CRISIS AND NURSING INTERVENTION

CHAPTER - 9

DEFINITIONS

Crisis is an acute time limited phenomenon experienced as an over whelming emotional reaction to a stressful event or the perception of that event. It is the struggle for equilibrium and adjustment when problems are perceived as insolvable.

Crisis intervention is a short term focuses on the solving of the immediate problem, aims to establish the former coping pattern and problem solving ability. It is usually limited to 4 – 6 week period after which resolution will be attained.

TYPES OF CRISIS

1

Maturational
-each development stage can be referred to as the same.

2

Situational
-arises from an external rather than an internal source.

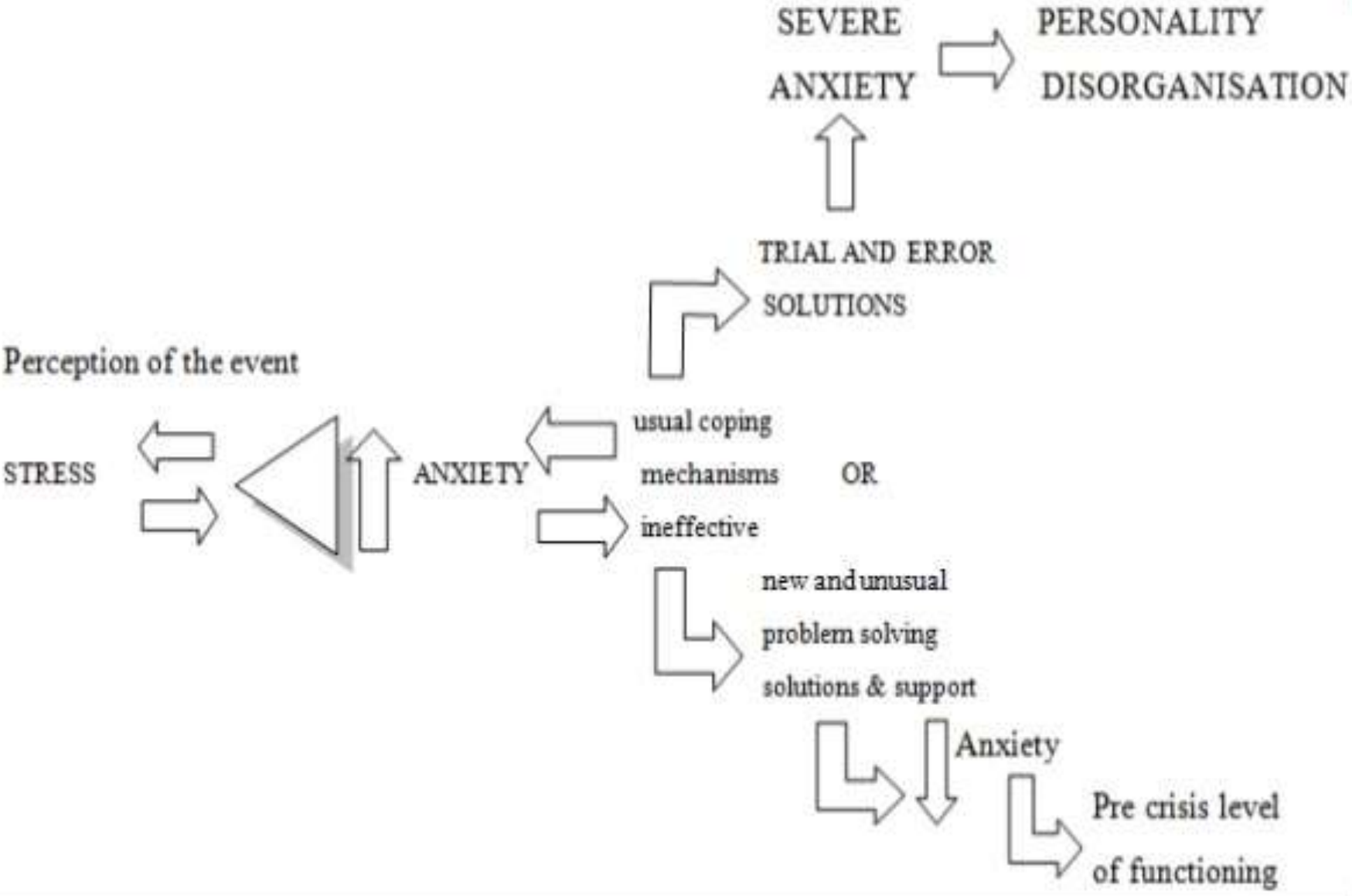
3

Adventitious
–it is not a part of every day life, is accidental and unplanned

CRISIS THEORY

- Erich Lindermann - 1940s conducted study of the grief reactions of close relatives of victims in a club fire. This study formed the foundation of crisis theory and clinical intervention. She showed that preventive intervention in crisis situations could eliminate or decrease serious personality disorganisation and other psychological consequences from the sustained effects of severe anxiety.
- Gerald Caplan -1960s defined crisis theory and outlined crisis intervention. Caplan identified four distinct phases of crisis.

