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What is This?

Crisis Intervention Strategies When Caring for Families of Children With Cancer

Verna L. Hendricks-Ferguson, PhD(c), MSN, RN, CS

A diagnosis of childhood cancer is an unexpected life event that often precipitates a situational crisis for all family members. Required cancer treatments and other ongoing stressors for both child and family will significantly disrupt the family's equilibrium and well-being. An increasingly important role of the pediatric oncology nurse is to facilitate crisis intervention strategies that help families adjust to the psychosocial stresses associated with childhood cancer, yet many nurses have little or no training in crisis theory and/or crisis intervention strategies. This article reviews family crisis theories and outlines crisis intervention strategies that are appropriate for the family of a child with cancer.
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THE DIAGNOSIS OF CANCER in a friend or family member is one of the most stressful life events, especially when that loved one is a child. Nearly every individual involved with a child diagnosed with cancer will experience a crisis state. This crisis state can be described as a "roller coaster ride" of positive and negative emotions. During the period of diagnosis and throughout the child's cancer treatments, the pediatric oncology nurse can be a primary agent to diffuse this crisis state and provide emotional support to the family. To plan effective crisis intervention strategies, the pediatric oncology nurse must identify stressors and reactions that parents may have when confronted with the onset of a serious illness. Therefore, a basic understanding of crisis theory and the family systems approach can assist the nurse in the assessment and planning phase of crisis intervention for these families (Kruger, 1992; MacPhee, 1995).

The diagnosis of a serious illness such as cancer is an example of a situational crisis (Aquilera & Messick, 1982). A situational crisis is described as a stressful life event that may or may not be anticipated. Johnson (1979) summarizes a situational crisis as an event that threatens an individual or family's biological, psychological, or social integrity. The situational crisis often produces individual or family reactions and stressors that inhibit previous support resources and results in a change in behavior. Other examples of situational crises include death of a loved one, natural disasters, accidents, job loss, unplanned pregnancy, and violent acts (Aquilera & Messick, 1982; Gilliland & James, 1993).

In comparison, Gilliland and James (1993) differentiate a situational crisis from other crises in that a situational crisis *emerges* with the occurrence of a random, sudden, shocking, intense, and catastrophic event. Thus, the crisis of a child diagnosed with cancer will precipitate a situational crisis within the family system, throwing the highly organized family system into a state of disequilibrium. During the crisis, the family confronts the crisis of having a child diagnosed with cancer and must reorganize to regain equilibrium. Often this is done by reestablishing roles and rules within the family system. How family

members carry out this process of reorganization may dramatically affect the ill child and other members of the family system both psychologically and physiologically (and positively or negatively). However, the total impact on parents of a seriously ill child is not well documented (Kruger, 1992).

According to Dattilio and Freeman (1994), the outcome of a crisis is associated with the individual's perception of the crisis event and his or her ability (or inability) to effectively cope with the event. The impact of a cancer diagnosis on family members often results in acute feelings of anticipatory grief (Davenport & Rice, 1995). Family members experience anger, anxiety, denial, depression, guilt, ambivalence, uncertainty, and/or spiritual bargaining (Cohen & Martinson, 1988; Canam, 1993; Clarke-Steffen, 1993). A child's diagnosis of cancer also triggers multiple stressors in family members and the family system. Specific stressors include role changes of family members, financial concerns, isolation from other family members, transportation for the child's health care needs, and/or meeting the needs of siblings.

Parents of a child with cancer must assume multiple caregiver roles (Tomlinson, Kotchevar, & Swanson, 1995), such as being an active participant in holding the child during painful bone marrow aspirations. The caregiver role requires direct observation of the child's emotional distress related to unavoidable diagnostic tests and chemotherapy treatments. These parents often experience a sense of uncertainty (Cohen & Martinson, 1988), helplessness, and/or powerlessness due to their loss of parental control (Whitley, Branscomb, & Moreno, 1979; Kruger, 1992; Tomlinson, et al., 1995)—the ability to protect their child from everyday stressors within the normal family system.

