Chapter 35
Behavioral and Psychiatric Disorders

Learning Objectives

• Define what constitutes a behavioral emergency.
• Identify potential causes for behavioral and psychiatric illnesses.
• List three critical principles that should be considered in the prehospital care of any patient with a behavioral emergency.
Learning Objectives

• Outline key elements in the prehospital patient examination during a behavioral emergency.
• Describe effective techniques for interviewing a patient during a behavioral emergency.
• Distinguish between key symptoms and management techniques for selected behavioral and psychiatric disorders.

Learning Objectives

• Identify factors that must be considered when assessing suicide risk.
• Formulate appropriate interview questions to determine suicidal intent.
• Explain prehospital management techniques for the patient who has attempted suicide.

Learning Objectives

• Describe assessment of the potentially violent patient.
• Outline measures that may be used in an attempt to safely diffuse a potentially violent patient situation.
• List situations when patient restraints can be used.
Learning Objectives

• Discuss key principles in patient restraint.
• Describe safety measures taken when patient violence is anticipated.
• Explain variations in approach to behavioral emergencies in children.

Understanding Behavioral Emergencies

• An estimated 26.2 percent of Americans age 18 and older suffer from diagnosable mental disorder in given year
  – About 57.7 million people
• National Institute of Mental Health has estimated that 1 in 7 individuals will need treatment at some point in life for emotional disturbance
  – Mental health problems are leading cause of disability in U.S. and Canada for people 15 to 44 years of age

Understanding Behavioral Emergencies

• No clear agreement or ideal model for “normal” behavior
• Considered to be adaptive behavior accepted by society
  – Can vary by culture and ethnic group
  – Concept of “abnormal” (maladaptive) behavior also is defined by society when behavior
    • Deviates from society’s norms and expectations
    • Interferes with well-being and ability to function
    • Harms individual or group
Can you think of a time in your life when you, a family member, or a close friend had a behavior that fit this definition? How did it make you feel?

Understanding Behavioral Emergencies

• Behavioral emergency
  – Change in mood or behavior that cannot be tolerated by involved person or others
  – Requires immediate attention
  – May range from brief inability to cope with stress or anxiety to situations in which patients may be dangerous to themselves and others
  – Most people with mental illness function well on daily basis

• Depression, anxiety disorders, mild personality disorders often are effectively managed with medication and counseling in outpatient mental health centers
• Most behavioral emergencies have a biological/organic, psychosocial, or sociocultural cause
Biological Causes

- Physical or biochemical disturbances in brain can result in significant changes in behavior
- Biological disturbances
  - Mental disorders that result from physical rather than a purely psychological cause

Biological Causes

- Examples of biological causes
  - Genetic factors
  - Prenatal and postnatal factors
    - Infection
    - Endocrine, metabolic, vascular disorders
  - Imbalance in brain chemistry (may have heritable component)
  - Alterations in neurotransmission
Biological Causes

- Specific genes that may influence balance of chemicals in brain
  - Neurotransmitters are responsible for communication among brain cells
  - Predominant neurotransmitters in brain
    - Glutamate, γ-aminobutyric acid (GABA)
    - Serotonin
    - Dopamine
    - Norepinephrine
  - Most scientists believe that mental illnesses result from problems with communication between these neurotransmitters and neurons in brain

Biological Causes

- Organic causes
  - Substance abuse
  - Trauma
  - Illness
  - Infections
  - Tumors
  - Dementia
- Consider possibility of these medical conditions as part of differential diagnosis in all behavioral emergencies

Psychosocial Causes

- Psychosocial mental illness
  - Often related to individual’s personality type
  - May be related to person’s ability to resolve situational conflict in life
    - Childhood trauma
    - Child abuse or neglect
    - Dysfunctional family structure that affects relationships with parents and siblings
  - Biological disorders may contribute to psychosocial causes of mental illness
Sociocultural Causes

- Related to way a person balances emotions, thoughts, and interactions in society
  - When balance shifts rapidly, person may experience emotional turmoil that results in crisis
  - Factors
    - Personal relationships
    - Family stability
    - Economic status
    - Social cohesion
    - Work environment
    - Personal belief systems and values

Sociocultural Causes

- Changes in behavior caused by personal or situational stress often linked to specific event or series of events
  - Environmental violence related to society
    - War
    - Terrorism
    - Riots
  - Personal violence
  - Ongoing discrimination or prejudice
  - Economic and employment problems

Assessment and Management

- Initial assessment and management
  - Ensure scene safety
  - Contain crisis
  - Provide proper emergency medical care
  - Transport patient to appropriate health care facility
  - Most EMS services have protocols that call for law enforcement to evaluate scene for possible danger and to control any acts of aggression by patient
Assessment

• Begin assessment by creating rapport with patient
  – Do this while gathering information needed for immediate management of life-threatening conditions
  – On arrival, survey scene for any relevant details
    • Evidence of substance abuse
    • Suicide attempt
    • Other clues that may shed light on patient’s state

Assessment

• Begin assessment by creating rapport with patient
  – Observe patient for emotional response
    • Fear
    • Anger
    • Confusion
    • Hostility

Assessment

• While providing patient care, focus evaluation on patient’s level of cognitive functioning
  – Alertness
  – Orientation
  – Speech patterns
  – Affect
  – Way in which patient interacts with friends, loved ones, family members
Assessment

- When possible, number of people around patient should be limited
  - Helps control scene
  - Anyone who interferes with scene or patient assessment or who adversely affects patient’s condition should be removed from area

Assessment

- Other information can be
  - Volunteered by patient
  - Obtained from patient interview
  - Provided by family members, bystanders, first responders
- Interview patient’s family or caregiver about
  - Patient’s usual level of functioning
  - Recent stress in patient’s life
  - Approaches that may help gain patient’s trust and cooperation

