Crisis Intervention for Nurses

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Cancer diagnoses and treatments can be crisis-causing events that overwhelm the usual coping abilities of patients and their families. Oncology nurses constantly are observing and attending to patients’ diverse needs, ranging from biomedical to emotional, social, and psychological. Nurses have the chance to be first responders in times of patient crises, as they are in the position to recognize the crisis, respond effectively, and transform the crisis into a pivotal learning experience. This article discusses a way to think about patient and family crises that empowers nurses to respond in a manner appropriate to the cultural context and respectful of the individual space of the patient.

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Patients in crisis provide nurses with an opportunity to help people in a way that few others can. In this article, the term crisis is used in a manner inspired by Parad and Caplan (1960) and later simplified by Gilliland and James (2013) in their Crisis Intervention Strategies textbooks. Crisis is not a situation itself but the perception and response of an individual who is facing a threatening situation and realizes that his or her usual coping strategies are not going to resolve the issue to an acceptable degree, therefore causing a precipitous rise in tension. More simply, crisis is characterized by an individual not seeing a way to effectively solve a problem that affects him or her directly or even indirectly. Oncology nurses regularly see how the diagnosis of cancer and aspects of cancer treatment are crisis-causing situations, ones that can overwhelm the usual coping abilities of an individual or family. Stressors include the initial diagnosis, delayed diagnosis, fear of recurrence, physical changes because of treatment, an awareness of death, changes in life priorities, and chemotherapy (Rawl et al., 2002). Patients experience altered moods related to pain, symptoms of their disease, problems with caregivers, and loss of function and mobility. As a result of these stressors, the patient may experience helplessness or an inability to function appropriately.

How crisis experiences are manifested vary vastly, and a patient’s own culture can account for some of this variation. Everyone grows up with exposure to one or more cultures that teach them how to respond to crisis and grief. How that cultural lesson is appropriated varies from person to person, but some ground is shared with those exposed to the same cultural lessons. Although the author cannot provide a panacea to all crisis situations for all cultural contexts, the aim of this article is to suggest some tips for improving nurses’ responses to cultural variations in crisis experiences.

Parad and Caplan (1960) had complementary insight when working with patients and families who had suffered through the Cocoanut Grove fire of 1942. The fire took the lives of almost 500 people who were in the overpacked Cocoanut Grove nightclub, injured many more, and left hundreds of friends, families, and entire communities in grief from the loss of some of their most vibrant citizens (Boston Fire Historical Society, n.d.). Caplan took part in the care of many surviving friends and families of the victims and had an insight that the author of the current article did not in her treatment of patients with cancer—once patients recognize that their coping mechanisms cannot handle the situation at hand, they tend to become susceptible to input that they otherwise would have (and perhaps previously had) resisted (Parad & Caplan, 1960). That input could be helpful or harmful, but those in crisis are going to be more open to it. Nurses can be the first to step in, providing beneficial input to patients if they train to recognize crisis and take it upon themselves to be first responders.

Using Aguiler’s (1998) paradigm as a guide, nursing professionals can provide helpful input when patients not only need it most but also will accept it most. Aguiler’s model is based on the idea that a lack of equilibrium among three balancing factors of event perception, situational supports, and coping mechanisms precipitates and perpetuates crisis situations.

Event Perception

Perception of events is how an individual rates his or her situation in terms of being problematic and solvable. For example, if a patient develops cancer-related symptoms but determines that nothing can be done when faced with these symptoms, he or she may deem the situation unsolvable and be unlikely to engage in potentially life-saving or life-improving actions in a timely manner. If that same patient is faced with too many treatment options to sort through, he or she may believe that the problem is solvable.
but feel unable to distinguish the best solutions from among all of the potential responses. Cultural context may affect crisis experiences greatly. Perceptions of severity and potential for action can be closely tied to cultural understandings of what constitutes a health threat, what responses are acceptable, and how one can choose from among potential responses. For example, is an individual expected to defer to his or her family’s decision regarding treatment options? Are some options considered taboo?

Situational Supports

Situational supports are resources that help a person deal with the issues at hand; foremost among these supports are personal and professional relationships. Friends, family, coworkers, and a supportive healthcare team can contribute to simplifying or complicating problems faced after a cancer diagnosis and throughout stages of treatment. By offering emotional reinforcement and practical assistance, individuals gain situational supports that may include insurance, sick leave, and access to health or childcare services. Personal and professional relationships also may place additional burden on patients who seek to reduce the impact of their conditions on their family and social network. How an individual perceives his or her role in these networks is cultural. Do not assume that involved social networks are wholly beneficial, taxing, or consistent in their impact through the entire progression of a patient’s disease. Rather, remember to be sensitive to the potential for these supports to affect patients and to be open to understanding the particular roles they play in patients’ experiences.

