
MANAGING THE PSYCHIATRIC CRISIS

Course # 2025
15 Contact Hours

Authors: Julie M. Mroczek, BSN. RN-BC, CLNC
Silvia Prodan Lange, R.N., M.N.
Expert reviewer: Meredith Patterson, RN, BSN, CRRN

Material Valid Through June 2020

Copyright © 2017

J.L. Keefer

All rights reserved

Published by the

National Center of Continuing Education, Inc.,

Lakeway, Texas.

Printed in the United States of America.



**No Exams,
Just Learning!**

Testing Mandatory For Electrologists, Florida & Ohio Only

A NATIONAL EPIDEMIC

WE ALL KNOW . . .

. . . that U.S. Copyright Law grants to the copyright owner the exclusive right to duplicate copyrighted, printed and recorded materials. Piracy involves the illegal duplication of copyrighted materials.

YOU MAY NOT KNOW . . .

- . . . that every time you use or make an illegal copy of any printed material in any form or by any method you may be liable for further litigation.
- . . . that your institution's duplication or processing equipment may also be confiscated and destroyed if involved in illegal duplication.
- . . . that the penalty for criminal violation is up to five years in prison and/or a \$250,000 fine under a tough new law. (Title 17, U.S. Code, Section 506, and Title 18, U.S. Code Section 2319).
- . . . that civil or criminal litigation may be costly and embarrassing to any organization or individual. We request you contact us immediately regarding illegal duplication of these copyrighted, printed materials. The National Center of Continuing Education will pay a substantial reward for information leading to the conviction of any individual or institution making any unauthorized duplication of material copyrighted by J.L. Keefer or The National Center of Continuing Education.

Table of Contents

About The Authors	3	Dealing With Anger and Violence.....	19
Purpose and Goals.....	3	Problem:	19
Instructional Objectives	3	Goal:	19
Self-awareness Explorations	3	Action:	19
Introduction	3	Life-Disrupting Conditions	20
Impact on Health Professionals	5	Anxiety	20
Reactions to Psychiatric Emergencies	5	The Continuum Of Anxiety.....	20
Stress	6	Helping Highly Anxious Patients.....	21
Stressors	6	Nonsuicidal Self-Injurious (NSSI) Behaviors	21
APA Survey Reveals Deepening Concerns About Connection		Factors Associated With NSSI.....	22
Between Chronic Disease and Stress.....	6	Risk Factors.....	22
Stress Reduction.....	8	Motivations	22
Promoting the Relaxation Response	8	Risk-Rescue Rating.....	22
The 5 R's of Stress/Anxiety Reduction.....	8	Risk factors	22
Understanding Crisis.....	8	Rescue factors	23
Crisis Theory and Intervention	8	Total rescue points	23
Caplan and Lindemann	8	Impaired Functioning.....	23
Danger And Opportunity	9	Actions	24
Aguilera And Messick.....	9	Drug Abuse Related Problems	25
Crisis Intervention.....	10	Problems and Goals	26
One Crisis After Another	11	Cerebral Dysfunction From Other Causes	26
Life-Threatening Conditions.....	12	Traumatic Brain Injury.....	26
Suicide.....	12	Assisting Survivors of Disaster.....	26
Assessment Of Suicidal Behavior.....	13	Defusing	28
Direct verbal warnings	13	Death Notification	28
Depression.....	13	Medications	28
Changes in Social Behavior	13	Environmental Interventions.....	30
Making Final Plans	14	Restraint Guidelines for Psychiatric Emergencies	30
Suicidal History.....	14	General Guidelines in Crisis Situations	31
Use of Drugs and Alcohol	15	Resources	31
Intuition of a person close to the individual.....	15	References and Suggested Readings.....	31
Problems and Goals	15	Appendix A	33
Caring For Acutely Suicidal Patients	15	Appendix B	34
Problem:	15		
Goal:	15		
Action:	15		
Suicide Precautions	16		
Violence	16		
Understanding Anger	17		
Assessment Of Violence	17		
Problems And Goals.....	19		

About The Authors

Julie M. Mroczek, BSN, RN-BC, CLNC, is certified as a Psychiatric/ Mental Health Nurse, serving as the mental health professional on Mental Health Boards in Nebraska for the past 20 years, which legally determines if a patient is mentally ill and dangerous, and determines the least restrictive treatment alternatives available. She has also served as the RN-case manager for Home Health and Hospice Care serving central Nebraska. Ms. Mroczek is also a Certified Legal Nurse Consultant.

Silvia Prodan Lange, R.N., M.N., clinical specialist in psychiatric/mental health nursing. She completed her graduate work at the University of Washington, Seattle. She has worked in a variety of psychiatric settings -- acute inpatient units, long-term state hospitals, VA units (acute and long-term), day treatment centers and outpatient work. The latter includes emergency room consultation and crisis intervention. She has taught psychiatric/mental health nursing and has formerly directed the Mental Health Program at the Seattle University School of Nursing. Her many professional publications include material on the violent patient, suicide and hope. As a mental health integrator, she applies concepts from psychiatric nursing to other clinical nursing situations.

Content review update provided by **Mer-edith Patterson, RN, BSN, CRRN**. She has worked in numerous clinical settings including acute psychiatric care, head injury rehabilitation and acute neurology. Her business, Brainstorm Mind Fitness, specializes in the education and application of brain health lifestyle practices to promote optimum cognitive function. Certified in rehabilitation nursing, she is past president of the San Antonio chapter of the Association of Rehabilitation Nurses and is a frequent guest speaker for conferences on mental and cognitive health topics.

Purpose and Goals

The goal of this course presents general guidelines for addressing and treating the most frequently encountered psychiatric emergencies including suicide, violence, anxiety, and substance abuse and self-harm.

Instructional Objectives

Upon completion of this course the student will be able to:

1. Define and describe the most common psychiatric emergencies.
2. Summarize Crisis Intervention and outline the model developed by Aquilera and Messick.
3. Apply crisis theory and intervention to

clinical situations.

4. List common signs and symptoms of depression, anger, anxiety, and nonsuicidal self-injurious (NSSI) behavior.
5. Assess suicide, violence potential and lethality.
6. Outline psychological, pharmacological, and environmental treatment approaches for the psychiatric patient.
7. Recognize professional and personal reactions to psychiatric emergencies.
8. Define and clarify the following terms: psychiatric emergency and crisis.
9. Relate the mnemonic code device for psychiatric emergencies.
10. Identify categories of psychiatric emergencies.
11. Expand and improve psychiatric nursing terminology.
12. Utilize the Social Readjustment Rating Scale.

Self-awareness Explorations

Write down your initial response to the question. There are no right or wrong answers. Refer back to this section as you go through the unit.

1. What's the first thing that comes to your mind when you hear the term "psychiatric emergency"?
2. Remember one crisis event that turned out to be tragic. How did you feel about it at the time? Now?
3. Remember one crisis event that turned out well. What was your part in it? What did you learn?
4. What makes you most anxious about a psychiatric emergency?
5. What's the most memorable dramatization of a psychiatric emergency that you've seen on TV, in the movies, in a play or read about in a book or newspaper?
6. What's the difference in your reactions to a crisis situation at work and in your personal life?
6. "Homicidal maniac!" What does this conjure up for you? Have you ever been faced with a violent person? What happened?
7. How do you feel about people who make multiple suicide attempts and who get repeatedly detoxed from alcohol or drugs and go back on them?
8. In your opinion, should people have the right to decide when and how they will die? Does this conflict with your professional ethics?
10. What do you think your reactions would be if you had to be part of restraining, medicating or hospitalizing patients against their wills?

9. In your wildest imagination, what possible psychiatric emergencies could happen to you or a significant other? How would you want others to help you?
10. List several areas where you feel that you may need some assistance as a nurse regarding the psychiatric aspects of patient care. (Helps identify weakness)
11. Make a list of several interpersonal interactions that you have experienced between staff to staff, patient to staff, which you feel required an improvement in communication techniques and/ or required someone to intervene and facilitate problem solving.

Introduction

Psychiatric emergency? Suicide! Violence! Panic! Though they don't occur too often, healthcare professionals must be prepared for these disturbing situations. When a psychiatric crisis hits, the health team must act quickly to mitigate a dangerous or life-threatening situation.

Healthcare professionals can be involved in these situations in the emergency room, general hospital, psychiatric unit and the community. Although nothing can take the place of actual clinical experience for one to become more competent and confident in handling psychiatric emergencies, prior preparation can help. Health professionals need an understanding of attitudes and reactions, a body of knowledge, and action approaches in order to meet the challenge of a crisis situation.

Consider these scenarios:

- An elderly man has recently been discharged from an alcohol detoxification unit. He calls one of the staff on the floor to "thank" her again and say good-bye. Sounding angry and intoxicated, he adds that he is in a phone booth at the Golden Gate Bridge and as soon as he hangs up, he is going to jump. If you were that nurse, how might you feel? What would you do?
- Following cardiac surgery, a woman begins to whisper to her husband that she's afraid of being cloned in the ICU. She begs him to take her home before the staff destroys her. The husband turns to the nurse, terrified that his wife has lost her mind and will need to be "put away."
- If you were that professional, what would you say to him? What would you do for the woman?
- The police surround a house where a man is holding his family hostage with an arsenal of guns. He rants, "God will punish the wicked!" The police recruit the man's priest to encourage him to give up and come to the nearest emergency room for help. You are the nurse working in the ER. How might

RIGHTS OF THE MENTAL HEALTH PATIENT

- The right to be treated as a human being, with decency and respect
- The right to integrity of mind and body
- The right to receive treatment and medication only when administered with informed consent
- The right to have access to one's own legal and medical counsel
- The right to refuse to work in a mental hospital and to receive the minimum wage for any work done there
- The right to decent and prompt medical attention
- The right to uncensored communication by phone or letter and with visitors
- The right to refuse to be locked up involuntarily, and to refuse to give fingerprints and photographs
- The right to decent living conditions
- The right to keep one's own personal possessions
- The right to counsel and a court hearing about any mistreatment
- The right to refuse to be a part of research for experimental drugs or treatments and the right to refuse to be used as a learning experience for students
- The right to protection from defamation of character
- The right to an alternative to commitment in a mental hospital

you feel? What would you do?

- On a psychiatric unit, a woman rips down the holiday decoration of Santa Claus and is heading right toward the Christmas tree. You are coming in the door at that moment. What will you do now?
- An elderly man hears that his best friend has just died. Immediately, his heart begins to pound and he starts to breathe rapidly. Sweat pours off as he feels a sense of impending doom. When the ambulance brings him to the hospital, he is yelling, "*I'm dying! Help!*" As the health professional, what would you do to help him now and after a myocardial infarction has been ruled out?
- A young girl sits in the corner of the waiting room, eyes wide and frightened. Her friends mention that she's taken some sort of hallucinogen as they head toward the exit. What would you do? How could they help her?
- On a surgical floor, a woman is making a very slow recovery from a mastectomy. The aide tells you that she has refused breakfast again, saying, "*What's the use?*" As the team leader, what would you do now? What do you need to know?

All of the above have the potential to be psychiatric emergencies. Each emergency generally involves a sudden serious psychological disturbance that affects behavior, with one or more of the following characteristics:

- sense of urgency: something must be done

now or very soon, or else . . . and a feeling of intolerable anxiety if relief is not immediate

- sense of being overwhelmed
- lack of adequate coping abilities
- recognition of a need for assistance from others to manage and alleviate the psychological distress

Psychiatric emergency and crisis are often used interchangeably. A psychiatric emergency can be viewed as a sudden, specific behavioral state that, if not responded to, will result in life-threatening or psychologically damaging consequences. A crisis is less immediate in that it has been developing over time within a psychological stress situation. If not alleviated, a crisis situation may develop into a psychiatric emergency specifically if it leads to acts of suicide, violence or severe agitation.

A mnemonic or code device for remembering the usual patterns of psychiatric emergency is the phrase, "*I've had it!*" This stands for the elements of:

I Impasse

V Victim or Violence

E Emergency

H Helplessness or Hopelessness

A Agitation or Apathy

D Despair and Disorganization

I Incapacitation

T Terror

Acute subjective distress and/or disturbed behavior can be alarming to the affected person and others, by any of the following routes:

1. The emergency arises while the person is already a hospitalized patient, in either a general hospital or psychiatric unit.
2. The individual comes to an emergency room or crisis center or is brought in by family, friends or the police.
3. The person is referred by a physician, another health professional, or an agency for additional evaluation and treatment.
4. There is a crisis phone call seeking help, direction and resources.

In addition to helping the identified patient, it is important to consider the needs and problems of the other people involved in the situation. Family and friends are valuable allies in assessing the crisis, especially if the patient is unable or unwilling to give information. They are also vital to treatment decisions. The decision to hospitalize an acutely disturbed individual, for example, may depend on whether or not there is a support system network for the person. Significant others may also be contributing to the emergency situation, and interventions may need to target them as well.

Psychiatric emergencies can be grouped into the following categories:

- Life threatening behavior, including threatened or attempted suicide, assault, homicide, or other violent acts.
- Life disrupting behavior, resulting from severe anxiety, loss of contact with reality, mood disorders such as depression or mania, self-injurious behavior or conversion reactions.
- Life impaired behavior, resulting from intoxication or withdrawal from alcohol or drugs, toxic or idiosyncratic reactions to medication, or cerebral dysfunction.

These groupings cut across many categories of psychiatric and medical diagnoses. The

focus in any psychiatric emergency is the immediate problem behavior, and how the person can regain equilibrium without destructive outcome for self or others.

Impact on Health Professionals

As health care patterns in the U.S. continue to change, more people are using emergency rooms and crisis units for help with pressing emotional problems. Part of this is due to the shift in psychiatric care from large state hospitals to community based treatment programs. Fewer patients are kept in psychiatric hospitals for any length of time. These people are treated rapidly and discharged to community facilities for follow-up care. Periods of increased stress leads to more patients seeking help at the emergency room for medication, rehospitalization, or other resources, including food and shelter. It is especially important to address these issues with patients and families dealing with dramatic mental healthcare changes in uncertain times.

The emergency room is where the initial psychiatric evaluation often occurs. Human beings have highly complex psychosocial and biological interactions. What seems to be a primary physical disorder may mask underlying anxiety or depression. And these syndromes may in turn mask or accompany other conditions that are organic in etiology. It takes skilled assessment and evaluation techniques to make the differential diagnosis. Physical examination, including appropriate tests and lab work, is often essential.

Suicide attempts and threatened suicide are among the most common psychiatric emergencies seen in nursing situations. Stressors connected with illness that may lead to depression and suicide include the threat of surgery with an unknown outcome, death of a loved one, agony of chronic pain with little relief, the prospect of chronic illness and incapacitation, and disfigurement from a radical burn or operation.

Suicide ranks among the leading causes of death in the United States, as one of the top public health concerns of today. The statistics generally quoted are misleading. Many suicides are not reported or recorded, and others are listed as alcohol-related accidents. Suicide is considered the tenth leading cause of death overall; according to National Center for Health Statistics, (April 2016), it ranks third among young adults (aged 15 to 24).

In addition to treating acutely suicidal patients, professionals also treat patients who show chronic patterns of self-destructive behavior. Any behavior that significantly shortens or threatens a person's lifespan can be con-

sidered self-destructive. Included are chronic alcohol and substance abuse, non-suicidal self-injurious behavior, anorexia and bulimia. Patient examples include the daredevil who has broken almost every bone in his body, the person with emphysema who refuses to quit smoking, and the person with an MI who insists on going right back to work.

A suicide attempt may result in a series of difficult and painful long-term disabilities, such as the person who swallows pills and needs extensive medical/surgical treatment or the person who sets herself on fire and lives, despite third-degree burns. Psychiatric emergency states may occur in the family members of a person who dies, especially if the death is sudden, particularly horrible or by suicide. The family and significant others need the opportunity to talk and express their grief, anger, bewilderment and sometimes relief. They may need temporary medication for sedation.

Other health professionals may be involved with psychiatric emergencies that occur within families. Stillbirth or delivery of an infant with a congenital defect may bring on overwhelming anxiety and depression, but the extreme reaction called postpartum psychosis can sometimes be precipitated even by normal childbirth. Acute or chronic illness in a child may develop into a crisis for the family as well as for the young patient.

Health education and recognition and treatment of depression and drug/alcohol abuse are important parts of school nursing jobs. Death, illness, or separation and divorce of parents can have a very significant impact on growing children. They may turn to the nurse in times of crisis.

Large numbers of previously hospitalized psychiatric patients are discharged to the community after the treatment of the psychiatric emergency. Follow-up care is usually needed, and the public health nurse or community mental health nurse then becomes responsible for providing care to this group of individuals. The number and severity of the psychosocial stressors in the individual's environment influence change in acuity level. These former patients are a population at high risk for catastrophic reactions to increased stress. They may develop acute psychosis, depression and/or suicidal and violent behavior. Crisis intervention and the patients' successful return to the community are the goals of community health care workers.

Another group at risk for psychiatric emergencies is the elderly. Faced with loneliness, death of loved ones, increasing disability and /or financial pressures, they begin to feel depressed and overwhelmed. Deterioration of emotional and social support systems is common. Declining memory and cognitive

abilities due to dementia may lead to confusion, reduced problem solving ability, and less effective use of previously acquired coping skills. Professionals in long-term care facilities and home health settings are often uniquely positioned to recognize and address crises in these patients.

Nurses are considered by many people as authorities on health issues; families and friends often seek their advice and support. However, nurses often face crisis situations in their personal and professional lives.

When this occurs, it is important to seek appropriate help, even if it is difficult to do so. A sizable number of healthcare professionals abuse drugs and alcohol. Some even resort to suicide. The suicide potential of a person should never be underestimated because of education or profession.

It is the skilled and properly educated professional who will be asked to provide psychiatric emergency care to those individuals in need. The present and future of healthcare practice require that all be prepared to administer safe and competent psychiatric care to those who need it. Skills in assessment, diagnosis, intervention, treatment, and evaluation of psychiatric emergencies are demanded in all areas of professional practice. An astute person realizes that a psychiatric emergency may occur anywhere and at any time.

Reactions to Psychiatric Emergencies

Anxiety is a common denominator in psychiatric emergencies. Anxiety is often referred to as the fear of the unknown. This fear is certainly a very natural response to a psychiatric emergency and affects everyone involved - the patient, family and staff. Anxiety itself is contagious. Persons who are in tenuous control over impulses to hurt themselves or others can be very frightening. This is especially true in an emergency room where the patient is often a stranger and the staff has little information immediately available on which to base a treatment plan.

If the disturbed behavior occurs on a general hospital unit, the staff may feel inadequate and overwhelmed by uncertainty. They may feel angry toward the person or family for causing "a scene" and taking them away from other patients who are acutely physically ill. Generally, if the behavior of such people is identified as coming from an organic disease, it is easier understood and tolerated. If it seems that the patient should have more control over the confused, belligerent, peculiar or depressed behavior, the staff may be more critical, even judgmental.

On a psychiatric inpatient unit or in a crisis center, the staff may be better able to take episodes of disturbed behavior in stride. However, the usual emphasis in that setting is on assessment, intervention and provision of adequate treatment so that psychiatric emergencies don't arise. When they do, the staff may feel guilty or angry with each other. They may feel they have failed. This is particularly true with suicidal behavior, especially if a patient in treatment attempts suicide. Patients who present recurrent emergencies may cause the staff to become frustrated, angry and rejecting of them. This generally stems from the staff's feelings of helplessness and inadequacy. They have done all they know to do and it has not worked or has not been effective.

Recurrent episodes of physical and psychiatric emergencies are often due to alcohol and drug use, and the patients sometimes encounter a negative attitude in treatment settings. There is the feeling that these patients "did it to themselves" and "deserve to suffer" to "teach them a lesson." Because health personnel put a high premium on health and recovery, they can find it difficult at times to cope with people leading highly self-destructive lives. They may feel a sense of social injustice, pity, fear or anger toward these patients.

These are all very human reactions and we need to recognize and deal with them when they occur. Increased understanding of the patient may help, along with awareness of what can and can't be done in the on-going situation. The important thing to keep in mind is that the patient and family come for some sort of help and the staff must be physically and emotionally able to provide it.

If a given agency or staff is not equipped to offer appropriate services, the professional obligation is to work out the best possible alternative plan. There are usually several resources available. A characteristic of a crisis situation is that those involved see few options or alternatives. Anxiety places "emotional blinders" on an individual and interferes with problem solving. The crisis worker, whether a nurse or other staff member, helps by providing objectivity and support, and by developing and reinforcing good coping strategies.

