Behavioral Emergencies

South Cook County EMS
September, 2020

Site Code: 0704-00-E-0921
Objectives

- Discuss the possible causes of behavioral emergencies.
- Explain how psychiatric S & S are categorized
- Discuss the assessment process
- Discuss general management of patients with psychiatric emergencies.
- List specific psychiatric disorders
- Recognize issues specific to PTSD
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
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
  – Diabetic ketoacidosis, etc..

• Environmental
  – Psychosocial and sociocultural influences
  – Consistent exposure to stressful events.
  – Sociological factors affect biology, behavior, and responses to the stress of emergencies.
Causes of Abnormal Behavior

• Injury and illness
  – Medical conditions
  – Traumatic events

• Substance-related causes:
  – Alcohol
  – Illicit drugs
  – Other substances
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.
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 (example, your conversation with the patient)
  – Check each system (of mental function) in order using COASTMAP.
COASTMAP

- Consciousness (alert, confused, responds to pain, unresponsive)
- Orientation (knowledge of current events, etc.)
- Activity (restless, agitated, pacing, etc.)
- Speech (flow, articulation, clear, slurred, mumbling, etc.)
- Thought (making sense?, reasoning? hallucinations?)
- Memory (memory loss, recent or remote?)
- Affect and mood (sad, angry, flat, withdrawn, etc.)
- Perception (hearing voices, etc.)
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 (initial medical care)
  – Testing blood glucose level
  – Administration of dextrose, if appropriate
  – 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.

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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 (feet only)
  – Place patient facedown

• Once in place:
  – Don’t remove restraints.
  – Don’t negotiate or make deals.
• Continuously monitor the patient.
• Check peripheral circulation every few minutes.
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, including though “insertions” which are unrealistic
  – A thorough examination is rarely possible.
  – Transport the patient without trauma.
  – Use COASTMAP.
Acute Psychosis

• Management
  – Reasoning doesn't always work.
  – Explain what is being done.
  – Directions should be simple and consistent.
  – Keep orienting the patient.
  – Safely restrain the patient, if needed
Agitated Delirium

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

- **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>
<thead>
<tr>
<th>Table 28-6 Risk Factors for Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression, or sudden improvement in depression</td>
</tr>
<tr>
<td>Male sex, age &lt; 55 years</td>
</tr>
<tr>
<td>Single, widowed, or divorced</td>
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<tr>
<td>Alcohol or other drug abuse</td>
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<tr>
<td>Recent loss of spouse or significant relationship</td>
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<tr>
<td>Chronic, debilitating illness</td>
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<tr>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Expresses suicidal thoughts and concrete plans for carrying them out</td>
</tr>
<tr>
<td>Caucasian</td>
</tr>
<tr>
<td>Social isolation</td>
</tr>
<tr>
<td>Previous suicide attempt(s)</td>
</tr>
<tr>
<td>Financial setback or job loss</td>
</tr>
<tr>
<td>Family history of suicide</td>
</tr>
</tbody>
</table>

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## 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.

### Management
- Don’t leave the patient alone.
- Collect implements of self-destruction.
- Acknowledge the patient’s feelings.
- Encourage transport and request law enforcement intervention, if needed.
Mood Disorders

- Unipolar mood disorder: mood remains at one pole of the depression-mania continuum.
- Bipolar mood disorder: mood alternates between mania and depression.
- 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
  – Lack of or extreme motor behavior
• Symptoms may be more prominent over time
• Complex disorder which is difficult to treat.
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.

• Panic disorder management
  – Separate from panicky bystanders.
  – Create a calm environment.
  – Tolerate the patient’s disability.
  – Reassure the patient.
  – Help the patient regain control.
# Neurotic Disorders

<table>
<thead>
<tr>
<th>Table 28-7</th>
<th>Signs and Symptoms of a Panic Attack</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Shortness of breath or a sensation of being smothered</td>
<td></td>
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<tr>
<td>- Palpitations or tachycardia</td>
<td></td>
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<tr>
<td>- Sweating</td>
<td></td>
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<tr>
<td>- Nausea or abdominal distress</td>
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<tr>
<td>- Chills or hot flashes</td>
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<tr>
<td>- Fear of dying</td>
<td></td>
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<tr>
<td>- Feelings of unreality or of being detached from oneself</td>
<td></td>
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<tr>
<td>- Feeling dizzy, unsteady, light-headed, or faint</td>
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<tr>
<td>- Trembling or shaking</td>
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<tr>
<td>- Feeling of choking</td>
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<tr>
<td>- Paresthesias</td>
<td></td>
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<tr>
<td>- Chest pain or discomfort</td>
<td></td>
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<tr>
<td>- Fear of losing control or going crazy</td>
<td></td>
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</tbody>
</table>

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.
Factitious Disorders

- Also called Münchausen syndrome
  - Patient produces or feigns physical or psychological signs or symptoms.
- Factitious disorder by proxy (Münchausen syndrome by proxy)
  - A parent makes a child sick for attention and pity.
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>
<thead>
<tr>
<th>Class</th>
<th>Generic Name</th>
<th>Trade Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRIs</td>
<td>Fluoxetine</td>
<td>Prozac</td>
</tr>
<tr>
<td></td>
<td>Citalopram</td>
<td>Celexa</td>
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<tr>
<td></td>
<td>Paroxetine</td>
<td>Paxil</td>
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<td></td>
<td>Escitalopram oxalate</td>
<td>Lexapro</td>
</tr>
<tr>
<td></td>
<td>Sertaline</td>
<td>Zoloft</td>
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<tr>
<td>SNRIs</td>
<td>Duloxetine</td>
<td>Cymbalta</td>
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<tr>
<td></td>
<td>Venlafaxine</td>
<td>Effexor</td>
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<tr>
<td>Heterocyclic (tricyclic and tetracyclic) antidepressants and related medications</td>
<td>Amitriptyline</td>
<td>Amitril, Endep, Elavil</td>
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<tr>
<td></td>
<td>Amoxapine</td>
<td>Asendin, Norpramin, Pertofrane</td>
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<tr>
<td></td>
<td>Desipramine</td>
<td>Adapin, Sinequan, Imavate, Janinime, Pramine, Presamine, Tofranil</td>
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<tr>
<td></td>
<td>Doxepin</td>
<td>Aventyl, Pamelor</td>
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<tr>
<td></td>
<td>Imipramine</td>
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<td></td>
<td>Nortriptyline</td>
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<tr>
<td>MAOIs</td>
<td>Isocarboxazid</td>
<td>Marplan</td>
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<tr>
<td></td>
<td>Phenelzine</td>
<td>Nardil</td>
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<tr>
<td></td>
<td>Tranylcypromine</td>
<td>Parnate</td>
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<tr>
<td>Miscellaneous</td>
<td>Trazodone</td>
<td>Desyrel</td>
</tr>
<tr>
<td></td>
<td>Bupropion</td>
<td>Wellbutrin</td>
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<tr>
<td></td>
<td>Mirtazapine</td>
<td>Remeron</td>
</tr>
</tbody>
</table>

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
Post Traumatic Symptom Disorder

- 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
Post Traumatic Symptom Disorder

• Four categories of PTSD symptoms:
  – Intrusive thoughts (distressing dreams, flashback, nightmares)
  – Avoiding reminders of the event (i.e. people, place, objects, situations, etc.)
  – Negative thoughts and feelings (such as fear, anger, guilt and shame)
  – Arousal and reactive symptoms (related to the event that cause problems sleeping or focusing on activities, or even self-destructive behaviors)