Assessment

- Information needed for full background and history of event
  - Past medical history
  - Medications
  - Past psychiatric problems
  - Precipitating factors
Interview Techniques

• After managing any life-threatening illness or injury, interview patient if possible
  – Do not ask for more details than needed
  – Limited and supportive interview strengthens rapport with patient
    • Helps establish and maintain relationship during patient care

Interview Techniques

• Effective interview techniques
  – Active listening
  – Showing support and empathy
  – Preventing interruptions
  – Respecting patient’s personal space by limiting physical touch

Mental Status Examination

• Mental status examination (MSE)
  – Appearance and behavior
  – Speech and language
  – Cognitive abilities
  – Emotional stability
Mental Status Examination

• Appearance and behavior
  – How does patient look?
    • Is patient neatly dressed and well groomed?
  – Is patient pleasant and cooperative or agitated?
  – Is patient’s behavior appropriate for particular situation?
  – What is patient’s body language?
  – Do body movements or posture suggest tension, anxiety, hostility, or aggression?
  – Does patient maintain eye contact during patient interview?

Mental Status Examination

• Speech and language
  – Is patient’s speech intelligible and normal in tone, volume, and rate?
  – Does tone of patient’s voice change?
  – Is speech spontaneous, with ease of expression?
  – Do patient’s words and sentences proceed in an orderly fashion?

Mental Status Examination

• Cognitive abilities
  – Is patient oriented to person, time, and place?
  – Does patient know who and where he or she is?
  – Does patient know who you are?
  – Can patient remain focused on your questions and conversation?
  – What is patient’s attention span?
  – Can patient follow a series of short commands?
  – Does patient respond to directions appropriately?
  – Are patient’s comments logical and presented in organized fashion?
Mental Status Examination

- Emotional stability
  - Is patient aware of his or her environment?
  - Can patient describe or rate his or her mood using a scale of 1 to 10?
  - Does patient appear happy, sad, depressed, or angry?
  - Is patient’s mood appropriate for the specific situation?
  - Does patient show mood swings or behaviors that indicate anxiety, depression, anger, or hostility?
  - Does patient stay focused during the interview or stray quickly to related topics?
  - Is patient experiencing perceptual distortions or hallucinations?

Think about interviewing techniques that you’ve seen EMS crews use when caring for patients with behavioral emergencies. Were the techniques effective? Could the paramedics have improved their patient care by using any of the techniques listed in Box 40-3?

Difficult Patient Interviews

- Some patients are difficult to interview
  - Refuse to talk
    - Especially if family requested EMS assistance without the patient’s consent
    - Speak to patient in quiet voice
    - Avoid questions patient may see as “interrogation”
    - Allow extra time to respond
Difficult Patient Interviews

- Some patients are difficult to interview
  - Extremely talkative and have disorganized speech
    - Focus attention on interview
    - Raise hand or call person's name
  - Confrontational
    - Additional help may be required to ensure scene safety

Other Patient Care Measures

- After initial assessment and history taking, remainder of examination is determined by patient’s overall condition and nature of psychiatric problem
  - Benefits of thorough physical examination must be weighed against risks of patient who might construe exam as physical violation
    - If reason to suspect organic cause for patient’s condition, physical examination should be performed
    - Care may be limited to maintaining effective rapport with patient during transport

Specific Behavioral and Psychiatric Disorders

- More than 250 psychiatric conditions identified by mental health professionals
  - Some patients may have symptoms associated with one or more conditions
- Common classifications
  - Cognitive disorders
  - Schizophrenia
  - Anxiety disorders
  - Mood disorders
Specific Behavioral and Psychiatric Disorders

- Common classifications
  - Substance-related disorders
  - Somatoform disorders
  - Factitious disorders
  - Dissociative disorders
  - Eating disorders
  - Impulse control disorders
  - Personality disorders

Specific Behavioral and Psychiatric Disorders

- Patient care for most behavioral emergencies is mainly supportive
  - Provide emotional support
  - Assess and manage coexisting emergency medical problems
  - Transport patient for evaluation by physician
  - May need to take measures to protect patient and others from harm
    - Possible use of physical and chemical restraint

Cognitive Disorders

- May have an organic cause (e.g., a disease process)
- May be result of physical or chemical injury, such as trauma or drug abuse
- All cognitive disorders result in disturbance of cognitive functioning
  - May manifest as delirium or dementia or autism spectrum disorder
Delirium

- Abrupt disorientation of time and place
  - Usually involves delusions and hallucinations
    - Delusions are false beliefs
    - Hallucinations are perception of sights, sounds, and other sensory phenomena not actually present
  - Symptoms vary according to
    - Individual’s personality
    - Environment
    - Severity of illness

Delirium

- Signs and symptoms
  - Inattention
  - Memory impairment
  - Disorientation
  - Clouding of consciousness
  - Vivid visual hallucinations

Delirium

- Treatment
  - Aimed at correcting underlying physical disorder to reduce anxiety
  - Sedatives may be required
Delirium

- Some groups of people more susceptible
  - Older adults
  - Children
  - Burn patients
  - Patients who have had major heart surgery
  - Patients with previous brain injury (e.g., stroke)
  - Patients with acquired immunodeficiency syndrome (AIDS)

Dementia

- Clinical state characterized by loss of function in multiple cognitive domains
  - Slow, progressive loss of awareness of time and place
  - Inability to learn new things or remember recent events
  - About 75 types of dementia have been identified
  - Most cases result from cerebrovascular disease and Alzheimer’s disease
  - Major health problem in U.S. because of Americans’ long life spans

Dementia

- Affects about 10 percent of those age 65 and older and nearly 50 percent of those age 85.8 and older
- Personal habits often deteriorate
- Speech may become incoherent
Dementia

• Many revert to “second childhood”
  – Need total care for feeding, toileting, and physical activities
  – Treatment of certain illnesses may help to slow mental decline associated with disease

Dementia

• Delirium and dementia may be difficult to differentiate
  – Both may cause disorientation and impaired memory, thinking, and judgment
  – Dementia usually occurs in people without diminished alertness, appears slowly, and worsens over time
  – Sleeping and waking problems occur less often in people with dementia than in those with delirium

Dementia

• May have difficulty with short- and long-term memory, impairment of judgment and abstract thinking
• Delirium sometimes may occur at same time as dementia
  – Especially in older adults or people with chronic illnesses
Besides auditory hallucinations, what other sensory hallucinations may be possible in these patients?