A professional who is responsible for the care of a patient in a psychiatric emergency attempts to understand how the patient feels at the time of the crisis. Professionals must be aware that an individual in a crisis is highly anxious. The patient also feels many other highly charged emotions along with the anxiety. A primary feeling of lack of trust for those around him is typical of the patient in a psychiatric emergency. Feelings of fear, doom, lack of hope, anger, hostility, loss of control, disorganization and decreased perceptual ability

are common symptoms in a psychiatric crisis.

During a psychiatric emergency a patient usually experiences physiological changes as well. These changes may include: altered appetite, thirst, sweating, dehydration, and an increase or decrease in blood pressure, pulse, respirations and temperature. Changes in all of the above can lead to electrolyte imbalances, leaving the patient exhausted and susceptible to other medical problems. Accurate and comprehensive diagnosis and assessment are necessary before intervention and appropriate treatment can be given to the patient in crisis.

Professionals need to stay calm and work together, not adding to the chaotic situation but doing their part to help. This requires knowing what general types of emergencies can be expected, and how to assess the specific situation including available treatments and other dispositions; and learning from each emergency in order to increase confidence and competence. The task of the treatment team is to convert the state of psychiatric emergency into a set of problems to be solved. Application of crisis theory and crisis intervention techniques is the first step.

Stress

In today's fast-paced and ever-connected world, stress has become a fact of life. Stress can cause people to feel overwhelmed or pushed to the limit. Financial concerns over the rising costs of gas, food, and healthcare can exacerbate stress levels.

The following are examples of definitions of stress:

- Stress is a conscious or unconscious psychological feeling or physical situation which comes after, as a result of physical or/and mental 'positive or negative pressure' to overwhelm adaptive capacities.
- Stress is a psychological process initiated by events that threaten, harm or challenge an organism or that exceed available coping resources and it is characterized by psychological responses that are directed towards adaptation.
- Stress is wear and tear on the body in response to stressful agents. Hans Selye called such agents "stressors" which can be physical, physiological, psychological or sociocultural.

A person typically is stressed when positive or negative (e.g., threatening) experiences temporarily strain or overwhelm adaptive capacities. Stress is highly individualized and depends on variables such as the novelty, rate, intensity, duration, or personal interpretation of the input, and genetic or experiential factors. Both acute and chronic stress can intensify morbidity from anxiety disorders. One person's fun may be another person's stressor.

Stressors

Stressors are the events or combinations of events that lead to crises and psychiatric emergencies. They usually occur within the year before the crisis often as recently as the month before and their effects are cumulative. Occasionally, the stressor is anticipation of a future event, such as pending surgery or retirement.

Biological stressors include illness and injury. Not only is the degree of actual impairment important, the meaning of the condition to the individual also has an influence on the degree of associated stress. Lack of sleep, inadequate nutrition, dehydration and chronic pain may contribute to a person's difficulty in coping with ongoing and new difficulties.

The specific psychosocial stressors vary in severity from minimal to catastrophic. These conditions are significant not only singly but also in combination. It is important to remember that changes for the "good" can result in stress just as do changes for the "bad." The Holmes/Rahe Social Readjustment Scale, **Figure 1**, is a popular representation of the relative stress inherent in many common life events.

APA Survey Reveals Deepening Concerns About Connection Between Chronic Disease and Stress

The American Psychological Association's (APA) report in February 2015, *Stress in America(TM): Paying With Our Health*, paints a troubling picture of the impact stress has on the health of the country, especially caregivers and people living with a chronic illness such as obesity or depression.

The Stress in America survey showed that many Americans consistently report high levels of stress (22 percent reported extreme stress, an 8, 9 or 10 on a 10-point scale where 1 is little or no stress and 10 is a great deal of stress). The results from this year's Stress in America(TM) survey also suggest that there are significant disparities in the experience of stress itself, and that stress also may be associated with other health disparities. The nearly one-quarter (23 percent) of adults who report that their health is only "fair" or "poor" have a higher reported stress level on average than those who rate their stress as "very good" or "excellent." For more information visit

<http://www.apa.org/news/press/releases/stress/2015/snapshot.aspx>

While low to moderate levels of stress can be good for you when managed in healthy ways, extreme stress takes both an emotional and physical toll on the individual.

With the consequences of poorly managed

Holmes-Rahe Social Readjustment Rating Scale

Life Event	Mean Value	Life Event	Mean Value
1. Death of spouse.....	100	26. Spouse beginning or ceasing work outside the home.....	26
2. Divorce.....	73	27. Beginning or ceasing formal schooling	26
3. Marital separation from mate.....	65	28. Major change in living conditions	25
4. Detention in jail or other institution	63	29. Revision of personal habits (dress, manners)	24
5. Death of a close family member	63	30. Trouble with the boss.....	23
6. Major personal injury or illness	53	31. Major change in working hours or conditions	20
7. Marriage.....	50	32. Change in residence	20
8. Being fired at work.....	47	33. Changing to a new school	20
9. Marital reconciliation with mate	45	34. Major change in type and/or amount of recreation.....	19
10. Retirement from work	45	35. Major change in church activities	19
11. Major change in health or behavior of a family member	44	36. Major change in social activities (dancing, movies).....	18
12. Pregnancy.....	40	37. Taking out a mortgage or loan for a lesser purchase (car, TV, freezer).....	17
13. Sexual difficulties.....	39	38. Major change in sleeping habits.....	16
14. Gaining a new family member through birth, adoption, older child moving in	39	39. Major change in number of family get togethers	15
15. Major business readjustment (merger, bankruptcy).....	39	40. Major change in eating habits	15
16. Major change in financial state	38	41. Vacation	13
17. Death of a close friend.....	37	42. Christmas.....	12
18. Changing to a different line of work.....	36	43. Minor violations of law (traffic tickets, disturbing the peace).....	11
19. Major change in the number of arguments with spouse (regarding child-rearing, personal habits)	35		
20. Taking out a mortgage or loan for a major purchase (e.g., home, business, etc.)	31		
21. Foreclosure on a mortgage or a loan.....	30		
22. Major change in responsibilities at work (promotion, demotion, lateral transfer)	29		
23. Son or daughter leaving home (marriage, college)	29		
24. Trouble with in-laws.....	29		
25. Outstanding personal achievement.....	28		
		TOTALS.....	1466

Adapted From: Holmes, T. H., and Rahe, R. H. (1967). *The Social Readjustment Rating Scale*. *Journal of Psychosomatic Research*, 11, 213-218.

Figure 1

stress ranging from fatigue to heart disease and obesity, it is important to know how to recognize high stress levels and take action to handle it in healthy ways. Being able to control stress is a learned behavior, and stress can be effectively managed by taking small steps toward changing unhealthy behaviors.

According to a recent scientific study for the National Institute of Mental Health (NIMH), entitled "Research Shows How Chronic Stress May be Linked to Physical and Mental Ailments", scientists have long known that the levels of certain hormones rise in response to chronic stress. The findings reveal how individual cells adapt to cope with sudden or extreme stress, and how repeated exposure to stress may be related to many physical and mental illnesses.

Cortisol is a hormone produced by the

adrenal glands that helps regulate blood pressure and cardiovascular function, as well as the body's use of proteins, carbohydrates and fats. Cortisol secretion increases in response to physical and psychological stress during the fight or flight response, which is why it's sometimes called "the stress hormone."

Because of its involvement in the body's stress response, cortisol levels are commonly used to measure the presence and intensity of stress in various situations. Cortisol in itself is not harmful, and is in fact a vital part of the body's healthy functioning. However, during times of chronic stress, the body can experience elevated levels of cortisol, which can have negative short-term and long-term ramifications for health. Because of the damage that elevated cortisol levels and long-term stress can do, it's vital to have an effective stress

management plan that includes multiple layers of stress relief strategies.

Stress Reduction

Stress-reduction strategies can be helpful to many stressed/anxious people. However, many cannot concentrate enough to use such strategies effectively for acute relief. Most stress-reduction techniques have their greatest utility as elements of a prevention plan that attempts to raise one's threshold to anxiety-provoking experiences.

Promoting the Relaxation Response

For this technique, basic elements such as a quiet environment, a comfortable posture, a mental device (a meaningful word or phrase)

and a passive attitude are used.

In a quiet environment and sitting in a comfortable position, eyes are closed and all muscles are deeply relaxed beginning from feet and progressing up to face (i.e., feet, calves, thighs, lower torso, chest, shoulders, neck, hand). Allow the muscles to remain relaxed. Focus on breathing and while breathing out, saying silently the word “one” or some other word or short phrase that is meaningful (i.e., breathe in; breathe out, saying “relax”; breathe in; breathe out, saying “two”).

This technique is continued for 15 minutes. Eyes can be opened periodically to check the time, but generally alarm is not used. It is performed once or twice daily and not within 2 hours after any meal.

After finishing each 15-minutes exercise. Sitting quietly for a few minutes, first eyes are shut and then eyes are opened.

The goal here is a passive attitude. Deep relaxation will not always occur, and distracting thoughts might come. When conscious of them, they are ignored and breathing exercise are sustained.

The 5 R's of Stress/Anxiety Reduction

There are five core concepts that are used in the reduction of anxiety or stress:

1. **Recognition** of the causes and sources of the threat or distress; education and consciousness raising.
2. **Relationships** identified for support, help, reassurance.
3. **Removal** from (or of) the threat or stressor; managing the stimulus.
4. **Relaxation** through techniques such as meditation, massage, breathing exercises, or imagery.
5. **Re-engagement** through managed re-exposure and desensitization.

With all this in mind, the APA also offers the additional tips on how to manage your stress:

- Understand how you experience stress. Everyone experiences stress differently. How do you know when you are stressed. “How are your thoughts or behaviors different from times when you do not feel stressed”
- Identify your sources of stress. What events or situations trigger stressful feelings? Are they related to your children, family, health, financial decisions, work, relationships or something else?”
- Learn your own stress signals. People experience stress in different ways. You may have a hard time concentrating or making decisions, feel angry, irritable or out of control, or experience headaches, muscle tension or a lack of energy.
- Gauge your stress signals.

- Recognize how you deal with stress. Determine if you are using unhealthy behaviors (such as smoking, drinking alcohol and over/under eating) to cope. Is this a routine behavior, or is it specific to certain events or situations? Do you make unhealthy choices as a result of feeling rushed and overwhelmed?”
- Find healthy ways to manage stress. Consider healthy, stress-reducing activities such as meditation, exercising or talking things out with friends or family. Keep in mind that unhealthy behaviors develop over time and can be difficult to change. Don't take on too much at once. Focus on changing only one behavior at a time.
- Take care of yourself. Eat right, get enough sleep, drink plenty of water and engage in regular physical activity. Ensure you have a healthy mind and body through activities like yoga, taking a short walk, going to the gym or playing sports that will enhance both your physical and mental health. Take regular vacations or other breaks from work. No matter how hectic life gets, make time for yourself—even if it's just simple things like reading a good book or listening to your favorite music.
- Reach out for support. Accepting help from supportive friends and family can improve your ability to manage stress. If you continue to feel overwhelmed by stress, you may want to talk to a healthcare professional, who can help you better manage stress and change unhealthy behaviors.

Understanding Crisis

At some point in life, EVERYONE will experience crisis. A crisis is an emotional upset that is caused by an unexpected event such as death of a loved one, divorce, loss of a job, a family conflict or serious illness. A crisis may leave you feeling helpless and unable to cope. How is crisis different from stress? A crisis event always creates stress, but stress does NOT ALWAYS create a crisis. How do you know if someone is in crisis?

Crisis can take the form of many emotions that can make one feel overwhelmed and confused. Here are some of the feelings that may accompany crisis:

- Fearful & alone
- Troubled
- Guilty, restless & anxious
- Life is out of control
- Life is not real - like a bad dream
- Difficulty doing usual activities
- Life is no longer worth living
- Intense Anger
- Problems with work or school
- Isolation

- Relying on alcohol or other substance to get through the day
- Change in sleeping and eating patterns

Crisis Theory and Intervention

A specific approach to helping people in acute emotional trouble is called crisis intervention. Caring for people in crisis is an enduring feature of family and community functioning. As a facet of professional health services, however, crisis intervention is quite young in the annals of history. Intentional crisis intervention based on crisis theory dates from the 1940's, primarily from work done by Gerald Caplan and Eric Lindemann.

Caplan and Lindemann

Gerald Caplan is considered the father of preventive psychiatry in the U.S. for his work in research and development of crisis intervention techniques. Caplan defined crisis as a state provoked when a person faces an obstacle to important life goals. The obstacle, during crisis, seems insurmountable when applying the usual means of problem solving. This definition led to the concept that constructive resolution of a crisis could lead to greater personality integration and coping ability. Furthermore, inability to master the situation results in reintegration on a lower level.

Much of the early work in this area came from studies of the survivors of the Coconut Grove nightclub fire, in which many people were trapped and burned to death. Those who survived had multiple long-term physical and psychological effects. Dr. Eric Lindemann studied the survivors and relatives of those in the tragedy. From his work and from subsequent applications came much of the present understanding of grief, mourning, reactions to death, and crisis intervention.

Those who were able to confront the crisis, turn to others, and express their conflicting feelings were better able to integrate this nightmare into their lives. Those who denied both the importance of the tragedy and their reactions to the tragedy continued to have symptoms and recurrent problems, especially chronic depression.

From the above study and subsequent research, it was postulated that in the face of a significant psychosocial stressor, there are adaptive and maladaptive patterns of behavior. The ways in which people meet and deal with challenging situations will have a major influence on their lives.

Danger And Opportunity

According to Caplan, a dichotomy exists associated with crisis. Danger and opportunity

exist. A crisis can be an opportunity when the individual grows from the crisis experience by developing new coping skills and altering perceptions. It can also be a danger when the individual does not seek help and rather comes out of the crisis state by use of defense mechanisms, resulting in a lowered functioning level and possibly psychosis or even death. When this concept was presented to a group of patients, one man reflected on the word “emergency.” He suggested, “It could mean ‘emerge and see’.”

This is why it is extremely important that help be available from both healthcare professionals and others. The discomfort felt is a catalyzing agent in asking for help and making changes. Crisis intervention aims at helping people to achieve a higher level of mental health than they experienced going into the crisis.

Aguilera And Messick

According to Aguilera and Messick, development of a crisis follows a sequence of predictable steps, as outlined in the diagram **Figure 2**. First, because of a stressful event or a series of events, the individual experiences a rise in tension and an inability to organize his behavior successfully enough to solve the problem. The individual experiences this lack of success in handling the tension, which in turn increases it. Existing internal and external resources are then mobilized. If successful, the mobilization results in diminished or solved problems as the individual uses emergency coping mechanisms; defines the problem in a new way; or gives up the goal as unreachable. If the problem cannot be solved or avoided, major personal disorganization may take place, manifested by anxiety, depression, confusion, or lack of impulse control, leading to suicidal or violent behavior.

One of the factors contributing to the restoration of equilibrium is situational support. A social network of close friends and family members can mean a great deal in weathering the storm of a crisis situation. This is a resource that health professionals should recognize and encourage.

For those lacking interpersonal resources, the healthcare system and professional workers can become a support system. Emergency facilities, hot lines, crisis centers, and drop-in clinics have support systems as part of their services. An important goal beyond emergency intervention is to help the person develop autonomous support systems.

Physical aspects of support include the basic needs of warmth, food, and shelter, as well as a balance between environmental stimulation and deprivation. One explanation for the degree of psychiatric disturbance in an intensive

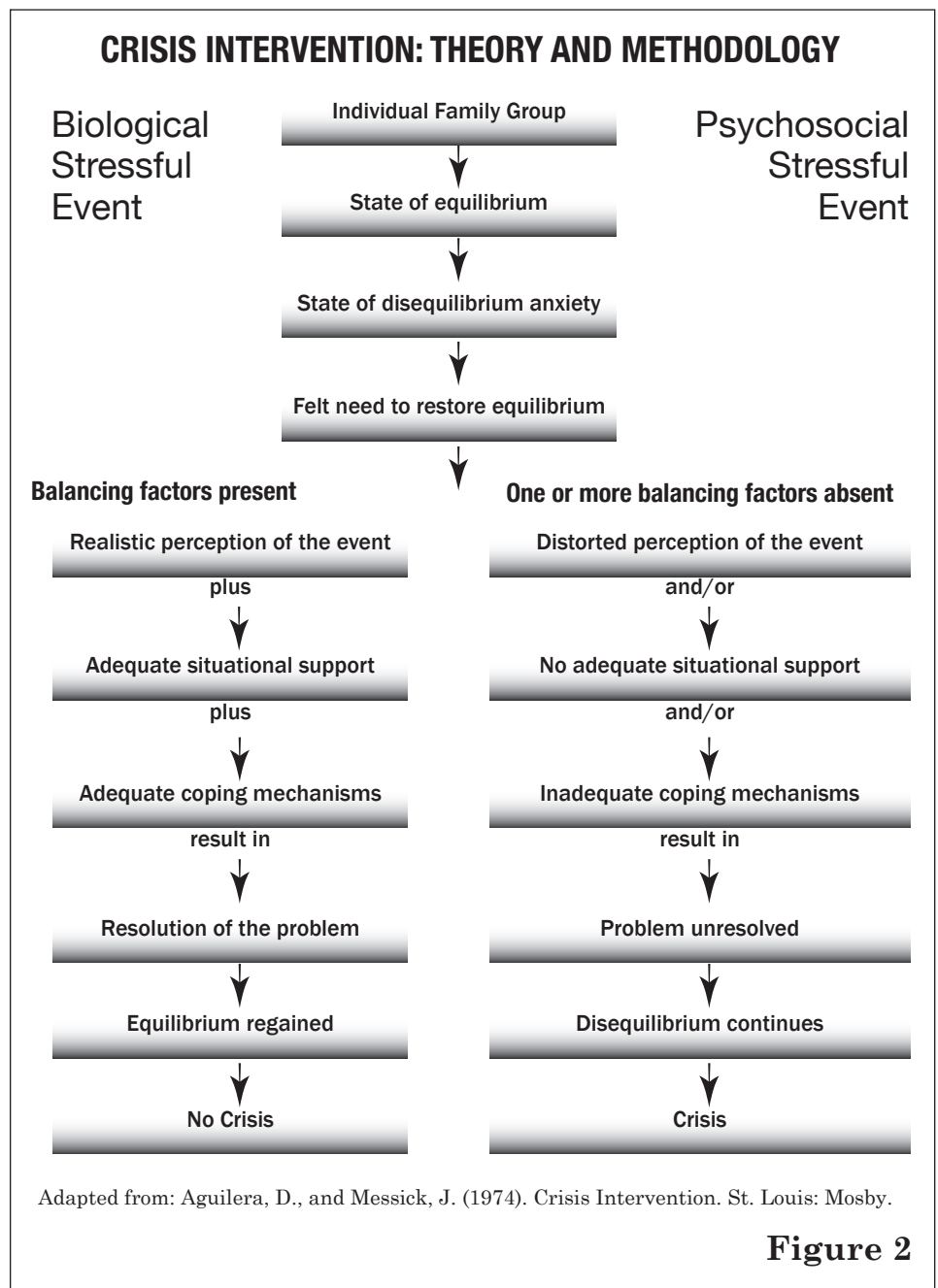


Figure 2

care unit, for example, is the level of incoming sensory stimulation from machines, lights, and action. The person may be overloaded and respond temporarily with psychotic disorganization.

Coping mechanisms are the individual’s habitual patterns of dealing with stress and other problems. They are generally characteristic of a person and may occur on a conscious or subconscious level. Coping mechanisms are what a person usually does to solve problems or feel better. In the formation of a crisis, a person’s usual patterns may not be working or the person may not be able to use them. Even psychotic behavior is a primitive form of coping and may bring the response of help and treatment from others.

One of the most common coping mecha-

nisms involves turning to others for support. Infants handle anxiety by turning to their mothers and this response adapts over maturity to include other sources of support such as friends, spouse, medical personnel, and clergy.

Physical movement and sustained action often result in tension relief; a variety of repetitive activities may be incorporated into coping mechanisms, including pacing, coughing, scratching, moving about restlessly, engaging in pointless hyperactivity, finger tapping, experiencing increased urination and defecation, increased sexual behavior, fighting, hand wringing, eating, smoking, using drugs and alcohol, playing sports, swimming, taking a long warm bath, having a massage, or being rocked.

More complex activity patterns may also

serve this purpose, including such things as cleaning the house, gambling, fast driving, or going on a shopping spree. Repetitive vocalizations provide tension relief for some individuals; these may include screaming, cursing, crying, joking, laughing, “talking it out.” Indeed, repetitive themes in routine conversation and rapid, “pressured” speech are often symptoms of significant psychological distress.

