of ICU patients.

Keywords: Ways of Coping, Family Members in the Intensive Care Unit, Proposed Clinical Practice Guidelines for Family Members, Proposed Coping Strategies

Introduction

Admission to an Intensive Care Unit (ICU) often causes significant distress and anxiety for both patients and their families. To provide truly holistic care, intensive care nurses must identify the specific needs of family members and implement appropriate supportive interventions.

Hospitalization can disrupt family dynamics, prompting role changes and emotional instability, including fear and insecurity, which may escalate into emotional crises. ICU admission generally indicates a serious condition requiring close monitoring and specialized care. Patients may be admitted following major surgery, severe trauma, respiratory distress requiring ventilator support, cardiovascular events such as myocardial infarction or unstable blood pressure, metabolic imbalances, or severe infections needing intensive treatment.

The stress of disease and hospitalization can challenge family members' beliefs and coping abilities. Extreme anxiety or depression may impair their capacity to support the patient effectively, sometimes unintentionally transferring fear or frustration that can interfere with recovery. Factors such as fear of death, uncertainty about prognosis, emotional conflicts, financial concerns, role changes, and disruption of daily routines exacerbate family stress.

Recognizing these challenges, this study aimed to assess the coping mechanisms of family members of ICU patients in selected hospitals in Cavite. Focusing on family members allows for the identification of recommended coping strategies and the development of integrated clinical practice guidelines, which can enhance family support and strengthen their involvement in the care of hospitalized loved ones.

Statement of the Problem

This study sought to identify ways of coping of family members in the intensive care units of selected hospitals in Cavite. Specifically, it's goal is to answer the following questions:

- **What is the demographic profile of the respondents in terms of:**
  - sex;
  - age;
  - relationship to the patient; and
  - duration of patient's confinement?
- **What are the ways of coping of family members in the Intensive Care Units in terms of:**
  - 2.1. acquiring social support;
  - 2.2. reframing:
  - 2.3. seeking spiritual support;
  - 2.4. mobilizing to acquire and accept help; and
  - 2.5. passive appraisal?
- What coping strategies for family members in the Intensive Care Units can be suggested by the respondents?
- What is the relationship of respondents' demographic profile and ways of coping?
- Based on the findings, what integrated clinical practice guidelines for support of family members in the Intensive Care Units can be proposed?

Hypothesis

Alternative Hypothesis: There is a significant relationship between the respondents' demographic profile and ways of coping

Null Hypothesis: There is no significant relationship between the respondents' demographic profile and ways of coping.

Scope and Delimitations of the Study

This study assessed the ways of coping of family members of patients admitted to the Intensive Care Units (ICUs) of selected hospitals in Cavite. The focus of the study was limited to the family members' coping mechanisms; therefore, data regarding the patients' own ways of coping were not included. This delimitation was set because previous studies have established that relatives of critically ill patients experience significant stress and high levels of anxiety during ICU hospitalization.

The respondents of the study were selected family members of patients currently admitted to the Intensive Care Units. These respondents were 12 years old and above, male or female, and were relatives of the patient within the immediate to third degree of consanguinity or affinity.

The findings of this study served as the basis for providing information necessary for the development of proposed integrated clinical practice guidelines aimed at supporting family members of patients admitted to Intensive Care Units.

REVIEW OF RELATED LITERATURE AND STUDIES

Hospitalization in an Intensive Care Unit (ICU) is a stressful experience not only for patients but also for their family members. The critical nature of ICU admissions, combined with uncertainty about prognosis and treatment, often leads to heightened anxiety, fear, and emotional strain (Thompson, 2016; Rukholm & Bailey, 2014). Factors contributing to family stress include financial concerns, role changes, disruption of daily routines, and uncertainty regarding patient outcomes (Rukholm & Bailey, 2014; Eaton, 2014). Female relatives and parents are particularly vulnerable to negative emotional symptoms due to a tendency to use emotion-focused coping strategies (Anderson, 2013).

