PSYCHIATRIC EMERGENCIES

BY

ZAWEDDE ALICE

DEFINITION

- Emergency: Is a situation that requires immediate attention.
- Psychiatric Emergency: Is a condition which puts the life of the patient, the health worker and the community at risk and it calls for immediate attention.
- Or
- Is a situation where a patient is at risk because of intensive personal distress, suicidal intention, self-neglect or poses risk to others.

Examples of Emergencies

- Aggression and violence
- Suicidal attempts.
- Status epileptics
- Mass hysteria
- Delirium tremens.
- Food refusal
- Catatonic stupor
- Puerperal psychosis
- Severe depression
- Escape attendances
- Manic excitement

SUCIDAL TENDANCIES

- **SUICIDE**: Is a deliberate act of ending one's life or self-destructive behavior.
- People commit suicide using different means e.g.
- Eating position
- Hanging by use of a rope
- Intentional accidents
- Intentional gunshots
- Intentional drug abuse
- Drowning
- Stabbing one's self up death using a knife or spear.
- Self-starvation
- Swallowing battery cells

CATEGORIES OF SUCIDE.

- Complete suicide: the person successes in ending his/her life.
- Attempted suicide: person tries to end life but fails or rescued

RISK FACTORS FOR SUCIDE/ WHY

- Loss of dear ones, job, divorce
- Chronic illness or chronic pain
- Alcohol and drugs
- Gender i.e. male are more prone to commit succeed because they are naturally aggressive
- Underlying mental illness
- To punish others

RISK FACTORS FOR SUCIDE/ WHY

- Familiar suicide liniments i.e. it follows in families
- Strong auditory hallucinations and commanding in nature
- Disfiguring conditions as a result of accidents being burnt by acid
- Physical illnesses like HIV, cancer
- Constant loss like items.

TYPES OF SUICIDE

- **Paradoxical**: some body conceals the plan of killing him/her self.
- **Suicide pact**: Two people agree to kill themselves.
- **Mass suicide**: many people agree to kill themselves.
- **Copycat suicide**: a group of suicide occur at the same time in the geographical area.
- **Vengeance suicide**: this is where one kills him or herself to punish others

MANAGEMENT OF SUICIDE

- **AIMS OF MANAGEMENT**
- TO prevent self-harm
- To restore the patients functional state
- To restore patient’s self esteem

- Suicide is a psychiatric emergency and if any attention is not given promptly the patient will lose life.
- Admit the patient in an open place near the nurse’s station for close monitoring and observation.
- Find out the cause of suicidal ideation and counsel the patient to drop the idea of committing suicide.
- Make a caution card for the patient, alert all people that the patient wants to commit suicide but don’t label the patient.

- Observe the patient for 24hrs i.e. handover the patient to the incoming nurse and sign on the caution card.
- Remove all the dangerous objects e.g. rope, sharp objects which the patient can use to kill himself.
- Occupy the patient with productive work so that he/she can withdraw the suicidal ideation.
- Check the patient’s pockets for any sharp objects which the patient may use to kill him or herself.
- After eating count the spoons and forks because the patient may stay with one and uses it to kill him or herself.

- Make sure you have they keys to the ward because the patient may use them to lock you up or lack himself up and kills him or herself.
- Re-assure the patient and relatives and talk about the patient’s condition to come up with solution.
- Initiate treatment for the patient i.e. sedate the patient using lagactile 200mg.
- Loroxyl 25-75mg, imipramine 25mg-75mg, mood stabilizers; carbamazepine, lithium carbonate, sodium valproate

MANAGEMENT OF SUICIDE (ATTEMPTED SUICIDE

- Assess the suicidal potential by;
- Determining the severity i.e. what method to use, suicidal thoughts.
- Copying pattern, strength and resources available that could assist in crisis.
- Psychological treatment i.e. develop a listening and understanding skill.
- Indicate concern and establish trust in this person (create support).
- Explore what really happened/identify the cause.
- Encourage the person to express him/herself

- Ask if the person has any future plan i.e. with no future plans is likely to commit suicide.
- Any person who has ever attempted to commit suicide before is likely to commit suicide again.
- **Note:**
- Married people are less likely to commit suicide then singles because they share problems and they come up with solutions.
- Men commit suicide than women and tend to use very dangerous means.
- ECT, if drugs fail, 2-3 shocks per week
- Rehabilitation to acquire skills to earn a living

