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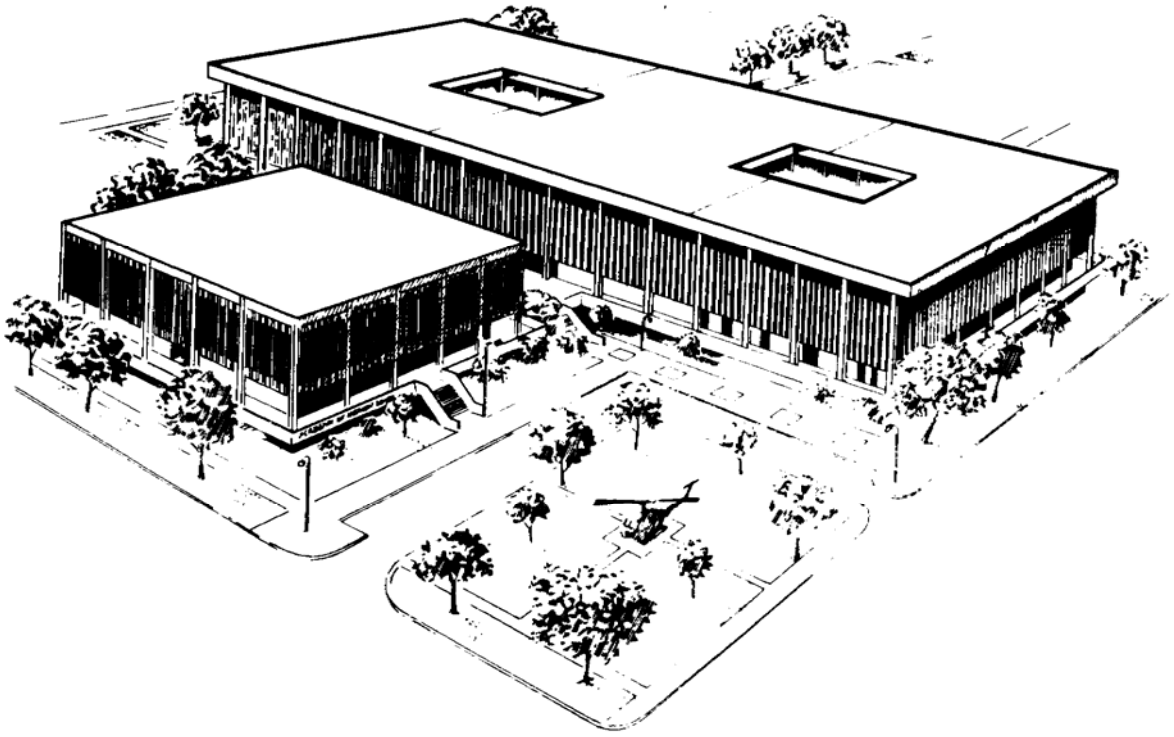

PSYCHOSOCIAL ISSUES

SUBCOURSE MD0549 EDITION 200

DEVELOPMENT

This subcourse is approved for resident and correspondence course instruction. It reflects the current thought of the Academy of Health Sciences and conforms to printed Department of the Army doctrine as closely as currently possible. Development and progress render such doctrine continuously subject to change.

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CLARIFICATION OF TERMINOLOGY

When used in this publication, words such as "he," "him," "his," and "men" 'are intended to include both the masculine and feminine genders, unless specifically stated otherwise or when obvious in context.

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CORRESPONDENCE COURSE OF
THE U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

SUBCOURSE MD0549

PSYCHOSOCIAL ISSUES

INTRODUCTION

You, as a medical specialist, will find that each patient or casualty is a unique individual with his own specific problems and his own ways of attempting to deal with those problems. The lessons present psychosocial issues that will involve you directly. Being able to cope with these issues and to provide medical care are initial steps in your career.

Subcourse Components:

The subcourse instructional material consists of seven lessons as follows:

Lesson 1, Substance Abuse.
Lesson 2, Provide Initial Care for a Casualty Suffering From Combat Stress Reaction.
Lesson 3, Apply Restraining Devices to Patients.
Lesson 4, Refer for Treatment a Potentially Suicidal Patient.
Lesson 5, Manage Behavioral Emergencies.
Lesson 6, Identify the Physical and Emotional Characteristics Associated with Death and Dying.
Lesson 7, Provide Postmortem Care.

Here are some suggestions that may be helpful to you in completing this subcourse:

--Read and study each lesson carefully.

--Complete the subcourse lesson by lesson. After completing each lesson, work the exercises at the end of the lesson, marking your answers in this booklet.

--After completing each set of lesson exercises, compare your answers with those on the solution sheet that follows the exercises. If you have answered an exercise incorrectly, check the reference cited after the answer on the solution sheet to determine why your response was not the correct one.

Credit Awarded:

Upon successful completion of the examination for this subcourse, you will be awarded 7 credit hours.

To receive credit hours, you must be officially enrolled and complete an examination furnished by the Nonresident Instruction Section at Fort Sam Houston, Texas.

You can enroll by going to the web site http://atrrs.army.mil and enrolling under "Self Development" (School Code 555).

A listing of correspondence courses and subcourses available through the Nonresident Instruction Section is found in Chapter 4 of DA Pamphlet 350-59, Army Correspondence Course Program Catalog. The DA PAM is available at the following website: http://www.usapa.army.mil/pdffiles/p350-59.pdf.

LESSON ASSIGNMENT

LESSON 1	Substance Abuse.
LESSON ASSIGNMENT	Paragraphs 1-1 through 1-7.
LESSON OBJECTIVES	After completing this lesson, you should be able to:

1-1. Identify terms commonly used in substance abuse.

1-2. Identify categories of commonly abused substances.

1-3. Identify signs and symptoms of substance abuse.

1-4. Identify procedures used for reporting and referral of suspected abusers.

1-5. Identify the procedures used to care for an overdosed patient.

SUGGESTION After completing the assignment, complete the exercises at the end of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 1

SUBSTANCE ABUSE

Section I. IDENTIFY A SUSPECTED SUBSTANCE ABUSER

1-1. GENERAL

a. Alcohol and drug abuse, commonly called substance abuse, is an ever increasing problem in the military services as well as in the civilian sector. Substance abuse is not limited to narcotics addition. It can also include abuse of food, solvents, alcohol, aspirin, drugs, and nicotine (figure 1-1).

Figure 1-1. Substance abuse

b. Substance abuse can affect combat readiness, job performance, and the health of military personnel and their families. It can also cost millions of dollars in lost time and productivity. More importantly, it can destroy the individual abuser.

c. As a medical specialist, you should be aware of your fellow soldier's suspected substance abuse. This lesson will include terminology commonly associated with substance abuse, signs and symptoms of substance abuse, categories of commonly abused substances, and procedures for reporting and referring suspected abusers.

1-2. TERMS COMMONLY USED IN SUBSTANCE USE

a. **Drug Use.** Drug use is the infrequent or recurrent use of any substance that has effect on the body, often used for social or recreational purposes.

NOTE: Drugs may be taken into the body by any route (for example, oral, inhalation, rectal, or injections).

b. **Drug Abuse.** Drug abuse is the frequent or recurrent use of any substance to:

(1) Achieve a state of intoxication (condition of "being drunk" or a "drunk-like" state).

(2) Escape from reality or problems.

(3) Alter moods.

c. **Tolerance.** Tolerance is the physical condition in which, after repeated exposure to a given drug, larger doses of the drug are required to achieve the desired effect.

d. **Withdrawal.** Withdrawal is a consistent pattern of physical responses that appears when regular drug use is discontinued. In general, drug withdrawal reactions tend to produce the opposite effect of the ingested drug (for example, alcohol [a depressant] causes hyperactivity in a withdrawing abuser).

e. **Drug Dependence/Addiction.** Drug dependence or addiction is the use of a drug to the extent that usage becomes more frequent, tolerance increases, and stopping would result in withdrawal. Disruption of normal social patterns occurs.

(1) Psychological dependence. In psychological dependence, a drug becomes necessary in order for a person to achieve or to retain a sense of well-being. Withdrawal of the drug results in compulsive drug seeking behavior.

(2) Physical dependence. In physical dependence, a drug becomes necessary in order for a person to function physically. This exists only if withdrawal symptoms occur when the drug use stops or if tolerance to the drug has developed.

1-3. CATEGORIES OF COMMONLY ABUSED SUBSTANCES

Drug abuse is not limited to one particular group of individuals. The majority of Americans is vastly overmedicated in one way or another, which is most likely due to the belief that there is a pharmacologic remedy for every problem. The list of commonly abused substances can be extremely long, ranging from caffeine and tobacco (nicotine) to over-the-counter sleep medications. We will limit this lesson to abused substances that fall into four major categories: depressants, stimulants, narcotics, and hallucinogens.

a. **Depressants (Downers).** Depressants are substances that affect the central nervous system (CNS). They decrease awareness and the mental capacity to function, slow reflexes, and may decrease the respiratory and heart rates.

(1) Alcohol. Alcohol is a liquid obtained by fermentation of carbohydrates with yeast. It is a powerful CNS depressant.

(2) Barbiturates (sedatives/hypnotics). Barbiturates are drugs that affect the CNS with remarkable effects similar to that of alcohol. They do not relieve pain, nor do they produce a specific "high." Sometimes an individual will use barbiturates with alcohol or with the opium analgesics to augment the effects of a weaker product.

