CHAPTER 67

Crisis Theory and Intervention

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Priority Concepts

Coping; Interpersonal Violence

I. Crisis Intervention

A. Description

1. **Crisis** is a temporary state of severe emotional disorganization caused by an event that presents a threat.
2. Everyone experiences crises; the outcome depends on coping mechanisms and support systems available at the time of the crisis.
3. The ability for decision making and problem solving is inadequate.
4. Treatment is aimed at assisting the client and the family through the stressful situation.

B. Phases of a crisis

1. Phase 1: External precipitating event (could be situational, developmental, cultural, or societal)
2. Phase 2
   a. Perception of the threat
   b. Increase in anxiety
   c. Client may cope or resolve the crisis.
3. Phase 3
   a. Failure of coping
   b. Increasing disorganization
   c. Emergence of physical symptoms
   d. Relationship problems
4. Phase 4
   a. Mobilization of internal and external resources
   b. Goal is to return the client to at least a precrisis level of functioning.

C. Types of crises (Box 67-1)

D. Crisis intervention

1. Treatment is immediate, supportive, and directly responsive to the immediate crisis.
2. The interprofessional health care team assists individuals in crisis to cope; interventions are goal directed.
3. Feelings of the client are acknowledged.
4. Intervention provides opportunities for expression and validation of feelings.
5. Connections are made between the meaning of the event and the crisis.
6. The client explores alternative coping mechanisms and tries out new behaviors.

II. Grief

A. Grief is a natural emotional response to loss that individuals must experience as they attempt to accept the loss.
B. Grief usually involves moving through a series of stages or tasks to help resolve the grief (Box 67-2).
C. Depending on the type of loss, feelings associated with grief include anger, frustration, loneliness, sadness, guilt, regret, and peace.
D. Healing can occur when the pain of the loss has lessened and the individual has adapted to the loss; if the grief is the result of the loss of a loved one, the individual continues to experience memories of the deceased.
E. Types of grief
    1. Normal grief: Physical, emotional, cognitive, spiritual, or behavioral reactions can occur; the process of resolution can take months to years.
    2. Anticipatory grief occurs before the loss of a loved one and is associated with an acute, chronic, or terminal illness.
    3. Disenfranchised grief occurs when a loss of a loved one is experienced and cannot be acknowledged openly (societal norms do not define the loss as a loss within its traditional definition).
    4. Dysfunctional grief occurs with prolonged emotional instability and a lack of progression to successful coping with the loss.
    5. Grief in children is based on the developmental level of the child (Box 67-3).

III. Loss

A. Loss is the absence of something desired or previously thought to be available.
B. Actual loss can be identified by others and can arise in response to or in anticipation of a situation.

C. Perceived loss is experienced by one person and cannot be verified by others.
D. Anticipatory loss is experienced before the loss occurs.
E. Mourning
    1. Mourning is the outward and social expression of loss.
    2. Mourning may be dictated by cultural, spiritual, and religious beliefs.
F. Bereavement
    1. Bereavement includes the inner feelings and the outward reactions of the individual experiencing the loss.
    2. Bereavement includes grief and mourning.

IV. Nurse's Role: Grief and Loss (Box 67-4)

A. Encourage the client to express feelings within a trusting, supportive, and nonjudgmental environment.
B. Allow ongoing opportunities for fully informed choices.
C. Facilitate the grief process; assess the individual's grief, and assist the individual to feel the loss and complete the tasks of the grief process.
D. Grief affects individuals physically, psychologically, socially, and spiritually; an interprofessional team approach, including a bereavement specialist, facilitates the grief process.

The nurse's role in the grief and loss process includes communicating with the client, family members, and significant other. The nurse must consider the individual's culture, spirituality, religion, family structure, life experiences, coping skills, and support systems.

V. Suicidal Behavior

A. Description
    1. Suicidal clients characteristically have feelings of worthlessness, guilt, and hopelessness that are so overwhelming that they feel unable to go on with life and feel unfit to live.
    2. The nurse caring for a depressed client always considers the possibility of **suicide**.
B. Individuals at risk
    1. Clients with a history of previous suicide attempts
    2. Family history of **suicide attempts**
    3. Adolescents
    4. Older adults
    5. Disabled or terminally ill clients
    6. Clients with personality disorders
    7. Clients with organic brain syndrome or dementia
    8. Depressed or psychotic clients (see Chapter 65 for

information on depression)
9. Substance abusers
10. Those who have been consistently bullied or rejected by peers or society
11. History of child maltreatment
12. Past psychiatric hospitalizations

C. Cues (Box 67-5)

D. Assessment (Box 67-6)

E. Interventions

1. Assess for suicidal intent or ideation and initiate suicide precautions.
2. The client's statements, behaviors, and mood are documented every 15 minutes.
3. Remove harmful objects.
4. Do not leave the client alone.
5. Provide a nonjudgmental, caring attitude.
6. Per agency procedure and policy, develop a no-suicide contract that is written, dated, and signed and indicates alternative behavior at times when suicidal thoughts occur and that they will notify the nurse when having suicidal thoughts.
7. Encourage the client to talk about feelings and to identify positive aspects about self.
8. Encourage active participation in own care.
9. Keep the client active by assigning achievable tasks.
10. Check that visitors do not leave harmful objects in the client's room.
11. Identify support systems.
12. Do not allow the client to leave the unit unless accompanied by a staff member.
13. Continue to assess the client's suicide potential.

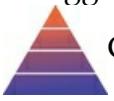
Provide one-to-one supervision at all times for the client at risk for suicide.

VI. Abusive Behaviors

A. Anger

1. Anger is a feeling of annoyance that may be displaced onto an object or person.
2. Anger is used to avoid anxiety and gives a feeling of power in situations in which the person feels out of control.

B. Aggression can be harmful and destructive when not controlled.



C. Violence is physical force that is threatening to the safety of self and others.

D. Assessment

1. History of violence or self-harm
2. Poor impulse control and low tolerance of frustration
3. Defiant and argumentative
4. Raising of voice
5. Making verbal threats
6. Pacing and agitation
7. Muscle rigidity
8. Flushed face
9. Glaring at others

E. Interventions

1. Ensure a safe and low stimuli environment.
2. Use a calm approach and communicate with a calm, clear tone of voice (be assertive, not aggressive, and avoid verbal struggles).
3. Maintain a large personal space and use a nonaggressive posture (e.g., arms and hands at the side rather than folded across the chest or placed on the hips).
4. Listen actively and acknowledge the client's anger.
5. Determine what the client considers to be her or his need.
6. Provide the client with clear options that deal with the client's behavior, set limits on behavior, and make the client aware of the consequences of anger and violence.
7. Discuss the use of **restraints (security devices)** or **seclusion** if the client is unable to control angry behavior that may lead to violence.
8. Assist the client with problem solving and decision making regarding the options.