The purposes of this article are to: (a) provide a review of crisis theory and family crisis theories, (b) critique key family crisis theories, and (c) provide an outline of appropriate crisis intervention strategies when caring for families of a child with cancer.

Literature Review

Some of the crisis theories addressed in the literature are more relevant than others to the pediatric oncology nurse caring for families of a child with cancer. No one theory is recommended or preferred in the clinical setting. In practice, the pediatric oncology nurse may choose an eclectic approach.

Crisis Theory

A crisis state is usually perceived as a state of emotional distress experienced by the individual and/or family. Several definitions of crisis have evolved in the literature. A composite definition of crisis is "a temporary state of upset and disorganization, characterized chiefly by an individual's inability to cope with a particular situation using customary methods of problem-solving and by the potential for a radical positive or negative outcome" (Slaiku, 1990, p. 15).

The crisis theory of Lindemann (1944, 1956) provides a foundation for health care professionals to recognize the grief responses of individuals whose crises were precipitated by a loss are normal, temporary, and amenable to short-term crisis intervention strategies. Caplan (1964) expanded Lindemann's crisis theory by describing a stressful or traumatic life event as a crisis period of disorganization and upset during which many abortive attempts at a solution may occur. In what is also referred to as the equilibrium model, Caplan proposed that people in crisis are in a state of psychological and emotional disequilibrium, and their usual coping mechanisms and problem-solving methods fail to meet their needs. Resolution of the crisis depends on the individual's selection and utilization of coping strategies and available supportive resources. A goal of this model is to assist the individual in attaining precrisis equilibrium.

Gilliland and James (1993) describe crisis resolution as a state of both danger and opportunity for an individual's personal growth and recognize three ways that individuals respond to a crisis. First, many individuals cope effectively with a crisis without assistance and develop strength from the

experience. Second, some individuals appear to overcome the crisis, yet they are actually blocking their awareness of the crisis, only to have it haunt them for years to come. Third, other individuals experience significant emotional distress at the onset of the crisis and require immediate psychological support.

According to Longo and Williams (1978), support is best provided by trusted individuals who are certain to offer assistance during a crisis period. These individuals are perceived as available, dependable, and consistent in their responsibilities to the individual. Thus, the pediatric oncology nurse and other members of the hematology-oncology team are in a key position to provide effective crisis intervention strategies that assist family members during the situational crisis of having a child diagnosed with cancer.

Family Crisis Theories

General Systems Theory. According to the general systems theory (von Bertalanffy, 1968), the family is a social group of interdependent, interacting individuals related to one another, either legally or by consent. A change in any family member affects all members, and changes in any member results in change in the entire system. Based on this theory, a life-threatening illness such as childhood cancer is not contained within the child, but rather impacts all members of the family system. Such an illness in a child causes stressors for family members and may even cause members to significantly change their lifestyle and/or usual roles in the family system. For example, a parent may take a leave of absence from work or permanently terminate employment to care for the child during required treatments/hospitalizations.

A criticism of the general systems theory is the potential to overlook individual family members' dispositions, contributions, and experiences (Kazak, 1989). However, the tenet of this model, that family members are interrelated and interdependent, is critical when assessing the family's functioning throughout the medical management of a child with cancer.

Hill's ABCX Crisis Model. The ABCX crisis model (Hill, 1966) is based on early research by Hill that focused on family reactions and responses to war-induced stressors. In this model, Hill describes the "A" factor, the stressor event, interacting with the "B" factor, the family's crisis-meeting resources, interacting with the "C" factor, the family's interpretation of the stressor event, resulting in the "X" factor, a family crisis. Hill proposed that the stressor event is a specific situation for which the family had little preparation or no previous experience.

