

11 Milieu Therapy—The Therapeutic Community

CORE CONCEPTS

Milieu Therapy

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KEY TERMS

milieu

therapeutic community

OBJECTIVES

After reading this chapter, the student will be able to:

1. Define *milieu therapy*.
2. Explain the goal of therapeutic community/milieu therapy.
3. Identify seven basic assumptions of a therapeutic community.
4. Discuss conditions that characterize a therapeutic community.
5. Identify the various therapies that may be included in the program of the therapeutic community and the health-care workers that make up the interdisciplinary treatment team.
6. Describe the role of the nurse in establishing and maintaining a therapeutic milieu.

HOMEWORK ASSIGNMENT

Please read the chapter and answer the following questions:

1. How are unit rules established in a therapeutic community setting?
2. Which member of the interdisciplinary treatment team has a focus on rehabilitation and vocational training?
3. How are client responsibilities assigned in the therapeutic community setting?
4. Which member of the interdisciplinary treatment team serves as the leader?

Standard 5F of the *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (American Nurses Association [ANA], American Psychiatric Nurses Association, & International Society of Psychiatric Nurses, 2014) states, “The psychiatric-mental health nurse provides, structures, and maintains a safe, therapeutic, and recovery-oriented environment in collaboration with healthcare consumers, families, and other healthcare clinicians” (p. 60).

This chapter defines and explains the goal of milieu therapy. The conditions necessary for a therapeutic environment are discussed, and the roles of the various health-care workers within the interdisciplinary team are delineated. An interpretation of the nurse’s role in milieu therapy is included.

Milieu, Defined

The word **milieu**, French for “middle,” is translated in English as “surroundings, or environment.” In psychiatry, therapy involving the milieu, or environment, may be called milieu therapy, the **therapeutic community**, or the therapeutic environment. The goal of milieu therapy is to manipulate the environment so that all aspects of the client’s hospital experience are considered therapeutic. Within this therapeutic community setting, the client is expected to learn

adaptive coping, interaction, and relationship skills that can be adapted to other aspects of his or her life.

CORE CONCEPT

Milieu Therapy

A scientific structuring of the environment in order to effect behavioral changes and improve the psychological health and functioning of the individual (Skinner, 1979).

Current Status of the Therapeutic Community

Milieu therapy came into its own from the 1960s through early 1980s. During this period, psychiatric inpatient treatment provided sufficient time to implement programs of therapy aimed at social rehabilitation. Lengths of stay averaged from 28 to 30 days for acute care hospitalizations and several months or years for long-term hospitalizations. Nursing's focus on establishing interpersonal relationships with patients fit well within this concept of therapy. Patients were encouraged to be active participants in their therapy, and individual autonomy was emphasized.

The current focus of inpatient psychiatric care has changed. Acute care hospitalization lengths of stay now average 2 to 3 days. Hall (1995) stated:

Care in inpatient psychiatric facilities can now be characterized as short and biologically based. By the time patients have stabilized enough to benefit from the socialization that would take place in a milieu as treatment program, they [often] have been discharged. (p. 51)

Although strategies for milieu therapy are still used, they have been modified to conform to the short-term approach to care or to outpatient treatment programs. Some programs (e.g., those for children and adolescents, clients with substance addictions, and geriatric clients) have successfully adapted the concepts of milieu treatment to their specialty needs (Jani & Fishman, 2004; Menninger Clinic, 2019; O-School, 2018; Valley View, 2019). Evidence supports

the benefits of therapeutic communities in prison settings for individuals with substance use disorders (National Institutes of Health [NIH], 2015). In this context, work assignments, peer support, formal treatment, and accepting responsibility for one's actions are key elements, and the therapeutic community treatment may last 12 months or more. Evidence also supports milieu therapy for longer-term treatment of patients with schizophrenia. For these patients, milieu therapy yields positive benefits at lower doses of antipsychotic medications, leading researchers to conclude that the positive emotional experience of milieu therapy is not only an important aspect of treatment but one that may enable lower doses of medication (Ciompi & Hoffman, 2004; Kvarnstrom, 2017).

Echternacht (2001) suggested that more emphasis should be placed on unstructured components of milieu therapy. She described these components as a multitude of complex interactions between patients, staff, and visitors that occur around the clock. Echternacht called these interactions "fluid group work." They involve spontaneous opportunities within the milieu environment for the psychiatric nurse to provide "on-the-spot therapeutic interventions designed to enhance socialization competency and interpersonal relationship awareness. Emphasis is on social skills and activities in the context of interpersonal interactions" (p. 40). With fluid group work, the nurse applies psychotherapeutic knowledge and skills to brief clinical encounters that occur spontaneously in the therapeutic milieu setting. Echternacht believes that by using these techniques, nurses can "reclaim their milieu therapy functions in the midst of a changing health care environment" (p. 40).

Meehan (2019) expands the concept of therapeutic milieu beyond the environment, describing it as a "distinctive nurse-created, nurse-led healing culture and atmosphere" within a nursing practice setting. In this description, the therapeutic milieu becomes an element of a professional practice model in which the nurse's attitudes and actions are central in constructing an environment that is "soothing and provides optimal safety and comfort."

Many of the original concepts of milieu therapy are presented in this chapter. It is important to remember that modifications to these

concepts are applied for practice in a variety of settings.

Basic Assumptions

Skinner (1979) outlined seven basic assumptions on which a therapeutic community is based:

- 1. The health in each individual is to be realized and encouraged to grow.** All individuals are considered to have strengths as well as limitations. These healthy aspects of the individual are identified and serve as a foundation for personality growth and the ability to function adaptively and productively in all aspects of life.
- 2. Every interaction is an opportunity for therapeutic intervention.** Within this structured setting, it is virtually impossible to avoid interpersonal interaction. The ideal situation exists for patients to improve communication and relationship development skills. Learning occurs from immediate feedback of personal perceptions.
- 3. Each individual owns his or her own environment.** Patients should have the opportunity to make decisions and solve problems related to the environment (milieu) of the unit. In this way, personal needs for autonomy as well as needs that pertain to the group as a whole are fulfilled.
- 4. Each individual owns his or her own behavior.** Each individual within the therapeutic community is expected to take responsibility for his or her actions.
- 5. Peer pressure is a useful and powerful tool.** Behavioral group norms are established through peer pressure. Feedback is direct and frequent so that behaving in a manner acceptable to the other members of the community becomes essential.
- 6. Inappropriate behaviors are dealt with as they occur.** Individuals examine the significance of their behavior, look at how it affects other people, and discuss more appropriate ways of behaving in certain situations.

7. Restrictions and punishment are to be avoided. Destructive behaviors can usually be controlled with group discussion. However, if an individual requires external controls, temporary isolation is preferred over lengthy restriction or other harsh consequences.

Conditions That Promote a Therapeutic Community

In a therapeutic community setting, the setting is the foundation, and everything that happens to the client or within the client's environment is considered part of the treatment program. Community factors—such as social interactions, the physical structure of the treatment setting, and schedule of activities—may generate negative responses from some clients. These stressful experiences are used as examples to help the client learn how to manage stress more adaptively in real-life situations.

Under what conditions, then, is a hospital environment considered therapeutic? Gunderson (1978) identified five elements of a community environment that are necessary for therapeutic outcomes:

- 1. Containment.** The environment is contained to create a sense of safety and security. Patients who are struggling with strong suicidal intentions, for example, often find that locked doors and lack of access to easy methods of self-harm provide the containment they need to resist self-destructive impulses.
- 2. Structure.** The environment needs to have a structure that promotes the goals of treatment. This includes a schedule of activities so that patients know what, when, and where activities are taking place. Group therapies, for example, are scheduled at specific times so patients can structure their day to attend. Knowing to whom they should go (perhaps a primary nurse or team leader) to express concerns, ask for medication, or contact other team members is another aspect of unit structure that promotes therapeutic outcomes.

- 3. Involvement.** The environment must encourage involvement so that patients develop a sense of social community. Common dining areas, small group seating arrangements, and community meetings to discuss aspects of community living are examples of elements that promote involvement.
- 4. Support.** The environment must be supportive and affirming rather than rigid or punitive. The nurse plays an active role in offering emotional support, reinforcing the expectations within the community environment to promote supportive interaction, and redirecting patients who are struggling to accomplish therapeutic interaction with others. Support also includes creating a sense that patients are not only involved in treatment but empowered in decision making and direction about their care.
- 5. Validation.** The environment must support and affirm the needs of the individual both within and separate from the community. Active, empathic listening to the patient's perceptions and concerns and promoting autonomy are examples of validation.

The Program of Therapeutic Community

Care for patients in the therapeutic community is coordinated by an interdisciplinary treatment (IDT) team. An initial assessment is made by the admitting psychiatrist, nurse, or other designated admitting agent who, in collaboration with the patient, establishes priorities for care. The IDT team then develops a comprehensive treatment plan and goals of therapy and assigns intervention responsibilities. (See [Box 11-1](#) for a QSEN teaching strategy on teamwork and collaboration within the interdisciplinary treatment team.) All members sign the treatment plan and meet regularly to update the plan as needed. Depending on the size of the treatment facility and scope of the therapy program, members representing a variety of disciplines may participate in the promotion of a therapeutic community. For example, an IDT team may include a psychiatrist, clinical psychologist, psychiatric clinical nurse specialist, psychiatric nurse, mental health technician, psychiatric social worker,

occupational therapist, recreational therapist, art therapist, music therapist, dietitian, and chaplain.



The patient, whenever possible, should be at the center of this team process and an active participant in decisions about the treatment plan. The essence of patient-centered care emphasizes patient involvement and decision-making authority unless the patient's cognitive processes and decision-making abilities are so impaired by illness that they are harmful to self or others. [Table 11–1](#) provides an explanation of the responsibilities and educational preparation required for professional members of the IDT team.

The Role of the Nurse in Milieu Therapy

One of the initial nursing interventions in establishing a foundation for trust and a therapeutic milieu is orienting the new patient to the environment, his or her rights and responsibilities within the unit milieu, the structured activities designed for personal growth, and any limits or restrictions necessary to maintain safety. Availability to provide support and validation to patients throughout their treatment is also an essential nursing competency in milieu therapy (ANA et al., 2014), and this, too, is rooted in a trusting relationship. Active listening and inquiring about the patient's expectations for treatment are key communication skills in providing support and validation and in establishing a foundation for patient-centered care.

