

Communication Coaching

A case study of family caregiver burden

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BACKGROUND: Problematic communication among providers, patients, and their family members can affect the quality of patient care, causing stress to all parties involved and decreased opportunities for collaborative decision making.

OBJECTIVES: The purpose of this article is to present one case from a pilot study of a family caregiver intervention focused on communication.

METHODS: The nurse-delivered communication intervention includes a written communication guide for family caregivers, as well as a one-time nurse communication coaching call. The call is aimed at identifying caregiver communication concerns, providing communication education, and role playing problematic communication.

FINDINGS: Psychological distress and caregiver confidence in communication were improved for the caregiver. Data presented from the case study demonstrate the need for family caregiver communication support and training and the potential benefits of such training.

KEYWORDS

family caregiver; caregiver burden; communication

DIGITAL OBJECT IDENTIFIER

10.1188/17.CJON.219-225

DECADES OF CAREGIVING RESEARCH ILLUSTRATE that family caregivers continue to have high unmet information needs (Glajchen, 2012; Northouse, Katapodi, Song, Zhang, & Mood, 2010) and experience distress and anxiety as a result of poor communication with providers, family, and friends (Hendriksen et al., 2015; Li & Loke, 2014; McCarthy, 2011). Poor communication with healthcare providers results from caregiver difficulty in understanding medical language and feeling overwhelmed by the amount and type of information provided (Robinson, Gott, & Ingleton, 2014). Caregivers also experience communication difficulties with patients and other family members because of differing communication styles or the desire to protect each other or avoid topics, or as a result of previous conflicts (Northouse, 2012). Family caregivers report feeling responsible for the psychological well-being of the patient (Mosher, Jaynes, Hanna, & Ostroff, 2013) and attempt to protect the patient and maintain hope by avoiding discussions about the diagnosis and illness trajectory (Caughlin, Mikucki-Enyart, Middleton, Stone, & Brown, 2011). In the absence of open communication, caregiver depression results from low patient cohesion and expressiveness and greater conflict (Siminoff, Wilson-Genderson, & Baker, 2010).

Family conflict can be a secondary stressor for caregivers (Kramer, Kavanaugh, Trentham-Dietz, Walsh, & Yonker, 2010; Wittenberg-Lyles, Demir, et al., 2012), and the psychological well-being of caregivers is affected most during lung cancer care (Grant et al., 2013). The quality of life among patients and caregivers is interdependent (Kim et al., 2015), and perceived family disagreement is associated with depression in patients with lung cancer and their caregivers (Zhang, Zyzanski, & Siminoff, 2010). Caregivers of patients with lung cancer worry about the impact of the illness on the family and the family's ability to cope with caregiving responsibilities and express a desire to care for their family (Maguire et al., 2013). For example, caregivers who do not live with the patient with lung cancer spend a considerable amount of time providing emotional support to the patient and other family members (Mosher, Jaynes, et al., 2013). Particularly salient in lung cancer populations, caregivers who blame the patient for getting lung cancer create depressive symptoms for the patient as well as for themselves (Siminoff et al., 2010). Among married couples, spousal caregivers are more likely to be depressed than nonspouse caregivers (Siminoff et al., 2010). Distressed