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Family Perspectives on ICU–ICCU Nurses' Assertive Communication at Universitas Airlangga Hospital for Service Excellence

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Abstract

Assertive communication by staff in intensive care units (ICU–ICCU) is essential for delivering family-centered care and achieving service excellence. This study aimed to explore patient families' perceptions of ICU–ICCU nurses' assertive communication at Universitas Airlangga Hospital, Surabaya. A quantitative descriptive-analytic design was employed involving 30 purposively selected family members. Data were collected using a validated 10-item assertive communication questionnaire ($\alpha = 0.93$; $r = 0.514–0.929$) and analyzed using descriptive statistics, one-sample t-test, one-way ANOVA, and Pearson correlation. The mean total assertive communication score was 36.9 ± 3.7, with 74.2% of respondents rating the nurses' communication as very assertive. The highest-rated indicators were empathetic listening (mean = 3.87) and comfort in asking for help (mean = 3.80), while openness to criticism received the lowest rating (mean = 3.07). A one-sample t-test showed the mean score was significantly higher than the theoretical midpoint of 25 ($t(29) = 17.80$; $p < 0.001$). No significant differences were found based on gender, age, education, or duration of accompaniment. However, a significant difference was observed based on the respondent's relationship to the patient ($F(3, 26) = 3.40$; $p = 0.032$). Although ICU–ICCU nurses were generally perceived as highly assertive communicators, the low rating for feedback openness reveals a relational gap. Assertive communication training should therefore emphasize not only clarity and confidence, but also empathy, receptiveness to criticism, and inclusive, relationship-centered approaches to strengthen family engagement in care.

Keywords: *Assertive communication; Feedback openness; ICU–ICCU; Family-centered care; Service excellence*

INTRODUCTION

Effective communication between nurses and patients' families in critical care settings such as the ICU and ICCU plays a pivotal role in delivering patient-centered care and reducing emotional distress. Despite its importance, various studies have shown that both therapeutic communication—which emphasizes empathy, trust-building, and emotional support—and assertive communication—which focuses on clarity, confidence, and respectful expression—remain suboptimal in high-stress environments where family members frequently

experience anxiety and uncertainty (Limaras et al., 2024; Ramadan et al., 2025). While therapeutic communication forms the relational foundation in nurse–family interactions, assertive communication ensures that vital information is delivered effectively, decisions are discussed clearly, and professional boundaries are maintained. In ICU–ICCU settings, these two communication approaches are complementary and mutually reinforcing: therapeutic strategies establish rapport, whereas assertiveness empowers nurses to convey critical information without ambiguity or hesitation. Families in these contexts are not passive observers; they seek clarity, reassurance, and emotional connection—needs that are often unmet due to the clinical focus solely on the patient.

This communication issue is not confined to isolated settings. Empirical data show that only 56% of family members in emergency departments rated nurse communication as "good" (Limaras et al., 2024), while in ICU settings, only 43.3% reported it as effective (Ramadan et al., 2025). At RSUP Dr. Sitanala Hospital, 30% of nurses admitted difficulty communicating, primarily due to language barriers and low confidence levels (Afrizal et al., 2023). Thakur (2024) further highlighted that communication with critically ill or unconscious patients in ICUs is influenced by institutional constraints, emotional burden, and lack of skill reinforcement, which may indirectly affect nurse–family interactions as well (Thakur et al., 2016).

These communication gaps are compounded by cultural and structural challenges in healthcare systems, including hierarchical environments and the absence of consistent assertiveness training (Mahvar et al., 2021; Chauhan & Tiwari, 2025a). A study in an Indonesian hospital also revealed that therapeutic communication by health personnel significantly impacts patient satisfaction, affirming the importance of addressing family involvement (Suraying et al., 2025). In line with this, a systematic review underscored the necessity of structured strategies and institutional support to improve nurse–patient communication (Suraya et al., 2024). Although efforts to train nurses in assertive communication have shown promising results—such as increased self-confidence and interpersonal effectiveness (Chauhan & Tiwari, 2025b), most existing studies still focus on the nurse–patient dynamic or general service quality. Only a few have examined how families perceive assertive communication by ICU–ICCU nurses, even though these families play a critical role in shaping care experiences. This lack of attention represents a substantial gap in achieving holistic service excellence in critical care. Therefore, this study aims to explore the perspectives of patient families regarding ICU–ICCU nurses' assertive communication as part of an effort to improve service excellence in critical care settings.