Hill (1966) described a serious illness, such as the onset of childhood cancer, as a significant stressor event that may result in a crisis situation for the family. The "A" factor, the psychosocial stressors associated with the onset of childhood cancer, can induce multiple stressors that temporarily exhaust the family's existing coping resources. The "B" factor, the crisis-meeting resources of the family of a child with cancer, includes open channels of family communication, experience in overcoming the stressors associated with past crisis situations, support systems, and religious convictions. According to Hill, the family's crisis-meeting resources will determine whether or not the stressor event is perceived by the family as a crisis. The "C" factor, the family's interpretation of having a child with cancer, is vital to the family's ability to cope with the stressor event. The family of a child with cancer may interpret this situation as a overwhelming negative experience or a positive family growth experience. The "X" factor, the family crisis of having a child with cancer, has the potential of creating the following disruptions in the family system: (a) the family's sense of uncertainty associated with necessary oncology treatments and the child's long-term survival, and (b) the family's adjustment to the child's illness over time.

Hill's model (Hill, 1966) has been recognized as an appropriate conceptual framework for explaining and predicting the psychosocial and religious experiences of families confronted with a serious illness such as childhood cancer (Mullen & Hill, 1990). Although noted for its usefulness when

conceptualizing adjustment to illness (Kazak, 1989), this model has been criticized for its lack of focus on the family's existing support resources, coping behaviors, and history of stressor events (McCubbin & Patterson, 1983).

Double ABCX Model of Family Adaptation. Building on Hill's ABCX crisis model, McCubbin and Patterson (1983) include a more comprehensive assessment of the family's adaptation to stress and crisis. McCubbin and Patterson termed their revised model the double ABCX model of family adaptation. In this revised model, the family is viewed as one member or system within a larger family system that includes other individual family members. The larger family system also exists within an even larger system called a community. Members of the specified systems strive to achieve adaptation through reciprocal relationships with one another.

McCubbin and Patterson (1983) describe members of a system in terms of demands (stressors and strains) and capabilities (resources, definitions, and coping behaviors) in that system (individual, family, or community). Adaptation is achieved when the demands of one member of a system are met by the capabilities of the individual and/or other member(s) of the system. Stress emerges when the pediatric oncology patient's needs exceed the system's capabilities for meeting those needs. Inadequate capabilities may result in an imbalance in the functioning of the system. In this model, adaptation is presented as a continuum of outcomes that reflect the individual's efforts to achieve a balance at the child-to-family and the family-to-community levels. Whereas the positive end of the continuum of family adaptation to a crisis situation is bonadaptation, the negative end of this continuum is maladaptation.

McCubbin and Patterson's double ABCX model includes four factors: (a) family demands: pile-up (aA factor); (b) family adaptive resources (bB factor); (c) family definition and meaning (cC factor); and (d) family adaptation balancing (xX factor). This expanded model of Hill's ABCX family crisis model is a more comprehensive description of family adaptation to a stressor or a crisis and adds another component to Hill's factors.

McCubbin and Patterson's model can be applied to the family crisis of having a child with cancer. The aA factor—family demands: pile-up—would encompass the specific demands or changes impacting the child with cancer, family members, the family system, and/or the family's community. The bB factor—family adaptive resources—include both the family's existing and expanded resources and are the coping behaviors that enable family members to find meaning in the child's illness and to share the burden of caring for the child. These coping behaviors assist in minimizing the stressor, in enabling one to recover from the crisis, and in restoring the family system. The cC factor—family definition and meaning—is the family's ability to redefine the situation and to find meaning in the seriousness of the child's illness and reflects the family's values and previous experience in confronting crises. The xX factor—family adaptation balancing—is the desired postcrisis outcome of the family's efforts to regain homeostasis of family functioning that was upset by the child's illness.

A strength of McCubbin and Patterson's double ABCX model of adjustment and adaptation is that it provides a theoretical framework for health care professionals to assess family functioning and adaptation during a crisis (Patterson & McCubbin, 1983; Smilkstein, 1984). In developing this model, Patterson and McCubbin were concerned that families experiencing stress are often adjusting to multiple life changes simultaneously rather than to a single stressor event. Hence, they incorporated the concept of pile-up of stressors and strains.

