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Support group as embracement strategy for relatives of patients in Intensive Care Unit

GRUPO DE SUPORTE COMO ESTRATÉGIA PARA ACOLHIMENTO DE FAMILIARES DE PACIENTES EM UNIDADE DE TERAPIA INTENSIVA

GRUPO DE SOPORTE COMO ESTRATEGIA PARA LA CONTENCIÓN DE FAMILIARES DE PACIENTES EN UNIDAD DE TERAPIA INTENSIVA

Lizete Malagoni de Almeida Cavalcante Oliveira¹, Marcelo Medeiros², Maria Alves Barbosa³, Karina Machado Siqueira⁴, Paula Malagoni Cavalcante Oliveira⁵, Denize Bouttelet Munari⁶

ABSTRACT

Admissions to the Intensive Care Unit (ICU) generate needs among relatives, which sometimes do not receive appropriate care. This study aimed at describing a support group (SG) that embraces the relatives of patients admitted to ICU and to evaluate its effectiveness in meeting their needs of information and emotional support. This descriptive study was performed in 2006 in a Hospital of Goiânia/GO, by means sessions of the Support Group for Families (SGF). The sessions were recorded and registered in a field-diary for further analysis of the group process. In addition, individual interviews were performed to evaluate if the needs for information and support were met. The SGF permitted to see to the needs of families, helping them cope with the hospitalization of their relative in the ICU. In conclusion, SGF helps to promote humanized care practice and to overcome care that is historically focused on patient and disease. Nurses should consider reorganizing their practice and the possibility of including the SGF as a strategy to meet the needs of the families.

KEY WORDS

Intensive Care Units.
Group processes.
User embracement.
Nursing care.
Professional-family relations.

RESUMO

Internações em Unidade de Terapia Intensiva (UTI) geram necessidades em familiares, nem sempre apropriadamente atendidas. O trabalho objetivou descrever grupo de suporte (GS) para acolhimento de familiares de pacientes internados em UTIs, e avaliar sua efetividade para satisfação de suas necessidades de informação/apoio emocional. Pesquisa descritiva desenvolvida em 2006, em Hospital de Goiânia/GO, por meio de sessões do Grupo de Apoio aos Familiares (GRAF), gravadas e registradas em diário de campo para análise do processo grupal, e de entrevistas individuais para avaliar atendimento das necessidades de informações e suporte. O GRAF possibilitou atendimento às necessidades dos familiares, ajudando-os no enfrentamento da internação do parente em UTI. Concluiu-se que GS colaboram para construção da assistência humanizada, possibilitando a superação do olhar historicamente centrado no paciente e na doença. Recomenda-se que os enfermeiros reflitam sobre reorganização da prática e possibilidade de inclusão do GS como estratégia de atendimento às necessidades dos familiares.

DESCRIPTORES

Unidades de Terapia Intensiva.
Processos grupais.
Acolhimento.
Cuidados de enfermagem.
Relações profissional-família.

RESUMEN

Las internaciones en la Unidad de Terapia Intensiva (UTI) generan necesidades en los familiares, las cuales no siempre son adecuadamente atendidas. El objetivo del estudio fue describir un grupo de soporte (GS) para la atención de familiares de pacientes ingresados en UTI y evaluar la efectividad de la satisfacción de sus necesidades de información y apoyo emocional. Investigación descriptiva desarrollada en 2006 en un hospital de Goiânia/Goias, a través de sesiones del Grupo de Apoyo a los Familiares (GRAF), que fueron grabadas y registradas en un diario de campo para el análisis del proceso grupal, y de entrevistas individuales para evaluar la atención de las necesidades de información y soporte. El GRAF permitió la atención de las necesidades de los familiares, ayudándolos a afrontar la internación del pariente en la UTI. Se llegó a la conclusión de que los GS cooperan en la construcción de una práctica humanizada del cuidado, lo que permite la superación del entendimiento históricamente centrado en el paciente y en la enfermedad. Se recomienda a los enfermeros reflexionar sobre la reorganización de la práctica y la posibilidad de incluir a los GS como una estrategia de atención de las necesidades de los familiares.

DESCRIPTORES

Unidades de Terapia Intensiva.
Procesos de grupo.
Acogimiento.
Atención de enfermería.
Relaciones profesional-familia.

