

Nursing Management of Patients with Psychiatric Emergencies

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Abstract

Psychiatric emergencies are situations in which individuals' thoughts and behaviours are acutely altered causing potential or actual risks to the life of the person or others in the environment. Prompt identification and appropriate interventions will reduce the mortality and disability caused due to psychiatric emergencies. This article reviews the major psychiatric emergencies such as suicide, violence, delirium tremens, stupor and drug-related emergencies and highlights the nursing care of patients with these psychiatric emergencies.

Keywords: Delirium, drug-related emergency, emergency, nursing management, psychiatry, stupor, suicide, violence

INTRODUCTION

The psychiatric emergencies are acute disturbances in thought, behaviour, mood or social relationship that requires immediate interventions; if untreated can cause harm to either the individual or the others in the environment. Of all emergencies reported in India, psychiatric emergencies contribute around 9%.^[1] Major emergencies are those which pose danger to the life of the patient or the others in the environment and minor emergencies are those when there is no threat to life but leads to incapacitation.^[1] In this article, the authors discuss the major life-threatening psychiatric emergencies and the nursing management. The following conditions are considered as emergency in psychiatric settings:

- Suicide
- Violence
- Delirium tremens
- Stupor
- Drug-related emergencies.

SUICIDE/ATTEMPTED SUICIDE

Suicide is a major public health concern in many developing countries. It contributes to premature mortality accounting for over 800,000 deaths worldwide ever year.^[2] The suicide rate in many western countries is between 8 and 30 per 100,000 population with a recent increase in suicide among young men.^[3] Several investigators have studied on suicide in different parts of India, using police records, and have reported that suicide rates vary from 6.8 to 58.3 per 100,000 population.^[4]

Definitions

Suicide is the death caused by self-directed injurious behaviour with any intent to die as a result of the behaviour, whereas attempted suicide or suicide attempt is a nonfatal self-directed potentially injurious behaviour with any intent to die as a result of the behaviour. A suicide attempt may or may not result in injury.^[5]

Methods of suicide attempt

- Physical attempts (jumping from heights, drowning, injuring self by cutting the throat and wrist and hanging)
- Attempts with the help of noxious chemicals, poisons and sleeping tablets.

Psychiatric conditions where suicide is common

- Acutely depressed clients, clients with schizophrenics who constantly ruminate over suicide
- Hysterical states, alcohol and substance abuse, personality and character disorders.^[6]

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Submitted: 05-May-2021

Revised: 20-May-2021

Accepted: 28-May-2021

Published: 07-Jul-2021

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How to cite this article: Gnanapragasam A, Paul D, Sebastian J, Sathiyaseelan M. Nursing management of patients with psychiatric emergencies. *Indian J Cont Nsg Edn* 2021;22:80-92.

Access this article online

Quick Response Code:



Website:
www.ijcne.org

DOI:
10.4103/ijcn.ijcn_40_21

Risk factors for suicide

The factors that increase the chance of attempting or considering suicide are as follows^[6]

- Previous suicide attempt(s) and history of mental disorders, particularly depression
- History of alcohol and substance abuse, family history of suicide and child maltreatment
- Impulsive and aggressive tendencies, barriers to accessing mental health treatment^[7]
- Financial loss, relationship loss, work loss and physical illness
- Easy access to lethal methods, local epidemics of suicide
- Isolation, a feeling of being cutoff from other people.

Access to the method of suicide is an important risk factor for and determinant of suicide. The method used depends on the availability of the means and the individual motivation to kill oneself. Pesticides are the most common method in India, so attention should be focused on reducing the access to pesticide.^[8]

Warning signs

There are some definite warning signs of suicide which indicate the intention of suicide in a person. They may include, appearing depressed or sad most of the time, feeling hopeless, expressing hopelessness, withdrawing from families and friends, sleeping too much or too little, feeling tired most of the time, making overt and covert statements, writing poems or notes about suicide or death, losing interest in most activities and giving away prized possessions.^[9]

Theories of suicide

Sociological theory of suicide

Durkheim^[10,11] categories the types of suicide based on an individual's integration into society, the types are as follows

1. Egoistic – It is the result of too little social integration, for example, suicide of a retired elderly widower
2. Altruistic – The consequence of excessive integration, for example, the death of a child which is viewed as more stressful/leading to suicide in parents following severe depression
3. Anomic – It results from too little regulation or the shattering of one's ties with the society, for example, divorce or unemployment
4. Fatalistic – This form is the result of excessive regulations coupled with high personal needs to control one's environment, for example, when a highly motivated college student takes his own life upon failing in an internal examination.

Psychological theory of suicide

Sigmund Freud believed that suicide was a response to the intense self-hatred that an individual possessed.^[12] Freud believed that suicide occurred as a result of an earlier repressed desire to kill someone else. He interpreted suicide to be an aggressive act towards the self that often was really directed towards others.