Autism Spectrum Disorder

- Range of neurodevelopmental disorders
  - Autistic disorder (classic autism)
  - Asperger's Syndrome
  - Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS, or atypical autism)

Autism Spectrum Disorder

- Characterized by
  - Impairment in social interaction
  - Communication deficits (both verbal and nonverbal)
  - Restricted, repetitive behaviors
    - Decreased imaginative play
    - Stereotyped behaviors
    - Inflexible adherence to routines
Autism Spectrum Disorder

• Degree to which these behaviors are manifested may vary between disorders, between each individual
  – Symptoms can usually be observed in infants by 18 months of age, but often go unnoticed and undiagnosed
  – More common in
    • Boys
    • Siblings of those with autism
    • People with certain developmental disorders

Autism Spectrum Disorder

• May engage in self-injurious behaviors
  – Hitting themselves
  – Head banging
  – Biting or scratching themselves
  – Picking at skin or sores

Autism Spectrum Disorder

• May not respond in normal fashion to pain
  – Combined with an impaired ability to communicate, presents challenges in assessment and patient care
    • Employ therapeutic communication techniques
    • Be prepared to provide gentle restraint to ensure safety of patient and others
Schizophrenia

• Group of disorders characterized by recurrent episodes of psychotic behavior
• Exact cause has not yet been identified
  – May result from combination of
    • Genetics (family history of schizophrenia often exists)
    • Chemical and hormonal changes
    • Autoimmune illness
    • Viral infection
    • Other stress factors

Schizophrenia

• Usually becomes apparent during adolescence or early adulthood
• Signs and symptoms
  – Appear slowly over time
  – Become more pronounced and bizarre as disease progresses

Schizophrenia

• Often develop abnormalities of
  – Thought processing
  – Thought content
  – Perception
  – Judgment
Schizophrenia

- Hallmarks
  - Paranoia
    - Intense and irrational feelings of mistrust or suspicions
  - Delusions
  - Auditory hallucinations

- Many patients function quite well with drug therapy
  - Others function poorly between frank psychotic episodes
    - Often result of failure to comply with drug therapy
  - Most patients require life-long therapy with antipsychotic drugs and medications that block action of dopamine
  - Compliance often controls symptoms
    - Noncompliance is common
  - Drugs may produce side effects, especially dyskinesia (abnormal muscular movements) and tremor

Anxiety Disorders

- Certain amount of anxiety is useful and necessary for adapting constructively to stress
  - Patient with anxiety disorder has persistent, fearful feeling that cannot be consciously related to reality
    - Can be disabling
    - May withdraw from daily activities
      - Usually unsuccessful attempt to avoid episodes of intense activity
    - Severe anxiety disorders may manifest in panic disorder ("panic attack")
      - Often have no precipitating cause of attack
Anxiety Disorders

• Signs and symptoms
  – Hyperventilation
  – Feeling of breathlessness or smothering
  – Blurred vision
  – Perioral and hand and foot paresthesias
  – Fear of losing control
  – Fear of dying
  – Somatic complaints

• Signs and symptoms
  – Chest discomfort
  – Palpitations or tachycardia
  – Dyspnea
  – Choking
  – Faintness
  – Syncope
  – Vertigo
  – Trembling and sweating
  – Urinary frequency and diarrhea

• Management is mainly supportive
  – Assure patients that although they may feel like they are dying, they are not
  – Assure that effective treatment is available
  – Panic attacks may mimic number of medical emergencies, including MI
    • Any patient who shows signs and symptoms should be fully assessed at scene and transported
    • Sedation may be required
    • Patients with anxiety disorders should not be left alone
Phobia

- Type of anxiety disorder
  - Transferred anxiety onto situation or object in form of irrational, intense fear
  - As object or situation comes closer, anxiety increases
  - If crisis is allowed to continue, anxiety may escalate into panic attack
  - Usually recognize fear is unreasonable but cannot overcome phobia
  - In some cases, phobia does not initiate EMS response but becomes secondary complication in emergency care
    - Example: phobic of water being trapped in submerged vehicle

Do you know someone with an intense fear of a situation or object? How do they behave when subjected to the object of their phobia?

Phobia

- Explain each step of an emergency or rescue procedure
- Show patience and understanding of phobia
  - Assure that no forceful steps will be taken to place person in unwilling position
Obsessive-Compulsive Disorder

• Psychiatric disorder in which person feels stress or anxiety about thoughts or rituals over which individual has little control
• Can take many forms
  – Excessive hand washing or showering
  – Upsetting thoughts
  – Obsessions also may involve special numbers, colors, single words or phrases, melodies

Obsessive-Compulsive Disorder

• Most adults realize obsessions and compulsions are without merit, have great difficulty stopping them
  – Children may not realize their behavior is unusual
  – Affects men and women equally
  – Can start at any age
  – May have heritable component
  – Often cleverly hide their condition from family, friends, and coworkers
  – Medications and behavior therapy often effective in controlling symptoms

Posttraumatic Syndrome

• Anxiety reaction to severe psychosocial events
  – Events often are life-threatening
  – Examples
    • Military service
    • Natural and man-made disasters
    • Rape
  – Often result in repetitive, intrusive memories
**Posttraumatic Syndrome**

- Manifestations
  - Depression
  - Sleep disturbances
  - Nightmares
  - Survivor guilt

