Psych & Behavioral Emergencies

Pea Ridge Fire Department

EMS refresher

Introduction

- The mind and body are inseparable.
  - Illness affects a person's behavior.
  - Changes in mental state affect physical health.

Definition of Behavioral Emergency

- Most experts define behavior as the way people act or perform.
  - Overt behavior is open and generally understood by those around the person.
  - Covert behavior has hidden meanings or intentions.

Definition of Behavioral Emergency

- Behavioral emergency
  - A disorder of mood, thought, or behavior that interferes with activities of daily living (ADLs)
- Psychiatric emergency
  - Behavior that threatens a person's health or safety or the health and safety of another person

Definition of Behavioral Emergency

- A behavioral or psychiatric emergency is defined by the person who dials 9-1-1.
- It can be difficult to understand the patient's confused and frayed feelings.

Medicolegal Considerations

- When behavior, speech, and thoughts are erratic, it can be difficult to communicate.
  - Spend time with the patient.
  - Obtain consent when possible.
  - Be clear in your explanations.
  - Take extra time to record the call.

Causes of Abnormal Behavior

- Four broad categories of causes:
  - Biologic or organic
  - Environmental
  - Acute injury or illness
  - Substance related

Causes of Abnormal Behavior

- Biologic or organic
  - Previously described as organic brain syndrome
  - Examples: hypoxia, seizure, brain injury, chronic alcohol and drug abuse, brain tumors
  - Conditions alter the functioning of the brain

Causes of Abnormal Behavior

- Environmental
  - Psychosocial and sociocultural influences
  - Consistent exposure to stressful events.
  - Sociological factors affect biology, behavior, and responses to the stress of emergencies.
- Injury and illness
  - Medical conditions
  - Traumatic events

Causes of Abnormal Behavior

- Substance-related causes:
  - Alcohol
  - Cigarettes
  - Illicit drugs
  - Other substances

Psychiatric Signs and Symptoms

- When mental health is challenged, mechanisms or behaviors work to return homeostasis.
  - Present as psychiatric signs, symptoms, or behaviors

Psychiatric Signs and Symptoms

Table 28-3 Classification of Psychiatric Signs and Symptoms

Function Affected	Psychiatric Signs and Symptoms
Consciousness	▪ Distractibility and inattention ▪ Confusion ▪ Delirium ▪ Stupor and coma
Motor activity	▪ Restlessness ▪ **Stereotyped movements** (repetition of movements that don't seem to serve any useful purpose) ▪ **Compulsions** (repetitive actions that are carried out to relieve the anxiety of obsessive thoughts) ▪ Slow movements
Speech	▪ Slow speech ▪ Acceleration or **pressure of speech** (the pouring out of words like water escaping under pressure) ▪ **Neologisms** (words the patient invents) ▪ **Echolalia** (the patient echoes words he or she hears) ▪ **Mutism** (the patient does not speak at all)
Thought progression	▪ **Flight of ideas** (accelerated thinking in which the mind skips very rapidly from one thought to the next) ▪ Slowness of thought ▪ **Perseveration** (repetition of the same idea over and over again) ▪ **Circumstantial thinking** (the inclusion of many irrelevant details)
Thought content	▪ Delusions ▪ Obsessions ▪ **Phobias** (obsessive, irrational fears of specific things or situations, such as fear of heights, fear of open places, fear of confined spaces, or fear of certain animals)
Mood and affect	▪ Anxiety ▪ Euphoria ▪ Depression ▪ **Inappropriate affect** (emotion that is out of sync with the situation; eg, wearing a smile while discussing a parent's death) ▪ **Flat affect** (the absence of emotion; appearing to feel no emotion at all)
Memory	▪ Amnesia ▪ **Confabulation** (inventing experiences to fill gaps in memory)
Orientation	▪ Disorientation to person, place, and time
Perception	▪ Illusions ▪ Hallucinations
Intelligence	▪ Difficulty learning

Patient Assessment

- Assessment of the patient with a psychiatric emergency differs from other methods.
  - You are the diagnostic instrument.
  - The assessment is part of the treatment.

Scene Size-Up

- Ensure your safety at the scene.
- Assess the environment for clues to the patient's condition or the cause of the emergency.
- Consider the mechanism of injury and/or nature of illness.