F. Restraints (security devices) and seclusion

1. Description
    a. Physical restraints: Any physical or environmental means of controlling an individual's behavior or actions that inhibits free movement
    b. Seclusion: A type of restraint in which a client is confined in a room specially designed for protection and close supervision from which they cannot freely exit.
    c. Chemical restraints: Medications given for a specific purpose of inhibiting a specific behavior or movement and

that have an impact on the client's ability to relate to the environment

2. Use of restraints and seclusion
    a. Restraints and seclusion should never be used as punishment or for the convenience of the health care staff.
    
    b. Restraints and seclusion are used when behavior is physically harmful to the client or others and when alternative or less restrictive measures are insufficient in protecting the client or others from harm.
    
    c. Restraints and seclusion are used when the health care team anticipates that a controlled environment would be helpful and requests restraints or seclusion.
    d. The nurse must document the behavior leading to the use of restraints or seclusion.
    e. In most settings, a primary health care provider's prescription is required prior to the use of restraints
    f. In an emergency, a qualified nurse may place a client in restraints or seclusion and obtain a written or verbal prescription as soon as possible thereafter.
    g. Per state guidelines, within 1 hour of the initiation of restraints or seclusion, the psychiatrist must make a face-to-face assessment and evaluation of the client and must continuously reevaluate the need for continued restraints or seclusion.
    h. While in restraints or seclusion, the client must be protected from all sources of harm.
    
    i. The client in restraints or seclusion needs constant one-to-one supervision; physical, safety, and comfort needs must be assessed every 15 to 30 minutes, and these observations are also documented

(e.g., food, fluids, bathroom needs, range-of-motion exercise, and ambulation).

j. The nurse must always follow agency procedures and policies regarding the use of restraints and must also be familiar with their use for the older client and juveniles.

Restraints require a written prescription by a primary health care provider, which must be reviewed and renewed per agency policy; the prescription must specify the type of restraint to be used, the duration of the restraint or seclusion, and the criteria for release (agency policy and procedures need to be followed).

VII. Bullying

A. Bullying is the **abuse** of power by an individual toward another through repeated aggressive acts.

B. It most often occurs in children and in high school or college environments but can also occur in the workplace or other environments.

C. The bully feels power from sources such as physical strength, maturity, or a higher status within a peer group; from knowing the victim's weaknesses; or from support of others.

D. Bullying can occur in the form of physical harm, relational aggression, isolation and exclusion, and verbal harm such as slander, rumors, or threats; it is both intentionally cruel and unprovoked.

E. Cyberbullying is also a form of bullying and occurs in the form of Internet messages on social media networks, text messages, e-mails, photos being posted, and rumors.

F. The bullied person repeatedly experiences negative actions from the bully(s).

G. These bullying acts can lead to depression, low self-esteem, humiliation, isolation, and social withdrawal in the victim; they could result in self-harm such as cutting, suicide, and murder.

H. The nurse's responsibility is to observe for signs of bullying and to educate teachers, school administrators, and parents about bullying behaviors and signs that bullying may be occurring.

VIII. Family Violence

A. Description (Fig. 67-1)

1. Violence begins with threats or verbal or physical minor assaults (tension building), and the victim attempts to comply with the requests of the abuser.
2. The abuser loses control and becomes destructive and

harmful (acute battering), whereas the victim attempts to protect herself or himself.

3. After the battering, the abuser becomes loving and attempts to make peace (calmness and diffusion of tension); undoing behavior is characteristic in which the abuser gives gifts and positive attention to the victim to undo the negative behavior.
4. The abuser justifies that violence is normal and the victim is responsible for the abuse.
5. Outsiders are usually unaware of what is happening in the family.
6. Family members are isolated socially and lack autonomy and trust among each other; caring and intimacy in the family are absent.
7. Family members expect other members of the family to meet their needs, but none is able to do so.
8. The abuser threatens to abandon the family.

B. Types of violence (Box 67-7)

C. The vulnerable person (victim)

1. The vulnerable person is the one in the family unit against whom violence is perpetrated.
2. The most vulnerable individuals are children and older adults.
3. The perpetrator of violence and the person targeted by the violence can be male or female.
4. Battering is a crime.

D. Characteristics of abusers

1. Impaired self-esteem
2. Strong dependency needs
3. Narcissistic and suspicious
4. History of abuse during childhood
5. Perceive victims as their property and believe that they are entitled to abuse them

E. Characteristics of victims

1. Some may have a dependent personality disorder
2. Feel trapped, dependent, helpless, and powerless
3. May become depressed as they are trapped in the abusers' power and control cycle (see Fig. 67-1)
4. As victims' self-esteem becomes diminished with chronic abuse, they may blame themselves for the violence and be unable to see a way out of the situation.

F. Interventions

1. Report suspected or actual cases of child abuse or abuse of an older adult to appropriate authorities

(follow state and agency guidelines).

2. Referral to appropriate sexual assault domestic violence (SADV) team or other appropriate agency team
3. Assess for evidence of physical injuries.
4. Ensure privacy and confidentiality during the assessment, and provide a nonjudgmental and empathetic approach to foster trust; reassure the victim that she or he has not done anything wrong. Box 67-8 lists sample assessment questions.
5. Assist the victim to develop self-protective and other problem-solving abilities.
6. Even if the victim is not ready to leave the situation, encourage the victim to develop a specific safety plan (a fast escape if the violence returns) and provide information on where to obtain help (hotlines, safe houses, and shelters); an abused person is usually reluctant to call the police.
7. Assess suicidal potential of the victim.
8. Assess the potential for homicide.
9. Assess for the use of drugs and alcohol.
10. Determine family coping patterns and support systems.
11. Provide support and assistance in coping with contacting the legal system.
12. Assist in resolving family dysfunction with prescribed therapies.
13. Encourage individual therapy for the victim that promotes coping with the trauma and prevents further psychological conflict.
14. Encourage individual therapy for the abuser that focuses on preventing violent behavior and repairing relationships.
15. Encourage psychotherapy, counseling, group therapy, and support groups to assist family members to develop coping strategies.
16. Assist the family to identify an access to community and personal resources.
17. Maintain accurate and thorough medical health records.

