Chapter 32
Psychiatric Disorders and Substance Abuse

Learning Objectives

 Define behavior and distinguish between normal and abnormal behavior
 Define behavioral emergency
 Discuss factors that may alter behavior and the emotional status of the ill/injured individual

Learning Objectives (Cont’d)

 Discuss the pathophysiology of psychiatric disorders
 Describe appropriate measures to ensure the safety of the patient, paramedic, and others
 Correlate abnormal findings in assessment with clinical significance in the most commonly abused drugs
Learning Objectives (Cont'd)

- Define the following terms:
  - Affect
  - Anxiety
  - Fear
  - Open-ended question
  - Posture
  - Phobia
  - Dysphoria
  - Euphoria

Learning Objectives (Cont’d)

- Describe circumstances in which relatives, bystanders, and others should be removed from the scene
- Describe techniques in gathering information from disturbed patients
- Identify techniques for physical assessment in a patient with behavioral problems

Learning Objectives (Cont’d)

- Be able to recognize various psychiatric disorders on the basis of assessment and the history of the present illness
- Integrate pathophysiological principles with the assessment of the patient with psychiatric disorders
Learning Objectives (Cont'd)

- Discuss the prevalence of behavior and psychiatric disorders
- Describe the history and physical findings associated with psychiatric disorders
- Describe management strategies for various psychiatric disorders

- List clinical uses, street names, pharmacological characteristics, assessment findings, and management for patients who have taken/been exposed to the following substances:
  - Cocaine
  - Marijuana
  - Methamphetamines
  - Barbiturates
  - Sedative-hypnotics
  - Narcotics or opiates

- List clinical uses, street names, pharmacological characteristics, assessment findings, and management for patients who have taken/been exposed to the following substances:
  - Common household substances
  - Drugs abused for sexual purposes, gratification
  - Alcohols
  - Hydrocarbons
  - Psychiatric medications
  - Newer antidepressants, serotonin syndromes
Learning Objectives (Cont'd)

- List clinical uses, street names, pharmacological characteristics, assessment findings, and management for patients who have taken/been exposed to the following substances:
  - Lithium
  - Monoamine oxidase inhibitors
  - Club drugs
  - Hallucinogens
  - Dissociatives

Learning Objectives (Cont'd)

- List situations in which you may have to transport a patient forcibly, against his or her will
- List risk factors for suicide
- List behaviors indicating a patient may be at risk for suicide

Learning Objectives (Cont'd)

- Describe verbal techniques useful in managing an emotionally disturbed patient
- Describe methods of restraint that may be necessary in managing an emotionally disturbed patient
- Describe medical and legal considerations for the management of emotionally disturbed patients
Learning Objectives (Cont’d)

• Describe the condition of restraint asphyxia and why you must never restrain a patient in prone position
• Define the following terms:
  ➢ Substance or drug abuse
  ➢ Tolerance
  ➢ Withdrawal
  ➢ Addiction

Learning Objectives (Cont’d)

• Discuss the incidence of drug abuse in the United States
• Describe the pathophysiology of commonly abused drugs
• List the most commonly abused drugs by chemical name and street name

Learning Objectives (Cont’d)

• Differentiate treatments and pharmacological interventions in the management of the most commonly abused drugs
• Integrate pathophysiological principles and assessment findings to formulate a field impression and implement a treatment plan for patients using the most commonly abused drugs
• Discuss signs and dangers of clandestine drug manufacturing laboratories
Behavior

- Person’s observable activities
- Normal
  - Norms, expectations of society
  - Religious, cultural factors
- Behavioral emergency
- Symptoms vary widely

Psychopathology

- Limbic system
  - Controls motivation, emotion
  - Limbic node
    - Neurons encircle inner structures of the limbic system, innermost layer of the cerebral cortex
  - Thalamus
    - Brain switchboard

Psychopathology (Cont’d)

- Limbic system
  - Hippocampi
    - Process, consolidate long-term memory
    - Filter incoming sensory information, determine dangerous stimuli
    - If important, commits to memory
  - Amygdala
    - Brain’s emotional sentinels
    - Attach emotional significance to stimuli passing through
Psychopathology (Cont’d)

- Limbic system
  - Hypothalamus
    - Bridge between nervous and endocrine systems
    - Housekeeping functions
    - Controls arterial blood pressure, water conservation response, thirst, body temperature, hunger responses
    - Physiological responses to emotions

Psychopathology (Cont’d)

- Organic etiology
  - Other conditions may show psychiatric symptoms
    - Alzheimer’s disease
    - Brain abscess
    - Brain neoplasm
    - Brain trauma
    - Hypoglycemia
    - Dehydration
  - Hypoxia
  - Hypothermia
  - Substance intoxication
  - Substance withdrawal
  - Stroke
Psychopathology (Cont'd)

- Genetic predisposition
- Biochemical factors
  - Relative imbalances in neurotransmitter levels responsible for psychiatric disorders
  - Drugs help relieve symptoms
  - Primary neurotransmitters

Psychopathology (Cont'd)

- Psychosocial factors
  - Life events affect emotional state
  - Only part of the picture
- Developmental factors
  - Emotional crisis early may predispose the patient

Psychopathology (Cont'd)

- Biopsychosocial concept
  - Biological makeup, behavior, surroundings relate, interact
Behavioral Emergency Patient Assessment

- Rescuer safety and scene assessment
  - Staging for police
  - Observe surroundings, living conditions
  - Approach residence from side, listen before knocking
  - Signs of violence
  - Patient advocate

Behavioral Emergency Patient Assessment (Cont’d)

- Patient contact and interview
  - Awareness of patient actions, behavior
  - Posture
  - If threatened, leave immediately, wait for police
  - Life-threatening problems are a priority
  - Watch self-positioning, patient personal space
  - Quiet, nonthreatening, there to help
  - Gain trust

Behavioral Emergency Patient Assessment (Cont’d)

- History of present illness
  - Open-ended questions
  - Primary complaint
  - Vital signs
  - May have both medical and behavioral problems
Behavioral Emergency Patient Assessment (Cont’d)

- Past psychiatric history
  - Allergies, medication, past medical history, psychiatric disorders
  - Psychiatric hospitalizations
  - Medication compliance

- Mental state examination
  - Appearance and behavior
    - Psychomotor agitation
    - Patient clothing
  - Speech and form of thought
    - Process information, create logical, flowing ideas
    - Mutism
    - Poverty of speech
    - Thought blocking
    - Pressured speech, racing thoughts
    - Circumstantial thinking
    - Tangential thinking
    - Flight of ideas
    - Word salad
Behavioral Emergency Patient Assessment (Cont’d)

- Mental state examination
  - Thought content
    - Psychosis
      - Highly distorted perceptions of reality
    - Suicidal, homicidal ideations, preoccupations
    - Hallucinations

- Mental state examination
  - Thought content
    - Delusions
      - False perceptions of situations and events believes to be true
      - Paranoid delusions
      - Grandiose delusions
      - Somatic delusions
      - Delusion of reference

- Mental state examination
  - Thought content
    - Preoccupations
      - Topics, ideas consistently, constantly return to one’s mind, dominating thoughts
      - Depersonalization
      - Derealization
Behavioral Emergency Patient Assessment (Cont’d)

- Mental state examination
  - Thought content
    - Delirium
    - Clouding of consciousness
    - Rapid onset, confusion
    - Intracranial, extracranial causes
    - Suspect in acute history of change in cognition, behavior, life function
    - Reversible

Behavioral Emergency Patient Assessment (Cont’d)

- Mental state examination
  - Thought content
    - Dementia
      - Memory loss with > cognitive deficit over time
      - Common with aging

Behavioral Emergency Patient Assessment (Cont’d)