A variety of mental processes have been identified that can serve as coping mechanisms, including fantasy, imagination, dreams, daydreams, mental rehearsing, lies, and humor. Ego defense mechanisms are more elaborate processes and are more likely to arise in the face of more serious, ongoing stressors. These include denial, repression, suppression, compensation, rationalization, reaction formation, projection, intellectualization and regression.

Crisis Intervention

Crisis intervention in psychiatric emergency situations is divided into four steps: assessment of the individual and his current problems, determination of the therapeutic intervention, intervention, and resolution of the crisis and anticipatory planning for the future. In actual practice, the steps are overlapping rather than consecutive. Also, the concept of crisis intervention may follow through in more than one place. For example, a person may call a crisis worker saying that she has made a suicide attempt with pills. The worker assesses the immediate situation and instructs a friend of the person to bring the person at once to the emergency room. There, medical evaluation and an extended suicide evaluation are done. Depending on the outcome, the person is referred for continued crisis work by the appropriate therapist, is hospitalized to prevent a further psychiatric emergency, or is discharged. The crisis model operates in many areas of medicine and nursing.

1. Assessment: First and foremost, it is necessary to assess the individual to determine if a crisis exists and the degree of severity. This is done during the initial interview, which reviews the immediate situation, the precipitating events and evaluates the person’s ability to cope.

Sometimes initial assessment shows there is no true crisis. The person may be in no particular discomfort and may be seeking treatment for other reasons: avoiding jail, punishing a spouse, getting drugs to maintain a habit, seeking compensation for an injury, getting a letter for disability or for release from responsibilities. In these cases, the coping devices have not failed. Instead, the person is using a characteristic pattern of manipulation to meet needs, and the crisis worker clarifies what is possible and available and what is not.

During the initial interview, the crisis worker should appear calm, interested, confident and resourceful. This may sound easier or harder to do than it is. One thing to remember is that most people in psychiatric emergencies really do want help. They are frightened and eager for relief. It is important to acknowledge the patient’s sense of urgency, while providing assurance that there is time to work out the problems. The patient must know that help is available, that there are solutions to be explored and used. The crisis worker must be an active, involved participant. This style of interviewing is more direct, empathic and active than traditional styles of psychotherapy, where the main focus is by the patient and silence is used as a therapeutic technique. The crisis worker often develops a pattern of setting the framework for the interview, encouraging the patient to express thoughts and concerns with attention paid to feelings, directly asking for information, stating back to the patient and family what the problems seem to be, and suggesting treatment options.

2. Determination of the therapeutic intervention: This is the data-gathering step and treatment planning component in handling the immediate crisis. In deciding what type of intervention is most appropriate, it is important to consider precipitating factors, the amount of disruption in the person’s life, the duration of the problem, and its impact on others.

The healthcare professional must concentrate on the events within the previous six-week period. If the patient goes back much further, they may be attempting to avoid, deny or confuse present events. Ask until clear, “Why now?” It is important to determine when the person was last adequately functioning, and specifically what happened to disrupt the balance. Memory is better for current events, and the events are less likely to be distorted. This is true of the patient as well as relatives, friends and co-workers. For people who want to delve extensively into the past, it is best to tell them gently that these are issues they may bring up in the future, especially if they go into psychotherapy.

It is important in this first emergency interview to determine if medication for immediate relief is necessary. Sometimes medication is essential before the assessment interview if the person is highly agitated or hostile.

Another important focus for decision-making is whether or not hospitalization is necessary. This is decided based upon 1) the degree of anxiety or depression, 2) the ability of the person to maintain control of impulses to hurt self or others and 3) the availability of other people to provide emotional and practical support.

In an emergency room a man was markedly

anxious and agitated, showing poor judgment and unable to sleep. The diagnosis was a manic episode. It was decided that he would not have to be hospitalized as long as he could follow this treatment plan: Begin appropriate medication; come daily to the Day Center; abstain from alcoholic beverages; and discontinue sailing his boat on which he lived. He and his family agreed to this contract. Over the first weekend, the nurse made a “boat call” to check on any adverse reactions to the medication, to reinforce the expectations about the boat and drinking and to further her therapeutic relationship with him by showing her concern.

3. Intervention: This third stage begins as soon as the person presents for treatment; actually, it is part of the first two stages but continues after they are completed. As individuals in crisis share what they perceive is happening, they often experience some immediate relief simply from having someone listen. People who have been struggling with feelings of depression, anxiety, hopelessness, and a battery of unpleasant physical symptoms often feel much better after talking, obtaining some release of feelings and getting direct and indirect reassurance that help is available.

In many instances, it is essential that patients deal with feelings before they can do any problem solving on an intellectual basis. The crisis worker can describe the discomfort by saying something like, “*I can see you’re very unhappy (angry, afraid, anxious, etc.).*” or “*Most people in your situation would feel very angry*” or “*You must feel very confused by the mixed messages you’re getting.*”

The crisis worker gives permission and encouragement for the patient to experience, recognize and express emotions. Many people are not in touch with the feelings behind their extreme discomfort. With the death of a loved one, the griever may be completely unaware of feelings of rejection, anger, guilt and resentment. A mother may be consciously aware of her happiness over the marriage of her last child and bewildered by feelings of depression and anxiety.

As the patient experiences some relief and begins to explore the immediate situation, some understanding occurs, but a full realization of the link between precipitating events and responses is not yet clear. The crisis worker may put a speculated conclusion into words for the person to think about.

It is important to identify strengths, abilities and unmet needs. Exploration into the significant life areas such as work, home, school and relationships with others will help: What is most distressing and disappointing right now? What coping mechanisms have been used successfully in the past? Alternative ways to cope with the current situation may also be

suggested.

Throughout the process of crisis intervention, it is important to focus on the ability of the patient to regain mastery and to accept responsibility for self. The crisis worker is an active partner in the problem-solving venture but continues to give the credit to the patient.

Externalizing the events in a crisis makes it easier for everyone to take a look at the factors. The patient may expect that the crisis worker will *"figure me out, know what's best, make me feel better and tell me how to live happily ever after."* If this kind of unrealistic belief in magic and power is encouraged, treatment will fail. It is important to restore gently the power of change to the patient and to present the crisis worker as an ally who will help the person to figure out the problems and possible solutions.

An emphasis on positive assets and strengths is an effective tool in resolving the crisis. What and when was the previous optimal level of performance? What are the strengths in the patient and the family? What are the advantages of increased coping? What are the advantages of decreased coping? Can these advantages be obtained by means successfully used in the past? Many people in crisis at the time experience only the frightened, helpless, incapacitated parts of themselves. They forget or neglect the ways in which they have mastered other life crises. Strengths should be identified, encouraged and reinforced.

In crisis intervention, the family and significant others in a person's life may be enlisted to help. The crisis worker may interview them in the E.R. or call for information. It is best to explain the need for these contacts to the patient and receive consent, but in certain circumstances confidentiality may be waived if in the patient's best interests. With suicidal persons, the family needs to know the extent of the problems and risks involved. With homicidal problems, laws vary as to who should be notified, the intended victim and the police in some instances. Professionals should know the laws in their state and hospital policies. Some crisis teams make home visits or ask that the total social network meet together for intensive planning.

If the crisis has been precipitated by death, divorce or separation from a significant person, a step in resolution is to *"re-people"* the individual's world. After the initial grief work is done, the person is actively encouraged to seek out others in old or new social settings. Organized clubs, social groups, church activities, and recreational settings are places where potential friends are available.

These psychological intervention strategies are often supplemented by the use of psychotropic medications and/or one of a variety of institutional placements.

4. Resolution: This is the final stage of crisis intervention and generally takes place within a six-week period. Psychological equilibrium is reestablished, whether at the previous level, or lower or (hopefully) higher on the mental health scale. Crisis is often a turning point at which important learning can take place. Shakespeare noted this in the phrase, "Sweet are the uses of adversity."

How well did the crisis intervention work? This is indicated by the answers to the following questions:

- Have the original presenting symptoms and manifested anxiety decreased to manageable proportions?
- Does the person feel better?
- Does the person experience more hope and have the ability to cope?
- Do the individuals involved feel they have been helped?
- Have they learned how to approach problem-solving more effectively?
- Are previously unmet needs being recognized and satisfied in healthy, appropriate ways?
- Do the individuals feel able to make it on their own with their own resources?
- Does the crisis worker have positive feelings about the outcome?
- Can a plan for future action be described?

During the resolution stage, the crisis worker helps by summarizing the changes, describing the increased effectiveness in living and encouraging the person to experience the gains again. To be forewarned is to be forearmed! Future possible conflicts are discussed, along with possible alternative responses.

It is important to convey the message that the person is now able to cope again, using what has been learned from the experience, and if more help is needed in the future, it will be available. Some patients who have successfully mastered a crisis feel ashamed if later they again feel unable to cope. They may feel that they have let the crisis worker down and have difficulty asking for assistance again. During the resolution period of crisis intervention, plans for longer-term psychotherapy may be worked out if indicated, desired and available.

One Crisis After Another

Crisis theory and crisis intervention are important concepts for health professionals in every clinical setting. People bring their characteristic coping patterns into any situation. The health and illness continuum provides multiple opportunities for the development of crisis, including the prospects of sudden alteration in the ability to function, fear of impending disability or death, sudden shifting

or reversing of social roles, and pain. Illness and accidents may necessitate sudden shifts in reality with which a person copes in many ways. Some methods of coping may lead to crisis and psychiatric emergencies.

Professionals are involved with people in potential crisis situations outside as well as inside the hospital setting. They see varying needs for crisis intervention in clinics, doctors' offices, schools, and day centers and in the home. Also, many areas of healthcare are stressful which may lead to crisis for the professional. They must recognize the need to get help when they are experiencing a crisis. Furthermore, they may see developing crises in patients and fellow staff. Sensitive, appropriate referral for services can make a great deal of difference.

In some crisis centers and mental health settings, nurses function as primary therapists, working directly with individuals and families. They receive from and give consultation to other members of the mental health team or to the general hospital units.

Centers that specialize in crisis intervention have made deliberate attempts to reach out to people in distress. Rather than regarding these people as "sick" or "crazy," they consider them as having difficulty with problems of living. This kind of agency may be more acceptable to many people than traditional psychiatric centers. There are fewer stigmas involved.

Many people have distorted or negative stereotypes of psychiatrists, psychologists and psychiatric social workers. Their impressions of nurses may be more positive. Nurses are seen as accessible and helping people. They bring a background of working with emergencies along with an understanding of family interactions.

With proper educational programs and adequate supervision, support and guidance, health professionals can become even more competent and confident in crisis intervention.

Life-Threatening Conditions

Suicide

- Why did he do it?
- I really thought she was bluffing.
- How could he have done that to his family?
- What will they do now?
- Nothing could be that bad.
- Maybe it was just an accident?
- What did I do wrong?

Suicide is the act of killing oneself. Suicide burdens those left behind with many painful feelings and perplexed thoughts. Whether those people are family, friends or members of the medical professions, they are touched

by the inherent tragedy and haunting thoughts that things could have worked out differently. Death from any cause leaves the living with many feelings, such as grief, anger, resentment, guilt and relief. Death from suicide intensifies these feelings because it leaves questions that will never be completely answered.

The thought of suicide is threatening to most people because it is an extreme act, frightening and final. However, suicidal behavior can be recognized, interrupted and neutralized. Suicide is not inevitable. In fact, it is often preventable.

“Acute suicidal behavior is a psychiatric emergency that demands immediate assessment and treatment.”

If the person has already acted on suicidal thoughts (for example, taken pills, cut wrists, etc.), the first aspect of the emergency is to assess and treat the physical consequences and needs. Following this, assessment of the potential for continued self-destructiveness is imperative.

If the person is threatening suicide but has not taken action, intervention involves alleviating the immediate discomfort and desperation in order to “buy time” to consider other alternatives. This is one reason for hospitalization of the acutely suicidal, providing protection and trained staff to explore with the patient what precipitated the suicidal crisis and alternative solutions. Many patients weather these periods of extreme distress without going into the hospital. Unfortunately, many people who later kill themselves have had recent contact with the medical profession. They have often given overt or subtle clues about the possibility of killing themselves. This is why suicidal behavior is often considered a “cry for help.”

Are all human beings capable of suicide? Many people do not want to consider this potential within themselves, they often repress or deny it. In reality, most have had at least transient thoughts of destroying themselves or never waking up. Children say in angry, guilt-provoking tones (to themselves if not aloud to parents), “You’ll be sorry when I’m dead and gone.”

Some people think of suicide as the final, desperate alternative. Others consider it quickly and often, and then put the thought into action. These people get labeled in emergency rooms and crisis centers as “repeaters,” and sometimes the treatment staff gets calloused or demoralized by the seeming futility of helping. Most people who kill themselves succeed on the first or second attempt, BUT the large majority of suicide attempters do not try again, especially if effective treatment is offered.

Many suicidal actions are intentional, deliberate, and the result of considerable thought and planning. Others are impulsive or carried out while usual emotional controls are lessened by alcohol or drugs. Those who are suicidal often have mixed feelings about ending their lives. This ambivalence is reflected in talk, thoughts, action and body language. These signal the despairing person’s conflict to others so that they can supply the vital human needs which help to tip the balance from death to life.

Suicidal behavior should always be taken seriously, especially in the initial phases of assessment. The stakes are high even though the odds for survival are good in this gamble. A suicidal crisis is often part of the highly complex pattern of an individual’s past, present and anticipated future. In regard to the degrees of intent, there are three main clusters.

Mild intent reflects the actions of a person who has thought of suicide and may be trying to solve a problem situation through a suicidal threat or gesture. The person often has an intense need for attention and recognition. Without asking directly, these people are trying to test others as to how much they care. In some cases it may involve use of suicidal behavior to manipulate or emotionally blackmail another.

In mild intent suicidal behavior, the methods used often do not result in serious harm and may be carried out in circumstances where rescue is certain. Someone may gulp aspirin in front of a spouse or superficially scratch a wrist. A difficulty with the suicide “gesture” is that others may not take the message seriously. Shaming, ridiculing or scolding the person will not help the situation. It is important to find out what the problems are and how to solve them in other ways besides through suicidal acts. If the interpersonal context does not change or the person becomes less able to cope, the suicidal potential may escalate to more dangerous levels. The tragedy of individuals who use suicidal threats and superficial gestures is both the unhappy atmosphere they generate while living and the potential danger that they might eventually succeed in killing themselves.

Many people with suicidal ideation are in the **moderate intent** category. They are seriously thinking about ending their lives if circumstances remain the same or get worse. These people are ambivalent, however, and hold out for a change. If they attempt suicide, they generally use methods that leave the final decision to other people or to fate. Suicidal individuals who take barbiturates, for example, and leave open the possibility that someone will find them are in this group.

People with serious or unquestionably **lethal intent** fully expect to die as the result of their actions. Many completed suicides come from this category. The method and timing are

designed to be fatal. Lethal methods include shooting oneself with a gun or jumping from a high building. Only ignorance of the actual lethal potential, a chance occurrence, or medical intervention saves them. People in the lethal group often feel that life is meaningless and hopeless. They have no significant relationships with others or no longer feel worthy to live. They no longer care, whereas individuals in the other groups are concerned with the impact of their actions on significant others.

The combination of factors which suggests that the suicide intent has reached emergency proportions can include:

- An agitated, impatient, insistent attitude that something must be done immediately to reduce the anguish and to remedy the situation. The person needs immediate relief.
- A definite, feasible and lethal suicide plan for which the person is unable or unwilling to consider alternatives.
- Character traits of pride, hyper-independence, distrust of others and insistence on self-reliance, which make asking for and receiving help from others very difficult.
- Lack of a supportive interpersonal network. The person lives alone and/or has few external resources.

Factors affecting the suicidal risk associated with lethal intent include the specificity of the plan, the potential lethality of the method chosen, and the availability of means to carry out the plan.

Suicidal ideation and attempt are the most important risk factors for completion. Recent large-scale studies of a cross section of adults aged 17 to 39 showed that one in six had thought seriously of suicide, and one in eighteen had made an attempt. Interestingly, although suicidal behavior is a key symptom of major depression, many people who commit suicide have no apparent psychiatric diagnosis or history of psychiatric problems. There are a number of unrelated factors, such as demographics and simple access to weapons, which are independently associated with suicidal behavior. Suicidal behavior tends to peak in the spring of the year. The proportion of suicide attempts that are successful rises with age. Men have a higher rate of successful suicide, although women have more attempts. Stresses associated with life transitions, from adolescent turmoil to midlife crisis, to the losses experienced in old age, can affect suicide risk. Family history of suicide may be significant. Persons with an unstable lifestyle, a history of multiple unsatisfactory relationships, and problems with alcohol and substance abuse may be at greater risk. Homosexual men have a higher rate of suicide in comparison to their heterosexual peers.

Serious medical illness is also a significant risk factor. Medical illness alone raises the odds from 1.0 to 1.3 for ideation and 1.6 for a suicide attempt. Persons with more than one serious medical condition face odds of 1.8 for ideation and 2.4 for attempt. Asthma and chronic bronchitis are associated with a two-thirds increase in the likelihood of ideation, and asthma or cancer is linked to a four-fold increase in frequency of attempted suicide. It should be noted that only one third of the positive respondents in this study met the criteria for major depression, so screening for suicide potential must go beyond general depression inventories in order to be effective. Another study reported that patients with chronic, unexplained medical symptoms were also at high risk for suicidal behaviors.

Notable signs and symptoms of suicide potential include a depressive or sub-depressive syndrome, with vegetative signs such as loss of appetite and sleep disturbances, and feelings of helplessness and hopelessness. Agitation associated with tension, guilt, shame, rage, anger, and a desire for revenge also warrants attention. Sudden changes in behavior, from active to reclusive and vice versa, and changes in mood from depressed and withdrawn to relaxed and content, may be significant. Psychotic states with poor reality testing may lead to bizarre attempts, and increased or excessive alcohol consumption increases risk.

Assessment Of Suicidal Behavior

Many people believe the myth that, if a person talks about suicide, he won't do it. This myth simply does not hold up. Most people who are considering killing themselves give multiple warnings, verbal and nonverbal, to people in their immediate environment. They may consult with physicians, nurses or other helpers in both inpatient and outpatient settings. They generally indicate that some sort of internal struggle is occurring around the question, "Is my life worth living?" Clues to suicide include:

- Direct verbal warnings
- Depressed behavior
- Changes in social behavior
- Making of final plans
- Suicidal history
- Use of drugs and alcohol
- Intuition of a person close to the individual

Direct verbal warnings

A certain number of people seek help for suicidal thoughts simply by telling health professionals of these impulses. Other fairly direct signals include:

1. Inability to keep going
"If I could only go to sleep and never

wake up."

2. Feelings of hopelessness and despair
"I have nothing to live for."
3. Bids for reaction from another person
"You'd (they'd) be better off without me."
"It's too bad I failed the last time. It won't happen again."
4. Hints as to specific plans
"How many sleeping pills does it take to kill a person?"

Those statements may be voiced by patients in many clinical situations. Health professionals have heard them, especially from people with painful, chronic conditions; from the elderly; and from people diagnosed as clinically depressed. They may or may not signal imminent suicidal intent. It depends on the context as well as on other behavior.

Another myth of suicide is that talking about suicide with a person will suggest the act. This is not so. Most suicidal people welcome the relief of sharing their burden. Asking specific questions about suicidal thoughts and feelings is the way to determine the lethal possibility as well as to provide initial relief and problem-solving potential.

Depression

What makes depressed behavior part of potential psychiatric emergencies is the link between this and suicide. Many people who are depressed consider suicide. They express feelings of emptiness, deep sadness, futility and hopelessness.

The physical symptoms of depression include insomnia, restlessness and early morning awakening. The darkness and aloneness of the long nighttime hours symbolically echo the bleakness of the person's life. Other physical symptoms include loss of appetite (for food and life), weight loss, fatigue, difficulty with concentration, and the inability to follow through. Loss of sex drive, impotence, and lack of pleasure are frequent and reduce the bonds between people. The physical symptoms can give rise to thoughts of a delusional quality as the person begins to fear cancer or heart disease.

When individuals are coming out of a deep depression, their suicidal potential increases. During the misery of an acute depression, they are often immobilized but may be thinking steadily and deliberately about suicide. With energy and opportunity, they may act. Even after apparent successful psychiatric hospitalization for acute depression, there is still an approximate three-month period in which suicidal acts may take place. An apparent change for the better may signal a suicidal decision in depressed people. They become more cheerful, calm and active once the ambivalence is resolved. It's then a matter of time.

Feelings of depression are common among those who are suicidal. However, the most significant single predictor of suicidal intent is the feeling of hopelessness that may be present without the syndrome of depression. Signs and symptoms of depression are listed in **Figure 3**.

