20 Questions: Psychiatric Emergencies

1. What are some common medical emergencies mistaken for psychiatric emergencies?
2. What are some clues that you are dealing with a medical problem?
3. Medical vs. psychiatric, which hallucinations are more common in each group? Visual vs. audio?
4. What does 'psychosis' mean, and why is a psychotic patient potentially dangerous?
5. Responding to a call to Assist Police, you find them restraining a young man who is violently and persistently combative. What could happen if the patient continues to struggle violently?
6. What are some examples of drugs that you can sedate violent people with?
7. What are the requirements for a Peace Officer to put a patient on a Transportation Hold to get an emergency medical or psychiatric evaluation?
8. What should you pay *extra* attention to when transporting a sedated patient?
9. Why do medics need to be careful around behaviorally unstable patients?
10. A patient you are transporting has a history of schizophrenia. Does this mean he has two personalities?
11. A patient recently started on Haldol is deteriorating. He is pacing the halls, yelling, and will not keep still. He is all over the cart squirming and wrestling the blanket. Why might giving more Haldol exacerbate the situation?
12. What is the third most common cause of death between 15-34 years of age, and the 8th most common overall in the population? (hint: it's a psych emergency)
13. Can depression lead to delusions?
14. What is ECT?
15. What is bipolar disease?
16. How prevalent is anxiety in our population?
17. What medical diseases are often missed in a patient thought to have a 'panic attack'?
18. You respond to a school where a 17 year old female had the sudden onset of painless paraplegia during a math test. What psychological disorder might this be?
19. How can you defuse a patient that is becoming more agitated and angry?
20. How many shelters are there for animals compared to those for battered women in the US?

20 Answers: Psychiatric Emergencies

1. This is unfortunately a common occurrence. The biggest two *reversible* causes are hypoglycemia or hypoxia. When the brain doesn't get enough of those two

things, it gets rowdy and can cause people to do/say very odd things. This should hint towards a perfusion problem (e.g. shock) or a metabolic problem (e.g. diabetic emergency). Also, things like thyroid dysfunction, liver disease, atypical seizure and substance abuse are common players.

2. Rapid onset of new symptoms in a patient is a good indicator of a medical problem, especially in the setting of no known psych history. Patients with psychiatric illness tend to maintain their own identity, such as facts about life (phone number, home town, etc) straight, where medical patients tend to have more global issues.
3. Visual hallucinations tend to be observed in MEDICAL patients. They are still actually quite rare despite how TV likes to portray them. Audio hallucinations are more consistent with a psychiatric illness and more common in general.
4. Psychotic patients are unable to perceive, retain, or act on information in a constructive way. A major problem is that they cannot prioritize stimuli, thus they may have a profound reaction to minimal changes in environment or stimulation. This coupled with impulsivity and inability to understand socially acceptable responses to stimuli is a potentially violent mixture.
5. Severe agitation, especially in the setting of stimulant drug use (e.g. cocaine or meth) is more dangerous than people may think. Extremely agitated patients can build up overwhelming levels of lactic acid and other metabolites, putting their cardiovascular function at risk. These patients need to be sedated quickly if they continue to struggle. In the setting of severe agitation, if patients become hemodynamically unstable, you need to aggressively fluid resuscitate +/- sodium bicarb. to combat the acidosis and metabolic disturbance. Don't forget that H+ / acidosis is part of the H's and T's that can cause a PEA arrest.
6. These will vary based on protocol and availability but common options are: Midazolom, Haloperidol, and Ketamine are common options used to sedate patients. Other less commonly used options prehospital are Ziprasidone (Geodon) and Olanzapine (Zyprexa).
7. Patients have to have one problem in each of the two following categories to qualify for a Transportation Hold to ensure they're safely transported for evaluation.
   A) Psychiatric disease OR Chemical Dependence problem
   B) Danger to themselves / Danger to others / Inability to care for themselves
8. AIRWAY. Especially with ketamine and Versed. This needs to be constantly monitored when using sedatives, especially because many of these patients have other drugs on board.
9. Lights, sirens, uniforms, intimidating EMS Fellow beards, and small, enclosed spaces bouncing down the road aren't exactly conducive to calming an escalating patient. Watch carefully for signs that the patient is becoming more anxious or distressed, and anticipate what you would do if you were

threatened. Control the environment as best you can to provide an atmosphere that is not intimidating and is devoid of weapons. As always, the safety of yourself and your partner is most important.