- Mental state examination
  - Emotion, affect, mood
    - Affect
      - Stability, appropriateness, intensity
      - Labile
      - Flat
      - Constricted
      - Intense
    - Mood
      - Dominant, sustained emotional state
      - Stability, changes over course of days
Behavioral Emergency Patient Assessment (Cont’d)

- Mental state examination
  - Orientation, memory, attention
    - Standard questioning for orientation to person, place, time, event
    - Test memory divisions

Behavioral Emergency Patient Assessment (Cont’d)

- Assessing for substance abuse
  - Direct questions
  - Needle marks, breath smell

Schizophrenia

- Description and definition
  - Set of conditions with positive and negative symptoms
    - Psychotic-positive
    - Thought disorder-positive
    - Negative
Schizophrenia (Cont’d)

- **Description and definition**
  - **Paranoid**
    - Positive symptoms dominant
    - Frequent hallucinations, delusions of persecution
  - **Disorganized**
    - Extreme disorders of thought, disorganized speech
    - Severe social impairment
  - **Catatonic**
    - Movement disorders

Schizophrenia (Cont’d)

- **Etiology**
  - Genetic predisposition
  - Excess dopamine in the brain
  - Brain abnormalities

Schizophrenia (Cont’d)

- **Epidemiology and demographics** [Obj. 13]
  - One in 100 adults worldwide
  - More severe in men, earlier onset
  - Lower socioeconomic status
  - Blacks, two times the general population

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Schizophrenia (Cont'd)

- History and physical findings
  - First stage
    - Slow increase in social withdrawal, poor communication, inappropriate affect, neglect hygiene/grooming
    - Sharp decrease in cognitive ability
  - Second stage/active
    - Major event, precursor to active stage
    - Have all the symptoms
    - Hospitalized
  - Third stage
    - Symptoms subside

Schizophrenia (Cont'd)

- Differential diagnosis
  - Addison’s disease
  - Alcohol intoxication
  - Bipolar disorder
  - Brain abscess
  - Brief psychotic disorder
  - Cocaine intoxication
  - Depression
  - Encephalopathy
  - Head trauma
  - Huntington’s disease
  - Hypoglycemia
  - Hypokalemia
  - Hypothyroidism
  - Phencyclidine (PCP) intoxication
  - Schizoaffective disorder
  - Wernicke-Korsakoff syndrome

Schizophrenia (Cont’d)

- Therapeutic interventions [Obj. 15]
  - Assess, treat suicidal, homicidal ideations
  - Calm violent, distressing psychotic episodes
  - Transport to facility with patient’s previous records
- Patient and family education
  - Explain that hallucinations and delusions are part of the disorder
Tardive Dyskinesia

- Description and definition
  - Degenerative neurological disorder
  - Repetitive movements of mouth, face
  - Rocking
- Etiology
  - Dopamine pathway suppression in brain by antipsychotic drugs over long-term use

Tardive Dyskinesia (Cont'd)

- Epidemiology and demographics
  - 15-30% antipsychotic drug users
  - Older women, blacks
- History and physical findings
  - Repetitive, involuntary motions of facial muscles, extremities

Tardive Dyskinesia (Cont'd)

- Differential diagnosis
  - Dystonic reaction
  - Parkinson's disease
  - Seizure disorders
- Therapeutic interventions
  - Lowering dose is helpful, no cure
Tardive Dyskinesia (Cont’d)

- Patient and family education
  - Risk of falls
  - Do not alter dose without prescribing physician’s permission
    - Abrupt cessation of medication causes rapid return of psychotic symptoms

Mood Disorders

- Major depression and dysthymia
  - Description and definition
    - Dysphoria, melancholy
    - Dysrhythmia
  - Etiology
    - Different severities of same disease
    - Possible serotonin alterations, increase limbic system activity
    - Psychosocial events

Mood Disorders (Cont’d)

- Major depression and dysthymia
  - Epidemiology and demographics
    - Most common mental illness
    - Women twice as frequent as men
    - Immediate family members, 1.5-3 times more likely to develop
    - Higher rates of alcohol, substance abuse
    - 8% attempt suicide
Mood Disorders (Cont’d)

- Major depression and dysthymia
  - History and physical findings
    - Common tasks difficult
    - Limbic system, hypothalamus dysfunction cause major homeostasis disruption

Mood Disorders (Cont’d)

- Major depression and dysthymia
  - Differential diagnosis
    - Alcoholism
    - Anemia
    - Anorexia nervosa
    - Anxiety disorders
    - Bipolar disorder
    - Bulimia nervosa
    - Chronic fatigue syndrome
    - Cushing syndrome
    - Dissociative disorders
    - Dysthymia
    - Graves disease
    - Hypercalcemia
    - Hyperthyroidism
    - Hypochondriasis
    - Hypoglycemia
    - Hypothyroidism
    - Insomnia
    - Lyme disease
    - Marijuana abuse
    - Menopause
    - Obsessive-compulsive disorder
    - Personality disorders
    - Posttraumatic stress disorder
    - Schizoaffective disorder
    - Schizophrenia
    - Somatoform disorders
    - Syphilis
    - Systemic lupus erythematosus
    - Wernicke-Korsakoff syndrome

Mood Disorders (Cont’d)

- Major depression and dysthymia
  - Differential diagnosis
    - Alcoholism
    - Anemia
    - Anorexia nervosa
    - Anxiety disorders
    - Bipolar disorder
    - Bulimia nervosa
    - Chronic fatigue syndrome
    - Cushing syndrome
    - Dissociative disorders
    - Dysthymia
    - Graves disease
    - Hypercalcemia
    - Hyperthyroidism
    - Hypochondriasis
    - Hypoglycemia
    - Hypothyroidism
    - Insomnia
    - Lyme disease
    - Marijuana abuse
    - Menopause
    - Obsessive-compulsive disorder
    - Personality disorders
    - Posttraumatic stress disorder
    - Schizoaffective disorder
    - Schizophrenia
    - Somatoform disorders
    - Syphilis
    - Systemic lupus erythematosus
    - Wernicke-Korsakoff syndrome
Mood Disorders (Cont’d)

- Major depression and dysthymia
  - Therapeutic interventions
    - Transport for evaluation
    - Suicidal, consult medical direction, follow protocols
    - Do not perform in-depth psychiatric interview

- Antidepressants [Obj. 16]
  - Monoamine oxidase inhibitors (MAOIs)
  - Tricyclic antidepressants (TCA)
  - Selective serotonin-reuptake inhibitors (SSRIs)

- Patient and family education
  - Serious condition, warn of suicide

Mood Disorders (Cont’d)

- Bipolar disorder and cyclothymia
  - Description and definition
    - Hypomania
    - Overwhelming sense of well-being, confidence
    - Mind moves quickly
    - Poor judgment, distractibility
Mood Disorders (Cont’d)

- Bipolar disorder and cyclothymia
  - Description and definition
    - Mania
      - Self-worth dangerously inflated, grandiose delusions
      - Elevated mood, limitless energy
      - Judgment impaired, irrational, risk

- Bipolar disorder and cyclothymia
  - Description and definition
    - Mixed episodes
      - Guilt, worthlessness of depression with energy, agitation of mania
      - Suicidal ideations

- Bipolar disorder and cyclothymia
  - Description and definition
    - Bipolar I
      - Shifts from melancholy to mania/mixed episode
    - Bipolar II
      - Depression, mood elevation stops at hypomania
Mood Disorders (Cont’d)

- Bipolar disorder and cyclothymia
  - Description and definition
    - Cyclothymia
      - Less severe
      - Hypomania periods, depression episodes
      - Shorter, more frequent

Mood Disorders (Cont’d)

