UNIT 2 NURSING MANAGEMENT OF PSYCHIATRIC EMERGENCIES

Structure

2.0 OBJECTIVES

After studying this unit, you should be able to:

a define psychiatric emergencies;

- list the basic principles of psychiatry emergencies;
- identify common psychiatric emergencies and their management; and

a explain the role of a nurse in handling various psychiatric emergencies.

2.1 INTRODUCTION

Psychiatric emergencies take many forms in the emergency department. These patients may arrive in emergency department with severe dysfunction of behavior, mood, thinking or perception that represents a significant threat to life, daily living, or psychological integrity. Severity is not only related to patient's ability to function and adapt but also on the person's support systems.

Working with the patren to who an admitted with a cychiatric emergencies require patience, understanding and flexibility. This has become a challenging field due to rise in incidence of violence, rape, abuse, addiction and murders in the society. Effective and prompt emergency care in the emergency room not only helps stabilizing the emergency condition but also lessens the burden on the routine services.

In this unit, the discussion will be about the nursing management of various Psychiatric Emergencies in which the patient may be overactive, under-active, it can be alcohol and substance abuse elated emergencies and some other psychiatric emergencies.

2.2 DEFINITION

Psychiatric Emergency is the treatment of disorders of mood, thought and behavior in an emergency setting. Psychiatric emergencies are conditions in which there is alteration in behaviors, emotion or thought presenting in an acute form needing immediate attention and care.

Psychiatric Emergency care is a time limited form of treatment available to clients who are unable or unwilling to utilize other forms of psychiatric treatment. These services are aimed at solving an immediate problem faced by the client and his/her family. As an alternative resource, it offers easy accessible care, access to highly trained psychiatric staff, minimal stigmatization when associated with general hospital setting and fewer motivational constraints when requesting care.

Psychiatric emergencies are seen mostly in emergency room of a hospital, but these can be encountered in any routine psychiatric set up. Psychiatric emergencies do not mean that patients are suffering from only psychiatric disorders. They may be present due to medical conditions or conditions unrelated to medical field like disaster, rape and violence.

2.3 BASIC PRINCIPLES OF EMERGENCY PSYCHIATRY

Nurses handling psychiatric emergencies should keep the following principles in mind:

- The initial approach to a client/patient should be warm, direct and concerned.
- A quick evaluation to identify the nature of the condition and to initiate care on the basis of seriousness is essential.
- A comprehensive history helps to understand the anatomy of crisis, the patient's strength and liabilities.
- Psychiatric history should be collected from both the patient and the informant.
- Detailed general, physical and neurological examination of the patient should be done.
- History and clinical findings should be recorded clearly in emergency file.
- Psychiatric evaluation should be modified and tailor made in order to save time in decision making.
- Patient's condition and plan of management should be explained in simple language to the person(s), who have accompanied the patient.

2.4 COMMON PSYCHIATRIC EMERGENCIES

The psychiatric emergencies is one emergencies which can be prevented by .psychiatric nurse.

2.4.1 Overactive

An overactive patient presents with increased psychomotor activity. S/he has an excessive activity either as a defense against anxiety or as an expression of

manic or schizophrenic state. Excessive intake of alcohol or withdrawal of narcotic or other addictive substances may also lead to over activity. An over active patient may show irritability and demanding behavior. He/she is prone to injuries which may go fatal also. In over activity we should discuss about management of violence, anxiety reaction and agoraphobia.

1) Violence

Excitement and violence is a common reason for a referral to an emergency psychiatry setting.

Treatment

- Reassurance — if required, restrain the patients.
- Sedation — Inj. Diazepam 10-20 mg W slowly. In case of psychosis Inj. Serenace (Haloperidol) 20 mg I/M or Inj. Largectil (Chlorpromazine) 50-100 mg I/M may be administered.
- ECT is given in patients exhibiting violence certain specific psychotic conditions.

Nursing Care

- Have a non-threatening approach and do not challenge the patient. Speak in low firm voice.
- Approach the patient from back if she is to be restrained.
- Keep the patient in isolation with minimum furniture.
- Reduce environmental structures-remove bright pictures, curtains etc.
- Minimize visitors.
- Provide high calorie diet. Finger foods may be provided.

Dont's

- Do not keep any potential weapon near the patient.
- Do not sit/stand backing the patient.
- Do not allow any provocative family member or a friend of the patient in his room.
- Do not confront with the patient in any way.
- Do not sit close to the patient—you are likely to be hurt.