Coping is the process through which individuals manage stress and adapt to challenging situations (Lazarus & Folkman, 2016). It involves both problem-focused strategies—aimed at addressing the source of stress—and emotion-focused strategies—aimed at regulating emotional responses (Folkman, 2016). Coping is influenced by **primary and secondary cognitive appraisals**, where family members evaluate the significance of a situation and their perceived ability to manage it (Lazarus & Folkman, 2016; Schwarzer & Leppin, 2015). Individuals draw on internal resources, such as optimism and resilience, and external resources, such as social support, to facilitate coping (Greenaway, 2015; Scheier & Carver, 2012). The effectiveness of coping strategies is dynamic and context-specific, shaped by prior experiences and situational demands (Carver et al., 2015; Folkman & Moskowitz, 2014).

McCubbin et al. (2012) identified five key family coping strategies: **acquiring social support**, **reframing**, **seeking spiritual support**, **mobilizing family to acquire and accept help**, and **passive appraisal**. Support groups, spiritual engagement, and effective communication have been shown to enhance family coping in ICU settings (Miranda & Luriato, 2015; Eaton & Davis, 2014). ICU-specific interventions, such as flexible visitation policies, family education, coping skills training, and involvement in patient care, have demonstrated effectiveness in reducing family anxiety and improving adjustment (Deveyra, 2012; Melnyk, 2012; Preyde, 2013; Lippincott & Wilkins, 2016).

Additionally, studies highlight that family members' perceptions of ICU stressors often mirror those of patients, including concerns about physical restraints, medical devices, or inability to communicate, which can intensify anxiety (Novaes & Knobel, 2013). Regular, clear information and structured support from the multidisciplinary ICU team—including nurses, physicians, social workers, and clergy—have been shown to improve satisfaction, coping, and family participation in care (Bailey & Sabbagh, 2014; Davidson et al., 2014). Understanding these mechanisms provides the theoretical and empirical foundation for evaluating family coping using structured tools such as the **Family Crisis Oriented Personal Evaluation Scale (F-COPES)** (McCubbin et al., 2012).

The Family Crisis Oriented Personal Evaluation Scale (F-COPES) provides a structured tool for assessing these coping strategies, capturing both problem-solving and emotional adjustment responses of families during crises (McCubbin et al., 2012). Understanding family coping mechanisms is critical for designing interventions that promote resilience and reduce anxiety among relatives.

Clinical practice guidelines have been shown to improve family support and satisfaction in ICUs. Flexible visitation policies, family education, coping skills training, and involvement in patient care reduce anxiety and enhance adjustment (Deveyra, 2012; Melnyk, 2012; Preyde, 2013; Lippincott & Wilkins, 2016). Evidence indicates that family presence at the bedside improves communication, promotes patient- and family-centered care, and increases staff satisfaction (Davidson et al., 2014). Interventions tailored to family needs, including information provision, peer support, and multidisciplinary involvement, are essential in mitigating stress and enhancing coping (Bailey & Sabbagh, 2014; Mouhelsy, 2013).

Overall, these studies highlight the importance of assessing family coping strategies, addressing their psychosocial needs, and implementing evidence-based interventions to support families during ICU hospitalization. Understanding these mechanisms forms the foundation for developing integrated clinical practice guidelines aimed at enhancing family resilience and involvement in patient care.

Theoretical Framework

This study is anchored on the **Double ABCX Model** developed by sociologists **H. I. McCubbin and J. K. Patterson (2012)**, which served as the theoretical framework of the research.

The Double ABCX Model evolved from the original **ABC Model of Family Stress** proposed by **Reuben Hill (1949)**. Building on Hill's work, McCubbin and Patterson expanded the model by incorporating post-crisis variables, such as coping mechanisms and adaptive processes, to explain how families recover from crises and achieve long-term adaptation.