Scene Size-Up

Table 28-4 Safety Guidelines for Behavioral Emergencies

Assess the scene. If the patient is armed or has potentially harmful objects in his or her possession, then have law enforcement personnel remove these objects before you provide emergency medical care.
Be prepared to spend extra time. You may need more time than usual to assess, listen to, and prepare the patient for transport.
Have a definitive plan of action. Decide who will do what. If restraint is needed, then how will it be implemented?
Know where the exits are. Identify your exit strategy in case the situation becomes volatile. Never let a patient get between you and the door! Park your ambulance in a location that gives you a safe and easy way out should it become necessary for you to leave the scene.
Don personal protective equipment. An agitated patient may try to spit on you or worse. Anticipate such a threat by wearing the necessary PPE.
Urgently de-escalate the patient's level of agitation. It's critical to keep a high-pressure situation from erupting into violence.
Identify yourself calmly. Try to gain the patient's confidence. If you begin shouting, then the patient is likely to shout louder or become more excited. Maintain a calm voice and demeanor to ensure a quieting influence.
Be direct. State your intentions and what you expect of the patient.
Stay with the patient. *Do not let the patient leave the area, and do not leave the area yourself unless law enforcement personnel can and will stay with the patient.* Otherwise, the patient may go to another room and obtain weapons, lock himself or herself in the bathroom, or take pills.
Encourage purposeful movement. Help the patient get dressed and gather appropriate belongings to take to the medical facility.
Express interest in the patient's story. Let the patient tell you in his or her own words what happened or what is going on now. However, don't play along with auditory or visual disturbances, as doing so may reinforce the patient's delusion or hallucination.
Keep a safe distance from the patient. Everyone needs personal space. Be sure you can move quickly if the patient becomes violent or tries to run away. Don't physically talk down to or directly confront the patient. A squatting, 45-degree angle approach is usually not confrontational, but may hinder your movements. Do not allow the patient to get between you and the exit.
Avoid arguing or fighting with the patient. Do not get into a power struggle. Remember, the patient is not responding to you in a normal manner; he or she may be wrestling with internal forces over which neither of you has control. You and others may be unknowingly stimulating these inner forces. If you can respond with understanding to the feeling that the patient is expressing, whether this is anger, fear, or desperation, then you may be able to gain his or her cooperation. If you must use force, then ensure that you have adequate help and move toward the patient quietly and with assured firmness.
Be honest and reassuring. If the patient asks whether he or she has to go to the medical facility, then your answer should be, "Yes, that is where you can receive medical help."
Don't judge. You may see behavior that you dislike. Set those feelings aside and concentrate on providing emergency medical care.

Abbreviation: PPE, personal protective equipment

Primary Survey

- Clearly identify yourself
- Form a general impression
- Airway and breathing
- Circulation
- Transport decision

History Taking

- Mental status examination
  - Key part of the assessment
  - Check each system in order using COASTMAP.

COASTMAP

- Consciousness
- Orientation
- Activity
- Speech

- Thought
- Memory
- Affect and mood
- Perception

Secondary Assessment

- Obtain vital signs.
- Examine skin temperature and moisture.
- Inspect the head and pupils.
- Note unusual odors on the breath.
- Examine extremities.

Reassessment

- Routinely performed during transport
- Monitor the patient for sudden changes in thought or behavior
- Discuss with the medical facility the need for restraints or medications.
  - If the patient is aggressive or violent, provide advance notice to the emergency department.

Emergency Medical Care

- Rule out and treat medical causes
  - Oxygen therapy
  - Testing blood glucose level
  - Administration of dextrose
  - General interventions for hypothermia or shock management

Communication Techniques

- Begin with an open-ended question.
- Let the patient talk.
- Listen and show that you are listening.

Communication Techniques

- Don’t be afraid of silences.
- Acknowledge and label feelings.
- Don’t argue.
- Facilitate communication.
- Direct the patient’s attention.
- Ask questions.
- Adjust your approach as needed.

Crisis Intervention Skills

- Be as calm and direct as possible.
- Exclude disruptive people.
- Sit down.
- Maintain a nonjudgmental attitude.