Biological theory of suicide

Recent studies with suicide attempters have focused on the genotypic variation in the gene for tryptophan hydroxylase, with results indicating significant association to suicidality.^[13] Some studies have revealed a deficiency of serotonin in depressed clients who attempted suicide.^[14]

Assessment and management of suicide

Suicide-related death is considered more preventable than any other death. The patient who is self-destructive needs close observation and active listening. It is acceptable to ask few questions regarding suicide clues and motive for suicide which will give information regarding the specificity of the plan and its degree of lethality. The assessment tool SAD PERSONS Scale is often used to determine the suicide intent.^[15]

Nursing management of suicidal individuals

The aim of the management is to prevent individuals from hurting themselves and promoting coping and a sense of inclusiveness.

Objective: To promote safety and prevent injury/death

An individual in a severely disturbed status, with acute thoughts of suicide, needs to be hospitalised for further management. Therefore, the individual and the family should be explained about the need for hospitalisation. In the inpatient facility, the person should be provided with a safe environment to avoid any triggers for suicide and also a suicidal attempt.

1. Establish a safe environment:
 - Constant/close observation (round the clock vigilance)
 - Take all suicidal threats or attempts seriously and notify the psychiatrist/physician immediately
 - Do not leave the drug tray within the reach of the patient
 - Make sure that the drugs administered are swallowed
 - Remove objects or items that could be used to inflict self-injury (e.g., knives, medications and razors)
 - Remove the bolts of the room/toilet/bathroom.
2. Recognise changes in mood or behaviour that could indicate a plan for self-injury including assessment for warning signs of suicide
3. Assist in meeting the basic needs of the patient so there is constant but subtle supervision
4. Obtain 'NO SUICIDE' contract with the patient. A written contract stating that when suicidal thoughts occur, the patient will approach the healthcare members instead of acting upon it
5. Assist in specific psychiatric treatment that includes psychotropic drugs, electroconvulsive therapy and psychotherapy
6. Encourage individual to involve in an activity which is an outlet for tension and anger.

Objective: To improve social interaction and support

1. Assess the non-verbal and verbal communications of the patient

2. Make frequent, brief visits and develop rapport
3. Stay with the patient even when the patient is not communicating
4. Use short sentences and open-ended questions to communicate
5. Initially talk about topics of the patient's interest
6. Introduce other staff and patients in the ward to the patient
7. Encourage the patient to participate in milieu activities.

Objective: To improve coping of individual and family

1. Assess and identify coping mechanisms used in the past by the patient and the family
2. Encourage open expressions of feelings and listen attentively
3. Teach adaptive coping skills such as diversional techniques and problem-solving skills
4. Spend time with the patient and family members and enhance the family and social support system.

Objective: Injury actual related to attempted suicide (inpatient setting)

1. Assess for vital signs
2. Check airway, if necessary clear airway
3. Start IV fluids, if pulse is weak
4. Emergency measures in case of self-inflicted injuries
5. Shift the patient to medical emergency service if further interventions are needed.

VIOLENCE

Introduction

The term violence came from the Latin word called 'Violentia'. Violence is something that has been for ages, and has been a part of expression of an individual's emotional outburst. Anger is expressed in varied ways which if not controlled can be expressed as violence. Violence is a severe form of aggressive behaviour.^[6] Nurses are one of the common victims of violence in healthcare settings, especially psychiatric units. A study done in Saudi Arabia reports that 81.3% of nurses were exposed to violent behaviours by the psychiatric patient^[16] and many a time, patient's relative become victims too.^[17] It is understood that 20% of patients admitted in emergency service of psychiatric units might show a behaviour of violence.^[18]

Definition

Oxford dictionary defines violence as 'Behavior involving physical force intended to hurt, damage, or kill someone or something' or as 'Strength of emotion or of a destructive natural force'^[19] In psychiatry, violence is an extreme form of aggression as defined by American Psychological Association^[20] which is exhibited in the form of assault, rape or murder. Reiss and Roth^[21] defines violence as 'behaviors by individuals that intentionally threaten, attempt or inflict physical harm on others'.