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INTRODUCTION

The satisfaction of patients' relatives is an important aspect in the assessment of care quality offered at health institutions, and an essential part of health professionals' responsibilities in their work at Intensive Care Units - ICUs⁽¹⁻²⁾. It is still common, though, to find relatives of ICU patients in corridors and waiting rooms, in a state of shock and afraid, receiving little or no attention from health professionals. Many nurses working at these units agree on the need for nursing care delivery to patients' relatives as well⁽³⁻⁴⁾, but are still almost exclusively active in patient care, alleging work overload and lack of specific preparation to deal with relatives⁽⁴⁻⁵⁾.

Nevertheless, the welcoming of health institution users, including patients' family, is a fundamental part of the care humanization process and demands health professionals' availability to identify and see to their needs⁽⁴⁾. In that sense, although it is not a routine practice for all nurses, group work can be an efficient strategy for nursing care delivery to clients, facilitating compliance with their information, orientation and psychological support needs. While participating in groups, people go through many significant experiences that can change their understanding of the facts of life and help to acquire healthier attitudes for problem coping^(4,6). This research investigated the use of group technology for nursing care delivery to relatives of patients hospitalized at ICUs, considering that providing information and orientations of common interest to different relatives at the same time can be a strategy for a more rational use of nurses' time and effort. For relatives, participating in a group of people who are going through similar situations can be a therapeutically valuable experience, both due to the support received from other participants and the opportunity to share their own experience and give support to other people⁽⁶⁻⁸⁾. Moreover, participating in a support group can relieve feelings of solitude and social isolation and permit experience exchanges and self-reflection⁽⁴⁾.

The use of support groups requires the creation of a setting in which participants can share their experiences and feelings, certain of being understood by other participants. Offering emotional support and information/orientations, these groups allow members to perceive the actual situation by knowing more solid data about the problem and decreasing related fantasies, helping them to cope with the crisis they experience⁽⁷⁾. This process is made possible by the opportunity to learn new behaviors in a climate of sharing and acceptance. It can be an excellent co-adjutant therapeutic resource to deal with people who go through crisis situations, with a view to promoting cohesion and support, raising their self-esteem and self-confidence^(7,9).

For relatives,
participating in a group
of people who are
going through similar
situations can be a
therapeutically
valuable experience...

OBJECTIVE

Describe the use of support groups as a strategy for welcoming the relatives of patients hospitalized at ICUs and participants' assessment on the use of this strategy to attend to relatives' information and emotional support needs.

METHOD

This qualitative and descriptive convergent care research⁽¹⁰⁾ was developed at the Clinical and Surgical ICUs of the Hospital das Clínicas (HC) at Universidade Federal de Goiás (UFG) and conceived based on the ethical care needed for research involving human beings. Approval for the project was obtained from the Internal Review Board at HC/UFG, Protocol No. 107/04.

The population comprised 51 people who complied with the following inclusion criteria: having a relative/friend hospitalized at one of the two ICUs during the study period, being 18 years of age or older, having participated in at least one Family Support Group (GRAF) meeting and accepting to participate in the research by signing the Free and Informed Consent Term (FICT), which included the permission to record and use the information while preserving identities. The relatives participated voluntarily, without any attached benefits, and the intention was to attend to all people who came to the group meetings, even if they did not accept to participate in the research.

The field work started by planning the creation and functioning of the GRAF, an open support group for relatives of patients hospitalized at the ICUs, with a view to contributing to their welcoming at the hospital, offering information and support as a form of nursing care. Two experienced researchers, under the supervision of a nurse specialized in Group Dynamics, coordinated the GRAF creation and practice process in all work phases.

The GRAF was planned to be limited to ten sixty-minute sessions⁽¹¹⁾, held on Mondays, Wednesdays and Fridays, involving all patient relatives/visitors who wanted to participate. With a view to facilitating participation by people who visited the ICUs at night, allowing people who worked during business hours to take part without delaying their return home, meetings were held from 18:30 to 19:30 hours. Session planning included three phases: 1) participant welcoming and presentation, 2) offering information and orientations and 3) closing and evaluation. The first and third phases were expected to take fifteen minutes and the second thirty minutes.

Data collection – Data were collected between January and April 2006, during GRAF meetings. Only group meet-

ings where at least three relatives/visitors participated were included in the research, who not necessarily had to belong to the same family. Group sessions were recorded and registered in a field diary. While one of the coordinators coordinated the meeting, the other wrote down significant events in the field diary so as to complement transcriptions of the recordings. After the end of the group, individual interviews were held with eight GRAF participants (who were located and accepted to participate), with a view to assessing the group's utility to help them face the crisis they experienced during their relative's stay at the ICU.