**Posttraumatic Syndrome**

- EMS personnel and other emergency responders may be subject to this syndrome as result of their work
  - Examples
    - Responding to major incidents with large number of injured people
    - Death of coworker
    - Sudden infant death syndrome (SIDS) death
    - Stress associated with responding to emergency calls

**Mood Disorders**

- Describes changes in emotions that person experiences in life
  - Happiness
  - Depression
  - Fear
  - Anxiety
Mood Disorders

- Two conditions commonly associated
  - Depression
  - Bipolar disorder
- Both associated with increased risk of suicide

Depression

- Mood disturbance characterized by feelings of
  - Sadness
  - Despair
  - Discouragement
- One of most prevalent major psychiatric conditions
  - Affects 10 to 15 percent of general population

Depression

- Usually episodic with periods of remission
  - Usually last more than 1 month
  - Either gradual or rapid onset
  - At times, clustering of episodes
Depression

• May show feelings of
  – Hopelessness
  – Extreme isolation
  – Tenseness
  – Irritability

Depression

• In severe cases may be followed by anhedonia
  – Inability to feel pleasure or happiness from experiences that ordinarily are pleasurable
• Other effects
  – Insomnia or hypersomnia
  – Weight loss from diminished appetite
  – Weight gain from overeating
  – Decreased libido
  – Deep feelings of worthlessness and guilt

Depression

• Mnemonic IN SAD CAGES identifies the major features of depression
  – Interest
  – Sleep
  – Appetite
  – Depressed mood
  – Concentration
  – Activity
  – Guilt
  – Energy
  – Suicide
Depression

- Common in elderly
  - Associated with increased risk of suicide for all age groups
- Care for depressed patients
  - Directed at quietly talking to patient about things that appear to be of interest
  - Try to gain responsiveness

Depression

- Treatment
  - Antidepressant drug therapy
  - Counseling
  - Psychotherapy
  - Small number of cases: electroconvulsive therapy (ECT)

Bipolar Disorder

- Biphasic emotional disorder in which depressive and manic episodes alternate
  - Mania is characterized by
    - Excessive elation
    - Talkativeness
    - Flight of ideas
    - Motor activity
    - Irritability
    - Accelerated speech
    - Delusions that center around personal grandeur
Bipolar Disorder

• Biphasic emotional disorder in which depressive and manic episodes alternate
  – Sometimes develop slowly over time
    • May occur abruptly and may be brought on by single event
    • Can be very brief or can last weeks to months
    • Compared with depression, mania is rare

Bipolar Disorder

• Most frequent age for initial episodes is 20 to 35 years, with initial bouts of depression occurring about 10 years later
• Treatment
  – Lithium
    • Has narrow therapeutic index
    • Common illness, such as influenza with diarrhea/vomiting, can result in lithium toxicity
Bipolar Disorder

- Emergency care
  - Calm, firm emotional support
  - Transport for evaluation by physician
  - If patient’s first manic episode, consider drug abuse as differential diagnosis
  - Keep stimulation to minimum
  - If condition allows, EMS transport should proceed without emergency lights and audible warning devices

Do you think patients would be at higher risk for suicide during the depressive or manic phase of their illness? Why?

Suicide and Suicide Threats

- Threat of suicide is indication that patient has serious crisis that calls for immediate intervention
  - Cry for help
  - May be form of direct or indirect communication
  - Others are effort by patient to manipulate relationships so patient is surrounded by people who are ready and willing to provide advice and support
Suicide and Suicide Threats

• In assessing risk, consider:
  – In 2006, suicide was 11th leading cause of death for people of all ages
    • 7th leading cause of death in males
    • 16th leading cause of death in females
    • Over 30,000 suicides occurred in U.S. (81 suicides per day; 1 suicide every 16 minutes)
  – In U.S., white men over age 75 have highest suicide rate
  – Women attempt suicide at two to three times the rate at which men do
  – Men commit suicide at four times the rate at which women do (79 percent of all U.S. suicides)

Suicide and Suicide Threats

• In assessing risk, consider:
  – Firearms are most commonly used method for suicide in men
  – Poisoning is most common method for suicide in women
  – Among young adults 15 to 24 years of age, about 100 to 200 attempts for every completed suicide
  – Among adults over 65 years of age, about four suicide attempts for every completed suicide
  – More specific and detailed suicide plan, greater suicide potential

Suicide and Suicide Threats

• Other factors associated with suicide threats
  – Recent death of loved one or loss of significant relationship
  – Financial setback or job loss
  – Chronic or debilitating illness
  – Social isolation
  – Alcohol or other drug abuse
  – Depression
  – Schizophrenia
Suicide and Suicide Threats

• If suicide attempt is suspected, discuss intentions with patient
  – “Do you have thoughts about killing yourself or others?”
  – “Have you ever tried to kill yourself?”
• Many depressed patients are willing to discuss their suicidal (or homicidal) thoughts

Suicide and Suicide Threats

• During patient interview, try to determine three important factors
  – Whether patient has plan (how and when suicide will be done)
  – Whether plan is intended to be successful
  – Whether patient has means or method to follow through with plan

How would you feel about asking a patient, “Have you ever thought about killing yourself?”
Suicide and Suicide Threats

• When responding to suicide attempt, request police protection before approaching scene
  – Armed patients must be considered homicidal as well as suicidal
  – After scene safety is ensured, survey for presence of dangerous objects

Suicide and Suicide Threats

• First priority in patient management is medical care
  – Unconscious patients
    • Airway, ventilatory, and circulatory support
    • Rapid transport
  – Conscious
    • Create rapport as soon as possible
    • Conduct brief interview to assess situation and determine need for and direction of further action