Pathophysiology

Violence may not always have a specific cause, it might be an interface of several types of influences such as individual,

situational and structural factors contributing to the occurrence of violence. Increased levels of dopamine and decreased levels of norepinephrine and serotonin are associated with irritability and associated behaviours.^[14]

Risk factors

There can be diverse ways of communicating an individual's anger or aggression, some characteristics that can help identify violence or otherwise called as the cues of violence are

- Pacing, restlessness
- Tense facial expression and body language
- Verbal or physical threats
- Loud voice, shouting, use of obscenities and argumentative
- Threats of homicide or suicide
- Increase in agitation, with overreaction to environmental stimuli
- Panic anxiety, leading to misinterpretation of the environment
- Disturbed thought processes, suspiciousness
- Angry mood, often disproportionate to the situation.^[6]

While assessing the risk factors of violence, one must consider the following three factors:

1. Past history of violence, which is considered as the major risk factor. Peter also describes violence was repetitive in his study^[22]
2. Client diagnosis, patients who get violent are usually those who are diagnosed with a psychiatric illness such as schizophrenia, those who are deluded and hallucinated^[22]
3. Current behaviour.^[6]

In general, male gender, patient's with psychiatric illness, especially schizophrenia, substance use and when there is past evidence of violent behaviour might be some factors that precipitate violence.^[18] Aggression is more connected with younger age, male gender, admission under involuntary consent, being single, having diagnosed with schizophrenia, multiple previous admissions, past history of violence, history of self-injurious behaviour and the use of substance.^[23]

Diagnosis

Violence being an acute phenomenon cannot be diagnosed by fixed criteria. The cues of violence can be part of the assessment. Diagnosis can be possible depending on the history and physical examination.

History in aspects of physical abuse would disclose non-accidental physical injury as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting and burning. Emotional abuse would be demeaning or rejecting the victim, ignoring or blaming the victim, isolation from normal routines, use of harsh and inconsistent discipline.^[6]

Management

The first step to manage violence is de-escalation,^[24] if not responding to de-escalation, then some common ways to manage physical violence are seclusion, use of restraint both physical and chemical and forced medication.^[25]

When an individual is restrained, ensure their hydration and nutritional status is kept to optimal status. Keep environment safe from hazardous equipment.^[24]

Other common interventions could be

1. Providing a safe house or shelter
2. Rendering psychosocial therapies such as individual psychotherapy, family therapy, cognitive therapy and milieu therapy.^[6]

Nursing management

Nursing diagnosis: risk for violence directed towards self or others related to command hallucinations, manic excitement and delusional thinking.

Objective: Patient will not harm self or others in the environment

1. Maintain low level of stimuli in patient's environment (low lighting, few people, simple decor and low noise level)
2. Observe client's behaviour frequently even while carrying out routine activities
3. Remove all dangerous objects from patient's environment
4. Intervene at the first sign of increased anxiety, agitation or verbal or behavioural aggression
5. Offer empathetic response to the patient's feelings
6. Offer some alternatives: to participate in a physical activity (e.g. punching bag and physical exercise), talking about the situation
7. Administer medications such as injection haloperidol 25–50 mg IM or injection lorazepam 1–2 mg IM as prescribed
8. Use physical restraints if needed and observe at least every 15 min to ensure that circulation to extremities is not compromised (check temperature, colour and pulses); to assist the client with needs related to nutrition, hydration and elimination and to position the client so that comfort is facilitated and aspiration is prevented
9. Remove one restraint at a time while assessing the client's response.^[6]

DRUG-RELATED EMERGENCIES

The common and severe drug-related emergencies are discussed below.

Lithium toxicity

Lithium is a smallest alkali ion discovered by Arfueson in 1817, used in the management of Gout.^[26] The use of lithium in the management of patients with mania was approved by the US Food and Drug Administration (FDA) in the year 1970.^[27]

Pharmacokinetics

The drug is available only as an oral preparation. It is absorbed rapidly from the gastrointestinal tract and the peak serum levels achieved within 30 min to 3 h.^[26] The half-life of lithium single dose ranges from 12 to 27 h. As it is not protein bound, the 95% is excreted through the kidneys,^[28] and it is filtered at the rate of glomerular filtration rate (GFR).^[29] It crosses placenta and is secreted in breast milk.

Mechanism of action

Lithium is a powerful anti-manic (mood stabilising) drug used in the management of manic episodes of bipolar disorder, schizoaffective disorder, cyclothymia, adjuvant in refractory depression and prophylaxis of bipolar mood disorder. The action of lithium is not known and not clearly understood. The probable action can be by increasing the pre-synaptic re-uptake of catecholamine and blocking the release of catecholamine at synapse. It also reduces the post-synaptic serotonin receptor sensitivity.^[24]

Dosage and therapeutic levels

The dosage is usually 900–2100 mg/day. Lithium has a very narrow therapeutic index. Therapeutic level in the treatment of acute mania is 0.6–1.2 mEq/L. The prophylactic level is 0.6–1.0 and >2 mEq/L is considered to be toxic.^[26]

Aetiology of lithium toxicity

1. Excessive intake: When patients take increased number of tablets accidentally or with an intention to attempt suicide and while patients are on long-term lithium treatment and the dosage is adjusted as part of treatment.^[28]