A specific script, based on the theoretical framework and research objectives, was used to guide the semistructured interviews. Besides identification data, the interviewees were asked to discuss their group experience, how they assessed the support group as a strategy for nursing care delivery to relatives of ICU patients and their opinion on the importance of this care for patients' family. The interviews took place at a time and place previously arranged with the participants, were recorded and later transcribed by the researchers.

Data organization and analysis – After their transcription, all meeting registers (recordings and field diary notes) were submitted to repeated reading so as to identify the facts and phenomena related to each phase of the sessions involving family care. Later, corresponding phases were compared among different sessions, so as to identify common patterns and particularities for analysis and description of the intervention. With regard to the interviews, after their transcription and exhaustive reading, the synthesis of their contents resulted in one single category, involving two analytic aspects that identify the facts and phenomena related to the subjects' assessment of the process they had experienced.

The results were analyzed with a qualitative focus, supported by some quantitative data for the sake of a better understanding of the study subjects' characteristics. Participants are presented with fictitious names, in line with the FICT's commitment to preserve identities. Personal statements taken from the sessions, interviews and field diary illustrate the analysis, founded on interpersonal interactions and the relatives' participation and analyzed based on the meanings they attribute to their acts⁽¹¹⁾.

RESULTS

The GRAF was put in practice initiating with its dissemination to the institution's board, health professionals and users, which the group coordinators did during the week before the meetings started. During visits to the ICUs, both professionals and relatives who were visiting patients received information and a print invitation to participate in the group, mentioning the day, place and time for meetings. In parallel, the group coordinators obtained the Administrative Board's permission for relatives to enter the

hospital before the start of visiting hours so as to participate in the meetings.

In the planning of group sessions, it was established that they should follow three basic and subsequent phases: participant welcoming / presentation; information and orientations; and closing / assessment of the meeting. In the plan, the verbal presentation technique, stimulating everyone's participation, would be chosen for the information and orientation phase, while techniques would vary for welcoming / presentation and closing / assessment. All resources needed to develop the different techniques would be provided, including a sound system to make the environment more receptive and help participants to relax. A classroom near the two ICUs was chosen for the meetings, always available at the established time, of adequate size, and guaranteeing comfort, privacy and freedom, without unwanted interventions⁽⁸⁾.

Description of the intervention (graf)

Ten group meetings took place in January and February 2006, on the average, there were 6.9 participants per session, ranging from three to fifteen. In total, 51 relatives of seventeen patients (11; 64.7% from the surgical ICU and 6; 35.3% from the clinical ICU) participated in GRAF meetings, most of whom (43; 84.3%) came to one session, five (9.8%) to two sessions and three (5.9%) to five or more groups meetings. Most participants (32; 62.7%) were women. Sons/daughters were the most frequent relatives (11; 21.6%), followed by brothers/sisters (9; 17.6%) and the patient's partner (8; 15.7%). The remaining 23 (45.1%) were parents, grandchildren, sons/daughters-in-law, friends, brothers-in-law, nephews and father-in-law.

1st Phase – Participant welcoming and presentation. The group coordinators received the participants at the entry of the meeting room, welcomed them and invited them to make themselves comfortable. When at least three participants were present, sessions started with one of the coordinators explaining the research, its goals and the use of the group as a data source. Next, the coordinators distributed copies of the FICT and read it aloud, answering questions, clarifying doubts and guaranteeing the right to participate even if the relatives/friends did not want to sign the FICT.

As the GRAF was an open group and, therefore, new members were constant, the coordinators took care to make them familiar with other participants and advise them about how to participate in the meetings, in accordance with literature recommendations⁽¹¹⁾. Besides welcoming the participants, all sessions started with a presentation/renewal of the group contract, including its objectives and rules for functioning. In this process, the coordinators proposed the basic rules but guaranteed the participants' right to refuse, alter or include new ones. The GRAF contract included: 1) all people present were equally important and entitled to participate as they wanted, talking or just lis-

tening; 2) the group was a private space for participants, without any obligation towards the institution, so that members could talk about what they wanted, without any fear of reprisals; 3) group members assumed the commitment not to talk about the subjects addressed, the participants' behavior or any other event that happened outside the setting; 4) the duration of the meeting was previously established and especially termination times would be respected, so as not to affect patient visits; and 5) in the group, all participants were free to talk about topics of interest with regard to the situation they experienced, to demonstrate their feelings, manifest their emotions, respecting the limits of other participants, the coordinators and the environment.

