

Summary of Key Points

General Characteristics of a Psychiatric Emergency

Presence of: extreme fear, anxiety, depression, mania, anger, confusion, withdrawal. Treat as potentially life-threatening.


Care of Client with Acute Nonpsychotic Reactions (e.g., Anxiety Attack, Panic Reaction)

Assess and treat *hyperventilation* symptoms.


Care of a Client with Delirium

1. Focus on physical and environmental aspects of care in *alcohol-related* condition.
2. Focus on “talking down” and environmental aspects of care in *hallucinogenic drug* intoxication.
3. Focus on removing toxic substances and providing reality orientation when *acute delirium* is due to electrolyte imbalances, infections, and metastatic cancer.


Care of a Client with Acute Psychosis

1. Build trust with consistency and short, frequent contacts.
2. Verbalize the observable: “You seem frightened,” or “I heard you speaking to someone.”
3. Provide safe environment away from others; give  *anti-psychotic* medications.
4. Give your perception: “I don’t hear voices.”

Care of a Client in Manic Reaction

1. Same as for *acute psychotic reaction* except:
2. *Avoid* stimulation; minimize talking.
3. Medication: *Lithium carbonate*. 

Care of a Client Who is Homicidal or Assaultive

1. Assess for clues of impending loss of self-control (e.g., agitation). The priority is prevention of violence.
2. Continue to speak quietly and firmly; inform the client that violence is not acceptable.
3. Take client out of immediate area, to a quiet room.
4. Call for extra help.
5. Consider prn medications and physical restraints. 

Care of a Client Who is Suicidal

1. *Assess for suicide risk factors*: age (under 19, older than 45); higher in men; history of previous suicide attempt; substance abuse; lack of social support (unmarried/no significant relationship); chronic or painful illness; sleep deprivation; organized *suicide plan*; recent crisis (stress, loss); identity crisis.
2. *Assessment of suicide clues*:
 - Depression and *sudden* recovery
 - Mania
 - Auditory hallucinations
 - Direct verbal comments
 - Cancelling plans
 - Giving away belongings
 - Putting affairs in order (will, funeral plans)
 - Social withdrawal
3. *Suicide precautions*: remove harmful objects (e.g., no phone cords, extension and equipment cords; no curtain cords; no belts; no matches or cigarettes; no razors); lock windows; have only break-proof glass and mirrors; use plastic flatware.
4. *Care of client who is suicidal*
 - Keep client always in view, especially when client goes to bathroom.
 - Ensure complete swallowing of medications.
 - Assess: mood, body posture, eye contact, and response to *direct* questions such as “Do you feel like hurting yourself?” “Do you have a plan?”
 - Give simple, clear directions.
 - Provide activities that do *not* require thinking or competition (e.g., folding papers, sticking labels on papers).
 - Increase suicide precautions when client’s behavior *appears* better (e.g., better groomed).

Crisis Intervention

Characteristics: brief; focus on here-and-now, immediate needs, and adaptive behaviors; relief of symptoms more important than exploring causes.