BOX 11–1 QSEN TEACHING STRATEGY

Assignment: Interviewing Members of the Interdisciplinary Team (IDT)

The Process of Teamwork and Collaboration

Competency Domain: Teamwork and Collaboration, Safety

Learning Objectives: Student will:

- Explain the process for collaboration between nursing and other members of the interdisciplinary team.
- Identify different team members' responsibilities regarding key safety issues such as suicide prevention, reporting to outside individuals and agencies regarding suspicions of abuse and duty to warn, and managing safety within the therapeutic milieu.
- Evaluate the contributions of each discipline within the interdisciplinary team to elements of milieu therapy.

Strategy Overview: This assignment is meant to familiarize the student with the roles and responsibilities of various members of the IDT and to evaluate the processes that promote teamwork and collaboration within milieu therapy. Students may be assigned to specific activities in preparation for a clinical conference discussion or asked to complete a reflective writing assignment on the function of the IDT in the provision of milieu therapy.

1. Attend an interdisciplinary treatment team meeting to evaluate individual disciplines' contributions and describe the process of collaboration.
2. Interview one or more members of the IDT to identify their perceptions of how the process of collaboration works between their discipline and nursing. Sample questions might include the following:
In what ways does your discipline collaborate with nursing?
How effective is the collaboration between disciplines within the IDT?
What barriers exist to effective collaboration between disciplines?
What is your discipline's role in:
 - Suicide prevention within the milieu?
 - Reporting to outside individuals or agencies?
 - Managing safety within the milieu?
3. Attend structured group activities to evaluate the contributions of various team members in promoting the therapeutic milieu.

TABLE 11–1 The Interdisciplinary Treatment Team in Psychiatry

TEAM MEMBER	RESPONSIBILITIES	CREDENTIALS
Psychiatrist	Serves as the leader of the team. Responsible for diagnosis and treatment of mental disorders. Performs psychotherapy; prescribes medication and other somatic therapies.	Medical degree with residency in psychiatry and license to practice medicine.
Clinical psychologist	Conducts individual, group, and family therapy. Administers, interprets, and evaluates psychological tests that assist in the diagnostic process.	Doctorate in clinical psychology with 2- to 3-year internship supervised by a licensed clinical psychologist. State license is required to practice.
Psychiatric clinical nurse specialist or psychiatric nurse practitioner	Conducts individual, group, and family therapy. Presents educational programs for nursing staff. Provides consultation services to nurses who require assistance in the planning and implementation of care for individual patients. May also prescribe and manage the medication regimen.	Registered nurse with a minimum of a master's degree in psychiatric nursing. Some institutions require certification by national credentialing association.
Psychiatric nurse	Provides ongoing mental and physical assessment of client condition. Manages the therapeutic milieu on a 24-hour basis. Administers medications. Assists clients with all therapeutic activities as required. Focus is on one-to-one relationship development.	Registered nurse with hospital diploma, associate degree, or baccalaureate degree. Some psychiatric nurses have national certification.
Mental health technician (also called psychiatric aide or assistant	Functions under the supervision of the psychiatric nurse. Provides assistance to clients in the fulfillment of their activities of daily living. Assists activity therapists as	Varies by state. Requirements include high school education, with additional vocational education

or psychiatric technician)

required in conducting their groups. May also participate in one-to-one relationship development.

or on-the-job training. Some hospitals hire individuals with a baccalaureate degree in psychology in this capacity. Some states require a licensure examination to practice.

Psychiatric social worker

Conducts individual, group, and family therapy. Is concerned with client's social needs, such as placement, financial support, and community requirements. Conducts in-depth psychosocial history on which the needs assessment is based. Works with client and family to ensure that requirements for discharge are fulfilled and needs can be met by appropriate community resources.

Minimum of a master's degree in social work. Some states require additional supervision and subsequent licensure by examination.

Occupational therapist

Works with clients to help develop (or redevelop) independence in performance of activities of daily living. Focus is on rehabilitation and vocational training in which clients learn to be productive, thereby enhancing self-esteem. Creative activities and therapeutic relationship skills are used.

Baccalaureate or master's degree in occupational therapy.

Recreational therapist

Uses recreational activities to promote clients to redirect their thinking or to rechannel destructive energy in an appropriate manner. Clients learn skills (e.g., bowling, volleyball, exercises, jogging) that can be used during leisure time and during times of stress following discharge from treatment. Some

Baccalaureate or master's degree in recreational therapy.

	programs include activities such as picnics, swimming, and group attendance at certain events (for example, the state fair).	
Music therapist	Encourages clients in self-expression through music. Clients listen to music, play instruments, sing, dance, and compose songs that help them get in touch with feelings and emotions that they may not be able to experience in any other way.	Graduate degree with a specialty in music therapy.
Art therapist	Uses the client's creative abilities to encourage the expression of emotions and feelings through artwork. Helps clients to analyze their own work in an effort to recognize and resolve underlying conflict.	Graduate degree with a specialty in art therapy.
Dietitian	Plans nutritious meals for all clients. Consults with clients with specific eating disorders, such as anorexia nervosa, bulimia nervosa, obesity, and pica.	Baccalaureate or master's degree with a specialty in dietetics.
Chaplain	Assesses, identifies, and attends to the spiritual needs of clients and their family members. Provides spiritual support and comfort as requested by the client or family. May provide counseling if educational background includes this type of preparation.	College degree with advanced education in theology, seminary, or rabbinical studies.

Milieu therapy can take place in a variety of inpatient and outpatient settings. In the hospital, nurses are generally the only professional members of the IDT team who spend time with the patients on a 24-hour basis, and they assume responsibility for management of the therapeutic milieu. In all settings, the nursing

process is used for the delivery of nursing care. In the management of the therapeutic milieu, the same model (ongoing assessment, diagnosis, outcome identification, planning, implementation, and evaluation) is necessary for effective treatment. Nurses are involved in all day-to-day activities that pertain to patient care, and their suggestions and options are given serious consideration in care planning for individual patients. Information from the initial nursing assessment is used to create the IDT plan. Nurses have input into therapy goals and participate in the regular updates and modification of treatment plans.

In some treatment facilities, a separate nursing care plan is required in addition to the IDT plan. In this case, the nursing care plan must reflect diagnoses specific to nursing and include problems and interventions from the IDT plan that have been assigned to the nurse.



Attention must be given to ensure that the nursing care plan effectively collaborates with the IDT plan so that care is coordinated and consistent among team members.

In the therapeutic milieu, nurses are responsible for ensuring that patients' physiological needs are met. Patients must be encouraged to perform as independently as possible in fulfilling activities of daily living. However, the nurse must make ongoing assessments and provide assistance for those who require it. Assessing physical status is an important nursing responsibility that must not be overlooked in a psychiatric setting.

Reality orientation for patients who have disorganized thinking or who are disoriented or confused is important in the therapeutic milieu. Clocks with large hands and numbers, calendars that give the day and date in large print, and orientation boards that discuss daily activities and news happenings can help keep patients oriented to reality. Nurses should ensure that patients have written schedules of assigned activities and that they arrive at those activities on schedule. Some patients may require an identification sign on their door to remind them which room is theirs. On short-term units, nurses who are dealing with psychotic patients usually rely on a

basic activity or topic that helps keep people oriented: for example, showing pictures of the hospital where they are housed, introducing people who were admitted during the night, and providing name badges with their first names.

Nurses are responsible for the management of medication administration on inpatient psychiatric units. In some treatment programs, patients are expected to accept the responsibility and request their medication at the appropriate time. Although ultimate responsibility lies with the nurse, he or she must encourage patients to be self-reliant. Nurses must work with the patients to determine methods that result in achievement and provide positive feedback for successes.

A major focus of nursing in the therapeutic milieu is the one-to-one relationship that grows out of developing trust between patient and nurse. Many patients with psychiatric disorders have never achieved the ability to trust. If trust can be developed in a relationship with the nurse, it may be generalized to other relationships in the patient's life. Within an atmosphere of trust, the patient is encouraged to express feelings and emotions and discuss unresolved issues that are creating problems in his or her life.

In acute care hospitalizations, the ability to establish trust quickly and to assess and collaborate with patients about their postdischarge needs has become an essential role for nurses, because many aspects of the recovery treatment plan will occur in treatment settings other than inpatient hospitalization. Do not underestimate the importance of these short-term relationships. Patients in outpatient treatment often identify that something a nurse said or something they learned within the hospital milieu planted the seeds for their ongoing recovery plan.

CLINICAL PEARL Developing trust means keeping promises. It means total acceptance of the individual as a person, separate from behavior that is unacceptable. It means responding to the patient with concrete actions that are easy to understand (e.g., “If you are frightened, I will stay with you”; “If you are cold, I will bring you a blanket”; “If you are thirsty, I will bring you a drink of water”).

The nurse is responsible for setting limits on unacceptable behavior in the therapeutic milieu. Establishing limits requires telling the patient in understandable terminology what behaviors are not acceptable and what the consequences will be if the limits are violated. These limits must be established, written, and carried out by all staff. Consistency in enforcing the consequences of violating the established limits is essential for learning is to be reinforced.