Suicide and Suicide Threats

• To help reduce potential for suicide
  – Provide support and honest assurance about patient’s well-being
  – Provide for physical safety, emotional security
    • Establish protective limits and measures
      – Helps to prevent injury to patient or others
      – Conveys message that paramedic will help them control their behavior until they can gain self-control
Suicide and Suicide Threats

• To help reduce potential for suicide
  – Listen to person, even if speech seems bizarre, inappropriate, unrealistic
    • Do not feel every statement must be answered or advice or opinions must be given
    • During interview, acknowledge patient’s feelings
    • Do not argue with patient’s wish to die
    • Explain alternatives to suicide patient may not have considered

Suicide and Suicide Threats

• To help reduce potential for suicide
  – Determine patient’s support system or significant others when possible
    • Others may be better able to communicate with and calm patient
  – Encourage and reassure patient during crisis
  – Transport patient to proper facility for emergency intervention

Substance-Related Disorders

• Some patients with behavioral emergency may also be using alcohol or illegal drugs
  – May cause difficulties during physical examination
  – Trying to “self-medicate” to improve mood or lessen anxiety associated with mental illness
  – Self-medicate before receiving diagnosis for illness or before seeking professional help
  – Signs of drug or alcohol use
    • Breath odor of alcohol
    • Presence of drug paraphernalia
    • Needle tracks on extremities
Patients with a Dual Diagnosis

• Some people struggle both with serious mental illness and substance abuse
  – May be difficult to identify because one disorder may mimic symptoms of other
  • Easy to attribute symptoms to only one of two afflictions
  • As many as 50 percent of mentally ill individuals have substance abuse problem
  • Drug most often used is alcohol
  • Next most commonly used drugs are marijuana and cocaine
  • Prescription drugs such as tranquilizers and sleeping medicines may also be abused

Patients with a Dual Diagnosis

• Factors associated with a dual diagnosis
  – Recreational use of alcohol or other drugs
  – Misguided attempts to self-medicate to relieve anxiety or depression
  – Susceptibility to mental illness and substance abuse
  – Environmental and social influences

Patients with a Dual Diagnosis

• May alternate between requesting EMS assistance for mental illness and for substance abuse
  – Two disorders must be treated at same time
Somatoform Disorders

• Conditions that suggest medical disorder when no physical cause found for patient’s symptoms
  – Most common: somatization disorder and conversion disorder
    • Both associated with anxiety, depression, threats of suicide
    • Treatment often requires psychotherapy, can address emotional conflicts that manifest
    • No definitive causes for most somatoform disorders

• Contributing factors
  – Genetic and environmental influences
  – Children raised in homes with high degree of parental somatization may model somatization
  – Sexual abuse associated with increased risk of somatization later in life
  – Poor ability to express emotions

• Condition in which individual has complaints (lasting several years) of various physical problems for which no physical cause can be found
  – More common in women than men
  – Sometimes results in unnecessary surgery and other treatments
Somatoform Disorders

- Common complaints
  - Neurological symptoms
    - Double vision
    - Seizure
    - Weakness
  - Gynecological symptoms
    - Painful menstruation
    - Painful intercourse
  - GI symptoms
    - Abdominal pain
    - Nausea

Conversion Disorder

- Mental illness in which painful emotions are repressed and unconsciously converted into physical symptoms
  - Loss of sensory or motor capabilities or of special senses may occur
    - May not be able to speak, hear, see, or feel, or arm or leg may be paralyzed
    - In many cases, areas of body affected do not correspond to actual arrangement of neural pathways
    - Symptoms also may come and go or may appear at different times and in different areas of body

Somatoform Management

- Manage symptoms as if they are real because differentiating these disorders from organic ailment may be difficult
  - Recognize patients are not “faking”
    - Patients believe their illness or loss of function to be factual
  - Require evaluation by physician
Factitious Disorders

• Group of disorders in which symptoms mimic true illness
  – Symptoms have actually been invented
  – Symptoms are under control of patient, who is attempting to gain attention
  – Most common disorder in this group is Munchausen syndrome
    • Makes routine pleas for treatment and hospitalization for symptomatic, but imaginary, acute illness

Factitious Disorders

• Other complaints
  – Bereavement
  – Cushing syndrome
  – Dental problems
  – Infection with human immunodeficiency virus (HIV)
  – Hypoglycemia
  – Stroke

Factitious Disorders

• Person injures or induces illness in others (usually children) in order to gain sympathy
  – Considered form of child abuse
• Symptoms often dramatic but plausible
  – Usually resolve with treatment
  – After treatment, person seeks treatment for another invented disease
  – Once diagnosed, treatment is aimed at protecting these people from unnecessary surgeries and other treatments they do not need
Dissociative Disorders

• Group of psychological illnesses
  – Particular mental function is separated (dissociated) from mind as whole
• Dissociative amnesia
  – Blocking out of critical personal information, usually of traumatic or stressful nature
  – Does not result from other medical trauma

Dissociative Disorders

• Dissociative fugue
  – Rare, individual suddenly and unexpectedly takes physical leave of surroundings
• Dissociative identity disorder
  – Been called “multiple personality disorder”
  – Depersonalization disorder
  – Marked by feeling of detachment or distance from one’s own experience, body, or self

Dissociative Disorders

• Usually associated with emotional conflicts
  – Conflicts are so repressed that split in personality occurs
    • Results in altered state of consciousness or confusion in identity
    • May be caused by inability to cope with severe stress or conflict
    • Dissociation occurs soon after catastrophic event, such as traumatic death of child or spouse
Dissociative Disorders

- Often unable to remember their names or personal histories
  - Can still speak, read, learn new material
- Treatment
  - Antianxiety medications
  - Hypnosis
  - Psychotherapy

Eating Disorders

- Two most common eating disorders considered forms of psychiatric illness are anorexia nervosa and bulimia nervosa
  - Both can lead to serious
    - Dehydration
    - Starvation
    - Electrolyte imbalances
  - May cause critical illness or death