(3) Nonbarbiturates (sedatives/hypnotics). Nonbarbiturates are drugs known as tranquilizers (drugs used to reduce mental disturbance, such as anxiety and tension). Some of the drugs are Thorazine, Valium, and Librium.

b. **Stimulants (Uppers).** Stimulants are drugs that affect the nervous system by increasing alertness, awareness, and mental and motor activity. In other words, they are known to excite the user. The effect on the individual will depend on the route of administration, the drug, its dose, and the circumstances. Some of the drugs in this category are listed below.

(1) Amphetamines. Amphetamines are stimulants taken to produce a general mood elevation. They include Dexedrine, Benzedrine, and Methedrine.

(2) Cocaine (street name is coke). Cocaine is a powerful stimulant that induces an extreme state of euphoria. It is often inhaled.

(3) Caffeine. Caffeine is a mild stimulant found in coffee, cola drinks, tea, and cocoa.

(4) Nicotine. Nicotine is a mild stimulant found in tobacco.

c. **Narcotics.** Narcotics are drugs that have a powerful analgesic (pain relieving) and sedative (calm and alleviate anxiety) effect on an individual. Some of these drugs are listed below.

(1) Opium. Opium is a bitter, brownish addictive narcotic drug that consists of the dried juice of the opium poppy.

(2) Morphine. Morphine is a bitter, crystalline addictive narcotic base drug that is used as an analgesic and sedative.

(3) Heroin. Heroin is a strongly physiologically addictive narcotic drug that is made from morphine, but is more potent than morphine.

(4) Methadone. Methadone is a synthetic addictive narcotic drug, used especially in the form of its hydrochloride for the relief of pain and as a substitute narcotic in the treatment of heroin addiction.

(5) Codeine. Codeine is a morphine derivative drug that is found in opium. Codeine is weaker in action than morphine and is used in cough remedies.

d. **Hallucinogens (Psychedelics).** Hallucinogens are drugs that alter the mind to produce hallucinations and intensifies perception. These drugs often result in dangerous psychiatric symptoms and behavior, attempts at suicide, or panic reactions. Some of these drugs are listed below.

(1) Marijuana (commonly known as "pot" or "weed"). Marijuana is an extract from the plant top of a flowering hemp plant that, when inhaled as smoke, produces euphoria, relaxation, and drowsiness.

(2) Hashish. Hashish is a form of cannabis from the flowering tops and spouts of female hemp plants, which contains the highest concentration cannabinolis.

(3) Lysergic acid diethylamide. Lysergic acid diethylamide (LSD)is a widely acclaimed drug. It is in the form of liquid and is usually placed on some material for oral injection.

(4) Phencyclidine . Phencyclidine (PCP) is a drug that can be absorbed by mouth or intravenously, as well as by smoking or snorting. It is a crystalline, water-soluble, and lipophilic substance.

NOTE: See Table 1-1 for a more detailed list of commonly abused substances.

DEPRESSANTS (Downers)	STIMULANTS (Uppers)	NARCOTICS	HALLUCINOGENS (Mind Affecting)
AMOBARBITAL (blue devils, barbs, Amytal	AMPHETAMINE (Benzedrine, bennies, pep pills, ups, cartwheels	CODEINE (often in cough syrup)	DMT
BARBITURATES (Dolls, barbs, rainbows)	BIPHETAMINE (bam)	DEMEROL	HASHISH
CHLORAL HYDRATE (Knockout drops)	CAFFEINE	DILAUDID	LSD (acid, sunshine)
GLUTEHIMIDE (doriden, goofers)	COCAINE (coke, snow)	HEROIN ("H", horse, junk, smack, stuff)	MESCALINE (peyote, mesc
METHAQUALONE (Quaalude, ludes, Sopors)	DESOXYN (black beauties)	METHADONE (dolly)	MORNING GLORY SEEDS
NON-BARBITURATE SEDATIVES (various tranquilizers, sleeping pills, Valium, Miltown, Equanil, meprobamate, Thorazine, Compazine, Librium, raserpine	DEXTROAMPHETAMINE (dexies, Dexedrine)	MORPHINE	PCP (angle dust, hog, peace pils)
PARALDEHYDE	METHAMPHETAMINE (speed, meth, crystal, diet pills, Methedrine	OPIUM (op, poppy)	PSILOCYBIN (magic mushrooms)
PENTOBARBITAL (yellow jackets, barbs)	METHYL-PHEMIDATE	PENTAZOCINE (Talwin)	STP (serenity, tranquility, peace)
PHENOBARBITAL (goofballs, phennies, barbs)	NICOTINE		
SECOBARBITAL (red devils, barbs, Seconal	PRELUDIN		

Table 1-1. Commonly abused substances.

1-4. SIGNS AND SYMPTOMS OF SUBSTANCE ABUSE

Due to the vast amount of signs and symptoms associated with each category of substance abuse, a general discussion on the psychosocial and physical signs and symptoms of substance abuse will be presented. Your early recognition and referral of an abuser of alcohol and drugs could possibly save his life and start him on the path of rehabilitation.

a. **Psychosocial**. Psychosocial Includes psychological and sociological. Psychological refers to the study of the mind and all its relationships, normal and abnormal. Sociological refers to the study of the interactions of the individual with other people.

(1) General personality changes.

(2) Mood/behavioral changes.

(a) Irritability.

(b) Nervousness.

(c) Agitation.

(d) Argumentative.

(3) Changes in work habits.

(a) Lowered quality/quantity of output.

(b) Inconsistent work pace (likely to change frequently without apparent reason).

(c) Errors in judgment.

(d) Lack of interest in work.

(4) Frequent or increases in:

(a) Lateness to work.

(b) Illness (especially vomiting and diarrhea).

(c) Absence from work area.

(5) Marital problems.

(6) Financial difficulties.

(7) Avoidance of family and friends.

(8) Deterioration of appearance, dress, and personal hygiene.

b. **Physical Signs and Symptoms.**

(1) Marked weight loss.

(2) Exhaustion.

(3) Lack of coordination.

(a) Staggering.

(b) Stumbling.

(c) Muscle tremors and/or twitching.

(d) Frequent accidents on and off the job.

(4) Slurred speech.

(5) Frequent skin problems.

(a) Ulcerations of the skin.

(b) Abscesses.

(6) Dilated or constricted pupils.

1-5. PROCEDURES FOR REPORTING AND REFERRING A SUSPECTED SUBSTANCE ABUSER

a. **Medical Treatment Facility (Ward, Clinic, Dispensary, and so forth).** You, the medical specialist, will inform the patient's physician of a suspected substance abuse.

b. **Unit Level (Company, Battalion, and so forth).** You, the medical specialist, will inform superiors of suspicions.

(1) Annotate on the DD Form 689 (Individual Sick Slip) that the suspected abuser exhibits behavior other than normal.

(2) Refer the suspected abuser to a physician at the nearest medical treatment facility. Inform the physician directly of the information and observations regarding the patient.

NOTE: In the medical chain of command, only the physician can notify the unit commander of the suspected substance abuser.

NOTE: Referral to the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) must be made in accordance with AR 600-85, Department of the Army's Alcohol and Drug Abuse Prevention and Control Program.

Section II. CARE FOR AN OVERDOSE PATIENT

NOTE: This section provides instructions and guidance to care for an overdose patient. It is also closely related to Section I, Identify a Suspected Substance Abuser. You should be well familiar with the categories, signs, and symptoms of commonly abused substances. You should look for signs (for example, spoons, lamps, or pipes) that will identify the substance. Examining the patient will give further clues of the agent used. Before beginning care for the patient, you must obtain the patient's history.

1-6. OBTAIN PATIENT'S HISTORY

a. **Determine What was Taken.** If there is a bottle, keep the bottle and its remaining contents with the patient. The label on the bottle and the number of pills remaining may give indication as to what and how much was ingested.

b. **Determine When it was Taken**. Speed and duration of different substances vary markedly.

c. **Determine How Much was Taken.** It is important to know how much of the substance the patient took.

d. **Determine Route of Administration.** Drugs can be taken by mouth or be injected by needle intravenously, subcutaneously (just under the skin), or into muscles. It is important to know if drugs were taken by any other route. Overdoses will usually represent a combination of agents.

e. **Determine What was Done to Correct the Situation.** The patient may have taken steps to help himself or bystanders may have assisted.

NOTE: Street resuscitation procedures are frequently as dangerous as the overdose itself, and the rescuer needs to know exactly what the patient has been given.

1-7. CARE FOR THE PATIENT

General principles of care will be presented in the form of "active" and "passive" treatment. These principles are the same in most overdoses of commonly abused drugs.

a. **Active Treatment.**

NOTE: Remember to continue to evaluate and treat the patient for other injuries. Consult STP 8-91W-SM-TG for additional information,

(1) Administer oxygen.

(2) Prevent aspiration.

(3) Initiate an intravenous (IV) infusion of normal saline (NS).

(4) Monitor the patient's vital signs and be alert for respiratory arrest.

(5) Prevent the patient from harming himself or others.

(6) Contact the Poison Control Center if readily accessible. (Some, but not all, overdoses are treated by inducing vomiting.)

CAUTION: Avoid stimulants for DEPRESSANTS.

b. **Passive Treatment.** Probable use with stimulant overdose.