The original ABCX Model explains family stress through the interaction of three key components: the **stressor event (A)**, the **family's resources (B)**, and the **family's perception of the stressor (C)**. The interaction of these factors determines whether a family experiences a **crisis (X)**. A crisis is more likely to occur when the stressor overwhelms the family's resources and coping capacity, especially when the stressor is perceived as threatening or unmanageable.

The model further assumes that families encountering stressors undergo phases of **adjustment and adaptation**, characterized by dynamic interactions among these variables. Through this process, families develop competencies, patterns of functioning, and coping behaviors that support individual family members, strengthen the family unit, and protect it from severe disruption during periods of transition and change.

In this study, the Double ABCX Model was utilized as the theoretical framework to assess the **ways of coping of family members of patients admitted to Intensive Care Units in selected hospitals in Cavite**, providing a structured lens for understanding how families respond to and manage the stress associated with critical illness and hospitalization.

Methods

Research Design

The study utilized a **descriptive research design** to assess the coping mechanisms of family members of ICU patients. This design was chosen because it allows the researcher to illustrate patterns and characteristics of the variables in real-life settings without manipulating any independent variables. The descriptive approach is suitable for this study as it provides a clear understanding of how different coping mechanisms relate to one another and to the population of interest (Campbell, 2015).

Sampling and Participants

The study employed **purposive sampling**, a non-probability sampling technique, where respondents were selected based on their availability and willingness to participate. The target population consisted of **family members of patients currently admitted to the Intensive Care Unit (ICU) in selected hospitals in Cavite**. A total of **30 respondents** participated in the study.

No demographic restrictions were applied in selecting participants to ensure accurate and viable data. **Demographic information collected** included age, sex, relationship to the patient, and duration of the patient's confinement in the ICU.

The participants were therefore **family members attending to patients in the ICU**, and each completed a standardized questionnaire to assess their coping mechanisms using the F-COPES instrument.

Data Collection Procedure

Data were collected using a **standardized questionnaire**, the Family Crisis Oriented Personal Evaluation Scales (F-COPES), which assesses coping mechanisms across five subscales: acquiring social support, reframing, seeking spiritual support, mobilizing family to acquire and accept help, and passive appraisal. The questionnaire was translated into Filipino and reviewed by a language expert for accuracy and validity. The questionnaire was divided into three parts:

1. **Part I:** Demographic profile of respondents (age, sex, relationship to the patient, duration of patient's confinement).
2. **Part II:** Assessment of coping mechanisms using the F-COPES 5-point Likert scale.
3. **Part III:** Suggested coping strategies, where respondents selected options from a provided list.

The researcher followed a **systematic process** to gather data:

- Letters of permission were submitted to the selected hospitals in Cavite.
- After approval, questionnaires were distributed to the target respondents.
- Instructions for completing the questionnaire were provided, and the researcher remained present to clarify any questions and ensure accurate responses.
- Completed questionnaires were immediately collected, organized, and reviewed by the adviser and validators.

All responses were tallied, analyzed, computed, and interpreted using descriptive research methods. Computations were verified by a qualified statistician to ensure accuracy and reliability.

Responses were measured on a 4-point Likert scale:

- 5= Strongly Agree
- 4 = Moderately Agree
- 3 = Neither Agree nor Disagree
- 2 = Moderately Disagree
- 1 = Strongly Disagree

Data Analysis

The collected data were analyzed using appropriate **descriptive and inferential statistical tools** to interpret respondents' demographic profiles and coping mechanisms:

1. **Frequency Count and Percentage** – Used to describe the demographic characteristics of respondents, including age, sex, relationship to the patient, duration of patient confinement, and patient case category. Frequency (f) represents the number of occurrences of each value (Reyes, 2015).
2. **Weighted Mean** – Used to determine the extent to which respondents utilized specific coping mechanisms. The mean was calculated by summing the responses and dividing by the total number of items. Interpretation followed a 5-point Likert scale:

Verbal Interpretation	Scale	Description
Strongly Agree	4.00–5.00	Respondents strongly utilize the coping mechanism
Moderately Agree	3.00–3.99	Respondents moderately utilize the coping mechanism

Neither Agree Nor Disagree	2.00–2.99	Respondents neither utilize nor avoid the coping mechanism
Moderately Disagree	1.00–1.99	Respondents somewhat do not utilize the coping mechanism
Strongly Disagree	0.10–0.99	Respondents do not utilize the coping mechanism

3. **Chi-Square Test** – Applied to determine whether significant differences exist between observed and expected frequencies, testing the null hypothesis that no significant differences are present among variables.

These statistical treatments provided both a descriptive overview of family members' coping strategies and an inferential analysis to identify significant patterns or relationships within the data.

Results

Demographic Profile of the Respondents

Table 1: Demographic Profile of the Respondents

Demographic Variable	Frequency (f)	Percentage (%)
Sex		
Male	12	40.0
Female	18	60.0
Age		
15-20	3	10.0
21-25	5	16.67
26-30	6	20.0
31-35	3	10.0
36-40	2	6.67
41-45	2	6.67
46-50	1	3.33
51-55	6	20.0
56-60	2	6.67
Relationship to Patient		
Parent	6	20.0
Spouse	3	10.0
Uncle/Auntie	4	13.33
Sibling	6	20.0
Grand Parent	1	3.33
Cousin	3	10.0
Child	6	20.0
Grand Child	1	3.33
Duration of Patient's Confinement		
Less than 1 month	10	33.33
Less than 2 months	9	30.0

Less than 3 months	5	16.67
Less than 4 months	1	3.33
Less than 5 months	3	10.0
Less than 6 months	2	6.67

Table 2: Ways of Coping of Family Members in the Intensive Care Units

Ways of Coping	**Weighted Mean**	**Verbal interpretation**
Acquiring Social Support	3.92	Moderately Agree
Reframing	4.00	Moderately Agree
Seeking Spiritual Support	4.28	Moderately Agree
Mobilizing to Acquire and Accept help	4.18	Moderately Agree
Passive Appraisal	4.16	Moderately Agree
Overall Mean	**4.11**	**Moderately Agree**

Table 2 presents the coping strategies utilized by the respondents, along with their corresponding weighted means and verbal interpretations. The overall mean of 4.11, interpreted as "Moderately Agree," indicates that respondents generally employed a wide range of coping strategies while dealing with the ICU situation.

Among the identified strategies, Seeking Spiritual Support obtained the highest weighted mean (4.28), suggesting that family members most frequently relied on spiritual or religious beliefs to manage emotional stress. This finding implies that spirituality serves as a significant source of comfort, hope, and emotional stability during critical health situations.

Mobilizing to Acquire and Accept Help (4.18) and Passive Appraisal (4.16) followed closely, indicating that respondents moderately utilized both external assistance and acceptance-based coping. Mobilizing support reflects the willingness of family members to seek help from others or utilize available resources, while passive appraisal reflects acceptance of circumstances that cannot be immediately changed. These strategies suggest a balance between active engagement and emotional regulation in coping with ICU-related stress.

Reframing yielded a weighted mean of 4.00, indicating that respondents moderately attempted to reinterpret stressful situations in a more positive or manageable way. This demonstrates the use of cognitive strategies to reduce emotional burden and promote psychological adjustment.

Lastly, Acquiring Social Support obtained the lowest weighted mean (3.92), although still interpreted as "Moderately Agree." This suggests that while social support was utilized, it was less emphasized compared to spiritual and acceptance-based strategies, possibly due to the restrictive and emotionally demanding ICU environment.

Overall, the findings indicate that respondents relied on a combination of spiritual, cognitive, and acceptance-based coping mechanisms, with spirituality emerging as the most prominent strategy. These results are consistent with the findings of Eaton and Davis (2014), who identified spirituality, acceptance, passive appraisal, avoidance, and communication with immediate family as common coping strategies among family members during hospitalization.