IX. Child Abduction

A. Description

1. Child abduction is the kidnapping of a child (or infant) by an older person.
2. Occurrences
    a. A stranger may kidnap a child for criminal or mischievous purposes.
    b. A stranger may kidnap a child (or

infant) to bring up him or her as that person's own child.

c. A parent removes or retains a child from the other parent's care (often in the course of or after divorce proceedings).

3. Because of the increased independence that occurs in the preschool-age child, parents are less able to provide the constant protection they once did when the child reaches this age; interventions that ensure protection (including teaching the child) are necessary.

4. Questions that help reveal the potential for abuse include: "Who do you play with most often? Is there anyone you do not like playing with? Are there games you don't like playing?"

B. Interventions

1. Instruct the parents to teach a child basic guidelines about personal safety that include the following:
   a. Do not go anywhere alone.
   b. Always tell an adult where you are going and when you will return.
   c. Say *no* if you feel uncomfortable with a situation.
   d. If any adult offers you anything without asking your parent first, step away, say no, and tell someone.
   e. If any adult asks for your help without asking your parent first, step away, say no, and tell someone.
   f. If any adult asks you to keep a secret, say no and step away, say no, and tell someone.
   g. Do not help anyone look for a lost dog or cat and do not accept candy or gifts from a stranger.
   h. If lost in a store, do not wander around looking for the parent; go at once to a clerk or guard.
2. Children need to learn their full name, address, parents' names and phone numbers.
3. Watch for post-traumatic stress disorder in any child who has experienced an abduction.

X. Child Abuse

A. Description

1. Abuse is the nonaccidental physical injury or the nonaccidental act of omission of care by a parent or person responsible for a child; abuse comprises neglect and physical, sexual, and emotional maltreatment.
2. Neglect can be in the form of physical or emotional neglect and involves the deprivation of basic needs, supervision, medical care, or education and failure to meet a child's needs for attention and affection.
3. Sexual abuse can involve incest, molestation, exhibitionism, pornography, prostitution, or pedophilia; findings associated with sexual abuse may not be easily apparent in a child.
4. Shaken baby syndrome is caused by the violent shaking of an infant and results in intracranial (usually subdural hemorrhage) trauma; this can lead to cerebral edema and death.

B. Assessment (Box 67-9)

C. Interventions

1. Support the child during a thorough physical assessment.
2. Assess injuries.
3. If shaken baby syndrome is suspected, monitor the infant for a decrease in level of consciousness, which can indicate increased intracranial pressure (ICP).
4. Report a case of suspected abuse; nurses are legally required to report all cases of suspected child abuse to the appropriate local or state agency.
5. Place the child in an environment that is safe, preventing further injury.
6. Document information related to the suspected abuse in an objective manner.
7. Assess parents' strengths and weaknesses, normal coping mechanisms, and presence or absence of support systems.
8. Assist the family in identifying stressors, support systems, and resources.
9. Refer the family to appropriate support groups.

Nurses are legally required to report all cases of suspected child abuse or elder abuse to the appropriate local or state agency; state laws and procedures may vary and are always followed.

XI. Latchkey Children

A. Description

1. Children who do not have adult supervision before or after school hours; they are left to care for themselves during these times.
2. Occurs when children are members of a single-parent family or when both parents work and need to leave the home before children are brought to school or arrive home after the children
3. This situation induces a stress-provoking environment for the children and places the children at risk for an unsafe situation, injury, and delinquent behavior.

B. Interventions

1. Identify the latchkey child.
2. Encourage the parent to teach the child about self-care and self-help skills.
3. Assist the parent to identify possible alternatives to leaving the child alone.
4. Inform the parent about available community resources such as after-school programs for children.

XII. Abuse of the Older Adult

A. Description

1. Abuse of an older adult involves physical, emotional, or sexual abuse; neglect; and economic exploitation.
2. Older adults at most risk include individuals who are dependent because of illness, immobility, or altered mental status.

3. Factors that contribute to abuse and neglect include long-standing family violence, caregiver stress, and the older adult's increasing dependence on others.
4. Victims may attempt to dismiss injuries as accidental, and abusers may prevent victims from receiving proper medical care to avoid discovery.
5. Victims often are isolated socially by their abusers.

B. Assessment

1. Physical abuse
    a. Sprains, dislocations, or fractures
    b. Abrasions, bruises, or lacerations
    c. Pressure sores
    d. Puncture wounds
    e. Burns
    f. Skin tears
2. Sexual abuse
    a. Torn or stained underclothing
    b. Discomfort or bleeding in the genital

area
c. Difficulty in walking or sitting
d. Unexplained genital infections or disease

3. Emotional abuse
   a. Confusion
   b. Fearfulness and agitation
   c. Changes in appetite and weight
   d. Withdrawal and loss of interest in self and social activities
4. Neglect
   a. Disheveled appearance
   b. Inadequate or inappropriate dress
   c. Dehydration and malnutrition
   d. Lack of physical needs, such as glasses, hearing aids, and dentures
5. Signs of medication overdose
6. Economic exploitation
   a. Inability to pay bills and fearful when discussing finances
   b. Confusion, inaccuracy, or no knowledge of finances

C. Interventions

1. Assess for physical injuries and treat physical injuries.
2. Ask if any injury is a result of someone harming them.
3. Report cases of suspected abuse to appropriate authorities (follow state and agency guidelines).
4. Separate the older adult from the abusive environment, if possible, and contact adult protective services for assistance in placement while the abuse is being investigated.
5. Explore alternative living arrangements that are least restrictive and disruptive to the victim.
6. The older adult who has been abused may need assistance for financial or legal matters.
7. Provide referrals to emergency community resources.
8. When working with caregivers, assess the need for respite care or counseling to deal with caregiver stress (see Priority Nursing Actions).

Priority Nursing Actions

Physical Abuse of an Older Client

1. Assess and treat the wounds.
2. Ensure that the victim is removed from the threatening environment.

3. Adhere to mandatory abuse reporting laws.
4. Notify the caseworker of the situation.
5. Document the occurrence, findings, actions taken, and the victim's response.

Reference

Varcarolis (2017), pp. 344-345.