Changes in Social Behavior

Individuals who are in a depressive state or suicidal may show marked changes in social behavior, either dramatically or gradually. Some of these are the following:

1. Withdrawing and cutting off social relationships
2. Going into a frenzy of work and play to ward off depression
3. Losing interest in former activities
4. Avoiding, rejecting or clinging to family and friends
5. Voicing self-denigrating and negative statements
6. Alienating others by rendering them helpless and frustrated
7. Not taking care of or having pride in personal appearance
8. Declining ability to work in job, home and school

Another group of behaviors that may precipitate suicide are those of a person who is becoming psychotic and losing the ability to test reality. The person may dread the recurrence of a former psychotic episode and act suicidal to avoid it. Or they may begin to hallucinate by hearing voices telling them to kill themselves. Those who become markedly paranoid, fear danger from many sources. They misinterpret other people and external stimuli and may act in suicidal ways in a desperate attempt (paradoxically) to be safe.

Changes in social behavior may be subtly coded as to suicidal meaning. A person may start philosophizing about life and death, become preoccupied with morbid subjects, death poetry, or the afterlife. They may ask or comment about a "friend" who is suicidal. Sometimes, planning a long trip or completing a long anticipated desire is a clue that the person is finishing up life's unfinished business before a suicide attempt.

Making Final Plans

Signs that suicide is being actively considered include such activities as putting things in order, making or revising a will, taking out more life insurance, checking about organ donations and arranging for a cemetery plot. The suicidal person may make ritualistic last visits to favorite places and friends, give away prized possessions and make arrangements for pets.

Persons who put their suicidal thoughts into writing or who draft a farewell note are

Signs & Symptoms of Depression

Physiological Changes

- ▶ Disturbance in sleep patterns — difficulty falling asleep, early morning awakening, insomnia, hypersomnia
- ▶ Fatigue
- ▶ Anorexia, with accompanying weight loss
- ▶ Constipation or diarrhea
- ▶ Increased eating and weight gain
- ▶ Urinary frequency
- ▶ Constriction in chest
- ▶ Dry mouth
- ▶ Impotence or frigidity decrease in sex drive
- ▶ Headache
- ▶ Shift in mood during the day — diurnal variation
- ▶ Hypochondriasis and somatic complaints
- ▶ Psychomotor retardation
- ▶ Agitation and restlessness

Behavioral Characteristics

- ▶ Loss of motivation
- ▶ Lack of interest
- ▶ Social withdrawal
- ▶ Slumped, hunched-over posture
- ▶ Dragging feet, shuffling gait — no zip
- ▶ Clinging, dependent interactions
- ▶ Whining, pleading voice tones
- ▶ Flat, sad expressions — no animation
- ▶ Suicidal talk and acts
- ▶ Decreased interest in sex
- ▶ Restless, agitated — pacing, hand wringing
- ▶ Crying spells or wanting to cry but not being able to
- ▶ Lack of enjoyment and participation in usual activities

Subjective Reactions

- ▶ “I am... depressed, sad, hopeless, worthless, a failure, inadequate.”
- ▶ “I feel like... giving up, quitting, hiding, going to bed and never getting up, crying, it’s all my fault, there’s no use.”
- ▶ “I feel like I did when... my parents died, my husband first left me, I was just a very little girl.”
- ▶ “I hate myself.”
- ▶ Guilt feelings over real or imagined misbehavior in the past
- ▶ Fears of real or imagined bad happenings, including physical illness
- ▶ Anxiety attacks
- ▶ Anger, envy, shame, loneliness, revenge, helplessness
- ▶ Loss of sense of humor

Mental Changes

- ▶ Negative self-concept
- ▶ Negative expectations for the future
- ▶ Impaired concentration
- ▶ Indecisiveness
- ▶ Doubting
- ▶ Constant rumination on the past, present and future worrying
- ▶ Self-deprecation and denigration
- ▶ Impaired memory or memory loss
- ▶ Delusions — often related to somatic conditions or guilt
- ▶ Exaggerated view of problems
- ▶ Suicidal ideation and thoughts of death

Figure 3

generally more intent on outcome. This is particularly true if they ask forgiveness from the family for the shame and consequences.

Actually obtaining the means to the suicide by buying a gun or hoarding pills is preparation to put the plan into action. The more specific and detailed the plan is, the greater the risk of carrying it through.

Suicidal History

Another important element is a history of a previous attempt. Those who kill themselves have often made one or more prior attempts. It is important to find out what the situation was, the means of attempt, the impact on others and the subsequent outcome.

Death by suicide of a parent, family member or close friend may influence later suicidal behavior. Children are particularly affected by the suddenness and mystery surrounding this kind of death. They may feel confused,

responsible and guilty. The child may also identify with the dead parent and later seek to rejoin the parent through suicide. This may occur on a conscious or subconscious level. The anniversary of the date of the suicide and the death age of the suicidal loved one are crucial times. Recent tragic death of one close to a person may precipitate suicide, especially if there is guilt or a strong desire to reunite.

An aging person with an increasing physical disability may go into a depression and suicidal crisis when cut off from friends, family and work. Death of a spouse may precipitate the wish for self-induced death.

Those attempting suicide due to a terminal disease such as cancer or AIDS may have no suicidal attempt history at all. Over the years there has been an increase in the number of people with AIDS who have attempted and completed suicide.

Use of Drugs and Alcohol

Many people who are depressed and distressed use drugs and alcohol as self-medication. This is potentially very dangerous. Alcohol and barbiturates increase depressed feelings, lowering impulse control and reducing ordinary caution in automobile driving. How many fatal car accidents are really suicide-related is difficult to assess.

Alcohol misuse is part of many attempted and successful suicides. A person may purposefully or accidentally overdose on combinations of drugs and alcohol. This can lead to a serious medical emergency that, if not treated in time, may be fatal. Under the influence of alcohol or drugs, some individuals provoke others to attack physically and even kill them. Serious fights in families and standoffs with police may be part of this self-destructive pattern.

Intuition of a person close

to the individual

A person who is emotionally close to an acutely suicidal person may pick up subtle clues that disaster is pending. Intuition is partially the result of the screening of many nonverbal messages. It is felt as a vague sense of foreboding, apprehension, a “hunch” that something bad may happen.

The dreams of both the suicidal person and significant others may give warnings. Typical suicide dreams include those of going into a dark, unknown territory, which may be either threatening or comforting; opening a door to the unknown; reuniting with a dead loved one; and jumping out a window or falling. Of course, these themes have many other meanings, depending on the individual involved.

Problems and Goals

The emergency aspect of suicidal behavior is that an individual has acted or is about to act in a self-destructive, potentially fatal way. This is the most immediate problem. The immediate goal is to preserve life.

The specific problems that lead to suicidal behavior are highly individualized. They will be identified through a careful history taking and an understanding of the larger picture. The long-range goal is that the person will develop alternative ways to cope with the conditions that led to the suicidal state. These goals include:

1. Increased impulse control
2. Increased willingness to live, even with difficulties
3. Increased hope, self-esteem and sense of mastery
4. Improved communication and interpersonal relations
5. Increased ability to deal with feelings: love, anger, depression, grief, loneliness, and guilt
6. Increased understanding of self-destructive patterns

Persons who are suicidal come to the attention of health professionals in different ways. They may be patients in active treatment in either an inpatient or outpatient setting for physical or psychiatric reasons. There may be a change in their condition, life circumstances, and ability to cope.

Many people who make suicide attempts go to an emergency room first. They may seek out this help or be brought by family. Cut wrists are sutured; overdoses are lavaged. If the physical condition is serious, the patient is admitted for intensive care or lifesaving surgery. Psychiatric evaluation must wait until the person is medically stable.

Many emergency rooms ask for a psychiatric evaluation for each attempt or threatened

attempt, if possible. After assessment, psychiatric treatment, either inpatient or outpatient, may be recommended.

Indications for psychiatric hospitalization include continued high risk of acting on suicidal impulses based on regrets that the attempt was unsuccessful and strong feelings of hopelessness and of being overwhelmed; increased depression, despite initiation of treatment; lack of available support system of family and friends; subtle suicide encouragement by family; severe personality disorganization or psychosis; gross disturbance of physiological balance; and need for specialized treatment.

The patient may not follow through with psychiatric treatment once the emergency is over. The stigma of mental illness stops many people from seeking help with their problems. They may be afraid to change or they may not be ready to face difficult interpersonal problems.

Another means by which a suicidal person comes for treatment is through telephone contact by self or others. Crisis centers and suicide prevention programs offer 24-hour services to the distressed. The professionals and volunteers in these programs are carefully trained to do assessment and treatment recommendation. They are also often available to do telephone consultation with other health workers. The police are another helping group who bring people in for help when needed.

An important aspect in working with suicidal people is for the staff to talk with one another. It is necessary to compare observations and information, as well as to share the many feelings that are evoked. Some suicidal patients are very trying and provocative; this behavior can be frustrating to those trying to help them.

Caring For Acutely Suicidal Patients

A psychiatric unit is usually the most appropriate treatment setting for seriously suicidal people during an acute crisis. The staff helps to protect these patients from hurting themselves while they carry on the tasks of daily living, such as eating, hygiene, exercise, sleep and communication. If depression is part of the picture, these activities may be greatly impaired.

Professionals form a human lifeline to distressed patients. They encourage use of onsite treatment programs, which is designed to increase self-esteem and allow safe expression of feelings of anger, fear and guilt. The interest and care of the staff give hope to the patient, increasing the motivation to live.

Problem:

1. Acute suicidal thoughts, feelings and impulses
2. Decreased impulse control

Goal:

To prevent physical and psychological injury

Action:

1. Be available to patients as advocates who stay with them, provide structure and assistance, meet physical needs and talk with them about the current crisis.
2. Provide one to one supervision, if needed; keep patient in observable place.
3. Restrict to unit or accompany to necessary appointments.
4. Supervise eating, toileting, smoking, sleeping.
5. Assess and evaluate changes in behavior, depressed behavior, suicidal ideation, plans, feelings and response to treatment.
6. Help patient evaluate strengths and other ways to cope.
7. Increase level of patient observation at change of shift, weekends, meal times.
8. Provide a safe environment where the patient is protected and cared for until self-destructive impulses are under control.
 - Maintain a basically safe unit. Shatterproof, lockable windows; no exposed pipes or hooks; safe area.
 - Remove potentially harmful objects and supervise use of razors, glass, sharp or pointed objects, drugs, chemicals
 - Use seclusion if patient is actively harming self; restrain if unable to control.
 - Monitor visits as needed.

Suicide Precautions

Many hospitals have specific procedures for “*Suicide Precautions*,” which can be ordered on a psychiatric or general unit. Patients who are too sick physically to be on a psychiatric unit may be acutely suicidal. If treated in an intensive care unit, they are relatively safe because of the degree of incapacitation and the constant observation and surveillance. If transferred to units with less staff, they may require a special nurse, a “sitter,” or constant observation by family and friends. It is important during this period to initiate and establish professional mental health referrals, if possible.

When a patient is suicidal, how closely is the patient to be observed by the staff? This is a question that requires careful individualized consideration.

Here is a scenario: A nineteen-year-old female was admitted to a leading psychiatric facility in New York City. She had told the staff many times that she planned to kill herself. On a daily basis she would describe to the staff what she planned to do. The nurse

assigned to her was told in detail about dreams the patient had in which she put a plastic bag over her head and ended it all. Her father had recently died and she wanted to die, too. She attempted suicide by drinking a bottle of rubbing alcohol. Even then she was not observed closely. Two weeks later, during report, she committed suicide. She accomplished this by placing a plastic bag over her head, tying a sheet around her neck and tying the sheet to the plumbing on the toilet. Who is responsible for her death? In a court of law who is negligent: the attending psychiatrist, the nurse or the hospital administration? The following guidelines are legal descriptions of degrees of suicidal observation. It is important for each staff member to understand and follow these guidelines.

Level 1 Constant Supervision - A staff member is assigned to the patient at all times and is responsible for the safety of the patient. Written documentation must reflect information based upon this guideline. The staff must be in an eye's view and seconds away from the patient under observation. The hospital and the medical and psychiatric nursing administration are responsible for assuring that this guideline is carried out. The goal of this observation is to preserve life. The staff is responsible to assure that all the contraband is removed from the immediate environment of the patient's room or anywhere the patient is during this strict period of observation. When the patient is considered a danger to self, the following items are removed: glasses, belts, shoelaces, bras, pantyhose, plastic bags, string, razors, knives, electric cords, hair pins and even money. Observation focuses on statements of the patient, indications that the patient is actively hallucinating or hearing voices suggesting self harm, thoughts of danger from others, and other significant behaviors laughing inappropriately, withdrawal, lack of interaction with staff or others, poor appetite, or poor sleeping patterns.

Level 2 Fifteen-Minute Observation - A staff member is assigned to the patient under observation. The patient is again maintained in eye's view and seconds away. The staff member is responsible to interact with and observe the patient every fifteen minutes. During the fifteen-minute intervals the patient is encouraged to participate in activities with other patients and staff. Documentation is carefully kept during these intervals and the staff member assigned is responsible to report the patient's behavior based upon the criteria described in the above guideline. Degree and frequency of suicidal ideation is reported and accurate documentation is critical. If the patient exhibits behaviors that demonstrate an increase in suicidal ideation or recurrence of hallucinations, then the patient will be placed

back on Constant Supervision.

Level 3 Altered Observation - Again, all dangerous objects are removed from the patient's immediate environment. The patient is still considered a danger to self. Legal documentation is required. The patient need not be assigned to one staff member at this time, however. All staff are responsible for the safety of the patient. If the patient begins to report voices and hallucinations telling him to hurt himself, he is returned to the Fifteen-Minute Observation.

The psychiatrist is responsible for accurate assessment of the degree of suicide potential of the patient. It is the unit staff who are responsible to assure that the proper suicidal observation is carried out in the clinical setting. The Constant Supervision may begin in the psychiatric emergency room when the patient is in the storm of psychiatric crisis. In a court of law, the judge will utilize these guidelines in most states to evaluate negligence. Nursing and medical staff should be aware of the legal aspects of psychiatric nursing practice, but the most important concern is the safety of the patient and the preservation of life.

These guidelines may also be implemented in other areas of the hospital. Nurses are responsible in critical care units, intensive care units, medical and surgical, oncology and all areas of the hospital to document and communicate suicidal ideation of patients to the appropriate channels for consultation. If the clinical specialist in the critical care unit identifies suicidal behavior in a post myocardial infarction patient, the medical department must carry out proper protocols for suicidal behavior in a cardiac patient. The staff must document and provide safety for the patient, and the physician must respond. If they fail to respond, they may find themselves in court even if the patient does not attempt suicide, but only interferes with medical treatment and develops complications as a result.

(Source: Review of decisions regarding suicide and malpractice, New York University Law Library)

Violence

Exposure to violence is increasingly more common for American adults and children, both as victims and as witnesses. Currently 40 to 80% of all emergency room visits are related to violent behaviors. Television, movies and newspapers give vivid reports of crime, assaults and murders. There is group violence in wars, mobs, sports and "entertainment." In many dramas and some real-life situations, the violent person is portrayed as having some degree of mental illness. In reality, the vast majority of violent crimes and other incidents of violent behavior are related to substance abuse.

Compared to alcohol and drugs, the contribution of mental illness per se to the incidence of violence in our society is negligible.

Experienced health care professionals realize that more people react to stress with anxiety and retreat than with anger and aggression. The actual incidence of violent acts in a hospital setting is quite low, which leaves the staff relatively inexperienced and unnerved when faced with a violent patient.

Outbursts of physical aggression are considered a danger to society and therefore are controlled by social institutions, the jail or the hospital. Violent people may be self-referred or brought by police, family or friends for evaluation and treatment. The four types of violence are categorized by individuals who: 1) fear they will act in a violent way; 2) who plan to act in a violent way; 3) who have just acted or are currently acting violently; or 4) who have a history of previous violent acts.

One of the fears of emergency room work or acute crisis intervention is that a dangerous person will present such a violent problem that the staff will not be able to handle it or that there will be an underestimation of the potential violence that might later result in murder. This fear of the unknown is often distressing. The potential for future violence is difficult to determine.

There are many parallels between assessment and crisis treatment of patients who are suicidal and those who are violent or homicidal. Both groups present potentially life-threatening situations, with extremely serious consequences, even if death does not occur. They both involve difficulty with impulse control. Just as most people have thought of suicide at some time, so have many people considered violence in some form or another. Many people report that they have thought or felt like killing someone at some time; few have acted. Like the suicidal impulse, the violent impulse may be time-limited and deterred by appropriate help.

Some violent behaviors that come to the attention of health professionals include: assaulting people; destroying property; experiencing barely controllable urges to hurt others; and perceiving the environment as overwhelmingly hostile, requiring self-protection and retaliation.

Understanding Anger

The emotion most directly related to violence is that of anger. Violence and murder are the extreme manifestations of anger. In order to understand and deal with a person showing violent behavior, it is important to understand anger. Anger is generally considered to be a reaction to frustration. Some common experiences of frustration include the following:

1. Interference with goal-directed activity
2. Withholding of desired needs
3. Violation of ideals
4. Unfulfilled expectation
5. Loss of self-esteem
6. Past emotional trauma

These experiences are generally threatening to the self. The person experiences a flood of anxiety. The choice, conscious or subconscious, is between fight, flight or compromise behavior. Anger arises as a way of handling the anxiety by fighting. The burst of power mobilizes a person to overcome, do battle, oppose and put down the threat. The angry person is often a very frightened person.

Anger may be expressed openly in verbal, nonverbal or physical ways. The “*danger*” may be driven away or destroyed; this brings relief. Or the danger may remain. Fear of retaliation or retaliation itself is a common result of the outward expression of anger. Guilt and shame about one’s behavior may be felt with subsequent anger. The vicious cycle continues.

Instead of conscious recognition and expression, the person may stifle awareness of the anger and turn it inward. The anger is then expressed in physical symptoms, depression, suicide, withdrawal, extensive use of defense mechanisms, and dreaming.

There are two groups of people who explode in violence and murder. Those in the first group are considered “*over-controlled*.” They quietly tolerate a chronically frustrating situation, usually a family relationship, while resentment and rage build. On the surface the person is cooperative and conforming, often described as quiet or good. They may suddenly erupt with violent and lethal actions toward known individuals or to strangers.

The “*under-controlled*” group is generally known to be violent. This behavior begins at an early age. Violence can be provoked by family, friends, and strangers. The person is often considered to “*have a chip on his shoulder*,” “*a beef*,” or a “*short fuse*.” Feeling the world is against them, the person feels that the best defense is the first offense.

These are the extremes of the nonproductive use and expression of anger. Although anger may be part of the core conflict of many people, it is an emotion that serves a purpose and can be used for constructive ends. Just as anxiety is a normal human reaction that can be used in the service of learning and growth, so is anger. Part of anger and aggressiveness is assertiveness, the ability to overcome obstacles that block needs.

Anger always has an object, usually the frustrating person or situation. Anger is first seen in the infant who shows undifferentiated rage. Experiencing discomfort from hunger, cold, wetness or pain, babies scream. In time

they learn that they can get what is necessary to achieve comfort and satisfy needs. They learn to wait for gratification.

Anger may be directed toward the self--the most extreme instance being suicide. Anger directed at another person has two objectives. One is to destroy or punish the person who threatens, damages or frustrates. The other goal is to manipulate the other by pain, punishment or threat. The overall goal again is to provide gratification and to satisfy needs.

Anger is expressed chiefly through the voluntary neuromuscular system. Vigorous action, constructive or destructive, results in a sense of control of the situation and thus relieves strong feelings. As opposed to harmful action, fantasy is often a constructive channeling of aggression. The signs and symptoms of anger are summarized in *Figure 4*.

Anger and hostility are not uncommon in healthcare situations whereas actual violence is considered uncommon. If expression of anger is viewed as an attempt to maintain or regain control, then the solution is to provide situations in which the person does not feel powerless. This is applicable whether a person is already a patient or is being evaluated for treatment.

Anxiety and agitation may be expressed in angry, violent behavior. These feelings are generally the result of two categories which stem from emotional or organic causes confusion and misperceived attack.

1. **Confusion:** The person is experiencing a fight-or-flight reaction after some sort of alteration of consciousness through trauma, drugs, alcohol, sensory deprivation or toxic processes. They simply do not know what is happening and, in panic, lash out.
2. **Misperceived attack:** Fear of assault or belief of being assaulted may relate to psychosis or intoxication. Hospital procedures may be misinterpreted by patients who are partially conscious, post MI, postictal, sedated, unsophisticated, have acute or chronic dementia, or brain injury, and they strike back in an attempt at self defense.

