Psychiatric and Behavioral Emergencies

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Who are the AMS patients?

Do psych patients even belong in the EMS system?

Is there a way to quickly assess what’s really going on?

Why can these calls be so frustrating?

How do I help these patients without them getting to me?
PATIENTS WITH MEDICAL CONDITIONS

PATIENTS WITH MENTAL ILLNESS

29% also MI

68% also medical
AGENDA

- History of Mental Illness in 17 minutes
- How do we approach and triage AMS patients?
- Untangling Med? or Substance Abuse? or Psych?
- Psychiatric Conditions 101 - what do they look like and what can we do?
- YOUR Emotional Survival
What is a behavioral emergency?

“Actions or ideations by a patient that are harmful to themselves or others.”
To Sum Up...

- What it takes for *you* to survive the psych call is exactly what it takes for you to help the *patient* on this call.
Ancient Greek ‘mental’ classifications

- “Hysteria” literally means ‘wandering uterus’
- “Melancholy” literally, ‘black bile’
- “Lunacy” - phases of the moon dictate behavior
Four Humors

- SANGUINE
- CHOLERIC
- MELANCHOLIC
- PHLEGMATIC
HIPPOCRATES
460-377 B.C.E.

- Father of Medicine
- Rational knowledge
- Observe the patient
- The principle of ‘harmony’
- The brain is man’s most important organ
- First classification of mental illnesses
Freud in 5 minutes
Conscious

Pre-conscious
Conscious Mind

Pre-conscious Mental Life

Unconscious
Frontal cortex Vs. Amygdala
Limbic system

Amygdalas
Hx of U.S. Mental Health Treatment...in 9 minutes

- The Case of “Ragman” - 1827
- Boston Prison Discipline Society of the Reverend Louis Dwight - early 1800’s
- Dorothea Dix - The American asylum building program - 1840’s
- 1880 Census of “Insane Persons”
1880 Census (USA)

- 91,959 “Insane persons” identified
- 41,083 living at home
- 40,942 in hospitals and asylums
- 9,302 in almshouses
- 397 in jail (0.7% of jail/prison population)
1880 Census

"Insane"  Asylum

91,000

397

0

.7%

.7 %
Anyone know what this is?
America’s Largest Social Experiment

1955 discovery of 
\textit{Thorazine}

“Deinstiutionalization”
Where have all the mental hospital beds gone?

1955: 580,000

Today: 35,000
Out of sight...
America’s mentally ill held in:
Per 100,000 adults

Source: B.E. Harcourt, “An Institutionalisation Effect”
Aw, this can’t be true for progressive Minnesota…

- Minnesota’s rank among all 50 states for ratio of mental health beds for its population:
  
  50th
Basic Protocol

SAFETY

Medical Eval & Triage

Substance Abuse

ORGANIC
“Pills”
or
PSYCHOLOGICAL
“Skills”
DISPATCH

“Probably that same Wacko from last week. Why are they calling us?”
“I didn't become a medic to pick up f’ing drunks and crazies.”
“…but what if this time he’s a…medical?”

PPE

“Asshole” or “not an asshole?”

SAFE OR NOT SAFE?

“Do I respect or not respect them?”
SICK OR NOT SICK?
Case Study - Part 1 1/24/15
Safety First
Remember......

- Police probably have **not** have frisked patient for weapons or harmful substances

- Patient may **not** be aware you are there

- Patient may **not** know WHY you are there

- Patient may well have had previous experiences with first responders
…few more tips

- Keep hands visible (yours and theirs)
- Look at patient’s eyebrow, don’t stare directly into their eyes
- 1 communicator
- Don’t lie
- If hallucinations - “I don’t hear the voices but you do.”
Can we predict which mentally ill people will become violent?

No
…the facts

- **Lifetime** prevalence of violence among people with **serious** mental illness is 16% compared with 7% of people not mentally ill, however, in any given year...

- Studies show serious mental illness contributes about 3-5% of violence in general population

- What about substance abuse?
Individuals who abuse drugs or alcohol but have no other psychiatric disorder are 7x more likely than those without substance abuse to act violently.