XIII. Rape and Sexual Assault

A. Description

1. Rape is engaging another person in a sexual act or sexual intercourse through the use of force or coercion and without the consent of the sexual partner.
2. The victim is not required by law to report the rape or assault.
3. Often, the victim is blamed by others and receives no support from significant others.
4. Acquaintance rape involves someone known to the victim.
5. Statutory rape is the act of sexual intercourse with a person younger than the age of legal consent, even if the minor consents.
6. Same-sex rape
    a. Females: Involves sexual touching, oral sex, or penetration with a finger or some other object
    b. Males: Same as for females; often experience stigma when seeking help
    c. See https://www.cdc.gov/violencepreventic for more information.
7. Marital rape
    a. The belief that marriage bestows rights to sex whenever wanted and without consent of the partner contributes to the occurrence of marital rape.
    b. Victims of marital rape describe being forced to perform acts they did not wish to perform and being physically abused during sex.

B. Assessment

1. Female client
    a. Obtain the date of the last menstrual period.
    b. Determine the form of birth control used and the last act of intercourse before rape.

c. Determine the duration of intercourse, orifices violated, and whether penile penetration occurred.
d. Determine whether a condom was used by the perpetrator.

C. Shame, embarrassment, and humiliation
D. Anger and revenge
E. Afraid to tell others because of fear of not being believed
F. Males may be sexually abused as children and as adults and are the usual targeted victim of pedophiles; males may have more difficulty with disclosing their abuse.
G. Rape trauma syndrome
1. Sleep disturbances, nightmares
2. Loss of appetite
3. Fears, anxiety, phobias, suspicion
4. Decrease in activities and motivation
5. Disruptions in relationships with partner, family, friends
6. Self-blame, guilt, shame
7. Lowered self-esteem, feelings of worthlessness
8. Somatic complaints
9. See Chapter 65 for information on post-traumatic stress disorder.

H. Interventions

1. Perform the assessment in a quiet, private area.
2. Referral to SADV nurse as appropriate
3. Stay with the victim and provide client safety.
4. Assess the client for physical injuries. Treat as appropriate.
5. Assess the victim's stress level before performing treatments and procedures.
6. Victim should not shower, bathe, douche (female), or change clothing until an examination is performed.
7. Obtain written consent for the examination, photographs, laboratory tests, release of information, and laboratory samples.
8. Assist with the female pelvic examination and obtain specimens to detect semen (the pelvic examination may trigger a flashback of the attack); a shower and fresh clothing should be made available to the client after the examination.
9. Preserve any evidence.
10. Treat physical injuries and provide client safety.
11. Administer prescribed medications.
12. Document all events in the care of the victim.
13. Reinforce to the victim that surviving the assault is most important; if the victim survived the rape, she or

he did exactly what was necessary to stay alive.
14. Refer the victim to crisis intervention and support groups.

Box 67-1

Types of Crises

Maturational

- Relates to developmental stages and associated role changes; examples include marriage, birth of a child, and retirement

Situational

- Arises from an external source, is often unanticipated, and is associated with a life event that upsets an individual's or group's psychological equilibrium; examples include loss of a job or a change in job, change in financial status, death of a loved one, divorce, abortion, addition of new family members, pregnancy, and severe physical or mental illness

Adventitious

- Relates to a crisis of disaster, is not a part of everyday life; it is unplanned and accidental. Adventitious crises may result from a natural disaster (e.g., floods, fires, tornadoes, earthquakes), a national disaster (e.g., war, riots, airplane crashes), or a crime of violence (e.g., rape, assault, murder in the workplace or school, bombings, or spousal or child abuse).

From Varcarolis E: *Essentials of psychiatric mental health nursing*, revised reprint, ed 2, Philadelphia, 2013, Saunders.

Box 67-2

The Grief Response

Stage 1: Shock and Disbelief

- Individual may have feelings of numbness, difficulties with decision making, emotional outbursts, denial, and isolation.

Stage 2: Experiencing the Loss

- If the grief response is the result of a loss of a loved one, the individual may feel

angry at the loved one who died or may feel guilt about the death.
- Bargaining or depression or both also may occur in this stage.

Stage 3: Reintegration

- Individual begins to reorganize her or his life and accepts the reality of the loss.

Box 67-3

Grief in Children

Birth to 1 Year

- Infant has no concept of death.
- Infant reacts to the loss of mother or caregiver.

1 to 2 Years

- Toddler may see death as reversible.
- Toddler may scream, withdraw, or become disinterested in the environment.
- Grief response occurs only to the death of the significant person in the toddler's life.

2 to 5 Years

- Child may see death as reversible.
- Regressive or aggressive behavior may occur.
- Child has a sense of loss and is concerned about who will provide care.

5 to 9 Years

- Child has difficulty concentrating.
- Child begins to see death as permanent.
- Child may feel responsible for the occurrence.

Preadolescent Through Adolescent

- Adolescent may regress.
- Adolescent sees death as permanent.
- Adolescent experiences a strong emotional reaction.

Box 67-4

Communication During Grief and Loss

- Determine how much the client and family want to know about the situation.
- Determine whether there is a spokesperson for the family.
- Be aware of cultural, spiritual, and religious beliefs and how they may affect the communication process; consider personal space issues, eye contact, and touch.
- Obtain an interpreter, if necessary.
- Allow opportunity for informed choices.
- Assist with the decision-making process if asked; use problem solving to assist in decision making, and avoid interjecting personal views or opinions.
- Establish trust with the client and encourage expression of feelings, concerns, and fears within a trusting, supportive, and nonjudgmental environment.
- Be honest, and let the client and family know that you will not abandon them.
- Ask the client and family about their expectations and needs.
- Be a sensitive listener; sit in silence if necessary and appropriate.
- Extend touch and hold the client's or family member's hand if appropriate.
- Encourage reminiscing.
- If you do not know what to do in a particular situation, seek assistance.
- If you do not know what to say to a client or family who is talking about death or another loss, listen attentively and use therapeutic communication techniques, such as open-ended questions or reflection.
- Acknowledge your own feelings; let the client and family know that the topic of conversation is a difficult one and that you do not know what to say.
- Realize that it is acceptable to cry with the client and family during the grief process.

Box 67-5

Suicidal Cues

- Giving away personal, special, and prized possessions
- Canceling social engagements
- Making out or changing a will
- Taking out or changing insurance policies
- Positive or negative changes in behavior
- Poor appetite
- Sleeping difficulties
- Feelings of hopelessness
- Difficulty in concentrating
- Loss of interest in activities

- Client statements indicating an intent to attempt suicide
- Sudden calmness or improvement in a depressed client
- Client inquiries about poisons, guns, or other lethal items or objects
- Sudden deterioration in school/work performance

Box 67-6

Suicidal Client: Assessment

Plan

- Does the client have a plan?
- Does the client have the means to carry out the plan?
- Has the client decided when she or he is going to carry out the plan?