Table 3: Summary of the Respondents' Suggested Coping Strategies.

Coping Strategies	No. of Respondents	Percentage
Acting	22	20.75
Appraisal	20	18.87
Deciding	22	20.75
Observing	15	14.15
Orienting	9	8.49
Reappraising	18	16.98
Total	106	100

Table 3 presents the recommended coping strategies identified by the respondents. Among these, "Acting" and "Deciding" were the most frequently suggested strategies, each recommended by 22 respondents (20.75%). These were followed by "Appraisal" with 20 respondents (18.87%), "Reappraising" with 18 respondents (16.98%), and "Observing" with 15 respondents (14.15%). "Orienting" was the least recommended strategy, with 9 respondents (8.49%).

The predominance of Acting and Deciding suggests that family members value active engagement in coping with ICU-related stress. Acting reflects the implementation of plans or decisions, while Deciding involves selecting a course of action after evaluating available information. These findings imply that family members perceive coping as a process that requires deliberate action rather than passive waiting, particularly in high-stress environments such as the ICU.

The relatively high endorsement of Appraisal and Reappraising highlights the importance of cognitive evaluation and adjustment in coping. Appraisal allows family members to assess the seriousness of the situation and available resources, while Reappraising enables them to reinterpret stressful circumstances in a more manageable or meaningful way. This cognitive flexibility may help reduce emotional distress and promote acceptance over time.

Although Observing and Orienting were less frequently recommended, their presence indicates that some family members recognize the value of careful attention, situational awareness, and emotional grounding before taking action. These strategies may serve as preparatory steps that support more decisive coping behaviors.

Overall, the findings suggest that respondents favor action-oriented and decision-based coping strategies, supported by continuous evaluation and reassessment of the situation. This pattern reflects a dynamic coping process in which family members actively engage with the ICU experience while adjusting their perceptions to manage stress more effectively.

Table 4: Summary of the Relationship of the Demographic Profile and Ways of Coping

Variables	Degree of Freedom	Significance Level	Chi Square Test of Independence	Prob. Value	Interpretation of the Results
Sex	4	0.05	1.500	9.488	Accept the Null Hypothesis

Age	36	0.05	25.444	55.758	Accept the Null Hypothesis
Duration of Patient's Confinement	20	0.05	18.095	31.410	Accept the Null Hypothesis
Relationship to patient	28	0.05	19.200	41.337	Accept the Null Hypothesis

Table 4 presents the relationship between the respondents' demographic profile and their ways of coping, as analyzed using the Chi-Square Test of Independence. The findings show that sex, age, duration of the patient's confinement, and relationship to the patient all yielded probability values greater than the 0.05 level of significance. Therefore, no statistically significant relationship was found between the respondents' demographic characteristics and their ways of coping, leading to the acceptance of the null hypothesis.

These results imply that the coping strategies employed by the respondents were not significantly influenced by their demographic profile. Regardless of sex, age, length of the patient's hospitalization, or relationship to the patient, respondents tended to utilize similar coping mechanisms. This finding contrasts with the study of Anderson (2013), which reported that variations in relatives' negative emotional symptoms were largely attributed to socio-demographic factors rather than patients' health status. Anderson emphasized the importance of considering socio-demographic variables when addressing the psychological well-being of relatives. However, the present study suggests that coping responses may be more universally shaped by the hospitalization experience itself rather than by individual demographic differences.

Conclusion

This study concludes that family members attending to patients in the Intensive Care Unit were predominantly female, mostly within the age ranges of 26–30 and 51–55 years, and were primarily immediate relatives such as parents, siblings, and children. Most respondents had family members who were confined for less than one month, indicating that the early phase of hospitalization is a critical period when families experience significant emotional and psychological demands. These findings highlight the central role of immediate family members as primary caregivers during ICU confinement.