- Bipolar disorder and cyclothymia
  - Etiology
    - Brain neurotransmitter level, receptor changes
    - Significant structural changes to limbic system
  - Epidemiology and demographics
    - Women more likely for rapid cycling
    - Bipolar II more frequent in women

Mood Disorders (Cont’d)

- Bipolar disorder and cyclothymia
  - History and physical findings
    - Manic episode is the defining symptom
    - Lack of sleep
    - Elevated, elated mood for 1+ week
    - Rushed, pressured speech
    - Loss of rationality, control
    - Substance abuse
Mood Disorders (Cont'd)

- Bipolar disorder and cyclothymia
  - Differential diagnosis
    - Anxiety disorders
    - Cushing syndrome
    - Head trauma
    - Hypothyroidism
    - Schizophrenia
    - Cancer
    - Neurosyphilis
    - Epilepsy
    - AIDS
    - Multiple sclerosis
    - Medication effects

- Bipolar disorder and cyclothymia
  - Differential diagnosis
    - Attention deficit hyperactivity disorder
    - Multiple personality disorder
    - Oppositional defiant disorder
    - Alcohol abuse, withdrawal
    - Stimulant abuse, withdrawal
    - Hallucinogen abuse
    - Opiate abuse, withdrawal

- Bipolar disorder and cyclothymia
  - Therapeutic interventions
    - Lithium toxicity possible
    - Initial assessment findings, secure venous access, monitor ECG, rapid transport
    - Patient and family education
    - Do not mean what they say during manic episode
Anxiety Disorders

- Description and definition
  - Fear
    - Physical, emotional reaction to real, perceived threat
  - Anxiety
    - Apprehension, worry about real/perceived future threats
  - Panic attack
    - Sudden, paralyzing anxiety reaction

Anxiety Disorders (Cont'd)

- Description and definition
  - Phobia
    - Intense fear of object/situation
  - Generalized anxiety disorder (GAD)
    - Not controlled
    - Prolonged stress symptoms
  - Posttraumatic stress disorder (PTSD)
    - Witnessing something terrible

Anxiety Disorders (Cont’d)

- Description and definition
  - Obsessive-compulsive disorder (OCD)
    - Obsession
    - Compulsion
    - Serotonin deficiency
Anxiety Disorders (Cont’d)

- **Etiology**
  - Marked hyperactivity in pons region, controlling sympathetic stimulation

- **Epidemiology and demographics**
  - 25% of Americans during their lifetime
  - Direct relation to depression

Anxiety Disorders (Cont’d)

- **History and physical findings**
  - Panic attack
    - Paralyzing terror
    - Chest pain, shortness of breath, nausea, diaphoresis, lightheadedness, dizziness
    - Extreme detachment from the environment
  - Phobias
    - Anxiety, avoidance reaction
  - PTSD
    - Days, months after event

Anxiety Disorders (Cont’d)

- **Differential diagnosis**
  - Addison’s disease
  - Alcohol intoxication, withdrawal
  - Anaphylaxis
  - Anorexia nervosa
  - Asthma
  - Marijuana intoxication, withdrawal
  - Conversion disorders
  - Major depression
  - Diabetes mellitus
  - Digitalis toxicity
  - Encephalopathy
  - Factitious disorder
  - Fibromyalgia
  - Hallucination intoxication, withdrawal
  - Malingering
  - Meningitis
  - Personality disorders
  - Autism
Anxiety Disorders (Cont’d)

- Differential diagnosis
  - Pulmonary embolism
  - Schizophrenia
  - Somatoform disorders
  - Stimulant intoxication, withdrawal
  - Unstable angina
  - Shock

Anxiety Disorders (Cont’d)

- Therapeutic interventions
  - Somatic symptoms must be investigated fully
  - Calm patient, remove external stimuli
  - Make eye contact, reassure
  - Attempt oxygen
  - Medical direction may authorize benzodiazepine
  - SSRIs
- Patient and family education
  - Patient has little control over symptoms

Somatoform Disorders

- Description and definition
  - Preoccupation with body
  - Conversion disorder
    - Convert psychological distress into pseudoneurological symptoms
  - Hypochondriasis
    - Preoccupation with having a serious medical illness
Somatoform Disorders (Cont’d)

- Description and definition
  - Somatization disorder
    - Multiple, recurring complaints resulting in medical treatment, impairment of life functioning
    - Pain in 4+ different sites
    - 2+ GI symptoms other than pain
    - 1+ sexual/reproductive symptom other than pain
    - 1+ neurological symptom other than pain

Somatoform Disorders (Cont’d)

- Etiology
  - Conversion disorder
    - Protective mechanism to shield yourself from emotional trauma, pain
  - Hypochondriasis
    - Failed attempt to cope with psychological needs

Somatoform Disorders (Cont’d)

- Epidemiology and demographics
  - Women, except hypochondriasis
- History and physical findings
  - Motor, sensory nervous deficits
Somatoform Disorders (Cont’d)

- Differential diagnosis
  - GAD
  - Major depression
  - Cerebrovascular accident/transient ischemic attack
  - Factitious disorder
  - Substance intoxication, withdrawal
  - Hundreds of medical conditions

Fictitious Disorder and Malingering

- Description and definition
  - Intentionally produce signs and symptoms to assume sick role
  - Munchausen syndrome
  - Medically knowledgeable
  - Factitious illness by proxy
  - Malingering

Fictitious Disorder and Malingering (Cont’d)

- Etiology
  - Lacked emotional care, support in early childhood
- Epidemiology and demographics
  - Unable, several aliases
- History and physical findings
  - Multiple symptoms, goes to extreme lengths to produce physical signs
Fictitious Disorder and Malingering (Cont'd)

- Differential diagnosis
  - Medical illness
  - Somatoform disorders
- Therapeutic interventions
  - Do not confront patient about feigning symptoms
  - Discretely inform physician of suspicions

Eating Disorders

- Description and definition
  - Anorexia nervosa
    - Distorted body image, drastic, intentional weight loss
  - Bulimia nervosa
    - Binging, purging of food

Eating Disorders (Cont'd)

- Etiology
  - Brain chemistry, structure abnormalities
  - Fear, helplessness
  - Self-control, independence
  - Bulimia, imbalance of brain neurotransmitters
  - Mood, anxiety disorders common
Eating Disorders (Cont'd)

- History and physical findings
  - Malnutrition
  - Hyperactivity
  - Delayed onset of menstruation, GI problems
  - Dehydration, hypotension, bradycardia, cardiac arrhythmias
  - Lanugo
  - Flat affect, psychomotor retardation
  - Bulimia, tooth decay

Eating Disorders (Cont’d)

- Differential diagnosis
  - Brain abscess
  - Cancer
  - Major depression
  - Anxiety disorders
  - AIDS

Eating Disorders (Cont’d)

- Therapeutic interventions
  - Treat symptoms
  - Avoid confrontation
- Patient and family education
  - Abnormal brain function
Personality Disorders

- Cluster A, odd and eccentric
  - Description and definition
  - Etiology
  - Epidemiology and demographics
  - History and physical findings
  - Differential diagnosis
  - Therapeutic interventions

Personality Disorders (Cont’d)

- Cluster A, odd and eccentric
  - Description and definition
    - Odd, eccentric
    - Paranoid personality disorder
    - Schizoid personality disorder
    - Schizotypal personality disorder

Personality Disorders (Cont’d)

- Cluster A, odd and eccentric
  - Etiology
    - Similar to schizophrenia
  - Epidemiology and demographics
    - 3%, schizotypal personality most common
  - History and physical findings
    - Emotionless, blunt affect
    - Delusions, hallucinations
Personality Disorders (Cont’d)

