Available online at www.scientiaresearchlibrary.com

Scientia Research Library

ISSN 2348-0416
USA CODEN: JASRHB

Journal of Applied Science And Research, 2018, 6 (4):21-27

(*http://www.scientiaresearchlibrary.com/arhcive.php*)

Crisis Intervention with children

VasanthaSingarayan, M.Sc. (N)

ABSTRACT

Crisis, as it applies within an educational venue, refers to an unanticipated event that actually or potentially disrupts or undermines the normal functioning of a significant segment of the school community, this article gives insights in to the causes, reactions, and role of the nurse during crisis events in the community as well as in the hospital.

INTRODUCTION

A crisis event can happen at anytime. Crises such as a schoolyard shooting, student suicide or death of a teacher, can emotionally debilitate teachers and classmates. If a family or friend has been seriously injured or killed or if a child's, school or home has been damaged or a change in the environment has occurred, there is a greater chance that the child will experience difficulties coping. Whatever the circumstance, the emotional effects on children can be tremendous. These external factors have a direct effect on the child's mental and emotional feelings. This could result in the need for crisis management and intervention.

A crisis occurs when a person is confronted with a critical incident or stressful event that is perceived as overwhelming despite the use of traditional problem-solving and coping strategies.

Disasters in a child's life can be varied. What may seem devastating to one child may be an ordinary event in the life of another. How we react to those situations may serve to help a child cope with a potential life threatening, injury-producing incident.

MATERIAL AND METHODS

Definition

Events that cause severe emotional and social distress may occur at any time and without warning. Such occurrences have been variously called traumatic incidents, critical incidents, crises, disasters and emergencies.

Goal of crisis intervention

Goals of crisis intervention are to provide counselling, screening, and referrals to any individuals potentially affected by a traumatic event. Rather than assume that individuals in need seek services independently, crisis intervention appropriately takes services to victims. For children exposed to traumatic events, schools are ideal loci for intervention, especially when collaborative relationships are forged with community-based resources.

When can a crisis event can happen?

Societal risk conditions

- Availability of, and easy access to , lethal methods for suicide;
- Irresponsible (factual) reporting and (fictional) representation of suicidal behaviour in the mass media;
- Socio-demographic change, including marital breakdown/divorce, later marriage;
- Adverse labour market conditions, including insecurity of employment;
- Adverse economic conditions, including level of unemployment and business confidence.
- Social attitudes to suicidal behaviour.

Psychosocial environment

- Impoverished social capital (low level of social cohesion, social integration and trust in the community) ;
- High level of social exclusion (eg neighbourhood poverty/deprivation) ;
- Impaired community capacities, resources and resilience.

Individual risk factors

- Inadequate social support (low levels of practical, emotional, financial and other forms of assistance from family, friends and neighbours) ;
- Socio-demographic characteristics (eg age (young-mid aged adult), gender (male), marital status (non-married), (lower) socio-economic status and (certain types of) occupation);
- Serious mental illness;
- Substance misuse;
- Previous deliberate self-harm;
- Recent discharge from psychiatric hospital, in particular following detention under mental health legislation;
- Experience of abuse (sexual and physical);
- Low educational qualifications, poor life skills and interpersonal skills;
- Life crises, especially interpersonal loss.

Critical incidents that may precipitate a Crisis

Development (i.e, life-transition events); Birth of child, graduation from college, midlife career change, retirement

Existential (i.e., inner conflicts and anxieties related to purpose, responsibility, independent, freedom, or commitment)

Realization that one will never make a significant impact on one's profession, remorse that one has never married or had children, despair that one's life has been meaningless.

Environmental (i.e., a newly diagnosed medical condition or an exacerbation of a current medical problem).

Multiple sclerosis, human immunodeficiency virus infection, infertility, myocardial infarction, cancer, medical problems that result in partial or total disability.

Psychiatric (i.e., actual syndromes and those that affect coping).

Depression or suicidal thoughts, events precipitating acute or post-traumatic stress disorder.

Situational (i.e., uncommon, situation-specific events); loss of job, motor-vehicle collision, divorce, rape.

Characteristics of Crisis

- Raphael (1986, p 6) has identified the following characteristics of 'crisis' :
- Rapid time sequences
- An overwhelming of the usual coping responses of individuals and communities
- Severe disruption, at least temporarily, to the functioning of individuals or communities and
- Perceptions of threat and helplessness and a turning to others for help.
- Flannery &Everly (2000), in trying to clarify some of the terms that are often used interchangeably, define a crisis as a response condition where :
- Psychological homeostasis has been disrupted
- The individual's usual coping mechanisms have failed to re-establish homeostasis and
- The distress engendered by the crisis has yielded some evidence of functional impairment.