(1) Summon military police (MP) assistance for a violent patient.

(2) Use verbal control ("talk down") with the patient, if possible.

(3) Provide a quiet place for the patient to "crash."

c. **Transport.** Transport the patient to the nearest medical treatment facility (MTF).

Continue with Exercises

EXERCISES, LESSON 1

INSTRUCTIONS: The following exercises are to be answered by marking the lettered response that best answers the question or best completes the incomplete statement or by writing the answer in the space provided.

After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers.

1. The abuse of _____and _____ is commonly called substance abuse.

2. List the four categories of substance abuse.

   _____

   _____

   _____

   _____

3. Select the drugs that are categorized as narcotics.

   a. PCP, hashish, marijuana.

   b. Heroin, valium, nicotine.

   c. Opium, morphine, codeine.

   d. Caffeine, methadone, codeine.

4. Which of the following drugs is taken from the top of a hemp plant?

   a. Opium.

   b. Heroin.

   c. Caffeine.

   d. Marijuana.

5. Which of the following signs/symptoms is NOT a psychosocial sign/symptom?

   a. Argumentative.

   b. Lack of coordination.

   c. Avoidance of family and friends.

   d. Increased absence from work area.

6. You are working on the orthopedic ward at Brooke Army Medical Center. You suspect that one of the patients may be a substance abuser. Whom would you inform of your findings?

   a. The patient's spouse.

   b. The patient's physician.

   c. The patient's company commander.

   d. Alcohol and Drug Abuse Control Program.

7. In obtaining a patient's history, why is it important to determine when the substance was taken?

   _____

   _____

8. "Talking down" a violent patient is considered _____ treatment.

SPECIAL INSTRUCTIONS FOR EXERCISES 9 THROUGH 18. Match the terms in Column A with its definition in Column B.

COLUMN A	COLUMN B
____ 9. Tolerance	a. Drugs that have a pain relieving and sedative effect on an individual.
____10. Withdrawal	b. A mild stimulant found in coffee.
____11. Physical dependence	c. Substances that affect the central nervous system by decreasing awareness and the mental capacity to function.
____12. Drug dependence/ addiction	d. Drugs that are sometimes used with alcohol or with opium analgesics to augment the effects of a weaker product.
____13. Drug use	e. The physical condition in which larger doses of a drug are required to achieve the desired effect.
____14. Depressants	f. A drug that becomes necessary in order for a person to function physically.
____15. Narcotics	g. The use of a drug to the extent that usage becomes more frequent, tolerance increases, and stopping would result in withdrawal.
____16. Stimulants	h. Consistent pattern of physical responses that appears when regular drug use is discontinued.
____17. Hallucinogens	i. The infrequent or recurrent use of any substance that has an effect on the body.
____18. Barbiturates	j. These drugs increase awareness; they excite the user.
	k. Drugs that often result in dangerous psychiatric symptoms and behavior, attempts at suicide, or panic reactions.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 1

1. Alcohol; drugs (para 1-1a)

2. Depressants
   Stimulants
   Narcotics
   Hallucinogens (paras 1-3a--d)

3. c (para 1-3c)

4. d (para 1-3d(1))

5. b (para 1-4a and b)

6. b (para 1-5a)

7. Speed and duration of different substances vary markedly (para 1-6b)

8. Passive (para 1-7b(2))

9. e (para 1-2c)

10. h (para 1-2d)

11. f (para 1-2e(2))

12. g (para 1-2e)

13. i (para 1-2a)

14. c (para 1-3a)

15. a (para 1-3c)

16. j (para 1-3b)

17. k (para 1-3d)

18. d (para 1-3a(2))

End of Lesson 1

LESSON ASSIGNMENT

LESSON 2	Provide Initial Care for a Casualty Suffering from Combat Stress Reaction.
TEXT ASSIGNMENT	Paragraphs 2-1 through 2-5.
LESSON OBJECTIVES	After completing this lesson, you should be able to:

2-1. Identify terms and definitions related to combat stress.

2-2. Identify types of stress in combat.

2-3. Identify types and symptoms of battle fatigue.

2-4. Identify the principles of treatment indicated for combat stress reactions.

SUGGESTION After completing the assignment, complete the exercises at the end of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 2

PROVIDE INITIAL CARE FOR A CASUALTY SUFFERING FROM COMBAT STRESS REACTION

2-1. GENERAL

Soldiers in combat situations can experience overwhelming reactions to stress both physically and mentally. These reactions may result from physical exhaustion, the fear of constant alertness, the trauma of seeing fellow soldiers wounded or killed, the fear of being killed or maimed, or the fear of killing other persons. Combat stress reactions can be temporary; the soldier may not always be required to be removed from combat duty. However, if a soldier cannot function effectively on his job, you, as a medical specialist, may provide initial treatment or psychological first aid to the soldier. The critical incident stress debriefing (CISD) is another form of treatment that is available after a significant event. This requires a team of trained personnel to respond shortly after the incident.

2-2. TERMS AND DEFINITIONS

a. **Combat Stress Reactions.** Combat stress reactions are the emotional reactions that are temporary and experienced by every person who undergoes the stress of combat (includes both battle fatigue and transient battle reactions).

b. **Transient Battle Reactions.** Transient battle reactions are the temporary, debilitating psychological disorders that usually subside following rest and initial treatment.

c. **Fear.** Fear is the emotional response that is aroused by anxiety, panic, fright, terror, horror, an/or apprehension to real danger.

d. **Anxiety.** Anxiety is the distress or uneasiness caused by danger or situational stress that involves the feeling of apprehension, uncertainty, and insecurity.

e. **Depression.** Depression is the low level of functioning that manifests itself through the feeling of sadness, despair, hopelessness, dejection, discouragement, and self-condemnation.

f. **Lethality.** Lethality refers to the accuracy and killing power of modern weapons, which may increase levels of psychological stress.

NOTE: The battlefield environment may include the possible use of nuclear, biological, and/or chemical weapons.

NOTE: All of the above can increase the level of psychological stress.

g. **Brevity, Immediacy, Centrality, Expectancy, Proximity, Simplic**ity **(BICEPS).** BICEPS is an acronym used for the principles of treatment for soldiers suffering from combat stress reactions.

2-3. TYPES OF STRESS IN COMBAT

Some of the types of stress in combat are listed below.

a. Physical/psychological strain. This lowers the overload tolerance, but does not produce battle fatigue unless fear and/or internal conflicts are added (for example, sleeping and eating are irregular in quantity, quality, and timing; excessive physical exertion).

b. Fear/anxiety of pain, mutilation, death.

c. Fear of failure/disgrace.

d. Grief, rage (loss of friends, hatred of enemy, incompetent leadership, and so forth).

e. Ethical limits (killing, firing at noncombatants, leaving patients to die, and so forth). The soldier may feel guilty of his own rage or acts.

f. Internal conflict (survival vs. mission, loyalty, and ideals [leaving wounded friend behind, short timer, and so forth].

g. Boredom, restriction, loss of privacy, and so forth.

h. Home front worries, disappointment.

2-4. COMBAT STRESS REACTION--BATTLE FATIGUE

a. **Battle Fatigue.** Battle fatigue is the temporary emotional disorder, of varying severity, experienced by previously normal soldiers as a reaction to overwhelming or cumulative stress of combat.

(1) Victims will include combat soldiers as well as support soldiers.

(2) Normal reaction to abnormal situation.

b. **Types of Battle Fatigue.**

(1) Mild. A soldier with mild battle fatigue can be rested and restored in own unit or its closest logistical support element.

(2) Moderate. A soldier with moderate battle fatigue is too much a burden to stay with unit. The soldier needs medical/mental health evaluation, but can be treated and assigned to nonmedical logistical unit.

(3) Severe. A soldier with severe battle fatigue is too disruptive to stay in nonmedical setting. The soldier requires specialized care, but still may recover fully and quickly.

c. **Symptoms of Battle Fatigue.** The following are indicators of battle fatigue.

(1) "Thousand-yard-stare" (normal and common after heavy combat; improves with 1 to 2 days rest).

(2) Hyperalertness.

(3) Tension, startle response, fine tremors (becomes selective in veterans, but increases again with sleep loss and cumulative combat).

(4) Psychological symptoms (normal and very common).

(a) Headaches.

(b) Back pain.

(c) Nausea, vomiting.

(d) Bowel and urinary symptoms.

(5) Irritability (warning signs--silent, withdrawn, or "vicious" in own group).

(6) Inability to concentrate.

(7) Insomnia, terror dreams (afraid to sleep; therefore, symptoms get worse).

(8) Inertia, indecision, tiredness (can lead to mistakes and increased stress).

(9) Depression (motor retardation, crying, survivor guilt).

(10) Anxiety reactions (gross tremors, extreme startle).

(11) Memory loss (amnesia, complete or partial; "fugue" flight).

NOTE: "Fugue" flight individuals perform acts of which they appear to be conscious but, upon recovery, have no recollections of the acts.

(12) Loss of functions ("conversion reactions" that impair the soldier's job).

(a) Sensory (eyes, ears, touch, and so forth).

(b) Motor (paralysis, abnormal tics).

(c) Speech (stuttering, mute, can't understand).

(d) May mimic NBC, laser, or other hidden injury.