Eclectic Crisis Intervention Theory. An eclectic approach encompasses knowledge of crisis theory and crisis intervention strategies (Gilliland & James, 1993). This approach is a hybrid of crisis intervention models and utilizes principles from Caplan's (1961) equilibrium model, Ellis's (1962) cognitive model, and/or Dorn's (1986) psychosocial transition model. The *equilibrium model* is designed to help individuals attain a precrisis

equilibrium. The *cognitive model* attempts to foster awareness of and to change faulty thinking. The goals of the *psychosocial transition model* are to assess both internal and external difficulties contributing to the crisis, to assist in selecting workable alternatives to current behaviors and attitudes, and to utilize supportive resources. Although the equilibrium model is recommended at the onset of the crisis, the cognitive model and the psychosocial model are recommended after the crisis is stabilized (Gilliland & James, 1993).

Two themes of an eclectic approach are: (a) each person and crisis is unique, and (b) all people and crises are similar. For example, the health care professional can expect the diagnosis of child with cancer to disrupt every family system, yet individuals will respond to the crisis with various emotions and behaviors. When working with families confronted with the crisis of having a child diagnosed with cancer, the health care professional should consider: (a) how the family perceives the crisis, (b) the ill child's position in the family, (c) how each family member responds to the child's illness, and (d) how this crisis impacts the family system.

A strength of an eclectic approach is that it encourages and enables health care professionals to select, integrate, and apply key principles and strategies from specific crisis interventions to helping individuals in crisis (Gilliland & James, 1993). In general, crisis theories all emphasize how experience with stressors significantly impact individual and family adaptation to a chronic illness (Woods, Haberman, & Packard, 1993). In this article, an eclectic approach is presented as a theoretical framework for selecting specific crisis intervention strategies to use when working with families of a child with cancer.

Crisis Intervention Strategy

When a child is diagnosed with cancer, the child, the parent(s), and other members of the family system are suddenly upset by the unexpected nature of this crisis. These family members will often respond with shock, anxiety, and/or depression (Cohen & Martinson, 1988; Canam, 1993; Clarke-Steffen, 1993). Unfortunately, many family members who experience such a crisis lack sufficient coping mechanisms that restore their sense of equilibrium and that reduce their feeling of extreme emotional discomfort (Cohen & Martinson, 1988; Canam, 1993; Clarke-Steffen, 1993; Kruger, 1982). According to crisis theory (Gilliland & James, 1993), crisis intervention strategies assist the family system in mobilizing effective coping mechanisms and achieving successful crisis resolution.

Following is an outline of specific steps of crisis intervention for a family confronted with the unexpected news that their child is diagnosed with cancer (Gilliland & James, 1993). The basic principles of these steps have been applied to the nursing process and the principles of crisis theories. These steps could be adapted when planning clinical crisis intervention for families in other crises situations.

Assessment Phase

The assessment phase of crisis intervention comprises four steps. The first step is to define and understand the crisis from the perspective of the parent(s) (Gilliland & James, 1993). During this critical step, the pediatric oncology nurse must ask open-ended questions and use sincere listening skills to accurately identify the parent's perspective of all aspects of the crisis. The nurse should always convey a caring attitude and a genuine willingness to support the family. Following are examples of appropriate assessment questions:

- What have you learned about your child's diagnosis?
- What can you tell me about your child's present condition?
- Can you describe your child's health prior to this diagnosis?
- What prior knowledge or experience do you have with cancer in your family?

The second step of the assessment phase is to obtain a family history (Gilliland & James, 1993). In this step, the nurse should ask questions related to the current composition of the child's family system, communication skills, perceived support, social back-

ground, parent(s) employment status, religion, and cultural influences. These attributes can profoundly influence an individual's or family system's perceptions and beliefs, often referred to as schemata (Dattilio & Freeman, 1994). The nurse must remember that an individual's schemata is in a state of constant change and evolution. Sample questions related to family history include:

- How often does your family discuss family issues?
- Are you (and your spouse) currently employed outside of the home?
- What is your educational background?
- What is your family's religious preference?