Age-Associated Reactions of Children exposed to Traumatic or Stressful Events

0-5 years

Crying, excessive clinging, regressive behaviors (e.g., thumb sucking, bedwetting, loss of bladder/bowel control, fear of darkness or animals, fear of being left alone, fear of crowds or strangers, inability to dress or eat without assistance), sleep terrors, nightmares, irritability, confusion, sadness, eating problems, re-enactment via play.

6-11 years

Regressive behaviours (bedwetting, excessive clinging, irrational fears), sleep terrors, nightmares, sleep problems, irritability, aggressiveness, disobedience, depression, somatic complaints, visual or hearing problems, school problems (eg. School refusal, behaviour problems, poor school performance, fighting, concentration problems, distractibility), withdrawal, lack of interest, peer problems, increased conflict with siblings.

12-17 years

Withdrawal, isolation, somatic complaints (e.g. nausea, headaches, chills), depression/sadness,

agitation or decreased energy level, antisocial behaviour, poor school performance, sleep and/or eating disturbance, irresponsibility, risky behaviour, alcohol and other drug use, diminished bids for autonomy, decreased interest in social activities, conflict with parents, concentration problems.

Principles of crisis management

Step 1 : Provide reassurance and develop rapport through validation of the problem and use of active listening skills.

Step 2 : Evaluate the severity of the crisis and assess the patient's mental, psychiatric, suicidal or homicidal, and medical statuses.

Step 3 : Ensure the safety of the patient and others through voluntary hospitalization, involuntary commitment, securing close monitoring by family and friends, or helping to remove the patient from a dangerous situation.

Step 4 : Stabilize the patient's emotional status, explore options for dealing with the crisis, develop a specific action plan, and obtain commitment from the patient to follow through.

Counteract the patient's use of inappropriate coping mechanisms such as denial, withdrawal, and reliance on harmful behaviours and substances.

Help the patient focus on his or her strengths and how these and other coping mechanisms were used successfully in the past.

Step 5 : Follow up with the patient to provide ongoing support and to reinforce appropriate action.

Strategies/techniques in Crisis intervention :

Be available. Make yourself available to students in their time of need without interruption.

Cancel other activities. If you had other scheduled tasks or duties during the time of the student's crisis, postpone them to address the child's immediate needs.

Locate counselling space. Secure a safe and confidential room for you to talk with the student.

Offer hope. Because clients in active crisis often feel despair and hopelessness, approach the client with a positive, optimistic attitude (*but don't offer promises!).

Stay event focused. Remain focused on the recent life event that caused the crisis.

Promote catharis. Allow for ventilation if it is not already occurring (some clients may be frozen/numb/expressionless).

Reconnect/mobilize support system. Help the client to keep connected to significant others and realize and reach out to/utilize these supports.

Help client to cope. Have client work on an immediate task not related to the trauma to help the client realize he/she can accomplish something.

Set routines. Help the family/teacher to keep usual routines (e.g., meal times, activities and bedtimes) as close to normal as possible. This allows a child to feel more secure and in control.

Special needs. Help families to allow the child be more dependent on them for a period of time (e.g., keeping light on at night, sleeping with parents, offering more hugs).

Lessen media coverage. Have parents turn off media coverage regarding incident because it can often be exaggerated or show they most sever scenes/pictures which can trigger stress-related symptoms/re-living the event.

Accept feelings. Your acceptance of the child's feelings will make a difference in how the child recovers from the trauma.

Set up a safety contract. If the child has admitted to wanting to hurt him/herself or has hinted to potentially hurting him/herself, set up a safety contract that consists of what should occur if he/she has these thoughts, who he/she can go to for help, and other contacts (e.g., calling 911) if he/she has these thoughts again outside of the counselling setting or if no one is around who can help. Also make sure the parent is aware of the contract and of the crisis situation if he/she is not already aware.

Get assistance if needed. Some crisis might be more extreme than originally anticipated if you need assistance do not hesitate in asking for help.

Support the faculty. Provide support and feedback to teachers and other school staff as needed.

Prevention of crisis

Prevention can be considered as taking steps to identify and then eliminate or reduce sources of risk. The use of the term 'mitigation', either instead of or in conjunction with prevention, serves to convey an additional focus on reducing any potential impact from a crisis when it is accepted that risk cannot be entirely removed.

