BEHAVIORAL EMERGENCIES: FACTS, FICTION, TREATMENT

Presented by

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Adapted from Jones and Bartlett Emergency Care in the Streets, 8th Edkition, and Emergency Care iand Transportation of the sick and Injured, 11th Edition

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

Myth v. Reality

- The most common misconception is that if you are feeling bad or depressed, you must be “sick.”
- There are many justifiable reasons for feeling depressed:
  - Divorce
  - Loss of a job
  - Death of a relative or friend

Myth v. Reality

Another myth is that all individuals with mental health disorders are dangerous, violent, or unmanageable.

- Only a small percentage fall into these categories.
- EMTs may be exposed to a higher proportion of violent patients.
- Restraints are rarely necessary
- Most patients will present more of a threat to themselves than others or a minimal threat in any case

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

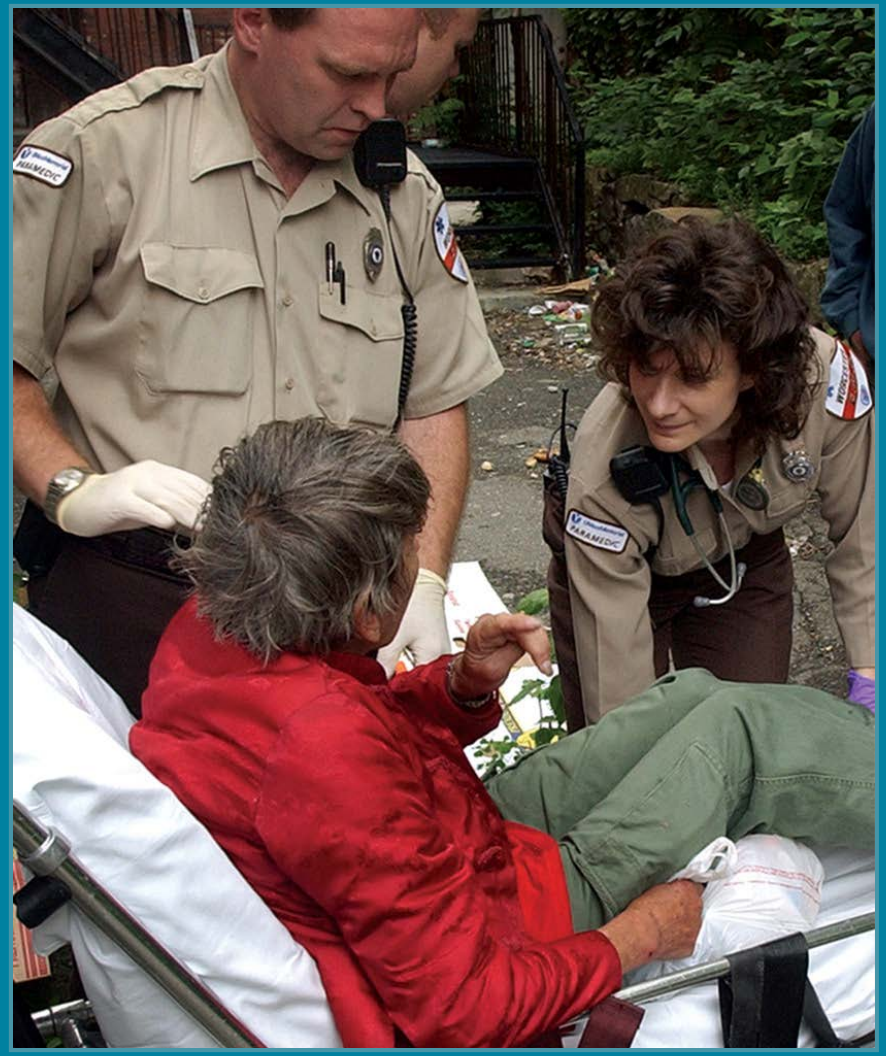
- Environmental
  - Psychosocial and sociocultural influences
  - Consistent exposure to stressful events.
  - Sociological factors affect biology, behavior, and responses to the stress of emergencies.
- Injury and illness
  - Medical conditions
  - Traumatic events

Causes of Abnormal Behavior

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

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.

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Physical Restraint

- Be careful if a combative patient suddenly becomes calm.
- Document everything in the patient's chart.
- Can you defend yourself if attacked? YES
- Can you use force beyond what is necessary to escape or check? NO.
- **Can you restrain absent an immediate threat without PD or physician involvement? NO**

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.