The third step of the assessment phase is to identify available family support resources (Gilliland & James, 1993). Specific questions might include:

- What relatives, friends, or neighbors might be available to help?
- Who might assist in the care or transportation needs of siblings at home?
- Who might be available to stay with your child in the hospital?
- Who has offered to help your family in the past?
- Who will help you make decisions related to your child's health care?

The fourth step of the assessment phase is to investigate and identify the family's available coping mechanisms (Gilliland & James, 1993). Questions to elicit this information may include:

- What previous experience has your family had with a serious illness like cancer?
- What was most helpful to get your family through the diagnosis period and required treatments for this past illness?
- What do your family members do to reduce stress?

A critical and integrated component throughout crisis intervention is to assess the risk of immobility (e.g., depression, withdrawal from parenting responsibilities) and/or lethality (e.g., suicide attempts, acts of vio-

lence) among members of the family system (Gilliland & James, 1993). Therefore, the nurse should carefully screen family members for signs of serious difficulty in coping with the crisis. These signs include: (a) total withdrawal from the crisis; (b) denial of the serious nature of the child's diagnosis; (c) projection of blame toward themselves, family member(s), and/or health care worker(s); and (d) inability to express thoughts or feelings. Individual family members who display any of these warning signs may require psychiatric consultation.

The assessment phase especially uses tenets from Hill's (1966) model (family's interpretation of the stressor event), McCubbin and Patterson's (1983) model (family definition and meaning), Ellis's (1962, 1982) cognitive model (change faulty thinking), and Dorn's (1986) psychosocial transition model (assess difficulties). A common philosophy of crisis theory is to assess the impact of the crisis on the individual and/or family. Therefore, the nurse's assessment should be based on the following criteria: (a) the impact of the crisis on the family's state of equilibrium; (b) the family's ability to continue its normal daily functions at school, work, and/or home; (c) the quality of available support resources to meet the emotional and physical needs of family members; and (d) the quality of family relationships.

Planning Phase

The first step of the planning phase (Gilliland & James, 1993) of crisis intervention involves setting short- and long-term goals by the family and the nurse. The second step in the planning phase is to explore options for meeting those goals. The nurse should encourage family members to focus their attention on options that they can perform independently. This strategy will empower the family system and represents the initial positive step for the family to return to its precrisis equilibrium.

During the planning phase, the nurse should educate the family about all available resources and services offered by the hospital and community. These services may in-

clude: (a) educational pamphlets on the child's disease, on the coping strategies geared for the child, siblings, and all family members; (b) housing options for the immediate family members available in the community, such as the Ronald McDonald House; (c) support groups for all family members; (d) support activities such as parties and camps for children with cancer and for other family members; and (e) emergency funds for the family's basic needs, such as food or transportation.

Throughout every crisis intervention phase, the nurse will facilitate family coping by continuously providing: (a) clarification of all issues related to the ill child's health care needs and the family's perceptions of these issues; (b) evaluation of how the crisis affects the current coping abilities of all family members; and (c) evaluation of the family's coping behaviors, being especially alert for signs of immobility and/or lethality (Gilliland & James, 1993). This phase especially utilizes tenets from Caplan's (1964) equilibrium model, Hill's (1966) model (family's crisis-meeting resources), McCubbin and Patterson's (1983) model (family adaptive resources), Ellis's (1962, 1982) cognitive model (change faulty thinking), and Dorn's (1986) psychosocial transition model (select alternatives).

Planned Intervention Phase

During this phase (Gilliland & James, 1993), the nurse should provide a structured environment and utilize short, simple directions when discussing problem-solving skills and coping mechanisms to be utilized by all members of the family system. As part of this process, the nurse reminds family members of their strengths, such as available support resources and appropriate coping mechanisms.