- Cluster A, odd and eccentric
  - Differential diagnosis
    - Schizophrenia
    - Major depression
    - Avoidant personality disorder
    - Borderline personality disorder

Personality Disorders (Cont’d)

- Cluster A, odd and eccentric
  - Therapeutic interventions
    - Avoid directly challenging the patient
    - Explain medical diagnoses, procedures in clear, plain language

Personality Disorders (Cont’d)

- Cluster B, emotional and dramatic
  - Description and definition
    - Impulsive, unpredictable, labile
    - Emotional, dramatic
    - Histrionic personality disorder
    - Borderline personality disorder
    - Antisocial personality disorder
    - Narcissistic personality disorder
Personality Disorders (Cont’d)

- Cluster B, emotional and dramatic
  - Epidemiology and demographics
    - 10-15% of psychiatric disorders, histrionic
    - Borderline, women
    - Substance abuse, alcohol
  
Personality Disorders (Cont’d)

- Cluster B, emotional and dramatic
  - History and physical findings
    - Histrionic
      - Flirtatious, conversion disorder symptoms
    - Borderline
      - Lacks emotional control, anger
      - Self-injury, suicide
      - Inability to form close relationships
  
Personality Disorders (Cont’d)

- Cluster B, emotional and dramatic
  - Differential diagnosis
    - Cyclothymia
    - Bipolar disorder
    - Atypical depression
    - Substance abuse
  - Therapeutic interventions
    - Management of self-destruction
Personality Disorders (Cont’d)

- Cluster C, anxious and fearful
  - Description and definition
  - Crippling shyness, anxiety
  - Avoidant personality disorder
  - Dependent personality disorder
  - Obsessive-compulsive personality disorder

Personality Disorders (Cont’d)

- Cluster C, anxious and fearful
  - Etiology
    - Possibly genetic
  - Epidemiology and demographics
    - 0.5-1% of the population, avoidant
    - Depression, anxiety disorders coexist
  - History and physical findings
    - Dependent, submissive
    - Compulsive, loss of control

Personality Disorders (Cont’d)

- Cluster C, anxious and fearful
  - Differential diagnosis
    - Anxiety disorders
    - Major depression
    - Obsessive-compulsive disorder
  - Therapeutic interventions
    - Reassurance, comfort
Suicidal Patient and Self-injury

- Epidemiology and demographics
  - 10% consider suicide
  - 0.3% attempt suicide
  - 3-10% are teenagers
  - Self-injury, 4% of the adult population

Suicidal Patient and Self-injury (Cont'd)

- Risk factors
  - Previous attempt, repeat 1-2 years
  - Mood disorders, higher risk
  - Drugs, alcohol
  - Chronic, terminal illnesses
- Assessment
  - Ask about suicidal, homicidal thoughts
  - Direct, open

Suicidal Patient and Self-injury (Cont'd)

- Management
  - Consider the patient violent
  - Stay away, wait for police
  - Life-threatening problems
  - Respiratory depression, failure
  - Respect, listen, dignified transport
  - Ethical, legal obligation ensure proper treatment
Impulse Control Disorders

- Failure to resist impulse, drive, temptation to perform harmful acts to self, others
- Increased arousal, excitement, tension before performing impulsive act, then sense of relief, pleasure

Impulse Control Disorders (Cont’d)

- Pathological gambling
  - Description and definition
    - Persistent, recurrent preoccupation, interferes with normal life functions
    - Neglect financial obligations, embezzle money, exploit relationships to finance gambling

Impulse Control Disorders (Cont’d)

- Pathological gambling
  - History
    - Phases
      - Winning
      - Losing
      - Desperation
      - Hopelessness
Impulse Control Disorders (Cont'd)

- Pathological gambling
  - History
    - Five or more of the following characteristics
    - Lies to conceal gambling habit
    - Increases frequency, funds to gamble to increase excitement
    - Anxiety, irritability when unable to gamble
    - Escape from life’s problems
    - Stolen money to support habit
    - Ignores other financial obligations
    - Borrows money to finance
    - Jeopardizes family, work

- Differential diagnosis
  - Social gambling
  - Manic episode
  - Antisocial, narcissistic personality disorders

- Therapeutic intervention
  - Recognition, acceptance of problem
  - Psychological counseling

Impulse Control Disorders (Cont'd)

- Kleptomania
  - Description and definition
    - Recurrent, compulsive theft
  - Etiology and epidemiology
    - Rare
    - Serotonin level abnormality
    - Women more common
Impulse Control Disorders (Cont'd)

- Kleptomania
  - History
    - Long history of theft, possibly multiple convictions
    - Tension, arousal before theft, release/pleasure after theft
    - No financial gain

Impulse Control Disorders (Cont'd)

- Kleptomania
  - Differential diagnosis
    - Manic episodes
    - Antisocial personality disorder
    - Conduct disorder
    - Ordinary criminal acts
    - Delusional acts
  - Therapeutic intervention
    - Recognition, acceptance of problem

Impulse Control Disorders (Cont'd)

- Trichotillomania
  - Definition and description
    - Habitual hair pulling, noticeable hair loss
    - OCD
  - Etiology and epidemiology
    - Women
    - Scalp, eyebrows, eyelashes
    - Tension-relief sensation
Impulse Control Disorders (Cont’d)

- Trichotillomania
  - History
    - Distress, normal life function impairment
  - Differential diagnosis
    - Alopecia
    - OCD
    - Munchausen syndrome
  - Therapeutic intervention
    - Behavior modification, habit reversal

Impulse Control Disorders (Cont’d)

- Intermittent explosive disorder
  - Scene safety, recurrent violent, aggressive outburst grossly out of proportion to stimulus
  - Must result in physical assaults on individuals/animals, property destruction

Impulse Control Disorders (Cont’d)

- Intermittent explosive disorder
  - Etiology and epidemiology
    - Disproportionate aggression, loss of control
    - Males
    - Does not accept responsibility for actions
    - Blames victim
  - History
    - Physical, verbal aggression toward people, animals, property, occurs two times/week for 1 month
Impulse Control Disorders (Cont’d)

- Intermittent explosive disorder
  - Differential diagnosis
    - Head trauma
    - Dementia
    - Personality disorders
    - Conduct disorders
    - Psychotic disorders

- Treatment
  - Ensure crew safety
  - Traumatic injuries
  - Psychiatric counseling, mood stabilizers, antidepressant medications

Impulse Control Disorders (Cont’d)

- Intermittent explosive disorder
  - Treatment
    - Ensure crew safety
    - Traumatic injuries
    - Psychiatric counseling, mood stabilizers, antidepressant medications

Impulse Control Disorders (Cont’d)

- Pyromania
  - Description and definition
    - Repeated, intentional fire setting
  - Etiology and epidemiology
    - Male children
    - Episodic
    - Must set two or more destructive fires
    - Poor social skills, dysfunctional parent relationship
Impulse Control Disorders (Cont'd)

- **Pyromania**
  - **History**
    - Intentional fire setting two or more times
    - Tension, excitement before event, pleasure, relief, gratification after
    - Obsession, preoccupation with fire
    - Not set for monetary gain, personal profit, vengeance, curiosity, hide the crime
    - Poor relationships with parents
    - Poor social skills
    - Poor learning ability
    - Emotional difficulties, disorders

- **Differential diagnosis**
  - Childhood curiosity
  - Arson
  - Malicious intent
  - Personality disorders
  - Conduct disorders
  - Manic episodes

- **Therapeutic intervention**
  - Treat resulting burns

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Principles of Behavioral Emergency Management

- **Patient rights and expectations**
  - Observation, evaluation, emotional support
  - Respect, attention
  - Privately question
Principles of Behavioral Emergency Management (Cont’d)