PHASES OF CRISIS



FOUR PHASES OF CRISIS PROCESS

1st phase - A person confronted by a conflict or problem that threatens the self concept responds with increased feelings of anxiety. The increase in anxiety stimulates the use of problem solving techniques in an effort to solve the problem and lower anxiety.

2nd phase - If the usual defence response fails, and if the threat persists, anxiety continues to rise and produce feelings of extreme discomfort. Individual functioning becomes disorganised.

FOUR PHASES OF CRISIS PROCESS

- **3rd phase-** If the recovering attempts fail, anxiety can escalate to severe and panic levels, and the person mobilizes automatic relief behaviour, such as withdrawal and flight (compromising needs or solutions should be made).
- **4th phase-** if the problem is not solved, anxiety can over whelm the person and leads to serious personality disorganizations. This maladaptive response can take the form of confusion, suicidal behaviour, yelling and running aimlessly.

Appraising Crisis Systematically:

- Systematic process deals with recurrent actual or potential crisises and the impact of these events.
- The nurse establishes goals in collaboration with the child,family and the interdisciplinary team members.
- The plans to care are then implemented through direct intervention.
- Systemic evaluation facilitates the child's progress towards his or her maximal level of function, especially as it changes during the various stages of development.

TERMINAL ILLNESS AND DEATH DURING CHILDHOOD

Introduction

- Developmental psychologists and thanatologists have suggested that death education be part of everyone's schooling since all are affected.
- Death education includes programs that teach about death, dying and grief, and are designed to help all people successfully deal with death and dying. Crisis intervention education is one type of death education program.

CONCEPTS OF ILLNESS

Meaning of terminally illness ill child

- A disease that cannot be cured and that is reasonably expected to result in the death of the child within a short period of time is termed as **Terminal Illness.**
- This term is more commonly used for progressive diseases such as Cancer or advanced heart disease than for trauma. It indicates a disease which will eventually end the life of the sufferer.

Terminal illness

- Disease that cannot be cured that will result in death

DECISION MAKING

- <u>Physician – health care team</u>
- progression of disease
- the availability of treatment options
- the impact of treatment
- child's overall prognosis
- child's age

- premorbid cognitive condition
- functional status
- pain or discomfort
- probability of survival
- quality of life
- E.g. DNR

PARENTAL DECISION MAKING

- When the death is unexpected, the confusion of emergency services and possibly an intensive care setting presents challenges to the parents as they are asked to make difficult choices.
- If the child has experienced a life threatening illness that has now reached its terminal phase, parents are often unprepared for the reality of their child's impending death.

Nurses should ensure the families that there are options. The nurse's first responsibility is to explore the family's wishes.

THE DYING CHILD

- Honest information about their illness, treatment and prognosis.
- An open conversation early in the course of illness
- Providing appropriate literature
- Decisions regarding involving child in care during their dying process and death, is an individual matter.
- The child's age or developmental stage is considered.
- A shared decision making is important to the child's and family's emotional health.
- Parents require professional support and guidance in this.
- Adolescents have autonomy in decision making with regard to care and treatment.

Treatment options

HOSPITAL CARE

HOME CARE

HOSPICE CARE

HOSPITAL

- Family may choose to remain in the hospital to receive care if the child's illness or condition is unstable and homecare is not an option or the family is uncomfortable with providing care at home.
- The setting should be made as homelike as possible.
- Families should be encouraged to bring familiar items from the home.
- There should be a consistent, coordinated care plan

for the family's comfort.

HOME CARE

- Some families prefer to take child home and receive service from home care agency.

  -Periodic visits of nurses to administer medication, equipment or supplies are provided.

  -The health care team promote this in the belief of providing hospice care to the child.

HOSPICE CARE

- Hospice is a community health care organisation that specializes in the care of dying patients by combining the hospice philosophy with principles of palliative care.
- Management of physical, psychological, social and spiritual needs of child and family.
- Care is provided by a multidisciplinary group of professionals in the patient's home. It is based on certain concepts.