2) Anxiety Reaction

These patients are agitated and are in panicstate. They are restless, have flushed face, perspire profusely, rapid pulse and respiration, dilated pupils. The major mental symptoms are external fear and a sense of impending death and doom. Patients are usually not able to indicate the source of their fear. Patient may feel confused and have problem in concentrating. They often insist that they are going to die of heart attack.

Treatment

Benzodiazepines are quickly effective but dependence, cognitive impairment and abuse are a few of the problems associated with their use. Alprazolam is effective and show tapering of it helps prevent dependence. Antidepressants may be required.

Nursing Management

— Sit and talk to the patient.

— Promote relaxation.

— Do not reinforce somatic complaint.

— Try to identify the source of anxiety.

— Help develop insight.

3) **Agorophobia**

It is fear of open spaces. These patients may come in emergency rooms in panic or intoxicated (an attempt to reduce symptoms) may be present.

Treatment

Alprazolam 0.25 mg to 2 mg depending on severity of symptoms. Long term treatment with propanolol or an anti .depressant may be required.

Check Your Progress 1

1) Define Psychiatric Emergencies.

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2) List any five basic principles of Emergency Psychiatry.

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2.4.2 Underactive

In underactive patient the psychomotor retardation is marked. The conditions in which under activity may occur includes depression and catatonic stress.

1) **Depression**

2) **Stupor**

Causes

Neurological disorders e.g. encephalitis, neoplasm dienencephalon, subdural haematoma.

Systematic and metabolic disorders e.g., diabetic ketoacidosis.

Drugs and poisoning.

Psychiatric disorders e.g. catatonic schizophrenia depressive stupor, manic stupor.

Since psychogenic stupor may easily be mistaken for organic stupor, steps should be taken before detailed examination is done, to prevent irreversible brain damage and death which may occur otherwise.

Follow "ABC" (Airway, breathing, circulation) principle.

2.4.3 Attempted Suicide

Suicide and homicide represent major source of morbidity and mortality in psychiatric practice. Suicide means killing of oneself. An **attempted suicide** is a suicidal act with non fatal outcome. It is common among all levels of people. The need to be loved and accepted along with a desperate wish to communicate, feeling of loneliness, worthlessness, helplessness and hopelessness often result in intense feelings of anxiety, depression and anger or hostility directed towards oneself. If no one is available to talk or to listen to such feelings of inferiority or inadequacy, a suicide attempt may occur in an effort to seek help or end as emotional conflict.

1) Causes

Psychiatric disorders e.g., depression, alcoholism drug dependence and schizophrenia. Physical Disorders patients with incurable or painful physical disorders like cancer and AIDS often commit suicide.

2) Nursing Interventions

- If the patient has attempted suicide, restore physical health.
- Maintain life support — institute CPR, apply pressure if client is bleeding.
- Assess vital signs and do a brief neurological assessment.
- Maintain an open air way.
- Maintain fluid and electrolyte balance.
- If client has overdosed, investigate name and quantity of drug taken, report immediately.
- Provide a warm nurturing and protective environment.
- Confine patient to a secure room and provide watchful care by staying with the person and by listening and be supportive.
- Provide safe environment.
- Establish a trusting relationship with the client by using empathy and respect.
- Help the client to recognize, ventilate and accept feeling.
- Secure a verbal stated promise not to attempt suicide again. Instead patient will seek out a staff member if he experiences suicidal thoughts.
- Give a message of hope by being optimistic that life can be better and the patient will receive help in an attempt to solve his problem.
- Once the person has inner control over self destructive behaviour, encourage to engage in an activity e.g. outlet for tension and hostility.
- Point out positive aspect about the patient.
- Monitor the patient when he takes prescribed medication so that he does not collect it for future suicidal attempts.

2.4.4 Alcohol Related Emergencies

Alcohol is one of the most serious health problems. Alcoholism is defined as a primary or chronic disease with genetic, psychological and environmental factors influencing development and manifestation. The disease is often progressive and fatal and is characterized by impaired control over drinking, preoccupation with the alcohol despite adverse consequences and distortion in thinking most notable denial.

1) Alcohol Idiosyncratic Intoxication

It occurs when a person who consumes only a small amount of alcohol, presents as if s/he has consumed more alcohol. It is treated with Benzodiazepine I/M or orally.