(13) Disorganization (impulsive, unpredictable behavior such as violent outburst, panic, freeze, stupor, hallucinations of battle).

2-5. PRINCIPLES OF TREATMENT

a. **Brevity, Immediacy, Centrality, Expectancy, Proximity, Simplicity**. Brevity, Immediacy, Centrality, Expectancy, Proximity, Simplicity (BICEPS) is used as a acronym for the principles of treatment for soldiers suffering from combat stress reaction. Brevity, Immediacy, Centrality, Expectancy, Proximity, Simplicity are explained below.

(1) Brevity. Treatment should be brief, lasting no more than three days. For more extensive treatment, ship the casualty to the rear.

(2) Immediacy. Identify the need for care early. You should not wait for consultant or evacuation to another facility.

(3) Centrality**.** Treat a casualty in one location separate from the hospital. This is done to maintain military image and to decrease self identification as sick person.

(4) Expectancy. Thorough verbal and nonverbal messages from staff, friends, and chain of command, the casualty should expect to return to duty after several days. The casualty should understand that no illness or lack of character exists, only normal stress reaction to combat exhaustion--recovery is assured.

(5) Proximity. Provide care as close as possible to casualty's unit of assignment in order to maintain bonding with unit and maintain support from friends.

(6) Simplicity. The goal of treatment is to return the casualty to combat, not to perform psychodynamic therapy.

b. **Other**. In addition to "BICEPS," the casualty should be provided with the following.

(1) Rest. This may include sedation for one or two nights, if necessary.

(2) Nourishing and appetizing food.

(3) Group support. This includes a chance to talk to others, compare feelings, and observe their recovery.

(4) Professional support. This bolsters the individual's defenses; emphasizes unit integrity, acceptance, and reassurance; and appeals to pride and duty.

(5) Military atmosphere. This includes rank, courtesies, field gear, uniform, performing relevant tasks, and quarters in a non-hospital environment.

NOTE: Some physicians, physician assistants (PA), and medics may feel it violates their ethical duty to establish a therapeutic goal of returning a combat fatigue soldier back to the dangers of combat. Remember:

--Somebody will go to the combat area as a replacement.

--The replacement, not psychologically bonded to the unit, will not have the support of friends and will be more at risk than others.

--The casualty being "helped" is being labeled a psychiatric patient. The results of this label may be a life-long chronic psychiatric disability.

NOTE: Seventy to eighty-five percent of casualties will return to duty within 72 hours, treated within division or near unit. An additional 10 to 20 percent of casualties treated in a combat zone will return to some duty within two weeks. Evacuation of a casualty is done only if a true, psychiatric disorder that will not respond within two weeks is evident.

Continue with Exercises

EXERCISES, LESSON 2

INSTRUCTIONS: The following exercises are to be answered by marking the lettered response that best answers the question or best completes the incomplete statement or by writing the answer in the space provided.

After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers.

1. _____ is the emotional response aroused by anxiety, panic, fright, terror, horror, or apprehension to real danger.

2. Which of the following statements is NOT a type of stress in combat situations?

   a. Thousand yard stare.

   b. Grief, rage, boredom.

   c. Home front worries, disappointment.

   d. Fear of failure/disgrace, pain, death.

3. List the types of battle fatigue.

   _____

4. All of the following symptoms are symptoms of battle fatigue EXCEPT:

   a. Depression.

   b. Inability to concentrate.

   c. Bowel and urinary symptoms.

   d. Good memory of actions performed.

5. What acronym is used to describe the principles of treatment for a soldier suffering from combat stress reaction?

   _____

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 2

1. Fear (para 2-2c)

2. a (paras 2-3, 2-4c(1))

3. Mild
   Moderate
   Severe (paras 2-4b(1), (2), (3))

4. d (para 2-4c)

5. BICEPS (para 2-5)

End of Lesson 2

LESSON ASSIGNMENT

LESSON 3	Apply Restraining Devices to Patients.
LESSON ASSIGNMENT	Paragraphs 3-1 through 3-5.
LESSON OBJECTIVES	After completing this lesson, you should be able to:
	3-1. Identify the principles that apply to the use of restraining devices to patients.
	3-2. Identify the proper procedures for applying restraining devices to patients.
SUGGESTION	After completing the assignment, complete the exercises at the end of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 3

APPLY RESTRAINING DEVICES TO PATIENTS

3-1. GENERAL

Restraints are used to immobilize a patient and to prevent him from harming himself or others. The patient's response to being restrained is rarely submissive. In many instances, he views the application of restraints as a personal, physical assault. He is frightened and responds by becoming combative. He is fearful of what is happening and is trying to protect his freedom. As a medical specialist, you must be aware of the patient's feeling and apply restraints to the patient in a most effective and expedient manner according to the needs of each patient.

3-2. PRINCIPLES OF APPLICATION OF RESTRAINING DEVICES

The following principles of application are important and must be observed when applying restraining devices.

a. Do not attempt to apply restraining devices alone. There should be an adequate number of personnel available to safely and efficiently restrain a patient.

b. The patient's ankles and wrists must be padded prior to applying restraints. Padding helps prevent chaffing and/or cutting of the skin.

c. Restraints should fit snugly to prevent escape, but should not restrict circulation or impair breathing. You should insert two fingers under the restraining straps to check for tightness. If your fingers can be comfortably inserted under the straps, the restraining straps are thought to be snug and should not restrict circulation.

d. Restraints must be placed so that no further injury will be done to a wound or interfere with therapeutic treatment such as IV infusions, tubes, or catheters. However, the restraints must prevent the patient from removing therapeutic devices.

e. When ankle restraints are applied, wrist restraints must also be applied. The wrist restraints will prevent the patient from using his hands to place himself in a position to hang from his ankles or to release the ankle restraints.

f. The patient should <u>never</u> be restrained on a portable commode or rocking chair. Both can be tipped over.

g. Straps should <u>not</u> be attached to the bed's side rails. If the side rails are lowered, the patient could be injured.

h. A depressed patient, or one having an altered level of consciousness, should not be restrained on his back with his limbs at his side. These patients should be placed in a prone position (face down) prior to applying restraints. Placing a patient in a prone position prevents aspiration if he should vomit.

NOTE: Aspiration and suffocation are potential dangers because the patient may have difficulty handling his secretions or emesis.

i. The patient should be checked frequently for signs of distress and security of restraints at least once every half hour or as directed by a physician. This check will also reassure the patient of your concern for him and that he is not being punished.

j. The restraints should be released one at a time and the patient's position should be changed at least once every two hours, day and night. Each of the patients limb should be exerci
sed through its normal range of motion.

NOTE: Release avoids excessive stiffening of muscles.

k. Keys to unlock the restraints must be readily available whenever a patient is placed in a locked restraint; all personnel must carry a key.

l. Restrained patients should be in a comfortable position. The head of the bed or litter may be elevated so that the patient can see his environment. This will assist in the patient's reorientation and decrease his confusion. The patient must know that you are concerned about his physical and emotional well-being and that the restraints are used for his protection.

3-3. HAZARDS OF RESTRAINTS

The following hazards are possible and could cause serious harm to the patient:

a. Tissue damage under the restraint.

b. Damage to other parts of the body.

c. Development of pressure areas.

d. Nerve damage.

e. Injury or death to the helpless, restrained patient due to fire or other occurrences.

f. Inability to effectively resuscitate a patient who had cardiac arrest.

NOTE: Shoulder dislocations are especially problematic if the patient is combative during the application of the restraints or has a grand mal seizure while restrained.

3-4. PREPARE AND APPLY RESTRAINTS

a. Check the Doctor's Orders or the Therapeutic Documentation Care Plan (Non-medications). Verify restraints or follow your supervisor's directive indicating that the patient is to be restrained and the type of restraining equipment to be employed.

NOTE: In a field environment, the need for restraints may be your own decision, especially in the absence of a senior medical specialist or physician.

b. Perform a patient care hand wash.

c. Gather equipment.

(1) Commercial restraints. This group includes limb holders or wrist type ("soft restraints"), body, jacket, elbow, leather (has a buckle with a locking device which requires a key to unlock), and papoose board or wrap (used for children).

(2) Improvised wrist and ankle restraints. This group includes abdominal (ABD) pads, washcloths, gauze sponges, sponge rubber roller gauze, and elastic bandages.

d. Verify the patient to be restrained.

NOTE: In case of emergency, paragraph 3-4d will be omitted.

e. Explain the procedure to the patient. Speak in a quiet, calm, reassuring voice and explain to the patient why the restraints are being applied in order to gain his cooperation. It may be necessary to repeat the explanation at frequent intervals, especially if the patient has been medicated with mind altering drugs or is confused. It is also essential that the patient's family and friends understand as well.

NOTE: If the patient is agitated or combative, keep the restraints out of his vision until he is in a position to be restrained.

f. Provide privacy for the patient. Place a screen/curtain around the patient's bed or close the patient's room door. Provide privacy to avoid upsetting other patients or causing embarrassment to the patient being restrained.

3-5. APPLY RESTRAINTS

Wrist and ankle restraints are used when it is necessary to restrict movement of the limbs. This will include when a patient is potentially harmful to himself or to others, to prevent the patient from removing tubes or other appliances, or to immobilize a part while a procedure is being done. These restraints may be leather, linen, or improvised from other materials.