The role of patient teacher is important in the psychiatric area, as it is in all areas of nursing. Nurses must be able to assess learning readiness in individual patients. Do they want to learn? What is their level of anxiety? What is their level of ability to understand the information being presented? Topics for patient education in psychiatry include information about medical diagnoses, side effects of medications, the importance of continuing to take medications, and stress management, among others. Some topics must be individualized for specific patients, whereas others may be taught in group situations. [Table 11–2](#) outlines various topics of nursing concern for patient education in psychiatry. (Sample teaching guides are online.) Echternacht (2001) stated:

Milieu therapy interventions are recognized as one of the basic-level functions of psychiatric-mental health nurses as addressed [in the *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (ANA, 2014)]. Milieu therapy has been described as an excellent framework for operationalizing [Hildegard] Peplau’s interpretation and extension of Harry Stack Sullivan’s Interpersonal Theory for use in nursing practice. (p. 39)

TABLE 11–2 The Therapeutic Milieu—Topics for Patient Education

1. Ways to increase self-esteem
 2. Ways to deal with anger appropriately
 3. Stress-management techniques
 4. How to recognize signs of increasing anxiety and intervene to stop its progression
 5. Normal stages of grieving and behaviors associated with each stage
 6. Assertiveness techniques
 7. Relaxation techniques
 - a. Progressive muscle relaxation
 - b. Imagery (selectively)
 - c. Deep breathing
 - d. Mindfulness meditation
 8. Medications (specify)
 - a. Reason for taking
 - b. Harmless side effects
 - c. Side effects to report to physician
 - d. Importance of taking regularly
 - e. Importance of not stopping abruptly
 9. Effects of (substance) on the body
 - a. Alcohol
 - b. Other depressants
 - c. Stimulants
 - d. Hallucinogens
 - e. Narcotics
 - f. Cannabinoids
 10. Problem-solving skills
 11. Thought-stopping/thought-switching techniques
 12. Sex education including information about sexually transmitted infections
 13. The essentials of good nutrition
 14. Exploring spiritual needs
 15. Management of leisure time
 16. Strategies for goal setting and accomplishment
 17. (For parents/guardians)
 - a. Signs and symptoms of substance abuse
 - b. Effective parenting techniques
-

Therapeutic Milieu as a Professional Nursing Practice Model

In describing the therapeutic milieu as part of a professional practice model for nursing, Meehan (2019) identifies six principles of nursing practice that are relevant in any practice setting. Some of these principles are patient centered; others pertain to the nurses; and some are the responsibility of the health-care team. These principles are listed as follows:

- 1. Contagious calmness.** This principle refers to the nurse's ability to maintain composure, even during stressful events. Nurses encounter patients' anxiety on a daily basis, and the nurse's ability to respond with calm composure creates the foundation for a healing environment for the patient.
- 2. Respect for inherent human dignity.** Widely recognized as a core value in nursing, this principle can be overlooked in practice if not given careful thought. Patients with mental illness have been victims of stigmatizing attitudes and behaviors. Referring to patients with derogatory language such as "those crazies" or "nuts," even when doing so with other health-care professionals, devalues the inherent dignity of the patient.
- 3. Nurse's care for self and one another.** Caring for self implies attending to one's own needs to achieve inner and outer wellness. Caring for others implies attending to relational wellness. Nurses sometimes express that their relationships with patients and their relationships with other team members are two mutually exclusive entities. However, patients who see inconsistencies in how health-care professionals relate to one another and their patients may have more difficulty trusting that the milieu is safe and therapeutic.
- 4. Intellectual engagement.** The therapeutic milieu is developed and enhanced by the nurse's active engagement in critical thinking, creativity, and problem-solving around relevant practice issues. Examples may include exploring the best ways to maintain a safe environment or studying a patient care intervention to improve its effectiveness. Intellectual engagement is the essence

of quality improvement, which has been identified as an essential Quality and Safety Education for Nurses (QSEN) competency.

5. **Caritas.** Caritas refers to the nurse's ability to experience and express benevolent affection for patients regardless of their characteristics. Patients with mental illness may say things that are reflections of disrupted thought processes; they may be anxious and angry; they may behave in ways that are not socially acceptable. The ability to relate to patients with caritas, or what Carl Rogers (1951) (the founder of client-centered psychology) described as "unconditional positive regard," is foundational to establishing a healing, therapeutic environment.
6. **Safe and restorative physical surroundings.** In the inpatient psychiatric unit, safety of the physical environment is paramount. Many adjustments are made to doors, windows, and furniture to minimize risks for suicide or violence toward others. Standards and unit policies dictate the manner and frequency with which patients are observed and assessed to ensure their safety. All of these efforts communicate to the patient a concern for a safe, therapeutic milieu and begin to lay the foundation for establishing trust.

Whether the therapeutic milieu is adopted as a treatment strategy within psychiatric treatment settings or broadened in scope to be viewed as a professional practice model for nurses in any setting, evidence supports that establishing a therapeutic environment of care is essential to the development of trust, relationship building, and therapeutic outcomes in patient care.

Summary and Key Points

- In psychiatry, milieu therapy (or a therapeutic community) constitutes a manipulation of the environment to create behavioral changes and to improve the psychological health and functioning of the individual.
- The goal of a therapeutic community is for the patient to learn adaptive coping, interaction, and relationship skills that can be

generalized to other aspects of his or her life.

- The community environment itself serves as the primary tool of therapy.
- According to Skinner (1979), a therapeutic community is based on seven basic assumptions:
 1. The health in each individual is to be realized and encouraged to grow.
 2. Every interaction is an opportunity for therapeutic intervention.
 3. The patient owns his or her own environment.
 4. Each patient owns his or her behavior.
 5. Peer pressure is a useful and powerful tool.
 6. Inappropriate behaviors are dealt with as they occur.
 7. Restrictions and punishment are to be avoided.
- Because the goals of milieu therapy relate to helping patients learn to generalize that which is learned to other aspects of their lives, the conditions that promote a therapeutic community in the psychiatric setting are similar to the types of conditions that exist in real-life situations. Conditions that promote a therapeutic community include the following:
 - The fulfillment of basic physiological needs
 - Physical facilities that are conducive to the achievement of the goals of therapy
 - The existence of a democratic form of self-government
 - The assignment of responsibilities according to patient capabilities
 - A structured program of social and work-related activities
 - The inclusion of the community and family in the program of therapy in an effort to facilitate discharge from treatment
- The program of therapy on the milieu unit is conducted by the interdisciplinary team (IDT).
- The team centers on the patient and includes some or all of the following professionals (and potentially others): psychiatrist, clinical psychologist, psychiatric clinical nurse specialist or nurse practitioner, psychiatric nurse, mental health technician, psychiatric social worker, occupational therapist, recreational therapist, art therapist, music therapist, dietitian, and chaplain.

- Nurses play a crucial role in the management of a therapeutic milieu. They are involved in the assessment, diagnosis, outcome identification, planning, implementation, and evaluation of all treatment programs.
- Six principles for establishing therapeutic milieu as a practice model for nurses in any health-care setting are contagious calmness, respect for inherent human dignity, caring for self and others, intellectual engagement, caritas, and maintaining safe and restorative physical surroundings (Meehan, 2019).
- Nurses have significant input into the IDT plans, which are developed for all patients. They are responsible for ensuring that patients' basic needs are fulfilled; assessing physical and psychosocial status; administering medication; helping the patient develop trusting relationships; setting limits on unacceptable behaviors; educating patients; and, ultimately, helping patients, within the limits of their capability, to become productive members of society.

For additional resources, please visit
www.fadavis.com

Review Questions

1. Which of the following are basic assumptions of milieu therapy? (Select all that apply.)
 - a. The person owns his or her own environment.
 - b. Each person owns his or her behavior.
 - c. Peer pressure is a useful and powerful tool.
 - d. Inappropriate behaviors are punished immediately.
2. On the milieu unit, duties of the staff psychiatric nurse include which of the following? (Select all that apply.)
 - a. Medication administration
 - b. Client teaching
 - c. Medical diagnosis
 - d. Reality orientation

- e. Relationship development
 - f. Group therapy
3. Which of the following activities would be a responsibility of the clinical psychologist member of the IDT?
- a. Locates halfway house and arranges living conditions for client being discharged from the hospital
 - b. Manages the therapeutic milieu on a 24-hour basis
 - c. Administers and evaluates psychological tests that assist in diagnosis
 - d. Conducts psychotherapy and administers electroconvulsive therapy treatments
4. Which of the following activities would be a responsibility of the psychiatric clinical nurse specialist on the IDT team?
- a. Manages the therapeutic milieu on a 24-hour basis
 - b. Conducts group therapies and provides consultation and education to staff nurses
 - c. Directs a group of clients in acting out a situation that is otherwise too painful for a client to discuss openly
 - d. Locates halfway house and arranges living conditions for client being discharged from the hospital
5. A client who was sexually abused as a child is admitted to the inpatient psychiatric unit with a diagnosis of borderline personality disorder after a suicide attempt. She has refused to talk to anyone. Which of the following therapies might the IDT team recommend for this client? (Select all that apply.)
- a. Music therapy
 - b. Art therapy
 - c. Seclusion
 - d. Electroconvulsive therapy

Clinical Judgment Questions

6. In a medication education group, which of the following actions is most important for reinforcing the therapeutic milieu?

- a. Allowing each person a specific and equal amount of time to talk
 - b. Reviewing group rules and interpersonal behavior expectations that apply to all clients
 - c. Reading the medication information
 - d. Restricting the group to only those clients who are currently adhering to medication schedules
7. One of the goals of a therapeutic milieu is for clients to become more independent and accept self-responsibility. Which of the following approaches by staff best encourages the fulfillment of this goal?
- a. Including client input and decisions into the treatment plan
 - b. Insisting that each client take a turn leading a group activity
 - c. Making decisions for the client regarding plans for treatment
 - d. Requiring that the client bathe, dress, and attend breakfast on time each morning
8. A client is admitted to the inpatient psychiatric unit, appears anxious, and states, "I've never been on a unit like this before." Which of these actions by the nurse is a priority for beginning to establish a therapeutic milieu?
- a. Instruct the client to remain in his room until he feels less anxious.
 - b. Orient the client to the physical surroundings, milieu rules, and activities.
 - c. Offer to medicate the client with antianxiety medication.
 - d. Instruct the client not to worry because he will only be on the unit for a few days.
9. A client approaches the nurse and says, "I'm sick of the rules on this unit about not touching each other. I'm an adult and if I want to give one of the ladies a massage, it's my own business." Which of these responses best incorporates milieu therapy principles?
- a. "If you don't follow the established rules, you will be put in seclusion."
 - b. "You don't make the rules, so just do as you're told."