Remember this
Scenes in which violence is more likely to occur:

- * Alcohol or drugs are consumed
- * Crowd incidents
- * Incidents in which violence has already occurred
- * Bystanders have their own agenda
- * Patient has inability to control language
- * Patient exhibits threatening behavior
Excited Delirium

- Long-term stimulant use? Heart disease? Genetic fault in moving excess neurotransmitters from stimulant use?
- Answers not clear.

- Patients usually TACHY, HTN, HYPERTHERMIC

- Differential DX: Hypoxia, Cocaine, Meth
- Chemical restraint, 100% O2, monitor respiration, ECG, Cool
Physical Restraint

- Know protocols
- Make a plan
- Prepare equipment
- De-escalate first
- Get help early
- Keep your cool
- Check blood glucose
- Watch for increased muscle tone (agitation)

- Restrain one limb at a time
- Do not restrict:
  - Breathing
  - Circulation
- HARD restraints?
- Reassess frequently
- Do not remove restraints prematurely
- Can I easily remove?
Chemical Restraint

- Benzodiazepines
  - Midazolam (Versed)
  - Lorazepam (Ativan)
- Butyrophenone
  - Haloperidol (Haldol)
  - And, if profound agitation: KETAMINE
Rapid tranquilization

- Be familiar with your protocol
- Assess agitation
- Consider manpower for restraint
- Versed 5 mg IV/IO/IM and/or
- Haldol 5-10 mg IV/IO/IM (wt & age based)
- or Ativan 2 mg IV/IO/IM + Haldol

- Profound Agitation: Ketamine 5mg/kg IM
- If Ketamine, administer 1 amp bicarb
Respiratory support including suction, O2, intubation

Monitor airway for laryngospasm (usually presents as stridor or abrupt cyanosis)

Watch for secretions, if present, consider Atropine 0.1-0.3 mg

If hallucinations post-ketamine, consider Midazolam 2-5mg
Safety

● How many rescuers is the preferred number to take down a combative patient?

● A 2
● B 5
● C 8
● D 12
Which should the medic be aware of when a restrained delirium patient suddenly becomes tranquil?

- A. Depression
- B. Exhaustion
- C. Renewed violence
- D. Cardiac collapse and death
Under which of the following would it be clearly legal to transport a patient having a behavioral emergency against his will?

- A When the patient is acting strange or bizarre
- B When ordered to transport by the on-line physician
- C When the patient is presenting a threat to himself or others
- D When the patient is confused about person, place and time.
Basic Protocol

SAFETY

Medical Eval & Triage

Substance Abuse

ORGANIC “Pills”  or  PSYCHOLOGICAL “Skills”
Triage

- Any one of the following symptoms or signs require immediate transport & evaluation:
- Loss of memory, disorientation (SUDDEN)
- Severe headache
- Extreme muscle stiffness, weakness
- Heat intolerance
- Unintentional weight loss
- Psychosis (NEW onset)
- Difficulty breathing

- Abnormal VS
- Overt trauma
- One pupil larger than the other
- Slurred speech
- Seizures
- Hemiparesis
Take Your Time
Your Personality

- Know your style for dealing with people?

- What hooks you?

- It’s not just your words but also how you come across

- What makes you impatient? tense?

- Do you talk to psych patients the way you talk to any other patient?

- Tip: Crazy ≠ Stupid
Here’s what you’re going to do, buddy.”

“I’m telling you to….”

“Shut up and listen”

“Listen, f….r, knock it off or we’ll kick your g.d. ass”
…this probably won’t work either

- “I trust you”
- “I’m with you”
- “You work this out”
‘FIRM but Respectful’

- Empathy - NOT sympathy - you understand what it’s like to be in their shoes
- Be yourself and be consistent
- LISTEN and use your expertise
- TAKE YOUR TIME
and, if the patient yells and uses provocative language?

- “That’s interesting. How come you say that?”
- “You need to stay in control so we can help you”
- “Let us help you get through this.”
- “It’s important to get this checked out.”
- We’re in no hurry. Take your time.”
- “That’s curious. Tell me more.”
- “You can keep yelling but I want you to put the ......down.”
PATIENT: “I don’t want the f…ing ER. I wanna get on with things.”