Impaired excretion: The factors that reduce the sodium level and the cause fluid deficit such as vomiting, diarrhoea, febrile illness, renal insufficiency, excessive exercise, water restriction, excessive sweating, low sodium diet and congestive heart failure impair the excretion of lithium. A reduction in GFR due to aging and drugs can also impair the excretion of lithium from blood causing a raised serum lithium levels. Drugs such as nonsteroidal anti-inflammatory drugs, angiotensin-I converting enzyme inhibitors and thiazides that affect the renal function also impair the excretion of lithium.^[30]

Types of lithium toxicity

- Acute toxicity – It occurs when a person takes excessive amount of lithium drug accidentally or purposefully
- Chronic toxicity – It occurs when a person takes a little extra dose daily for a long time
- Acute-on-chronic toxicity – It occurs when a person is on lithium for a long time and takes one drug extra either accidentally or purposefully.^[31]

Symptoms of lithium toxicity

Symptoms of toxicity varies with serum lithium levels^[12]

1. 1.5–2.0 mEq/L: Individuals may present with blurred vision, ataxia, tinnitus, persistent nausea, vomiting and severe diarrhoea which may indicate rising lithium levels
2. 2.0–3.5 mEq/L: A serum lithium level of above 2 is serious and causes many adverse effects. Individuals may complain of excessive urine output, dilute urine, increasing tremors, muscular irritability, hyper-reflexia, psychomotor retardation and mental confusion
3. >3.5 mEq/L: This level can be lethal and may cause death if not identified early. Impaired consciousness, nystagmus, seizures, coma, oliguria/anuria, arrhythmias, myocardial infarction and cardiovascular collapse are manifestations seen when lithium levels are dangerously high.

Treatment

There is no specific antidote for lithium toxicity, if untreated, it may be life-threatening. The following treatment would reduce the adverse effects and may help in preserving life.^[28] The objective of the intervention is to hasten maximum elimination of the drug from the body as early as possible and stop worsening of patients' condition

- Withhold the drug until there is clinical improvement in a patient and the serum concentration of lithium is within the therapeutic range^[32]
- The first step is to assess and stabilise circulation, airway and breathing, if a patient presents with altered mental state
- Hydrate with isotonic saline to ensure maximum elimination of lithium
- Gastric lavage in case of acute intoxication
- Bowel irrigation using polyethylene glycol for sustained release drugs
- Monitor serum lithium level every 2–4 h initially, later when symptoms reduce monitor every 6–12 h
- Haemodialysis if lithium levels are >4 mEq/L or >2.5 mEq/L in a patient with severe intoxication and renal insufficiency.^[29]

Patient education

Psycho-educate the patients to take only the prescribed dose and not to double dose a missed dose. Take adequate salt in the diet. Monitor the intake and output regularly and report to the prescriber if vomiting and diarrhoea persist. Monitor the therapeutic level of lithium on regular basis. Avoid excessive use of beverages that contain caffeine such as coffee, tea and cola drinks.^[6]

Acute dystonia

Acute dystonia is characterised by slow sustained muscular spasms causing involuntary movements or postures.^[24]

Acute dystonia generally occurs within first few days after the initiation or increase in the dose of antipsychotics and antiemetics. 50% occurs within 48 h and 90% within 5 days after the initiation of treatment.^[33]

Aetiology

It is believed to be due to the imbalance of dopaminergic-cholinergic pathway in basal ganglia.^[34] The risk factors include, male gender, younger age, history of acute dystonia in the past, family history of dystonia and history of cocaine and alcohol use.^[33,34]

Clinical features

The clinical features vary depending on the group of the muscle that is involved. The Buccolingual presents as trismus, risus sardonicus, dysarthria, dysphagia, grimacing and tongue protrusion. Oculogyric Crisis occurs due to the spasm of the extra ocular muscles and presents as upward lateral movement of the eyes. Torticollis involves the neck muscles leading to abnormal asymmetric head or neck position. Tortipelvic crisis causes abnormal contractions of the abdominal wall, hip and

pelvic musculature. Opisthotonus occurs when the whole body is involved and the patient arches on the bed. Laryngeal dystonia/laryngospasm is a rare but serious side effect characterised by dysphonia and stridor. In pseudomacroglossia, tongue swells and protrudes.^[30,31,34]

Treatment

Specific drugs help in controlling and relieving the symptoms.^[33,35] Patients generally respond within 15–30 min after the administration of drugs. Anticholinergic drug, Injection bztropine 1–2 mg IM/slow IV is given initially and can be continued as a oral dose of 1–2 mg twice a day for 2 days to prevent recurrence. Antihistamine, Injection diphenhydramine 1–2 mg/kg IM/slow IV needs to be administered in the acute phase and can be continued as oral dose every 6 h for 1–2 days to prevent recurrence of symptoms. Also, injection promethazine 25–50 mg IV/IM can be administered. If patients do not respond to anticholinergic drugs, benzodiazepines can be used. IV or IM lorazepam at 0.05–0.10 mg/kg or IV diazepam at 0.1 mg/kg may be considered. Oxygen therapy should be initiated for patients with laryngospasm. Patients need to be monitored for recurrence of acute dystonia and if needed can be continued with anticholinergic drug.