- c. "Why are you on this unit?"
 - d. "Let me try to explain why these rules are important for everyone's safety."
- 10.** A group of clients in a long-term psychiatric hospital setting complains to the nurse that they feel like there's not much to do during the day. One client says, "It seems like we're just sitting around watching TV all day." Which of these actions by the nurse best supports a therapeutic milieu?
- a. Instruct clients that the milieu is intentionally designed to provide for relaxation and minimal structured activities.
 - b. Suggest that the clients organize some games and activities for their peers.
 - c. Instruct these clients that they should be focusing on getting better rather than complaining.
 - d. Explore with clients and IDT members activities that would create more structure and support treatment goals.

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12 Crisis Intervention

CORE CONCEPTS

Crisis

CHAPTER OUTLINE

Objectives

Homework Assignment

Characteristics of a Crisis

Phases in the Development of a Crisis

Types of Crises

Crisis Intervention

Phases of Crisis Intervention: The Role of the Nurse

Disaster Nursing

Application of the Nursing Process to Disaster Nursing

Summary and Key Points

Review Questions

Clinical Judgment Questions

KEY TERMS

crisis intervention

disaster

OBJECTIVES

After reading this chapter, the student will be able to:

1. Define *crisis*.
2. Describe four phases in the development of a crisis.
3. Identify types of crises that occur in people's lives.
4. Discuss the goal of crisis intervention.
5. Describe the steps in crisis intervention.
6. Identify the role of the nurse in crisis intervention.
7. Apply the nursing process to care for victims of disasters.

HOMEWORK ASSIGNMENT

Please read the chapter and answer the following questions:

1. Name the three factors that determine whether or not a person experiences a crisis in response to a stressful situation.
2. What is the goal of crisis intervention?
3. Individuals in crisis need to develop more adaptive coping strategies. How does the nurse assist with this process?
4. Describe behaviors common to preschool children following a traumatic event.

Stressful situations are part of everyday life. Any stressful situation can precipitate a crisis. Crises result in a disequilibrium from which many individuals require assistance to recover. **Crisis intervention** and resolution require problem-solving skills that are often diminished by the level of anxiety accompanying disequilibrium. Assistance with problem-solving during the crisis period preserves self-esteem and promotes growth with resolution.

In recent years, individuals in the United States have been faced with a number of catastrophic events, including natural disasters such as tornados, earthquakes, hurricanes, and floods. Man-made disasters, such as the Oklahoma City and Boston Marathon bombings, the attacks on the World Trade Center and the Pentagon, and mass shootings have created considerable psychological stress in populations around the world.

This chapter examines the phases in the development of a crisis and the types of crises that occur in people's lives. The methodology of crisis intervention, including the role of the nurse, is explored. A discussion of disaster nursing is also presented.

CORE CONCEPT

Crisis

An acute event perceived by the individual as distressing and in which coping mechanisms and support systems are inadequate to manage associated anxiety.

Characteristics of a Crisis

The concept of crisis has several defining characteristics (Aguilera, 1998; Caplan, 1964):

1. Crisis occurs in all individuals at one time or another and is not necessarily equated with psychopathology.
2. Crises are precipitated by specific, identifiable events.
3. Crises are personal by nature. What may be considered a crisis situation by one individual may not be so for another.
4. Crises are acute, not chronic, and will be resolved in one way or another within a brief period.
5. A crisis situation contains the potential for psychological growth or deterioration.

Individuals who are in crisis feel helpless to change. They do not believe they have the resources to cope with the precipitating stressor. Levels of anxiety rise to the point that the individual becomes nonfunctional, thoughts become obsessional, and all behavior is aimed at relief of the anxiety being experienced. The feeling is overwhelming and may affect the individual physically as well as psychologically.

Bateman and Peternelj-Taylor (1998) have stated:

Outside Western culture, a crisis is often viewed as a time for movement and growth. The Chinese symbol for crisis consists of the characters for *danger* and *opportunity* [Fig. 12–1]. When a crisis is viewed as an opportunity for growth, those involved are much more capable of resolving related issues and more able to move toward positive changes. When the crisis experience is overwhelming because of its scope and nature or when there has not been adequate preparation for the necessary changes, the dangers seem paramount and overshadow any potential growth. The results are maladaptive coping and dysfunctional behavior. (pp.144–145)

危机

FIGURE 12-1 Chinese symbol for crisis.

Phases in the Development of a Crisis

The development of a crisis follows a relatively predictable course. Caplan (1964) outlined four phases through which individuals progress in response to a precipitating stressor and that culminate in the state of acute crisis.

Phase 1: *The individual is exposed to a precipitating stressor. Anxiety increases; previous problem-solving techniques are employed.*

Phase 2: *When previous problem-solving techniques do not relieve the stressor, anxiety increases further. The individual begins to feel a great deal of discomfort at this point. Coping techniques that have worked in the past are attempted, only to create feelings of helplessness when they are not successful. Feelings of confusion and disorganization prevail.*

Phase 3: *All possible resources, both internal and external, are called on to resolve the problem and relieve the discomfort. The individual may try to view the problem from a different perspective or even to overlook certain aspects of it. New problem-solving techniques may be used, and, if effectual, resolution may occur at this phase, with the individual returning to a higher, a lower, or the previous level of precrisis functioning.*

Phase 4: *If resolution does not occur in previous phases, Caplan states that “the tension mounts beyond a further threshold or its burden increases over time to a breaking point. Major disorganization of the individual with drastic results often occurs” (p. 41). Anxiety may reach panic levels. Cognitive functions are*

disordered, emotions are labile, and behavior may reflect the presence of psychotic thinking.

These phases are congruent with the transactional model of stress adaptation outlined in [Chapter 1](#), “The Concept of Stress Adaptation.” The relationship between the two perspectives is presented in [Figure 12-2](#). When an individual perceives a stressor as a threat to his or her well-being and lacks adaptive coping strategies or employs maladaptive strategies, crisis ensues. Similarly, Aguilera (1998) spoke of “balancing factors” that affect how an individual perceives and responds to

a precipitating stressor. A schematic of these balancing factors is illustrated in [Figure 12-3](#).

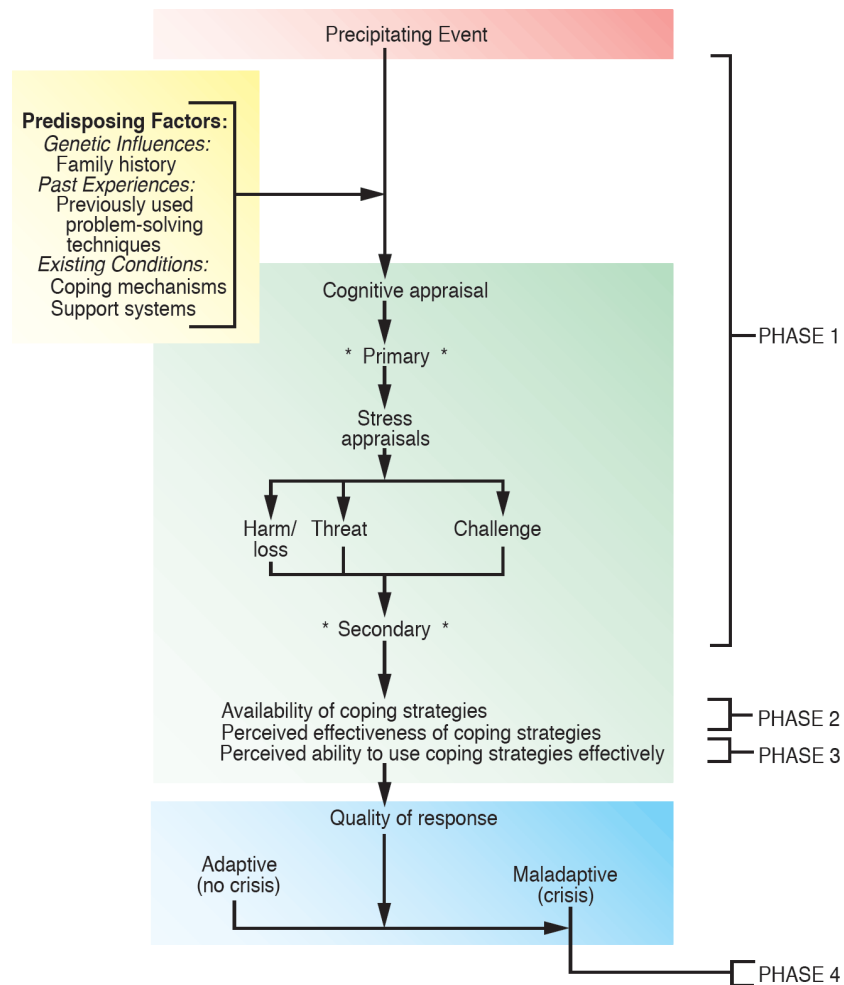


FIGURE 12-2 Relationship between transactional model of stress/adaptation and Caplan's phases in the development of a crisis.

The paradigm set forth by Aguilera suggests that whether or not an individual experiences a crisis in response to a stressful situation depends on the following three factors:

- 1. The individual's perception of the event:** If the event is perceived realistically, the individual is more likely to draw upon adequate resources to restore equilibrium. If the perception of the event is distorted, attempts at problem-solving are likely to be ineffective, and equilibrium is not restored.
- 2. The availability of situational supports:** Aguilera stated, "Situational supports are those persons who are available in the environment and who can be depended on to help solve the

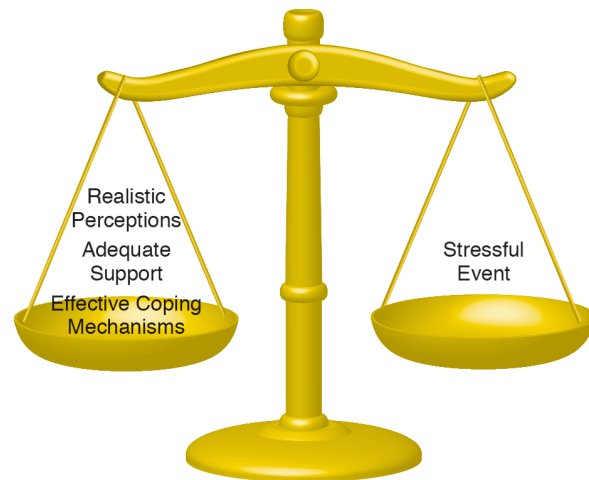
problem” (p. 37). Without adequate situational supports during a stressful situation, an individual is most likely to feel overwhelmed and alone.