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
- 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

- 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

- 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

- 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

Substance-Related Disorders

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

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

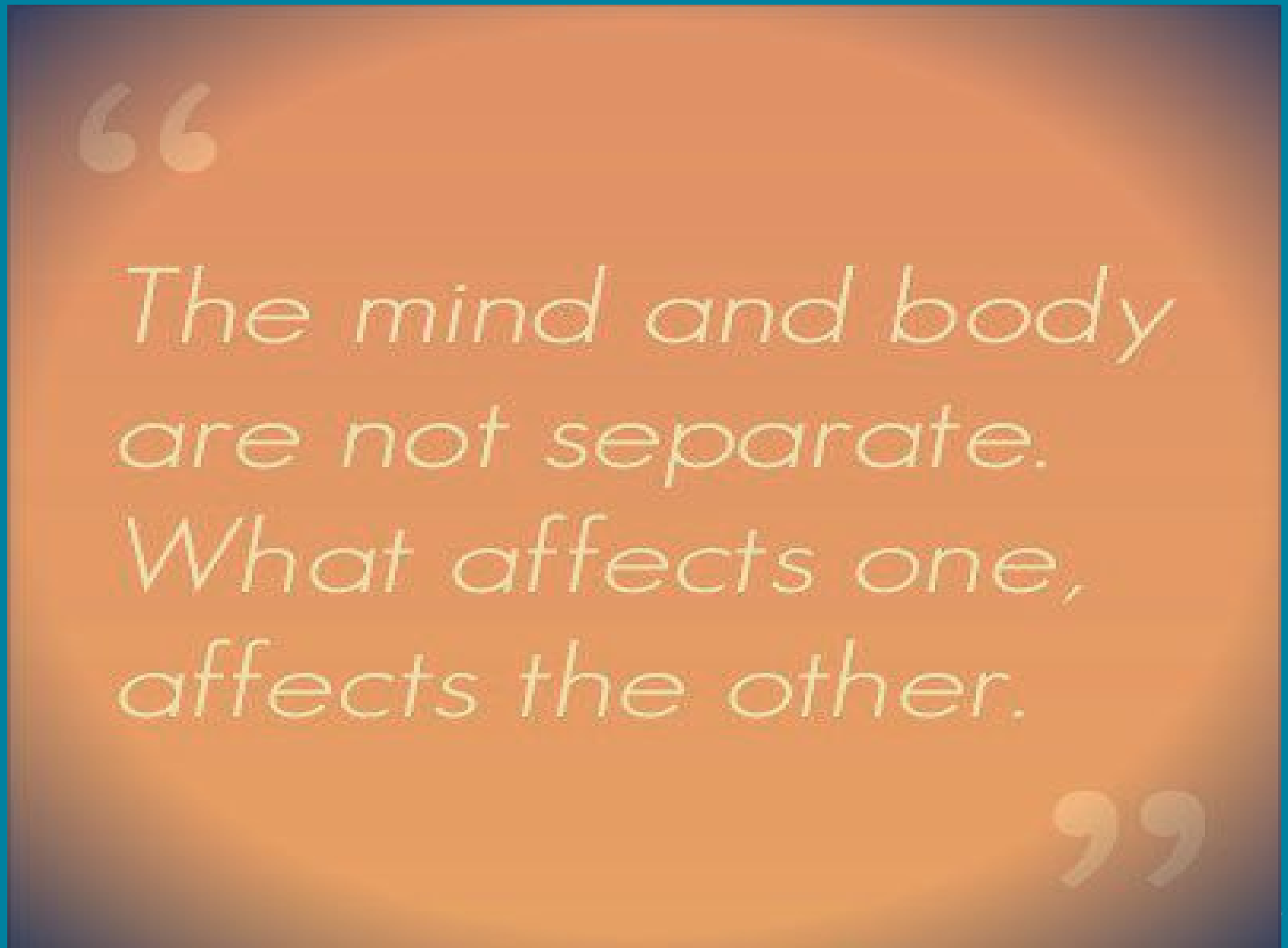
- The ways of relating to others become dysfunctional or cause distress to other people.
- Another psychiatric illness is likely to be present at the same time.
- Patients tend to do poorly during treatment.
- Remain calm and professional.

Pitfalls in Assessment and Treatment

- Failure to recognize underlying or concurrent medical/traumatic issues
- Failure to perform an adequate history and physical exam
- Taking the bait
- Restraining inappropriately
- “Tune ups”
- Letting your own prejudices take over

Pitfalls in Assessment and Treatment

- Not assessing medication compliance
- Lack of awareness of the mental health system
- Labelling everything involving stress as “PTSD” (it’s a specific diagnosis)
- Losing situational awareness
- FORGETTING YOU ARE TREATING A HUMAN BEING


“
The mind and body are not separate. What affects one, affects the other.
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