Eating Disorders

- Treatment
  - Supervision and regulation of eating habits
  - Psychotherapy
  - Sometimes, antidepressants
  - Most patients require hospitalization
Anorexia Nervosa

- Eating disorder
  - Characterized by
    - Intense fear of being obese
    - Severe weight loss
    - Malnutrition
    - Amenorrhea (absence of menstrual bleeding)
  - Feels intensely hungry, hunger pains are denied

Anorexia Nervosa

- Signs and symptoms
  - Weight loss
  - Obsession with exercise
  - Fatigue
  - Binge eating
  - Induced vomiting
  - Use of laxatives to promote weight loss

Anorexia Nervosa

- Mainly seen in adolescents, mostly girls
- Associated with emotional stress or conflict
- Difficult to identify exact underlying cause
Bulimia Nervosa

• Sometimes considered form of anorexia
• Insatiable craving for food
  – Results in episodes of binge eating followed by
    • Purging (through self-induced vomiting or use of laxatives)
    • Depression
    • Self-deprivation

• Most common in adolescent girls and young women
• Anorexic and bulimic patients often worry about their compulsive behavior
  – May become depressed and suicidal

Impulse Control Disorders

• Group of psychiatric conditions
  – Characterized by
    • Inability to resist impulse or temptation to perform some act that is unlawful, socially unacceptable, self-harmful
• Intermittent explosive disorder
  – Condition marked by frequent and often unpredictable episodes of extreme anger or physical outbursts
  – Between episodes, usually no evidence of violence or physical threat
Impulse Control Disorders

- Kleptomania
  - Failure to resist impulses to steal things not needed for either personal use or for their monetary value
- Pathological gambling
  - Persistent and maladaptive pattern of gambling that causes difficulties with interpersonal, financial, vocational functioning

Impulse Control Disorders

- Pyromania
  - Deliberate and purposeful fire setting for nonmonetary gain
  - Typically associated with tension or heightened arousal before act and with gratification or relief afterward
- Trichotillomania
  - Recurrent pulling out of one's own hair, which results in significant hair loss

Impulse Control Disorders

- Often difficult to treat
  - Most managed with behavior modification and drug therapy
  - Failure to control these disorders may result in violent behavior or unlawful activities
  - Incarceration is common
Personality Disorders

• Large group of conditions distinguished by failure to learn from experience or to adapt appropriately to changes
  – Results in personal distress and impairment of social functioning
  – May have environmental component
  – May be genetic
  – Become especially obvious during times of stress

Personality Disorders

• Symptoms
  – First recognized in early adolescence, continue throughout person’s life
  – Vary in frequency and intensity, relatively constant
  – Affect most aspects of patient’s life
    • Thoughts
    • Emotions
    • Relationships and interpersonal skills
    • Impulse control

Personality Disorders

• Antisocial personality disorder
  – Long-standing pattern (after age 15) of disregard for rights of others
  – Associated with irresponsible behavior and lack of remorse for wrongdoing
Personality Disorders

• Borderline personality disorder
  – Pattern of unstable relationships
  – Poor or negative self-image
  – Mood swings
  – Poor impulse control
  – Associated with destructive and self-harming behaviors
  – Intense fear of abandonment
  – Displays of sudden anger

Personality Disorders

• Narcissistic personality disorder
  – Pattern of grandiosity
  – Need for admiration
  – Sense of entitlement
  – Associated with
    • Exaggerated achievements
    • Fantasies about unlimited success, power, love, or beauty

Personality Disorders

• Factors associated with development
  – Unstable relationships during childhood
  – Family violence
  – Childhood abuse or neglect

• Treatment
  – Behavior modification techniques
  – Counseling
  – Drug therapy
  – Individual psychotherapy
Special Considerations

- Paramedics may have to deal with complications arising from situation or other factors affecting patient
  - Among these factors are patient’s age and possibility of violent behavior

When responding to a behavioral emergency that involves a child or an adolescent, do you use the same safety guidelines that you use with an adult?

Behavioral Problems in Children

- Young children who are victims of emotional crisis need to be managed with techniques different from those used to care for older children and adults
- Guidelines for dealing with some children
  - Gain child's trust and try to convince child that you are a friend who can help
  - Make it clear that you are strong enough to be in control but will not hurt child
  - Keep interview questions brief; child's attention span may be extremely short
Behavioral Problems in Children

• Guidelines for dealing with some children
  – Never lie; be honest
  – Use all available resources to communicate (e.g., drawing pictures, telling stories)
  – Involve parents or caregivers in interview or examination if appropriate
  – Take any threat of violence seriously

Behavioral Problems in Children

• If restraint necessary, use only humane and reasonable force
  – Minimum force necessary to ensure patient’s safety and safety of EMS crew
  – Sufficient manpower should be available
  – Calming measures may fail to work
  – If so, wrapping child in full body blanket secured to stretcher with straps often is sufficient during transport
  – Monitor child’s airway and circulation and ensure they are not compromised
  – Documentation should be thorough and complete

Behavioral Problems in Elderly Patients

• Estimated 15 to 25 percent of elderly people in U.S. suffer from significant symptoms of mental illness
  – Over 6.5 million elderly individuals are clinically depressed
  – Most of these disorders can be diagnosed and treated successfully
    • Many do not seek care
Behavioral Problems in Elderly Patients

- Problem behavior in elderly patient can be sign of
  - Long-standing psychiatric disorder
  - Newly emerging psychiatric problem
  - Medical illness
  - Substance abuse
  - Drug noncompliance or drug interactions

Behavioral Problems in Elderly Patients

- Communicating with some elderly patients
  - Identify yourself and speak at eye level to make sure patient can see you
  - Address patient by surname (e.g., “Mr. Jones” or “Miss [or Mrs.] Smith”) unless directed otherwise
  - Speak slowly, distinctly, respectfully
  - Ask one question at a time and allow time for complete answers

Behavioral Problems in Elderly Patients

- Communicating with some elderly patients
  - Listen closely
  - Explain what you are doing and why
  - Provide reassuring physical touch
  - Be patient
  - Permit family members and caregivers to remain with patient if appropriate
  - Preserve patient’s dignity
Assessing Potentially Violent Patient

• Only small number of people with mental health problems are potentially violent
  – Assessment and management of potentially violent patient should be part of EMS protocol
• Factors that help determine potential for violence
  – Past history
    • Has patient previously shown hostile, aggressive, or violent behavior?