RESEARCH METHOD

This study employed a quantitative descriptive-analytic design to analyze the assertive communication levels of ICU–ICCU nurses based on patient families' perspectives. The approach was selected to explore not only the distribution of communication assertiveness but also its statistical relationship with demographic factors. The research was conducted at the Intensive Care Unit (ICU) and Intensive Cardiac Care Unit (ICCU) of Universitas Airlangga Hospital, Surabaya, Indonesia. A total of 30 family members of patients hospitalized in ICU–ICCU were recruited

as respondents using a purposive sampling technique, based on inclusion criteria such as being the primary caregiver and present during the period of hospitalization. Data were collected using a validated assertive communication questionnaire comprising 10 items measured on a 4-point Likert scale, ranging from 1 (strongly disagree) to 4 (strongly agree). The instrument demonstrated strong internal consistency, with a Cronbach's alpha value of 0.93, and item-total correlation coefficients ranging from 0.514 to 0.929, confirming its reliability and validity. The total possible score ranged from 10 to 40, which was interpreted into four assertiveness categories: scores between 36 and 40 were classified as very assertive, 31 to 35 as assertive, 21 to 30 as tending to be passive or aggressive, and 10 to 20 as less assertive. Participants were approached after obtaining informed consent, and the questionnaires were distributed and completed during visiting hours or after nurse–family communication sessions. Anonymity and confidentiality were maintained throughout the data collection process.

Data were analyzed using IBM SPSS version 25. The analysis began with descriptive statistics to determine the distribution of assertive communication levels among participants. A one-sample t-test was then used to compare the observed mean score with a predetermined theoretical mean, providing insight into whether the perceived level of assertiveness differed significantly from the expected norm. To examine whether demographic factors such as age, gender, or education influenced perceptions of assertiveness, a one-way ANOVA test was applied. Additionally, a Pearson correlation test was conducted to explore potential associations between participants' demographic characteristics and their perception of assertive communication.

RESULT AND DISCUSSION

This section presents the findings of the study regarding patient families' perceptions of ICU–ICCU nurses' assertive communication and analyzes their implications in the context of service excellence. The results are organized based on the demographic characteristics of respondents, the distribution of assertiveness perception scores, and the outcomes of statistical tests conducted to examine differences and relationships among variables. These findings are then interpreted in light of previous research and theoretical frameworks to provide a comprehensive understanding of assertive communication in critical care settings.

1. Demographic Characteristics of Respondents

The demographic characteristics of the 30 respondents in this study—who were family members of patients admitted to the ICU–ICCU—are presented in Table 1. These characteristics provide context for understanding their perceptions of nurses' assertive communication. Variables examined include gender, age, education level, relationship to the patient, and duration of accompaniment during hospitalization. Describing these attributes is essential, as demographic factors may influence how communication behaviors are interpreted and valued by family members in critical care environments.

Table 1. Demographic Characteristics of Respondents (n=30)

Variable	Category	n	Percentage (%)
Gender	Male	11	36.7
	Female	19	63.3
Age (years)	Mean ± SD	43.6 ± 8.1	-
Education Level	Senior High School (SMA)	9	30
	Diploma (D-3)	10	33.3
	Bachelor's Degree (S-1)	11	36,7
Relationship to Patient	Spouse	6	20
	Parent	13	43.3
	Sibling	9	30
	Child	4	13.3
Duration of Accompaniment	<3 days	12	40
	3–7 days	12	40
	>7 days	6	20

Sources: Author, 2025 (edited)

Based on Table 1, the majority of respondents were female (63.3%) with a mean age of 43.6 ± 8.1 years. Over one-third held a bachelor's degree (36.7%), and most were the patients' parents (43.3%). The most frequent duration of patient accompaniment was between 3–7 days (40%). These demographic patterns suggest that most respondents were in early to middle adulthood, a stage often associated with emotional and psychological maturity. Additionally, their relatively high educational attainment may enhance their capacity to process medical information and engage in rational health-related decision-making.

Recent studies support this interpretation, noting that adult family members tend to demonstrate greater emotional stability and can provide effective emotional support, while also serving as communication bridges between patients and healthcare professionals (Zhang & Wu, 2025; Khoshkesht et al., 2021). Higher education levels are further linked to improved health literacy, which in turn fosters more active participation in care decisions and promotes better patient outcomes (Suárez Vázquez et al., 2022). Companions' involvement in information-seeking and advocacy roles has been shown to be critical, especially in high-dependency care units such as ICU and ICCU. Furthermore, educational interventions for companions can enhance their confidence and performance in supporting both emotional and clinical aspects of care (Silva et al., 2021). These findings underscore the significance of considering demographic and educational factors when evaluating the roles of patient families in critical care communication dynamics.

