Defense Mechanisms, Crisis Intervention, and Suicide NCLEX Review

I. COPING AND DEFENSE MECHANISMS

1. **Coping mechanisms**

- Coping involves any effort to decrease anxiety.
- Coping mechanisms can be constructive or destructive, task-oriented in relation to direct problem solving, or defense-oriented and regulating the response to protect oneself.

2. **Defense mechanisms**

- As anxiety increases, the individual copes by using defense mechanisms.
- A defense mechanism is a coping mechanism used in an effort to protect the individual from feelings of anxiety; as anxiety increases and becomes overwhelming, the individual copes by using defense mechanisms to protect the ego and decrease anxiety

Types:

1. Compensation - over-achievement in one area to offset real or perceived de?ciencies in another area

- Napoleon complex: diminutive man becoming emperor • Nurse with low self-esteem works double shifts so her supervisor will like her

2. Denial - Failure to acknowledge an unbearable condition; failure to admit the reality of a situation, or how one enables the problem to continue

- Diabetic eating chocolate candy • Spending money freely when broke • Waiting 3 days to seek help for severe abdominal pain

3. Displacement - Ventilation of intense feelings toward persons less threatening than the one who aroused those feelings

- A person who is mad at the boss yells at his or her spouse. • A child who is harassed by a bully at school mistreats a younger sibling.

4. Identi?cation - Modeling actions and opinions of in?uential others while searching for identity, or aspiring to reach a personal, social, or occupational goal

- Nursing student becoming a critical care nurse because this is the specialty of an instructor she admires.

5. Intellectualization - Separation of the emotions of a painful event or situation from the facts involved; acknowledging the facts but not the emotions

- Person shows no emotional expression when discussing serious car accident.

6. Introjection - Accepting another person’s attitudes, beliefs, and values as one’s own

- A person who dislikes guns becomes an avid hunter, just like a best friend.

7. Projection - Unconscious blaming of unacceptable inclinations or thoughts on an external object

- Man who has thought about same-gender sexual relationship but never had one, beats a man who is gay.
- A person with many prejudices loudly identi?es others as bigots.

8. Rationalization - Excusing own behavior to avoid guilt, responsibility, con?ict, anxiety, or loss of self-respect • Student blames failure on teacher being mean. • Man says he beats his wife because she doesn’t listen to him.

9. Reaction Formation - Acting the opposite of what one thinks or feels

- Woman who never wanted to have children becomes a super-mom. • Person who despises the boss tells everyone what a great boss she is.

10. Regression - Moving back to a previous developmental stage in order to feel safe or have needs met

- Five-year-old asks for a bottle when new baby brother is being fed.
- Man pouts like a four-year-old if he is not the center of his girlfriend’s attention.

11. Repression - Excluding emotionally painful or anxiety-provoking thoughts and feelings from conscious awareness

- Woman has no memory of the mugging she suffered yesterday. • Woman has no memory before age 7 when she was removed from abusive parents.

12. Sublimation - Substituting a socially acceptable activity for an impulse that is unacceptable • Person who has quit smoking sucks on hard candy when the urge to smoke arises. • Person goes for a 15-minute walk when tempted to eat junk food.

13. Substitution - Replacing the desired grati?cation with one that is more readily available • Woman who would like to have her own children opens a day care center.

14. Undoing - Exhibiting acceptable behavior to make up for or negate unacceptable behavior

- A person who cheats on a spouse brings the spouse a bouquet of roses. • A man who is ruthless in business donates large amounts of money to charity

II. Crisis Intervention and Suicide

Crisis is a temporary state of severe emotional disorganization caused by *failure of coping mechanisms* and *lack of support.*

- an experience of being confronted by a stress in which the individual is unable to cope/problem-solve
- self-limiting; usually exists for 4 to 6 weeks.
- The ability for decision making and problem solving is inadequate.
- Anxiety and tension accompany the experience, making it more difficult to cope
- Hopelessness and/or helplessness results in a state of disorganization where previous experience and coping fail to enable the individual to problem- solve

Types of Crisis:

- Maturational crises (sometimes called *developmental crises*), are predictable events in the normal course of life such as leaving home for the ?rst time, getting married, having a baby, and beginning a career.
- Situational crises are unanticipated or sudden events that threaten the individual's integrity such as the death of a loved one, loss of a job, and physical or emotional illness in the individual of family member.
- Adventitious crises, (sometimes called *social crises*), include natural disasters like ?oods, earthquakes, or hurricanes; war; terrorist attacks; riots; and violent crimes such as rape or murder.
- Cultural crises accompany culture shock while adapting or adjusting to a new culture or returning to one's own culture after being assimilated into another

Crisis intervention – "Here and Now Therapy"

