اورژانسهای روانپزشکی

خودکشی

- Suicide: یک کلمه لاتین است
- Chronic suicide: خودکشی مزمن

واژه های در برگیرنده افکار و اعمال خودکشی

Aborted suicidal attempt: خودکشی بی نتیجه

Delibrate self harm: اسیب عمدی

Suisidal ideation: افکار خودکشی

Suicidal attempt تلاش برای خودکشی

اپیدمیولوژی

- کشورهای بالای ۲۵ در صد هزار نفر خودکشی:
- لیتوانی کره جنوبی سریلانکا روسیه

- کشورهای کمتر از ۱۰ در صد هزار نفر خودکشی:
- پرتقال هلند استرالیا اسپانیا افریقای جنوبی مصر

اپیدمیولوژی

- امار خودکشی ایران در سال ۹۲:حدود ۶ در صد هزار نفر بوده وبیشترین تعداد در استانهای تهران کرمانشاه گیلان بوده و کمترین در استانهای خراسان شمالی و جنوبی و کهکیلویه بویراحمد دیده شد

ریسک فاکتورها

- جنسیت
- سن
- نژاد
- مذهب
- تاهل
- اشتغال
- بیماری جسمی

ریسک فاکتورها

- سلامت روان
- اقدام به خودکشی قبلی

علت شناسی

- تئوری دورکیم:تقسیم بندی انواع خودکشی
- Egoistic
- Altruistic
- anomic

علت شناسی

- از نظر روانشناسی:
- به وقوع پیوستن رویاها

علت شناسی

- از نظر بیولوژیک:
- کاهش غلظت متابولیتهای سروتونین

رفتارهای شبه خودکشی

- خودزنی و اسیب به خود بدون قصد مرگ

پیشگویی اقدام به خودکشی

Adolescence and late life
Bisexual or homosexual gender identity
Criminal behavior
Cultural sanctions for suicide
Delusions
Disposition of personal property
Divorced, separated, or single marital status
Early loss or separation from parents
Family history of suicide
Hallucinations
Homicide
Hopelessness
Hypochondriasis
Impulsivity
Increasing agitation
Increasing stress
Insomnia
Lack of future plans
Lack of sleep
Lethality of previous attempt
Living alone
Low self-esteem
Male sex
Physical illness or impairment
Previous attempts that could have resulted in death
Protestant or nonreligious status
Recent childbirth
Recent loss
Repression as a defense
Secondary gain
Severe family pathology
Severe psychiatric illness
Sexual abuse
Signals of intent to die
Suicide epidemics
Unemployment
White race

(From Slaby AE. Outpatient management of suicidal patients in the era of managed care. *Prim Psychiatry.* 1995;Apr:43, with permission.)

Variable	High Risk	Low Risk
Demographic and Social Profile		
Age	Over 45 years	Below 45 years
Sex	Male	Female
Marital status	Divorced or widowed	Married
Employment	Unemployed	Employed
Interpersonal relationship	Conflictual	Stable
Family background	Chaotic or conflictual	Stable
Health		
Physical	Chronic illness	Good health
	Hypochondriac	Feels healthy
	Excessive substance intake	Low substance use
Mental	Severe depression	Mild depression
	Psychosis	Neurosis
	Severe personality disorder	Normal personality
	Substance abuse	Social drinker
	Hopelessness	Optimism
Suicidal activity		
Suicidal ideation	Frequent, intense, prolonged	Infrequent, low intensity, transient
Suicide attempt	Multiple attempts	First attempt
	Planned	Impulsive
	Rescue unlikely	Rescue inevitable
	Unambiguous wish to die	Primary wish for change
	Communication internalized (self-blame)	Communication externalized (anger)
	Method lethal and available	Method of low lethality or not readily available
Resources		
Personal	Poor achievement	Good achievement
	Poor insight	Insightful
	Affect unavailable or poorly controlled	Affect available and appropriately controlled
Social	Poor rapport	Good rapport
	Socially isolated	Socially integrated
	Unresponsive family	Concerned family

(From Adam K. Attempted suicide. *Psychiatr Clin North Am.* 1985;8:183, with permission.)

دیگر اورژانسهای روانپزشکی

- یک اختلال در فکر احساسات یا عملکرد که نیاز به مداخله فوری داشته باشد

I. **Self-protection**
   A. Know as much as possible about the patients before meeting them.
   B. Leave physical restraint procedures to those who are trained.
   C. Be alert to risks of impending violence.
   D. Attend to the safety of the physical surroundings (e.g., door access, room objects).
   E. Have others present during the assessment if needed.
   F. Have others in the vicinity.
   G. Attend to developing an alliance with the patient (e.g., do not confront or threaten patients with paranoid psychoses).