2) Management

The priorities are to protect the acutely intoxicated person from self harm and from doing violence to others and to identify medical problems that require immediate attention. Use restraints if required. If required, small dose of benzodiazepines like diazepam, lorazepam etc. or paraldehyde are recommended.

3) Alcohol Withdrawal Delirium

Individuals with severe alcoholism experience withdrawal syndrome when their serum ethanol drops below the patient's normal level. Symptoms may be mild during early hours of withdrawal and can progress to full blown delirium tremors within days. It is important to note that symptoms occur when there is a drop below the person's normal level, not necessarily when there is no alcohol in the person's system.

Symptoms of Alcohol Withdrawal

- Restlessness, irritability, agitation, anxiety.
- Anorexia, nausea, vomiting, tremor.
- Elevated heart rate, increased blood pressure.
- Insomnia, intense dreaming, nightmares.
- Increased sensitivity to sounds, alteration in tactical sensations.
- Delirium: disorientation to time, place and situation.
- Hallucination: audio, visual tactile.
- Delusion: usually paranoid.
- Gradual seizures.
- Elevated temperature.

Management

- Acute treatment of alcohol withdrawal includes a safe environment and treatment of nutritional and electrolyte deficiencies.
- Monitor vital signs like TPR and BP because of chances of hyperthermia and vascular collapse.
- Restrain to prevent harm to self and others.

- Benzodiazepines are effective and are drugs of choice. Lorazepam is preferred for individuals with liver dysfunction because it does not depend on hepatic metabolism for clearance.

- Inj. Thiamine I/M is given because of expected thiamine deficiency.

Check Your Progress 2

Fill in the blanks:

i) Patient may become underactive in ..... and .....

ii) Clinical syndrome of Akins's and mutism but with relative presentation of conscious awareness is called .....

iii) Suicidal attempt with a non fatal outcome is called ....

iv) A condition in which a person who consumes only a small quantity of alcohol presents as if he has consumed more alcohol is called ....

v) Individuals with severe alcoholism experience ..... when their serum ethanol drops below the patient's normal level.

2.4.5 Barbiturate, Sedative, Hypnotic or Anxiolytic Intoxication and Withdrawal

This Emergencies related to substance abuse may be acute or chronic. The patient may come to the emergency department in acute withdrawal, severe drug intoxication or seeking help for addiction. Substance abuse has been discussed in detail in Unit **3** of Block 3. The intoxication and withdrawal of barbiturate. Sedative hypnotic s or anxiolytics may cause alteration in mood, thought and behavior requiring emergency care.

Management

Collect history of drug use. Withdrawal from barbiturates is performed in a hospital because of risk of medical complications.

2.4.6 Opioid Intoxication and Withdrawal

Patients addicted to opioids may present requesting withdrawal or more commonly present in withdrawal requesting relief. The characteristic signs of acute intoxication include clouded consciousness, severe respiratory depression and pinpoint pupils. Death from intoxication is due to respiratory failure. Anoxia may cause circulatory failure At this end stage, pupils are dilated.

Management

In case of opium toxicity, if patient is toxic, W administration of narcotic antagonist (example naloxone) is required. If patient is withdrawing, he may be referred to a de-addiction clinic.

2.4.7 Other Psychiatric Emergencies

1) Psychotropic Drug Withdrawal

Abrupt cessation of antipsychotic, benzodiazepines result in symptoms of withdrawal including abdominal pain, insomnia, drowsiness, agitation, anxiety, weakness, chills, delirium and in the extreme with benzodiazepines.

Symptoms of psychotropic drug withdrawal disappears with time and disappears with reinstitution of the drug. Symptoms of antidepressant withdrawal can be successfully treated with anti cholinergic agents such as atropine.

2) AIDS Associated Emergencies

AIDS related psychiatric emergencies include changes in behavior secondary to illness due to infection with lymph adenopathy associated virus (LAV, Human T–Lymphocytic virus – 3rd [H+]).

Depression, anxiety. suicidal ideation and attempts, delusions, denial, sexual promiscuity, relative psychosis, hypochondriasis, mutism, agitation, restlessness, psychomotor retardation.

Treatment: Evaluation and management of suicide risk and treatment of reversible organic illness are first task in emergency situation. High potency low dose antipsychotic (example 2 mg haloperidol) is used to counter agitation.