Client History of Attempts

- What suicide attempts occurred in the past and what harm occurred?
- Was the client accidentally rescued?
- Have the past attempts and methods been the same, or have methods increased in lethality?

Psychosocial Factors

- Is the client alone or alienated from others?
- Is hostility or depression present?
- Is the client experiencing hallucinations? Type of hallucination (audio/command, visual)?
- Is substance abuse present?
- Has the client had any recent losses or physical illness?
- Has the client had any environmental or lifestyle changes?

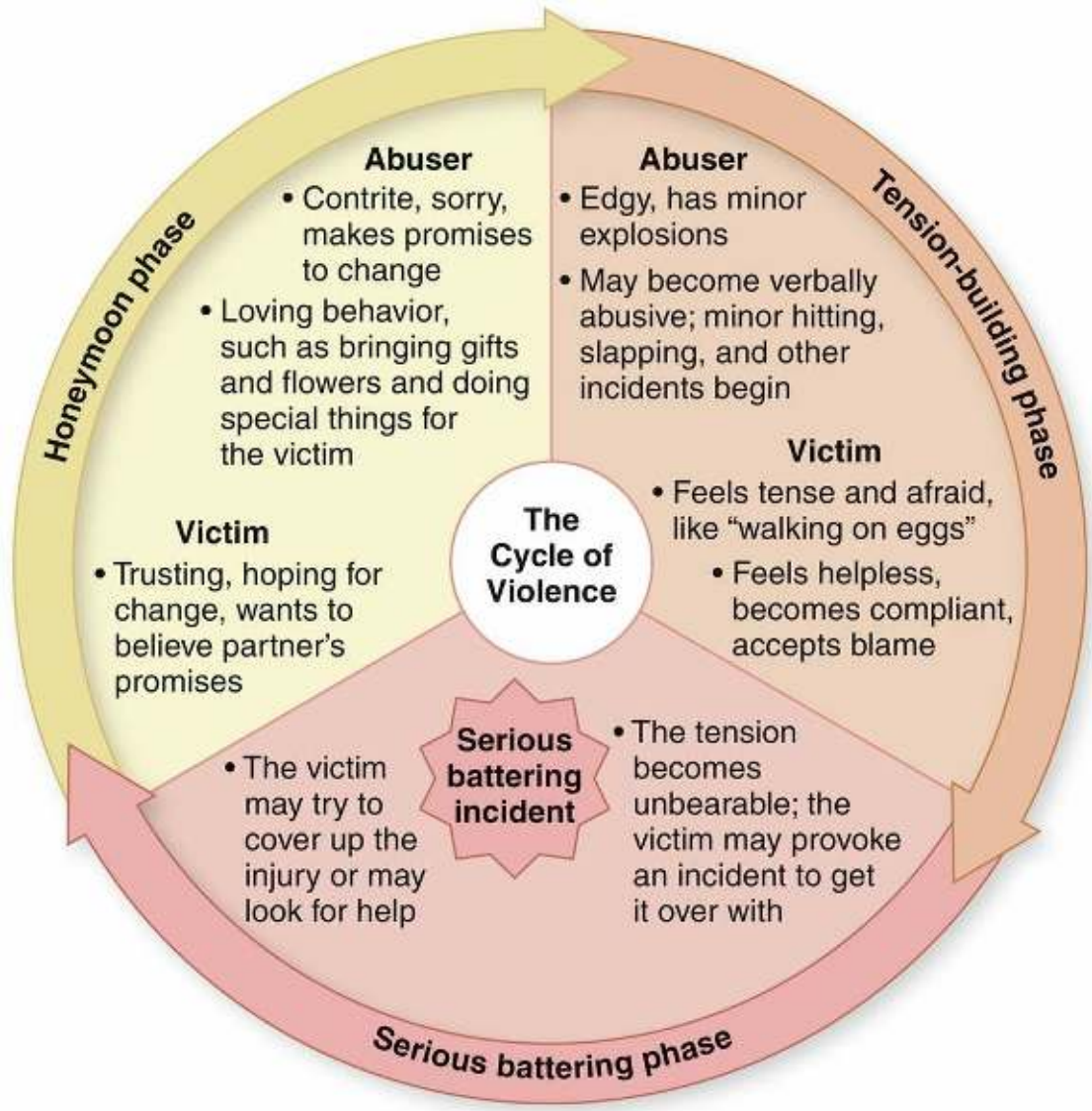


FIG. 67-1 The cycle of violence.

Box 67-7

Types of Violence

Physical Violence: Infliction of physical pain or bodily harm
Sexual Violence: Any form of sexual contact without consent
Emotional Violence: Infliction of mental anguish
Physical Neglect: Failure to provide health care to prevent or treat physical or emotional illnesses
Developmental Neglect: Failure to provide physical and cognitive stimulation needed to prevent developmental deficits
Educational Neglect: Depriving a child of education
Economic Exploitation: Illegal or improper exploitation of money, funds, or other resources for one's personal gain

Box 67-8

Assessment Questions for Violence and Abuse

- "Has anyone ever touched you in a way that made you uncomfortable?"
- "Are these injuries a result of someone harming you?"
- "Is anyone hurting you now?"
- "How do you and your partner deal with anger (or disagreement)?"
- "Has your partner ever hit you?"
- "Have you ever been threatened by _____?"
- "Does your partner prevent you from seeing family or friends?"
- "Does your partner ever use the children to manipulate you?"
- "Did (or does) anyone in your family deal with anger by hitting?"