PREVENTION OF SUICIDE

- Patients should be properly managed in the hospital i.e. show a good attitude to the patient while in the hospital
- Early identification of problems that may cause mental health disorders
- Early and proper treatment of physical and psychological problems
- Teach the community about factors that contribute to mental and physical illness
- People should learn to plan for their lives i.e. not someone to plan for them

- people should learn to be job creators but not job seekers
- people should learn to deal with difficult situations and effective copying mechanisms and stress management skills
- counselling to people with social and physical health problems
- people should learn to share problems
- Family should be helped to stay together

AGRESSION AND VIOLENCE

- These are severe forms of anger were the patient will be irrational, uncooperative, delusional and assaultive.
- **Violence**

refers to the state in which he patient develops excessive force to destroy property and disorganise whatever may be in the environment.

- **Aggression**

is a state in which the patient shows redness to attack, assault, harm or injure others.

SIGNS AND SYMPTOMS OF VIOLENT PATIENT

- Restlessness & flown face (wrinkles)
- Sweating i.e. noise, axilla and palms
- Verbal threats of violence.
- Worsening delusions or hallucination directed towards.
- Repeated violent behavior
- Banging doors or tables.
- Shouting or whispering
- Fast breathing
- Palpitations (increased heart beat)
- Pupils of the eye are dilated.

CAUSES OF AGRESSION AND VIOLENCE.

- hallucination i.e. the patient may hear voices telling him to behave that way
- delusions e.g. paranoid in which the patient may think that fellow patient or staff has been sent for him or grandiosity
- organic psychiatric disorders like delirium, dementia
- acute stress reaction
- panic disorder
- provocation either by nurse or fellow patient
- personality disorders
- poor nurse patient relationship

- alcohol and drug abuse
- pre or post- Icto phases of epilepsy
- forced confinement
- denial, delayed or poor meals
- forced medication
- denial of discharge
- denial of communication with family members or friends

MANAGEMENT OF VIOLENCE AND AGGRESSION

- **General principles of management**
- patient should not be hurt
- staff should not be hurt
- other patients or people around should not be hurt
- property should not be destroyed

MANAGEMENT OF AN OPEN VIOLENT EPISODE

- In case a violent patient is brought to the facility tied with ropes and chains, untie the patient so as to remove the humiliation of being tied in that manner
- in cases were violence occurs on ward, a number of staff has to be alerted availed and one to confrontation should in any way be prohibited.
- emergency education on the basic principles of management and sharing of personal and clear responsibilities during confrontation is done
- staff should have a pre-arranged plan as who should do what thus avoiding situations where everyone is diving for one arm or limb

- use a firm and kind approach to talk to the patient to see if he responds
- in case patient fails to respond to the sweet talk, he is confronted and swiftly transferred to the bed or floor where he can be immobilised by firmly joining the major joints, shoulders and limbs if possible
- physical battles with the patient should be avoided as much as possible
- shoes, gumboots, belts and neck ties should be loosened, removed or unfastened
- prepared medication usually a major tranquilizer like chlorpromazine CPZ 50-100 IM or a major sedative like Haldol 10-20mg IM or diazepam 10-20mg IV are given

PHYSICAL RESTRAIN

- About 3-5 nurses are needed.
- One nurse engages the patient in a talk but with a very polite voice another nurse comes from behind ad covers the patient’s face, the other nurse comes and tightly grasps the patient and medication a sedative is given.
- The nurse talking to the patient the changes his voice and informs the patient that know we are to use force.
- After sedating the patient isolate the patient for a while

- once patient is sedated, collect history carefully from relatives to identify the possible causes
- carry out thorough physical examination and investigations to rule out any medical condition or symptoms of dehydration and manage accordingly
- keep less furniture in the room and remove any sharp instruments, ropes, glass items, ties, strings or match boxes from the patients vicinity
- keep environmental stimuli such as lighting and noise levels minimum and limit interaction with others
- stay with the patient when hyperactivity increases to reduce anxiety and foster feelings of security

- Redirect violent behaviour with physical outlets such as exercises, outdoor activities etc.
- Encourage the patient to talk out his aggressive feelings rather than acting them out and the patient should promise not to resort to violence again. this can be done by making him sign a NO VIOLENCE ACT
- if the patient is not calmed by talking out and medication is refused, restraints may become necessary