However, despite these theoretically advantageous characteristics, the practical realities reveal a noticeable gap between family members' potential and the actual quality of assertive communication experienced within ICU-ICCU settings. While existing literature emphasizes that educated adult companions are better equipped to engage in shared decision-making and comprehend clinical information, many still report feeling excluded from care discussions or insufficiently informed by healthcare providers. This disconnect suggests that the capacity of family members to actively participate in patient care is not always matched by the staff's ability to

communicate assertively and empathetically. Therefore, the theoretical strengths of the family as informed and emotionally stable partners are not being fully harnessed in practice. This gap reinforces the urgency of improving ICU-ICCU staff's assertive communication skills as a foundational element in delivering family-centered care and achieving service excellence.

2. Assertive Communication Score Distribution and Descriptive Profile

This section presents the descriptive analysis of assertive communication as perceived by the patients' families. The analysis includes the mean and standard deviation of each communication indicator (Table 2), as well as the distribution and overall descriptive statistics of total assertive communication scores (Table 3). These findings provide an overview of both specific communication behaviors and the overall assertiveness level demonstrated by the nursing team.

Table 2. Mean and SD of Assertive Communication Indicators

No	Statement	Mean	Standard Deviation
1	Information about the patient's condition was delivered clearly and politely	3.73	0.53
2	I was given the right to delay or refuse treatment	3.67	0.59
3	I felt confident and unafraid to ask the doctor about the patient's condition	3.80	0.41
4	I was able to communicate with the nurse calmly without being scolded or reprimanded	3.80	0.41
5	I felt brave enough to express differing opinions in nursing team discussions	3.53	0.64
6	The care team listened to family members' complaints with empathy and without interrupting	3.87	0.34
7	I could express criticism or suggestions to the care team constructively	3.07	0.73
8	I felt comfortable asking the healthcare team for help when needed	3.80	0.41
9	Communication was accompanied by appropriate body language (eye contact, tone of voice, posture)	3.67	0.65
10	The care team remained polite yet firm when reminding patients or families about hospital policies	3.73	0.51

Sources: Author, 2025 (edited)

Table 3. Distribution and Descriptive Statistics of Assertive Communication Scores (n=30)

Section	Item	Value
Categorical Distribution	Very Assertive (36–40)	23 (74.2%)
	Assertive (31–35)	6 (19.4%)
	Tends to be Passive/Aggressive (21–30)	2 (6.5%)
	Less Assertive (10–20)	0 (0.0%)
Descriptive Statistics	Mean	36.90
	Standard Deviation	3.69
	Minimum	26.00
	Maximum	40.00
	Median	38.00
	Interquartile Range (Q1–Q3)	35.50 – 39.50

Sources: Author, 2025 (edited)

The descriptive results (Table 2) show that the highest-rated indicator of assertive communication was "The care team listened to family members' complaints with empathy and without interrupting" with a mean score of 3.87 (SD = 0.34), indicating a consistently strong performance in empathetic listening. Meanwhile, the lowest-rated indicator was "I could express criticism or suggestions to the care team constructively", which had a mean score of 3.07 (SD = 0.73), suggesting greater variability and a potential area for improvement in receiving input from patients' families. Overall, the total assertive communication scores (Table 3) ranged from 26 to 40, with a mean of 36.90 (SD = 3.69) and a median of 38.00, indicating generally high perceptions among participants. The interquartile range (Q1–Q3) was 35.50 to 39.50, reflecting that most participants scored within the very assertive category. Categorically, 74.2% of participants rated the team as very assertive, followed by 19.4% as assertive, and 6.5% as tending to be passive or aggressive. Notably, no participants perceived the communication as less assertive. These findings highlight strong communication behaviors among the care team, particularly in empathy and calm interaction, while also identifying areas—such as openness to constructive criticism—for further development.