NOTE: Disposable and reusable linen may be used as wrist and ankle restraints, but only if the purpose is to limit movement. They are not a secure method of restraining violent patients.

a. **Wrist and Ankle Restraints**.

(1) Clean the patient's skin of the wrist and ankles, then powder the skin.

(2) Pad the patient's limb with an ABD pad.

NOTE: Some cloth restraints are pre-padded with soft flannel or cotton that eliminates the need to apply additional padding.

(3) Position the restraint over the patient's limb and bring the strap, which is sewn at the tape, through the slot in the broad end (figure 3-1).

(4) Pull the strap snug enough to restrict free movement of the patient's limbs and tie the strap to the bed frame.

Figure 3-1. Limb holder or wrist restraint.

b. **Improvised Restraints**.

(1) Clean the patient's skin at the wrist and ankles and powder the skin.

(2) Pad the patient's limb with any soft cloth, such as towels, clothing, gauze, compresses, or clean handkerchief.

(3) Secure the restraining material to the patient's limb with a clove hitch (figure 3-2).

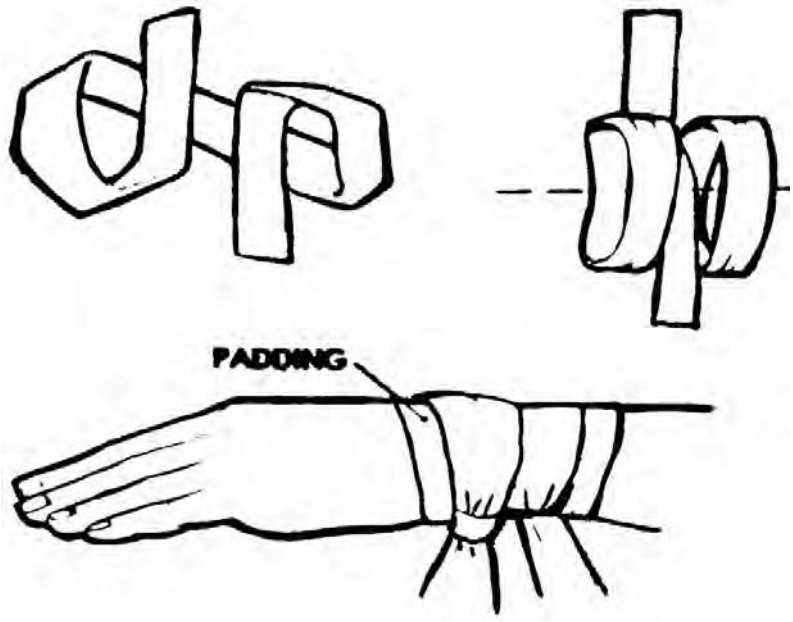

Figure 3-2. Improvised restraints.

(4) Pull the knot to fit the patient's limb snugly and tie both free ends to the bed frame.

(5) Repeat the steps above for the patient's other three limbs.

c. **Mitt Restraints**.

(1) Place the patient's hand in a naturally flexed position. This will allow for unrestricted circulation and provides minimal strain to the muscles.

(2) Place soft-rolled dressing or washcloth in the patient's hand and close the patient's hand. This permits the patient to flex his hand while the mitten is in place.

(3) Place padding between patient's fingers as shown in figure 3-3.

(4) Wrap the patient's entire hand snugly with Kerlix bandage (figure 3-3).

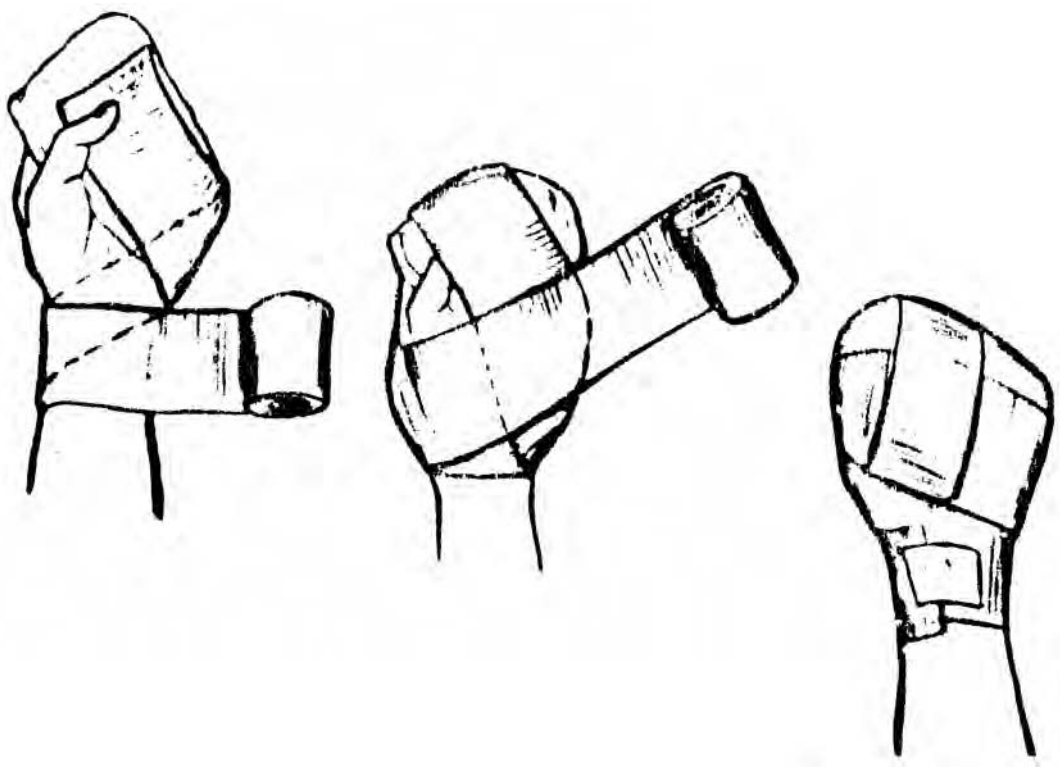

Figure 3-3. Mitt restraint.

(5) Secure the bandage with tape.

(6) Remove and reapply the mitt at least every six hours.

(a) Clean the patient's skin.

(b) Have patient perform range of motion exercises.

NOTE: Mitt restraints are often used to prevent the patient from scratching severe rashes, eczemas, and so forth. Commercially prepared mitts may be used, if available.

d. **Sheet and Litter Restraints**. This type of restraint is extremely uncomfortable and should be used as a temporary restraint only for a patient who is combative or uncontrollable.

(1) Unfold a sheet, hold at opposite corners, and fold lengthwise.

(2) Twist the sheet into a tight roll.

(3) Place the patient in a prone position on the litter. Turn his head to the side to help prevent aspiration in case the patient should vomit.

WARNING:

Frequently check patient because of possibility of suffocating while in a prone position.

(4) Place the middle of the roll diagonally across the patient's upper back and shoulder.

(5) Bring both ends of the sheet under the litter.

(6) Cross the ends of the sheet under the litter.

(7) Bring the ends of the sheet up and over the patient's other shoulder and other side of the patient's upper back and tie ends snugly in the middle of the patient's back with a square knot.

(8) Secure one of the patient's wrists to the litter parallel to the thighs using a wrist restraint.

(9) Secure the patient's other wrist overhead to the nearest litter-carrying handle using a wrist restraint.

(a) This method prevents the patient from pushing himself up from the litter.

(b) Also, it keeps the patient's arms and hands within confines of the litter.

NOTE: This procedure requires another person to assist.

e. **Bed Restraint**.

(1) Fold sheet in half, lengthwise.

(2) Tuck sheet approximately 2 feet of one end under one side of mattress at patient's chest level.

NOTE: Ensure there is adequate sheet under the mattress in order to prevent the sheet from being easily pulled out.

(3) Bring the other end of the sheet over the patient's chest.

(4) Keeping the sheet over the patient's chest and arms, tuck the free end of sheet snugly under other side of mattress.

CAUTION: This restraint should in no way take the place of side rails and should be considered one of the lease effective methods of restraints.

NOTE: If further restriction is desired, sheets may be applied in the same manner at the level of the patient's abdomen, legs, knees, and/or ankles.

f. **Field Expedient Restraints**. Under field conditions, standard restraining devices may not be available. However, violent patients must be restrained. By utilizing materials commonly carried by the soldier in the field, patients can be effectively placed in field-expedient restraints. Field expedient restraints may be improvised from such items as two litters, rifle slings, web belts, bandoleers, and cravats (folded cloth). The field-expedient restraints should be replaced with regular restraining devices as soon as possible and should not be used for long periods of time. With any field-expedient restraint, the same considerations used in applying regular restraints must be followed.

(1) Mixed equipment. A variety of equipment (rifle slings, web belts, bandoleers, cravats, rope, and so forth) can be used to restrain a patient in the field. See figure 3-4 for an example.