Concepts of hospice care

1. Family members are the principle care givers and are supported by team of professional and volunteer staff.
2. The priority of care is comfort. The child's needs are considered. Pain and symptom control are primary concerns and no extra ordinary efforts are taken to prolong life.
3. Family's needs are considered to be as important as child's needs.
4. It is considered with the family's post death adjustment and care may continue for one year or more.

PERCEPTIONS OF DEATH

(according to developmental stage of child)

CHILD'S CONCEPT OF DEATH

INFANTS AND TODDLERS

- Infants and toddlers view death in relation to the loss of a caretaker and the subsequent emptiness in their lives.
- Children of this age react to the dying process based upon the sadness, anger and anxiety conveyed by their parents.
- Reactions will be expressed through crying, attachment to primary caregiver, and separation anxiety.

PRESCHOOLERS-

- Preschoolers view death as a separation or departure and believe it to be only temporary.
- Death is also seen as reversible.
- Magical thinking and egocentricity at this age often leads to guilt and shame because children may believe that their thoughts or actions caused the death.
- Preschooler facing an impending death frequently views their condition as punishment for behaviours or thoughts.

- SCHOOLER

-They associate misdeeds or bad thoughts with causing death and feel intense guilt and responsibility for the event.

-They respond well to the logical explanations about death.

-They have a deeper understanding about death.

-They personify death as devil, monster etc.

-By age of 9 – 10 they have an adult concept of death, realising it is inevitable, universal and irreversible.

ADOLESCENTS

- They have a mature understanding of death.
- They are still influenced by the remnants of magical thinking and are subject to guilt and shame.
- They are likely to see deviations from accepted behavior as reasons for their illne

Children's Understanding of Death

- ***Ages 0-2:*** NO concept of what death is
- ***Ages 3-5:*** Death perceived as sleeping
- ***Ages 6-9:*** Death is a personification of what the media portrays; TV, Movies, Computer Games, often create false imagery of what death really is
  - Most people start to understand the finality of death around the age of 10, but misinformation often causes confusion for some people well into their teens
- ***Ages 10-12:*** Death can be misunderstood, and often viewed as being immortal
- ***Teens & Up:*** Death is usually recognized as being final and an inevitable part of life

Perceptions of Death

- 1-3 years: "Mommy, after I die, how long will it be until I'm alive again?"
- 3-5 years: "I have been a bad boy, so I have to die."
- 5-10 years: "How will I die? Will it hurt? Is dying scary?"
- 10-13 years: "I'm afraid if I die my mom will just break down."
- 14-18 years: "This is so unfair! I just need to be alone."