Recent studies emphasize that assertive communication within healthcare teams plays a vital role in fostering effective relationships among healthcare professionals, patients, and their families, as well as enhancing patient safety and service quality. Effective assertive communication is characterized by the ability to listen empathically without interruption—an aspect reflected in the highest-rated indicator of this study—and has been identified as a key factor in building trust and collaboration in clinical settings (Antić et al., 2024; Krstić & Kekuš, 2023; Gutgeld-Dror et al., 2024). However, an area requiring further development is the team's openness to receiving constructive criticism or suggestions, which is often hindered by organizational hierarchy, cultural norms, and fear of causing disharmony (Gutgeld-Dror et al., 2024; Al-hawaiti et al., 2025). Assertive communication training, particularly those based on simulation and interprofessional education models, has been shown to effectively enhance assertiveness, empathy, and receptivity to feedback, resulting in positive impacts on team behavior and performance (Jitwiriyanont et al., 2025; Eklics et al., 2023; Omura et al., 2017; Al-

hawaiti et al., 2025). Furthermore, research highlights the importance of leadership support, continuous training, and culturally sensitive communication techniques to optimize the implementation of assertive communication practices (Omura et al., 2018; Al-hawaiti et al., 2025; Gutgeld-Dror et al., 2024). Overall, the high perception of assertive communication within the care team indicates that most team members already demonstrate assertive behaviors; however, ongoing efforts are still needed to improve receptiveness to constructive feedback to foster more open and collaborative communication (Gutgeld-Dror et al., 2024; Al-hawaiti et al., 2025; Antić et al., 2024).

The findings of this study reveal that, although the overall perception of assertive communication among the nursing team is notably high, a disparity remains between the dimension of empathy and that of openness to feedback. The high rating on empathic listening suggests that the practice of attentive, non-interruptive communication has become well-established in daily care interactions. However, the low score on the indicator related to expressing criticism or suggestions constructively exposes a persisting gap in enabling truly reciprocal and balanced communication. This discrepancy reflects that while the team has achieved a strong presence of empathy, it is not fully accompanied by a corresponding level of openness to feedback—a fundamental component in assertive communication theory. The fact that openness emerges as a weakness implies the presence of underlying structural or cultural barriers that limit the creation of psychologically safe spaces for families to voice concerns. Thus, despite the classification of assertive communication as “very high,” this does not equate to a fully actualized communication culture. Focused interventions are needed not only to enhance communicative competence but also to reframe team dynamics, leadership engagement, and organizational norms toward greater receptiveness. Without addressing this core limitation, empathic communication may remain unidirectional and fail to truly empower patients' families as active partners in care.

3. Inferential Analysis of Assertive Communication Perception

To deepen the understanding of how patient families perceive assertive communication from ICU–ICCU nurses, several inferential statistical analyses were performed. A one-sample t-test was conducted to determine whether the observed mean score significantly differed from a predefined theoretical value. Additionally, a one-way ANOVA was used to examine differences in assertiveness perception across demographic groups, including gender, education level, relationship to the patient, and duration of accompaniment. Lastly, a Pearson correlation test assessed the relationship between respondents’ age and their perception of assertive communication. The detailed outcomes of these inferential tests are summarized in Table 4.

Table 4. Summary of Inferential Analysis of Assertive Communication Scores

Test	Independent Variable	Statistic (df)	p-value	Interpretation
One-Sample t-test	Compared to theoretical mean (25)	t(29) = 17.80	< 0.001	Significant. Overall score significantly higher than midpoint.
Independent t-test	Gender (Male vs Female)	t(28) = 0.79	0.434	Not significant. No difference in scores based on gender.
One-Way ANOVA	Relationship to Patient	F(3, 26) = 3.40	0.032	Significant. Score differs based on patient-family relationship.
One-Way ANOVA	Education Level (SMA, D3, S1)	F(2, 27) = 0.14	0.870	Not significant. No difference across education levels.
One-Way ANOVA	Duration of Accompaniment	F(2, 27) = 0.92	0.409	Not significant. No difference based on length of stay.
Pearson Correlation	Age	r = 0.08	0.690	Not significant. No correlation with age.
Pearson Correlation	Education Level (ordinal)	r = 0.08	0.664	Not significant. No linear correlation with education level.

Sources: Author, 2025 (edited)

The inferential analysis results, as presented in Table 4, show that the overall assertive communication score was significantly higher than the theoretical midpoint of 25 ($t(29) = 17.80$; $p < 0.001$), indicating generally positive perceptions among respondents toward the nursing team's communication. However, there were no significant differences in assertive communication scores based on gender ($t(28) = 0.79$; $p = 0.434$), education level ($F(2, 27) = 0.14$; $p = 0.870$), or duration of accompaniment ($F(2, 27) = 0.92$; $p = 0.409$). Additionally, Pearson correlation analysis indicated no significant relationship between assertive communication scores and age ($r = 0.08$; $p = 0.690$) or ordinal education level ($r = 0.08$; $p = 0.664$). Notably, a statistically significant difference was observed based on the respondent's relationship to the patient ($F(3, 26) = 3.40$; $p = 0.032$), suggesting that perceptions of assertive communication may vary depending on emotional closeness and family role, such as being a spouse, child, parent, or sibling of the patient.