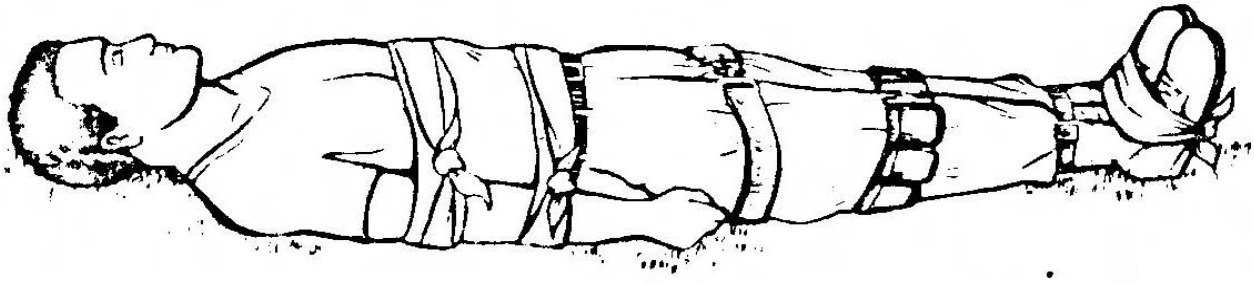

Figure 3-4. Mixed equipment restraint.

(2) Double litters with litter strap.

NOTE: Be sure to obtain adequate help to assist with the patient.

(a) Place the patient on the litter in the prone position and turn his head to one side.

(b) Place each of the patient's hands along his thigh and use wrist restraints to secure his hands to the litter.

(c) Place the other litter, carrying side down, on top of the patient.

(d) Bind litters together with two or more litter straps (figure 3-5).

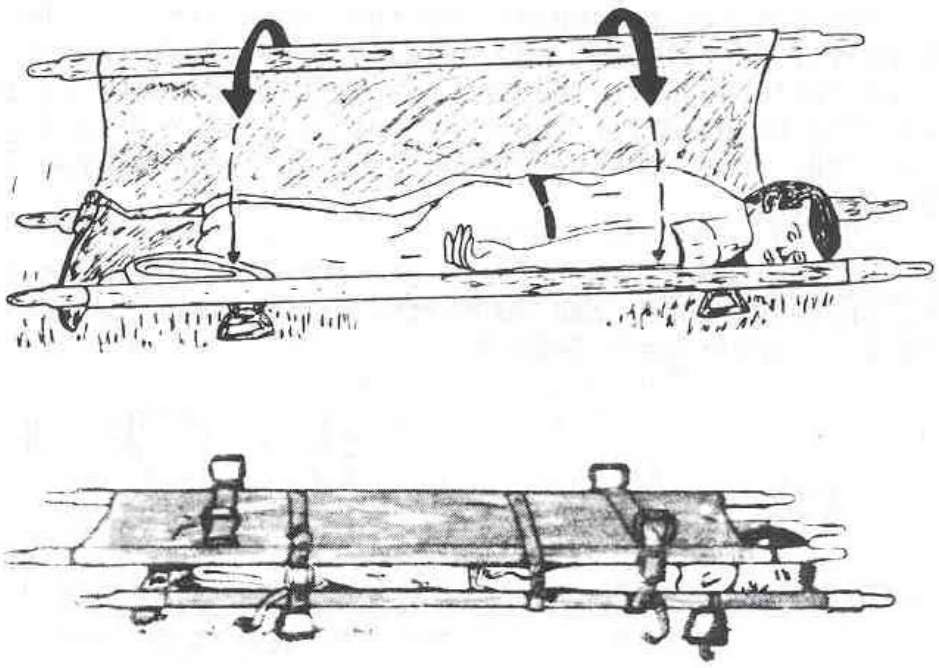

Figure 3-5. Double litter restraint.

g. **Record and Report Action Taken**.

(1) Record the date and time the restraint was applied.

(2) Record the type of restraint applied.

(3) State reason for the application of the restraint.

(4) State the patient's tolerance of the procedure.

Continue with Exercises

EXERCISES, LESSON 3

INSTRUCTIONS: The following exercises are to be answered by marking the lettered response that best answers the question or best completes the incomplete statement or by writing the answer in the space provided.

After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers.

1. List three possible hazards of restraints that could seriously harm a restrained patient.

   _____

   _____

   _____

2. What is the first step to be taken while preparing to apply restraints to a patient?

   a. Gather equipment.

   b. Verify the patient to be restrained.

   c. Explain the procedure to the patient.

   d. Check the Doctor's Orders or the Therapeutic Documentation Care Plan.

3. Name the two types of commonly used restraints.

   _____

   _____

4. Which of the following statements is NOT a hazard to a restrained patient?

   a. Nerve damage.

   b. Mental damage to patient.

   c. Tissue damage under the restraint.

   d. Damage to other parts of the body.

5. Why should a patient's wrist and/or ankles be padded before applying restraints?

   _____

   _____

6. Restraints should fit snugly to prevent escape but it should NOT restrict

   _____ or _____.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 3

1. Any three of the below.

   Tissue damage under the restraint.
   Damage to other parts of the body.
   Development of pressure areas.
   Nerve damages.
   Injury or death to the helpless, restrained patient due to fire or other occurrences.
   Inability to effectively resuscitate a patient who had cardiac arrest. (para 3-3)

2. d (para 3-4)

3. Commercial.
   Improvised. (para 3-4c)

4. b (para 3-3)

5. To prevent chaffing and/or cutting of his skin. (para 3-2b)

6. Circulation, impair breathing. (para 3-2c)

End of Lesson 3

LESSON ASSIGNMENT

LESSON 4	Refer for Treatment a Potentially Suicidal Patient.
TEXT ASSIGNMENT	Paragraphs 4-1 through 4-8.
LESSON OBJECTIVES	After completing this lesson, you should be able to:

4-1. Define terms commonly used in relation to a potential suicidal person.

4-2. Identify how depression relates to suicidal patients.

4-3. Identify the physical and psychosocial symptoms or possible contributing factors in depression.

4-4. Identify how crises development is associated with a potentially suicidal patient.

4-5. Identify suicidal tendencies.

4-6. Identify appropriate intervention measures for a potentially suicidal patient.

SUGGESTION After completing the assignment, complete the exercises at the end of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 4

REFER FOR TREATMENT A POTENTIALLY SUICIDAL PATIENT

4-1. GENERAL

a. Suicide is the tenth leading cause of death in the United States and the third leading cause of death for adolescents and adults under thirty. Additionally, the suicide rate for this group is increasing. Suicide attempts typically occur when close emotionally attachments are endangered or when a significant individual in the patient's life has been lost. The suicidal patient often has feelings of being unable to manage his own life, a sense of worthlessness, and a lack of self-esteem. Each suicidal act or gesture must be taken seriously and the patient referred to trained medical personnel for appropriate action.

b. Seventy-five percent of potential suicides visit a medical facility within six months prior to their death. Timely awareness of pre-suicidal signs and symptoms can lead to correct intervention and prevention. The suicide rate among soldiers during wartime tends to decrease. Aggressive drives are often channeled toward the enemy. Nonetheless, some deaths due to inappropriate behavior during combat may, in reality, be suicides. It is possible that you, the medical specialist, may be involved directly with persons who are potentially suicidal.

4-2. TERMS COMMONLY USED IN RELATION TO A POTENTIAL SUICIDAL PERSON

a. **Behavior Signs**. Behavior signs are actions or behaviors that a person takes, such as spending more money than usual or increasing alcohol consumption. These signs may also give some indication of the person's thinking.

b. **Crisis**. Crisis is the point at which customary problem-solving or decision-making methods are no longer adequate. At this turning point, a person may choose suicide as a way to solve the problem.

c. **Depression**. Depression refers to feelings (moods) of sadness, despair, and discouragement, and (as such) may be a normal state. Depression that may be disruptive to the soldier is commonly manifested in decreased thinking processes or purposeful physical activity, guilt, self-condemnation, hopelessness, and disorders of eating and sleeping.

d. **Intervention**. Intervention is treatment by health care personnel when there is some question of the individual's ability to cope with his own resources and requires assistance. This action is also known as "crisis intervention" when the individual shows signs of reaching a crisis point.

e. **Stress**. Stress is any situation or action that places physical or psychological demands upon a person. Exhaustion refers to prolonged and unrelieved strain and tension generated in a person by situations encountered in life.

f. **Stressors**. Stressors are specific situations that may trigger stress in a person (for example, taking a test, playing a game of football, receiving or not receiving a promotion, a permanent change of station).

g. **Suicide**. Suicide is the act of intentionally killing oneself.

h. **Suicidal Attempt**. A suicide attempt is the act of self-damage inflicted with self- destructive intention, however vague and ambiguous. Sometimes this intention has to be inferred from the person's behavior.

i. **Verbal Signs**. Verbal signs are spoken words or acts or interpersonal communication, such as telephone calls or an ordinary conversation. These signs may reveal the thoughts of a person.

4-3. DEPRESSION

Depression is the single most outstanding characteristic of individuals who attempt suicide and suicidal victims. The individual often believes that nothing can be done or no one can help the situation.

a. **Types of Depression**.

(1) Situational loss. This includes the loss of a loved one, loss of self-esteem, and/or the inability to admit or to express anger.

(2) Internal. This type is not related to an event or situation; it may be due to a chemical imbalance in the brain.

b. **Physical Symptoms of Depression.**

(1) Change in eating habits.

(a) Extreme weight loss.

(b) Extreme weight gain.

(2) Change in sleeping habits.

(a) Inability to sleep (insomnia).

(b) Excessive sleep.

(3) Change in normal energy level.

(a) Low energy level (chronic tiredness).

(b) Overactivity (agitation).

(c) Restlessness.

(d) Physical exhaustion.

(4) Change in normal mental response.

(a) Difficulty in decision-making.