Neuroleptic malignant syndrome

It is a rare but life-threatening complication associated with the use of neuroleptics/antipsychotic drugs and occurs in 1–2/10,000 population.^[36] Most cases occur within 2 weeks after the initiation to 30 days of treatment.^[37]

Aetiology

It is believed to be due to the decreased central dopaminergic activity in the nigrostriatal, hypothalamic and mesolimbic/mesocortical pathways due to the D2 dopamine receptor blockade.^[38] The risk factors are treatment with high potent typical antipsychotic drugs, use of long-acting antipsychotic drugs, parenteral route of administration, higher rates of titration, abrupt stoppage/reduction in dopaminergic drugs, use of multiple antipsychotic drugs, agitated and catatonic patient and previous history of neuroleptic malignant syndrome (NMS). Men are affected more than women.^[36,38,39]

Clinical features

The clinical features last up to 7–10 days.^[40] The patients can present with severe muscle rigidity and elevated temperature 102°F–104°F, diaphoresis, dysphagia, tremor, incontinence, changes in level of consciousness ranging from confusion to stupor and coma, mutism, sialorrhoea, diaphoresis, flushing, skin pallor, tachycardia and elevated or labile blood pressure. Patients may develop rhabdomyolysis that causes leucocytosis, elevated creatine phosphokinase and haemoglobinuria that can lead to renal failure.^[38]

Treatment

Treatment of NMS involves a combination of management interventions.^[38,41] Discontinue the treatment with neuroleptic medication immediately. If NMS is precipitated by stopping dopaminergic drugs, restart the drug. Administer intravenous

fluids to hydrate the patient. Institute fever management to control the hyperthermia. Administer benzodiazepines to control agitation.

Pharmacological treatment

Injection dantrolene 1–2.5 mg/kg IV is administered initially followed by 1 mg/kg to a maximum 10 mg/kg/day. Tablet bromocriptine 2.5 mg can be administered through nasogastric tube every six hours. Other dopaminergic agents such as amantadine hydrochloride 200–400 mg per day in divided doses,^[42] levodopa and apomorphine can also be administered. Injection Lorazepam 1–2 mg IM/IV every 4–6 hrs or diazepam 10 mg every 8 hrs can be given.

Nursing management

Objective: To alleviate anxiety promote a sense of calmness in mind

1. Assess the level of anxiety
2. Stay with the patient and maintain a calm, nonthreatening approach
3. Provide reassurance in subtle and acceptable manner
4. Explain the situation and the procedures in simple words
5. Provide a low stimuli environment
6. Teach the patient various methods to relax like deep breathing exercises and guided imagery
7. Administer anti-anxiety drugs such as benzodiazepines.

Objective: To restore and maintain fluid and electrolyte balance

1. Monitor the vital signs
2. Check the weight regularly
3. Monitor the electrolytes, if required correct the imbalances
4. Increase the intake of oral fluids and administer intravenous fluids to ensure adequate hydration
5. Maintain a strict the intake and output
6. Assist in haemodialysis to maintain a fluid and electrolyte balance.

Objective: To maintain normal body temperature

1. Monitor vital signs regularly
2. Provide a well-ventilated, cool environment
3. Remove excessive clothing, blankets and linen and provide light clothing
4. Increase the fluid intake and administer intravenous fluids if needed
5. Maintain an accurate record of intake and output
6. Institute the nursing measures such as cold compress, ice cap and tepid and cold sponging.
7. Administer antipyretic drugs.

DELIRIUM TREMENS

Introduction

Psychoactive substances can be addictive when abused, and can lead to dependence and further to withdrawal.^[6] Delirium tremens is a complication of alcohol withdrawal, which can lead to death

also if not treated effectively on time. The term delirium tremens was first used by the English physician Thomas Sutton in his Tracts.^[43] It is seen in <1% among general population and nearly 2% of the patients who are diagnosed with alcohol dependence.^[44]

Definition

Delirium tremens is a condition where an individual has a group of symptoms of variable clustering and severity occurring on absolute or relative withdrawal of a psychoactive substance after persistent use of that substance. The withdrawal state is complicated by delirium and convulsions may also occur.^[45]

Clinical manifestations

The psychological manifestations include confusion, motoric activation, sensory hyperarousal (auditory, visual and tactile hallucinations and illusions are common) and autonomic hyperactivity in individuals.^[43] Delirium tremens being a withdrawal complication which might occur within 4–12 h of cessation of or reduction in heavy and prolonged alcohol intake, can cause physical manifestations such as (1) coarse tremors of hands, tongue or eyelids, (2) nausea or vomiting, (3) malaise or weakness, (4) tachycardia, (5) sweating, (6) elevated blood pressure, (7) anxiety, (8) depressed mood or irritability, (9) transient hallucinations or illusions, (10) headache, (11) insomnia, (12) disturbances in cognition, (13) disorientation and (14) clouding of consciousness.^[6]