To present the members, the coordinators explained the selected technique and gave advice about the use of available resources, according to each techniques: printed card-

board strips with positive and negative feelings, scrap, colored cards, colored pens and markers, round white cardboard molds for drawing and others. Next, using the available material or not, participants presented themselves, mentioning their name, whom they had come to visit and telling / showing how they had reached the group. Finally, the coordinators returned to what the participants had addressed, highlighting the experiences and feelings shared and common elements in the initial statements.

2nd Phase – Information and orientations. As giving information about the patient's condition was not part of the group's objective, the themes the participants presented for discussion were related to information about the ICU, aspects they were in doubt about and forms of coping with the situation, among others. Chart 1 shows the themes the participants addressed during GRAF meetings and how the group coordination worked with them.

Chart 1 - Presentation of themes indicated by participants for discussion in the information, orientation and support phase of GRAF sessions - Goiânia - 2006

Theme	Approach
1. How to act when you are with the patient. <i>And what if she opens her eye? I am so scared!...</i> (Neusa) <i>You don't know if you can touch, if you can't touch...</i> (Eunice)	Coordinators – explain that relatives can touch the patient, talk to him/her, hold his/her hand, kiss him/her, etc. reaffirm their rights as patient relatives.
2. Lack of knowledge about the ICU, its goals and functioning. <i>I cannot understand why my father had to come to the ICU... what's the use of the ICU...</i> (Roberto). <i>Why are patients undressed at the ICU? Isn't that bad, because of the constant airco?</i> (Vanda). <i>You get kind of scared, because you've never been through this, right?</i> (Márcia). <i>I got really frightened [...] because [...] I've never had any relative who went to an ICU</i> (Marcos).	Coordinators – clarify doubts, attempting to calm down the relatives about what an ICU is, its goals and functioning, correcting their concepts. Participants – tell personal experiences with relatives and friend who were hospitalized at an ICU and recovered.
3. Previous negative experiences with relatives hospitalized at ICUs and other units. <i>My father had a lung problem, pulmonary thrombosis and that was not a good experience... And I think that's such a hard moment! [...] I remember that my father... I felt so powerless that until today [...] I still have that image in my head [...] a very painful image remained...</i> (Eunice). <i>... I was hospitalized for a while and had two nurses. One was really sweet... One was a... [negative head gesture]. [...] If you work in the profession and love it, you do it with affection and it's well done!</i> (Dionízio)	Coordinators – calm down participants about ICU conditions and professionals' qualification. Mention that professionals' not very cordial behavior should not be considered a rule but an exception. Participants – tell positive ICU hospitalization experiences, praising professionals, affirming that they have faith in the patient's treatment.
4. Information about the patient – doubts about the information physicians transmit and complaints about news obtained by telephone. <i>... I think there's very little information. [...] some more communication is missing between the doctors and his relatives</i> (Luana). <i>I just want to get news about her [...] real news because [...] information by phone is... cruel</i> [...] (Sônia) <i>... the way people talk is not right, you know? [...] I asked [...], he read the bulletin [...] we don't know what that means...</i> (Elisabete).	Coordinators – highlight that relatives are entitled to information about the patient's conditions. Affirm that they understand relatives' dissatisfaction with this form of receiving news. Inform that information passed by phone about patients' health state generally comes from employees without training for this purpose, who merely read what is written on the bulletin.
5. 1. Emotional and physical overload for some family members. <i>... I am tired!... I am so tired!... [cries] Because [...] I'm the one who has to make all decisions... I don't know if I'll be able to bear this</i> (Roberto). <i>... I can't stand it anymore! (...) I cry... my body even hurts. [...] I am not happy about anything... I feel sad... headache...</i> (Cristina) <i>Your mind gets exhausted. [...] I wake up, go to work, but it's difficult! [...] My wife is tired of coming here. [...] we work, you know, so life can't stop for us to stay with them</i> (Dionízio). <i>I don't sleep, I can't eat... so... [cries]. [...] It's difficult, you know, I have never been through this, I have never had a relative at the ICU...</i> (Elisabete).	Coordinators – talk with participants about the issue, demonstrating that they understand the burden they are carrying. Talk about different ways of coping and the need to find healthy mechanisms to deal with them. Comment that, in crisis situations, each family member does what he can, that it's useful to set your own limits and acknowledge that you are doing your best, even if that's not all you would like to be able to do.