Assessing Potentially Violent Patient

• Factors that help determine potential for violence
  – Posture
    • Is patient sitting or standing?
    • Does patient appear to be tense or rigid?
  – Vocal activity
    • Loud, obscene, and erratic speech indicates emotional distress
  – Physical activity
    • Is patient pacing or agitated or protecting his or her physical boundaries?

Assessing Potentially Violent Patient

• If any signs of potentially violent behavior are present, reduce effect of stress while avoiding confrontation
  – Prepare way to cope with crisis that reduces potential for life-threatening incident
    • Reduces chance for psychologically damaging consequences

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Controlling Violent Situations

• Severely disturbed patients who pose threat to themselves or others may need to be restrained, transported, hospitalized against their will
  – Each state has law setting out criteria for involuntary commitment
    • Be familiar with all relevant laws
    • Premise on which most state laws are based suggests that one person may restrain another to protect life or prevent injury

Controlling Violent Situations

• When psychiatric patient refuses care, EMS consult with medical direction
  – Decision to restrain, treat, or release patient is medical direction decision
  – If violent behavior must be contained, “reasonable force” should be used to restrain patient
    • Should be used as humanely as possible and with respect for patient’s dignity
    • In most cases, restraint duty (if needed) should be given to law enforcement personnel
    • Carefully document details of incident

Controlling Violent Situations

• When dealing with patient who may require restraint
  – Provide safe environment
  – Gather significant medical and psychiatric history
  – Attempt to gain patient’s cooperation
  – Be confident but not confrontational
Have you ever seen an EMS or law enforcement person lose control of his or her own behavior when dealing with a violent patient? How did it affect the patient’s physical or psychological state?

Restraint Guidelines

• Restraint guidelines
  – If patient is homicidal, do not attempt restraint without assistance from law enforcement personnel
  – If patient is armed, move everyone out of range and retreat from scene
    • Wait for law enforcement personnel
  – Remember that patient may not be responsible for his or her actions

Restraint Guidelines

• Restraint guidelines
  – When planning restraining action, include backup plan in case initial attempt fails
  – Make sure adequate help is available
    • This means at least four capable people should be available to help restrain an adult patient
  – Keep in mind that potential for personal injury and legal liability is always present
Restraint Methods

• Gentle, nonthreatening, low-profile technique should be attempted first
  - Move to more direct intervention as needed
  - Options of physical restraint should always be explained to patient before force is applied
  - If still unwilling to cooperate, patient should be informed restraint is required to protect against injury and ensure safety of others

Restraint Methods

• Before approaching violent patient, be aware of patient’s surroundings
  - Seemingly harmless items should be noted
    • Ashtrays
    • Lighted cigarettes
    • Hot coffee
    • Letter openers
    • Soda bottles
    • Cans
    • Furniture

Restraint Methods

• No attempt should be made to enter patient’s physical space until other members involved in restraint action are ready to proceed
  - Usually considered to be one arm’s length
Restraint Methods

• Patient’s muscle groups and potential range of motion should be considered before restraint is initiated
  – Plan to position patient in way that limits strength and range of motion
  – Each member of restraint team should be assigned specific body part or responsibility before actual restraint procedure begins

Restraint Methods

• Paramedics must be familiar with restraint devices available
  – Should be able to improvise if need arises
  – Preferred method is to use commercially manufactured wrist/waist/ankle padded leather or Velcro straps, or full jacket restraints

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Restraint Methods

- Effective restraints also may be improvised using common materials
  - Small towels can be wrapped around patient’s wrists and ankles and secured with tape to stretcher
  - Cravats
  - Webbed straps ordinarily used to secure patients to spine boards
  - Roller bandage
  - Blanket roll
- Should be strong enough to achieve desired effect
  - Should not compromise circulatory or respiratory status

Sequence of Restraint Methods

- Paramedic offers patient one final chance to cooperate
- If patient does not respond, at least four rescuers move swiftly toward person
  - Position themselves close to and slightly behind patient
  - Two rescuers should then position inside leg in front of patient’s leg to force patient to ground if necessary
  - Swift movement by several rescuers minimizes patient’s ability to focus on restraint actions
  - Reduces accuracy of kicks or blows
  - During restraint procedure, patient should be continually reassured by rescuer not involved in physical maneuver
**Sequence of Restraint Methods**

- If patient calms and agrees to be transported without restraints, paramedic positions patient lateral or supine on stretcher (if not contraindicated by mechanism of injury or medical condition)
  - Paramedic secures patient with straps to limit range of motion
  - If patient becomes dangerous en route to hospital, restraints should be used

- Once applied, restraints should not be removed until patient is delivered to emergency department or adequate resources to control situation
  - Patient’s respiratory and circulatory status should be assessed frequently and documented
    - Ensures that restraint action has not compromised vital functions
  - If change in restraints is required, additional manpower must be available for assistance
  - Only one limb should be repositioned at a time
Sequence of Restraint Methods

- Restraint procedures should be fully documented on patient care report
  - Any attempts at negotiation
  - Description of patient’s behavior before restraint
  - Circulatory evaluation and continued monitoring of patient
- Physical restraint is advised only when
  - All verbal and nonverbal techniques exhausted
  - Person presents danger to self or others