Throughout the crisis period, family members may display a variety of coping behaviors, requiring the nurse to use various strategies that redirect the family's focus on planned interventions. In one strategy (Gilliland & James, 1993), the nurse helps family members prioritize their daily goals. In another strategy, the nurse helps the family

identify support resources who might assist with daily tasks. Delegation of tasks can greatly lessen existing stressors on the family. These tasks may include making phone calls to update relatives and friends, arranging car pooling for siblings, preparing family meals, mailing bills, shopping, doing laundry, and caring for pets.

During this phase, the nurse should continue to encourage family members to recognize and express their feelings while continuing to assess coping behaviors such as denial, guilt, depression, anxiety, and anger (Whitley, et al., 1979; Patterson & Geber, 1991). The nurse should assure family members that coping behaviors are normal and not indicative of psychiatric illness. The nurse's nonjudgmental, accepting attitude creates a trusting environment for family members to reveal their coping behaviors.

This phase utilizes tenets of the general systems (von Bertalanffy, 1968) theory (interdependent family members), Caplan's (1964) equilibrium model (attain precrisis equilibrium), Hill's (1966) model (stressor event, family's crisis-meeting resources, family's interpretation, family crisis), McCubbin and Patterson's (1983) model (family adaptive resources, family adaptation balancing), Ellis's (1962, 1982) cognitive model (change faulty thinking), and Dorn's (1986) psychosocial transition model (utilize supportive resources).

Crisis Resolution and Follow-Up Services Phase

The final steps in crisis intervention are resolving the crisis and providing for anticipated follow-up needs of the family system. Resolution of the crisis is evident during the course of the interventions when the coping abilities of the child with cancer and the family system have increased and when a reduction in family members' anxiety and depression has occurred. Again, the pediatric oncology nurse should continue to facilitate family coping by recognizing any gains achieved in problem-solving skills and in family coping mechanisms. Strategies during this phase should include: (a) summarizing the adjustments that have occurred, and

(b) allowing the family to reexperience the positive goals that individual family members have achieved (Aquilera & Messick, 1982; Canam, 1993). The nurse should also help the family identify realistic plans for the future and specific interventions to overcome future crises. At the completion of required treatments, the nurse should encourage each member of the family system to take advantage of the support of the pediatric oncology team in future crises.

Follow-up support services can be helpful to family members in maintaining their confidence in their own coping status (Gilliland & James, 1993). These services should reinforce the family's new coping skills and support resources. They should also provide a foundation of knowledge and support often needed to foster continued family coping with the appearance of future stressful crises. Thus, the nurse must remember that families dealing with childhood cancer not only need crisis intervention services at the time of diagnosis, but also will continue to need emotional support throughout all treatment phases.

This phase especially utilizes tenets from Hill's (1966) model (family's interpretation of the stressor event), McCubbin and Patterson's (1983) model (family adaptive resources, family adaptation balancing), Ellis's (1962, 1982) cognitive model, and Dorn's (1986) psychosocial transition model.

Implications for Pediatric Oncology Nursing Practice

Accurate assessment of psychosocial stressors and reactions of children with cancer and their family members is a primary concern of the pediatric oncology nurse. With knowledge and application of crisis theory and crisis intervention strategies, the pediatric oncology nurse can provide effective crisis intervention strategies for family members of a child with cancer. The crisis intervention strategies presented in this article can also be easily adapted and used in other clinical areas of family-centered nursing.

References

Aquilera, D.C., & Messick, J.M. (1982). *Crisis intervention: Theory and methodology* (4th ed.). St. Louis, MO: C.V. Mosby.

Canam, C. (1993). Common adaptive tasks facing parents of children with chronic conditions. *Journal of Advanced Nursing, 18,* 46-53.

Caplan, G. (1964). *Principles of preventive psychiatry.* New York: Basic Books.

Clarke-Steffen, L. (1993). Waiting and not knowing: The diagnosis of cancer in a child. *Journal of Pediatric Oncology Nursing, 10,* 146-153.

Cohen, M.H., & Martinson, I.M. (1988). Chronic uncertainty: Its effect on parental appraisal of a child's health. *Journal of Pediatric Nursing, 3,* 89-96.