Violent behavior is a symptom. It is important to discover the etiology so that appropriate treatment can begin. Differential diagnoses include temporal lobe epilepsy; explosive personality; acute organic brain syndrome secondary to drug ingestion, especially hallucinogens; schizophrenia, especially paranoid type; alcohol intoxication; antisocial personality disorder; uncontrollable violence secondary to interpersonal stress; organic states, including tumor, infections, and brain response to toxins; and dissociative states.

It may take extended time, observation and

diagnostic testing to determine which of the above fits a particular patient. While the state of psychiatric emergency is occurring, rapid treatment must take place to protect everyone - the intended victims, the staff and the violent person. Safety is the first consideration. There are three levels of urgency:

1. **Acute:** when the person is actively violent, combative and dangerous and no cooperation is obtainable;
2. **Subacute:** when the person is threatening and acutely agitated, but violence has not occurred; cooperation may or may not be obtained; and
3. **Chronic quiescent:** when the person has recurrent episodes of violence but is currently in good control and judged to need help to prevent future outbursts; cooperation may or may not be obtained.

In the first two cases, control of the person is the first order. Medication is generally indicated. It should be prepared ahead of actually restraining the patient, if possible. For acute patients the medication will probably be given via injection, either IV or IM. The room or bed should be readied and open, and if restraints become necessary, they should be available.

Assessment Of Violence

As in other types of psychiatric emergencies, the question with violent behavior is, “Why now?” What event or combination of events has created the situation that may lead to destructive, even lethal, behavior?

As part of the psychosocial history and mental status evaluation, the following questions should be asked:

- What has the person done?
- How threatening was the action?
- Has it ever happened before?
- Do you know whether alcohol or drugs were involved?
- The person being evaluated should be asked:
 - With the problems and feelings that you have, have you thought of harming someone else?
 - What are your thoughts and feelings about this person? Why?
 - What do you think the outcome will be?
 - Have you ever felt like killing someone? Tried? How about now?
 - Have you had trouble with the police?

These questions, along with the nonverbal aspects of behavior in the situation, help to determine the three most significant factors: previous history of violent behavior, the type of violence already expressed or expected, and the degrees of impulse control expressed both physically and verbally.

There are many other questions that help not

1

Signs & Symptoms of Anger

3

Physiological Changes

Increased heart rate; increased blood pressure, respiration rate and/or perspiration; tremor; cold, clammy hands or feet; need to urinate or defecate; loss of appetite; sleeplessness or disturbed sleep pattern; muscle tenseness; disturbances of the endocrine, autonomic nervous and circulatory systems; norepinephrine response.

Behavioral Characteristics

Facial expressions: eyelids tensely narrowed, eyes glaring, pupils constricted, mouth open, grin tense, lips retracted, teeth clenched, face red, veins distended, nostrils widened, jaw jutting, expression frowning

Body stance: head toward object, "attack," muscles tense, fists clenched, gestures quick and forceful

Speech: very controlled, precise and hesitating OR forceful, loud, high-pitched, loud cursing, inappropriate, mirthless laughter, threatening tone, shouting, sarcastic, sullen tone

Actions: restlessness, pacing, stony withdrawal, negative responses to rules and requests, hitting, destroying property, direct verbal warnings, driving recklessly, excessive friendliness, ingratiating attitude, joking at the expense of others, forgetting names and appointments, being late, mutilating, killing, suicide.

2

Subjective Reactions

"I am annoyed, angry, mad, enraged, furious, pissed off."

"I feel like exploding, knocking his block off, shouting, slamming the door, killing."

"I'm hot under the collar, livid, seeing red, steaming, fighting mad."

"You got my goat, pissed me off, are a pain in the neck, in the ass, can shove it!"

Mental Attitudes

Fear of loss of control, fear of retaliation, paranoid thinking, misinterpreting other people and the environment, marked ambivalent attitudes toward others, difficulty concentrating, indecisiveness and the need to take some action, perception of being controlled by others, misperceived attack, perception of the world as dangerous and hostile, low self esteem, aggression and violence perceived as sanctioned, approved ways to behave.

4

Figure 4

only to round out the picture of possible violent behavior but also suggest the appropriate treatment. Some of these include questions that deal with life experiences that have resulted in feelings of bitterness, resentment, and the desire for revenge; frequent quarrels with family members; association with a significant person who is violent; violence as a way of life; low self-esteem or defective self-image; interest in and availability of weapons, especially guns; violent fantasies and daydreams; childhood history of parental brutality and/or seduction; childhood history of arson, enuresis or cruelty to animals; alcohol and drug abuse; and impaired reality testing with specific fears of attack from others.

Dangerousness and murder potential are much easier to assess in hindsight than foresight. This becomes a medical, legal and moral

problem. Medical personnel are dedicated to saving lives and alleviating distress. When someone who is potentially homicidal comes in for evaluation and treatment, most staff react with some degree of fear and uncertainty.

Profiles of those who have committed murders generally highlight early as well as immediate circumstances. The person often comes from a family in which the quality of life was poor, especially between father and son. There was often physical violence in the home directed at the child and between the parents.

Often people who murder have had limited relationships with peers as children and have been socially isolated for most of their lives. They have little evidence of early team or sport activity. Deep-seated feelings of inadequacy, rage and desire for revenge become part of

their personality. This lack of family and friend development has left the person particularly susceptible to derision and shaming. What leads to the homicidal crisis is gradual decompensation. This manifests as the failure to generate effective psychological coping mechanisms in response to stress, resulting in personality disturbance or disintegration at school, work and in social situations. The person has repetitive feelings of helplessness, along with a great need to succeed and to be approved. The person feels generally hopeless in regard to other people's being able to help.

Within this context a crisis situation develops. The potentially violent person is often devoid of pleasure, feels helpless in inner life and begins to experience stress in the extreme. Impulse control slips and use of alcohol or drugs may increase, in turn increasing the potential

for violent action. These factors precipitate a state of actual or threatened violence that is a psychiatric emergency, requiring immediate assessment, treatment and disposition.

Problems And Goals

The immediate problem presented by these patients is one of safety. They are acting or are about to act on angry feelings in ways that will be harmful to other people and/or property. After the initial behavior is brought under control, other problems will be identified. These can include low self-esteem, low frustration tolerance, anxiety, and difficulty with interpersonal relations.

The long-range goal in working with a person who acts violently is to help them find other means of expressing feelings, especially fear and anger. With increased self-esteem, the person is less likely to feel as powerless and afraid of others.

Aggressive, assaultive behavior causes many difficulties in interpersonal relations. Spouse, parent and child abuse are all related to this problem. Many times the abusing parent has been a battered child. In this way maladaptive patterns that lead to misery, injury and death are perpetuated. Those who work with people who resort to physical violence hope to help them learn more adaptive ways of handling feelings and relating to others. Aggressive patients who use physical threats and acts to manipulate and bully others may, however, lack the motivation to understand and change their behavior patterns after the initial crisis is over.

Dealing With Anger and Violence

The type of intervention with an angry, potentially violent patient will depend on several factors: the degree of danger, the treatment setting, the cause of anger and the skills of the nurse. The degree of danger ranges from minimal to life threatening. Verbal expression of anger can relieve the feeling or can escalate into physical action. People who are acutely angry must be evaluated in terms of what action they may take with their thoughts, feelings and impulses. Violence does not usually occur without a warning through behavior and verbal signs.

A patient in a general hospital may show angry behavior in reaction to the stress of illness. Anger is part of the basic personality and toxic effects of the illness and treatment, especially drug interactions, may evoke it. The nurse may or may not intervene. If the behavior escalates to violence, action must be taken. Immediate safety and control of the patient are the first actions. Psychiatric consultation may be requested. Drug and environmental interventions

are used for immediate resolution.

If the person is being evaluated in an E.R. or crisis center, nurses are often the primary crisis workers. They participate in the evaluation, treatment and disposition aspects of this psychiatric emergency.

A person may be hospitalized on a psychiatric unit to regain control over angry, violent behavior. In this setting, patients are helped to control this behavior and to express themselves in ways that lead to greater awareness, understanding and social adaptation rather than violence and destruction.

It is important to find out why the patient is angry to the point of violence. If there are external, realistic reasons, the nurse can correct these if possible. If the anger stems from deep-seated conflicts and habit patterns, intervention is limited to the immediate situation.

Health professionals can increase their skills. At first, they may feel frightened and threatened. As knowledge and experience increase, they become more comfortable.

Problem:

1. Violence or potential aggressive behavior
2. Decreased impulse control

Goal:

1. Bring violent behavior under control
2. Increase impulse control so that the person no longer acts in a violent, destructive manner.

Action:

1. Recognize that the patient is experiencing feelings of anger and anxiety which may be exhibited through attempts to attack, control or injure others; somatic symptoms such as headaches; suicidal and depressed behavior; withdrawal, especially related to distrust and suspicion; or excessive use of defense mechanisms, especially projection, denial and rationalization.
2. Determine whether the patient recognizes the anger. If asked about it directly, the patient may be able to describe feelings and estimate ability to handle them. If the person is not aware of feelings of anger, the professional can make suggestions.
3. With patients who are able to talk about their anger, help them go through the learning process for anger management.
 - Describe fully the situation in which anger is occurring.
 - Discuss various alternative solutions to violent and negative expression.
 - Decide on an alternative solution.
 - Use it the next time the situation occurs, and evaluate its effectiveness.
 - Continue the process until a

satisfactory solution is found.

4. Assist the patient to maintain impulse control. When the person isn't able to talk about feelings or shows evidence that controls are lessening, the following approaches may help:
 - Divert the patient into motor activities running, hitting a punching bag
 - Separate the patient from potential problem situations and people: going to his room before losing control; electing not to see family members
 - Express an expectation that the patient will be responsible for their actions "You can control yourself."
 - Assign staff with whom the patient has good relations to stay with them
 - Use patient groups and community meetings to channel disputes and condone talking things over rather than using physical force.
 - Medicate as prescribed and indicated consider using medication prophylactically when stressful events are anticipated
5. Recognize when the preceding steps are ineffective, and provide external controls and limits by:
 - Direct verbal command, "Stop it!", "Get hold of yourself," "No!"
 - Direct physical intervention have enough skilled staff present so that no one gets hurt
 - Medication as needed as a temporary chemical restraint and for treatment
 - Mechanical restraints as needed for safety seclusion room, partial or full restraints, blankets
 - Limiting other patients or bystanders
6. Utilize the violent episode as a teaching opportunity. When the patient has calmed down, help them to talk about:
 - What happened
 - Correlation of action and verbal language
 - Plans for alternate ways to express feelings
 - How thoughts and feelings are different from actions
 - Whether apology or restitution would help alleviate guilt, raise self-esteem and reduce fear of retaliation
7. Share the problems of working with angry, violent patients with other staff members in order to decrease fear, plan effective action, learn from and evaluate the experience, and decide how to help other patients who may be frightened, angry or having difficulty with their own impulse control.
8. Recognize and replace the behaviors that interfere with helping an angry patient:
 - Ignoring the behavior of the patient

- Attempting to joke or humor a person out of it
- Prodding a patient to express more than they are ready to
- Focusing on other topics when the patient wants to express feelings
- Reinforcing angry, violent behavior by calling attention to it, while ignoring positive, constructive behaviors
- Shaming the patient or implying the patient should feel guilty
- Not recognizing when they feel angry toward a patient or have acted in an angry way
- Moving in too close physically, invading the person's space "trapping" or "cornering".

Life-Disrupting Conditions

Anxiety

Anxiety is inherent in most healthcare situations. People who are physically or emotionally ill are concerned about their biological and psychological safety. Anxiety stems from threats to security on both a conscious and subconscious level. Patients and families are faced with difficult adaptive tasks related to significant disruptions in living, illness, injury and death including:

1. Dealing with the discomfort, incapacitation and other symptoms of illness or injury.
2. Managing the stress of the emergency room, special treatments and the hospital or treatment environment.
3. Developing and maintaining adequate relationships with the physicians, nurses and other professionals. Needing to "trust them with lives."
4. Preserving a satisfactory self-image and maintaining a sense of competency and mastery difficult when feeling weak and helpless.
5. Preserving a reasonable emotional balance of many disturbing feelings: anxiety, grief, uncertainty, guilt, shame, resentment, and anger.
6. Preserving relationships with family and friends despite a changed role.
7. Preparing for an uncertain future where further loss or death, as well as recovery, is possible.

The problems just listed can all be highly anxiety provoking. Anxiety is the feeling of apprehension, tension and uneasiness that stems from the anticipation of danger from some unknown source. It is similar to fear in the physiological reactions it elicits. In fear, the threat is known and external. Anxiety is

considered to be primarily of intrapsychiatric origin. Anxiety is ubiquitous, common to everyone. It becomes pathological when it is present to the extent that it interferes with reasonable emotional comfort, effectiveness in living and the achievement of goals.

Anxiety becomes a psychiatric emergency when a person is experiencing extreme anxiety or panic. In this condition, the person feels overwhelmed with acute, intense feelings and physiological reactions. Panic often is accompanied by other feelings and behaviors, such as depression, agitation, anger, somatic complaints, and confusion. With panic, there is personality disorganization, perceptual distortion and impaired cognitive function. The person seems "*scared to death*."

The extreme of panic is called psychotic terror. People suffering in this state are frightened, easily startled and highly disorganized in thinking. They may be hallucinating and delusional, especially with paranoid content. The psychotic state may stem from psychological factors or from organic etiology, especially in reaction to drugs such as hallucinogens.

Panic attacks may occur while a person is already being treated for physical or emotional reasons. They may be part of the extremely stressful present and uncertain future. Medications may interact to produce states of high anxiety and confusion. Individuals may seek treatment through an E.R., crisis center or outpatient department because of extreme anxiety and fear of recurrent panic attacks.

Panic behavior may be life-threatening if the individual attacks others or crashes into walls, runs into traffic or jumps out of a window. Immediate action must be taken to control, contain and protect the patient and others. More often, however, the patient's behavior affords time to do a physical examination and initial history assessment.

There are many medical conditions that are present with prominent features of anxiety. Some of these are angina pectoris, aspirin intolerance, alcohol, barbiturate and other drug withdrawal, caffeine excess, cerebral arteriosclerosis, epilepsy, especially psychomotor and temporal lobe types. Others include hypoglycemia, hyperinsulinism, internal hemorrhage, and post-concussion syndrome. COPD, asthma, paroxysmal tachyarrhythmias, thyrotoxicosis, hyperthyroidism, and drug-induced psychosis resulting from ingestion of cocaine, amphetamine, or PCP. The appropriate treatment will depend on the specific cause and course. It is important to maintain a calm attitude in talking with and treating a highly anxious person.

The Continuum Of

Anxiety

Anxiety ranges on a continuum from mild, moderate, severe, to panic. A person may move up or down the continuum. A goal in most care is to help the patient to reduce anxiety to manageable proportions.

With mild anxiety the senses are sharpened so that learning is enhanced and the person is more vigilant. With moderate anxiety, the person has a narrowed perceptual field—seeing, hearing and grasping less. Considerable discomfort is experienced, and there is a blurring of reality as the person distorts cues. The person experiences interference with learning.

Severe anxiety describes the state of the person about to panic. Such individuals seem oblivious to the world around them and temporarily become primitive, tortured and incapacitated human beings. Extreme hyperactivity or complete immobility can be signs of overwhelming anxiety. Some of the behaviors observed in severe anxiety are disorientation to time, place or person; memory loss; decreased ability to attend and respond to surroundings; emotional lability, with episodes of crying, screaming, or laughing; agitation and hyperactivity; incoherence and confusion; hallucinations; delusional thoughts and verbalizations; verbal and physical aggression; reaching out for help by crying, begging, or touching; and rapid, pressured speech or uncharacteristic silence. All these can indicate that the person is in great mental anguish. Specific signs and symptoms of anxiety are listed in *Figure 5*.

Helping Highly Anxious Patients

Health professionals are cognizant of common factors in medical settings which may precipitate anxiety: admission to a unit, strangeness of the routine, difficulty maintaining a sense of identity, confronting relatives, laboratory tests, fear of the diagnosis, prognosis and treatments, and death of a loved one.

Anxiety can be alleviated by discussion. However, it is also contagious. When an acutely anxious patient comes to a unit, staff must be aware of the increase in anxiety in themselves as well as the other patients. Intervention includes:

1. Assessing the anxiety through physiologic, emotional and behavioral cues
2. Encouragement verbally to recognize and express feelings
3. Exploration of the thoughts and circumstances that led to the anxiety
4. Coping with what is now an identified specific threat

These steps are all part of crisis intervention and enable the person to cope adequately with

Signs & Symptoms of Anxiety

Physiological Changes

Increased heart rate, blood pressure and respiration; tremor; increased perspiration; cold, clammy hands and feet; need to urinate or defecate; loss of appetite; sleeplessness or disturbed sleep pattern; muscle tenseness; disturbances of the endocrine, autonomic nervous and circulatory systems.

Behavioral Characteristics

Facial expressions: raised forehead and eyebrows, wide open eyes with fixed stare, pupils dilated, blanched complexion, sweat, trembling lips and chin, licking of lips

Body stance: ready for fight or flight, trembling, rigid, guarded posture and gestures, holding on to self, restless hands and feet

Speech: trembling, halting, rapid, high or low pitched, repetitive rambling, disjointed, muteness, screaming, crying, swearing, excessively controlled, pressured laughter

Action: random, purposeless activity; excessive smoking, eating or drinking; use of drugs; mechanical quality to routine activity

Subjective Reactions

"I am: afraid, anxious, nervous, timid, apprehensive, terrified, panicked."

"I feel like: running, going to pieces, hiding, crying, exploding, cracking up, screaming, falling apart."

"I feel like I did when: I had terrible nightmares, had my appendix out, my parents were killed in an accident, I flunked my final."

"I've got: butterflies in my stomach, jelly legs, ice water in my veins, cold feet, hair standing on end, goose pimples."

Mental Changes

Difficulty thinking, concentrating, learning new things; distortion of perceptions; preoccupation with self, body processes and dreaded thoughts.

Figure 5

the precipitating causes of the anxiety.

Professionals can assist patients with anxiety before it reaches panic proportions. Be alert to subjective and objective indications of anxiety. The following may help diminish the terror:

1. Stay with the person and maintain a sense of calmness in voice tone, actions and words. Establish and maintain eye contact. Speak slowly and clearly, and use short, uncomplicated sentences.
2. If necessary, remove the person from the stressful situation to a quiet, undisturbed place.
3. Use touch if it seems appropriate and helpful holding the person's hand or putting an arm around the shoulder. This is particularly indicated if the patient is a child. Give something to drink water or something warm.
4. If the patient is disoriented, tell them repeatedly of their location and that they will be getting help. Use direct reassurance.
5. If the patient is hyperventilating, help regulate breathing.

- Verbally instruct the person to change breathing patterns; to slow down and take deeper breaths
 - Standing close to the person, breathe along with him and instruct him to follow your pace as you gradually decrease it.
 - Instruct the person, "That's enough. You're getting yourself more upset. Open your eyes and look at me."
6. If patients show by behavior that they are anxious but deny it verbally, give feedback to help integrate the physical and emotional. Examples include:
 - "You say you don't feel upset. You look frightened to me."
 - "You're very restless. I wonder if something isn't bothering you?"
 - "Most people are apprehensive the night before surgery. Maybe you're more worried than you think."

Nonsuicidal Self-Injurious (NSSI)

Behaviors

It is estimated that one to two million people in the U.S. deliberately and repeatedly cut, burn, bruise, mark, scratch or mutilate different parts of their own bodies.

Self Injurious Behavior (SIB) includes self-injury (SI) and self-poisoning and is defined as the intentional, direct injuring of body tissue most often done *without* suicidal intentions. The most common form of self-harm is skin-cutting but self-harm also covers a wide range of behaviors including, but not limited to, burning, scratching, banging or hitting body parts, interfering with wound healing, hair-pulling (trichotillomania) and the ingestion of toxic substances or objects. Although suicide is not the intention of self-harm, the relationship between self-harm and suicide is complex, as self-harming behavior may be potentially life-threatening. There is also an increased risk of suicide in individuals who self-harm to the extent that self-harm is found in 40-60% of suicides.