Continues...

...Continuation

Theme	Approach
6. Lack of information about machines connected to the patient and their uses. <i>If her pressure goes up, she gets off the oxygen [respirator]? What's this oxygen doing? [...] sometimes it's the machine that hurts... (Aurora). ... she used a small device to put a drug for pressure, to make it higher... Then I was thinking... what kind of device is that? (Sônia).</i>	Coordinators – inform names and uses of equipment and give other advice.
7. 1. Authorization to take a physiotherapist to take care of the patient. <i>... what do we do to bring a physiotherapist for the patient? Because my uncle is needing one, but the staff says that [...] there's nobody to take care of him (Isabela).</i>	Coordinators – advise the relative to get more detailed information from the ICU physician and nurse, explaining the situation.
8. Difficulty to understand to meaning of the signs and symptoms the patient presents and to interpret what is happening to the patient. <i>And the problem that happened in her lung, what's that? (...) Why does she get agitated? [...] She was evacuating blood on Sunday... Why would that be? (Sônia). ...Why does her pressure go down? [...] Is there any problem with her lung? Does she know everything that is happening? So she's not in a coma? (Aurora).</i>	Coordinators – give the requested explications, advising participants about their right to detailed information about what is happening to the patient.
9. Fear of death and difficulty to accept things of life <i>... I know that our life here is passing, nobody is here forever... It's difficult! [...] we need to be strong, we have to fight! [...] face the pains of life more realistically (Isabela). We go through problems as God wants us to. [...] Our life [...] it's full of ups and downs. [...] we need to be strong, right, to face it... what God sets out for us, right? [...] you can't get desperate... (Dionízio). God knows that I can handle this burden, but if he [hospitalized husband] passes away, it's going to be a tremendous loss... (Melissa).</i>	Coordinators – talk about life and things we consider unfair, difficult and unwanted. Highlight death as an unavoidable event for everyone and as a possibility when a person has a severe or risky disease, like ICU patients, but that they should not get obsessed with this or blame themselves for thinking about this.
10. Difficulty due to not living in the city and having to stay in hospital all day, without adequate accommodations. <i>... I came from Rio Verde, I stay in hospital all day and I feel really alone (Elisa) I don't know anything here [...] I come here in the morning [...] I stay here all day because, when it's time to visit at two [o'clock] I want to see how she is [...] sometimes I have lunch, [...] sometimes we just eat in the afternoon. When visiting times end, right, we leave... (Elina).</i>	Coordinators – show that they understand the difficulties experienced and advise relatives to seek help from the hospital's Social Service.
11. Information about health. <i>... my normal pressure is 90 to 100 over 70... I think that's a normal person, right? [...] salt raises pressure a lot, right? (Dionízio). What causes the high pressure? What do you feel? And low pressure? (Aurora). That's [diabetes] is hereditary, right, in the family? But [...] she didn't have high pressure, is it a consequence of the diabetes? (Vilmar).</i>	Coordinators – give information about the diseases, treatment and care, strengthening preventive aspects of the disease itself and its possible complications.

3rd Phase – Closing and assessment of the meeting. Independently of the technique used, the relatives' assessment of their participation in the group was always positive, indicating that the activity had been useful to help them at that moment. All participants considered it important to have someone to talk to, feel that someone is concerned with them, the support received from the coordinators as well as other group members and to perceive that they are not the only people who experience difficulties, according to their statements:

This support is very important to calm us down a little, because.. when you get here and go straight to the ICU, it's difficult, right? Very good! (Márcia).

... there are many words that make us feel relieved [...] we get satisfied with the support you are giving us. We ... need some words like that (Dionízio).

I liked it a lot [...] there's someone to advise us, right, to help us [...] to strengthen us [...] there's you, right, to help us at that moment... (Maristela).

This moment here is another emotion I feel. [...] I got really satisfied and grateful for the care I received. This meeting

of yours created a space to help us [...] It's excellent... really good! (Marcos).

Assessment of the intervention (GRAF) by the interviewed relatives

The systemic assessment process of the group as a nursing care strategy has not always been a concern for professionals using this tool. One of the possibilities to assess the efficacy of this type of action is knowing the group participants' opinion about the use of this strategy to attend to their needs^(8, 11). In this research, all relatives' statements about their experience of participating in the GRAF meeting(s) mainly included benefic effects, which contributed to their feeling welcomed at the institution, as some participants manifested:

I [...] thought it was good... to find someone to talk to. [...] You know that the problem is not over, you know, but... it's so good to talk to someone... (Sônia).