MEDIC: “Great. That’s my job, get things rolling so you can get on with things. Bottom line - people will need to see if it’s safe for you to do that. We can help with that, too”
<table>
<thead>
<tr>
<th></th>
<th>DX</th>
<th>What do we see?</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>HTN, Hepatic</td>
<td>Headache, restless, blood retina, seizure</td>
</tr>
<tr>
<td>E</td>
<td>Electrolytes</td>
<td>Arrhythmia, Dehydration, Rhabdo</td>
</tr>
<tr>
<td>S</td>
<td>Stroke</td>
<td>Severe, Aphasia (Broca’s)</td>
</tr>
<tr>
<td>T</td>
<td>TBI, brain bleed</td>
<td>Can we see this in the field?</td>
</tr>
<tr>
<td>O</td>
<td>Opiates</td>
<td>Pinpoint pupils, OD, sluggish</td>
</tr>
<tr>
<td>P</td>
<td>Psychosis (fake?)</td>
<td>Real (or fake)</td>
</tr>
<tr>
<td>S</td>
<td>Seizure</td>
<td>Typical or atypical?</td>
</tr>
<tr>
<td>T</td>
<td>Temperature</td>
<td>Feel hot, shiver, headache</td>
</tr>
<tr>
<td>O</td>
<td>On set</td>
<td></td>
</tr>
</tbody>
</table>
HE STOPS for TIPS on VOWELS

<table>
<thead>
<tr>
<th></th>
<th>DX</th>
<th>What do we see?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Acidosis</td>
<td>DKA (+BGL), HHNC, Endocrine, drugs,</td>
</tr>
<tr>
<td>E</td>
<td>Endocrine</td>
<td>Fatigue, depression, dry hair, constipation, memory,</td>
</tr>
<tr>
<td></td>
<td>Intoxication</td>
<td>memory, cold</td>
</tr>
<tr>
<td>I</td>
<td>Intoxication</td>
<td>ETOH, Benzos, SSRs, Tylenol</td>
</tr>
<tr>
<td>O</td>
<td>Oxygen</td>
<td>Elevated CO2, Low O2</td>
</tr>
<tr>
<td>U</td>
<td>Uremia</td>
<td>Blood in urea</td>
</tr>
</tbody>
</table>
Disorders that May Cause Acute Psychosis

METABOLIC DISORDERS

Hypoxia
Hypercalcemia (overactive parathyroid, cancer)
Hypercarbia (COPD, asthma, ventilatory failure, ARDS)
Hypoglycemia
Hyponatremia (CHF, cirrhosis, renal failure – What about STD?)
Medical Disorders that May Cause Acute Psychosis

INFLAMMATORY Disorders

Sarcoidosis (autoimmune inflammation)
Lupus
Temporal (giant cell) arteritis - PMR

ORGAN FAILURE

Heptic encephalopathy
Uremia (toxicity in kidney of nitrogenous substances)
Medical Disorders that May Cause Acute Psychosis

ENDOCRINE DISORDERS

Addison’s disease  (adrenal gland insufficiency)
Cushing’s disease  (too much ACTH from anterior pituitary)
Panhypopituitarism  (pituitary gland malfunction)
Parathyroid disease
Postpartum psychosis
Recurrent menstrual psychosis
Sydenham’s chorea  (St Vitus Dance – acute rheumatic fever)
Thyroid Disease  (Mimics bipolar)
Lewy body
Neurologic Disorders that May Cause Acute Psychosis

- Alzheimer’s disease*
- Parkinson’s disease*
- Lewy Body Dementia*
- CVA (or just CV disease)*
- Encephalitis (including HIV)
- Epilepsy
- Huntington’s disease
- Multiple sclerosis
- Neoplasms
- Normal-pressure hydrocephalus
  - Pick’s disease (frontotemporal dementia)
- Wilson’s disease (inherited – copper accumulation)
Age 80, 4 years with PD
Pharmacologic Agents that May Cause Acute Psychosis