Example of "Scratching" behavior

Self-injury has long been recognized as being related to many mental disorders. It is listed in the DSM-IV-TR as a symptom of borderline personality disorder. However, patients with other diagnoses may also self-harm, including those with depression, anxiety disorders, sub-



stance abuse, eating disorders, post-traumatic stress disorder, schizophrenia, and several personality disorders. Symptoms associated with each of these diagnoses will vary as they relate to NSSI; common symptoms include somatic problems, emotional inexpressivity, distress resulting from trauma, impulsivity, and other self-destructive behaviors. Self-harm is also apparent in high-functioning individuals who have no underlying clinical diagnosis. The motivations for self-harm vary and it may be used to fulfill a number of different functions. These functions include self-harm being used as a coping mechanism that provides temporary relief of intense feelings such as anxiety, depression, stress, emotional numbness or a sense of failure or self-loathing and other mental traits including low self-esteem or perfectionism. Self-harm is often associated with a history of trauma and abuse, including emotional and sexual abuse. There are a number of different methods that can be used to treat self-harm and which concentrate on either treating the underlying causes or on treating the behavior itself. When self-harm is associated with depression, antidepressant drugs and treatments may be effective. Other approaches involve avoidance techniques, which focus on keeping the individual occupied with other activities, or replacing the act of self-harm with safer methods that do not lead to permanent damage.

Self-harm is most common in adolescence and young adulthood, usually first appearing between the ages of 12 and 24. Self-harm in childhood is relatively rare but the rate has been increasing since the 1980s.

Factors Associated With NSSI

Features typically associated with NSSI

can be divided into two broad categories: risk factors and motivations. Risk factors can be defined as those behaviors, symptoms, or diagnoses empirically associated with self-injury with regard to client actions as well as clinical judgment and perceptions. To properly assess and treat self-injurious behaviors, it is important to be aware that clinically significant risk factors may influence the severity and type of NSSI used by clients to cope with emotional distress.

Awareness of risk factors associated with a client's presenting issues may also provide clues to the purpose or motivations of the thoughts, feelings, and behaviors reported.

Risk Factors

In assessing NSSI it is important to be aware of common co-occurring behaviors and diagnoses so as to determine the possible purpose, severity, and treatment of the client's self-injurious behaviors.

Motivations

Self-injury is a purposeful behavior with a variety of motivations linked to a need for emotional regulation and control of present experience. For example, individuals may utilize NSSI to internally regulate emotions by using the behavior to stop, start, or limit feelings. They may also use NSSI to regulate their external environment (avoid something, get attention in order to fulfill needs, elicit a reaction for various purposes). Such behaviors may also serve a variety of functions that may change over time as individuals gain more experience with NSSI and as developmental needs change.

Though numerous organizations collect information on fatal and non-fatal self-directed violence or NSSI, there is considerable confusion about how to define the phenomenon. To address the current lack of uniform definitions, the Centers for Disease Control and Prevention (CDC) proposes the following definitions for self directed violence (SDV). Use of consistent terminology with standardized definitions will improve communication among researchers, clinicians, and others working in this important area.

It is recognized that categorizing SDV behavior into suicidal and non-suicidal categories can be difficult. This is due to several considerations, first that the behavior is multi-dimensional rather than unitary and second, that if information is collected from patients' self-reports, that the way the individual perceives his/her intent can change within a few hours. Nevertheless, due to the essential nature of this information to clinical and public health decision-making, it is critical to try to obtain it.

Risk-Rescue Rating

The risk-rescue rating scale was developed by the CDC as a guideline intended to serve as a starting point resource to help identify, and evaluate potential acts of harm. It can be utilized in a variety of settings where surveillance systems are either in-place or planned such as states, counties, or health clinics, emergency departments, hospitals, and institutions responsible for completing death certificates.

Definition: A term used in assessing a suicide act that indicates the degree to which the situation allowed for the possibility of intervention by others to prevent death.

Uses: This scale is a descriptive and quantitative method of assessing the lethality of SDV. There are five risk and five rescue factors that are defined, weighted and scored. Documentation of the circumstances surrounding an incident may assist in developing and evaluating preventive interventions.

Risk factors

(numbers = scoring points)

A. Risk mechanism:

1. Ingestion, cutting, stabbing
2. Drowning, asphyxiation, strangulation
3. Jumping, shooting

B. Risk impaired consciousness:

1. None in evidence
2. Confusion, semi-coma
3. Coma, deep coma

C. Risk lesions/toxicity:

1. Mild
2. Moderate
3. Severe

D. Risk reversibility:

1. Good, complete recovery expected
2. Fair, recovery expected with time
3. Poor, residual expected, if recovery

E. Risk treatment required:

1. First aid, outpatient Includes hospital emergency department
2. Hospital admission, routine in-patient care
3. Intensive care, special treatment

Total risk points _____

Risk score: **High risk:** 13-15 risk points;
High moderate: 11-12 risk points; **Moderate:** 9-10 risk points **Low moderate:** 7-8 risk points
Low risk: 5-6 risk points

Rescue factors

(numbers = scoring points)

A. Rescue location:

1. Familiar
2. Non-familiar, non remote
3. Remote

B. Rescue person initiating rescue:

1. Passerby
 2. Professional
 3. Key person (knows or is known by the subject)
- C. Rescue probability of discovery by any rescuer
1. Accidental discovery
 2. Uncertain discovery
 3. High, almost certain
- D. Rescue accessibility to rescue:
1. Does not ask for help
 2. Drops clues
 3. Asks for help
- E. Rescue delay until discovery:
1. > 4 hours
 2. > 1 hour but < 4 hours
 3. Immediate < 1 hour

Total rescue points _____

Rescue score*:

Least rescuable: 5-7 rescue points;

Low moderate: 8-9 rescue points;

Moderate: 10-11 rescue points;

High moderate: 12-13 rescue points

Most rescuable: 14-15 rescue points;

Self rescue automatically yields a rescue score of 5.

*The risk-rescue rating is determined by the formula risk score/risk score + rescue score. Scores range from 17 to 83. Low= 17-39, Moderate=40-59, High=60-83.

Impaired Functioning

Organic Brain Syndromes

These conditions of psychiatric emergencies have mixed psychological and physical components. They are the result of organic brain dysfunction which may present as confusion, memory disturbance, disorientation, altered levels of consciousness, motor difficulties such as poor balance or coordination, decreased impulse control, impaired judgment, and disturbances of physiological functioning which could lead to death. They may stem from alcohol or drug overdose, withdrawal, or toxic or idiosyncratic reactions; or they may be due to brain dysfunction from trauma, vascular infections, disturbances in metabolic functioning, or neoplasms of the central nervous system.

These and a wide variety of other medical conditions may present with similar symptom profiles. It is essential to have a thorough physical examination to rule out pneumonia, thyroid imbalance, diabetes and other general medical conditions that can affect brain function.

Alcohol Related Problems

Alcohol is the most abused drug in the

United States. Two of the most common medical problems found among persons who abuse alcohol are acute intoxication and withdrawal from continued use. These conditions are considered both psychiatric and medical emergencies because if left untreated, they could lead to the death or injury of the person or others due to the impaired behavior resulting from the alcohol. A high percentage of fatal accidents occur with a driver of a motor vehicle under the influence of alcohol. The risk of suicide and homicide increases significantly when alcohol is used.

Acute alcohol intoxication

An uncomplicated picture of an acutely intoxicated person includes alcohol odor, unsteady gait, slurred speech, and sometimes nausea, dizziness and vomiting. Giddiness and uninhibited speech and behavior are common. This person usually needs only to be protected, prevented from drinking more, escorted home or to an overnight facility to “*sleep it off*,” and observed in case of other complications.

More serious degrees of alcohol intoxication are suggested by central nervous system disturbances such as lack of coordination, dysequilibrium and impaired level of consciousness. Behavioral warning symptoms include excessive crying, laughing, hostility, aggressive behavior, depression and seizures. Medical evaluation and treatment are indicated.

In addition to the physical examination and monitoring of vital signs, the following questions help in the evaluation. The individual or other informants may be able to give the answers, which must always be regarded with some degree of skepticism.

1. How long has the person been drinking? What? How much? When was the last drink?
2. What is the drinking history over a period of time? Treatment?
3. Previous seizures?
4. Delirium tremens? Hallucinations?
5. Has the person taken Antabuse within the past five days?
6. Any other drugs recently or concomitantly with the alcohol?
7. What other physical conditions are known: ulcer, diabetes, heart condition?
8. Have any other injuries or accidents occurred during the drinking bout falling down, struck by another person or object?
9. Is there a history suggesting significant psychiatric disorder?

The very young, the elderly, and people with organic brain damage are unusually susceptible to alcohol. Alcohol taken with other drugs may produce disorientation to time, place and person. This may produce panic, which should be treated by a calm attitude and protection until

time helps to wear off the effects. A person who is combative or assaultive behavior while drunk may be suffering from other underlying conditions. They may have ingested drugs, especially the hallucinogens or stimulants. Gross disturbance, belligerence and confusion can result.

Many people use alcohol as self-medication. If it is being used to ward off a psychotic state, this becomes more apparent as the acute intoxication subsides. Alcohol lowers defenses and inhibitions and can result in rage reactions, suicidal behavior and agitation. Many interpersonal confrontations take place during drinking with assault and violence the outcome. Intimate partner and child abuse are often linked with alcohol intoxication.

Those who become significantly depressed while drinking need to be evaluated for the degree of intoxication and for suicide potential. Driving a motor vehicle while intoxicated may result in planned or unintentional accidents and death.

A seizure in an intoxicated person may indicate the beginning of delirium tremens or an underlying seizure disorder. Some people with temporal lobe epilepsy are unusually sensitive to alcohol. The seizure often takes the form of an unprovoked rage reaction that results in fights or assaults on property.

Crisis management of the patient with acute alcohol intoxication: The health team works together to help the patient during the acute medical situation. Their situation may be compounded by behavior that is uncooperative, aggressive, abusive or demanding. It is important during this period not to take this personally or to react with retaliation. As with any person with an acute brain syndrome, the person is “not in his right mind.” Action includes:

- Approach with a non-judgmental attitude of helpfulness, firmness and consistency
- Don’t be intimidated or antagonized by belligerence, hostility or uncooperativeness
- Speak calmly, firmly with reassurance
- Don’t laugh, ridicule or challenge
- Use safety precautions and enough staff with a potentially assaultive person
- Maintain observation and check vital signs frequently
- Keep a patent airway remove foreign objects from mouth and throat, such as mucous, blood, vomit, dentures
- Draw blood for alcohol and drug level determination if indicated
- Examine for injuries and other physical conditions
- Sedate the restless, noisy, belligerent
- Allow the person to “sleep it off” while under observation
- Hospitalize if indicated

- When the patient is conscious, offer fluids by mouth, especially fruit juices

After acute treatment, refer to longer-term treatment resources.

Alcohol withdrawal states: Those who are physically dependent on alcohol develop characteristic withdrawal symptoms within 12-24 hours after the blood alcohol begins to drop. The person may have stopped drinking or have lessened the usual amount of intake. Withdrawal symptoms range from relatively mild, though miserable, to reactions that are severe and life threatening. Delirium tremens (D.T.'s) is the most extreme withdrawal reaction, with a death rate that has been estimated from 5-30%.

Planned withdrawal from alcohol occurs when individuals gradually or abruptly decrease alcohol intake. They may or may not seek medical attention with the subsequent reactions. Planned withdrawal is also called detoxification. Many communities offer both medical and non-medical options to help with safe withdrawal.

Unplanned withdrawal occurs when an addicted person is suddenly cut off from alcohol through lack of funds, lack of supply or the decision to quit abruptly. Patients who are hospitalized for medical conditions or accidents may develop withdrawal symptoms while being treated. This may drastically affect their recovery.

Signs and symptoms of acute withdrawal may include coarse tremor of hands, tongue and eyelids that is more apparent with movement ("the shakes"); anorexia, nausea and vomiting; malaise and weakness; anxiety, sense of dread, uneasiness, jumpiness; autonomic hyperactivity tachycardia, sweating, increased blood pressure; depressed mood; irritability; insomnia or disturbed sleep with bad dreams; orthostatic hypotension and dizziness; and distortions in visual perceptions. These symptoms generally begin about 24 hours after the onset of abstinence and reach their peak in another 24 hours, although they may occur at any time within the next 15 days.

Moderate to severe withdrawal syndromes in otherwise healthy individuals can be handled on an outpatient basis through supportive measures that include bed rest, adequate fluids, adequate vitamins and nutrition, continued abstinence from alcohol and planned short-term use of minor tranquilizers (Valium, Vistaril, Klonopin, or Ativan)

The medical and psychiatric emergency aspects of withdrawal indicate hospitalization when:

1. The person wants to quit drinking but has a poor social support system. There is no one to help or there are active drinkers who would discourage the effort to quit.

2. There is a history of previous severe reaction to withdrawal and the person fears return of the D.T.'s or other frightening symptoms.
3. The person has already started to withdraw with symptoms of anxiety, seizures, extreme agitation, hallucinations or delusions.
4. The person is physically debilitated or has an alcohol related condition, such as cirrhosis, peripheral neuropathy or pneumonia. Wernicke's syndrome from thiamine deficiency requires immediate treatment to prevent permanent brain damage. (In many settings, it is routine to administer at least one dose of thiamine IV or IM to all alcoholic patients admitted to the hospital with altered mental status).

Alcohol withdrawal delirium: This condition is generally known as delirium tremens or the D.T.'s, an acute brain syndrome that is due to the cessation or reduction of alcohol consumption in an addicted person. It occurs most often in those with a history of heavy drinking over 3 to 5 years or longer. Delirium tremens is a medical emergency. It is a serious and dangerous reaction characterized by autonomic hyperactivity, seizures, agitated behavior with restlessness and overtalkativeness, coarse tremor, confusion and disorientation, delusions, and hallucinations - most often visual and tactile and often terrifying.

Symptoms often get worse at night. D.T.'s result from a disturbed metabolic state. They require adequate medical treatment and skilled health care. Successful recovery occurs within 3 to 10 days. After a period of prolonged sleep, the patient wakes refreshed, oriented and free of hallucinations. Alcohol-withdrawal delirium is often precipitated by abrupt alcohol withdrawal due to trauma or infection. The patient may be in the hospital for these reasons when the withdrawal syndrome begins. Chronic alcohol abusers are poor surgical risks because of lowered resistance and organ damage. They have a poor response to anesthesia. If excessive use of alcohol is known, the metabolic balance of the patient can be evaluated before surgery. Often, the impending D.T.'s are not recognized until postoperatively, which gravely affects recovery.

Professional action in treatment of delirium tremens: The problem of this disorder is the acute medical syndrome with subsequent behavioral manifestations, including agitation, combativeness, terror and disorientation.

The goals of treatment are to control the delirium, lessen agitation, restore fluid and electrolyte balance, and control seizures. A combined medical and nursing approach is necessary to control the terror of the delirium

and to restore health.

Actions

- Provide a well-lit room with few external stimuli.
- Reassure and reorient repeatedly.
- Limit the number of staff and visitors.
- Protect the patient from self-injury or acting on the delusions or hallucinations by getting out of bed, running through windows, etc.
- Speak in a calm, soothing voice.
- Use mechanical restraints only when absolutely necessary as the patient may fight against them.
- Administer prescribed medication to decrease agitation - Vistaril, or a benzodiazepine like Ativan or Klonopin Valium, paraldehyde and chloral hydrate may be prescribed, depending on the medical regimen. The goal is to provide rest and sleep, without inducing coma or stupor.
- Administer and record appropriate intravenous fluids with necessary vitamins and minerals added.
- Prevent or treat seizures by administering appropriate anticonvulsant medication.

When the patient has recovered from this acute emergency situation, many treatment teams make concerted efforts to arrange for longer-term treatment of the alcoholism and other problems. Some patients are motivated and able to follow through. Others return to treatment units in desperate condition again and again. This can lead to discouragement and cynicism among the staff if their feelings and the dynamics of this difficult condition are not reviewed and discussed.

Drug Abuse Related Problems

Drugs, other than alcohol, are also often the cause of psychiatric and medical emergencies. The most frequent drugs of abuse include:

1. The opiates: opium, morphine, heroin, codeine, Dilaudid, methadone, Demerol and Darvon.
2. Central nervous system depressants: the barbiturates and similarly acting drugs (other than alcohol), bromides, anesthetic gases and vapors, chloral hydrate, paraldehyde, methaqualone, Placidyl, meprobate, Equanil, Valium and Librium.
3. Central nervous system stimulants: cocaine, amphetamines and similarly acting substances, dextroamphetamines, methamphetamine (speed), Ritalin, Adderall, and many combinations of "diet pills."

The main problems arising from use of these substances are:

1. acute intoxication, which is also referred to as overdosing or poisoning, planned or unintentional; and
2. withdrawal symptoms on cessation of the drug-taking.

Acute intoxication or overdose: This is the result of sufficient intake of the drug to produce signs and symptoms of distress. An organic brain syndrome occurs, which ranges from moderate to severe. The acute organic brain syndrome may be characterized by disorientation; impairment of memory, judgment, and intellectual function; emotional lability; decreased coordination; dysarthria (slurred speech); fine tremor; and unsteadiness of balance and gait.

The first step when an overdose is suspected is to assess the seriousness of the potential emergency. A person may overdose on drugs as a suicide attempt, through mistakes in self-medication, through confusion because drug potency is increased or by a combination of drugs and alcohol. The range of seriousness is:

1. Life-threatening - immediate medical care is needed to prevent death
2. Serious - requires hospitalization for treatment and further evaluation
3. Potentially serious but not requiring hospitalization
4. Not immediately dangerous but requiring evaluation and possible referral

The serious complications of acute drug intoxication are coma, respiratory failure and circulatory collapse. Every case of drug overdose is regarded as potentially serious until medical attention is given. The patient's physical condition can shift rapidly to a more life-threatening level.

People found unconscious from drug overdose must be taken immediately to an E.D. Mouth-to-mouth resuscitation, oxygen and other life support systems may be necessary en route. Specific treatment for the drug overdose will vary with the substance and the physiological response. At this point, the emergency is a medical one.

Part of the evaluation is a drug history, either from the person, if possible, or those who know them. This includes specific drug taken, how much, whether and when physician prescribed; use of street drugs; medical history, especially of diabetes and seizure disorders; concomitant use of alcohol; known drug use; and previous overdoses and outcomes. During the medical history and evaluation it is important to establish if the patient has ever used intravenous drugs. In consideration of community health problems and the rapid spread of disease, many psychiatric emergency facilities are screening patients for AIDS virus and hepatitis C for the patient's safety well as for the safety of the health care workers and other patients.

After the person has been adequately treated medically, they should be evaluated in terms of emotional state. If the overdose was suicidal in intent, the person should be evaluated further for suicide risk. Referral to special drug facilities or mental health facilities is indicated but may or may not be acted upon.

Withdrawal from drugs: An abstinence or withdrawal syndrome occurs after cessation of taking a drug to which one has become addicted. The symptoms vary with the specific drug, as does the treatment. At this point the primary concern and treatment are medical.

Withdrawal treatment for barbiturates should take place within a hospital because of the difficulties in reducing the amount of medication needed, the likelihood of seizures and the period of transient psychosis which is marked by confusion, disorientation, agitation and hallucinations.

The term "bad trip" was coined several decades ago to describe a negative outcome of drug intake that still can occur today. Instead of the anticipated pleasant experience, there is a state of unpleasant-to-horrifying perceptions and feelings. Panic and confusion predominate. The person may develop a toxic psychosis with agitation, hallucinations, and delusions. This may be precipitated by one of the central nervous system stimulants or by a hallucinogen.

Amphetamines are in the former category and hallucinogens include mescaline, psilocybin, D-lysergic acid diethylamide (LSD), STP, phencyclidine (PCP), marijuana and hashish. PCP is a particularly powerful agent that can produce extreme agitation or a state resembling a catatonic reaction. Many times treatment within a hospital will be necessary because of the severity of the symptoms and the unpredictability of the person's actions. Anticholinergic drugs include the active agents of atropine and scopolamine. These are easily obtained as nonprescription drugs, often for sleep problems.

These drugs are taken for the experiences they produce and are marked by perceptual changes. Body, time and reality distortions become a problem if the person loses the perspective that these are drug-induced and develops a panic reaction. Psychosis may result, and this is when the experience becomes a psychiatric emergency. Symptoms include increased paranoid ideation which results in terror and potential aggression; fear of going crazy; and impaired judgment, resulting in injuries from such behaviors as running into traffic or believing one can fly out the window.

The need for treatment of these reactions depends on the severity. Many of them are time-related. As the drug wears off, so do the disturbing experiences. If medication is needed, it will probably be Valium by mouth or in-

jection. Use of barbiturates and phenothiazines (Thorazine) is contraindicated. This is true also if the drug reaction is from an anticholinergic agent. Acute reactions may be treated by quiet, supportive talking with the panicked person. Drug-experienced friends and counselors can be helpful during this time to "talk the person down." Helpful steps include the following.