- Verbal restraint
  - Voice tone can anger, never raise voice
  - Businesslike, courteous
  - Do not take insults personally, many not aware of actions
  - Never leave partner alone

Principles of Behavioral Emergency Management (Cont’d)

- Involuntary transport and patient restraint
  - Verbal comes first
  - Physical, chemical as last resort
  - Restraints for capable never permissible
  - Law enforcement present

Principles of Behavioral Emergency Management (Cont’d)

- Involuntary transport and patient restraint
  - Plan
    - Five personnel
    - Designate a team leader
    - Careful coordination prevents injury
    - Standard precautions
    - Proper equipment
    - Soft restraints
    - No police handcuffs
    - Explain why transporting against will, offer opportunity for voluntary transport
Principles of Behavioral Emergency Management (Cont’d)

• Involuntary transport and patient restraint
  ➢ Plan
    • On backboard
    • One wrist above head, other by hips
    • Secure legs with seat belt across thighs, just above knees
    • Nonrebreather, surgical mask to prevent spitting
    • One finger fit beneath restraint

Principles of Behavioral Emergency Management (Cont’d)

• Involuntary transport and patient restraint
  ➢ Physically restrained should be chemically restrained
    • Calm behavior with altering consciousness
    • Benzodiazepine, butyrophenone
    • Monitor respiratory rate, pulse oximetry, mental status, ECG

Principles of Behavioral Emergency Management (Cont’d)

• Restraint asphyxia
  ➢ Description and definition
    • Inability to expand chest cavity, create negative lung pressure for inspiration
  ➢ Etiology
    • Positional asphyxia
    • Do not hog tie
    • Too tight, incorrect application
    • May strangle, escape attempt
Principles of Behavioral Emergency Management (Cont’d)

- Restraint asphyxia
  - Epidemiology and demographics
  - 142 deaths in 10 years
  - History and physical findings
    - Asystole, apnea within minutes
    - Ceases struggling, becomes quiet

- Differential diagnosis
  - Suicide attempt
  - Excited delirium
  - Complications from unknown medical condition
  - Overdose, adverse drug effects, alcohol

- Therapeutic interventions
  - Prevention
  - Never prone position

Principles of Behavioral Emergency Management (Cont’d)

Restraints with Handcuffs
Principles of Behavioral Emergency Management (Cont’d)

Proper Restraints

Improper Restraints

Substance Abuse

- Use, abuse, and addiction
  - All-consuming compulsion
  - Continued need
  - Consistent craving, desire to curb use
  - Malnutrition
  - Often combine drugs to increase effect
Substance Abuse (Cont’d)

- Tolerance and withdrawal
  - Over time, repeated use, receptors become less sensitive, higher doses needed
  - Disrupt homeostasis with abrupt stop
  - Addiction indicator

Ethanol

- Description and form
  - Intoxicating ingredient in liquor, wine, beer

- Epidemiology and demographics
  - Most commonly used, abused
  - Alcoholism
    - 38% of all traffic fatalities
  - Leading cause of death, disability in the United States

Ethanol (Cont’d)

- Routes and pathophysiology
  - Absorbed into bloodstream through digestive tract, 20% by stomach, remainder through small intestine
  - Blood alcohol content (BAC)
    - Milligrams of ETOH/deciliter of blood/100
    - Excreted through urine, lungs, metabolized by liver
Ethanol (Cont’d)

- Paraphernalia
  - Bottles, cans, kegs
  - Mixed with nonalcoholic beverages

Ethanol (Cont’d)

- Subjective effects and physical findings [Obj. 6]
  - Vary widely
  - Lose ability to make decisions, risky behavior
  - Neurological symptoms
  - Tachycardia, vasodilation
  - Dysrhythmias

Ethanol (Cont’d)

- Tolerance and withdrawal
  - Hangover
  - Delirium tremens (DT)
    - Psychosis, confusion, generalized seizures
    - Sympathetic stimulation causes diaphoresis, hyperthermia, hyperventilation, dehydration
    - If untreated, 35% fatal
Ethanol (Cont’d)

- Long-term effects
  - Liver toxicity
    - Portal hypertension
    - Blood backing up from liver
  - Alcoholism
    - Biological, psychological, and social symptoms

Ethanol (Cont’d)

- Long-term effects
  - Wernicke-Korsakoff syndrome
    - Inability to absorb thiamine
    - Confusion, odd movements, eye muscle paralysis, abnormal gait
    - Hypothermia, hypotension
    - Amnesia, inability to learn, permanent psychosis

Ethanol (Cont’d)

- Differential diagnosis
  - Hyperosmolar hyperglycemic nonketotic coma
  - Pancreatitis
  - Diabetic ketoacidosis
  - Hypoglycemia
  - Meningitis, encephalitis
  - Status epilepticus
  - Subarachnoid hemorrhage
  - Ethylene glycol poisoning
  - Lithium toxicity

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Ethanol (Cont'd)

- Therapeutic interventions
  - Protect airway
  - Assess mental status
  - DT, oxygen, IV with normal saline
- Patient and family education
  - Altered mental status, patient must be transported
  - Potential for aspiration, hypotension, death

Stimulant Drugs

- Cocaine
  - Description and form
    - CNS stimulant
    - Schedule II medication
  - Epidemiology and demographics
    - Most frequent cause of drug-related visits to ER

Stimulant Drugs (Cont'd)

- Cocaine
  - Routes and pathophysiology
    - Smoked, injected, oral, intranasally
    - Block dopamine reuptake, heavy activation of brain’s reward system
    - Highly addictive
    - Speedballing
Stimulant Drugs (Cont’d)

- Cocaine
  - Subjective effects and physical findings
  - Euphoria, intense energy, seizures
  - Tactile hallucinations/cocaine bugs
  - Bizarre, erratic, violent behavior possible
  - Dilated, sluggish pupils, tachycardia, vasoconstriction
  - Sudden death
  - Within 1 hour of use, 24× risk of heart attack
  - Affects temperature-regulating centers in the hypothalamus

- Cocaine
  - Long-term effects
    - Dependence, addiction
    - Heart disease
    - Narrows cerebral arteries, decreases blood flow to brain, impairs cognition
    - Loss of sense of smell
    - Weight loss, malnutrition
  - Tolerance and withdrawal
    - Lethargy, severe depression, anxiety, anhedonia, intense cravings

- Cocaine
  - Differential diagnosis
    - Alcohol intoxication
    - Encephalitis
    - Hypoglycemia
    - Hypokalemia
    - Panic attack
    - Ischemic stroke
    - Subarachnoid hemorrhage
    - Anticholinergic toxicity
    - Antidepressant toxicity
    - Benzodiazepine intoxication
    - Methamphetamine intoxication
    - Hallucinogenic mushroom intoxication
    - PCP intoxication
Stimulant Drugs (Cont’d)

- **Cocaine**
  - **Therapeutic interventions**
    - Crew safety
    - Monitor patient behavior, body language for violence
    - Call police as needed
    - 100% O₂, nonrebreather mask
    - 12-lead ECG
    - IV access by isotonic crystalloid, avoid large amounts of fluid
    - Chest pain, benzodiazepines per medical direction
    - Advanced cardiac life support protocols

Stimulant Drugs (Cont’d)

- **Ecstasy**
  - **Description and form**
    - 3,4-Methylenedioxymethamphetamine (MDMA)
    - Methamphetamine, mescaline structure
    - Pill
    - Schedule I drug

Stimulant Drugs (Cont’d)

- **Ecstasy**
  - **Routes and pathophysiology**
    - 1–2 mg/kg effectiveness
    - Mostly tablets, rarely liquid
    - Effects begin within 20–40 minutes
    - 6–10 hours lasting effect
    - Blocks reuptake molecules on presynaptic neuron, floods synapses of brain with serotonin
    - Candy flipping
Stimulant Drugs (Cont'd)