ANTIANXIETY AGENTS

Alprazolam (Xanax)
Chlordiazepoxide (Librium)
Clonazepam (Klonopin)
Chlorazepate (Tranxene – benzodiazepine)
Diazepam (Valium)
Ethchlorvynol (old sedative)

ANTICONVULSANTS

Ethosuximide
Phenobarbital
Phenytoin (Dilantin)
Primidone (Mysoline)
Pharmacologic Agents that May Cause Acute Psychosis

ANTIBIOTICS
- Isoniazid
- Rifampin

ANTIDEPRESSANTS
- Amitriptyline (Elavil)
- Doxepin (Silenor)
- Imipramine (Tofranil)
- Protriptyline (Vivactil)
- Trimipramine (Surmontil)
Pharmacologic Agents that May Cause Acute Psychosis

MISCELLANEOUS DRUGS

Antihistamines
Antineoplastics (anticancer drugs)
Bromides (some inhalants)
Cimetidine (Tagamet)
Corticosteroids
Disulfiram (Antabuse)
Heavy metals

DRUGS OF ABUSE

ETOH
Amphetamines
Cannabis
Cocaine

Hallucinogens
Opioids
Phencyclidine
Sedative hypnotics
Kratom Abuse

- Low Dose S & S: increased alertness, talkative, high energy, edgy, nervous

- High Dose S & S: Constricted pupils, insensitivity to pain, nausea, vomiting, itching, sweating, dreaminess

- Overdose S & S: Delusions, lethargy, respiratory depression, shakiness, combativeness, paranoia, severe nausea and vomiting
Cardiovascular Drugs that May Cause Acute Psychosis

Captopril (Capoten, ACE inhibitor)
Digitalis*
Disopyramide (Norpace, antiarrhythmic)
Methyldopa (Aldomet, Aldoril – anti HTN)
Procainamide (antiarrhythmic)
Propranolol (Inderal – beta blocker)
### "MADFOCS" Table

<table>
<thead>
<tr>
<th>&quot;MADFOCS&quot;</th>
<th>MEDICAL</th>
<th>PSYCHIATRIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory deficit</td>
<td>Recent</td>
<td>Past/Remote</td>
</tr>
<tr>
<td>Problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Lethargic</td>
<td>Repetitive</td>
</tr>
<tr>
<td></td>
<td>Ataxia</td>
<td>Rocking</td>
</tr>
<tr>
<td>Distortions</td>
<td>Visual</td>
<td>Auditory</td>
</tr>
<tr>
<td>Feelings</td>
<td>Emotional</td>
<td>Flat (not always)</td>
</tr>
<tr>
<td>Orientation</td>
<td>Disoriented</td>
<td>Oriented(maybe)y(depends)</td>
</tr>
<tr>
<td>Cognition</td>
<td>Some lucidity</td>
<td>Scattered</td>
</tr>
<tr>
<td></td>
<td>Comes/Goes</td>
<td>Unfiltered</td>
</tr>
<tr>
<td>SOME others</td>
<td>Age &gt;40</td>
<td>Age&lt;40</td>
</tr>
</tbody>
</table>
Select which best describes a victim at highest risk of being assaulted in a domestic violence incident

- A. A person with developmental disabilities
- B. Children in a low-income home
- C. Males living in the inner city
- D. Females living in a suburban area
Suicide

- Roughly 39,000 people will complete suicide each year
- 20,000 by firearm
Suicide Rate per 100,000 (by age, gender, race)
Which of the following situations poses the greatest risk factor for suicide?

- A. Divorce
- B. Depression
- C. Living alone
- D. Alcohol or drug abuse
Myth or Fact?

“Talking about suicide with a patient can put the idea into his or her head.”
Myth or Fact?

“Talking about suicide with a patient will put the idea into his or her head.”