- following application of restraints,, observe patient so see whether nutritional and elimination needs are met and this is done every after 15munutes
- following a restraint, the patient should not be released indefinitely however a gradual release is preferred to avoid precipitants to further violence
- when a patient has been released from a restraint, timely medication should be resumed as prescribe

- if this occurred on ward and it was due to hospital management the clinical team should meet to consider and review the general policies or consider general changes in ward policies

GUIDELINES FOR SELF- PROTECTION WHEN HANDLING A VIOLENT PATIENT

- never confront a potentially violent patient alone
- keep a comfortable distance away from the patent i.e. keep an arm length
- be prepared to move as a violent patient can strike out suddenly
- maintain a clear exit route for both staff and patient
- ensure that the patient has no weapon in his possession before approaching him
- if patient has a weapon, ask him to keep it on the table or floor rather than fighting him to take it away
- distract the patient momentarily so as to remove weapon e.g. throwing water in the patients face or yelling etc.
- sedate the patient and give prescribed antipsychotics

POSTPARTUM PSYCHOSIS

(Puerperal Psychosis)

- This is one of the psychiatric emergencies that occur in the first 2-12 weeks after child birth and progresses rapidly. Both mother and child they are at risk.
- This can be detected on the basis of mothers illness/physical health history of mental illness and social support.

Signs and symptoms

- Severe agitation and restlessness and even failing to breast feed the baby.
- Hallucinations which may be visual, auditory or tactile.
- Delusions usually focused on hating the baby.
- Infanticide may occur
- Suicidal wishes and attempts

- Poor sleep
- They may have fever and this could be a sign of delirium which may require specific investigations and management
- Breast engorgement due to failure to breast feed.
- The specific presentation may depend on whether it’s a mood disorder (depression or bipolar disorder), schizophrenia, other unspecified psychoses or delirium

Management

- Admit mother as she is a danger to herself and the child and it better if it is a mental hospital.
- Calm down the mother by giving a sedative like tablet of diazepam 10mg.
- Specific management depends on the clinical presentation as noted above.
- Give an antipsychotic to treat the psychotic features.
- Treat underlying physical problems.
- Supportive psychotherapy to the mother and family.

- Keep the baby around to maintain mother to child bond.
- Monitor the mother **never leave the mother alone with the baby to avoid possible harm.**
- **Other anxiety disorders can be managed through counseling.**
- **NB**. Mental health problems during child birth present danger to the baby and mother.
- All health workers should educate mothers about these problems at antenna period and be able to assess mothers at postpartum period and provide the care needed in order to prevent them.

DELIRIUM

- Delirium is an acute organic mental disorder characterized by impairment of consciousness, disorientation and disturbances in perception and restlessness (acute agitation). This is one of the psychiatric emergencies that are very common in medical surgical inpatients and it is very common in post operative patients.

CAUSES OF DELIRIUM

- Vascular disorders such as hypertensive encephalopathy, cerebral arteriosclerosis, intracranial bleeding may lead to delirium.
- Infections such as cerebral malaria, encephalitis (inflammation of brain tissue), meningitis (inflammation of meninges may all cause delirium, septicemia)
- Space occupying lesions (Neoplasm’s) may cause delirium.
- Intoxication, this may be chronic intoxication with toxic drugs or may be acute as in poisoning.

CAUSES OF DELIRIUM

- Traumatic events to the brain such as subdural and epidural hematoma, laceration post operative may also cause delirium.
- Endocrine and metabolic disorders such as diabetic coma, shock, myxedema, hyperthyroidism, hepatic failure may cause delirium.
- Anoxia, anemia, pulmonary or cardiac fail

SIGNS AND SYMPTOMS OF DELIRIUM

- Patients in delirium may present with any of the following signs and symptoms;
- Impaired consciousness- the patient may have clouding of consciousness ranging from drowsiness to stupor and coma or confusion.
- They may have impaired level of attention and concentration that they may find it difficult in shifting, focusing and sustaining attention.