(b) Confused thinking.

(c) Short attention span.

(5) Complaints about physical problems.

(a) Chest, stomach, back.

(b) Head, extremities.

(c) Constipation.

(d) Decreased sexual performance, desire.

NOTE: The medical specialist should be alert to possible emotional problems which may be signaled by surface physical complaints. Remember that a substance abuser may also exhibit some of the physical problems.

(6) Personal injury, accidental dismemberment, or carelessness around field equipment.

NOTE: Depression is the single most outstanding characteristic of suicide and potential suicide; thus, the signs and symptoms of depression and potential suicide are the same.

c. **Psychosocial Symptoms or Possible Contributing Factors in Depression**. Psychosocial symptoms refer to human emotions and the context of change in the life-pattern of an individual. Many of these symptoms are caused by stress due to some current situation (recently or within the last year). Remember that a substance abuser may exhibit some of these same psychosocial symptoms. The symptoms include the following.

(1) Depressed mood.

(a) Feels low, sad, gloomy.

(b) Expresses self-reproach, self-depreciation.

(c) Tearfulness and/or trembling.

(2) Change in appearance.

NOTE: Changes in appearance are indicative of the person's mood and deteriorating self-image.

(a) Self-neglect of hair and/or personal hygiene.

(b) Lack of concern for dress.

(c) Bodily movement slowed, decrease in gestures, stooped and bent posture.

(d) Facial expression may be blank, old, or sad.

(3) Change in work habits.

(a) Lowered quality/quantity.

(b) Inconsistent work pace. Pace of work is likely to change frequently, without apparent reason.

(c) Compulsive work.

(d) Lack of interest in work.

(4) Changes in usual patterns of behavior.

(a) Loss of interest in recreation/hobbies.

(b) Loss of interest in people. The individual may avoid family and friends; may have a decreased sexual drive.

(5) Marital and family problems.

(a) Separation/divorce.

(b) Difficulties with spouse.

(c) Child-rearing problems.

(d) Loss of self-control.

(e) Social isolation.

(6) Financial problems.

(a) Debts.

(b) Living within tight budget.

(7) Interpersonal problems.

(a) Lover's quarrels.

(b) Difficulty in accepting authority.

(c) Homesickness.

(d) Loss of supportive community/family ties.

(e) Difficulty with people at work.

4-4. CRISIS DEVELOPMENT

a. **Definition**. Crisis development is an emotionally significant event or radical change of status in an individual's life. This emotional state occurs when an individual faces an obstacle in reaching important life goals. A crisis develops when the individual decides that goals cannot be attained because "normal" methods of problem solving do not work.

b. **Precipitating Events**.

(1) Situational events. These are stressful events that threaten one's sense of biological, psychological, or social integrity (death in family, drastic change in social role, physical illness, divorce, rape, suicide, and so forth).

(2) Maturational events. These events are normal processes of growth and development that evolve over an extended period of time. Frequently, the individual is required to make many changes (infancy, early childhood, preschool, pre-puberty, adolescence, young adulthood, late adulthood, old age).

NOTE: In the absence of support systems and coping skills, a stressful event could result in a crisis. A successfully resolved crisis usually results in some degree of personal growth and learning. A person in a crisis situation that he cannot resolve may find himself in an ever increasing cycle of anxiety and perceived helplessness. It is in these types of persons we may see what we call "extreme" crisis behaviors--that is, suicide, homicide, assault, or aggression.

4-5. SUICIDAL TENDENCIES

Suicidal tendencies refer to acts against one's self to commit suicide. Many factors influence a patient's decision to try to end his own life; loneliness seems to be a primary reason. The patient who does not identify himself with some group (such as a family, church, or community) is more susceptible to suicidal tendencies.

a. **Definitions**.

(1) Completed suicide. This is the taking of one's life with conscious intent. There are approximately 40,000 completed suicides in the US each year.

NOTE: According to medical and legal aspects, unless there was a clear intention to die, the victim did not commit suicide.

(2) Attempted suicide. This is a very serious self-destructive act that could easily result in death if it were not for "fortuitous circumstances" beyond the person's control.

NOTE: A "fortuitous circumstance" in this case means that the suicidal act was not completed or that the victim was found after completing the act, but before he died.

EXAMPLES: COL Doe put a loaded gun to his head, pulled the trigger, and nothing happened.

PVT James severely lacerates her wrists. She is discovered by her roommates before bleeding to death.

NOTE: There are approximately one-half million attempted suicides in the US each year. Eight percent of attempted suicides are successful.

(3) Suicide gestures. A suicide gesture is an act that is indicative of self-destructiveness, but the level of lethality is so low that it could not cause death.

NOTE: A suicide gesture is usually made in front of at least one other person or the person making the gesture anticipates discovery shortly after the act.

EXAMPLES: After being dumped by his girlfriend, SGT Act goes to the latrine and scratches his wrists with a ball-point pen.

One evening in his quarters, SGT Jinx puts an unloaded pistol to his head and tells his wife, "I won't put up with this anymore."

(4) Suicidal threat. This refers to saying or doing something that reveals a self-destructive desire. These threats are made by people who are wishing to call attention to their situation and who are trying to manipulate others.

EXAMPLE: A husband tells his wife, "if you leave me, I'll drive my car off a mountain."

(5) Suicidal ideation. This refers to having thoughts about killing yourself. It is normal for people to have such thoughts at one time or another in their lives.

(6) Hardcore suicide. This refers to persons who comprise a small percentage of those who attempt suicide. They do not give warning signals or clues, nor do they seek help for their suicidal feelings. They make the decision to kill themselves impulsively and select a means or method which kills quickly. Very little can be done to help these people.

NOTE: When persons are expressing self-destructive intent in words, or behavior, it is always serious. Persons who are considering ending their lives are experiencing intense levels of anxiety and feel helpless to act in what they perceive to be a hopeless situation. You should treat any situation of this nature for the crisis it is. Do not attempt to dismiss the situation by saying it's just a threat, gesture, and so forth. You may well be this person's "last hope."

NOTE: Suicide is widely dispersed and is not limited by age, sex, race, social-economic status, or profession.

b. **General Observations About Suicide**.

(1) The overwhelming majority of suicidal people do not want to die. They are generally seeking relief from an "intolerable" situation involving more stress or pain than they can bear.

(2) The "typically" suicidal person wants to be rescued. These persons have difficulty asking for help, are not certain to whom to turn for help, and do not know what they specifically want done.

(3) Most persons experience a suicidal episode only once in their lives, and are acutely suicidal for an extremely brief period. If one can stop them from committing suicide during this "crisis period," the chances for future attempts are greatly reduced.

(4) Suicidal feelings tend to be episodic.

(5) Three "H" words associated with suicidal thoughts and actions:

(a) Hopelessness: people only kill themselves when their lives are devoid of hope.

(b) Helplessness: suicidal persons often see themselves as unable to meaningfully alter their situation.

(c) Haplessness (unhappy): may involve presence of personality disorders, poor stress tolerance/coping skills, or no resources to help in times of crisis.

NOTE: Suicidal persons are generally experiencing multiple problems, which are impacting simultaneously, and thus cannot concentrate on dealing with any one of them.

c. **Danger Signals**.

(1) Suicidogenic situation. A suicidogenic situation is when the situation itself is conducive to suicidal thoughts and feelings.

EXAMPLES: Cadet Smith ranks at the top of his class at West Point and is the star of the football team. One weekend, he is in a serious car accident and both of his legs are amputated.

After being with his company for 20 years, top man in the firm and totally dedicated to his work, Mr. Executive is suddenly fired without an explanation.

(2) Depressive symptoms. Depressive symptoms include but not limited to:

(a) Insomnia.

(b) Inability to concentrate.

(c) Loss of appetite.

(d) Apathy/social withdrawal.

(e) Poor personal hygiene/sloppiness.

(f) Crying.

(g) Feelings of worthlessness.

(3) Verbal warnings. The mythology surrounding suicide leads people to believe that those who talk about killing themselves do not actually do so. Nothing could be further from the truth. Some examples of verbal warnings are:

(a) "I'm getting out/tired of it all."

(b) "I wish I were dead."

(c) "I can't go on any longer."

(d) "If such and such happens (or doesn't happen), I'll kill myself."

(e) "You're going to regret how you've treated me."

(f) "Here, take this (valued possession), I won't be needing it anymore."

(4) Behavioral warnings. A person may not give verbal warnings as to incipient suicidal feelings, but may demonstrate his intent behaviorally. Some of these behavioral warnings are:

(a) Organizing personal/business matters as one would if going away for an extended period of time.

(b) Planning one's own funeral shortly after the death of a loved one.

(c) Suddenly resigning from organizations such as clubs or church groups.

(d) Crying for no apparent reasons.

(e) Unexplained deviation from ingrained behavior patterns. A non-drinker begins drinking to excess. A person who hates guns suddenly buys one.

(f) Composing a suicide note.

NOTE: Suicide notes are sometimes found days before the suicide occurs.

(g) Sudden, unexplained recovery from a severe depression.

NOTE: Some persons who have decided to kill themselves may appear quite happy. Actually, they are not happy, but are relieved of their burden of stress and pain by the decision to kill themselves. You cannot tell the difference just by looking at them.

(h) Attempted suicide is the strongest behavioral warning.