- Find a quiet place where external stimuli are minimal. If in the E.R. find a place away from the mainstream.
- Do not leave the person in isolation or in a potentially unsafe place.
- Establish eye contact, and use a calm, gentle attitude and voice.
- Remind the patient that the experiences are drug-induced and will wear off. Repeat and reassure over and over and over.
- Reorient to time, place and person.
- Stay in the immediate "now."
- Instruct the person to keep eyes open and focus on external reality an object or picture.
- Keep friends and other drug-experienced people around.
- Gently hold or touch the person if this doesn't seem threatening.
- Encourage the person to talk about the immediate sensations and experiences to decrease the sense of alienation.
- Explain reasons for medication, if needed, especially by injection.

Problems and Goals

The initial and most pressing problems associated with substance abuse are the physical results of the organic brain syndrome. The physical problems include intoxication, withdrawal and undesired responses to the drugs, and the basic cause(s) of the brain pathophysiology whatever that cause may be. Physical complications may include respiratory depression, cardiovascular collapse, shock, temperature dyscontrol, renal problems, and seizures. The short-term treatment goals are:

1. Restore physiological equilibrium by careful detoxification and withdrawal; prevent further medical complication; treat current conditions
2. Restore impulse control
3. Prevent suicide or violent behavior
4. Establish communication
5. Increase reality orientation
6. Develop plans for long-term treatment
7. Establish working relationships with family and significant others
8. Dehydration to fluid overload
9. Changed electrolyte balances

Emergency medical treatment can save lives, but does not solve the problem of drug and alcohol abuse and addiction. To help prevent future emergencies and possible death by substance abuse, the following long-term goals

are identified:

1. Recognition by the person of the significance and dangers of continued substance abuse
2. Improved health abstinence or decreased use
3. Increased social participation and meaningful relations with others
4. Discontinuance of criminal behavior
5. Improvement of family relationships
6. Increased use of job potential and skills
7. Alternative ways of coping with stress and needs

Cerebral Dysfunction From Other Causes

As noted above, the presenting symptoms of brain trauma, bacterial and viral infections, metabolic problems, brain tumors, epilepsy, and a host of other medical conditions can be very similar to those resulting from alcohol and drug use. Consequently, it is imperative that anyone presenting with cognitive or behavioral disturbances be given a thorough examination as soon as possible, which includes a detailed history and lab tests. These patients may exhibit behavior that is disruptive, combative, uncooperative and disoriented. General nursing actions can be used to handle the immediate situation and assist in the differential diagnosis.

Often family members are highly distressed about the changes in their loved one, and they need support and realistic reassurance. They may also be helpful in supplying needed information and in staying with and comforting the patient.

Traumatic Brain Injury

Traumatic brain injury is an “*organic*” psychiatric disorder, in that the physiological changes that cause it are clear and relatively well understood. It is frequently seen in medical offices, the E.R. and clinics, and is often misdiagnosed. When dealing with a psychiatric emergency, the professional must be knowledgeable and skillful in identification and evaluation of this group. Virtually any trauma to the head can potentially result in a traumatic brain injury and affect the function of the brain.

How many times have you taken care of patients who come to an E.R. after having been in an auto accident? The patient is examined and there is no visible sign or symptom of trauma. Although the patient may complain of pain, dizziness or confusion, everything appears normal on physical examination and the patient is sent home. Cognitive or behavioral changes, especially if mild, are commonly attributed to the psychological effects of the accident, and the staff, family and friends may even suspect

that the patient is faking it to get attention or for lawsuit purposes.

Days or even weeks later the patient has experienced altered sleep patterns and starts to develop behaviors that could be considered disturbed: confusion, irritability, and poor impulse control. He may even be hostile and aggressive, posing a danger to self and to others.

The initial injury may not be recalled or reported, especially if it was dismissed as inconsequential by medical personnel. Is this a bipolar disorder? Is the patient experiencing a schizophrenic episode? What does the psychiatrist say? What does the neurologist say? All too often the patient is diagnosed with a psychiatric illness, and inappropriate treatments, if any, are offered.

Traumatic brain injury and related syndromes are complicated conditions that are considered a gray area of psychiatry, medicine, neurology, nursing and law practice. It is the unfortunate patient who is incorrectly diagnosed. A vicious cycle develops. If the patient does not respond to the psychiatric medications, the physician or psychiatrist may increase the dosages. As the need for increased medication continues, the patient is looked upon as severely psychiatrically disabled; when, in fact, the true etiology is neurological trauma and requires an entirely different approach to patient care. Just imagine the increasing frustration of the patient. All of a sudden, he has become a mentally disabled individual.

In many cases of head trauma, there are no concrete lab and/or x-ray findings. Even structural and space occupying lesions such as subdural or epidural hematomas and brain contusions may not show up immediately after the injury, but develop slowly over time. The more common injuries, especially those resulting from motor vehicle accidents, involve damage to the axons of individual nerve cells as the brain twists and turns on its axis and bounces against the surface of the skull from the forces of the impact. These may be accompanied by tiny punctate hemorrhages of the surrounding capillaries which are similarly stretched and torn, but otherwise remain invisible to neuroimaging techniques. Swelling may also add to the problem. Recovery of cognitive functions may take months to years, and is based on healing of injured brain tissue as well as compensation through use of alternative neural pathways.

Appropriate rehabilitation and consultation can be of significant benefit to the patient throughout this recovery process. Misdiagnosis may deprive the patient of needed treatment, while prescription of unneeded psychotropic medications may complicate the underlying neurological problem. Head trauma

patients who present a psychiatric emergency need to be treated for the immediate behaviors they exhibit. After the psychiatric emergency is dealt with, an in-depth and on-going evaluation must take place. The professional can help to discover the etiology of the present problem by making an accurate and comprehensive on-going nursing assessment, with careful evaluation of the effectiveness of the interventions made.

Assisting Survivors of Disaster

The task of helping survivors of a disaster is a difficult one, and often any action taken seems far too little given the magnitude of the disaster and its consequences. Nevertheless, nurses and other health professionals can make significant contributions to the recovery of survivors, whether they are assigned to disaster teams as part of their professional responsibilities, or simply happen upon a disaster that has occurred in their community.

Helping interventions are best understood in the context of when, where, and with whom the interventions take place. For example, emergency on-site interventions with ambulatory survivors will have their primary focus on providing a safe and secure base from which survivors can regain a degree of equilibrium. Weeks following the disaster, interventions provided in community settings are likely to be educational and exploratory, with the objective of increasing awareness of the impact of the event and ways to facilitate coping. Six months later, interventions are most likely to be provided in clinical settings and may include formal assessment and treatment protocols for persistent symptoms related to post-traumatic stress.

At the site of the disaster the first mental health services are usually provided on an improvised basis by voluntary bystanders who may or may not have professional training or skills. When mental health professionals are sent to a disaster by an agency, they rarely are the first responders. Therefore, even if a mental health professional enters the disaster site only a few minutes or hours after impact, their first responsibility is to identify these natural helpers, join with them in providing crisis care, and rapidly but sensitively relieve them of these responsibilities. Helping bystander crisis responders to get to a safe and appropriate place outside the impact area is a delicate but important early step in caring for disaster survivors.

A critical first step in disaster intervention is a pragmatic one: to protect survivors from further harm and from further exposure to trauma. The less traumatic stimuli people see,

Basic Principles of Emergency Care in Disaster Situations

1. Provide for basic survival needs and comfort (e.g., liquids, food, shelter, clothing, heat/cooling).
2. Help survivors achieve restful and restorative sleep.
3. Preserve an interpersonal safety zone protecting basic personal space (e.g., privacy, quiet, personal effects).
4. Provide nonintrusive ordinary social contact (e.g., a sounding board, judicious uses of humor, small talk about current events, silent companionship).
5. Address immediate physical health problems or exacerbations of prior illnesses.
6. Assist in locating and verifying the personal safety of separated loved ones/friends.
7. Reconnect survivors with loved ones, friends, trusted other persons (e.g., AA sponsors, work mentors).
8. Help survivors take practical steps to resume ordinary day-to-day life (e.g., daily routines or rituals).
9. Help survivors take practical steps to resolve pressing immediate problems caused by the disaster (e.g., loss of a functional vehicle, inability to get relief vouchers).
10. Facilitate resumption of normal family, community, school, and work roles.
11. Provide opportunities for grieving for losses.
12. Help survivors reduce problematic tension, anxiety or despondency to manageable levels.
13. Support survivors' own support systems through consultation and training about common stress reactions and stress management techniques.

During the early-post impact phase, 24 to 48 hours after the onset of the disaster event, the pragmatic activities described above are supplemented by the addition of general psychoeducational interventions. Nurses may be called upon to provide user-friendly educational materials and presentations, and should choose materials with plain language, preferably not above the 5th grade reading level; they may also participate in debriefings and stress management educational programs. Health professionals can help survivors cope with normal stress reactions by providing unobtrusive practical and emotional support designed to reduce helplessness and enhance recovery. They will also continue to identify individuals and families at risk for longer-term psychological problems.

Much of the material in this section was provided by the National Center for Post-Traumatic Stress Disorder.

For more information visit their Website at www.ncptsd.org

Figure 6

hear, smell, taste, and feel, the better off they will be. The survivors need to feel a sense of safety from further trauma, and this will include protection from onlookers and the media. Survivors are likely to be in shock and may be experiencing some degree of dissociation. Kind, gentle, firm direction away from the site of destruction and from the severely injured will protect them from further danger and trauma.

The survivors at the scene will experience a sense of unreality and lack of connection to the world that was familiar to them. Supportive, compassionate, and nonjudgmental verbal or non-verbal exchanges between the survivors and crisis workers may help begin the reconnection process. No matter how brief and inconsequential the contact might seem, the availability of such opportunities for relationship are important elements of the recovery or adjustment process. Interactions with survivors should focus on provision of ac-

curate information and appropriate resources, including where they will be able to receive additional support.

The majority of disaster survivors experience normal stress reactions. However, some may require immediate crisis intervention to help manage intense feelings of panic or grief. Signs of panic are trembling, agitation, rambling speech, and erratic behavior. Signs of intense grief may include loud wailing, rage, or catatonia. In such cases, the most important steps are to establish a degree of therapeutic rapport, ensure the survivor's safety, acknowledge and validate the survivor's experience, and offer empathy and support. When possible, stay with the survivor in acute distress or find someone else to remain with him/her until the feelings subside. Medication, if available, may be both appropriate and necessary.

Those survivors who require immediate crisis intervention to help manage intense feelings of panic or grief can be helped significantly by

a supportive presence.

Some basic principles of emergency care in a disaster situation are given in *Figure 6*.

Defusing

Defusing is a term that has been used to describe the process of helping through the use of brief conversation. Because post-disaster settings where survivors congregate are often chaotic, the majority of defusings are short. A defusing may take place in passing, in a line for services, while eating, etc. Broadly speaking, defusings are designed to give survivors an opportunity to receive support, reassurance, and information. In addition, defusing provides the clinician with an opportunity to assess and refer individuals who may benefit from more in depth social or mental health service. More specifically, defusing may help the survivor shift from survival mode to focusing on practical steps to achieve restabilization. It may

also help survivors to better understand the many thoughts and feelings associated with their experience.

In the course of most defusings, survivors are able to disclose and reflect upon recollections, thoughts, and feelings with some distress, but with a gradually increasing sense of understanding and relief. However, for a small number of individuals, the recollection or disclosure of disaster experiences may precipitate intense emotional distress, cognitive confusion, and/or behavioral disinhibition (e.g., angry outbursts, suicidal ideation, panic attacks). These adverse reactions are not necessarily caused by defusing. Their occurrence may be imminent even if they are, in part, reactions to the defusing experience. Defusing thus offers a potentially important opportunity to screen for at-risk individuals who might otherwise have undetected adverse stress reactions or deteriorating pre-existing mental health problems. Clinical management of these serious incidents should follow the steps outlined earlier in the course.

Death Notification

Among the most difficult tasks a nurse or other health professional may face is telling family and friends of a patient that their loved one has died. Here are some factors to keep in mind when you are called upon for this task.

1. Break the news in person if at all possible. If there is absolutely no alternative to a phone call, arrange for a professional, neighbor, or a friend to be with the next of kin when the call comes.
2. Sit down, ask them to sit down, and be sure you are speaking with the nearest next of kin. Never notify a child, and never use a child as a translator.
3. Use the victim's name. "Are you the parents of _____?"
4. Inform simply and directly with warmth and compassion. Say something like: "I'm afraid I have some very bad news for you." Pause a moment to allow them to prepare. "_____ has been involved in _____ and (s)he has died." Pause again. "I am so sorry." Adding your condolence is very important because it expresses feelings rather than facts, and invites them to express their own.
5. Continue to use the words dead or died during the conversation, and try to avoid expressions like expired, passed away, or we've lost _____. Continue to use the victim's name, not body or the deceased.
6. Do not blame the victim in any way for what happened, even though they may have been fully or partially at fault.

7. Remember that intense reactions are normal. Expect fight, flight, freezing, or other forms of regression. If someone goes into shock have them lie down, elevate their feet, keep them warm, monitor breathing and pulse, and call for medical assistance.
8. Join the survivors in their grief without being overwhelmed by it. Do not use clichés. Helpful remarks are simple, direct, validate, normalize, assure, empower, express concern. Examples: "I am so sorry." "It's harder than people think." "Most people who have gone through this react similarly to what you are experiencing." "If I were in your situation, I'd feel very _____ too."
9. Answer all questions honestly, and have the facts before you begin. Do not give more detail than is asked for, but be honest in your answers.
10. Ask the family if they are ready to receive (name's) clothing, jewelry, etc. Honor their wishes. Possessions should be presented neatly in a box and not in a trash bag. Clothing should be dried thoroughly to eliminate bad odor. When the family receives the items, explain what the box contains and the condition of the items so they will know what to expect when they decide to open it.
11. If there is anything positive to say about the last moments, say it now. Give assurances such as; "most people who are severely injured do not remember the direct assault and do not feel pain for some time." Do not say, they did not know what hit them unless you are absolutely sure.
12. Let the survivor(s) know you care. The most beloved professionals are those who are willing to share the pain of the loss. Attend the funeral if possible. This will mean a great deal to the family and reinforces a positive image of your profession.
13. Be ready to access immediate medical or mental health care should family members experience a crisis reaction that is beyond your response capability.
14. Debrief your own personal reactions with caring and qualified professionals on a frequent and regular basis, don't try to carry the emotional pain all by yourself, and don't let your emotions and the stress you naturally experience in empathizing with the bereaved build into a problem for you.

Adapted from: Lord, J. Trauma death and death notification (pp. 44-53). Dallas, TX: Mothers Against Drunk Driving.

Medications

In many psychiatric emergencies, use of psychotropic medication plays an important part in de-escalating the immediate situation. It is prescribed most often for the target symptoms of acute agitation, excitement, moderate-to-severe anxiety, hostility and ideas of persecution.

The severity of the symptoms is evaluated by the degree of psychomotor disturbance, whether extreme agitation or extreme retardation; presence of extreme conceptual disorganization or psychosis; marked symptoms of anxiety; or history of protracted sleep disturbances. Often in an acutely disturbed person, these symptoms are all present. The decision to use medication depends on both the severity of the symptoms and the person's response to the interview situation.

Medication may be necessary before the situation can be assessed in depth if the person is too agitated to talk or respond. In that case, in order to rule out organic factors, the person should have a brief medical examination during which vital signs are taken and information about medical history and drug ingestion is ascertained. In the very rare case, this examination is not possible and immediate medication is required. This is generally given by IM, IV or by rapid sedation.

With a less drastic situation, medication is postponed while assessment takes place. If the person is able to respond to the interviewer and generally calms down, only oral medication may be needed if any at all. For some people, the very act of receiving a pill or shot reassures them that something is being done, and impulse control may be strengthened as in placebo response.

Medication may be part of the time-limited period of crisis intervention or part of the long-term treatment. It may be administered on an inpatient or outpatient basis. For outpatient treatment, the patient must be able to cooperate with the regimen as the dosage is adjusted. Depressed people on antidepressants must be in good enough control so that they will not act on suicidal impulses before the medication becomes effective. It typically takes up to two weeks or more for the desired antidepressant effects to occur, although the patient may notice some earlier improvement in depression-related cognitive difficulties such as poor concentration. To assure safety and compliance, it is best for the individual to keep close contact, with the clinic to review the prescription and recommended dosage.

Acute treatment of agitated patients has traditionally consisted of a combination of typical antipsychotics and benzodiazepines, usually administered IM. An 8 to 10 mg dose

of haloperidol (Haldol) is generally effective in reducing acute symptoms, but higher doses only result in increased adverse effects. Benzodiazepines are effective in controlling acute agitation also, and are better tolerated than the typical antipsychotics. IM lorazepam (Ativan) acts as quickly and as effectively as IM haloperidol in most instances, and oral lorazepam acts much more quickly than oral haloperidol. Recent studies have shown that lorazepam with risperidone (Risperdal) is generally equivalent to lorazepam with IM haloperidol in controlling acute agitation; given the greater tolerability of risperidone, this combination may become the treatment of choice.

A number of medications have been shown effective in control and treatment of aggression in a variety of psychiatric conditions. Clozapine (Clozaril) has been demonstrated to decrease substantially the need for restraints and seclusion of aggressive psychotic patients in hospital settings; however, potentially serious side effects include seizures and agranulocytosis. Risperidone has been demonstrated to be more effective in reducing hostility among schizophrenic patients than haloperidol, and it is also effective in reducing aggression in patients with dementia and mental retardation. Olanzapine (Zyprexa) and quetiapine (Seroquel) have alleviated hostility and aggression in psychotic patients as well. Mood stabilizers have also been tried. Lithium has been reported to reduce anger and aggression, but has also been reported to increase aggression. Divalproex (Depakote) has been shown to be a safer alternative to lithium among most patient groups, and has been used to control aggression successfully in patients with neurological illness across a wide age range.

Impulsive behaviors are seen in many psychiatric emergencies. Impulsivity is a tendency to participate in spur of the moment behavior that has a high probability of negative outcome. It is associated with higher rates of aggression, suicide, and substance abuse as well as being a component of many psychiatric disorders. Many classes of medications have been used to treat impulsivity. Among these are the antidepressants, typical and atypical antipsychotics, beta blockers, lithium, and anticonvulsants.

Benzodiazepines are generally contraindicated, as they can have a disinhibitory effect similar to that of alcohol, which may actually increase impulsivity. Also, they present a potential for addiction in a population that may already be at risk for substance abuse. Among the antidepressants, MAO inhibitors are infrequently used due to their problematic safety profile. The tricyclic antidepressants may increase irritability due to their stimulation of the norepinephrine system. Selective serotonin reuptake inhibitors have been used

with some success.

Among the beta blockers, propranolol (Inderal) has been used to control impulsivity and agitation, but use must be monitored carefully for potentially dangerous effects on cardiovascular function. Both carbamazepine (Tegretol) and divalproex have been used effectively, with divalproex often chosen due to its relatively benign side effect profile.

For dementia patients, research suggests that antidepressants can be an effective treatment for behavioral and related psychological symptoms. Specifically, studies have shown that the antidepressant drugs sertraline and citalopram may help reduce agitation. Antidepressants may also treat apathy (when a person shows a general lack of interest and motivation), which is commonly seen in people with Alzheimer's disease. In addition to this, some psychotic symptoms may respond to the use of antidepressants. https://www.alzheimers.org.uk/site/scripts/documents_info.php?3FdocumentID=110

Many psychiatric drugs interact with other drugs to increase or decrease their action. The professional should interview the patient and/or family and establish data regarding the current medications the patient is taking, both prescription and non-prescription. Of particular concern are interactions with anti-diabetic medications, cardiac and respiratory medications, and anti-seizure medications.

Some psychiatric drugs can cause life-threatening side effects. Perhaps the most serious of these is neuroleptic malignant syndrome, a rare but potentially fatal idiosyncratic reaction that occurs in about 0.2% of patients on antipsychotic drugs. The syndrome can develop at any time, but onset is usually within the first thirty days of therapy. It is characterized by very high fever, change in mental status, labile blood pressure, and increased pulse rate. Mortality rates range from 5 to 20%. Treatment includes discontinuation of the antipsychotic medication immediately; and provision of supportive therapy including IV hydration and cooling blankets, and monitoring of ventilation.

More common side effects include extrapyramidal manifestations such as apathy, akathisia, postural hypotension, muscle rigidity, shuffling gait, tremors, gesticulatory movements of the face and mouth, drooling, difficulty swallowing, and swollen tongue. These side effects need to be monitored carefully, not only because they influence many patients to quit taking the medication, but also because a number of them can continue after cessation of the medication.

Evaluate nutrition and fluid balance of the patient, even in psychiatric emergency situations. Many patients who present themselves in a psychiatric emergency have a long history

of psychiatric treatment and may be on psychiatric drugs at the time of their admission. Effectiveness of the psychiatric emergency drug administered may depend on these factors, as well as the patient's overall physical condition.