- 3. The availability of adequate coping mechanisms:** When a stressful situation occurs, individuals draw upon behavioral strategies that have been successful for them in the past. If these coping strategies work, a crisis may be diverted. If not, disequilibrium may continue and tension and anxiety increase.

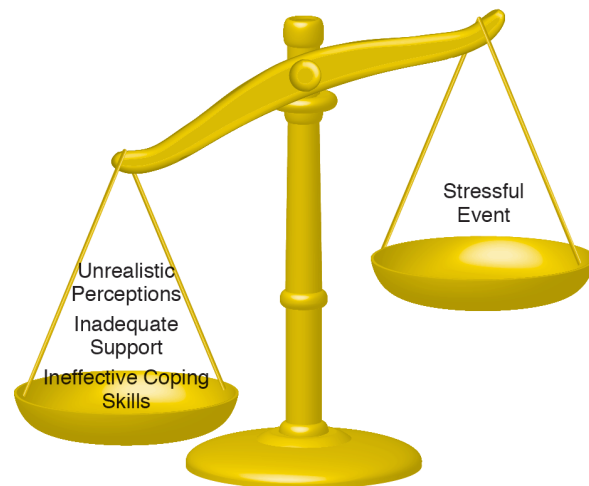
Crises are acute, time-limited situations that will be resolved in one way or another within 1 to 3 months. Crises can become growth opportunities when individuals learn new methods of coping that can be preserved and used when similar stressors recur. However, when new coping mechanisms or balancing factors are not identified and incorporated, the crisis can evolve into longer-term problems and sometimes symptoms of emotional or mental illness, including depression, anxiety, and trauma/stressor-related disorders.

Types of Crises

Baldwin (1978) identified six classes of emotional crises, which progress by degree of severity. As the measure of psychopathology increases, the source of the stressor changes from external to internal. The type of crisis determines the method of intervention selected.



Stressful event is balanced by realistic perceptions, adequate support, effective coping mechanisms → Equilibrium → No crisis



Problem unresolved → Disequilibrium → Crisis

FIGURE 12-3 The effect of balancing factors in a stressful event.

Class 1: Dispositional Crises

Definition An acute response to an external situational stressor.

Example

Brittany and Ethan have been married for 3 years and have a 1-year-old daughter. Ethan has been having difficulty with his boss at work. Twice during the past 6 months, he has exploded in anger at home and become abusive with Brittany. Last night he became angry that dinner was not ready when he expected. He grabbed the baby from Brittany and tossed her, screaming, into her crib. He hit and punched Brittany until she feared for her life. This morning when he left for work, she took the baby and went to the emergency department of the city hospital, not knowing what else to do.

Intervention Physical care of wounds and screening for domestic violence issues should be conducted in the emergency department. The mental health counselor can provide support and guidance in terms of presenting alternatives for managing the health and safety of herself and her child. The emergency department nurse should encourage and empower Brittany to clarify her needs and issues so referrals for agency assistance can be made.

Class 2: Crises of Anticipated Life Transitions

Definition Normal life-cycle transitions that are anticipated but over which the individual may feel a lack of control.

Example

College student J.T. is placed on probationary status because of low grades this semester. His wife had a baby and had to quit her job. He had increased his working hours from part time to full time to compensate and therefore had little time for studies. He presents himself to the student-health nurse practitioner complaining of numerous vague physical complaints.

Intervention Physical examination should be performed (physical symptoms could be caused by depression) and expression of feelings encouraged. Reassurance and support should be provided as needed. J.T. should be referred to services that can provide financial and other types of assistance. Problematic areas should be identified and approaches to change discussed.

Class 3: Crises Resulting From Traumatic Stress

Definition Crisis precipitated by an unexpected external stressor over which the individual has little or no control and as a result of which he or she feels emotionally overwhelmed and defeated.

Example

Ava is a waitperson whose shift ended at midnight. Two weeks ago, while walking to her car in the deserted parking lot, she was abducted by two men with guns, taken to an abandoned building, and raped and beaten. Since that time, her physical wounds have nearly healed. However, Ava cannot be alone; is constantly fearful; relives the experience in flashbacks and dreams; and is unable to eat, sleep, or work at her job in the restaurant. Her friend offers to accompany her to the mental health clinic.

Intervention The nurse should offer Ava the opportunity to talk about the experience and express her feelings about the trauma when she demonstrates readiness. The nurse should offer reassurance and support and discuss how rape may precipitate feelings of loss, including loss of control, power, and sense of self-worth, that trigger the grief response. After a discussion of the stages of grief, the nurse should identify support systems that can help Ava to resume her normal activities and explore new methods of coping with emotions arising from a situation with which she has had no previous experience. These interventions should be conducted in an environment that is sensitive to the impact of trauma on a person's sense of self, and all interventions should convey dignity, respect, and hopefulness and promote the patient's empowerment to make choices in her or his care (SAMHSA, 2014). See [Chapter 28](#), "Trauma- and Stressor-Related Disorders," for more information on trauma-informed care.

Class 4: Maturation/Developmental Crises

Definition Crises that occur in response to failed attempts to master developmental tasks associated with transitions in the life cycle.

Example

Jada and Caleb have been married for 2 years, and their firstborn child is 4 months old. Jada's mother was recently diagnosed with cancer, and the prognosis is unclear. Over the past 3 weeks, Jada has become increasingly anxious and disorganized, calling the nurse practitioner 10 to 15 times each day with new fears that she is not addressing her child's health needs. Jada has been screaming at Caleb that he is never there when she needs help with the baby and states she is thinking of dropping their child off at the Children's Service Agency because she believes they are both unable to be good parents. She agrees to see a counselor at Caleb's insistence.

Intervention The primary intervention is to help Jada with anxiety reduction. When individuals have intense anxiety, their ability to gain insight about contributing factors and explore options for behavior change is impaired. The safety of their child should also be carefully assessed. Referrals and guidance in parenting skills may lessen the anxiety associated with this new developmental phase. Anxiety and grief related to Jada's mother's illness could also be explored as a possible factor contributing to the current crisis.

Class 5: Crises Reflecting Psychopathology

Definition A crisis that is influenced or triggered by preexisting psychopathology. Examples of psychopathology that may precipitate crises include personality disorders, anxiety disorders, bipolar disorder, and schizophrenia.

Example

Sonja, age 29, was diagnosed with borderline personality disorder at age 18. This disorder is believed to be rooted in a deep fear of abandonment. She has been in weekly therapy for 10 years, with several hospitalizations for suicide attempts during that time. She has had the same therapist for the past 6 years. This therapist told Sonja today that she is to be married in 1 month and will be moving across the country with her new husband. Sonja is distraught, stating that no one cares about her and that she would be better off dead. She is found wandering in and out of traffic on a busy expressway, oblivious to her surroundings. Police bring her to the emergency department of the hospital.

Intervention The initial intervention is aimed at helping Sonja to reduce her anxiety. She requires that someone stay with her and reassure her of her safety and security. After the feelings of panic and anxiety have subsided, she should be encouraged to verbalize her feelings of abandonment. Regressive behaviors should be discouraged. Positive reinforcement should be given for independent activities and accomplishments. The primary therapist will need to pursue this issue of termination with Sonja and facilitate transfer of services to another therapist or treatment program. Hospitalization may be necessary to maintain patient safety.

Class 6: Psychiatric Emergencies

Definition Crisis situations in which general functioning has been severely impaired and the individual is rendered incompetent or unable to assume personal responsibility for his or her behavior. Examples include acute suicide risk, drug overdose, reactions to hallucinogenic drugs, acute psychoses, uncontrollable anger, and alcohol intoxication.

Example

Jennifer, age 16, had been dating Joe, the star high school football player, for 6 months. After the game on Friday night, Jennifer and Joe went to Jackie's house, where several high school students had gathered for an after-game party. No adults were present. About midnight, Joe told Jennifer that he did not want to date her anymore. Jennifer became hysterical, and Jackie was frightened by her behavior. She took Jennifer to her parent's bedroom and gave her a Valium from a bottle in her mother's medicine cabinet. She left Jennifer lying on her parent's bed and returned to the party downstairs. About an hour later, she returned to her parent's bedroom and found that Jennifer had removed the bottle of Valium from the cabinet and swallowed all of the tablets. Jennifer was unconscious, and Jackie could not awaken her. An ambulance was called, and Jennifer was transported to the local hospital.

Intervention Emergency medical care, including monitoring vital signs, ensuring maintenance of adequate airway, and initiating gastric lavage or activated charcoal, is the priority in this case. Jennifer is a minor, so notifying the parents is essential as well.

Inpatient hospitalization is justifiable to ensure patient safety. Discussing feelings about self-esteem, rejection, and loss will help Jennifer explore more adaptive methods of dealing with stressful situations.

Crisis Intervention

Individuals experiencing crises have an urgent need for assistance. In **crisis intervention**, the therapist or other intervener becomes part of the individual's life situation. Because of the individual's emotional state, he or she is unable to problem-solve and consequently requires guidance and support from another to help mobilize the resources needed to resolve the crisis.

Lengthy psychological interpretations are not appropriate for crisis intervention. It is a time for doing what is needed to help the individual get relief and for calling into action all the people and resources required to do so. Aguilera (1998) has stated:

The goal of crisis intervention is the resolution of an immediate crisis. Its focus is on the supportive, with the restoration of the individual to his precrisis level of functioning or possibly to a higher level of functioning. The therapist's role is direct, supportive, and that of an active participant. (p. 24)

Crisis intervention takes place in inpatient settings, outpatient settings, and the community. In the past few decades, people with mental illness have been increasingly involved with criminal justice personnel as first responders to manage mental health crisis situations. In 1988, the fatal shooting by police officers of a man with mental illness prompted the development of the *crisis intervention team (CIT) model* to ensure that a subset of police officers are trained to identify mental illness and substance abuse, use de-escalation techniques, and divert individuals from criminal justice systems to mental health professionals (Watson & Fulambarker, 2012). Not all states have CIT training programs, but several studies have demonstrated improved safety outcomes for patients with mental illness where CIT-trained officers are available. Other

resources that may be available for patients with mental illness who are experiencing an acute crisis include 24-hour crisis phone lines, walk-in crisis centers, mobile crisis teams, respite and residential services, and hospital services, including emergency departments and 23-hour observation beds (National Alliance on Mental Illness [NAMI], 2019). Nurses have a responsibility to know what resources exist in their community of practice. They can then become advocates for crisis intervention training in communities and provide support to families by encouraging them to ask for CIT-trained police officers (where available) when faced with a family member's psychiatric crisis.

