BEHAVIORAL EMERGENCIES:
FACTS, FICTION, TREATMENT

Presented by

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Adapted from Jones and Bartlett Emergency Care in the Streets, 8th Edition, and Emergency Care and Transportation of the sick and Injured, 11th Edition
<table>
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<th>Definition of Behavioral Emergency</th>
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<tr>
<td>• Behavioral emergency</td>
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<tr>
<td>- A disorder of mood, thought, or behavior that interferes with activities of daily living (ADLs)</td>
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<td>• Psychiatric emergency</td>
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<td>- Behavior that threatens a person’s health or safety or the health and safety of another person</td>
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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
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."