Crisis Intervention Skills

- Provide honest reassurance.
- Develop a plan of action.
- Encourage some motor activity.
- Stay with the patient at all times.
- Bring all medications to the medical facility.
- Never assume that it is impossible to talk with any patient until you have tried.

Physical Restraint

- Improvised or commercially made devices
- Be familiar with restraints used by your agency.
- Make sure you have sufficient personnel.
- Discuss the plan of action before you begin.
- If the show of force doesn't calm the patient, move quickly.
- The best position for securing the patient is supine.

Physical Restraint

- Never:
  - Tie ankles and wrists together
  - Hobble tie
  - Place patient facedown
- Once in place:
  - Don’t remove restraints.
  - Don’t negotiate or make deals.

Physical Restraint

- Continuously monitor the patient.
- Check peripheral circulation every few minutes.

Physical Restraint

- Be careful if a combative patient suddenly becomes calm.
- Document everything in the patient's chart.
- You may defend yourself against an attack.

Chemical Restraint

- Use of medication to subdue a patient
  - Only use with approval from medical control.
  - Follow local protocols and guidelines.
  - Not always easier than physical restraint, and it has its own hazards.

Chemical Restraint

- Medications most often used:
  - Short-acting benzodiazepines
  - Antipsychotics
  - Dissociative agents
  - Antihistamines

Chemical Restraint

- Benzodiazepines
  - Shorter acting ones may be given intranasally.
  - Only midazolam and lorazepam have reliable intramuscular absorption.
  - Adverse effects are usually mild and easily treated.

Chemical Restraint

- Antipsychotic medications
  - Ziprasidone
  - Droperidol
  - Haloperidol

Chemical Restraint

- CAUTION
  - Droperidol
    - Associated with prolonged QT syndromes
  - Haloperidol
    - Higher doses and IV administration associated with higher risk of QT prolongation and torsades de pointes

Chemical Restraint

- Haloperidol
  - Commonly administered IV
  - Should not be administered to:
    - Patients younger than 14 years
    - Those with a suspected head injury
    - Those who may be pregnant

Chemical Restraint

- Typical antipsychotics
  - May cause seizures or extrapyramidal symptoms
- Atypical antipsychotics
  - Fewer extrapyramidal symptoms
  - Lower incidence of anticholinergic effects

Chemical Restraint

- Closely monitor the patient for:
  - Hypotension
  - Bradycardia
  - Glucose levels

Chemical Restraint

- Antihistamines
  - Used for many years in the treatment of psychiatric patients
  - Best known for sedative properties
  - Produces anticholinergic effect
  - Used for both adult and pediatric patients

Pathophysiology, Assessment, and Management of Specific Emergencies

Table 28-5 Categorization of Psychiatric Disorders

Type of Disorder	Specific Disorder
Cognitive	▪ Agitated delirium
Thought	▪ Schizophrenia ▪ Acute psychosis
Mood	▪ Bipolar mood disorder ▪ Manic behavior ▪ Depression
Neurotic	▪ Generalized anxiety disorder ▪ Phobias ▪ Panic disorder
Substance-related disorders and addictive behavior	▪ Substance use ▪ Substance intoxication ▪ Substance abuse ▪ Substance dependence ▪ Eating disorders (bulimia nervosa, anorexia nervosa)
Somatoform	▪ Hypochondriasis ▪ Conversion disorder (physical problem that has no identifiable pathophysiology; results from a psychological conflict)
Factitious	Condition in which a person acts as if he or she has an illness by deliberately producing or feigning symptoms ▪ Münchausen syndrome (most severe type of factitious disorder; most symptoms are physical) ▪ Münchausen syndrome by proxy (mental illness in which caregiver makes up or produces illness or injury in a person under his or her care; eg, a parent intentionally makes his or her child sick; also called factitious disorder by proxy)
Impulse control	▪ Intermittent explosive disorder (acting on aggressive impulses involving the destruction of property) ▪ Kleptomania (acting on the urge to steal things) ▪ Pyromania (acting on the urge to set fires) ▪ Pathologic gambling
Personality	▪ Odd or eccentric disorders ▪ Dramatic, erratic, or emotional disorders ▪ Anxious or fearful disorders

Acute Psychosis

- Pathophysiology
  - Person is out of touch with reality.
  - Psychoses or episodes occur for many reasons.
  - Episodes can be brief or last a lifetime.
- Assessment
  - Characteristic: profound thought disorder
  - A thorough examination is rarely possible.
  - Transport the patient without trauma.
  - Use COASTMAP.