... I thought it was great! [...] there you manage to [...] ask questions, solve a lot of doubts. [...] it can help to remove some of the anguish (Isabela).

... it becomes easy to understand more, there are competent people to inform us, explain the times, everything... So, I got very satisfied [...] with the reception, the love you showed use (Marcos).

The interviewees also unanimously affirmed that the opportunity to participate in the group made them feel that they were receiving the care they needed from nursing, especially with regard to emotional support, according to their statements:

Yes, because we hardly talk to the nurses during visiting hours, right, they are not even around. [...] On the day there was the meeting first, at the time we got in [...] I was... calmer, you know, to see my sister... easier... (Sônia).

Ah, it did! [...] Because there, at the meeting, we [...] know that there is someone to talk to, someone to ask what we don't know, to listen to what we want to say, right? [...] And [...] we saw that we could trust you (Dionizio).

I felt that it did. [...] we get so weakened [...] that when you receive some attention, no matter from whom, you feel more relieved, more hopeful (Vanda).

As to their opinion about the use of this intervention as a strategy for nursing care delivery to relatives of ICU patients, all interviewees agreed about its value and importance to help them face the situation, including recommendations not to end the group:

...for me, this is super important! [...] it gives us strength when we are weaker [...] you start to understand a little of what is happening... (Eugênia).

I hope that... you... continue, it's... doing these... meetings, because [...] it does not decrease [the suffering], but it helps a lot to get through it (Roberto).

I find it important and I admire it a lot [...] because I think that afflicted people need this part, you know? (Marcos).

DISCUSSION

As planning is an essential phase for the success of any group work^(6,8), in the GRAF, the entire context was aimed at seeing to the relatives' information and support needs, with a view to contributing to their welcoming at the institution. In the group, the family members interacted with other participants who were going through similar situations in an environment that favored the exchange of experiences and clarification of doubts about the hospitalized relative's situation, helping to decrease their social isolation.

The intent was to create a space where relatives had someone who listened to them and whom they could trust, a fundamental aspect in care delivery to these people⁽¹²⁻¹⁴⁾. To guarantee this, organizing the *setting* is an important phase of group planning. Chairs should be arranged in a circle to allow all participants to see other members, so that everyone feels involved and part of the whole^(8,11). The

circle creates a psychological space and delimits the group's activity area, facilitating interaction among participants⁽⁹⁾.

Considering that new members could enter the GRAF at any time, all sessions started with the renewal of the group contract with the relatives who were present⁽¹⁰⁾. That is a psychological contract, i.e. an agreement between the coordinator and members, as well as among participants, which rules the development of group activities, defining acceptable behaviors and inadequate conducts in the group⁽⁹⁾.

The techniques used in the three phases of all sessions were selected in view of the group type, participant number and characteristics, objectives of the group and technique, time available for application and material resources needed. In this choice, group coordinators should remind that the technique cannot be a goal in itself, but a means to help and achieve the group's objectives and needs, and never to satisfy one of the coordinator's needs⁽⁹⁾. As GRAF participants were only known at the time of each meeting and all of them were going through a crisis moment, techniques were used that permitted participation without constraints or excessive self-exposure and allowed for contact according to each person's conditions and possibilities. The use of techniques that discriminate against participants or threaten their safety can provoke fears and apprehension, breaking the bond of trust between coordinator and group. This puts the process' credibility at risk, can generate mistrust among participants and, hence, make them leave the group⁽⁹⁾.

To finish that first phase of the meetings, the coordinators helped the group to elaborate the phenomena that had occurred, returning them to the participants for the sake of a broader comprehension. This return is important to allow them to understand the experience; it is a moment of reflection in which the group has the opportunity to move beyond the emotional level of the experience and manage to critically think about what was done and felt^(9,15). To the extent that participants identified with similar experiences that were mentioned, they started to show more security to express their feelings, evidencing the importance of perceiving themselves as part of that group and as being accepted by other members⁽⁶⁾.