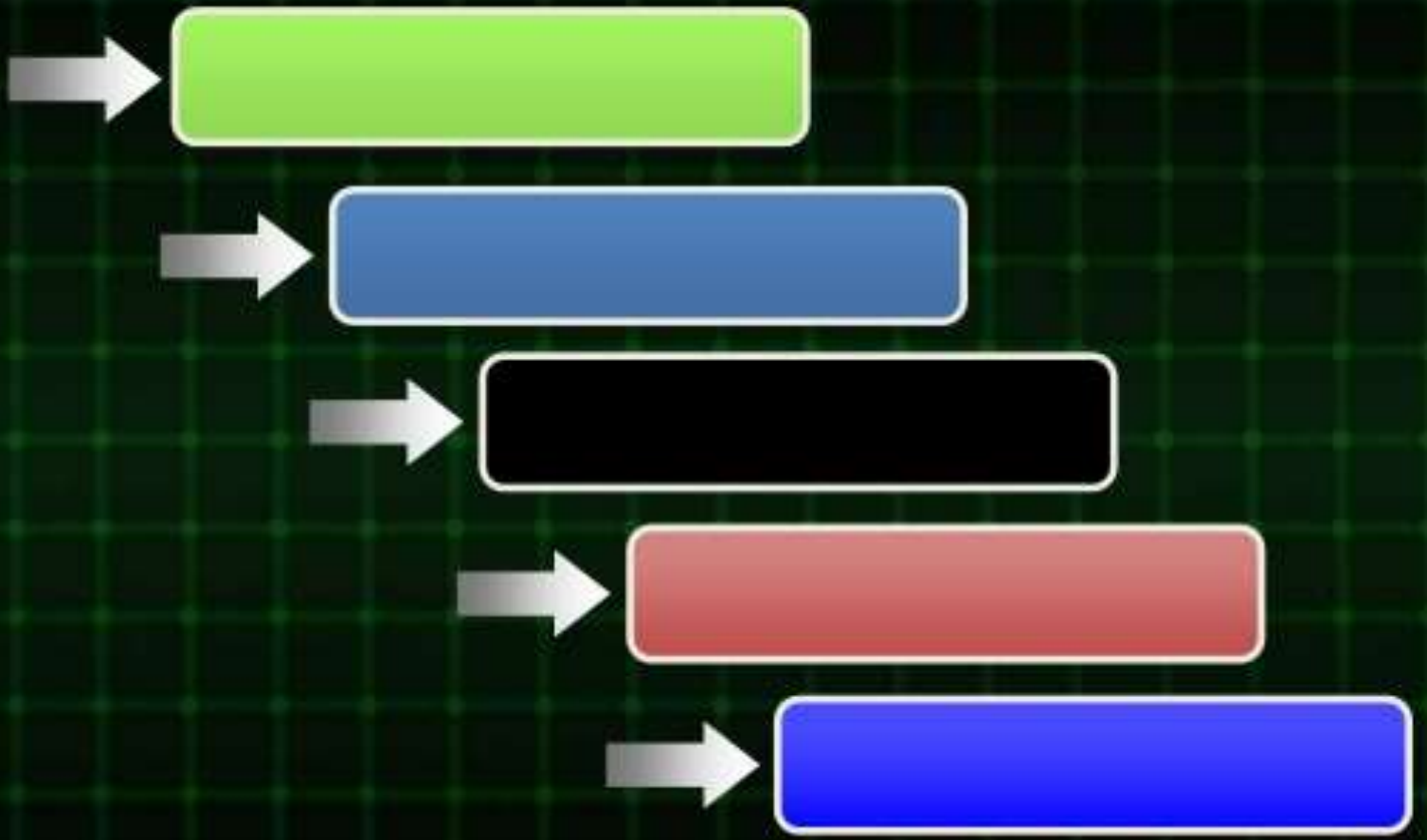
TYPICAL QUESTIONS AND STATEMENTS ABOUT DYING	THOUGHTS THAT GUIDE BEHAVIOR	DEVELOPMENTAL UNDERSTANDING OF DEATH	STRATEGIES AND RESPONSES
MOs-3 YR			
"Mommy, don't cry" *"Daddy, will you still tickle me when I'm dead?"*	Limited understanding of events, future and past, and of the difference between living and nonliving.	May have "sense" that something is wrong. Death is often viewed as continuous with life. Like being awake and being asleep.	Optimize comfort, and consistency; familiar persons, objects, routines. Use soothing songs, words, and touch. *"I will always love you."* *"I will always take care of you."* *"I will tickle you forever."*

3-5 YR			
"I did something bad and so I will die." *"Can I eat anything I want in heaven?"*	Concepts are simple and reversible. Variations between reality and fantasy.	The child may see death as temporary and reversible, and not universal. May feel responsible for illness. Death may be perceived as an external force that can get you.	Assure child that illness not his/her fault. Provide consistent caregivers. Promote honest simple language. Use books to explain the life cycle and promote questions and answers. *"You did not do anything to cause this."* *"You are so special to us and we will always love you."* *"We know (God, Jesus, Grandma, Grandpa) are waiting to see you."*

5-10 YR			
"How will I die?" *"Will it hurt?"* *"Is dying scary?"*	The child begins to demonstrate organized, logical thought. Thinking becomes less esoteric. The child begins to problem solve concretely, reason logically, and organize thoughts coherently. However, he or she has limited abstract reasoning.	The child begins to understand death as real and permanent. It means that heart stops, blood does not circulate, and you do not breathe. It may be viewed as a violent event. The child may not accept death could happen to himself or herself or anyone he or she knows but starts to realize that people he or she knows will die.	Be honest and provide specific details if they are requested. Help and support the child's need for control. Permit and encourage the child's participation in decision making. *"We will work together to help you feel comfortable. It is very important that you let us know how you are feeling and what you need. We will always be with you so that you do not need to be afraid."*

10-18 YR			
"I'm afraid if I die my mom will just break down." *"I'm too young to die. I want to get married and have children."* *"Why is God letting this happen?"*	Abstract thoughts and logic possible. Body image is important. Need peer relationships for support and for validation. Altruistic values — staying alive for family — parents, siblings — donating organs/tissue Disbelief that he/she is dying.	Understand death as irreversible, inevitable and universal. Needs reassurance of continued care and love. Search for meaning and purpose of life.	Reinforce child/adolescent's self-esteem, sense of worth, and self-respect. Allow need for privacy, independence, access to friends and peers. Tolerate expression of strong emotions and permit participation in decision-making. *"I can't imagine how you must be feeling. Despite it all, you are doing an incredible job. I wonder how I can help?"* *"What's most important to you now?"* *"You have taught me so much, I will always remember you."*