MYTH
“Have you, at any time, done anything that anyone could see as being self destructive, even suicidal?”
“Are you hopeless, discouraged right now?”
“Are you so unhappy you thought of killing yourself?”
“Do you have a plan?”
“How likely that you’re going to do it?”
“Previous attempts?”
Ever injured yourself without the intent to die?”
“Can we help you get past this?”
Patients at Highest Risk

1. Seriousness of Previous Attempt
2. Hx of Attempts
3. Acute Suicidal Ideation
4. Severe Hopelessness
5. Attraction to Death
6. Family Hx of Suicide
7. Acute ETOH overdose
8. Loss/Separations
Double-check risk factors for….

- **ETOH** - Impulsivity or Suicidal communication
- **Older adults** - Serious of attempt/illness
- **Schizophrenia Patients** - Command hallucination, Rx noncompliance
- **Adolescents** - Medical seriousness of previous attempt, accessible means, childhood abuse
Military Suicide Study

- 40,820 soldiers

- Biggest risk factors:
  - AT LEAST ONE PRIOR HOSPITALIZATION (15x more likely)
  - Previous attempt
  - Hx of using weapons
  - TBI
  - Higher IQ
  - Age >26 at enlistment
What do we do pre-hospital?

• Treating the suicidal patient:
  – Early identification (Talk about it)
  – Assess lethality
  – Stay with the patient at all times*
  – Detailed HX if possible
  – Transport to hospital for evaluation
  – Enlist law enforcement if necessary
Which of the following would suggest to you that a patient is at increased risk of suicide?

- A  Sudden improvement from depression
- B  Thought about death after seeing an autopsy
- C  An 8-year old who is being held back in school
- D  Just received a job promotion he was expecting
...and one last thing

- Who’s the most likely to kill you during the course of your career?
  - Diagnosis:
  - Age:
  - Gender:
  - Race:
  - Situation:
Statistically, you are the most likely one.
A Word about Our Culture
Basic Protocol

SAFETY

Medical Eval & Triage

Substance Abuse

ORGANIC “Pills”
or

PSYCHOLOGICAL “Skills”
The Feeling Chart

Euphoria

Normal

Pain
Stages of the Addiction Cycle.
Alcoholism and Addiction

- Learning, seeking, preoccupied with mood swing
- Delusion: Lose track of where you are in the cycle
- Classic set of defenses
- Primarily a “relationship” disorder? a “learned” disease ~ diabetes?
- What’s the BIG BOOK say?
- “Obsession of the mind, Craving of the body”
- What the evidence says about TX?
- Role of the Co-Dependent
ETOH Withdrawal
What are we going to see…

- nausea or vomiting
- insomnia
- anxiety
- psychomotor agitation
- + pulse, rr, body temp, bp
- hand tremor
- transient hallucinations
- generalized tonic-clonic seizures

- Symptoms begin within 8 hours after blood alcohol level decrease, peak at 72 hours
ETOH Withdrawal
What are we going to do....

- ABCs
- O2
- IV NS if dehydrated
- D50 if BGL <60
- Be prepared with seizure protocol
Which of the following reasons explains why we modify our approach when treating a patient with a behavioral emergency?

- A. We may make a borderline patient suicidal.
- B. Treating the patient in a hurry can make the situation worse.
- C. You need to take time so the hospital can prepare.
- D. The underlying cause of behavioral emergencies is psychological.
How do we ‘grow up’?
<table>
<thead>
<tr>
<th>Age</th>
<th>Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy</td>
<td>0 - 1 yr</td>
</tr>
<tr>
<td>18 mos - age 3</td>
<td>TRUST</td>
</tr>
<tr>
<td>age 3 - 11</td>
<td>AUTONOMY</td>
</tr>
<tr>
<td>Adolesc.</td>
<td>INITIATIVE, INDUSTRY</td>
</tr>
<tr>
<td>12 - 18</td>
<td>IDENTITY</td>
</tr>
<tr>
<td>YOUNG ADULT</td>
<td>INTIMACY</td>
</tr>
<tr>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td>ADULT</td>
<td>GENERATIVITY</td>
</tr>
<tr>
<td>MATURE AGE</td>
<td>INTEGRITY</td>
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</table>
Basic Protocol

SAFETY

Medical Eval & Triage

Substance Abuse

ORGANIC
“Pills”

or

PSYCHOLOGICAL
“Skills”
Brain’s wiring stunted

- Normal (l) vs. Childhood onset schizophrenia (r)