II. **Prevent harm**
   A. Prevent self-injury and suicide. Use whatever methods are necessary to prevent patients from hurting themselves during the evaluation.
   B. Prevent violence toward others. During the evaluation, briefly assess the patient for the risk of violence. If the risk is deemed significant, consider the following options:
      1. Inform the patient that violence is not acceptable.
      2. Approach the patient in a nonthreatening manner.
      3. Reassure, calm, or assist the patient's reality testing.
      4. Offer medication.
      5. Inform the patient that restraint or seclusion will be used if necessary.
      6. Have teams ready to restrain the patient.
      7. When patients are restrained, always closely observe them, and frequently check their vital signs. Isolate restrained patients from surrounding agitating stimuli. Immediately plan a further approach—medication, reassurance, medical evaluation.

III. **Rule out organic mental disorders.**
IV. **Rule out impending psychosis.**

اختلال طبی با علایم روانپزشکی

- شروع حاد
- اولین حمله
- سن بالا
- بیماری طبی اخیر
- مصرف مواد
- اختلال حسی غیر شنوایی
- علایم سیستم عصبی
- علایم شناختی

بیمار تهاجمی

- سایکوز ناشی از مواد
- اختلال شخصیت ضد اجتماعی
- اسکیزوفرنی
- عفونتهای سیستمیک
- بدخیمیهای مغز
- وسواس ناتوان کننده
- اختلالات شخصیتی
- اختلال تجزیه ای
- اختلالات جنسی
- صرع ناحیه تمپورال
- اختلال دوقطبی

نحوه برخورد با بیمار تهاجمی

- سایکو تراپی
- درمان دارویی
- مهار فیزیکی

Preferably five or a minimum of four persons should be used to restrain the patient. Leather restraints are the safest and surest type of restraint.

Explain to the patient why he or she is going into restraints.

A staff member should always be visible and reassuring the patient who is being restrained. Reassurance helps alleviate the patient's fear of helplessness, impotence, and loss of control.

Patients should be restrained with legs spread-eagled and one arm restrained to one side and the other arm restrained over the patient's head.

Restraints should be placed so that intravenous fluids can be given, if necessary.

The patient's head is raised slightly to decrease the patient's feelings of vulnerability and to reduce the possibility of aspiration.

The restraints should be checked periodically for safety and comfort.

After the patient is in restraints, the clinician begins treatment, using verbal intervention.

Even in restraints, most patients still take antipsychotic medication in concentrated form.

After the patient is under control, one restraint at a time should be removed at 5-minute intervals until the patient has only two restraints on. Both of the remaining restraints should be removed at the same time, because it is inadvisable to keep a patient in only one restraint.

Always thoroughly document the reason for the restraints, the course of treatment, and the patient's response to treatment while in restraints.

(Data from Dubin WR, Weiss KJ. Emergency psychiatry. In: Michaels R, Cooper A, Guze SB, et al., eds. *Psychiatry*. Vol. 2. Philadelphia: Lippincott; 1991.)

سندرم نورولپتیک بدخیم

- ناشی از مصرف انتی سایکوتیکها

علایم

- علایم حرکتی رفتاری:سفتی و دیستونی عضلانی سکوت بی قراری
- اختلال سیستم اتونوم:افزایش دمای بدن تعریق زیاد افزایش نبض و فشار خون
- تغییرات ازمایشگاهی:افزایش گلبولهای سفید کراتین فسفوکیناز انزیمهای کبدی میوگلوبولین پلاسما اختلال عملکرد کلیه

درمان

Intervention	Dosing	Effectiveness
Amantadine	200 to 400 mg PO/day in divided doses	Beneficial as monotherapy or in combination; decrease in death rate
Bromocriptine	2.5 mg PO bid or tid, may increase to a total of 45 mg/day	Mortality reduced as a single or combined agent
Levodopa/carbidopa	Levodopa 50 to 100 mg/day IV as continuous infusion	Case reports of dramatic improvement
Electroconvulsive therapy	Reports of good outcome with both unilateral and bilateral treatments; response may occur in as few as three treatments	Effective when medications have failed; also may treat underlying psychiatric disorder
Dantrolene	1 mg/kg/day for 8 days, then continue as PO for 7 additional days	Benefits may occur in minutes or hours as a single agent or in combination
Benzodiazepines	1 to 2 mg IM as test dose; if effective, switch to PO; consider use if underlying disorder has catatonic symptoms	Has been reported effective when other agents have failed
Supportive measures	IV hydration, cooling blankets, ice packs, ice-water enema, oxygenation, antipyretics	Often effective as initial approach early in the episode

PO, orally; bid, twice a day; tid, three times a day; IV, intravenously; IM, intramuscularly.
(Adapted from Davis JM, Caroff SN, Mann SC. Treatment of neuroleptic malignant syndrome. *Psychiatr Ann*. 2000;30:325–331, with permission.)

دلیریوم

- کاهش ناگهانی هوشیاری وشناخت بخصوص نقص در توجه وتمرکز
- اختلال خواب
- اختلال در سایکوموتور
- تهدید کننده حیات