Diagnosis

Diagnosis of delirium tremens is usually made by the presenting symptoms and proper history collection. Certain assessments that are made include severity of alcohol withdrawal, evaluation of delirium and screening for underlying medical co-morbidities among which liver disease is common.^[44]

Management

The treatment of delirium tremens can be classified into two approaches, (1) using pharmacological agents that are cross-tolerant and cross-dependent with alcohol and slowly eliminated from the body which is called substitution and (2) use of agents that reduce neuronal hyper excitability and autonomic hyperarousal. Substitution is a more straight forward approach and is commonly in practice.^[43] Benzodiazepines are commonly used in the management of delirium tremens where diazepam and lorazepam are mostly preferred.^[44] Chlordiazepoxide (Librium) and oxazepam (Serax) are also used amongst benzodiazepines. The use of benzodiazepines is to start with relatively high doses and reduce the dose by 20%–25% until withdrawal is complete.^[6] In case benzodiazepines do not work effectively, medications such as phenobarbital, propofol and dexmedetomidine are used.^[44] These anticonvulsants are used to manage withdrawal seizures. Replacement therapy with Vitamin B1, thiamine, is replaced in the body to prevent side effects of the above drugs such as neuropathy, confusion and encephalopathy.^[6]

Nursing management

The major role of nurse in rendering care to a patient who has delirium tremens would be to provide optimal safety and meet the basic needs of the patient.

Objective: To maintain normal sensory perception, and reorient to reality

1. Decrease the amount of stimuli in client's environment
2. Do not reinforce the hallucinations, let the patient know that you do not share the perception
3. Maintain reality through reorientation and focus on real situations and people
4. Provide reassurance of safety if patient responds with fear to inaccurate sensory perception as patient's safety and security are nursing priorities^[46]
5. Have watchfulness attitude throughout the care, as the physical symptoms might wade away as withdrawal symptoms cease and might not need much of interventions
6. Have the side rails up all the time, to ensure physical safety of the patient
7. Monitor strict intake and output chart, to balance fluid and electrolyte imbalance if any exist
8. Administer benzodiazepines as per advise as it might help in the detoxification of the patient and help sedate the patient to improve insomnia.

STUPOR

Introduction

Stupor is a psychiatric emergency which is associated with disorders like drug overdose, stroke, and lack of oxygen, meningitis, or cerebral oedema. The individual with stupor becomes dependent on all their needs, as they become immobile, and tend to remain in a kind of vegetative state yet their consciousness remains intact. The term stupor comes from Latin word meaning "numbness or insensible", it is also referred to as 'obtunded'. Psychomotor inhibition and obstruction may produce a general slowing down of activity in patients with stupor.^[47]

Definition

Stupor as defined by ICD-10 by the code R401 states that those in a stuporous state are rigid, mute and only appear to be conscious, as the eyes are open and follow surrounding objects.^[45] Stupor is a state of more or less complete loss of activity where there is no reaction to external stimuli.^[47] Stupor is a clinical syndrome of akinesia and mutism but with relative preservation of conscious awareness.^[26]

Aetiology

Some common causes of stupor are

1. Neurological disorders such as post-encephalitic Parkinsonism and limbic encephalitis, etc.
2. Systemic and metabolic disorders such as diabetic ketoacidosis, acute intermittent porphyria and hyperparathyroidism which causes hypercalcaemia, etc.
3. Drugs and poisoning due to organic alkaloids, antipsychotics and disulfiram, etc.
4. Psychiatric disorders such as catatonic schizophrenia, depressive stupor, manic stupor, periodic catatonia, conversion and dissociative disorder, reactive psychosis and during hypnosis.^[26]

Types

Stupor is usually presented clinically as (1) manic stupor, (2) depressive stupor, (3) catatonic stupor, (4) withdrawal stupor, (5) delirious stupor and (6) organic stupor.

Clinical manifestation

Extreme psychomotor retardation – It is a decrease in spontaneous movements and activity, mutism, negativism, waxy flexibility and posturing.^[6] Individuals presenting with stupor respond poorly or not at all to stimuli and after recovery no recollection of events during the episode. Patients with depressive stupor appear depressed and especially when emotional topics are discussed. Catalepsy, obstruction, stereotypies, changes in muscle tone and incontinence of urine and faeces do not occur. In manic stupor, the manifestation is slowing of thinking. Catatonic stupor manifests as pure akinesia and all muscles are flaccid, snout spasm is sometimes seen.