KUBLER ROSS - REACTION TO TERMINAL ILLNESS



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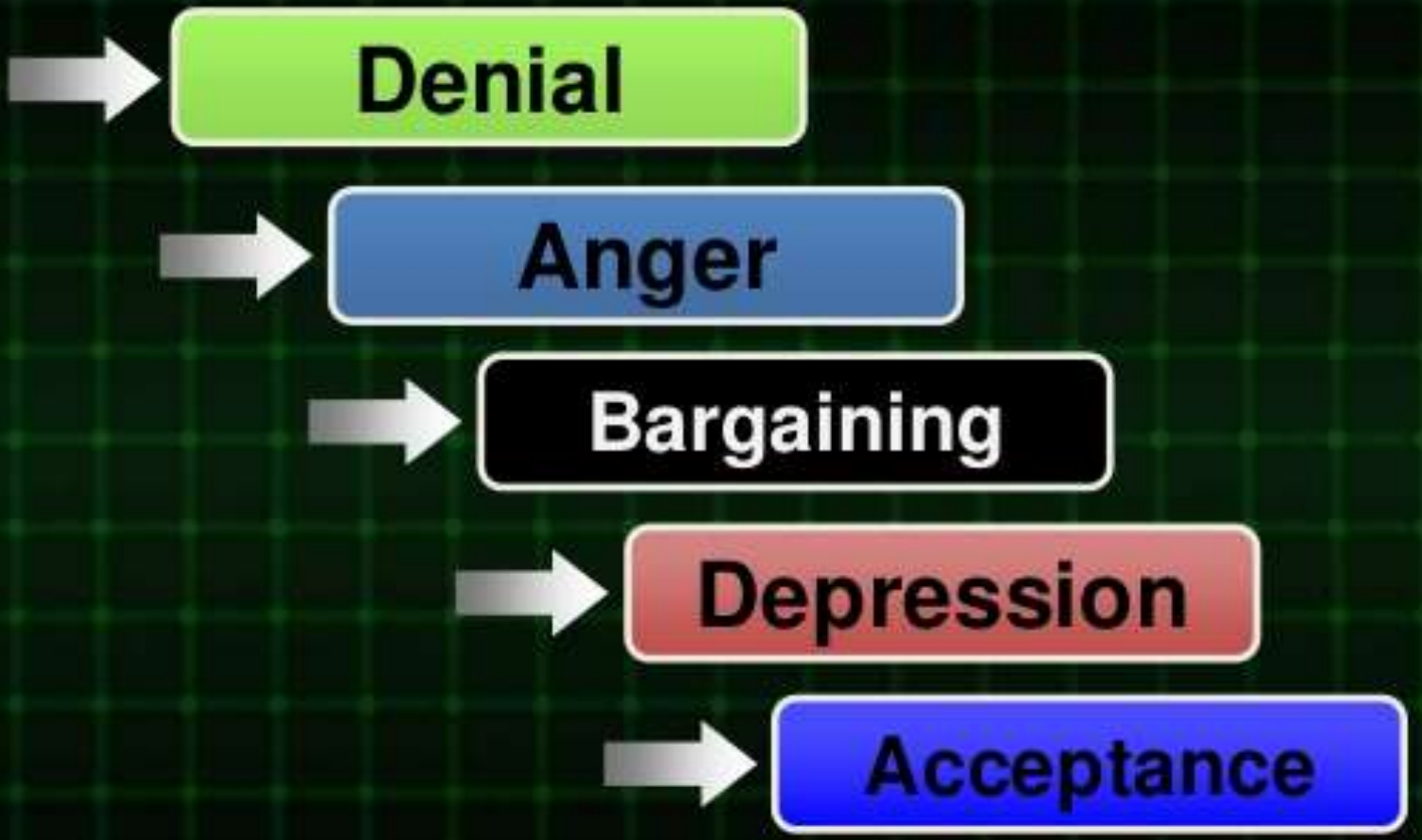


A. Kübler-Ross's Stages of Dying

- **Denial**: Many people confronted with a terminal diagnosis react with some form of denial, a psychological defence that may be useful in the early hours and days after such a diagnosis
- **Anger**: Anger often expresses itself in thoughts that life is not fair, but may also be expressed toward God, or toward doctors, nurses, or family members
- **Bargaining**: The patient in stage 3 tries to make "deals" with doctors, nurses, family, or God
- **Depression**: When bargaining fails as a result of declining physical status, the patient sinks into depression
- **Acceptance**: Kübler-Ross views this depression as a necessary preparation for the final step of acceptance since a person must grieve for all that will be lost with death. When such grieving is finally done, the individual is ready to die

Palliative Care: *Definition*

"The active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems, is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with anti-cancer treatment."