SINGNS AND SYMPTOMS

- There may be disturbance of cognition that is impairment of abstract thinking and comprehension, impairment of immediate and recent memory that is the patient being unable to recall anything during the interview
- They have perception disturbances especially illusions (misinterpretation of real stimuli) or visual hallucinations-seeing things that other people do not see
- They may have emotional disturbances that is they may be depressed, anxious, fearful, irritable, euphoria (excessively happy), apathy (lack of emotional expression)

SIGNS AND SYMPTOMS CONTINUE

- They may have disturbance of the sleep- awakening cycle that is may have insomnia or in severe cases total sleep loss or reversal of sleep wake cycle, daytime drowsiness, nocturnal worsening of symptoms, disturbing dreams, or nightmares which may continue as hallucinations after awakening.
- They may have psychomotor disturbances with hypo or hyperactivity, aimless grabbing or picking at the bed clothes

MANAGEMENT OF DELIRIUM

- Identification of the cause and immediate correction is very important for example administer oxygen for hypoxia.
- You can give 50m/s of 50% dextrose in case of hypoglycemia
- I.V fluids for fluid for electrolyte balance

NURSING INTERVENTIONS

- Provide safe environment by restricting environmental stimuli, keep the unit calm and well illuminated. There should always be somebody at the patient’s bedside reassuring and supporting
- Alleviate patient’s fear and anxiety by removing any object from the room that seem to be a source of misinterpreted perception. As much as possible have the same person all the time by the patient’s bedside this could be the same relative attending to the patient

- The nurse should meet the patient’s physical needs such as;
- Use of appropriate nursing measures to reduce high fever if present
- Maintaining a fluid intake and output chart
- Maintaining patient’s hygiene including mouth and body hygiene
- Monitoring vital signs and documentation care for the patient’s bowel and bladder

- Observe the patient for any extreme drowsiness and sleep as this may be an indication that the patient is slipping into a coma

Facilitate orientation

- Since the patients with delirium are disoriented, repeatedly explain to the patient where he is and what date, day and time it is.
- Introduce people with names even if the patient misidentifies them
- Have a calendar and wall clock in the room and tell the patient what day it is

DELIRIUM TREMENS

- This is an acute condition resulting from acute withdrawal of alcohol. It is a psychiatric emergency which commonly end up in general hospitals after a person who has been dependent on alcohol suddenly stops to take them. It only occurs in patients with alcohol dependency.

SIGNS AND SYMPTOMS OF DELIRIUM TREMENS

- Patients in delirium tremens may present with;
- disorientation
- vivid hallucinations and illusions
- agitation, restlessness and shouting
- evident fear
- prolonged insomnia
- tremors
- ataxia (staggering gait).

SYMPTOMS CONTINUE

- Physically the patient may present with:
- excessive sweating and raised blood pressure
- dilated pupils
- palpitations
- dehydration and electrolyte disturbances.

Delirium tremens may begin with convulsions in some 5% of cases. These convulsions are called Ram fits

HOW TO DIAGNOSE DELIRIUM TREMENS

- Positive history of excessive consumption of alcohol over a period of time
- Recent abstinence from or heavier intake of alcohol consumed at a special social gathering or event such as a party or ceremony
- Low grade fever of sudden onset
- Confusion of acute onset and its worse at night.
- Prominent hallucinations that is vivid and commanding in nature and of insult
- Hallucinations may be associated with persecutory delusions
- May experience coarse tremors which are severe

MANAGEMENT OF DELIRIUM TREMENS

- Keep the patient in a quiet and safe environment like a room.
- Avoid too many changes in nursing staff because this worsens the confusion.
- Ensure plenty of fluids intravenously if the patient cannot feed orally and maintain a fluid and electrolyte balance chart.
- Sedation is usually given with diazepam 10mg or lorazepam 4mg intravenously followed by oral administration. Follow doctor’s prescription for over administration of drugs may cause another addiction.
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MANAGEMENT CONTINUE

- Ensure adequate rest under sedation of the patient.
- Provide multivitamins especially vitamin B. Complex. Other forms of treatment depend on clinical presentations.
- For fits, diazepam is used or any other anticonvulsants For hallucinations (alcoholic hallucinosis) haloperidol us used but not chlorpromazine

PROGNOSIS

- Delirium tremens is associated with a mortality rate of 10-25% if improperly managed. Delayed recognition and treatment may lead to korsakoff's psychosis (this is a chronic condition presenting with confusion and memory loss).
- Delirium tremens is common in expectant mothers who use alcohol on a daily basis and may even give birth to babies with alcohol intoxication and such babies will be very small at birth and may fail to survive a condition called fetal alcohol syndrome

PANIC ATTACKS

- These are episodes of acute anxiety which occur as part of psychotic or neurotic illness.
- It is a psychiatric emergency characterized by palpitations, sweating, tremors, and feeling of choking, chest pain, and nausea, and abdominal distress, fear of dying, chills or hot flushes

SIGNS AND SYMPTOMSPANIC ATTACKS.