- Ecstasy
  - Paraphernalia
    - Stuffed animal for feel sensation
    - Lights intensify effect
    - Menthol rub
    - Lollipop to prevent teeth grinding

Stimulant Drugs (Cont'd)

- Ecstasy
  - Subjective effects and physical findings
    - Increased energy, euphoria, heightened sexuality, expanded consciousness
    - Tachycardia, hypertension, hyperthermia, dilated pupils
    - Clenched jaw, teeth grinding
    - Doses 4-5 mg/kg, sharp body temperature spike, rapid/severe dehydration, brain damage, death

Stimulant Drugs (Cont'd)

- Ecstasy
  - Tolerance and withdrawal
    - Depression, anxiety, fear
    - Sympathomimetic toxicity
  - Long-term effects
    - Decreased memory, cognitive impairment
Stimulant Drugs (Cont’d)

- Ecstasy
  - Differential diagnosis
    - Alcohol intoxication
    - Encephalitis
    - Hypoglycemia
    - Hypokalemia
    - Panic disorder
    - Ischemic stroke
    - Subarachnoid hemorrhage
    - Anticholinergic toxicity
    - Antidepressant toxicity
    - Benzodiazepine intoxication
    - Methamphetamine intoxication
    - Hallucinogenic mushroom intoxication
    - PCP intoxication

- Ecstasy
  - Therapeutic interventions
    - Mental status, monitoring vital signs
    - Cooling measures when indicated
    - IV with isotonic crystalloid, large-bore catheter for fluid administration
    - Advanced cardiac life support protocols
  - Patient and family education
    - Not safe
    - Hyperthermia
    - Fluid intake needed

Stimulant Drugs (Cont’d)

- Methamphetamine
  - Description and form
    - White, powdered form
    - Crystal more pure
  - Epidemiology and demographics
    - 18-25 years, males
    - Native Hawaiians, Pacific Islanders, American Indians
Stimulant Drugs (Cont’d)

- Methamphetamine
  - Routes and pathophysiology
    - Crystal, smoked
    - Powdered, smoked, ingested, injected, snorted
    - Onset of 30 seconds, last for 24 hours
  - Paraphernalia
    - Pipe, syringes, short straws

- Methamphetamine
  - Subjective effects and physical findings
    - Binging, craving
    - Tachycardia
    - Hypertension
    - Tachypnea
    - Hyperthermia
    - Palpitations
    - Premature ventricular contractions
    - Dry mouth
    - Abdominal cramps
    - Suppressed appetite
    - Twitching
    - Pallor
    - Dilated pupils
    - Tweeking
    - Hallucinations, delusions

- Methamphetamine
  - Tolerance and withdrawal
    - Depression, anxiety, fatigue, paranoia, aggression, intense craving
  - Long-term effects
    - Severe, permanent damage
    - Brain neurons out
    - Loss of cognitive function
    - Age lasting
Stimulant Drugs (Cont'd)

- Methamphetamine
  - Differential diagnosis
    - ETOH intoxication
    - Encephalitis
    - Hypoglycemia
    - Hypoxemia
    - Panic disorder
    - Ischemic stroke
    - Subarachnoid hemorrhage
    - Anticholinergic toxicity
    - Antidepressant toxicity
    - Benzodiazepine intoxication
    - Cocaine intoxication
    - Hallucinogenic mushroom intoxication
    - PCP intoxication

Stimulant Drugs (Cont'd)

- Methamphetamine
  - Therapeutic interventions
    - Crew safety
    - Monitor patient behavior, body language for violence
    - Call police as needed
    - Uncomplicated intoxication, supportive care
      - 100% oxygen, nonrebreather mask
      - 12-lead ECG
      - IV access by isotonic crystalloid, avoid large amounts of fluid
      - Chest pain, benzodiazepines per medical direction
      - Advanced cardiac life support protocols

Excited Delirium

- Description and definition
  - Paranoia, aggression, hyperthermia, increased strength, pain insensitivity, sudden death

- Etiology
  - Long-term stimulant abuse, heart disease
  - Genetic fault, prevents brain from adjusting to drug receptors in limbic system
Excited Delirium (Cont’d)

- **Epidemiology and demographics**
  - Men, aged 20-40 years
  - Long history of stimulant abuse

- **History and physical findings**
  - Tachycardic, hypertensive, hyperthermic, combative
  - Restraints, calm/quiet, respiratory, cardiac arrest

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Excited Delirium (Cont’d)

- **Differential diagnosis**
  - Restraint asphyxia
  - Cocaine toxicity
  - Methamphetamine toxicity

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Excited Delirium (Cont’d)

- **Therapeutic interventions**
  - Prevention
  - Chemical restraints with physical restraints
  - 100% oxygen
  - Rapid cooling measures
Depressant Drugs

- Sedative-hypnotics
  - Description and form
    - Powerful relaxation, euphoria
    - Anxiety relief, insomnia, control seizures
    - Barbiturates, benzodiazepines

Depressant Drugs (Cont’d)

- Sedative-hypnotics
  - Routes and pathophysiology
    - Ingested through prescription
    - Injected
  - Subjective effects and physical findings
    - Sleepy, sedated feeling, reduces anxiety/worry
    - With alcohol, bradycardia, slowed respiratory rate, death
    - Suicide attempts

Depressant Drugs (Cont’d)

- Sedative-hypnotics
  - Tolerance and withdrawal
    - Surge of brain activity, seizures
  - Long-term effects
    - Addiction, tolerance
    - Amnesia, irritability, anger
Depressant Drugs (Cont’d)

- Sedative-hypnotics
  - Differential diagnosis
    - ETOH abuse, withdrawal
    - Brain abscess
    - DT
    - Diabetic ketoacidosis
    - Epidural hematoma
  - Hyperosmolar hyperglycemic nonketotic coma
  - Hypertensive emergencies
  - Hypoglycemia
  - Metabolic acidosis
  - Brain tumor

Depressant Drugs (Cont’d)

- Sedative-hypnotics
  - Therapeutic interventions
    - Secure airway, IV
  - Patient and family education
    - Addicting, side effects

Depressant Drugs (Cont’d)

- Gamma-hydroxybutyrate
  - Description and form
    - White powder, narcolepsy treatment
    - Liquid ecstasy
  - Epidemiology and demographics
    - Greatly reduced in past years
Depressant Drugs (Cont’d)

- Routes and pathophysiology
  - Subjective effects and physical findings
    - Rapid unresponsiveness
    - Nausea, vomiting, tremors, agitation, hallucinations, bradycardia
    - Overdoses: Cheyne-Stokes respirations, seizures, death

Depressant Drugs (Cont’d)

- Routes and pathophysiology
  - Tolerance and withdrawal
    - Tachycardia, hypertension, tremor, confusion, nausea, vomiting
    - Hallucinations, paranoia, anxiety, disorientation
    - 3-15 days
  - Long-term effects
    - Unknown

Depressant Drugs (Cont’d)

- Routes and pathophysiology
  - Differential diagnosis
    - Opioid intoxication
    - ETOH intoxication
    - Suicide attempt
    - Neurological illness, injury
    - Date rape
  - Therapeutic interventions
    - Protect airway
    - Nasopharyngeal airways, atropine
Depressant Drugs (Cont'd)

- **Opioids**
  - **Description and form**
    - Analgesics
    - Morphine, codeine, oxycodone, heroin, opium
    - Pills, tablets, syrups
  - **Routes and pathophysiology**
    - Ingestion, injection, intranasal inhalation, smoking
    - 5-8 minute onset
    - Euphoria
  - **Paraphernalia**
    - Flame, spoon, syringe