Acute Psychosis

- Consciousness
- Orientation
- Activity
- Speech

- Thought
- Memory
- Affect and mood
- Perception

Acute Psychosis

- Management
  - Reasoning doesn't always work.
  - Explain what is being done.
  - Directions should be simple and consistent.
  - Keep orienting the patient.
  - When nonpharmacologic methods fail, it may be appropriate to:
    - Safely restrain the patient
    - Administer a medication to help the behavior

Agitated Delirium

- Pathophysiology
  - Agitated delirium/excited delirium: a state of global cognitive impairment
  - Dementia: more chronic process
  - Patients may become agitated and violent.

Agitated Delirium

- Assessment
  - First try to reorient patients to surroundings and circumstances.
  - Assess thoroughly.
- Management
  - Identify the stressor or metabolic problem.

Suicidal Ideation

- Pathophysiology
  - Any willful act designed to end one's life

Table 28-6 Risk Factors for Suicide

- Depression, or sudden improvement in depression
- Male sex, age <55 years
- Single, widowed, or divorced
- Alcohol or other drug abuse
- Recent loss of spouse or significant relationship
- Chronic, debilitating illness
- Schizophrenia
- Expresses suicidal thoughts and concrete plans for carrying them out
- Caucasian
- Social isolation
- Previous suicide attempt(s)
- Financial setback or job loss
- Family history of suicide

Suicidal Ideation

- Assessment
  - Every depressed patient must be evaluated for suicide risk.
  - Most patients are relieved when the topic is brought up.
  - Broach the subject using a stepwise approach.
  - Identify patients at a higher risk.

Suicidal Ideation

- Management
  - Don’t leave the patient alone.
  - Collect implements of self-destruction.
  - Acknowledge the patient’s feelings.
  - Encourage transport.

Patterns of Violence, Abuse, and Neglect

- Abuse and neglect
  - Assess the following:
    - The patient
    - The environment
    - Other persons involved
  - Document your findings and report your concerns according to local protocols.

Patterns of Violence, Abuse, and Neglect

- Violence
  - Most angry patients can be calmed by a trained person who conveys confidence.
  - Encourage the patient to talk
  - Be prepared to deal with hostile or violent behavior.

Patterns of Violence, Abuse, and Neglect

- Identify situations with the potential for violence.
  - Be psychologically prepared for a possible violent encounter.
  - Don’t rely completely on dispatcher’s information.
  - Develop survival awareness.

Patterns of Violence, Abuse, and Neglect

- Risk factors
  - Scenarios including:
    - Alcohol or drug consumption
    - Incidents involving crowds
    - Violence that has already occurred
  - People who are:
    - Intoxicated
    - Psychotic
    - Experiencing withdrawal or delirium

Patterns of Violence, Abuse, and Neglect

- Warning signs include:
  - Posture: sitting tensely
  - Speech: loud, critical, threatening
  - Motor activity: unable to sit still, easily startled
  - Clenched fists, avoidance of eye contact
  - Your own feelings

Patterns of Violence, Abuse, and Neglect

- Management of the violent patient
  - Assess the whole situation.
  - Observe your surroundings.
  - Maintain a safe distance.
  - Try verbal interventions first.

Mood Disorders

- Unipolar mood disorder: mood remains at one pole of the depression-mania continuum.
- Bipolar mood disorder: mood alternates between mania and depression.

Mood Disorders

- Manic behavior
  - Patients typically have exaggerated perception of happiness with hyperactivity and insomnia.
  - Patients are typically awake and alert but easily distracted.
- Depression
  - Can occur in episodes with sudden onset and limited duration.
  - Onset can also be subtle and chronic in nature.