1. Treatment is immediate, supportive, and directly responsive to the immediate crisis.
2. Interventions are goal-directed.
3. Feelings of the client are acknowledged.
4. Intervention provides opportunities for expression and validation of feelings.
5. Connections are made between the meaning of the event and the crisis.
6. Assist the person in crisis to reestablish equilibrium by using **previously effective coping techniques**
7. The client explores alternative coping mechanisms and tries out new behaviors if former coping techniques are no longer effective

The process of crisis intervention contains four steps:

- Assessment
- planning of therapeutic intervention
- implementation of therapeutic intervention
- resolution of the crisis with anticipatory planning and evaluation

Psychopharmacology as Treatment during Crisis

A crisis is not a psychiatric illness, nor a prolonged condition, *therefore pharmacologic interventions are not the intervention of choice.*

Pharmacologic agents may be used to treat target symptoms that interfere with the client's ability to function:

- Anxiolytics of the benzodiazepine group such as alprazolam (Xanax), clonazepam (Klonopin), diazepam (Valium). lorazepam (Ativan), etc. may be used to treat anxiety, panic, and sleep disturbances that accompany a crisis
- Antidepressant trazadone (Desyrel) may be used for the management of insomnia
- Neuroleptic medications: the atypicals, such as olanzapine (Zyprexa), risperidone (Risperdal), quetiapine (Seroquel) and typical agents such as haloperidol (Haldol). etc.). may be used to treat psychotic symptoms that emerge

SUICIDE

SUICIDE

- is the intentional act of killing oneself.
- common in people with mood disorders, especially depression.

Nursing Diagnosis: Risk for injury directed to self; Ineffective coping

Suicidal ideation - means thinking about killing oneself.

Risk Factors:

- A history of previous suicide attempts; the first 2 years after an attempt represent the highest risk period, especially the first 3 months
- Those with a relative who committed suicide; the closer the relationship, the greater the risk.
- Adolescents
- Older adults
- Disabled or terminally ill client
- Clients with personality disorders
- Clients with organic brain syndrome or dementia
- Depressed or psychotic clients
- Substance abusers
- antidepressant treatment

The single *most predictive psychiatric disorder for suicide* is the presence of a **mood disorder**

Warning signs:

- changes in personal habits such as appetite, sleep patterns, personal appearance and personality
- use of alcohol and other drugs
- bodily complaints
- self-depreciating comments
- making wills and/or giving away personal/meaningful belongings
- decline in academic/occupational performance
- decreased interactions with peers and friends
- Client statements indicating an intent to attempt suicide
- Sudden calmness or improvement in a depressed client
- Client inquiries about poisons, guns, or other lethal objects

Suicidal Client: Assessment

Plan

Does the client have a plan?

What is the plan, how lethal is the plan, and how likely is death to occur?

Does the client have the means to carry out the plan?

Client History of Attempts

What suicide attempts occurred in the past and what harm occurred?

Was the client accidentally rescued?

Have the past attempts and methods been the same, or have methods increased in lethality?

Psychosocial Factors

Is client alone or alienated from others?

Is hostility or depression present?

Do hallucinations exist? Is substance abuse present?

Has client had any recent losses or physical illness? Has client had any environmental or lifestyle changes?

Interventions

1. Initiate suicide precautions.
2. Remove harmful objects.
3. Do not leave the client alone.
4. Provide a nonjudgmental, caring attitude.
5. Develop a contract that is written, dated, and signed and that indicates alternative behavior at times of suicidal thoughts.
6. Encourage the client to talk about feelings and to identify positive aspects about self.
7. Encourage active participation in own care.
8. Keep the client active by assigning achievable tasks.
9. Check that visitors do not leave harmful objects in the client's room.
10. Identify support systems.
11. Do not allow the client to leave the unit unless accompanied by a staff member.
12. Continue to assess the client's suicide potential.

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

III. Milieu Therapy

Description

1. The milieu refers to the *physical and social environment* in which an individual is receiving treatment.
2. Milieu therapy uses a safe environment to meet the individual client's treatment needs.
3. Safety is the most important priority in managing the milieu.
4. Milieu therapy is staffed by persons educated to provide support, understanding, and individual attention; all encounters with the client have the goal of being "therapeutic."
5. All members of the treatment team contribute to the planning and functioning of the milieu; the team generally includes a registered nurse, social worker, exercise therapist, recreational therapist, psychologist, psychiatrist, occupational therapist, and clinical nurse specialist or nurse practitioner.
6. All members of the treatment team are viewed as significant and valuable to the client's successful treatment outcomes.
7. Focus of milieu therapy

- The focus of milieu therapy is to empower the client through involvement in setting his or her own goals and to develop purposeful relationships with the staff to assist in meeting

these goals.

8. The physical and social environment is used to effect a positive change directed toward accomplishing the client's treatment goals.

9. Community meetings, activity groups, social skills groups, and physical exercise programs are used to accomplish treatment goals.

10. One-to-one relationships with staff are used to examine client behaviors, feelings, and interactions within the context of the therapeutic group activities.