Composite MRI scan data showing areas of gray matter loss over 5 years, comparing 12 normal teens (left) and 12 teens with childhood onset schizophrenia.
Thought Disorders

- Psychosis
  - Problems forming logical thoughts
  - Loss of contact with reality
  - Internal world mistaken for the outside world
<table>
<thead>
<tr>
<th>Medical or Substance Abuse</th>
</tr>
</thead>
</table>

**Table 2. Differential Diagnosis of Psychosis.**

- Secondary psychosis
- Delirium
- Dementia
- Medical illness (including neurologic diseases)
- Substance use
  - Alcohol and sedatives
  - Illicit drugs (e.g., hallucinogens, cannabinoids, stimulants, phencyclidine, synthetic designer drugs)
  - Medications (e.g., glucocorticoids)
Psychiatric Illness

Primary psychosis
Schizophrenia spectrum disorders
  Schizophrenia
  Schizoaffective disorder
  Schizotypal personality disorder
Delusional disorder
Acute and transient psychotic disorders
Psychotic mood disorders (e.g., bipolar disorder, recurrent depression)
Psychosis-like experiences
  Borderline personality disorder
  Post-traumatic stress disorder
  Autism spectrum disorder
  Attenuated psychosis syndrome (e.g., schizophrenia prodrome)
Obsessive–compulsive disorder
Body dysmorphic disorder
Paranoid personality disorder
Malingering
- Talk side-to-side rather than face-to-face
- Avoid direct eye contact
- Speak indirectly (counterintuitive!)
- Identify with the fight
- DON’T RATIONALIZE (Don’t even expect logic to work)
- Postpone education/treatment
- Show respect
…what I hope you got from that clip…. 

- It’s “like nightmares when you are awake”
- Not a split person, but a “shattered mind”
- Wanted to live without medication
- Patients are often brittle, tense
- Crazy ≠ Stupid
Schizophrenia DX

- Delusions (false beliefs)
- Hallucinations (false perceptions)
- Disorganized thought/speech - a "private logic"
- Extremely disorganized behavior
- Restricted range of emotions
<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
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<tbody>
<tr>
<td>Clozapine</td>
<td>Clozaril</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>Zyprexa</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>Seroquel</td>
</tr>
<tr>
<td>Risperidone</td>
<td>Risperdal</td>
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<tr>
<td>Ziprasidone</td>
<td>Geodon</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>Abilify</td>
</tr>
</tbody>
</table>
Reasons people give for not taking meds......

- side effects
- denial (“I don’t need it”)
- feeling better
- meds aren’t working (can happen after years, efficacy declines)
- forgot to take it
- $$$
What are we going to do pre-hospital?

- Safety
- Respect
- Reassurance
- Medical Hx including Rx Hx/Compliance
- Transport
Tourettes Syndrome

- Motor and vocal tics
- Tics occur many times a day (bouts) nearly everyday over period of 3 months
- Onset < age 18
- Not due to direct evidence of substance (stimulants) or med condition (Huntington’s or post-viral encephalitis)
Tic-Suppressing Medications

- Alpha-agonists (Clonidine, Guanfacine)
- Antipsychotics (Haloperidol, Fluphenazine - Prolixin, Pimozide - Orap, Risperidone - Risperdal)
- Dopamine depleter (Tetrabenazine)
- Deep brain stimulation
What depression is NOT…..

- Grief
- Disappointment
- Falling short of expectations
- Laziness
- Boredom
- Hangover
....and it is **not**...
The Victim Identity
Depression: What do we see?

- **Feelings** - sad, anxious, low
- **Energy** - tired, not relieved by sleep
- **Sleep** - broken, early AM wakening, oversleep
- **Thinking** - can’t concentrate, fuzzy headed
- **Interests** - colorless, shrinks even food and sex
- **Value** - useless, unworthy, damned, wicked
- **Aches** - chest pain, headache, old injury
- **Life** - suicidal
Depression in the Elderly

- Common > age 60
- Co-morbidities with medical conditions
- Often follows hospitalization
- Complicated by polypharmacy
- If late life onset, r/o neurological problem
What are we going to do pre-hospital?