10. No. Multiple personality syndromes (unlike simple profound moodiness, like your partner exhibits) are poorly described. Schizophrenia is a thought disorder that until 30 years ago consigned a patient to lifelong hospitalization. Now, with proper medical therapy many of these persons can lead productive and enjoyable lives. Delusions, hallucinations (especially auditory), disorganized behavior, flat speech, and deterioration of function are key features. These features must be present for at least 6 months for a diagnosis to be made. Usual onset is by the mid 20s. Patients who have been off their medications are obviously more dangerous. Keep this in mind if "patient just moved here and doesn't have their meds" or "patient was incarcerated and wasn't getting their meds."
11. Akathisia is drug-induced restlessness. It can be prominent in normal patients, but in the mentally ill it is less well tolerated, often leading to a significant worsening in function with a high degree of agitation. Unfortunately, it often isn't recognized until the dosage of the medication has been increased several times, with worsening of the patient's condition. It usually responds well to Benadryl or Cogentin, and some patients are on these medications chronically to prevent this side effect. You may also see a dystonic reaction which manifests as torticollis, or tightening of muscles (traditionally the sternocleidomastoid). Also should respond to Bendaryl, but is very unsettling for the patient and their family.
12. Suicide.
13. Absolutely. Depression is a spectrum of disease. It is not uncommon to have depression with psychotic features which involve profound delusions, etc. These usually vanish as the depression is treated. Depression with anxious features is also quite common.
14. Electroconvulsive therapy is a treatment for major depression that is quite effective. Basically, the patient is anesthetized and medically paralyzed. Electrical stimulation is delivered by scalp electrodes at a level which causes seizures. After a few minutes, the current is shut off, and the patient wakes up. A series of treatments usually occurs. 70-90% of patients have good results after 6-12 treatments. Tachycardia, hypertension, and increased intracranial pressure occur temporarily during treatment. Dysrhythmias occur rarely. Memory loss and some confusion may occur, but this is usually transient and resolves over a few weeks.
15. Bipolar disease is present in <1% of the population. Alternating episodes of mania (hyperactivity, flight of ideas, pressured speech, elation, lavish spending, etc.) and depression occur.

16. 30-40% of the population will experience an anxiety state at some point that is severe enough to warrant treatment. 15% of the population takes a tranquilizer at least once a year, and 6% on a regular basis. Anxiety up to moderate levels improves learning and performance, but beyond that becomes rapidly destructive. Only about 25% of patients with severe anxiety attacks will ever seek treatment from the medical system. Impulsive suicide during panic attacks is relatively frequent.
17. Many medical diseases are misdiagnosed as panic attacks. Most common are angina, dysrhythmias, mitral valve prolapse, endocrine disease, PE, asthma, seizures, and intoxications.
18. Conversion disorder is the abrupt onset of a single symptom, typically a neurologic problem, without any possible physical explanation (eg: abrupt onset of paraplegia in a healthy person with normal MRI scan, labs, etc.) Note that these symptoms are NOT under conscious control so you can try as hard as you want to get the person to walk, etc. but they will not recover until something sub-consciously allows them to recover! Pseudo-seizures will often fall into this category as well.
19. Many techniques (verbal judo) can be effective, and the scope of training is far beyond what can be covered here. Make sure to tell the patient honestly what is happening to them, tell them how you are feeling (I'm afraid you're going to hit somebody) and acknowledge what you see (You seem angry). Supportive statements can be extremely helpful (You're doing a great job controlling yourself). All paramedics should be skilled at verbal de-escalation techniques, as truly an ounce of prevention is worth a pound of cure in this case. Never, however, put yourself at risk. Make sure adequate help and restraints are available if needed and if the tension is mounting despite your best efforts, intervene as necessary to prevent injury to you and your patient.
20. There are three animal shelters in the US for every battered women's shelter despite the fact that up to 30% of women have been assaulted by a partner within the last year. Physicians and paramedics detect less than 5% of partner abuse cases. Good reminder to stay vigilant out there.