World Health Organization, 1990

PALLIATIVE CARE

- Focus on quality of life
- There can be joy and hope amidst the sadness and grief
- Good symptom control
- Whole-person approach: consider the dying person's life experience and current situation
- Consider also the other people who matter to that person
- Support autonomy and choice
- Emphasize open and sensitive communication with patients, family, colleagues
- Managing pain: the WHO analgesic ladder for pain relief

NURSING MANAGEMENT

1. Fear of pain and suffering
2. Pain and symptom management
3. Fear of dying alone
4. Fear of actual death

Home

NURSING CARE OF THE CHILD AND FAMILY AT THE END OF LIFE

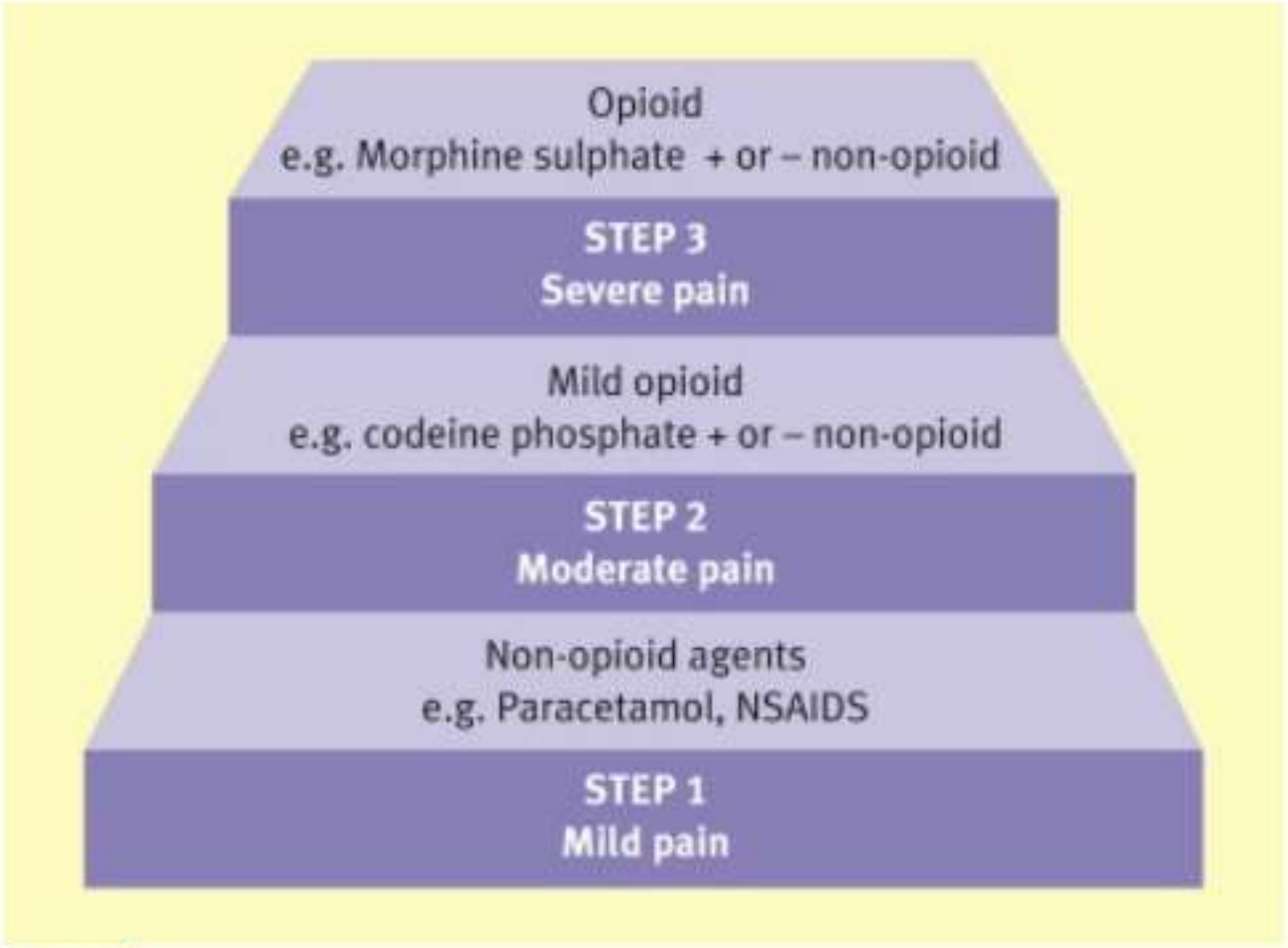
FEAR OF PAIN AND SUFFERING

- The presence of unrelieved pain in a terminally ill child can have very detrimental effects on the quality of life experienced by the child and family
- Nurses can alleviate the fear of pain and suffering by providing interventions aimed at treating the pain and symptoms associated with the terminal process in children.