Box 67-9

Child Neglect and Abuse: Assessment Findings

Neglect

- Inadequate weight gain
- Poor hygiene
- Consistent hunger
- Inconsistent school attendance
- Constant fatigue
- Reports of lack of child supervision
- Delinquency

Physical Abuse

- Unexplained bruises, burns, or fractures
- Bald spots on the scalp
- Apprehensive child
- Extreme aggressiveness (typically boys) or withdrawal (typically girls)
- Fear of parents
- Lack of crying (older infant, toddler, or young preschool child) when approached by a stranger
- Spiral fractures without history of trauma from a sports injury
- Poor performance in school

Emotional Abuse

- Speech disorders
- Habit disorders such as sucking, biting, and rocking
- Psychoneurotic reactions
- Learning disorders
- Suicide attempts

Sexual Abuse

- Difficulty walking or sitting
- Torn, stained, or bloody underclothing
- Pain, swelling, or itching of genitals
- Deformities, bruises, bleeding, or lacerations in genital or anal area
- Unwillingness to change clothes or unwillingness to participate in gym activities
- Poor peer relations
- Poor performance in school

Shaken Baby Syndrome

- External signs of trauma are usually absent
- Ophthalmoscopic examination reveals retinal hemorrhages
- Full bulging fontanels and head circumference greater than expected

Practice Questions

827. The nurse observes that a client with a potential for violence is agitated, pacing up and down the hallway, and making aggressive and belligerent gestures at other clients. Which statement would be **most appropriate** to make to this client?
    1. "You need to stop that behavior now."
    2. "You will need to be placed in seclusion."
    3. "You seem restless; tell me what is happening."
    4. "You will need to be restrained if you do not change your behavior."
828. The nurse is reviewing the assessment data of a client admitted to the mental health unit. The nurse notes that the admission nurse documented the client is experiencing anxiety as a result of a situational crisis. The nurse plans care for the client, determining that this type of crisis could be caused by which event?
    1. Witnessing a murder
    2. The death of a loved one
    3. A fire that destroyed the client's home
    4. A recent rape episode experienced by the client
829. The nurse is conducting an initial assessment of a client in crisis. When assessing the client's perception of the precipitating event that led to the

crisis, which is the **most appropriate** question?

1. "With whom do you live?"
2. "Who is available to help you?"
3. "What leads you to seek help now?"
4. "What do you usually do to feel better?"

830. The nurse is creating a plan of care for a client in a crisis state. When developing the plan, the nurse should consider which factor?
    1. A crisis state indicates that the client has a mental illness.
    2. A crisis state indicates that the client has an emotional illness.
    3. Presenting symptoms in a crisis situation are similar for all clients experiencing a crisis.
    4. A client's response to a crisis is individualized and what constitutes a crisis for one client may not constitute a crisis for another client.
831. The nurse in the emergency department is caring for a young female victim of sexual assault. The client's physical assessment is complete, and physical evidence has been collected. The nurse notes that the client is withdrawn, distracted, tremulous, and bewildered at times. How should the nurse interpret these behaviors?
    1. Signs of depression
    2. Reactions to a devastating event
    3. Evidence that the client is a high suicide risk
    4. Indicative of the need for hospital admission
832. A depressed client on an inpatient unit says to the nurse, "My family would be better off without me." Which is the nurse's **best** response?
    1. "Have you talked to your family about this?"
    2. "Everyone feels this way when they are depressed."
    3. "You will feel better once your medication begins to work."
    4. "You sound very upset. Are you thinking of hurting yourself?"
833. The nurse has been closely observing a client who has been displaying aggressive behaviors. The nurse observes that the behavior displayed by the client is escalating. Which nursing intervention is **most** helpful to this client at this time? **Select all that apply.**
    - ☐ 1. Initiate confinement measures.
    - ☐ 2. Acknowledge the client's behavior.
    - ☐ 3. Assist the client to an area that is quiet.
    - ☐ 4. Maintain a safe distance from the client.
    - ☐ 5. Allow the client to take control of the situation.
834. Which behavior observed by the nurse indicates a suspicion that a depressed adolescent client may be suicidal?
    1. The adolescent gives away a DVD and a cherished autographed picture of a performer.
    2. The adolescent runs out of the therapy group, swearing at the group leader, and to her room.
    3. The adolescent becomes angry while speaking on the telephone

and slams down the receiver.
4. The adolescent gets angry with her roommate when the roommate borrows the client's clothes without asking.

835. The police arrive at the emergency department with a client who has lacerated both wrists. Which is the **initial** nursing action?
1. Administer an antianxiety agent.
2. Assess and treat the wound sites.
3. Secure and record a detailed history.
4. Encourage and assist the client to ventilate feelings.

836. A moderately depressed client who was hospitalized 2 days ago suddenly begins smiling and reporting that the crisis is over. The client says to the nurse, "I'm finally cured." Based on the client's behavior and statement, which intervention should the nurse include in the plan?
1. Suggesting a reduction of medication
2. Allowing increased "in-room" activities
3. Increasing the level of suicide precautions
4. Allowing the client off-unit privileges as needed

837. The nurse is planning care for a client being admitted to the nursing unit who attempted suicide. Which **priority** nursing intervention should the nurse include in the plan of care?
1. One-to-one suicide precautions
2. Suicide precautions with 30-minute checks
3. Checking the whereabouts of the client every 15 minutes
4. Asking the client to report suicidal thoughts immediately

838. The emergency department nurse is caring for an adult client who is a victim of family violence. Which **priority** information should be included in the discharge instructions?
1. Information regarding shelters
2. Instructions regarding calling the police
3. Instructions regarding self-defense classes
4. Explaining the importance of leaving the violent situation

839. A female victim of a sexual assault is being seen in the crisis center. The client states that she still feels "as though the rape just happened yesterday," even though it has been a few months since the incident. Which is the **most appropriate** nursing response?
1. "You need to try to be realistic. The rape did not just occur."
2. "It will take some time to get over these feelings about your rape."
3. "Tell me more about the incident that causes you to feel like the rape just occurred."
4. "What do you think that you can do to alleviate some of your fears about being raped again?"

840. A client is admitted to the mental health unit after an attempted suicide by hanging. The nurse can **best** ensure client safety by which action?
1. Requesting that a peer remain with the client at all times.
2. Removing the client's clothing and placing the client in a hospital gown.
3. Assigning to the client a staff member who will remain with the client at all times.

4. Admitting the client to a seclusion room where all potentially dangerous articles are removed.

841. A client is admitted with a recent history of severe anxiety following a home invasion and robbery. During the initial assessment interview, which statement by the client should indicate to the nurse the possible diagnosis of post-traumatic stress disorder? **Select all that apply.**

- ☐ 1. "I'm afraid of spiders."
- ☐ 2. "I keep reliving the robbery."
- ☐ 3. "I see his face everywhere I go."
- ☐ 4. "I don't want anything to eat now."
- ☐ 5. "I might have died over a few dollars in my pocket."
- ☐ 6. "I have to wash my hands over and over again many times."