Personal Safety

- Measures for preventing personal injury
  - When possible, remain at safe distance from patient
  - Do not allow patient to block exit
  - Keep large furniture between you and patient
  - Do not allow single paramedic to remain alone with patient
  - Do not make statements patient might perceive as threatening
  - Use folded blankets or cushions to absorb impact of thrown objects

Personal Safety

- Various training programs have been developed to provide safety and security to rescuer and violent patient
  - Paramedics should learn nonviolent personal protection maneuvers
  - Practice these maneuvers under supervision of someone trained in them
Chemical Restraint

• Use of drugs to control behavior
  – Drug treatment varies
    • Generally intended to provide sedation
  – Two groups of drugs effective for chemical restraint
    • Benzodiazepines
    • Antipsychotics

Chemical Restraint

• Benzodiazepines
  – Bind to specific receptors in cerebral cortex and limbic system
    • Major integrating system that governs emotional behavior
  – Drugs are popular because of their very high therapeutic index

Chemical Restraint

• Benzodiazepines
  – Four main actions
    • Anxiety reducing
    • Sedative-hypnotic
    • Muscle relaxing
    • Anticonvulsant
Chemical Restraint

• Benzodiazepines
  – Commonly used for chemical restraint
    • Diazepam
    • Midazolam
    • Lorazepam

• Antipsychotics
  – Block dopamine receptors in specific areas of CNS
  – Primarily used to treat schizophrenia
  – Used to treat other conditions that produce disturbed behavior
  – Well-known antipsychotic used for chemical restraint
    • Haloperidol
    • Lorazepam
  – Short-term use of antipsychotics rarely produces extrapyramidal reactions
    • If reactions occur, diphenhydramine may reverse side effects

Chemical Restraint

• Benzodiazepines and antipsychotics can be very effective at controlling hostile or combative patients
  – Consult with medical direction
  – Follow protocol
  – Carefully document event
Summary

• Behavioral emergency is a change in mood or behavior
  – Change cannot be tolerated by involved person or others
  – Calls for immediate attention
• Physical or biochemical disturbances can result in significant changes in behavior
  – Psychosocial mental illness is often result of childhood trauma, parental deprivation, or dysfunctional family structure

Summary

• Changes in behavior caused by interpersonal or situational stress are often linked to specific incidents, such as environmental violence, death of a loved one, economic or employment problems, or prejudice and discrimination

Summary

• When dealing with behavioral emergencies, paramedic should contain the crisis
  – Begins by establishing rapport with patient
  – He or she should provide proper emergency care
  – Transport patient to appropriate health care facility

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Summary

• During patient assessment, determine patient’s mental state, name and age, significant past medical history, medications (and compliance), past psychiatric problems, and precipitating situation or problem
• Effective interviewing techniques include active listening, being supportive and empathetic, limiting interruptions, and respecting patient’s personal space

Summary

• Mental status exam includes assessment of appearance and behavior, speech and language; cognitive abilities, and emotional stability
• All cognitive disorders result in disturbance in thinking that may manifest as delirium or dementia

Summary

• Schizophrenia is characterized by recurrent episodes of psychotic behavior
  – May include abnormalities of thought process, thought content, perception, and judgment
• Anxiety disorders may cause a panic attack
  – Anxiety disorders include phobias, obsessive-compulsive disorders, and posttraumatic syndrome
Summary

• Depression is a mood disorder
  – Person with depression may have feelings of hopelessness, loss of appetite, decreased libido, and feelings of worthlessness and guilt
• Bipolar disorder is manic-depressive illness
  – Depressive and manic episodes alternate

Summary

• Suicide threats or attempts indicate patient has serious crisis
  – Certain factors increase risk of suicide
  – Patients who express wish to harm or kill themselves should be transported

Summary

• Somatoform disorders are conditions in which there are physical symptoms for which no physical cause can be found
  – Cause is thought to be psychological
  – Include somatization disorder and conversion disorder
• Factitious disorders are disorders in which symptoms mimic true illness
  – Symptoms have been invented and are under control of patient
Summary

• Dissociative disorders are a group of psychological illnesses
  – In these disorders, particular mental function is separated from mind as a whole
• Most common eating disorders considered forms of psychiatric illness are anorexia nervosa and bulimia nervosa

Summary

• Impulse control disorders are characterized by inability to resist an impulse or temptation to do some act that is unlawful, socially unacceptable, or self-harmful
• Personality disorders are conditions characterized by failing to learn from experience or adapt appropriately to changes
  – Results in personal distress and impairment of social functioning

Summary

• Threat of suicide is an indication that patient has serious crisis
  – Requires immediate intervention
• Questions that determine the patient’s ideation, plan, intent, means to commit suicide should be asked
### Summary

- After ensuring scene safety, first priority in patient management after a suicide attempt is medical care
  - If patient is conscious, developing rapport as soon as possible is crucial
- Assessment of potentially violent patient should include past history of violence, posture, vocal activity, physical activity

### Summary

- When trying to defuse situation involving potentially violent patient, paramedic should ensure a safe environment, gather patient’s history, try to gain patient’s cooperation, avoid threats, and explain paramedic’s role in providing care
- Severely disturbed patients who pose threat to themselves or others may need to be restrained

### Summary

- Reasonable force to restrain patient should be used as humanely as possible
  - Adequate number of personnel is needed
    - Will ensure patient and rescuer safety during restraint
    - Risk of personal injury and legal liability is always present
Summary

- Personal safety measures while responding to a behavioral emergency should include
  - Not allowing patient to block exit
  - Keeping large furniture between you and patient
  - Working as team
  - Avoiding threatening statements
  - Using soft objects to absorb impact of thrown objects

Summary

- When caring for children with behavioral emergencies, paramedic should attempt to
  - Gain their trust
  - Tell them they won’t be hurt
  - Keep questions brief
  - Be honest
  - Involve parents (if appropriate)
  - Take threats of violence seriously

Questions?