PAIN/SYMPTOM MANAGEMENT

- The current standard of treating pain management in children's pain is according to the WHO's analgesic stepladder
- This approach promotes tailoring the pain interventions to the child's level of reported pain.
- Children's pain should be assessed frequently, and medications adjusted as necessary.

WHO Analgesic Ladder



FEAR OF DYING ALONE

- When a child is being cared for at home, the burden of care experienced by parents and family members can be great.
- When a child is dying in the hospital, parents should be given full access to the child at all times.
- Nurses should advocate for parent's presence in intensive care and emergency departments and attend to the parent's need for food , drinks, comfortable chairs, blankets and pillows.

FEAR OF ACTUAL DEATH

Home death

- The child has slowly become less alert in the days before the actual death.
- The nurses can assist the family by providing them with information about what changes will occur as the child progresses through the dying process.
- Nursing visits often become more frequent and longer in duration to provide the family with additional support as the death nears.

Hospital deaths:

- There is an increased presence of nurses and health team to provide comfort.
- A child in ICU often requires active withdrawal of life supporting intervention such as bypass machine or ventilator. But this situation raises ethical issues.
- After death, parents should be allowed to remain with body or rock the body if they wish.
- A sibling needs preparation for post death services. They should be permitted to stay as long as they wish and also give private time to say good bye.
- Parents should prepare the sibling.

NURSING CARE

- Answering the question
- Helping the parents
- Helping the dying child

ORGAN DONATION

- Benefit another human being
- irreversible cessation of neurologic function of the brain
- discuss the topic with family
- Healthy child who dies unexpectedly, children with cancer, chronic disease etc should be considered for organ donation

FEW NURSING INTERVENTIONS

Pain –

- limit unnecessary painful procedures
- sedation and giving pre-emptive analgesia prior to a procedure (e.g., including sucrose for procedures in neonates)
- Address coincident depression, anxiety, sense of fear or lack of control.
- Consider guided imagery, relaxation, hypnosis, art/pet/play therapy, acupuncture/acupressure, biofeedback, massage, heat/cold, yoga, transcutaneous electric nerve stimulation,

Dyspnoea or air hunger-

- Suction secretions if present
- positioning, comfortable loose clothing, fan to provide cool, blowing air.
- Limit volume of IV fluids, consider diuretics if fluid overload/ pulmonary oedema present.
- Behavioural strategies including breathing exercises, guided imagery, relaxation, music

Nausea/vomiting –

- Consider dietary modifications (bland, soft, adjust timing/ volume of foods or
- feeds) Aromatherapy: peppermint, lavender; acupuncture/
- Constipation - Increase fibres in diet, encourage fluids

Oral lesions/dysphagia –

- Oral hygiene and appropriate liquid, solid and oral medication formulation
- (texture, taste, fluidity). Treat infections, complications (mucositis, pharyngitis, dental abscess, esophagitis).Orophayngeal motility study and speech (feeding team) consultation

Anorexia–

- Manage treatable lesions causing oral pain, dysphagia, and anorexia.
- Support caloric intake during phase of illness when anorexia is reversible.
- Acknowledge that anorexia is intrinsic to the dying process and may not be reversible. Prevent/treat coexisting constipation

RESPONSE TO DEATH AND DYING

CHILD'S RESPONSE-

- A child who is dying wants to feel safe and does not want to be alone or in pain.
- The frequently traumatising experiences of a chronic condition and its treatment tend to make children more mature and wise beyond their years.
- Children with a terminal illness see treatment as worse than death.
- Children may speak of seeing or even interacting with angels or the higher being recognized by their specific faith.

