

Article Critique

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Compton, S., Levy, P., Griffin, M., Waselewsky, D., Mango, L. M., & Zalenski, R. (2011).

Family-witnessed resuscitation: Bereavement outcomes in an urban environment. *Journal of Palliative Medicine*, 14(6), 715-722.

The purpose of the article is to bridge the knowledge gap regarding whether bereaved-related depression and post-traumatic stress disorder (PTSD) results from witnessing or not witnessing the cardiopulmonary resuscitation (CPR) proceedings in the emergency department (ED). The objective justifies the need for a study to eliminate doubt that surrounds the impacts of either witnessing cardiopulmonary resuscitation (CPR) or not.

Hypothesis:

- (a) Witnessing CPR is significantly related to PTSD and bereaved-related depression;
- (b) Witnessing CPR is not significantly related to PTSD and bereaved-related depression.

These hypotheses are based on pre-assumptions that CPR is associated with PTSD and bereaved-related depression. Therefore, the article's main objective is to ascertain the assumptions based on the level of significance. Since the hypothesis focused on the two sides of the study, it is expected to lead to an impartial conclusion.

Thesis Statement: Although witnessing CPR in the ED exposes people to bereavement-related depression and post-traumatic stress disorder (PTSD), the magnitude of such effect is not associated with witnessing or not-witnessing CPR. Such statement seems to be inclusive and justified for further clarification during the study.

Family-witnessed resuscitation (FWR) is a practice that was developed to allow the family members to witness CPR practices due to increased likelihood of death after cardiac arrest. According to the authors, although the witness might obstruct the resuscitation process,

FWG often reduces grieving process. The fact that witnessing CPR might lead to PTSD and bereaved-related depression created a great concern to the researchers (Compton et al., 2011). As such, the study revealed a high level of depression and PTSD symptoms during CPR procedure: an observation that was common for FWR and Non-FWR.

Data Collection

The extent of exposure of the participants varied; this could influence the results. For instance, participants might have been exposed to patient's health condition prior to the study; therefore, it was most probable that the participants did not experience the perceived impact during the survey. Similarly, since the participants were selected randomly, some important factors such as age were not considered, yet such factors could interfere with the final conclusion. The authors reported a bereavement difference between FWR and Non-FWR, especially at 60 days. However, "the results did not differ significantly between the FWR and Non-FWR groups" at 30 days (Compton et al., 2011, p. 717). Moreover, whereas the results were based on observed behavior among participants, the balance between FWR and Non-FWR sample sizes could influence the results thereby leading to a biased conclusion. For example, the variance in the sample size could lead to varying mean depression scores and mean PTSD scores between participants. This is because the larger the sample size, the smaller the effect of the sample on the study. On the other hand, small sample sizes have more effects on the conclusion. Given that the study involved 24 FWR and 41 non-witnesses, such difference in sample size must have influenced the final conclusion and most probably, the rejection of the null hypothesis (Witnessing, CPR is not significantly related to PTSD).

Moreover, given that the information was collected based on observant and participant's willingness to respond, participants could offer exaggerated experiences thus negatively

impacting on the final conclusion on the study. For instance, participants “could wish not to respond to the bereavement outcome portion of the interview due to emotional difficulties” (Compton et al., 2011, p. 717). Such statement reflected the perception that the data could be emotionally-driven rather than based on clinical tests. The results were also subjected to other factors, such as the relationship between the participant and the patient and self-confidence among others.

Research Design

This was “a prospective, quasi-experimental, comparison group study” (Compton, et al, 2011, p. 716). Most of the hospitals where the study was conducted were located “out-of-hospital where cardiac arrest was almost uniformly fatal” (Compton, et al, 2011, p. 716). This implies that most participants had knowledge of the CPR and that each of them was affiliated with the ED (Compton et al., 2011, p. 716). As such, the participants were likely to provide refined information that could be utilized to make relevant conclusion.

Training of Researchers

The authors reported that in-service sessions were provided for FWR and that practitioners trained as the family member escorts were issued with specific instructions. Since the instructions could have made it easier for practitioners to gather particular data from participants, it was probable that the practitioners could influence the results through attitudes and preferences.

Instruments

The prevalence of CPR rates in different hospitals was ascertained through a pilot study. It justified the basis of the prevalence of a family member in the ED, which then facilitated the study. The pilot study further ensured that the majority of those involved in the study were

family members thereby avoiding using strangers or visitors who might not portray significant bereaved-related and PTSD impacts.

The article also used depression scale to gather information regarding bereaved-related depression. The categories involved in the scale included “no/low” and “mild to moderate” (Compton et al., 2011). Although these instruments could collect relevant data, they are often characterized by the lack of participant’s trustworthiness and willingness to give experience-based information. Similarly, the participants might experience the bereaved-related depression, but failed to interpret it for the purpose of the study. That makes the depression scale less reliable in determining the relationship between CPR and PTSD symptoms and depression.

Data Analyzes

The data presented in graphs for both PTSD and depression at 30 and 60 days indicated that FWR-participants depicted insignificantly low levels of PTSD compared to Non-FWR participants. Such data confirmed the hypothesis and the thesis statement. Similarly, the graph for the levels of depression among FWR-participants compared to Non-FWR participants reported low levels of depression for FWR-participants and relatively higher bereaved-related depression among Non-FWR participants. According to Compton et al. (2011), the data plotted was based on results obtained from the follow-up period of 30 to 60 days. The ground for the choice of the follow-up period is valid from the view that bereaved-related depressions are expected to be evident for certain duration. The authors cite, “This time is the earliest point at which capture of symptoms associated with PTSD can be achieved” (Compton et al., 2011, p. 719). Moreover, bereavement is a dynamic process; that is, its symptoms are expected to appear immediately after the study and decline with time. As such, the period chosen for the follow-up study was justified.

The authors concluded that PTSD symptoms and bereavement-related depression are common among the family members of the deceased and non-traumatic cardiac arrest victims among others. However, the levels of the effects are insignificantly related to either witnessing or not-witnessing CPR for patients. The conclusion was based on the results of the data presented on the depression scale, graphical presentations, and other statistical evidence. In addition, it led to the rejection of the hypothesis that “witnessing CPR is significantly related to PTSD.” Nevertheless, the study overlooked some important factors such as age, prior exposure to patients at bad health conditions, trust, willingness, and emotional control that might have influenced evidence like depression levels.

To sum up, the study is justified owing to the fact that the theoretical information and statistical evidence were consistent throughout the article. Although there were certain variables that were left out during data collection, overall the article is resourceful in studying the relationship between witnessing and not-witnessing CPR and PTSD symptoms.

References

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