Answers

827. ***Answer:*** 3

Rationale: The most appropriate statement is to ask the client what is causing the agitation. This will assist the client to become aware of the behavior and may assist the nurse in planning appropriate interventions for the client. Option 1 is demanding behavior that could cause increased agitation in the client. Options 2 and 4 are threats to the client and are inappropriate.

Test-Taking Strategy: Note the **strategic words**, *most appropriate.* Eliminate option 1 because of the demand that it places on the client. Eliminate options 2 and 4 because they indicate threats to the client.

Level of Cognitive Ability: Applying
Client Needs: Psychosocial Integrity
Integrated Process: Communication and Documentation
Content Area: Mental Health
Health Problem: Mental Health: Abusive Behaviors
Priority Concepts: Anxiety; Communication
Reference: Varcarolis (2017), pp. 140, 143.

828. ***Answer:*** 2

Rationale: A situational crisis arises from external rather than internal sources. External situations that could precipitate a crisis include loss or change of a job, the death of a loved one, abortion, change in financial status, divorce, addition of new family members, pregnancy, and severe illness. Options 1, 3, and 4 identify adventitious crises. An adventitious crisis refers to a crisis of disaster, is not a part of everyday life, and is unplanned and accidental. Adventitious crises may result from a natural disaster (e.g., floods, fires, tornadoes, earthquakes), a national disaster (e.g., war, riots, airplane crashes), or a crime of violence (e.g., rape, assault, murder in the

workplace or school, bombings, or spousal or child abuse).

Test-Taking Strategy: Note the **subject**, situational crisis. Recall that this type of crisis arises from an external source, is often unanticipated, and is associated with a life event that upsets an individual's or group's psychological equilibrium. This will direct you to the correct option.

Level of Cognitive Ability: Applying
Client Needs: Psychosocial Integrity
Integrated Process: Nursing Process—Planning
Content Area: Mental Health
Health Problem: Mental Health: Anxiety Disorder
Priority Concepts: Anxiety; Coping
Reference: Varcarolis (2017), pp. 325-326.

829. ***Answer:*** 3

Rationale: The nurse's initial task when assessing a client in crisis is to assess the individual or family and the problem. The more clearly the problem can be defined, the better the chance a solution can be found. The correct option would assist in determining data related to the precipitating event that led to the crisis. Options 1 and 2 assess situational supports. Option 4 assesses personal coping skills.

Test-Taking Strategy: Note the **strategic words**, *most appropriate*. Also note the **subject**, assessment techniques for the client in crisis, and note the words *precipitating event* and *led to the crisis*. Eliminate options 1 and 2, because these data would determine support systems. Eliminate option 4, because this question would be asked when determining coping skills.

Level of Cognitive Ability: Analyzing
Client Needs: Psychosocial Integrity
Integrated Process: Nursing Process—Assessment
Content Area: Mental Health
Health Problem: Mental Health: Crisis
Priority Concepts: Anxiety; Coping
Reference: Varcarolis (2017), pp. 327-329.

830. ***Answer:*** 4

Rationale: Although each crisis response can be described in similar terms as far as presenting symptoms are concerned, what constitutes a crisis for one client may not constitute a crisis for another client, because each is a unique individual. Being in the crisis state does not mean that the client has a mental or emotional illness.

Test-Taking Strategy: Eliminate option 3 because of the **closed-ended word** "all." Next, eliminate options 1 and 2, because a crisis does not indicate "illness."

Level of Cognitive Ability: Creating
Client Needs: Psychosocial Integrity
Integrated Process: Nursing Process—Planning
Content Area: Mental Health
Health Problem: Mental Health: Crisis
Priority Concepts: Caregiving; Coping

Reference: Varcarolis (2017), p. 329.

831. ***Answer:*** 2

Rationale: During the acute phase of the rape crisis, the client can display a wide range of emotional and somatic responses. The symptoms noted indicate an expected reaction. Options 1, 3, and 4 are incorrect interpretations.
Test-Taking Strategy: Note the **subject**, client response to a crisis. Use knowledge regarding client responses to devastating events and focus on the symptoms noted in the question to direct you to the correct option.
Level of Cognitive Ability: Analyzing
Client Needs: Psychosocial Integrity
Integrated Process: Nursing Process—Assessment
Content Area: Mental Health
Health Problem: Mental Health: Crisis
Priority Concepts: Caregiving; Coping
Reference: Varcarolis (2017), pp. 354-355.

832. ***Answer:*** 4

Rationale: Clients who are depressed may be at risk for suicide. It is critical for the nurse to assess suicidal ideation and plan. The nurse should ask the client directly whether a plan for self-harm exists. Options 1, 2, and 3 do not deal directly with the client's feelings.
Test-Taking Strategy: Note the **strategic word**, *best.* Recalling **therapeutic communication techniques** will assist in directing you to the correct option. Option 4 is the only option that deals directly with the client's feelings. In addition, clients at risk for suicide need to be assessed directly regarding the potential for self-harm.
Level of Cognitive Ability: Applying
Client Needs: Psychosocial Integrity
Integrated Process: Communication and Documentation
Content Area: Mental Health
Health Problem: Mental Health: Suicide
Priority Concepts: Clinical Judgment; Safety
Reference: Varcarolis (2017), pp. 207, 367-368.

833. ***Answer:*** 2, 3, 4

Rationale: During the escalation period, the client's behavior is moving toward loss of control. Nursing actions include taking control, maintaining a safe distance, acknowledging behavior, moving the client to a quiet area, and medicating the client if appropriate. To initiate confinement measures during this period is inappropriate. Initiation of confinement measures, if needed, is most appropriate during the crisis period.
Test-Taking Strategy: Focus on the **strategic word**, *most*, and focus on the subject, the most helpful nursing interventions. Also note the words *aggressive behaviors* and *escalating*. Recalling that, during the escalation period, the client's behavior is

moving toward loss of control and that the least restrictive measures should be used will direct you to the correct options.
Level of Cognitive Ability: Analyzing
Client Needs: Psychosocial Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Mental Health
Health Problem: Mental Health: Violence
Priority Concepts: Clinical Judgment; Safety
Reference: Varcarolis (2017), pp. 379-380.

834. ***Answer:*** 1

Rationale: A depressed suicidal client often gives away that which is of value as a way of saying goodbye and wanting to be remembered. Options 2, 3, and 4 deal with anger and acting-out behaviors that are often typical of an adolescent.
Test-Taking Strategy: Eliminate options 2, 3, and 4 because they are **comparable or alike**. The correct option is different and is an action that could indicate that the client may be "saying goodbye."
Level of Cognitive Ability: Analyzing
Client Needs: Psychosocial Integrity
Integrated Process: Nursing Process—Assessment
Content Area: Mental Health
Health Problem: Mental Health: Suicide
Priority Concepts: Mood and Affect; Safety
Reference: Varcarolis (2017), p. 366.