- Screen for suicidality
- Rule/Out medical and substance disorders
- Hx of medication and compliance
- Support
- Transport
Anti-Depressive Drugs that may cause acute Psychosis

Amitriptyline (Elavil)
Doxepin (Silenor)
Imipramine (Tofranil)
Protripyline (Vivactil)
Trimiprimine (Surmontil)
Bacteroides fragilis
Homelessness/High Utilizers

- Lots of stuck thinking wheels
- Many use ED as their personal physician
- Many use ED as their pharmacy
- Work with staff for options
- Keep your powder dry
- Document well

What’s really going on with them?
…let’s revisit our roadmap about how we grow up…

- mistrust
- shame
- guilt
- inferiority
- confusion
- isolation
- stagnation
- despair
Cognitive Behavioral Tx

- Our thoughts affect our feelings
- Negative thinking is identified and challenged
- Specific behaviors are practiced in small, manageable chunks
- Homework assignments
- CBT can be mixed/matched w/other tx
Elation

- F - enthusiastic, optimistic, never better
- E - super energy
- S - need little sleep
- T - races, flighty
- I - 1001 things
- V - greater than the greatest
- A - no pains
- L - live forever
Medications for Mania

- Lithium carbonate (Eskalith, Lithane, Lithobid, Lithonate, Lithotabs)

- Lithium citrate (Cibalith)

- Carbamazepine (Tegretol)

- Valproic acid (Depakote)
Lithium Side Effects

- Restlessness
- Dry mouth
- Bloating or indigestion
- Acne
- Unusual discomfort to cold
- Joint or muscle pain
- Brittle nails or hair
Other Drugs used for Bi-polar

Lamotigrine (Lamictal)*

Anticonvulsants* like Gabapenten (Neurotin), Topimax and Triepctal

Antipsychotics: Zyprexa, Risperidone, Seroquel

* suicide warning on label
What OCD is not….

- Normal rumination or worry
- Anxiety or depression - frequently misdiagnosed
Common Symptoms in OCD

- Contamination
- Sexual
- Religious
- Aggressive
- Control-related
- Pathological doubt
- Superstitions
- Symmetry and exactness
IN YOUR LIFE HAVE YOU EVERY HAD AN EXPERIENCE SO FRIGHTENING THAT IN THE PAST MONTH, YOU:

- Had nightmares about it, thought about it when you didn’t want to?
- Tried hard to go out of your way to avoid situations that reminded you of it?
- Were constantly watchful, onguard, easily startled?
- Felt numb, detached from others, activities, surroundings?
Eating Disorders

- Anorexia - calorie restricters, distorted body image, use of diuretics common

- Bulimia - Frequent binge eating, followed by self-induced vomiting

- Binge Eating Disorder
S&S Eating Disorder

- Hypotensive (<90 mHg SBP)
- Bradycardic (HR < 60)
- IF TACHY, LOOK FOR CAUSE IMMEDIATELY!

- Look for fever, dehydration, AMS

- Cardiac disrrythmias

- Up to 1/2 have substance abuse issue
TX Eating Disorder

- Stabilize with fluids, DO NOT FLOOD
- Monitor - ECG
- Screen for suicidal ideation
- Electrolyte replacement (ED)
- Hypokalemia common (esp w/purging)
Basic Protocol

SAFETY

Medical Eval & Triage

Substance Abuse

ORGANIC “Pills”
or

PSYCHOLOGICAL “Skills”
Anxiety Disorders

- Panic Disorder
- Separation Anxiety
- Selective Mutism
- Social Anxiety Disorder/
- Specific Phobia
- Agoraphobia
- Generalized anxiety disorder
- Substance-abuse/Medical induced anxiety
Panic Disorder
(The Evidence)

- Most common psych emergency

- 80% of patients have major life stressor in previous 12 months

- For heavy users of med services and unexplained illness, 2 questions have 95% diagnostic accuracy:
1) In the past six months, did you ever have a spell or attack when all of a sudden you felt frightened, anxious, or very uneasy?