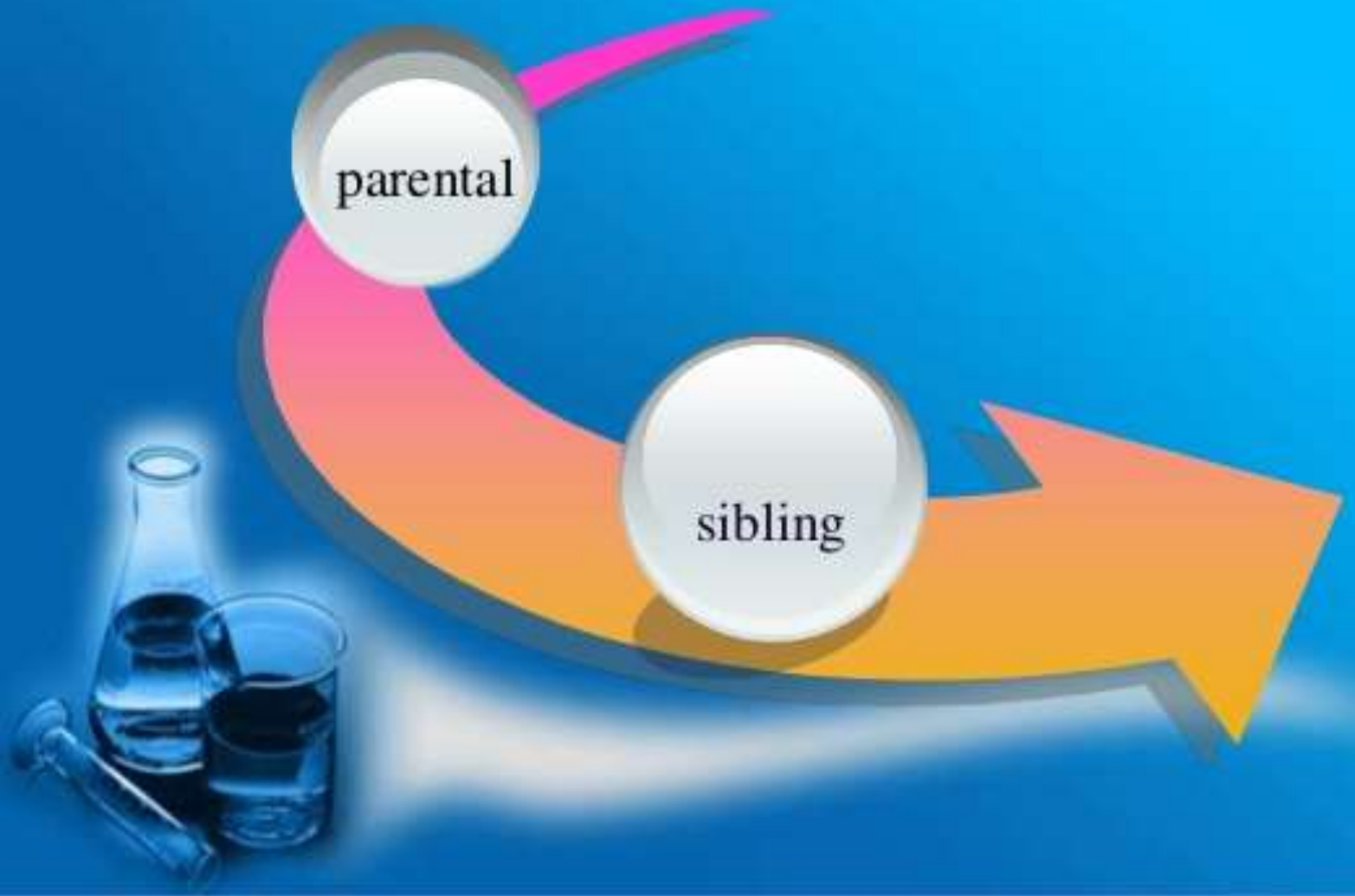
SIBLING'S RESPONSE

- Siblings may experience emotions same as those experienced by their parents.
- In relation to their level of cognition and development, they may not be as equipped to understand, cope, and work their way through the grieving process as smoothly and successfully.
- Unresolved grief may contribute to many problems in adult life.
- They often need assistance to complete the process.

GRIEF AND BEREAVEMENT

- *Grief* is the emotional response to that loss.
- *Bereavement* is the acknowledgment of the objective fact that one has experienced a death.

GRIEF



STAGES OF BEREAVEMENT

Ways to mourn and express the loss

- Accepting the loss
- Experiencing pain that comes with grief
- Trying to adjust without that person
- Finding new place to put emotional energy

Death and Bereavement

Counseling strategies

- Listen carefully and respond clearly
- Allow children to express their grief
- Help with understanding – talk about a plant or animal dying
- Work with family's clergy
- Always a question on whether they should attend the funeral – depends but probably
- Work to reduce stress
- Beware of possible regression
- Watch for triggers of grief


Thank you