

The family as victim in trauma

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In trauma, the intense immediate need for medical intervention and stabilization has focused attention on the victim's physical injuries, and away from the traumatic psychosocial impact on his life and family. Trauma teams are prepared to respond quickly and efficiently to sudden life and death situations, with the most up-to-date knowledge, technology and care. Until recently however, little organized, comprehensive attention has been given to the psychosocial responses of the patient and the family. It is now time to prepare ourselves to offer this other important aspect of trauma care — the psychosocial component. As a part of this preparation, I would like to present the Family as Victim in Trauma.

I know many of you know and do these things that I'm going to discuss with you, but I want to bring this idea of the Family as Victim in Trauma home to you.

The call can come at any time. You, the family member, are never prepared for it. It is sudden, unexpected and traumatic. A person you don't know has called to tell you that someone you love or care for has been injured and is at the hospital. You hang up the phone, your heart begins to pound, and your breathing is rapid. Your hands shake. You can't remember the name of the person who just called or what hospital it was or how to get there. Questions begin to flood your mind. "How bad is he? Is he conscious? Will he die? Will I get there in time? Whom should I call? What should I do?"

You are having a terrifying new experience and the old answers don't seem to apply. People speak to you but you have difficulty hearing or understanding them. Life as you perceived it moments before has changed, perhaps forever. The predictability of tomorrow is gone.

Even though you are not the patient, *you are* the victim of trauma. If it is your parent, your husband or your child who is injured, the whole structure and meaning of your daily life is threatened, and perhaps permanently altered. You are frightened that soon you might no longer be a daughter, or a wife or a mother. Nothing has prepared you for this moment. You feel afraid and alone. There is a compelling need to act. Although your goal is to get to your loved one, you have difficulty

thinking what to do next.

Perhaps even worse, this news didn't come to you by phone. Perhaps you were there; you witnessed or were a part of the trauma event; you saw, heard and felt it. You saw the blood, the injuries, the mutilated or broken body of your loved one. You heard the cries of pain. You felt the impact of the crash or you watched helplessly the fall you could not stop. Perhaps you saw other victims: bloody, injured or dead. You experienced the panicky wait for help to arrive, saw the intense, bewildering and fast-paced actions of the first responders, rode the wailing ambulance or noisy helicopter, then saw strangers closing in on your loved one, and you were suddenly left alone. You had to give over the life and body of your loved one to others. At that point you can only hope and trust — and wait.

Speaking for us as caregivers, the first contact that is made with the family whether by phone or at the hospital is very important. It begins the process the family must go through in order to accept and adapt to the injury and its possible life-long circumstances to the patient and to its members. At best, there will be a period of healing. But very possibly there will be an adjustment to permanent or long-term disabilities for both patient and family. It is best to establish early a healthy rapport with the patient's family.

The initial notification should be made by a person who will be available to the family for at least the next few hours. It should not be left up to a unit secretary or registrar.

As you prepare to make this call, remember that you are about to subject the person on the other end of the line to a sudden, traumatic disruption in his or her life. Even minor traumatic events are frightening to lay persons.

When you as caregiver have reached a family member, identify yourself clearly and slowly and where you are calling from. Give him or her whatever positive information you have. If the patient was able to tell you whom to call, begin with that.

"Hello, this is Vanessa Brown at Queen's Medical Center. Your son John has asked me to call you to let you know he has been in an accident and is in our emergency department."

This lets the family know that the patient is awake and able to speak and provide information, even as they learn about the injury. This is a very different picture than the one given when you call and say: "Hello, this is Queen's Emergency. Your son was hit by a car and brought in by Medivac."

You want to reduce the level of anxiety induced by your

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call. Tell the truth but don't volunteer unnecessary, frightening information; there is plenty of time for details once the family arrives at the hospital. It is in everyone's best interest to keep family members functioning at the most rational level possible. Ask if the person will be driving or if there is someone who can provide transportation. Give directions; repeat your name and tell him or her that you will be the contact person.

Briefly answer what questions you can: "He is having x-rays; the doctors are with him now; we don't know the extent of his injuries, but he is awake and talking to us."