2) In the past six months, did you ever have a spell or attack when for no reason your heart suddenly began to race, you felt faint, or you couldn’t catch your breath?
S&S Panic Disorder

- SOB - or feeling of being smothered
- Tachy or palpitations
- Sweating
- Nausea
- Flushes or chills
- “Fear of dying”
- Feelings of unreality
- Dizziness - syncope
- Paresthesias*
- Chest pain
- Fear of going crazy
What’s the ED want to know?

- R/O hyper/hypo thyroidism, temporal lobe epilepsy, asthma, cardia arrhythmias, pheochromocytoma, caffeine use, alcohol withdrawal, steroid use

- Depression and suicidality

- Current medications/compliance
Somatic Disorders

- **Factitious** (think “fake” or exaggerated)

- Dramatic, inconsistent Hx
- Unclear symptoms, change a lot
- Predictable relapse after improvement
- Extensive med knowledge
- Surgical scars - mucho
- New S&S after negative tests
- Symptoms only when observed

- Will go so far as to hurt self/others
Case Study - Early Nov 2015
Malingering

- Drug seekers
- Acting suicidal to avoid jail time
- Usually a clear or transparent motive
Drug-Seeking Patients

- Anxiety and/or pain is out of proportion to objective findings
- Patient is specific about what medication he or she needs
- Patient states normal provider not available
- Hostile demands
Personality Disorders

Think of our road map of growing up
<table>
<thead>
<tr>
<th><strong>Cluster A</strong></th>
<th><strong>Cluster B</strong></th>
<th><strong>Cluster C</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“Odd”</strong></td>
<td><strong>“Dramatic”</strong></td>
<td><strong>“Anxious”</strong></td>
</tr>
<tr>
<td>Paranoid</td>
<td>Antisocial</td>
<td>Dependent</td>
</tr>
<tr>
<td>Schizoid</td>
<td>Histrionic</td>
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<tr>
<td>Schizotypal</td>
<td>Narcissistic</td>
<td>Avoidant</td>
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<tr>
<td></td>
<td>Borderline</td>
<td></td>
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</tbody>
</table>
Impulse Control DO

- Lack the ability to resist a temptation or can’t avoiding acting on a drive

- Kleptomania
- Pyromania
- Pathological gambling
- Compulsive Shopping
- Intermittent explosive disorder
• CORTISOL ROLLER COASTER
• OUR CULTURE
• RESILIENCE OR RUIN
• SELF-DEFEATING BEHAVIORS
Emotional Survival

- Read at your earliest opportunity:

- **EMOTIONAL SURVIVAL FOR LAW ENFORCEMENT** by Kevin Gilmartin
You can’t un-see what you have seen

You can’t un-hear what you have heard
It’s not just Critical Incidents, it’s the cumulative effect of what you’re seeing everyday.

If it is a Critical Incident - and it’s been debriefed….Follow Up!

How are you going to deal with: The Three Year Honeymoon Switch - when your shield of cynicism and boredom snaps into lock position?
I’ll bet you’ve heard…

- “Ten more years and I’m out of here.”
- “Think if I had it to do all over again, I’d be a coach…some other line of work.”
- “Just counting the days, man.”
- “How does anyone live in the inner city.”
- “The whole thing is collapsing. People just can’t see it.”
- “Management sucks…no idea what they’re doing.”
Resilience
5 Questions

- Who are you?
- What do you do?
- Why do you do it?
- Who do you do it for?
- What do they get from it?
10 Most Common Reasons for Not Getting Help

- 10. Where to go? Who to see?
- 9. What will others think?
- 8. Side effects
- 7. No time
- 6. Harmful consequences (hospital, tx)
- 5. Embarrassed
- 4. Probably will go away on its own
- 3. Not necessary (“I don’t see it”
- 2. I can cope!
- 1. I don’t (didn’t) think anyone could help me
To Sum Up...

- What it takes for you to survive the psych call is exactly what it takes for you to help the *patient* survive this experience.
Psychiatric and Behavioral Emergencies

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March 4, 2016

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