In the next phase, the use of the verbal presentation technique allowed all participants to freely express themselves, facilitating the offering of information, orientations and clarification of doubts. An analysis of the information/orientations the relatives requested (Chart 1) shows that they do not differ much from what is routinely heard at ICUs and from what nurses have sufficient knowledge to offer. In the group, however, the coordinator should be prepared to adapt the approach of the topic to the moment participants experience and to their needs, avoiding counsel and privileging everyone's participation to encourage the sharing of knowledge and experiences, instead of providing answers and requested information themselves. The coordinator is responsible for attentive listening, in order

to correct interpretation errors and misunderstandings about the theme that is addressed and to introduce new knowledge with a view to health promotion, prevention of diseases/complications and forms of coping with the crisis⁽¹⁶⁾. Besides the valuable opportunity to develop health education actions among family members, offering the requested information and orientations by itself has a therapeutic effect on participants, because it creates an environment that allows them to clarify doubts and obtain the necessary orientations and because it complies with their information needs⁽⁸⁾.

In support groups, especially open ones, where relatives can participate in one single meeting, the closing and assessment phase is a valuable moment for participants to reflect on their participation in the meeting and to judge how their participation in the group contributed to help them at that moment^(6,8,11). All relatives who participated in the GRAF confirmed the group's benefic effects, highlighting the importance of this care, both due to the opportunity of being heard, getting clarifications for their doubts and to the support from other participants, and also because they observed that they were not alone to face a situation that threatened with the disability or loss of a loved one. Their statements expressed the value of information, support and experiences shared with people going through similar situations, indicating that the group contributed to comply with their needs^(6,8,11,17).

It is not easy to work with support groups to people (patients and relatives) going through a disease situation, especially those that involve risks of losses or changes in personal and family functioning, but this may show to be a good opportunity to deconstruct myths and prejudices and to elaborate feelings mobilized by the disease process⁽¹⁸⁾. In this research, all interviewees affirmed that the group is a good strategy for nursing care to relatives, ratifying that it can be valuable for nurses to get closer to patients' family, seeing to their needs and humanizing that relation.

Due to the suffering, despair, impotence towards the situation, fear, anxiety and anguish about an uncertain future make relatives of severe or high-risk patients feel great need for attention, appreciating any attempt to improve their tranquility and comfort. For these people, more important than the strategy professionals use is to receive some kind of response to their needs^(1,4,12-14,17). According to the study subjects' assessment, the support group was considered adequate for nursing care to these family members, because it allows them to feel cared for by someone who is concerned and willing to pay them some attention⁽⁴⁾.

CONCLUSION

The description of the trajectory followed from the planning to the actual GRAF meetings and their assessment can

facilitate professionals' and especially nurses' work, who are interested in similar interventions to offer care to relatives and other clients. The detailing of each phase of the group work, with basic tools, facilities and bottlenecks faced to put the group technology in practice confirmed that the systemization of care is fundamental for the success of the intervention.

The time to attend the family members through group technology (from the preparation to the session in practice) was about ninety minutes. Holding two weekly meetings would demand approximately three hours/week of nursing work, permitting this care even in services where professionals have little time for this activity. Although dealing with these relatives' suffering and anguish can be a challenge for nurses, it is gratifying to observe the relief they express in their statements, as a result of a mere space for them to talk about their feelings, certain of being heard and understood.

As for the themes that can emerge in the group, these are part of ICU professionals' own body of knowledge and should not represent a bottleneck for putting this strategy in practice. The work of coordinating groups demands specific qualification and preparation; nevertheless, supervision from professionals specialized in this work and in human relations helps a lot to understand the participants and coordinators' difficulties and needs and to propose new forms of professional action.

The interviewed relatives assessed their experience in the GRAF positively, indicating that, by participating in the group, the information/orientation and emotional support needs were attended to and that the support group can be an efficient strategy for nursing care to families of ICU patients. The combined analysis of the group process and of the GRAF participants' assessment showed that the support group is an appropriate strategy to attend to the information and emotional support needs of ICU patients' relatives, helping them to feel welcomed at the institution and to cope with the crisis experienced. The welcoming process, however, cannot be reduced to one single intervention nor be the responsibility of a single professional / professional category. Hence, the use of support groups should be considered only one part of the welcoming process, which demands additional interventions to meet other needs.

The use of support groups as a therapeutic resource can collaborate with the construction of a humanized and welcoming care practice that promotes respect for people, making it possible to move beyond the historically patient and disease-centered perspective. Considering the good results of this study, nurses should reflect on the reorganization of their practice and the possibility of including group technology as a strategy for nursing care to family members' needs.

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