A recent development in some states, counties, and mental health facilities is to use *peer support specialists*. These individuals have personal experience with mental illness and are trained or credentialed to help clients navigate everyday challenges of living with a mental illness. Evidence has demonstrated their effectiveness in diffusing psychiatric crises and reducing hospitalizations (Bouchery et al., 2018).

The basic methodology for crisis intervention by health-care professionals relies on orderly problem-solving techniques and structured activities focused on change. Through adaptive change, crises are resolved, and growth occurs. Because of the time limit of crisis intervention, the individual must experience some degree of relief almost from the first interaction. Crisis intervention, then, is not aimed at major personality change or reconstruction (as may be the case in long-term psychotherapy), but rather at using a given crisis to restore functioning and at most to enhance personal growth.

Phases of Crisis Intervention: The Role of the Nurse

Nurses respond to crisis situations on a daily basis. Crises can occur in every unit in the general hospital, home setting, community health-care setting, schools and offices, and private practice. Nurses may

be called on to function as crisis helpers in virtually any setting committed to the practice of nursing.

Roberts and Ottens (2005) describe the clinical application of Robert's seven-stage model of crisis intervention. Aguilera (1998) described four phases in the technique of crisis intervention that are clearly comparable to the steps of the nursing process. These phases are discussed in the following paragraphs.

Phase 1. Assessment

In this phase, the nurse gathers information regarding the precipitating stressor and the resulting crisis that prompted the individual to seek professional help. A nurse in crisis intervention might perform some of the following assessments:

- Ask the individual to describe the event that precipitated this crisis.
- Determine when it occurred.
- Assess the individual's mental *and* physical status.
- Determine whether the individual has experienced this stressor before. If so, what method of coping was used? Have these methods been tried this time?
- If previous coping methods were tried, what was the result?
- If new coping methods were tried, what was the result?
- Assess suicide or homicide potential, plan, and means.
- Assess the adequacy of support systems.
- Determine the level of the individual's precrisis functioning. Assess the usual coping methods, available support systems, and ability to problem-solve.
- Assess the individual's perception of personal strengths and limitations.
- Assess the individual's use of substances.

Next, information from the comprehensive assessment is analyzed, and appropriate nursing diagnoses reflecting the immediacy of the crisis situation are identified. Some nursing diagnoses that may be relevant include the following:

- Ineffective coping
- Anxiety (severe to panic)

- Disturbed thought processes
- Risk for self- or other-directed violence
- Rape-trauma syndrome
- Post-trauma syndrome
- Fear

Phase 2. Planning of Therapeutic Intervention

In the planning phase of crisis intervention, the nurse selects the appropriate nursing actions for the identified nursing diagnoses. In planning the interventions, the type of crisis, as well as the individual's strengths, desired choices, and available resources for support, are considered. Goals are established for crisis resolution and a return to or increase in the precrisis level of functioning.

Phase 3. Intervention

During phase 3, the actions identified in phase 2 are implemented. The following interventions are the focus of nursing in crisis intervention:

- Use a reality-oriented approach. The focus of the problem is on the here and now.
- Remain with the individual experiencing panic anxiety.
- Establish a rapid working relationship by showing unconditional acceptance, active listening, and attending to immediate needs.
- Discourage lengthy explanations or rationalizations of the situation; promote an atmosphere for verbalization of true feelings.
- Set firm limits on aggressive, destructive behaviors. At high levels of anxiety, behavior is likely to be impulsive and regressive. Establish at the outset what is acceptable and what is not, and maintain consistency.
- Clarify the problem the individual is facing by describing the problem and comparing it with the individual's perception of the problem.
- Help the individual determine what he or she believes precipitated the crisis.

- Acknowledge feelings of anger, guilt, helplessness, and powerlessness without judgment.
- Guide the individual through a problem-solving process by which he or she may move in the direction of positive life change.
- Help the individual confront the factors that are contributing to the experience of crisis.
- Encourage the individual to discuss changes he or she would like to make. Jointly determine whether or not desired changes are realistic.
- Encourage exploration of feelings about aspects of the situation that cannot be changed and explore alternative ways of coping more adaptively in these situations.
- Discuss alternative strategies for creating changes that are realistically possible.
- Weigh the benefits and consequences of each alternative.
- Assist the individual in selecting alternative coping strategies that will help alleviate future crisis situations.
- Identify external support systems and new social networks from which the individual may seek assistance in times of stress.

CLINICAL PEARL Coping mechanisms are highly individual, and the choice ultimately must be made by the patient. The nurse may offer suggestions and provide guidance to help the patient identify realistic coping mechanisms that can promote positive outcomes in a crisis situation.

Phase 4. Evaluation of Crisis Resolution and Anticipatory Planning

To evaluate the outcome of crisis intervention, the nurse should reassess the individual to determine whether the following objectives have been achieved:

- Have positive behavioral changes occurred?
- Has the individual developed more adaptive coping strategies? Have they been effective?

- Has the individual grown from the experience by gaining insight into his or her responses to crisis situations?
- Does the individual believe that he or she could respond with healthy adaptation in future stressful situations to prevent crisis development?
- Can the individual describe a plan of action for dealing with stressors similar to the one that precipitated this crisis?

During the evaluation period, the nurse and patient summarize what has occurred during the intervention. They review what the individual has learned and anticipate how he or she will respond in the future. A determination is made regarding follow-up therapy; if needed, the nurse provides referral information.

Disaster Nursing

Although there are many definitions of a **disaster**, a common feature is that the event overwhelms local resources and threatens the function and safety of the community. A violent disaster, whether natural or man-made, may cause devastation to property or life. These crises leave victims with a damaged sense of safety and well-being and varying degrees of emotional trauma. Spiritual distress often occurs as victims question, “How could this have happened?” and “What is most important in life?” A care plan for responding to spiritual distress is included in [Table 12–1](#). Children, who lack life experiences and coping skills, are particularly vulnerable. Their sense of order and security has been seriously disrupted, and they are unable to understand that the disruption is time-limited and that their world will eventually return to normal.

(Text continued on page 220)

Table 12–1 | CARE PLAN FOR THE PATIENT WHO HAS EXPERIENCED A TRAUMATIC EVENT

NURSING DIAGNOSIS: ANXIETY (PANIC)/FEAR

RELATED TO: Real or perceived threat to physical well-being; threat of death; situational crisis; exposure to toxins; unmet needs

EVIDENCED BY: Persistent feelings of apprehension and uneasiness; sense of impending doom; impaired functioning; verbal expressions of having no control or influence over situation, outcome, or self-care; sympathetic stimulation; extraneous physical movements

OUTCOME CRITERIA	NURSING INTERVENTIONS RATIONALE	
Patient demonstrates that anxiety is at a manageable level. Patient demonstrates use of positive coping mechanisms to manage anxiety.	<ol style="list-style-type: none">1. Determine degree of anxiety/fear present, associated behaviors (e.g., laughter, crying, calm or agitation, excited or hysterical behavior, expressions of disbelief or self-blame), and reality of perceived threat.2. Note degree of disorganization.3. Create as quiet an area as possible. Maintain a calm, confident manner. Speak in even tone using short, simple sentences.4. Develop trusting relationship with patient.5. Identify whether incident has reactivated preexisting or coexisting	<ol style="list-style-type: none">1. Clearly understanding the patient's perception is pivotal to providing appropriate assistance in overcoming the fear. Individual may be agitated or completely overwhelmed. Panic state anxiety increases risk for the patient's safety and the safety of others in the environment to be compromised.2. The patient may be unable to handle activities of daily living or work requirements and need more intensive intervention.3. Decreases sense of confusion or overstimulation; enhances sense of safety. Helps the patient focus on what is said and reduces transmission of anxiety.4. Trust is the basis of a therapeutic nurse-patient relationship and enables effective collaboration.5. Concerns and psychological issues may be recycled each time

situations (physical or psychological trauma).

trauma is reexperienced and affect how patient views the current situation.

6. Determine presence of physical symptoms (e.g., numbness, headache, tightness in chest, nausea, and pounding heart).
 7. Identify psychological responses (e.g., anger, shock, acute anxiety, panic, confusion, denial). Record emotional changes.
 8. Discuss with patient the perception of what is causing the anxiety.
 9. Assist the patient in correcting any distortions in thinking. Share perceptions with client.
 10. Explore with the patient or significant other the manner in which patient has previously coped with anxiety-producing events.
 11. Engage the patient in learning new coping behaviors (e.g., progressive muscle relaxation, thought-stopping).
6. Physical problems need to be differentiated from anxiety symptoms so that appropriate treatment can be given.
 7. Although these are normal responses at the time of the trauma, they will repeatedly recycle until they are dealt with adequately.
 8. Increases the ability to connect symptoms to subjective feeling of anxiety, providing opportunity to gain insight/control and make desired changes.
 9. Perceptions based on reality will help to decrease fearfulness. How the nurse views the situation may help the patient to see it differently.
 10. May help the patient regain sense of control and recognize significance of trauma.
 11. Replacing maladaptive behaviors can enhance ability to manage and cope with stress. Interrupting obsessive thinking allows the patient to use energy to address underlying anxiety, whereas continued rumination about the

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|--|--|
| <p>12. Encourage use of techniques to manage stress and vent emotions such as anger and hostility.</p> <p>13. Give positive feedback when the patient demonstrates better ways to manage anxiety and is able to calmly and realistically appraise the situation.</p> <p>14. Administer medications as indicated: antianxiety: diazepam, alprazolam, oxazepam; or antidepressants: fluoxetine, paroxetine, bupropion.</p> | <p>incident can retard recovery.</p> <p>12. Reduces the likelihood of eruptions that can result in abusive behavior.</p> <p>13. Provides acknowledgment and reinforcement, encouraging use of new coping strategies. Enhances ability to manage fearful feelings and gain control over situation, promoting future successes.</p> <p>14. Antianxiety medication provides temporary relief of anxiety symptoms, enhancing ability to cope with situation. Antidepressants lift mood and help suppress intrusive thoughts and explosive anger.</p> |
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NURSING DIAGNOSIS: SPIRITUAL DISTRESS

RELATED TO: Physical or psychological stress; energy-consuming anxiety; loss(es), intense suffering; separation from religious or cultural ties; challenged belief and value system

EVIDENCED BY: Expressions of concern about disaster and the meaning of life and death or belief systems; inner conflict about current loss of normality and effects of the disaster; anger directed at deity; engaging in self-blame; seeking spiritual assistance

OUTCOME CRITERIA	NURSING INTERVENTIONS	RATIONALE
Patient expresses beliefs and values about spiritual issues.	1. Determine the patient's religious/spiritual orientation, current involvement, and presence of conflicts.	1. Provides baseline for planning care and accessing appropriate resources.
	2. Establish environment that promotes free	2. Promotes awareness and identification of feelings

expression of feelings and concerns. Provide calm, peaceful setting when possible.

so they can be processed.