Recent studies on assertive communication within nursing teams highlight its vital role in enhancing interaction quality, reducing interpersonal tensions, and improving patient care outcomes (Al-hawaiti et al., 2025; Chen et al., 2023). Systematic reviews have confirmed that structured assertive communication training programs can significantly enhance "speaking up" behaviors, particularly in critical situations such as medical errors, while also boosting nurses' confidence in expressing their opinions (Zwilling & Osborne, 2025). Several factors influence assertive communication in clinical settings, including organizational hierarchy, cultural norms, work experience, and interpersonal relationships among healthcare

staff (Al-hawaiti et al., 2025; Mansour et al., 2020; Chen et al., 2023). Studies also reveal no significant differences in assertive communication levels based on gender, education, or age; however, perceptions of assertiveness may vary depending on the emotional closeness and familial role of the patient's relatives (Al-hawaiti et al., 2025; Mansour et al., 2020). Although nursing education across countries emphasizes the importance of assertive communication skills, a gap remains between theoretical knowledge and actual practice, particularly due to structural and cultural barriers (Mansour et al., 2020; Al-hawaiti et al., 2025). Effective training programs should integrate diverse learning approaches and provide sufficient duration to support sustained behavioral change (Chen et al., 2023; Zwilling & Osborne, 2025). Overall, assertive communication has been shown to play a critical role in promoting effective teamwork, strengthening patient advocacy, and fostering a healthier work environment for nurses (Al-hawaiti et al., 2025; Chen et al., 2023; Mansour et al., 2020).

This study revealed that family members perceived ICU-ICCU nurses' assertive communication positively, with total scores significantly exceeding the theoretical midpoint. However, inferential analyses showed that these perceptions were not influenced by demographic variables such as gender, age, education level, or duration of accompaniment. This suggests that assertive communication, in the context of critical care, may not be shaped by individual characteristics. Interestingly, a statistically significant difference was found based on the respondent's relationship to the patient, indicating that emotional proximity and family roles influence how assertiveness is perceived. This finding highlights a critical gap between the theoretical view of assertive communication as a universally applicable skill and the practical realities in emotionally complex care settings. Within the ICU-ICCU environment, where service excellence is a primary goal, these results suggest that technical assertive communication training may be insufficient to meet family expectations. Training programs must incorporate relational sensitivity, cultural responsiveness, and an empathetic understanding of the family's emotional role in the care process. Thus, advancing assertive communication for service excellence requires a holistic approach—not only enhancing nurses' communication skills but also transforming the organizational culture to be more inclusive of family perspectives as integral stakeholders in patient care.

These findings suggest that from the family's perspective, assertive communication—particularly empathetic listening and respectful engagement—serves as a key indicator of service excellence in critical care settings. Families equate timely, clear, and receptive communication with respect, trust, and professional competence. Therefore, gaps in openness to feedback may compromise their overall experience of care quality. By aligning communication practices with family expectations, ICU–ICCU teams not only strengthen interpersonal relationships but also fulfill the core dimensions of service excellence: responsiveness, reliability, empathy, and assurance.

CONCLUSION

This study highlights that from the perspective of patient families, ICU–ICCU nurses generally demonstrate a high level of assertive communication, particularly in aspects of empathy and calm interaction. The consistently strong ratings in empathic listening indicate that many nurses have integrated core components of assertiveness into their daily practice. However, the lower ratings regarding the opportunity for families to provide feedback or constructive criticism reflect a significant gap between empathy and mutual engagement. Although demographic factors such as gender, age, education, or duration of accompaniment did not significantly influence perceptions, the patient–family relationship played a critical role, pointing to the importance of emotional proximity in shaping communication experiences. These findings suggest that assertive communication practices aligned with family expectations directly contribute to perceived service quality—making family perspectives a valuable metric in evaluating and enhancing service excellence in critical care settings. To support service excellence in critical care settings, future interventions must go beyond technical communication training and embrace a relational and culturally sensitive approach. Assertive communication development should be embedded within organizational policies and team cultures that prioritize psychological safety, openness, and family inclusion. It is recommended that healthcare institutions design tailored training programs that integrate interprofessional simulations, emphasize receptivity to feedback, and empower nurses to collaborate meaningfully with families. These efforts are essential to fully actualize the role of families as informed partners in care and to elevate the standard of communication toward a more inclusive and responsive critical care environment.

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CONSENT FOR PUBLICATION

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