If the patient is critical, on the other hand, and the family asks, tell them so. If the patient has died, it is better for the physician to tell the responsible family member face to face after he or she has arrived at the emergency facility.

Family and friends who come to the hospital in response to the emergency do not know what to expect or what is expected of them. As far as the family is concerned, the injured patient is the only one in the emergency department or in the intensive care unit. Ringing phones, orders called out, equipment being moved about, are all interpreted by family members in relation to their loved one. Staff persons standing around who are chattering or laughing will give the appearance of being cold or indifferent. Keep in mind how things will look to frightened and worried family members. Whenever possible, move them to a quiet, private place, near enough for communication with staff, but away from all the usual hospital activity. Provide them with a phone and phone book for calling other family members.

Family members will have a tremendous need for information in order to make sense of what has happened. And yet, their ability to absorb and retain information may be diminished by their anxiety and fear.

The caregivers work daily around ill and injured people. We see blood, pain and death. What is commonplace and meaningful to us is not so to patients and their families. They often cannot interpret what they see and hear. They must be informed and educated by us.

Family members will want to know if the patient is conscious, if he or she is in pain or going to die, or even about the mechanism of injury. Verbal information is not the only medium; the family also will want to see the patient as soon as possible. This will help them realize for themselves the patient's condition.

The patient benefits as well, physiologically¹ and psychologically, by seeing and hearing his family around him. Therefore, as soon as possible, allow the family member(s) in to see the patient. They may be able to reassure and support the patient in ways that medical personnel cannot. This visit with the patient is beneficial, rather than disruptive, and is to be encouraged and supported.

Prepare the family members before they go in for what they will see; tell them about what all the lines, tubes, and equipment that are attached are for; about the injuries that are obvious, and whether the patient can see or hear them. Briefly explain that the medical equipment is to help the patient. Properly prepared, most families handle the visit well. Seeing,

touching and talking to the patient is reassuring.

The event becomes a reality with which to cope, rather than a nightmare, and the family can begin to move on to becoming allies in the treatment plan, rather than Victims of Trauma.

You, the "contact" caregiver, should keep the family abreast of what is occurring, what procedures are anticipated, when the patient will be moved, and what physicians may be involved. Present information in a calm and empathetic manner. Use lay terms; repeat as necessary and update. Become a liaison between the medical team and the family, carrying information both ways. Asking family members about past medical history and injuries, medications, allergies, and even about insurance coverage, when done at an appropriate time, increases the family's sense of participation and decreases their feelings of helplessness and separateness.

Patients and families bring all levels of coping skills and personal or cultural responses to the hospital with them. Some may express denial; some may weep loudly or act-out angrily. Some will be calmed readily and be able to take on the task of helping other family members. Some may require repeated intervention. Angry feelings and thoughts are often expressed as a part of responding to the traumatic event. Such angry words should be accepted but not taken personally by health personnel, although such behavior on the part of a family member may need to be assuaged and controlled so that no one is harmed.

Family members may blame themselves and each other, saying: "If only I had stayed home today," or "I told you not to let him buy a motorcycle." These thoughts and ideas are better expressed and discussed then and there. However, do not rush in too quickly to reassure and fix their ideas for them.

It is important that the health care worker assisting the family provide initial support, guidance and structure to its members. It is equally important to identify the family member or members who will be able to take on a supportive or leadership role within the family and to reinforce their strengths and skills. Gradually, the contact person must phase out and begin to hand over tasks and responsibilities to family members. Decreasing family dependence on the health care worker and institution enhances the restructuring and healing of the traumatized family.

Eventually the family will need to function independently in order to cope with the aftermath of the trauma and what may be a long struggle to adapt and redefine life purpose for both the patient and themselves.

It is essential to good trauma care to bring the family from being "Victims of Trauma," to becoming a part of the healing and rehabilitation process. This transformation should begin with the very first contact in order to make it as good as it can be.

REFERENCE

1. Kleeman KM. Family Systems Adaptation in Trauma Nursing, From Resuscitation Through Rehabilitation. W.B. Saunders, 1988, Philadelphia. ■