Crisis intervention / grief and loss

Crisis
is a temporary state of severe emotional distress caused by failure to cope and lack of support.
-problem solving and decision making ability is inadequate
-tx is aimed at seeing the client and family through the stressful situation

Phases of crisis
Phase 1. : external event/ trigger
Phase 2. : perception of threat, increased anxiety, client may cope or resolve the crisis.
Phase 3. : failure to cope, increased disorganization, physical symptoms, relationship problems
Phase 4. : mobilization of external / internal resources, goal is to return the client to pre crisis level of fx

Crisis intervention
- Tx is immediate, supportive and directly responsive to the crisis
- Interventions are goal oriented
- Interventions provide opportunities for expression and validation of feelings, connections are made between the event and the crisis
- Exploration of alternative coping mechanisms

Types of crisis
Maturational : r/t developmental stages and associated role changes (marriage, birth, retirement)

Situational: arises from an eternal source, often unanticipated (loss of a job, death, divorce, abortion, pregnancy, physical or mental illness)

Adventitious: relates to crisis of disaster (flood, earthquake, hurricane, terrorism, murder, abuse)
Grief

Natural emotional response to loss that individuals must go through as they move towards acceptance of the loss.
- Usually involves moving through a series of stages
- Feelings associated are usually anger, frustration, loneliness, sadness, guilt, regret, and peace.
- Healing occurs when the pain has lessened, in some cases it takes longer (see types of grief)

Types of grief
- **Normal grief**: physical, emotional or cognitive reactions may occur, resolution can take months to years
- **Anticipatory grief**: occurs before the loss of a loved one as a result of acute, chronic, or terminal illness.
- **Disenfranchised grief**: loss is experienced and can't be acknowledged (gay couple divorces, couple was still secret about marriage)
- **Dysfunctional grief**: prolonged emotional instability and lack of progression (mom still doesn't go to work after 18 months of son passing, it's too hard for her to get out of bed)

*Kubler Ross: Stages of grief*
- Denial
- Anger
- Bargaining
- Depression
- Acceptance

Grief in children based on the developmental stage of the child.

*Birth to 1 year*: no concept of death, reacts to loss of mother or caregiver

*1-2 years*: toddler may see death as reversible, response of grief is usually to a loss of a significant, toddler may scream withdraw or become distressed in the environment

*2-5 years old*: child may see death as reversible, child may have a sense of loss and concern about who will provide care. Regressive or aggressive behavior may occur

*5-9 years old*: child sees death as permanent, child may feel responsible, difficulty concentrating

*Preadolescent-Adolescent*: sees death as permanent, strong emotional reaction, regression may occur

Loss

Absence of something desired thought to be available
- **Actual loss**: can be identified by others, and can rise in response to a situation
- **Perceived loss**: experienced by the person only can't be identified by others
- **Anticipatory loss**: before the loss occurs

- Mourning: outward and social expression of loss
  - May be dictated by culture or religion

- Bereavement: inner feelings and outward reactions of the individual experiencing the loss
  - Mourning and grief are included in bereavement
**Nurses role in grief and loss**
- Allow ongoing opportunities for fully informed choices, facilitate the grief process, assist the individual to feel loss and complete tasks of grief.
- Grief can affect individuals, physically, emotionally, psychologically, socially and spiritually, allow for multidisciplinary team approach (social workers, therapists)

**Suicide**
- Feelings of worthlessness, guilt, hopelessness, that are so overwhelming that they are unable to go on with life and feel unfit to live.
- The nurse caring for a client with depression always must consider suicide

**High risk groups**
- Persons that have already attempted suicide
- Family HX, teens, older adults, disabled or terminally
- Clients with personality disorders, organic brain syndrome, dementia, depressed or psychotic clients
- Substance abuse

**Suicide clues**
- Giving away personal belongings, cancelling social, making/ changing a will
- Behavior changes +/-, poor appetite, sleep disturbances, feeling hopeless, difficulty concentrating
- Loss of interest in activities, statements that indicate intent, sudden calmness
- Inquiries about poison, guns, or other lethal items

**Suicide assessment**

**Plan:** does the client have a plan? What is the plan, how lethal is the plan? Does the client have the means to carry out the plan?

**HX of attempts:** have they occurred, what harmed happened? Was the client rescued accidentally? Have methods of past attempts been the same? Have they increased in lethality?

**Psychosocial:** is the client alone or alienated? Is hostility present or depression? Do hallucinations exist, do they abuse drugs? Any recent loss or trauma? Any environmental or lifestyle changes?

**Interventions**
- Initiate suicide precautions remove harmful objects, do not leave client alone.
- Provide support, nonjudgmental, develop a no suicide contract, encourage the client to talk about feelings.
- Encourage active participation in care, identify support systems, do not allow the client to leave the unit
- Identify support system continue to assess the clients suicide potential.