Outstanding features of stupor are deadpan facial expression, change in muscle tone, catalepsy, stereotypies and incontinence or urine. Psychological pillow is also a manifestation in which patient lies down with the head raised few inches off the bed,^[48] occurs when sternomastoid muscles are usually contracted. Psychogenic stupor may present as if the patient was paralysed with fear.^[47] Stupor is often associated with catatonic signs and symptoms (catatonic withdrawal or catatonic stupor). The various other catatonic signs include stupor, ambitendency, echolalia (repeating the words of the examiner), echopraxia (repeating the movements of the examiner), automatic obedience, mannerisms (involuntary, repetitive goal-directed movements), purposeless excitement, impulsiveness, combativeness or nudism.^[26]

Risk factors

The following are some of the risk factors for developing stupor

1. NMS
2. The diagnosis of catatonic schizophrenia
3. Affective disorders which might present as stupor
4. Substance withdrawal with complications such as Wernicke's encephalopathy
5. Advanced stages of organic brain syndromes.

Management

The management of stupor would be based on the cause of the stupor. The following steps of intervention must be taken to manage the unconscious patient. The cardiac functioning, airway patency and fluid electrolyte imbalance become priority to ensure there are no threats to life of the patient.

- Monitor cardiac functioning and stabilise the patient if cardiac functioning is altered, as stupor could be a presentation of cardiac malfunction also
- Ensure the airway is patent, if needed provide ventilation with oxygenation
- Correct and maintain if any fluid and electrolyte imbalance occurs

- Correct hypoglycaemia, as decrease in blood glucose level can be misinterpreted as stupor. If not recognised hypoglycaemia can lead to coma.
- If the cause is poisoning, provide antidotes as per policy^[26]
- Administer tablet lorazepam as per advice, as benzodiazepines can help reverting stupor^[49]
- Draw blood for necessary investigations and ensure laboratory investigations are done, to investigate whether the cause of stupor is psychological or organic.

In case it is caused due to NMS, discontinue the medication. In other cases, the management of the illness will relieve the symptoms of stupor. Tablet quetiapine is found to be effective in treating catatonic stupor.^[50] Among patients who were resistant to pharmacological therapy, ECT was found to be more effective.^[51] Benzodiazepines are widely used to treat stupor, especially tablet lorazepam is commonly administered to relieve acute stuporous symptoms. Amongst other types of schizophrenia, catatonic schizophrenia has good prognosis too.^[49]

Nursing management

The nursing management of stupor would include meeting the basic needs of the patient such as hygiene, elimination, comfort and nutrition needs as the patient might be unresponsive to environmental stimuli despite being conscious. The nursing care is elaborated with nursing process method.

Objective: To enable patient to have effective health maintenance which could be related to perceptual or cognitive impairments, inability to make appropriate judgement, ineffective individual coping

1. Assess patient's use of substances, eating and sleeping habits
2. Assess if the patient understands his or her problem, issues-related treatment and sleep and stay of a patient
3. Teach patients the basics of self-care, to make them self-sufficient. Once the patients are out of acute phase of the illness, by administering tablet lorazepam which relieves the stupor symptoms, they will attain the ability to meet their self-care needs on their own. Teaching them the basics of self-care is done to ensure they meet the need and become self-sufficient
4. Assist the patient with crisis intervention
5. Assess physical and mental health to deal with psychosocial issues and ensure the patient continues to take the medications prescribed.

Objective: To enable the patient to meet his or her own self-care needs

1. Identify aspects of self-care that may be within the patient's capabilities. Work on one aspect of self-care at a time
2. Offer positive feedback to enhance self-esteem and encourages repetition of desirable behaviour
3. Encourage the patient to perform normal activities of daily livings to his or her level of ability

4. Encourage independence
5. Show the patient how to perform activities as concrete thinking of the patient prevails, explanations must be provided at the client's concrete level of comprehension.^[46]

CONCLUSION

Psychiatric emergencies need prompt attention and immediate intervention. However, this area of concern is often not highlighted in healthcare settings other than psychiatric facilities. Nurses working in any setup need to be aware of the common psychiatric emergencies and the management strategies to make appropriate and informed decisions related to interventions and referral as needed.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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CE Test No. 40 Questions