Depressant Drugs (Cont'd)

- **Opioids**
  - **Subjective effects and physical findings**
    - Euphoria, depression
    - Pupils constricted, decreased heart rate, orthostatic blood pressure changes, pulmonary edema
  - **Tolerance and withdrawal**
    - Opioid withdrawal within a few hours
    - Yawning, runny nose, nausea, vomiting, diarrhea, sweating, muscle pain, bone pain, anxiety, tachycardia
Depressant Drugs (Cont’d)

- **Opioids**
  - Long-term effects
    - Scarred, collapsed veins
    - Blood/heart valve infections
    - Skin abscess
    - Ischemic conditions
    - HIV
    - Hepatitis

Depressant Drugs (Cont’d)

- **Opioids**
  - Differential diagnosis
    - Cardiac arrest
    - ETOH intoxication
    - GHB intoxication
    - Dissociative intoxication

Depressant Drugs (Cont’d)

- **Opioids**
  - Therapeutic interventions
    - Open airway, avoid oral, endotracheal intubation
    - Lungs adequately ventilated, naloxone IV
  - Patient and family education
    - Smoking, snorting heroin is as dangerous as injection
Marijuana

- Description and form
  - Cannabis sativa
  - Tetrahydrocannabinol (THC) primary
  - Hashish
  - Schedule I drug

Marijuana (Cont’d)

- Routes and pathophysiology
  - THC enters bloodstream from smoking
  - Eating

- Paraphernalia
  - Cigarettes, cigars, pipes

Marijuana (Cont’d)

- Subjective effects and physical findings
  - Sensation, perception, thinking, coordination
  - Relaxed euphoria, sleepiness
  - Mild tachycardia, bronchodilation
  - Increased appetite, dry mouth, urinary retention
  - Angina, myocardial infarction
Marijuana (Cont’d)

- Tolerance and withdrawal
  - Dependence, addiction
  - Irritability, insomnia, nausea, decreased appetite, restlessness

Marijuana (Cont’d)

- Long-term effects
  - Throat, pulmonary tree damage
  - Three times as much tar and five times as much carbon monoxide as cigarettes
  - Spontaneous pneumothorax/pneumomediastinum
  - Hippocampus affected

Marijuana (Cont’d)

- Differential diagnosis
  - Alcoholism
  - Anxiety disorders
  - Bipolar disorders
  - Depressive disorders
  - Hallucinogen abuse
  - Inhalant abuse
  - Opioid abuse
  - Panic attack
  - Schizophrenia
  - Cocaine abuse
  - Dissociative drug abuse
Marijuana (Cont'd)

- Therapeutic interventions
  - Calm, coach
  - Treat dyspnea, chest pain
- Patient and family education
  - Long-term consequences harmful

Inhalants

- Description and form
  - Glue, shoe polish, gasoline, hydrocarbons
- Epidemiology and demographics
  - Teenagers, young adults, males

Inhalants (Cont'd)

- Routes and pathophysiology
  - Fumes into lungs, bloodstream through alveoli
  - Pass freely through blood-brain barrier
  - Hypoxia, hypercarbia result
- Paraphernalia
  - Containers, plastic bags, whippets
Inhalants (Cont’d)

• Subjective effects and physical findings
  ➢ Euphoria, speech slurred, staggering gait
  ➢ Hallucinations, drowsiness, sleep
  ➢ Uninhibited, impulsive, trauma
  ➢ Suffocation
  ➢ Sudden sniffing death syndrome
  ➢ Strong chemical odor on breath

Inhalants (Cont’d)

• Tolerance and withdrawal
  ➢ Switch chemical
  ➢ Frontal lobe damage, lowers intelligence, impairs decision-making ability, further abuse
  ➢ Insomnia
  ➢ Irritability
  ➢ Jitteriness
  ➢ Nausea, vomiting
  ➢ Tachycardia

Inhalants (Cont’d)

• Long-term effects
  ➢ Suicidal ideations, other abuse
  ➢ Damage to heart, lungs, liver, kidneys, brain
  ➢ Congestive heart failure
  ➢ Renal failure
  ➢ Immune system inhibition
  ➢ Brain atrophy, dementia, loss of coordination
Inhalants (Cont’d)

- Differential diagnosis
  - ETOH intoxication
  - Stimulant intoxication
  - Dissociative intoxication
  - Hallucinogen intoxications
  - Traumatic brain injury

Inhalants (Cont’d)

- Therapeutic interventions
  - Scene safety
  - Poisonous, flammable fumes
  - Airway control, 100% high-flow oxygen, monitor ECG, avoid epinephrine
  - Prevention, education

Hallucinogens

- Description and form
  - Distort perceptions of reality
  - Mushrooms
  - Cactus, mescaline
  - LSD
Hallucinogens (Cont’d)

- Routes and pathophysiology
  - Ingested, skin absorption
  - Alter concentrations of serotonin, norepinephrine within the brain, cerebral cortex
  - 30-90 minute onset
- Paraphernalia
  - Paper

Hallucinogens (Cont’d)

- Subjective effects and physical findings
  - Trips
  - Visual hallucinations, distortion of spatial perception
  - Labile
  - Intensified memories
  - Time moves slowly

Hallucinogens (Cont’d)

- Tolerance and withdrawal
  - Within a few days
- Long-term effects
  - Melancholy, mania
  - Flashbacks
Hallucinogens (Cont’d)

- Therapeutic interventions
  - Calming, comforting
  - Trauma management

Hallucinogens (Cont’d)

- Differential diagnosis
  - Dissociative intoxication
  - ETOH intoxication, withdrawal
  - MDMA intoxication
  - Excited delirium

Dissociatives

- Description and form
  - Distort sight, sound perceptions
  - Detachment
  - PCP, ketamine, dextromethorphan
Dissociatives (Cont'd)

- Routes and pathophysiology
  - Injection, orally, snorted, smoked
  - Seconds to minutes
- Paraphernalia
  - Plastic inhaler

Dissociatives (Cont'd)

- Subjective effects and physical findings
  - Euphoria, agitation, violence, rage, unpredictable behavior
  - Unresponsive, extension posturing, muscle rigidity
  - Hyperthermia
  - K-land
  - Hallucinations, distortions

Dissociatives (Cont'd)

- Tolerance and withdrawal
  - Addiction, severe withdrawal for ketamine
  - Craving, dysphoria, sleep disturbances
- Long-term effects
  - Decreased memory, attention, cognition, flashbacks
Dissociatives (Cont’d)

- Differential diagnosis
  - Hallucinogen abuse
  - ETOH abuse, withdrawal
  - MDMA abuse
  - Psychosis
  - Schizophrenia

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Dissociatives (Cont’d)

- Therapeutic interventions
  - Violent, irrational, combative, superhuman strength
  - Excited delirium
  - Do not talk down
  - Airway, supplemental oxygen

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Clandestine Laboratories

- Methamphetamine
  - Meth laboratories
  - Common ingredients
  - Located in inconspicuous places
  - Quickly evacuate
  - Do not stop chemical reactions, turn off heat sources
  - Request law enforcement, hazardous materials teams
Club Drugs and Drugs Abused for Sexual Purposes

- MDMA
- Ketamine, dextromethorphan
- Facilitate sex, sexual assault
  - May cause impotence
  - Used with treatment for erectile dysfunction

Club Drugs and Drugs Abused for Sexual Purposes (Cont’d)

- Sexual assault
  - CNS depressants
  - GHB
  - ETOH
  - Rohypnol

Chapter Summary

- Most essential skill for dealing with behavioral emergencies is listening
- "Normal" behavior usually measured against standards and expectations of society
- Behavioral emergency results when patient’s ideas and actions are harmful, potentially harmful to himself, herself, and/or others
Chapter Summary (Cont’d)