Dattilio, F.M., & Freeman, A. (Eds.). (1994). *Cognitive-behavioral strategies in crisis intervention* (pp. 1-22). New York: The Guilford Press.

Davenport, L.B., & Rice, M. (1995). Life-threatening situations: Supporting the child survivor and the family. *Journal of Pediatric Nursing, 10,* 219, 223.

Dorn, F.G. (Ed.). (1986). *The social influence process in counseling and psychotherapy.* Springfield, IL: Charles C. Thomas.

Ellis, A.E. (1962). *Reason and emotion in psychotherapy.* New York: Lyle Stuart.

Ellis, A.E. (1982). Major systems. *Personnel and Guidance Journal, 61,* 6-7.

Freeman, A., & Dattilio, F.M. (1993). Chapter 1: Introduction. In F.M. Dattilio & A. Freeman (Eds.), *Cognitive-behavioral strategies in crisis intervention* (pp. 1-22). New York: The Guilford Press.

Gilliland, B.E., & James, R.K. (1993). *Crisis intervention strategies* (2nd ed.). (pp. 3-26). Pacific Grove, CA: Brooks/Cole.

Hill, R. (1966). Contemporary developments in family theory. *Journal of Marriage and Family, 28,* 10-25.

Johnson, S.H. (1979). *High-risk parenting: Nursing assessment and strategies for the family at risk.* Philadelphia: J.B. Lippincott Company.

Kazak, A.E. (1989). Families of chronically ill children: A systems and social-ecological model of adaptation and challenge. *Journal of Consulting and Clinical Psychology, 57,* 25-30.

Kruger, S. (1992). Parents in crisis: Helping them cope with a seriously ill child. *Journal of Pediatric Nursing, 7,* 133-139.

Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry, 101,* 141-148.

Lindemann, E. (1956). The meaning of crisis in individual and family. *Teachers College Record, 57,* 310.

Longo, D.C., & Williams, R.A. (1978). *Clinical practice in psychosocial nursing: Assessment and intervention.* New York: Appleton-Century-Crofts.

MacPhee, M. (1995). The family systems approach and pediatric nursing care. *Pediatric Nursing, 21,* 417-423.

McCubbin, H.I., & Patterson, J.M. (1983). The family stress process: The double ABCX model of adjustment and adaptation. In H.I. McCubbin, M.B. Susman, & J.M. Patterson, *Social stress and the family: Advances and developments in family stress theory and research* (pp. 7-37). New York: The Haworth Press, Inc.

Mullen, P.M., & Hill, W. (1990). Family stress theory: A perspective on pastoral care. *Journal of Religion and Health, 29,* 29-39.

Patterson, J.M., & McCubbin, H.I. (1983). The impact of family life events and changes on the health of a chronically ill child. *Family Relations, 32,* 255-264.

Patterson, J.M., & Geber, G. (1991). Preventing mental health problems in children with chronic illness or disability. *Children's Health Care, 20,* 150-161.

Slaiku, K.A. (1990). *Crisis intervention* (2nd ed.). Boston, MA: Allyn & Bacon.

Smilkstein, G. (1984). The physician and family function assessment. *Family Systems Medicine, 2,* 263-278.

Tomlinson, P.S., Kotchevar, J., & Swanson, L. (1995). Care giver mental health and family health outcomes following critical hospitalization of a child. *Issues in Mental Health Nursing, 16,* 533-545.

Von Bertalanffy, L. (1968). *General systems theory: Foundation, development, and applications.* New York: Braziller.

Whitley, S.B., Branscomb, B.V., & Moreno, H. (1979). Identification and management of psychosocial and environmental problems of children with cancer. *The American Journal of Occupational Therapy, 33,* 711-717.

Woods, N.F., Haberman, M.R., & Packard, N.J. (1993). Demands of illness and individual, dyadic, and family adaptation in chronic illness. *Western Journal of Nursing Research, 15,* 10-30.