Nursing Management of Patients with Psychiatric Emergencies

1. Stupor can be explained as a state where the individual
 - a. Has severe muscle rigidity
 - b. Doesn't respond to stimuli yet being conscious
 - c. Doesn't respond to stimuli and being unconscious
 - d. Cannot control involuntary movements of extremities
2. Stupor becomes an indication for
 - a. Insulin therapy
 - b. Group therapy
 - c. Electroconvulsive therapy
 - d. Marital therapy
3. The group of medication which is given acutely to treat stupor is
 - a. Anti-manic
 - b. Anti-psychotic
 - c. Benzodiazepine
 - d. Antabuse
4. Withdrawal is best explained as the range of symptoms that
 - a. Arise after the treatment of substance abuse
 - b. Arise after cessation of heavy substance use
 - c. Denote that patient is going into complications
 - d. Mark the severity of complications
5. Types of hallucinations present in Delirium Tremens are
 - a. Auditory, olfactory and visual
 - b. Visual, auditory and gustatory
 - c. Auditory, visual and tactile
 - d. Tactile, gustatory and olfactory
6. The common type of medication administered to treat Delirium Tremens are
 - a. Tab. Chlorpromazine
 - b. Tab. Clonazepam
 - c. Tab. Carbamazepina
 - d. Tab. Chlordiazepoxide
7. The vitamin that is replaced in the body during replacement therapy is
 - a. Vitamin B1
 - b. Vitamin B2
 - c. Vitamin B5
 - d. Vitamin B6
8. Death caused by self-directed injurious behavior with any intent to die as a result of the behavior is
 - a. Suicide
 - b. Stupor
 - c. Violence
 - d. Delirium Tremens
9. Which among the following example denotes the psychological theories of suicide
 - a. Deficiency of serotonin in depressed patients
 - b. Suicide of retired widowed wife
 - c. Suicide of highly motivated student when she failed in one subject
 - d. Husband committing suicide to punish his wife's wrong doing
10. A risk factor for suicide is
 - a. Impulsive & aggressive tendency
 - b. No history of suicide in the past
 - c. Being married
 - d. Occupation in an highly secure environment
11. The common method of suicide in India is
 - a. Use of lethal weapons
 - b. Drowning
 - c. Use of pesticides
 - d. Hanging
12. A farmer commits suicide to highlight the difficulties of farmers in his region is an example of
 - a. Egoistic suicide
 - b. Altruistic suicide
 - c. Anomic suicide
 - d. Fatalistic suicide
13. The therapeutic level of Lithium is
 - a. 0.5 to 1.1 mEq/L
 - b. 0.6 to 1.2 mEq/L
 - c. 0.7 to 1.3 mEq/L
 - d. 0.8 to 1.4mEq/L
14. An individual takes excessive amount of Lithium accidentally, this indicates which type of lithium toxicity
 - a. Acute

- b. Chronic
 - c. Acute on chronic
 - d. Induced
15. Slow sustained intense involuntary muscular spasms is caused due to
- a. Attempted suicide
 - b. Lithium toxicity
 - c. Acute dystonia
 - d. Neuroleptic Malignant syndrome
16. Mr. X is started on Tab. Haloperidol 10 mg BID, his temperature is 104 F. The possible reason is
- a. Acute dystonia
 - b. Lithium toxicity
 - c. Neuroleptic Malignant Syndrome
 - d. Delirium Tremens
17. Indication for hemodialysis for a patient with lithium toxicity is lithium level more than
- a. 3 mEq/L with renal insufficiency
 - b. 1.5 mEq/L without renal insufficiency
 - c. 2.5 mEq/L with renal insufficiency
 - d. 3.5 mEq/L without renal insufficiency
18. The drug used to treat violence
- a. Inj. Haloperidol
 - b. Inj. Risperidone
 - c. Inj. Olanzapine
 - d. Inj. Midazolam
19. The first step to manage violence is
- a. Physical Restraints
 - b. Chemical Restraints
 - c. Seclusion
 - d. De-Escalation
20. Nursing management of a patient with violence includes the following EXCEPT:
- a. Maintain low level of stimuli
 - b. Observe client's behavior frequently
 - c. Remove all dangerous objects
 - d. Using Judgmental attitude

ANSWERS FOR CE TEST NO. 39: TEAM BASED LEARNING

- | | |
|-------|-------|
| 1. C | 11. A |
| 2. D | 12. A |
| 3. A | 13. B |
| 4. B | 14. C |
| 5. A | 15. C |
| 6. B | 16. B |
| 7. B | 17. D |
| 8. D | 18. D |
| 9. C | 19. D |
| 10. D | 20. C |

CE Test No: 40

Nursing Management of Patients with Psychiatric Emergencies

Select the best answer and shade the circle against the suitable alphabet in the answer form provided.

ANSWER FORM

1. <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D	2. <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D	3. <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D	4. <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D	5. <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D
6. <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D	7. <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D	8. <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D	9. <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D	10. <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D
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16. <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D	17. <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D	18. <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D	19. <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D	20. <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D

Evaluation: Listed below are statements about the CNE on 'Nursing Management of Patients with Psychiatric Emergencies'. Please circle the number that best indicates your response.

	Strongly Disagree	Disagree	Agree	Strongly Agree
Stated Objectives were met	1	2	3	4
Content was clearly presented	1	2	3	4
Content was related to the objective	1	2	3	4
Test questions were clearly stated	1	2	3	4

NAME: _____

PRESENT MAILING ADDRESS: _____

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