Nursing care: *Conscious and unconscious fear of contamination or stigmatization* leads family and others to withdraw from patients with AIDS. That can result in a depressive crisis severe enough to provoke suicide. Peer support groups, provision of information and enhancement of social supports are effective at times of crisis.

3) Adolescent Crisis

Adolescents presenting crisis due to suicidal ideation or attempts are, due to decline in school performance, truancy, difficulty with the law, pregnancy, abortion, alcoholism, running away, eating disorders and psychosis

Treatment

Adolescent crisis is always a family problem of suicidal potential, extent of substance use. Immediate management of crisis entails crisis oriented family therapy and individual therapy. When appropriate Hospitalization may be required. While all adolescent crisis represent family problems and require a family approach, not all families are responsible for the behavioral aberrations, pressure (particularly with substance use and suicide) and genetic factors may be responsible.

4) Puerperal Psychosis

.Child birth can precipitate schizophrenia, depression and mania.

Management: it depends on the nature of the symptoms. Danger to self and others (including infant) must be evaluated and proper precautions must be taken.

5) Rape

All may not report of rape. Conversely a person may report being delusional or vindictive but has not been sexually abused Silent rape reactions may be characterized by loss of appetite, sleep disturbance, anxiety and sometimes agoraphobia. In case of rape by a stranger there is a real fear of violence and death as well as of contracting a STD or being pregnant.

Management: Encourage mental ventilation. Use social support, reinforcement of healthy traits and encouragement to return to the previous level of functioning as rapidly as possible. Thorough physical examination and legal counsel is required. If victim is woman all alternatives to pregnancy should be offered. If victim has contracted V.D, appropriate antibiotics are provided.

2.5 ROLE OF THE NURSE

Psychiatric nurses in emergency care attempt to meet clients during a time of immediate need. The goal is to evaluate the problem from both the clients' perspective and nurses clinical expertise. The nurse develops a plan of care that is clinically sound, attends to the client's perceived needs and effectively utilizes available resources. Element of suicidal and homicidal risk needs to be evaluated.

Nurses need to show confidence, empathy knowledge and ability to engage in a systematic approach to problem solving.

Check Your Progress 3

1) List the symptoms of opioid intoxication.

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2) List the symptoms of opioid withdrawal.

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3) True or False:

a) In case of opium toxicity, I/V administration of Naloxone is done. (T/F)

b) Symptoms of antidepressant withdrawal can be treated with atropine. (T/F)

c) Adolescent crisis is an individual problem an not related to family. (T/F)

d) Victims of rape should be discouraged to talk abut their feelings. (T/F)

2.6 LET US SUM UP

In this unit you have learnt about different types of psychiatric emergencies. The basic principles of emergency psychiatry which the nurses should keep in the mind have been discussed. Common psychiatric emergencies including

emergencies, drug intoxication and withdrawal have been discussed along with their nursing managent. You have also learnt about some other psychiatric emergencies including psychotropic drug withdrawal, AIDS associated emergencies, adolescent crisis, puerperal psychosis and rap. Nurses handling psychiatric emergencies need to have knowledge and skills to care for patients more briskly. It will enable nurses to prevent violent, homicidal and suicidal attempts of the patients and handle these emergencies more effectively.

2.7 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) Psychiatric emergencies are conditions in which there is alteration is behaviour, emotion or thought presenting in an acute form needing immediate attention and care.

2)
- The initial approach to a client/patient should be warm, direct and concerned.
- A quick evaluation to identify the nature of the condition and to initiate care on the basis of seriousness is essential.
- **A** comprehensive history helps to understand the anatomy of crisis, the patient's strength and liabilities.
- Psychiatric history should be collected from both the patient and the informant.
- Detailed general, physical and neurological examination of the patient should be done.

Check Your Progress 2

a) Depression, catatonic stupor

b) stupor

c) attempted suicide

d) alcohol idiosyncratic intoxication

e) withdrawal

Check Your Progress 3

1) a) 'Clouded consciousness

b) Severe respiratory depression

c) Pinpointed pupils

2) Opiod withdrawal symptoms include dysphoric mood, nausea, vomiting, muscle aches, joint pains, lacrimation, rhinorhea, frequent yawning, pupillary dilatation, sweating, marked diarrhoea, restlessness and insomnia.

3) a) T

b) T

c) F

d) F