- Accelerated heart rate.
- Sweating
- Trembling
- Sense of shortness of breath
- Feeling of chocking
- Check pain/discomfort
- Nausea
- Dizziness
- Fear of dying
- Chills and lot flashes
- Palpitations
- Abdominal distress/discomfort

MANAGEMENT OF PANIC ATTACKS

- Mild cases of panic attacks can be effectively treated with cognitive behavioral therapy with more emphasis on relaxation and instruction on miss interpretation of physiological symptoms.
- Breathing exercises
- Expose to the fear
- Occupy the patient
- Give re-assurance first
- Administer diazepam10mg or lorazepam 2mg.
- Continue with counselling

EPILEPSY RELATED EMERGENCIES

- Status epilepticus
- This is a repeated attack of generalized tonic colonic fits without gaining consciousness in between.

These may be caused by;

- Sudden withdrawal of antiepileptic drugs
- Infections such as malaria Sudden
- stressful situation for example over working
- Starvation and poor electrolyte balance
- Hormonal changes as in pregnancy

MANAGEMENT OF STATUS EPILEPTICUS

- The management of status epileptics is very important to be handled with urgency since it is life threatening to the patient.
- Remove the patient from danger that is if the patient is near sharp instruments these should be removed.
- 1. If she is on the ground she should be protected from hurting the head.
- 2. Loosen tight clothing to allow a clear airway.
- 3. Do not restrain the jerking
- 4. Clear airway

MANAGEMENT CONTINUES

- 5. Do not give any thing by mouth
- 6. Position the patient in lateral position or semi prone position
- 7. Refer the patient to hospital for further management
- 8. While in the hospital I.V fluids, oxygen, I.V diazepam, and parenteral phenytoin are the emergency measures to be used.

EPILEPTIC FUROR

- This follows an epileptic attack whereby the patient may behave in a strange manner and become excited and violent. The patient may wander off and run into danger like being knocked down by a vehicle.
- **Management**
- Patient is sedated with Diazepam 10mg I.V followed by oral anticonvulsants Haloperidol 10mg I.V helps to reduce psychotic behavior.
- As she regains her understanding she should be reoriented.

CATATONIC STUPOR

- This is a psychiatric emergency characterized by mutism, negativism, stupor, ambitendency (feeling to do something and not to do), automatic obedience (a patient obeying every command), posturing, mannerisms (habitual involuntary movements), stereotypes (persistent mechanical repetition of speech or motor activity

MANAGEMENT

Since the patient is not active in all ways ensure that the patient is given appropriate nursing care because the patient's life is in danger by doing the following;

- 1. Ensure patient airway is clear.
- 2. Administer I.V fluids to ensure patient is not starved.
- 3. Collect history and perform physical examination
- 4. Draw blood for investigations before starting any treatment
- 5. Provide the rest of care as for unconscious patient.

HYSTERICAL ATTACKS

- A hysterical attack may mimic abnormality of any function, which is under voluntary control. This psychiatric emergency may present in the following forms;
- Hysterical fits where the patient experiences falls without loss of consciousness and do not hurt themselves
- Hysterical ataxia where the patient presents with abnormal posture and gait
- Hysterical paraplegia where the patient may have paralysis of one side of the body
- All presentations are marked by a dramatic quality and sadness of mood.

MANAGEMENT OF HYSTERICAL ATTACKS

- 1. Hysterical fits should be distinguished from genuine epileptic fits since they do not have warning signs, no tongue biting, no incontinence of urine and faeces, no loss of consciousness and they usually occur indoors or in safe places.
- 2. Since hysterical symptoms can cause panic among relatives, explain to them the psychological nature of symptoms. Re-assure that no harm would come to the patient.
- 3. Help the patient to realise the meaning of the symptoms and help him find alternatives ways of coping with stress