Mood Disorders

- Depression (cont'd)
  - Diagnostic features (GAS PIPES)
    - Guilt
    - Appetite
    - Sleep disturbance
    - Paying attention
    - Interest
    - Psychomotor abnormalities
    - Energy
    - Suicidal thoughts

Schizophrenia

- Typical onset occurs during early adulthood.
- The patient may experience:
  - Delusions
  - Hallucinations
  - A flat affect
  - Erratic speech
  - Emotional responses
  - Lack of/extreme motor behavior

Neurotic Disorders

- Collection of psychiatric disorders without psychotic symptoms
  - Generalized anxiety disorder (GAD)
  - Phobias
  - Panic disorder

Neurotic Disorders

- Generalized anxiety disorder (GAD)
  - Patient worries for no particular reason or worrying prevents decision-making abilities.
  - Worry must be difficult to turn off or control.
  - When dealing with a patient with GAD:
    - Identify yourself in a calm, confident manner.
    - Listen attentively.
    - Talk with the person about his or her feelings.

Neurotic Disorders

- Phobias
  - Unreasonable fear, apprehension, or dread of a specific situation or thing
  - The patient usually realizes the fear is unreasonable.
  - When managing a patient, explain each step of treatment in detail before carrying it out.

Neurotic Disorders

- Panic disorder
  - Sudden, unexpected, and overwhelming feelings of fear and dread
  - If allowed to continue, panic attacks can cause severe lifestyle restrictions.
  - Signs and symptoms usually peak in 10 minutes and last about an hour.
  - Can mimic several medical conditions.

Neurotic Disorders

Table 28-7 Signs and Symptoms of a Panic Attack

- Shortness of breath or a sensation of being smothered
- Palpitations or tachycardia
- Sweating
- Nausea or abdominal distress
- Chills or hot flashes
- Fear of dying
- Feelings of unreality or of being detached from oneself
- Feeling dizzy, unsteady, light-headed, or faint
- Trembling or shaking
- Feeling of choking
- Paresthesias
- Chest pain or discomfort
- Fear of losing control or going crazy

Data from: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Washington, DC: American Psychiatric Association; 2013.

Neurotic Disorders

- Panic disorder (cont'd)
  - Separate from panicky bystanders.
  - Create a calm environment.
  - Tolerate the patient's disability.
  - Reassure the patient.
  - Give the symptoms a name.
  - Help the patient regain control.

Substance-Related Disorders

- Regarded on four levels:
  - Substance use
  - Substance intoxication
  - Substance abuse
  - Substance dependence
- Determining the most effective treatment requires an integrative approach.

Eating Disorders

- There are two major types: bulimia nervosa and anorexia nervosa.
- Persons may experience severe electrolyte imbalances.
- Anxiety, depression, and substance abuse disorders are often present in those diagnosed.

Eating Disorders

- Bulimia nervosa
  - Consumption of large amounts of food
  - Compensated by purging techniques
- Anorexia nervosa
  - Weight loss jeopardizes health and lives
  - Patients lose weight by exerting extraordinary control over their eating.

Somatoform Disorders

- Preoccupation with physical health and appearance
  - Hypochondriasis: Anxiety or fear that the person may have a serious disease
  - Conversion disorder: A physical problem results from faking a physical disorder

Factitious Disorders

- Also called Münchausen syndrome
  - Patient produces or feigns physical or psychological signs or symptoms.
- Factitious disorder by proxy (Müchausen syndrome by proxy)
  - A parent makes a child sick for attention and pity.

Impulse Control Disorders

- Lack of ability to resist a temptation
- Examples include:
  - Intermittent explosive disorder
  - Kleptomania
  - Pyromania
  - Pathologic gambling

Personality Disorders

- The ways of relating to others become dysfunctional or cause distress to other people.
- Another psychiatric illness is likely to be present at the same time.
- Patients tend to do poorly during treatment.
- Remain calm and professional.