3. Listen to the patient's and significant others' expressions of anger, concern, alienation from God, belief that situation is a punishment for wrongdoing, and so on.
 4. Note sense of futility, feelings of hopelessness and helplessness, lack of motivation to help self.
 5. Listen to expressions of inability to find meaning in life and reason for living. Evaluate for suicidal ideation.
 6. Determine support systems available to patient.
 7. Ask how you can be most helpful. Convey acceptance of the patient's spiritual beliefs and concerns.
 8. Make time for nonjudgmental discussion of philosophical issues and questions about spiritual impact of current situation.
 9. Discuss difference between grief and guilt and help the patient to
3. It is helpful to understand the patient's and significant others' points of view and how their faith is affected in the face of tragedy.
 4. These thoughts and feelings can result in the patient feeling paralyzed and unable to move forward to resolve the situation.
 5. May indicate need for further intervention to prevent suicide attempt.
 6. Presence or lack of support systems can affect patient's recovery.
 7. Promotes trust and comfort, encouraging the patient to be open about sensitive matters.
 8. Helps the patient to begin to look at basis for spiritual confusion. *Note:* There is a potential for the care provider's belief system to influence the patient's thoughts. Therefore it is most beneficial for caregivers to remain neutral and not express their individual beliefs.
 9. Blaming self for what has happened impedes

<p>identify and explore each, assuming responsibility for own actions, expressing awareness of the consequences of acting out of false guilt.</p>	<p>dealing with the grief process.</p>
<p>10. Use therapeutic communication skills of reflection and active-listening.</p>	<p>10. Helps the patient find solutions to concerns.</p>
<p>11. Encourage the patient to experience meditation, prayer, and forgiveness as they are willing. Provide information that anger with God is a normal part of the grieving process.</p>	<p>11. These actions can help the patient to reconnect with spiritual supports and coping mechanisms to heal past and present pain.</p>
<p>12. Assist the patient in developing goals for coping with life situation.</p>	<p>12. Enhances commitment to goal, optimizing outcomes and promoting sense of hope.</p>
<p>13. Identify and refer to resources that can be helpful (e.g., pastoral/parish nurse or religious counselor, crisis counselor, psychotherapy, Alcoholics/Narcotics Anonymous).</p>	<p>13. Specific assistance may be helpful to recovery (e.g., relationship problems, substance abuse, suicidal ideation).</p>
<p>14. Encourage participation in support groups.</p>	<p>14. Discussing concerns and questions with others can help the patient gain support and identify new coping strategies.</p>

NURSING DIAGNOSIS: RISK FOR POST-TRAUMA SYNDROME

RELATED TO: Events outside the range of usual human experience; serious threat or injury to self or loved ones; witnessing violent or tragic events; exaggerated sense of responsibility; survivor’s guilt or role in the event; inadequate social support

OUTCOME CRITERIA	NURSING INTERVENTIONS	RATIONALE
Community demonstrates	1. Determine involvement in	1. All those concerned with a

ability to deal with emotional reactions in an individually appropriate manner.

event (e.g., survivor, significant other, rescue/aid worker, health-care provider, family member).

traumatic event are at risk for emotional trauma and have needs related to their involvement in the event. *Note:* Close involvement with victims affects individual responses and may prolong emotional suffering.

2. Evaluate current factors associated with the event, such as displacement from home due to illness or injury, natural disaster, or terrorist attack. Identify how the patient's past experiences may affect current situation.
 3. Listen for comments of taking on responsibility (e.g., "I should have been more careful or gone back to get her").
 4. Identify the patient's current coping mechanisms.
 5. Determine availability and usefulness of the patient's support systems, family, social contacts, and community resources.
 6. Provide information about signs and symptoms of post-trauma response, especially if individual is involved in a high-risk occupation.
 7. Identify and discuss the patient's strengths as well as vulnerabilities.
 8. Evaluate individual's perceptions of events and
2. Affects the patient's reaction to the current event and is the basis for planning care and identifying appropriate support systems and resources.
 3. Statements such as these are indicators of "survivor's guilt" and blaming self for actions.
 4. Noting positive or negative coping skills provides direction for care.
 5. Family and others close to the patient may also be at risk and require assistance to cope with the trauma.
 6. Awareness of these factors helps individual identify need for assistance when signs and symptoms occur.
 7. Provides information to build on for coping with the traumatic experience.
 8. Events that trigger feelings of despair and

personal significance (e.g., rescue worker trained to provide lifesaving assistance but recovering only dead bodies).

hopelessness may be more difficult to cope with and require long-term interventions.

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| 9. Provide emotional and physical presence by sitting with patient/significant other and offering solace. | 9. Offering oneself promotes the establishment of trust and the potential to provide emotional and physical comfort measures. |
| 10. Encourage expression of feelings. Note whether feelings expressed appear congruent with events experienced. | 10. It is important to talk about the incident repeatedly. Incongruencies may indicate deeper conflict and can impede resolution. |
| 11. Note presence of nightmares, reliving the incident, loss of appetite, irritability, numbness and crying, and family or relationship disruption. | 11. These responses are normal in the early postincident time frame. If prolonged and persistent, they may indicate a need for more intensive therapy. |
| 12. Provide a calm, safe environment. | 12. Promotes the patient's ability to regain a sense of balance and control. |
| 13. Encourage and assist the patient in learning stress-management techniques. | 13. Promotes relaxation and helps individual exercise control over self and what has happened. |
| 14. Recommend participation in debriefing sessions that may be provided following major disaster events. | 14. Exploring stress and identifying coping strategies promptly may facilitate recovery from the event or prevent exacerbation. |
| 15. Identify employment, community resource groups. | 15. Provides opportunity for ongoing support to cope with recurrent feelings related to the trauma. |
| 16. Administer prescribed | 16. Low doses of antipsychotic medications |

medications as indicated, such as antipsychotic medications (e.g., chlorpromazine, haloperidol, olanzapine, or quetiapine) or carbamazepine (Tegretol).

may be used for reduction of psychotic symptoms when loss of contact with reality occurs, usually for patients with especially disturbing flashbacks. Carbamazepine may be used to alleviate intrusive recollections or flashbacks, impulsivity, and violent behavior.

NURSING DIAGNOSIS: INEFFECTIVE COMMUNITY COPING

RELATED TO: History of exposure to disasters (earthquakes, tornados, floods, reemerging infectious agents, terrorist activity); ineffective or nonexistent community resources (e.g., lack of or inadequate emergency medical system, transportation system, or disaster planning systems), inadequate resources for problem-solving

EVIDENCED BY: Deficits of community participation; community does not meet expectations of its members; expressed perception of vulnerability and powerlessness; stressors perceived as excessive; excessive community conflicts or problems (vandalism, robbery, unemployment, homicides, terrorism, poverty); high illness rates

OUTCOME CRITERIA	NURSING INTERVENTIONS RATIONALE	
Community demonstrates an increase in activities to improve community functioning.	<ol style="list-style-type: none"> 1. Evaluate community activities that are related to meeting collective needs within the community and between the community and the larger society. Note immediate needs, such as health care, food, shelter, funds. 2. Note community reports of functioning, including areas of weakness or conflict. 3. Identify effects of related factors on community activities. 	<ol style="list-style-type: none"> 1. Provides a baseline to determine community needs in relation to current concerns or threats. 2. Provides a view of how the community sees these areas. 3. In the face of a current threat, local or national, community resources need to be evaluated,

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| | updated, and given priority to meet the identified need. |
| 4. Determine availability and use of resources. Identify unmet demands or needs of the community. | 4. This information is necessary to identify additional resources that are needed to meet the current situation. |
| 5. Determine community strengths. | 5. Promotes understanding of the ways in which the community is already meeting the identified needs. |
| 6. Encourage community members/groups to engage in problem-solving activities. | 6. Promotes a sense of working together to meet the needs. |
| 7. Develop a plan jointly with the members of the community to address immediate needs. | 7. Provides insight into potential deficits in community response to crisis. |
| 8. Create plans managing Interactions within the community and between the community and the larger society. | 8. Meets collective needs when the concerns/threats are shared beyond a local community. |
| 9. Make information accessible to the public. Provide channels for dissemination of information to the community as a whole (e.g., print media, radio/television reports and community bulletin boards; internet sites; speaker's bureau; reports to committees, councils, advisory boards). | 9. Readily available accurate information can help citizens cope with the situation. |
| 10. Make information available in different modalities and geared to differing educational levels and cultures of the community. | 10. Using languages other than English and making written materials accessible to all members of the community promotes understanding. |

11. Seek out and evaluate needs of underserved populations.

11. Homeless individuals and those residing in lower-income areas may have special requirements that need to be addressed with additional resources.

Source: Doenges, M.E., Moorhouse, M.F., & Murr, A.C. (2019). *Nurse's pocket guide: Diagnoses, prioritized interventions, and rationales* (15th ed.). Philadelphia: F.A. Davis. With permission.