835. ***Answer:*** 2

Rationale: The initial nursing action is to assess and treat the self-inflicted injuries. Injuries from lacerated wrists can lead to a life-threatening situation. Other interventions, such as options 1, 3, and 4, may follow after the client has been treated medically.
Test-Taking Strategy: Note the **strategic word**, *initial*. Use **Maslow's Hierarchy of Needs theory** to prioritize. Physiological needs come first. The correct option addresses the physiological need.
Level of Cognitive Ability: Applying
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Complex Care: Emergency Situations: Management
Health Problem: Mental Health—Suicide
Priority Concepts: Caregiving; Safety
Reference: Varcarolis (2017), p. 367.

836. ***Answer:*** 3

Rationale: A client who is moderately depressed and has only been in the hospital 2 days is unlikely to have such a dramatic cure. When a depression suddenly lifts, it

is likely that the client may have made the decision to harm herself or himself. Suicide precautions are necessary to keep the client safe. The remaining options are therefore incorrect interpretations.

Test-Taking Strategy: Focus on the **subject**, suicide precautions. Options 1 and 4 support the client's notion that a cure has occurred. Option 2 allows the client to increase self-isolation and would present a threat to the client's safety. Knowing that safety is of the utmost importance will direct you to the correct option.

Level of Cognitive Ability: Analyzing
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Planning
Content Area: Mental Health
Health Problem: Mental Health: Mood Disorders
Priority Concepts: Caregiving; Safety
Reference: Varcarolis (2017), pp. 369-370.

837. ***Answer:*** 1

Rationale: One-to-one suicide precautions are required for a client who has attempted suicide. Options 2 and 3 may be appropriate, but not at the present time, considering the situation. Option 4 also may be an appropriate nursing intervention, but the priority is identified in the correct option. The best intervention is constant supervision so that the nurse may intervene as needed if the client attempts to harm herself or himself.

Test-Taking Strategy: Focus on the **strategic word**, *priority*, noting the words *attempted suicide*. The correct option is the only one that provides a safe environment.

Level of Cognitive Ability: Applying
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Implementation
Content Area: Complex Care: Emergency Situations: Management
Health Problem: Mental Health: Suicide
Priority Concepts: Caregiving; Safety
Reference: Varcarolis (2017), pp. 369.

838. ***Answer:*** 1

Rationale: Tertiary prevention of family violence includes assisting the victim after the abuse has already occurred. The nurse should provide the client with information regarding where to obtain help, including a specific plan for removing the self from the abuser and information regarding escape, hotlines, and the location of shelters. An abused person is usually reluctant to call the police. Teaching the victim to fight back is not the appropriate action for the victim when dealing with a violent person. Explaining the importance of leaving the violent situation is important, but a specific plan is necessary.

Test-Taking Strategy: Note the **strategic word**, *priority*. Focus on the **subject** of the question, which relates to providing the client with a safe environment. The correct option provides a specific plan for safety.

Level of Cognitive Ability: Applying

Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Implementation
Content Area: Mental Health
Health Problem: Mental Health: Violence
Priority Concepts: Interpersonal Violence; Safety
Reference: Varcarolis (2017), pp. 330-331, 343.

839. ***Answer:*** 3

Rationale: The correct option allows the client to express her ideas and feelings more fully and portrays a nonhurried, nonjudgmental, supportive attitude on the part of the nurse. Clients need to be reassured that their feelings are normal and that they may express their concerns freely in a safe, caring environment. Option 1 immediately blocks communication. Option 2 places the client's feelings on hold. Option 4 places the problem solving totally on the client.

Test-Taking Strategy: Note the **strategic words**, *most appropriate*. Also, focus on the **subject**, that the client feels that the rape just happened yesterday. Use **therapeutic communication techniques**. The correct option is the only one that addresses the client's feelings. Always address the client's feelings first.

Level of Cognitive Ability: Applying
Client Needs: Psychosocial Integrity
Integrated Process: Caring
Content Area: Mental Health
Health Problem: Mental Health: Therapeutic Communication
Priority Concepts: Communication; Coping
Reference: Varcarolis (2017), p. 355.

840. ***Answer:*** 3

Rationale: Hanging is a serious suicide attempt. The plan of care must reflect action that ensures the client's safety. Constant observation status (one-to-one) with a staff member is the best choice. Placing the client in a hospital gown and requesting that a peer remain with the client would not ensure a safe environment. Seclusion should not be the initial intervention, and the least restrictive measure should be used.

Test-Taking Strategy: Note the **strategic word**, *best.* Focus on the **subject**, care of the client at risk for suicide. Eliminate option 4, because seclusion should not be the initial intervention. Eliminate option 1 next, because safeguarding a client is not the peer's responsibility. Eliminate option 2, because removing one's clothing would not maximize all possible safety strategies.

Level of Cognitive Ability: Applying
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Implementation
Content Area: Mental Health
Health Problem: Mental Health: Suicide
Priority Concepts: Caregiving; Safety
Reference: Varcarolis (2017), p. 367.

841. ***Answer:*** 2, 3, 5

Rationale: Reliving an event, experiencing emotional numbness (facing possible death), and having flashbacks of the event (seeing the same face everywhere) are all common occurrences with post-traumatic stress disorder. The statement "I'm afraid of spiders" relates more to having a phobia. The statement "I have to wash my hands over and over again many times" describes ritual compulsive behaviors to decrease anxiety for someone with obsessive-compulsive disorder. Stating "I don't want anything to eat now" is vague and could relate to numerous conditions.

Test-Taking Strategy: Focus on the **subject**, post-traumatic stress disorder. There is no indication about a fear of spiders being part of the problem. There is no information in the question to support that the client has ritual behaviors. The client stating that they do not want anything to eat at the time is not relevant to this client's situation. Responses 2, 3, and 5 all indicate that the client is experiencing post-traumatic stress disorder from a recent home invasion and robbery event.

Level of Cognitive Ability: Analyzing
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Assessment
Content Area: Mental Health
Health Problem: Mental Health: Post-Traumatic Stress Disorder
Priority Concepts: Anxiety; Coping
Reference: Varcarolis (2017), p. 123.