Coping Mechanisms

Coping mechanisms are behaviors aimed at reducing stress. Coping mechanisms vary considerably, and each person generally has a range of techniques, conscious or unconscious, that vary in their effectiveness and directness when dealing with a situation. The specific response selected likely will be the one that the person has been able to use successfully in the past. Inappropriate defense mechanisms such as denial, repression, regression, and projection, triggered perhaps by the uniqueness or severity of a particular problem, may distort perceptions of reality and interfere with normal coping mechanisms. Keep an eye out for indications that patients are using inappropriate defense mechanisms, but also realize that the manifestation of such use can vary considerably across individuals and cultures. For example, the author has found that silence and apparent avoidance have different meanings in the face of poor prognoses among patients with strong roots in Korean and Japanese cultures than similar responses among patients from Western cultures. An older female patient who abided by traditional Korean values was in the author’s care for several days, during which time her husband of 40 years was constantly with her, silent and stoic. One day, outside her room, he spoke about her condition and began to sob. His love and concern for her were intense, but it was important for him to provide her strength through his stoicism in the hospital room. Actions previously interpreted as coldness or denial were his culturally inspired methods of helping his beloved wife cope. Aguilera (1998) described how balancing factors can be adjusted with the help of nurses.

The ultimate goal is to achieve the balance that obviates crisis (i.e., to return individuals to their precrisis state of functioning). Once a nurse recognizes a crisis state, she or he can initiate crisis intervention.

Discussion

Treatment is provided by a therapist, should be immediate, and is time limited, generally lasting one to six sessions. Variations in crisis experience and expression founded on cultural differences do not mean that nurses unfamiliar with those cultural variations can or should do nothing to intervene. Cultural and individual boundaries of acceptability are not static but fluid and generally pragmatic. The Korean couple mentioned earlier were open to therapy and opening up to one another to process their feelings together. They were able to negotiate among competing desires and expectations to find a set of communication and coping strategies that worked for them. Although nurses need to be sensitive to cultural variations as well as individual ones, and to respect that many approaches to difficult and crisis situations are equally valid, they should not place patients and their cultures into boxes and assume that what seems appropriate to them is predetermined and unchanged. People in crisis adjust, and with sensitivity and understanding, nurses can help them do so in healthy ways.

Oncology nurses frequently recognize basic identifiable patterns that are adaptive or maladaptive after specific types of events (Jacobson, Strickler, & Morley, 1968). In working with patients with cancer, Fawzy et al. (1993) found three general coping methods among those patients: an attempt to change some aspect of the disease by active means (e.g., exercise, meditation, frequent consultations with healthcare providers), an attempt to find a positive aspect to having the illness, and avoidance through hiding feelings or simply refusing to think about the illness. Oncology nurses have seen these and possibly other categories of coping methods in their routine interactions with patients. Schoultze, Lohnberg, Tallman, and Altmairer (2011) found that avoidance coping styles prior to treatment increased interference from common cancer symptoms six months after hematopoietic stem cell transplantation. Patients employing those maladaptive coping mechanisms had increased interference from skin (e.g., rash), eye (e.g., gritty feeling), mouth (e.g., sores), and gastrointestinal symptoms. More avoidant coping also predicted higher rates of interference from cognitive symptoms such as fear, worry, and difficulty maintaining a train of thought. In short, maladaptive coping mechanisms do not just appear problematic but also are associated with poorer outcomes. Although the association cannot prove causation alone, these results certainly are consistent with the theory that coping strategies affect outcomes.

Other studies have not only supported the concept of causation but also the idea that nurses can play a central role in helping patients use adaptive coping mechanisms. Fawzy (1995) found that intervention by nursing staff could improve coping and decrease distress among patients newly diagnosed with cancer. The nurses provided
education regarding health, coping skills, and stress-management techniques that were associated with significant decreases in fatigue, anxiety, and confusion, and decreased use of ineffective coping strategies. Rawl et al. (2002) demonstrated a positive impact early in cancer therapy when information about symptom management, emotional distress, and community resources were provided as a means to direct coping toward problem solving rather than emotional reactivity.

Implications for Nursing Practice

Thanks to the insights of Parad and Caplan (1960) regarding the vulnerability of patients in crisis to input, Aguilera’s (1998) model can be put to use by staff nurses tending daily to patients whose crisis statuses change with new developments, new insights, and increasingly stressed resources. As crisis sets in and patients become more open to outside influences as they seek something to grasp onto after having lost the certainty of their old coping mechanisms, remember to recognize how pivotal this time is and take action. Many nurses are used to patients ignoring their well-intentioned suggestions and even their firm directives. At some point, the nurses stop repeating themselves (their own coping mechanism to deal with one of the job’s frustrations). Knowing that patients who once ignored or scorned advice actually will take it to heart when in crisis, nurses can be more attentive to the balance of patient perceptions, resources, and coping mechanisms as indicators of actual or impending crisis. Nurses can be the first to step in and offer appropriate suggestions or care options and even take a few pointers from Aguilera (1998) in assessing the crisis and intervening as first responders.

Conclusions

Doing all of this in culturally appropriate ways remains a barrier to many nurses, but they can increase the likelihood that they will be aware of signals and be able to respond to the needs of patients with different cultural backgrounds. First of all, nurses can take advantage of the cultural variations among fellow staff members and engage in formal and informal exchanges that mutually build on one another’s strengths of understanding. A formal option may be to hold regular seminars hosted by individual units or divisions that invite nurses, doctors, and other healthcare practitioners working in the hospital to share their experiences and cultural understandings. Nurses also can open themselves up to patients and let them express what cannot be perceived through the lens of the nurses’ own experiences, even when a cultural gap stands between them. The author hopes nurses walk away from this article with a sense of optimism regarding their potential for recognizing crisis and how to turn moments of crisis into opportunities for growth among patients. Nurses can be the first to recognize crisis, the first to respond to it, and the most trusted sources of help and advice for patients.

References