Application of the Nursing Process to Disaster Nursing

Background Assessment Data

Individuals respond to traumatic events in many ways. Grieving is a natural response following any loss, and it may be more extreme if the disaster is directly experienced or witnessed. The emotional effects of loss and disruption may occur immediately or appear weeks or months later.

Psychological and behavioral responses common in adults following trauma and disaster include anger; disbelief; sadness; anxiety; fear; irritability; arousal; numbing; sleep disturbance; and increases in alcohol, caffeine, and tobacco use. Preschool children commonly experience separation anxiety, regressive behaviors, nightmares, and hyperactive or withdrawn behaviors. Older children may have difficulty concentrating, somatic complaints, sleep disturbances, and concerns about safety. Adolescents' responses are often similar to those of adults.

Traumatic bereavement is a term used to describe the grief process that accompanies unexpected losses resulting from traumatic events such as disasters. In such circumstances, the survivor must come to grips not only with the loss but also the manner in which the loss occurred, and this can include powerful emotions ranging from guilt (at having survived when others lost their lives) to anger and rage (Assist Trauma Care, 2015). Ongoing assessment includes evaluation for signs of post-traumatic stress

disorder (PTSD) and major depression that require additional intervention and treatment.

Nursing Diagnoses and Outcome Identification

Information from the assessment is analyzed, and appropriate nursing diagnoses reflecting the immediacy of the situation are identified. Some nursing diagnoses that may be relevant include the following:

- Risk for injury (trauma, suffocation, poisoning)
- Risk for infection
- Anxiety (panic)
- Fear
- Spiritual distress
- Risk for post-trauma syndrome
- Ineffective community coping

The following criteria may be used for measurement of outcomes in the care of the patient having experienced a traumatic event. Timelines are individually determined.

The patient:

- Demonstrates behaviors necessary to protect self from further injury
- Identifies interventions to prevent/reduce risk of infection
- Does not have an infection or physical injury
- Maintains anxiety at a manageable level
- Expresses beliefs and values about spiritual issues
- Demonstrates ability to cope with emotional reactions in an individually appropriate manner
- Demonstrates an increase in activities to improve community functioning

Planning and Implementation

Table 12–1 provides a plan of care for the patient who has experienced a traumatic event. Selected nursing diagnoses are

presented, along with outcome criteria, appropriate nursing interventions, and rationales for each.

Evaluation

In the final step of the nursing process, a reassessment is conducted to determine whether the nursing actions have been successful in achieving the objectives of care. Evaluation of the nursing actions for the patient who has experienced a traumatic event may be facilitated by gathering information using the following types of questions:

Has the patient:

- Been assessed and treated for serious injury or infections, or have they been resolved?
- Been able to maintain anxiety at a manageable level?
- Demonstrated appropriate problem-solving skills?
- Discussed his or her beliefs about spiritual issues?
- Demonstrated the ability to cope with emotional reactions in an individually appropriate manner?
- Verbalized a subsiding of the physical manifestations (e.g., pain, nightmares, flashbacks, fatigue) associated with the traumatic event?
- Recognized factors affecting the community's ability to meet its own demands or needs?
- Demonstrated increased activities to improve community functioning?
- Established and put in place a plan to deal with future contingencies?

When acute crises are not resolved, an individual may be vulnerable to acute stress disorders and trauma-related disorders. See [Chapter 28](#) (“Trauma- and Stressor-Related Disorders”) for more information on these topics.

Summary and Key Points

- A *crisis* is defined as an acute event in one's life, perceived by the individual as distressing and in which coping mechanisms and support systems are inadequate to manage associated anxiety.
- All individuals experience crises at one time or another. A crisis does not necessarily indicate psychopathology. However, individuals with psychopathology are also vulnerable to crisis and may experience an exacerbation of psychiatric symptoms when in crisis.
- Crises are precipitated by specific identifiable events and are determined by an individual's perception of the situation.
- Crises are acute rather than chronic and generally last no more than a few weeks to a few months.
- Crises occur when an individual is exposed to a stressor, and previous problem-solving techniques are ineffective, causing an increase in the level of anxiety. Panic may ensue when new techniques are tried, but resolution fails to occur.
- Six types of crises have been identified: dispositional crises, crises of anticipated life transitions, crises resulting from traumatic stress, maturation/developmental crises, crises reflecting psychopathology, and psychiatric emergencies. The type of crisis determines the method of intervention selected.
- Crisis intervention is designed to provide rapid assistance for individuals who have an urgent need.
- The minimum therapeutic goal of crisis intervention is the psychological resolution of the individual's immediate crisis and restoration to at least the level of functioning that existed before the crisis period. A maximum goal is improvement in functioning above the precrisis level.
- Nurses regularly respond to individuals in crisis in all types of settings. The nursing process is the vehicle by which nurses assist individuals in crisis with a short-term problem-solving approach to change.
- A four-phase technique of crisis intervention includes assessment/analysis, planning of therapeutic intervention, intervention, and evaluation of crisis resolution and anticipatory planning.

- Through this structured method of assistance, nurses help individuals in crisis develop more adaptive coping strategies for dealing with stressful situations in the future.
- Nurses have many important skills that can assist individuals and communities in the wake of traumatic events. Nursing interventions presented in this chapter were developed for the nursing diagnoses of panic anxiety/fear, spiritual distress, risk for post-trauma syndrome, and ineffective community coping.

For additional resources, please visit
www.fadavis.com

Review Questions

1. Which of the following is a correct assumption regarding the concept of crisis?
 - a. Crises occur only in individuals with psychopathology.
 - b. The stressful event that precipitates crisis is seldom identifiable.
 - c. A crisis situation contains the potential for psychological growth or deterioration.
 - d. Crises are chronic situations that recur many times during an individual's life.
2. Crises occur when an individual:
 - a. Is exposed to a precipitating stressor.
 - b. Perceives a stressor to be threatening.
 - c. Has no support systems.
 - d. Experiences a stressor and perceives coping strategies to be ineffective.
3. Which of the following events would likely precipitate a crisis? (Select all that apply)
 - a. First-time parenthood when the parents perceive they have inadequate support and education.

- b. Receiving a pay raise when the worker perceived they had to work very hard to accomplish their financial goals.
 - c. A natural disaster such as a forest fire in which lives and property were lost.
 - d. A peer or family member dies by suicide.
4. Which of the following is a desired outcome of working with an individual who has witnessed a traumatic event and is now experiencing panic anxiety?
- a. The individual will experience no anxiety.
 - b. The individual will demonstrate hope for the future.
 - c. The individual will identify that anxiety is at a manageable level.
 - d. The individual will verbalize the acceptance of self as worthy.
5. The client, a firefighter who responded to an industrial explosion, lost a coworker and close friend when they entered a building that collapsed. The client reports that since this event, he has had frequent nightmares and anxiety attacks. He says to the mental health worker, "I should have died, but instead I lost my best friend!" This statement suggests that the client is experiencing:
- a. Spiritual distress.
 - b. Night terrors.
 - c. Survivor's guilt.
 - d. Suicidal ideation.

Clinical Judgment Questions

6. A client whose home was destroyed during a tornado expresses to the nurse that she has been having disabling anxiety and nightmares for the last 2 weeks following this disaster. The most appropriate crisis intervention would be to:
- a. Encourage her to recognize how lucky she is to be alive.
 - b. Discuss stages of grief and feelings associated with each.
 - c. Identify community resources that can help Amanda.
 - d. Suggest that she find a place to live that provides a storm shelter.

7. A teenager tells the high school nurse that her parents are drinking alcohol every day and she doesn't know what to do. Her grades are starting to drop, and she complains of feeling anxious and overwhelmed. The most appropriate nursing action in response to the client's complaint would be to:
 - a. Facilitate arrangements for her to start attending Alateen meetings.
 - b. Help her identify the positive things in her life and recognize that her situation could be a lot worse than it is.
 - c. Teach her about the effects of alcohol on the body and that it can be hereditary.
 - d. Refer her to a psychiatrist for private therapy to learn to cope with her home situation.

8. A college student, who is an only child and attending school 500 miles away from his parents, reports to the nurse practitioner at the student health center that he has been having difficulty making decisions and will not undertake anything new without first consulting his mother. He has recently started having anxiety attacks. Which nursing action is most appropriate in response to this client's maturational crisis?
 - a. Suggest that he move to a college closer to home.
 - b. Help him to explore unresolved dependency issues.
 - c. Help him find someone in the college town from whom he could seek assistance rather than calling his mother regularly.
 - d. Recommend that the college physician prescribe an antianxiety medication for him.

9. A client is brought to the emergency department by her college roommate and appears to be emotionless. The client reports that she was raped at a party earlier that evening. Which of these actions by the nurse is a priority?
 - a. Ask the client if she would like to shower before she is examined.
 - b. Confront the client about her apparent lack of emotion and ask if this was consensual sex.

- c. Affirm the client for seeking help and ask her to describe what happened.
 - d. Ask the roommate if the client is typically so emotionless.
- 10.** A client is admitted to the inpatient psychiatric unit after a suicide attempt. He reports that he has a history of depression but he became acutely suicidal after he recently lost his job. Which of these nursing actions is a priority in response to this client's psychiatric crisis?
- a. Assess why the client lost his job.
 - b. Ensure that the client remains safe and free from further self-injury.
 - c. Explore career interests and other job opportunities.
 - d. Assess for substance use disorder.

Communication Exercises

- 1.** A patient you have been working with for several days approaches you with apparent signs of agitation and yells in a loud voice, "I want out of this hospital right now! You don't listen to a thing I say, and my doctor just wants my money." How will you respond?
- 2.** Shelley enters the emergency department accompanied by a friend who reports that Shelley was raped after leaving a college campus party the night before. Shelley is staring off into space, exhibits a closed posture, and is mumbling inaudibly. How will you introduce yourself and begin to intervene in this situation?
- 3.** Thomas was secluded and restrained after punching another patient on the inpatient psychiatric unit. The next day he asks you what happened last night, stating he does not remember, and says he wants to know why he was arrested and tied up like an animal. What will you communicate to Thomas about the prior events and the crisis intervention process?

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