Medications for Psychiatric Disorders and Behavioral Emergencies

- Drugs that affect mood, thought, or behavior
- Patients may be taking any of several types of psychotropic drugs.
- During your assessment, identify:
  - Which medications have been prescribed
  - Whether they are being taken

Psychiatric Medication Types

- Antidepressants
  - Combat the symptoms of depressive illness
  - Alter levels of neurotransmitters in the autonomic nervous system

Table 28-8 Depression Medications

Class	Generic Name	Trade Name
SSRIs	Fluoxetine	Prozac
	Citalopram	Celexa
	Paroxetine	Paxil
	Escitalopram oxalate	Lexapro
	Sertraline	Zoloft
SNRIs	Duloxetine	Cymbalta
	Venlafaxine	Effexor
Heterocyclic (tricyclic and tetracyclic) antidepressants and related medications	Amitriptyline	Amitril, Endep, Elavil
	Amoxapine	Asendin
	Desipramine	Norpramin, Pertofrane
	Doxepin	Adapin, Sinequan
	Imipramine	Imavate, Janimine, Pramine, Presamine, Tofranil
	Nortriptyline	Aventyl, Pamelor
MAOIs	Isocarboxazid	Marplan
	Phenelzine	Nardil
	Tranylcypromine	Parnate
Miscellaneous	Trazodone	Desyrel
	Bupropion	Wellbutrin
	Mirtazapine	Remeron

Abbreviations: SNRIs, serotonin-norepinephrine reuptake inhibitors; SSRIs, selective serotonin reuptake inhibitors; MAOIs, monoamine oxidase inhibitors

Data from: Mancano MA, Gallagher JC. *Frequently Prescribed Medications: Drugs You Need to Know.* 2nd ed. Burlington, MA: Jones & Bartlett Learning; 2014; and Videbeck SL. *Psychiatric Mental Health Nursing.* 6th ed. Hagerstown, MD: Wolters Kluwer Health/Lippincott Williams & Wilkins; 2014.

Psychiatric Medication Types

- Benzodiazepines
  - May be prescribed for severe emotional distress
  - Contraindicated in patients with:
    - Known hypersensitivity to benzodiazepines
    - Acute, narrow-angle glaucoma
    - First-trimester pregnancy

Psychiatric Medication Types

- Antipsychotics
  - Newer medications have less risk of adverse effects and are more effective.
    - Known as atypical antipsychotic (AAP) drugs
  - Relieve delusions and hallucinations.
  - Improve symptoms of anxiety and depression.

Psychiatric Medication Types

- Antipsychotics (cont'd)
  - May cause metabolic adverse effects
  - Have different cardiovascular effects, depending on the medication
  - May cause an acute dystonic reaction
  - May cause atropine-like effects

Psychiatric Medication Types

- Amphetamines
  - CNS and PNS stimulants
  - Help with attention deficit disorder with hyperactivity (ADHD) and narcolepsy
  - Raise systolic and diastolic blood pressure

Psychiatric Medication Types

- Amphetamines
  - Psychological effects depend on:
    - Dose
    - Mental state
    - Personality
  - Results include:
    - Alertness
    - Elevated mood
    - Increased motor and speech activities

Problems Associated with Medication Noncompliance

- Increases the likelihood that a person with mental illness will commit a violent act
- When obtaining medication history, include:
  - Previously prescribed medications
  - Missed doses

Emergency Use of Medications

- Emergency use of medications may be indicated in an escalating behavioral crisis.
  - The potential danger is too great not to intervene.
- Before administering chemical restraint, complete your assessment with:
  - A thorough understanding of the chief complaint
  - Attention to allergies
  - Medical and medication history
  - Weigh the risks against the benefit

The Psychological Effect of War

- Traumatic stressful events can lead to psychological trauma.
- Military personnel who have experienced combat have a high incidence of PTSD.
- Four categories of PTSD symptoms:
  - Intrusive thoughts
  - Avoiding reminders
  - Negative thoughts and feelings
  - Arousal and reactive symptoms

The Psychological Effect of War

- Acute stress disorder
  - People experiencing intense stress often develop symptoms within days of the event.
  - Symptoms differ from PTSD in that they are dissociative.
  - Considered a precursor to PTSD

The Psychological Effect of War

- Military cultural competency
  - A specific skill that assists in identifying sometimes-subtle indicators of discharged military personnel

The Psychological Effect of War

- When you encounter military personnel experiencing medical or behavioral problems, use
  - Compassion
  - Understanding
  - Protocols
  - Cognizance of their cultural background

Thank You

Please continue to the next section