It is important to know if the patient is taking medication at the time of admission for a psychiatric emergency and to evaluate lab values, since many psychiatric drugs have a narrow range of therapeutic levels (Lithium, Dilantin, etc.). Some patients may come to the psychiatric emergency room exhibiting behavior that is the direct result of over or under medication.

It is important to become familiar with each of the drugs currently available to treat psychiatric emergencies. However, there has been an explosion in recent years in the number of new drugs available as well as new uses for older medications. If you are not familiar with a particular drug or indications for its use, refer to the Physician's Desk Reference, telephone the hospital pharmacy, or ask a physician or nurse who is immediately available. The information on psychiatric pharmacology is too extensive to be covered in detail here. To become a safe practitioner in psychiatric emergency care, the professional must develop a comprehensive understanding of psychiatric pharmacology. Many continuing education classes, lectures, seminars and medical manuals are available to assist.

Environmental Interventions

There have been many changes over the last several years in the facilities and resources available for treatment of patients with acute psychiatric problems. As mentioned, emergency rooms and designated crisis clinics have become both screening and treatment centers. General hospitals have developed psychiatric units or integrated admissions to medical units. The trend in most inpatient psychiatric units is short-term treatment based on the crisis intervention model.

Communities have developed a variety of other resources, which include residential programs as alternatives to hospitalization, halfway houses, day-or-night treatment centers, non-medical detoxification programs for alcohol and drugs, and crisis intervention centers.

If a patient in the general hospital develops a psychiatric emergency, there may be a service there that can help. In some hospitals, psychiatric clinical nurse specialists are available to help staff with difficult patients. This is often preferable to transferring the patient to a psychiatric unit that is generally ill equipped to deal with acute physical problems in medical

and surgical patients.

Another approach to a crisis problem could be to remove a family member from an explosive situation and have them spend the night with friends or in a hotel. Getting a person physically out of a problem situation may help to de-escalate matters. Follow-up work is generally needed. Some cities offer residential refuge to wives and children of physically abusing men. Rape services also offer temporary housing as well as all other aspects of crisis intervention and support.

Despite the growing number of alternatives, however, the best interests of the patient in a psychiatric emergency may require hospitalization. Hospitalization is an important decision that should never be taken lightly. The fact of hospitalization will significantly affect the person in the future in terms of jobs, government opportunities, and later treatment by medical and psychiatric personnel. Hospitalization may be voluntary or involuntary. The laws and criteria for involuntarily holding a person for psychiatric reasons vary in different states. They generally include some aspects of danger to self and others; being gravely disabled (unable to care for basic needs); and being acutely psychotic but not dangerous.

Criteria for admission to a psychiatric inpatient unit can include one or more of the following:

1. The person is a danger to self or others, as identified by a suicide or homicide/violence evaluation.
2. The person's disturbed behavior the patient is unable (bizarre, inappropriate, agitated, regressed, depressed or aggressive) has become intolerable to those around him (or to care for his basic needs).
3. In addition to disturbed behavior, the patient has physical problems, such as withdrawal from alcohol or drugs, which must be treated.
4. Medication or other treatments cannot be safely administered on an outpatient basis or the person is unreliable or uncooperative in following necessary regimens.
5. There are no other resources; family, friends, community agencies or the person needs to be temporarily removed from a highly disturbing interpersonal setting.

Factors which are against psychiatric hospitalization include the determination that:

1. The person is already in treatment and needs to work out problems and plans with the therapist or agency.
2. Hospitalization is sought primarily to evade responsibilities.
3. The family or person is requesting

admission, but the circumstances do not warrant inpatient treatment.

4. Other facilities are more appropriate; medical unit, nursing home, day program, specialized drug or alcohol programs.
5. The person only needs housing, not psychiatric treatment.
6. Hospitalization would increase problems for the person and family through disruption in roles, financial burden, job change, time adjustments, or childcare.
7. The social stigma and consequences may outweigh the benefits.

Whether or not the person is hospitalized, the ongoing process of crisis intervention is used to handle the psychiatric emergency.

Regardless of the setting, administration of medication to a highly agitated, uncooperative or aggressive person requires that safety precautions be taken. There is a reason for having a special "holding" room in emergency facilities and treatment centers where the patient can be adequately medicated and supervised; this may extend over a period of hours. The room is a physically safe place where potential for injury to self and others is lessened. Even if the patient will be hospitalized, arrangements take time. In the meantime, the patient needs protection and relief from overwhelming anxiety. If it becomes necessary to restrain the patient, several people will be required from among the staff and security forces on the scene. Five people, one for each extremity and one to give the medication, is the usual rule. The team must be prepared to hold the patient until the medication takes effect or the person becomes calm. In extreme situations, mechanical restraints may be used.

Restraint Guidelines for Psychiatric Emergencies

There are specific laws in most states regarding the use of mechanical and chemical restraints to control a patient. Nursing and medical policies, documentation guidelines, and forms used in hospitals and psychiatric facilities are developed to reflect the laws of each state. In general, a physician's order is required, describing the specific type of restraint ordered. The time must be entered on the order sheet, and the order must be renewed every 24 hours.

If a patient verbally threatens to strike other patients, staff or visitors, the staff should chart the patient's behavior and verbal threats in the written documentation. The patient must be structured by staff (cued and redirected to more appropriate behavior) and medicated without results before they can legally be placed in

restraints. How the patient was "structured" must be clearly documented. For example, "Mr. Smith, it is important that you try to control yourself. Hitting people is not a good way to express your anger. It is better to tell someone that you feel angry and that you want some help." It is a good idea to assign a staff member to talk the patient through their feelings about hostility and anger. The professional continues to observe the patient's behavior and document relevant information. Remember: It is not legal to restrain a patient without following and documenting the above steps.

If a patient has actually hit or struck another person, the patient is legally considered a danger to self or others, and a restraint may be applied at that time. A physician's order is required, as is appropriate documentation. The documentation must include a description of the patient's behavior, any p.r.n. medication given, doctor notification, restraints applied, type of restraints, circulation status of extremities, and patient's vital signs. Other data should be recorded, including circulation checks at least every two hours, fluids and food given, and care for personal hygiene. Specific considerations in the proper use of restraints are summarized in **Appendix A**.

Freeing nursing home residents from unnecessary restraints was enacted into legislation with the 1987 Nursing Home Reform Act passed by Congress. This legislation declared that every nursing home must protect and promote the rights of each resident including "the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms." <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter09-11.pdf>

Before the Nursing Home Reform Act was adopted it widely accepted to use restraints as an acceptable option to manage the behavior of residents who wandered, were agitated or who, in the view of the staff, needed restraints to prevent injury to themselves. However, the standard use of restraints is not supported by research and may result, instead, in significant medical complications. As a result of such legislation, restraint use has decreased significantly and many long-term care facilities have declared themselves "restraint free" environments.

The goal of all care facilities to minimize the use of physical restraints as much as possible consistent with patient safety. Studies in gerontological nursing have determined that any effort to change restraint practices must include the nursing staff as a main target for change. The studies concluded that, following education and implementation of a restraint-

reduction program, the majority of nursing staff participants found restraint use to be less critical in caring for the elderly. The changes were most notable immediately following in-service education, which were most accepted by nurses with more years of experience. Ongoing education was recommended to decrease feelings of frustration and stress, and to provide staff with workable alternatives to the use of restraints.

Psychiatric professionals who have much experience caring for aggressive and assaultive patients offer some tips for coping with violent behavior. They suggest planning and practicing the specific intervention before approaching the patient whenever possible. Use six staff members to apply restraints: one for each extremity, one for the body and one for the head. This will minimize possible injury to staff. If the patient starts to bite, put a towel over his face. Whenever the patient is to be transported, be sure he is placed in the prone position to prevent grabbing of staff. Always have one staff member coordinate the transport to avoid confusion.

General Guidelines in Crisis Situations

The specific intervention in a psychiatric emergency situation depends on what the emergency is, where it occurs and the actions of other members of the health team. Specific action for patients with suicidal, violent and anxious behaviors has been described in previous sections. General guidelines are:

1. Professionals participate in the identification of a psychiatric emergency through observation and anticipation of stressors. They contribute to the immediate treatment plan and carry out activities such as preparing and administering medication. They report and record changes in behavior, especially decompensation and improvement.
2. Professionals are available to patients as interested, caring advocates who stay with them, provide structure and reality testing, help meet immediate physical and social needs, and talk with them about the current crisis.
3. Professionals provide a safe environment where the patient is protected from loss of impulse control toward self or others. Enough staff members are used to establish safety and security.
4. Professional team members maintain a treatment program where patients can increase impulse control, decrease anxiety, raise self-esteem and reestablish hope. Patients can learn to express anger and other feelings in constructive ways,

and they gradually resume responsibility for themselves.

5. Be aware of the many feelings that are aroused by psychiatric emergencies. Be conscious of the effects on staff, other patients and significant others. Discuss and learn from each situation to be more effective in the future.
6. Recognize the importance of teamwork in crisis situations. Establish rapport with families and significant others and include them in treatment and discharge planning. The staff should be familiar with community resources in order to make appropriate referrals.
7. Professionals need to know the laws and hospital policies in regard to involuntary hospitalization, use of seclusion and restraints, and restriction of patients' rights. They must be aware of the malpractice implications of healthcare action. If court action is initiated as the result of a psychiatric emergency, the staff should consult with supervisors and legal counsel for the hospital before making any responses to inquiries, requests or subpoenas.
8. Professionals recognize the importance of teamwork, especially during psychiatric emergencies. They support each other during the crisis and afterward. They apply the principles of crisis intervention to their on-going work.

Resources

American Red Cross

www.arc.org

American Foundation for Suicide Prevention

www.afsp.org/index-1.htm

American Association of Suicidality

www.suicidology.org

National Suicide Prevention Lifeline

1-800-273-TALK (1-800-273-8255)

www.suicidepreventionlifeline.org

References and Suggested Readings

Auhadar D, Aam M. Effectiveness of psychoeducation in reducing internalized stigmatization in patients with

bipolar disorder. *Arch Psychiatr Nurs*, Feb 2014, 28(1) p62-6

Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision [DSM-IV-TR]; American Psychiatric Association [APA], 2000). Accessed October 4, 2016

Crosby AE, Ortega L, Melanson C. Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2011

Curtin SC, Warner M, Hedegaard H. Increase in suicide in the United States, 1999-2014. NCHS data brief, no 241. Hyattsville, MD: National Center for Health Statistics. 2016.

Drugs to treat bipolar disorders. *J Psychosoc Nurs Ment Health Serv*, Jun 2014, 52(6) p21-2

Farchaus Stein K. Self-management in persons with major mental disorders: a common but complex treatment goal. *J Am Psychiatr Nurses Assoc*, Nov-Dec 2014, 20(6) p367-8

John RL, Antai-Otong D. Contemporary Treatment Approaches to Major Depression and Bipolar Disorders [In Process] *Nurs Clin North Am*, Jun 2016, 51(2) p335-51

Johnson K, McGuinness TM. Disruptive mood dysregulation disorder: a new diagnosis in the DSM-5. *J Psychosoc Nurs Ment Health Serv*, Feb 2014, 52(2) p17-20

Kurdal E, Tanriverdi D, Savas HA. The effect of psychoeducation on the functioning level of patients with bipolar disorder. *West J Nurs Res*, Mar 2014, 36(3) p312-28

McKenzie K, Chang YP. The effect of nurse-led motivational interviewing on medication adherence in patients with bipolar disorder. *Perspect Psychiatr Care*, Jan 2015, 51(1) p36-44

Ross SM. Psychophytomedicine: an overview of clinical efficacy and phytopharmacology for treatment of depression, anxiety and insomnia. *Holist Nurs Pract*, Jul-Aug 2014, 28(4) p275-80

Sawyer MC, Nunez DE. Cognitive-behavioral therapy for anxious children: from evidence to practice. *Worldviews Evid Based Nurs*, Feb 2014, 11(1) p65-71

Scrandis DA. Identification and management of bipolar disorder. *Nurse Pract*, Oct 15 2014, 39(10) p30-7

How to Use Restraints Properly

Under federal guidelines, health care institutions should have a policy on the use of restraints. Such a policy should describe:

1. alternatives to attempt before resorting to restraints
2. indications that restraints are necessary
3. how long (time frame) the client should be restrained
4. how and when the restrained client should be assessed

You must have a physician's order now that restraints are considered "prescription devices." (Some states authorize other licensed health care professionals to prescribe restraints.) The caregiver should consult the institution policy and find out what procedures to follow in an emergency.

The federal government is also requiring the manufacturers of restraints to develop better labeling and to modify their equipment so that it meets new regulations. Look for labels that say "prescription only" and provide graphic instructions on how to apply the restraints.

What can you do to make restraints safer? Always follow the Food and Drug Administration's (FDA's) guidelines as listed below:

- A. Assess why you are considering the use of restraints, and try alternatives first.
- B. Make sure restraints are used only under the supervision of a licensed health care provider, such as yourself, for a strictly defined period.
- C. When you have to use restraints, tell the patient and family members why and obtain informed consent from the patient or guardian. (Consult your institution's policy to find out what to do when you cannot obtain informed consent.)
- D. Attend a staff-development program on how to use restraints. The program should include a demonstration on how to properly apply them, and an opportunity for supervised practice.
- E. Before applying restraints, read and follow the manufacturer's directions.
- F. Display the instructions on how to use restraints in a highly visible location and translate them, as necessary, into languages other than English.
- G. Select restraints that are appropriate to the patient's condition.
- H. Use the correct size restraint.
- I. Carefully apply the restraint and adjust it properly so that it maintains body alignment and assures patient comfort.
- J. Secure bed restraints to the bedsprings or bed frame, never to the mattress or bed rails. If the bed is adjustable, secure restraints to parts of the bed frame that will move with the patient.
- K. Tie knots with appropriate hitches so they can be released quickly.
- L. Check on the restrained patient frequently.
- M. Remove the restraints at least every 2 hours (more if necessary), and allow for activities of daily living.
- N. Continue to assess the patient regularly and remove the restraints as soon as possible. Restraints should be considered only a temporary solution to a problem.
- O. Clearly document the medical reason for using restraints, the length of time they were used, and any alternatives that were tried.
- P. Know and follow local and state laws on the use of restraints.
- Q. Make sure all deaths and injuries associated with the use of restraints are reported to the FDA.

Appendix B

ACUTE PSYCHIATRIC SITUATIONS				
ORGANIC DISORDERS AFFECTING BRAIN FUNCTION	PSYCHOGENIC DISORDERS AFFECTING BEHAVIOR			
DEGREE OF DISTURBANCE				
NON-PSYCHOTIC TO PSYCHOTIC	PRE-PSYCHOTIC TO PSYCHOTIC	NON-PSYCHOTIC TO PSYCHOTIC	NON-PSYCHOTIC TO PSYCHOTIC	NON-PSYCHOTIC
DEVIANCY				
Brought in by police or others for violence, intoxication, inappropriate behavior, found unconscious	Brought in by police or others for bizarre behavior, violence, self-mutilation	Brought in by police or others for suicide attempt, bizarre behavior, acting out in public	Fights, assault	Seeking to avoid law, drug seeking, malingering
DYSPHORIA				
Anxiety, Anger, Depression, Grandiosity	Anxiety, Depression, Anger, Grandiosity, Guilt	Depression, Elation, Grandiosity, Anxiety, Guilt, Acute Grief	Anger, Acute Grief, Anxiety	Anxiety, Depression, Anger
DEPENDENCY				
Unable to care for self	Unable to care for self	Unable to care for self	Issues with a past, Family issues	Resourceless person, Munchausen syndrome, Drug seeking
PRIORITY GOALS				
Provide immediate protection, Alleviate physical cause, Increase impulse control	Provide immediate protection, Prevent violence and/ or suicide, Increase reality contact, Decrease agitation, Increase impulse control	Provide immediate protection. Prevent suicide. Decrease agitation. Restore physiological balance. Increase impulse control	De-escalate crisis, Reduce anxiety, Clarify situation	Identify source of complaint, Reduce anxiety
ACTIONS				
Detain legally if necessary. Mobilize safety measures, personal, family, temporary restraint, locked room. Diagnose correctly, through physical examination, lab tests, psychiatric history and mental status exam. Institute immediate appropriate treatment. Medicate as indicated. Hospitalize in medical, surgical, psychiatric, alcohol or drug unit. Confer with family, significant others.	Treat suicide attempt. If necessary mobilize safety, functions, personnel, family, locked room, rest. Assess and diagnose through ruling out physical causes. Do physical history and mental status exam. Medicate if needed anti-psychotic drugs, hospitalize, voluntary and involuntary if needed. Alternative to hospital, confer with significant others.	Treat suicide attempt detain legally if needed. Asses suicide lethality. Arrange for treatment. Hospitalize voluntary or involuntary. Alternate treatment. Refer to MD to be started on anti-depressants or lithium treatment.	Treat suicide attempt . Begin crisis intervention. Arrange temporary environmental changes. Medicate short-term. Refer to appropriate facility. Contact appropriate authorities in child abuse cases.	Diagnose correctly through physical exam, lab tests, psychiatric history and mental status exam, previous hospital and ER records. Sodium amytal interviews, institute appropriate treatment. Refuse treatment if indicated. Referral to social service agencies.

Appendix B

ACUTE PSYCHIATRIC SITUATIONS				
ORGANIC DISORDERS AFFECTING BRAIN FUNCTION	PSYCHOGENIC DISORDERS AFFECTING BEHAVIOR			
DIAGNOSIS				
Acute Alcohol, Delirium Tremens, Acute Drug Reactions, Drug Withdrawal, Epilepsy, Hyperventilation Syndrome, Metabolic/endocrine Disorders, Brain Tumor, Subdural Hematoma, Infectious/exhaustive Disorder, Porphyria, Dementia. Suicide Attempt.	Schizophrenic Disorders: Paranoid, Catatonic Excitement or Stupor, Paranoid Disorders, Schizophreniform Disorder; Borderline Personality. Suicide Attempt.	Affective Disorders, Depression; Retarded or Agitated, Manic-depressive Disorder; Manic or Depressed. Suicide Attempt.	Interpersonal Crisis: Family or Significant Other. Acute Disorganization. Fights and Violence. Suicide Attempt. Possible Psychiatric Disorder in One or More Members. Acute Grief Reaction.	Other: Victims of Rape and Assault, Dissociative States, Fugue, Amnesia, Panic, Malingering, Munchausen Syndrome, Drug Seeker, Resourceless Person, Explosive Personality, Disaster Victim
DEGREE OF DISTURBANCE				
NON-PSYCHOTIC TO PSYCHOTIC	PRE-PSYCHOTIC TO PSYCHOTIC	NON-PSYCHOTIC TO PSYCHOTIC	NON-PSYCHOTIC TO PSYCHOTIC	NON-PSYCHOTIC
PROBLEMS				
Organic Disease, Somatic Concerns Regulation of Energy: Agitation, Stupor Anxiety Depression Disorientation Confusion Hallucinations / Delusions Suspiciousness Poor Impulse Control Violence Suicide Socioenvironmental	Sleep Disorder Eating Disorder Regulation of Energy: Agitation / Stupor Somatic Concerns Anxiety Depression Confusion Emotional Withdrawal Hallucinations Delusions Suspiciousness Poor Impulse Homicide / Suicide Socioenvironmental	Sleep Disorder Eating Disorder Regulation of Energy: Agitation / Stupor Exhaustion Anxiety Depression Confusion Emotional Withdrawal Hallucinations Delusions Suspiciousness Poor Impulse Homicide / Suicide Socioenvironmental	Anxiety Anger Poor Impulse Control Inter Personal Relationships (Couple) Family Job Suicidal Children Homicide Socioenvironmental	Anxiety Anger Confusion Manipulation Somatic concerns Phobias Socioenvironmental
DANGER OF DESTRUCTIVENESS				
Worsening of Condition, Brain Damage, Death, Violence, Loss of Impulse Control, Suicide, Refusal of Treatment	Decompensation, Panic, Violence, Suicide, Loss of Impulse Control, Refusal of Treatment, Exhaustion	Decompensation, Suicide, Physical Deterioration, Refusal of Treatment, Exhaustion, Manic or Depressed	Decompensation, Violence, Suicide, Child Abuse	Decompensation, Missed Diagnosis, Panic
DISORGANIZATION				
Confusion, Hallucinations, Delusions, Inability to care for self, Agitation	Confusion, Agitation, Stupor, Hallucinations, Delusions	Agitation, Stupor, Delusions, Inability to care for self	Disruption of family system with impact on all, especially children	Loss of Identity