- Majority of human emotional experience originates in the limbic system of the brain
- Organic behavioral emergencies have biological causes (e.g., stroke, hypoglycemia)
- Alterations in concentrations, actions of neurotransmitters in the brain linked to many psychiatric and substance abuse disorders

Chapter Summary (Cont’d)

- Psychosocial factors, life changes, events that may worsen psychiatric problems
- Events during childhood help cause mental illness; these are called developmental factors
- Biopsychosocial concept of mental illness proposes that mental illnesses result from complex interactions among biological makeup, behavior, and a person’s environment

Chapter Summary (Cont’d)

- For the majority of behavioral emergencies, such as a violent/suicidal patient, stage away from the scene, wait for law enforcement before entering
- Careful study of patient’s residence and surroundings yields important clues about his or her state of mind and illness
Chapter Summary (Cont’d)

• When interviewing a patient with behavioral emergency, maintain a quiet, non-threatening environment with equal and open access to exits for you and for the patient
• Do not be afraid to ask bystanders, family, and friends to leave the scene; move the patient to an ambulance to create a private and quiet setting

Chapter Summary (Cont’d)

• Open-ended questions about how patient has been feeling and acting yield best results
• Assess and treat all reports of pain and discomfort per local protocols; do not dismiss somatic complaints of patients with behavioral emergencies

Chapter Summary (Cont’d)

• Always suspect organic illness in patients with sudden-onset behavioral emergency with no prior history
• Perform a neurological examination and detailed interview for all patients with behavioral emergencies
Chapter Summary (Cont’d)

- Speech patterns and mannerisms can be assessed to learn more about the patient’s form of thought, specifically the rate of speech and looseness of associations
- Psychosis is a state of highly distorted perceptions of reality with hallucinations and delusions

Chapter Summary (Cont’d)

- Hallucination is false sensory information that originates within the brain; delusion is a false perception/interpretation of events and situations
- Preoccupations are ideas that consistently and constantly return to the patient’s mind
- Affect is an outward expression of a patient’s emotions as observed and described by the interviewer

Chapter Summary (Cont’d)

- Mood is a dominant and sustained emotional state of the patient, a lens through which he or she sees world
- Affect can be an emotional weather that fluctuates around mood and emotional climate
Chapter Summary (Cont’d)

- Dysphoria is an extremely depressed/low mood; euphoria is an exaggerated feeling of joy and happiness
- Schizophrenia is a neurological illness marked by psychotic symptoms, disorders of thought, and a decrease of social interactions

Chapter Summary (Cont’d)

- Anhedonia is defined as a lack of enjoyment of activities and of people the patient used to find pleasurable
- Long-term use of antipsychotic medications often leads to tardive dyskinesia, a neurological disorder characterized by involuntary movements of the mouth and face

Chapter Summary (Cont’d)

- Mood runs in a continuum from melancholy at the low end to mania at the high end
- Dysthymia is a chronic, constant, low-grade depression
Chapter Summary (Cont’d)

- Patients with melancholic episodes only have unipolar depression; patients whose melancholic episodes alternate with hypomania, mania, and mixed episodes have bipolar disorder
- Cyclothymia is a lesser form of bipolar disorder

Chapter Summary (Cont’d)

- Fear is a physical and emotional reaction to a real or perceived threat; anxiety is apprehension and worry about future event
- Panic attacks are sudden, severe, paralyzing anxiety reactions

Chapter Summary (Cont’d)

- Phobias are intense fears of specific objects and situations
- Excessive, persistent worrying about everyday events is termed generalized anxiety disorder
Episodes of vivid, disturbing memories and dreams alternating with periods of emotional numbness after a traumatic event define PSD.

OCD consists of unwanted, intrusive ideas (obsessions), specific, repetitive rituals that patients believe they must perform (compulsions).

Somatoform disorders are characterized by abnormal preoccupations with the body and physical symptoms.

Patients with factitious disorder intentionally produce signs and symptoms of illness to assume a sick role.

Faking illness for tangible gain is malingering.

Patients with anorexia nervosa consistently see themselves as overweight, take drastic measures to become thin, have strange behaviors and rituals associated with food and eating.

Eating large amounts of food in one setting (binging) and forcing oneself to vomit/use laxatives (purging) to avoid gaining weight are characteristic of bulimia.
Chapter Summary (Cont’d)

- Personality disorders are abnormal, damaging ways of thinking about and interacting with the world that are always present.
- Three groupings of personality disorders exist: odd and eccentric disorders (cluster A), emotional and dramatic disorders (cluster B), and anxious and fearful disorders (cluster C).

Chapter Summary (Cont’d)

- Suicide is an act of ending one’s own life
  - Suicidal ideations are thoughts of suicide
  - Suicide attempts are unsuccessful tries to end one’s own life
- Self-injury
  - Cutting, burning, and hurting oneself is an unhealthy coping mechanism for overwhelming and troubling emotions.

Chapter Summary (Cont’d)

- To care for behavioral patients, move out of the mindset characterized by invasive procedures and drugs into one of observation, evaluation, and emotional support.
- Stop violent situations by preventing them.
Chapter Summary (Cont’d)

- Physical and chemical restraints are last resorts; use them only to prevent patients from harming themselves and others
- Patient restraint carries medical, legal, ethical risks

Chapter Summary (Cont’d)

- Patients should never be restrained in a prone position and never transported while handcuffed
- Chemical restraint should be used after physical restraint to prevent continued struggling and development of excited delirium

Chapter Summary (Cont’d)

- Restraint asphyxia results from an inability to expand the chest cavity, create negative pressure for inspiration
- Using a substance for any reason other than its approved and accepted purpose is known as abuse
Chapter Summary (Cont’d)

- Addiction, dependence, is an uncontrollable need to use a substance despite negative consequences.
- Long-term use of a drug makes its receptors in the brain less sensitive, forcing users to take more of a substance to achieve the same effects; this is known as tolerance.

Chapter Summary (Cont’d)

- Withdrawal symptoms result when patient abruptly stops using a drug after his or her body has adapted to its constant presence.
- Those who abuse drugs rarely choose only one; polysubstance abuse and overdose are common, making assessment and treatment difficult.

Chapter Summary (Cont’d)

- Intoxicating agent in alcoholic beverages such as wine, beer, and liquor is called ETOH.
- Stimulant drugs such as cocaine, methamphetamine, and MDMA are highly addictive; they carry high risks of side effects and withdrawal syndromes.
Chapter Summary (Cont’d)

- Excited delirium can produce wildly abnormal behavior characterized by aggression, paranoia, hyperthermia, superhuman strength, and insensitivity to pain
- Excited delirium is related to the use of stimulant drugs; it often ends in sudden death

Chapter Summary (Cont’d)

- Drugs that relax and relieve anxiety and induce sleep are called sedative-hypnotics
- Opioids are powerful pain-killing drugs with a high potential for abuse and addiction

Chapter Summary (Cont’d)

- Sedative-hypnotics, GHB, ketamine, ETOH are used separately/together to facilitate sexual assault
- Marijuana is dried, shredded leaves, stems, and seeds of the hemp plant; it is smoked/eaten to cause euphoria and relaxation
Abuse of inhalants causes a rush of euphoria of short duration; it is most common among older children and teenagers.

Hallucinogens, such as LSD, psilocybin mushrooms, peyote, and mescaline, cause hallucinations and distort perceptions of reality.

Dissociatives, such as ketamine, PCP, and dextromethorphan, create a feeling of detachment (dissociation) of mind, body, and the user’s surroundings.

Questions?