In terms of coping mechanisms, the respondents moderately agreed with all identified coping strategies, with **Seeking Spiritual Support** emerging as the most frequently utilized. This indicates that family members rely heavily on spirituality and religious beliefs to manage stress, uncertainty, and emotional burden associated with having a loved one in critical condition. Spirituality appears to serve as a stabilizing and accessible source of comfort, helping families find meaning and emotional strength during hospitalization. This underscores the importance of recognizing spiritual needs as part of holistic family-centered care in critical care settings.

Furthermore, **Acting** and **Deciding** were identified as the most suggested coping strategies, suggesting that family members are encouraged to remain actively involved in the patient's care. Being attentive, making informed decisions, and taking appropriate actions appear to empower relatives and enhance their

ability to support the patient effectively. Overall, the findings suggest that while family members rely on spiritual coping, they also value practical involvement and decisiveness, emphasizing the need for healthcare providers to support both the emotional and participatory roles of families in the ICU environment.

Recommendation

Based on the findings of this study, it is recommended that **Intensive Care Unit nurses** actively involve family members in the care of patients and maintain consistent, clear, and supportive communication. Strengthening nurse–family interactions may help family members feel more engaged, informed, and emotionally supported while coping with the critical condition of their loved ones. In addition, the **Nursing Service Department** may adopt and implement standardized Clinical Practice Guidelines focused on family support in the ICU to ensure uniformity of care and promote meaningful family engagement across units.

Moreover, **hospital administrators** are encouraged to develop and implement programs that provide guidance, emotional support, and health education for family members of ICU patients. Such initiatives may help families cope more effectively during hospitalization and enhance their participation in patient care. Administrators may also support continuous training and professional development programs for nurses to strengthen competencies in family-centered care. Finally, **future researchers** are encouraged to conduct macro-level studies on the coping strategies of family members in the ICU, incorporating additional demographic variables such as educational attainment, to further explore factors influencing coping mechanisms and to generate broader, more generalizable findings.

Table 5: Proposed Clinical Practice Guidelines for Support of Family Members in the Intensive Care Units

Sites where Clinical Practice Guidelines applies	All Intensive Care Units in different hospitals
Beneficiaries	Family members of patients in the Intensive Care Units
Intended Users	Doctors, nursing staff, and attendants
Description	This guideline is intended for use by all medical staff such as doctors, nursing staff, and attendants who are involved in the care of clients in the Intensive Care Units for the support of their family members and relatives.
Guidelines	
Aim: To improve service for support of family members in the Intensive Care Units 1. Establish support groups for families with hospitalized most especially to the immediate family members such as parents, children, and 2. Allocate a place for family members where they can exercise their spiritual beliefs that may be applicable to any type of religion or members to put action and carry out all the	

decisions made while discreet attention towards the hospitalization of the relative or what is really going on.
4. Encourage family members to provide as much care as the patient's condition will allow and they are comfortable providing regardless of their sex, age, and demographic profile.
5. Assess family needs and family members' stress and anxiety level and provide as much as emotional support and counseling as possible.
members receive regular updates in
language they can understand, but the number of health professionals who provide information is kept to a minimum.
7. Provide family members with ample information in a variety of formats on emotional needs in the ICU and methods appropriate to comfort and assist in care.

HOW:
1. Key person should be assigned to facilitate support groups activity and counseling for family members such as one of the family members or attendants that could consistently provide support to the group established
2. Governing bodies may mandate all hospitals to allocate a place for family members where they can exercise their spiritual beliefs not only a place applicable to only one religion.
3. Encourage family members to express their anxiety and frustration to the Attendants, Nursing Staff, and Doctors; advise workers to be as open and approachable as possible.
4. Training in how to assess family needs and anxiety should be provided for Intensive Care Unit Staff and Doctors.
5. Nursing and physician staffs assigned to each patient should be as consistent as possible.

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