Many kinds of risks and hazards are obvious and predictable regardless of the setting. Fire, for example, would be considered a risk factor in most kinds of building. Steps can be taken to reduce the risks associated with fire, for example, by reducing or removing readily combustible materials, having extinguishers, smoke detectors and alarms in place, and having comprehensive and practised evacuation procedures.

Suicide prevention

Risk can be identified and reduced in other areas and in other ways. In Western Australia, youth suicide prevention became a high priority in the late 1980s when there was a state-government-sponsored response to the dramatic rise in the incidence of young people taking their lives. The rate of suicide among youth in Western Australia increased from 6.1 in 1970 to 16.3 per 100000 in 1989. In 1980, 1 in 10 deaths among Western Australian males aged 15-24 was due to suicide; by 1989 this proportion had increased to 1 in 5 (Silburn, Zubrick, Hayward &Reidpath 1991). The Western Australian state strategy gave particular attention to schools and, using a public health model, aimed to have skills available at the school level to identify and intervene with high-risk students. The key objectives for the strategy were :

- Early identification of students at risk of suicide or self-harm;
- Appropriate intervention using best practice guidelines of reduce risk;
- Provision of sound, effective management based on an established crisis management plan that specifically addresses suicide in the event of a completed suicide or serious self-harm, to reduce the potential for contagion and facilitate a healthy resolution of issues; and,
- To promote primary prevention of youth suicide by enhancing mental health and well-being (WA Youth Suicide Advisory Committee 1998).

Role of Nurse in crisis intervention

Step 1 : Reassure and support the patient

The first step in communicating with a patient experiencing a crisis is to reassure the patient that it is safe to discuss the presenting concern and that the nurse will be available to assist the patient through this crisis. If the patient is distressed, he or she should be encouraged to use deep breathing techniques and refocus on the problem

Step 2 : Evaluate the crisis severity and assess the patient's status

As rapport builds, the nurse should evaluate the severity of the crisis and assess the patient's mental, psychiatric, suicidal or homicidal, and medical statuses. It is essential to define the triggering situation precisely and to understand the problem from the patient's point of view.

Step 3 : Ensure the safety of the patient and others

After obtaining information regarding the crisis and assessing the patient's mental, psychiatric and medical statuses and risk for causing harm, the nurse may need to ensure the safety of the patient and others.

Step 4 : Develop an action plan

When safety issues have been addressed, the nurse can assist the patient in developing a constructive response to the crisis. Throughout this process, the nurse must emphasize that although the patient may be unable to control the event that precipitates a crisis, he or she can control the response to it. Nurse can help the patient stabilize acute distress, explore options, make a plan and commit to the plan.

Step 5 : Follow up

Supportive follow-up is recommended to check on the patient's status and to reinforce his or her positive efforts. The immediacy of the contact should be determined by the seriousness of the problem and the trust that the nurse has in the patient and the plan. Follow-up provides patients with a lifeline and improves the likelihood that they will follow through with the action plan.

During follow-up, the nurse should assess progress regarding the specific plan of action and reinforce even small therapeutic gains. Reinforcing success increases patient's resilience, which should allow them to handle future crisis situations more successfully.

REFERENCES

[1] RashmiSabu, Principles of Crisis intervention. Feb. 2017.

[2] Juan Carlos, Alejandra Eslo, Andres. Crisis intervention strategy for attempted suicide in children and adolescents. Journal of Psychology. 2015; Vol. 8.

[3] Katherine Tyron. Loyala University Chicago. An empowering approach to crisis intervention and brief treatment with pre-school children.

[4] Maryland School Mental Health alliance. http://csmn.umaryland.edu.

[5] Clinks Children north east. Supporting families in crisis. Clinks cone. 2016.

[6] Jonathan. Crisis and crisis management integration, interpretation, and research journal of management. Vol.43, July 2017, 1661-1692.

[7] Crisis intervention : A guide for school based clinicians. Centre for school mental health assistance, 2002

Wilson Macmil. Crisis management in schools. Journal of Educational enquiry Vol. 7.

Michael G Karen, Thomas P. A practical guide to crisis management. American Academy of Family physicians.

SchwglerWhelcock. Helping kids in crisis managing psychiatric emergencies in children and adolescents. American Psychiatry publication; 2015.

April L Wrile, Elizabeth. Combining crisis management and evidence based management; Journal of management education, 135 – 160.