NOTE: A person who has attempted suicide does not automatically cease to be suicidal. Approximately half of the people who kill themselves have previously attempted to do so.

4-6. EXAMPLES OF METHODS OF SUICIDE

Some examples are given below.

a. Self-inflicted gunshot.

b. Throat slashing.

c. Jumping from high place.

d. Overdose of medication (for example, aspirin, Tylenol, "sleeping pills").

e. Wrist-cutting.

f. Hanging.

g. Automobile (carbon monoxide poisoning, "accidents").

4-7. APPROPRIATE INTERVENTION ACTION

a. **When to Intervene**. The medical specialist should take appropriate intervention actions, when the individual displays potentially suicidal behavior or there is a clear and present danger to the individual or others.

(1) Communication with patient should explicitly convey a message of caring and hope that solutions to patient's problems can be found. Convey your willingness to listen and understand.

(2) Assessment of suicidal risk is not easily accomplished. If there is any suspicion of possible suicidal intentions, the medical specialist should refer the individual to specially trained personnel such as 91X (mental health specialist).

(3) If an individual should confront the medical specialist with immediate means of suicide on his person (such as medication, knife. or gun), intervention may be necessary, but extreme caution should be exercised so as not to endanger other people or yourself.

b. **Take Appropriate Intervention Actions**. Notify your immediate supervisor or non-commissioned officer in charge (NCOIC) of possible need for intervention, without delay.

CAUTION: Do not leave the individual alone at any time; he might kill himself.

(1) If physical and psychosocial symptoms are observed and indirect verbal and behavioral warning signs are noted, discuss the situation with the NCOIC or professional personnel in accordance with (IAW) local directives.

(2) If physical and psychosocial symptoms are observed and direct verbal and behavioral warning signs are noted, contact professional medical personnel by emergency call. Proceed IAW local directives.

(3) You may accompany individual to referral agency or to consulting professional for assessment or turn the individual over to the official transportation arranged for by professional personnel.

4-8. CLOSING

As a medical specialist, you should become familiar with and knowledgeable about potential suicidal patients. Awareness of presuicidal symptoms and signs could lead to intervention and prevention. Surely all of us experience times in our lives when we simply cannot face another day, when life just doesn't seem worth the agony and pain it forces us to endure. Yet, however "appropriate" and strong these feelings of utter hopelessness seem to be, and the fleeting impulse to end it all, most of us don't give into the impulse. The most important response to any suicide threat is to take it seriously--as if someone's life depended on your being concerned.

Continue with Exercises

EXERCISES, LESSON 4

INSTRUCTIONS: The following exercises are to be answered by marking the lettered response that best answers the question or best completes the incomplete statement or by writing the answer in the space provided.

After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers.

SPECIAL INSTRUCTIONS FOR EXERCISES 1 THROUGH 9. Match the terms in Column A with its correct definition in Column B. Place the letter of the definition in the blank space to the left of Column A.

COLUMN A	COLUMN B
___ 1. Depression	a. At such time when customary problem-solving or decision-making methods are no longer adequate.
___ 2. Stress	b. The act of self-damage inflicted with self-destructive intention.
___3. Suicide	c. Actions or behaviors that a person takes which may indicate the way he is thinking.
___ 4. Intervention	d. Refers to feelings (moods) of sadness, despair, and discouragement.
___5. Crisis	e. Acts, spoken words, or interpersonal communication that may reveal a person's thoughts.
___ 6. Suicide attempt	f. Any action or situation that places physical or psychological demands upon a person.
___ 7. Stressors	g. Treatment by health care personnel when there is indication of an individual's inability to cope with his own resources and requires assistance.
___8. Behavior signs	h. Specific situations that may trigger stress in a person.
___ 9. Verbal signs	i. Intentionally killing oneself.

10. What is the single, most outstanding characteristic of a person who attempts suicide?

_____

11. List the two types of depression.

_____

_____

12. _____ _____ refers to human emotions and the context of change in the life pattern of an individual.

13. What are the two types of events of crisis development?

_____

_____

SPECIAL INSTRUCTIONS FOR EXERCISES 14 THROUGH 19. Match the suicidal tendencies in Column A with the statement in Column B. Place your answer in the blank spaces to the left of Column A.

COLUMN A	COLUMN B
___14. Hardcore suicide	a. Mr. Jones shoots himself in the head and dies immediately.
___15. Suicidal threat	b. Mrs. Keys tells her husband that she is going to jump off the top of their three-story house.
___16. Attempted suicide	c. A person thinks of committing suicide.
___17. Suicide gesture	d. PVT Jinson puts a knife through his throat and is immediately discovered by his DS (Drill Sergeant).
___18. Completed suicide	e. After an argument with his wife, SGT Meads goes in the kitchen and drinks a gallon of vinegar.
___19. Suicide ideation	f. For no apparent reason, SFC Lawson steps out in front of an eighteen-wheel truck that is traveling at a very fast speed.

20. List the three "H" words associated with suicidal thoughts and actions.

_____

_____

_____

21. List the danger signals of suicidal tendencies.

_____

_____

_____

_____

22. Which of the following situations is NOT an example of method of suicide?

a. Throat-slashing.

b. Wrist-cutting.

c. Overdose of medication.

d. Sleeping for two days.

e. Jumping from high places.

f. Self-inflicted gunshot.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 4

1. d (para 4-2c)
2. f (para 4-2e)
3. i (para 4-2g)
4. g (para 4-2d)
5. a (para 4-2b)
6. b (para 4-2h)
7. h (para 4-2f)
8. c (para 4-2a)
9. e (para 4-2i)
10. Depression (para 4-3)
11. Situational loss; Internal (para 4-3a)
12. Psychosocial symptoms (para 4-3c)
13. Situational; Maturational (para 4-4b)
14. f (para 4-5a(6))
15. b (para 4-5a(4))
16. d (para 4-5a(2))
17. e (para 4-5a(3))
18. a (para 4-5a(1))
19. c (para 4-5a(5))
20. Hopelessness; Helplessness; Haplessness (para 4-5b(5))
21. Suicidogenic situations; Depressive symptoms
    Verbal warnings; Behavioral warnings (para 4-5c)
22. d (para 4-6)

End of Lesson 4

LESSON ASSIGNMENT

LESSON 5	Manage Behavioral Emergencies.
TEXT ASSIGNMENT	Paragraphs 5-1 through 5-9.
LESSON OBJECTIVES	After completing this lesson, you should be able to:

5-1. Identify terms and their definitions of behavioral emergencies.

5-2. Identify precipitating factors/causes of disoriented, confused, and/or violent behavior.

5-3. Identify how acute alcohol intoxication, disorientation, and violent behavior relates to behavior emergencies.

5-4. Identify the procedures used to manage an armed, violent patient.

5-5. Identify when and how restraints are used on a violent patient.

SUGGESTION After completing the assignment, complete the exercises at the end of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 5

MANAGE BEHAVIORAL EMERGENCIES

5-1. GENERAL

Dealing with an individual who has an extreme, confused, or violent behavior could cause serious injury to you or the individual himself. This lesson presents common characteristics of the acutely alcohol intoxicated, the disoriented, and the violent patient. It also presents management procedures of the violent patient who is unarmed and of the violent patient who is armed.

5-2. TERMS AND DEFINITIONS

You must first become familiar with terms and definitions of behavior emergencies as listed below.

a. **Alcoholic Hallucinations**. These are hallucinations that are seen in the alcoholic patient as part of the alcoholic withdrawal syndrome.

b. **Anxiety**. Anxiety is a feeling of apprehension, uncertainty, and fear with no identifiable cause (faceless fear).

c. **Delirium**. Delirium is disorientation for time and place, usually with hallucinations and delusions. It is a state of mental confusion and excitement.

d. **Delirium Tremens**. Delirium tremens is a serious manifestation of the alcohol withdrawal syndrome with restlessness, fever, confusion, agitation, disorientation, and hallucinations. These patients are extremely ill and have a high mortality rate.

e. **Dementia**. Dementia is an irreversible deterioration of intellectual faculties with emotional disturbance and disorientation; usually due to an organic disease of the brain (for example, "senile dementia" in the elderly).

f. **Disorientation**. Disorientation is a disturbed mental state characterized by confusion regarding one's relationship to physical surroundings, time, or person.

g. **Disturbed**. Being disturbed refers to having emotional problems--to be troubled emotionally or mentally.

h. **Hallucinations**. A hallucination is sensory impression (sight, touch, sound, smell, or taste) that has no basis in external stimulation. It can have psychological causes (mental illness) or can result from drugs, alcohol, or organic illnesses.

i. **Intoxication**. A person who is intoxicated is affected by alcohol or another drug to the point of losing physical and mental control.

j. **Violent Behavior**. Violent behavior is behavior that is potentially hazardous to the patient/casualty or others. It is not peculiar to any one type of diagnosis.

5-3. POSSIBLE PRECIPITATING FACTORS/CAUSES OF DISORIENTED, CONFUSED, AND/OR VIOLENT BEHAVIOR

Not only psychological, but also physical conditions, illnesses, and injuries are common causes of behavioral emergencies. The following examples can produce changes in the cerebral chemistry or tissue, disrupting the cerebral metabolism and oxygenation which consequently leads to neurological dysfunction.

a. Medical illness.

(1) Organic brain syndrome (disruption of and impairment of function of brain tissue from variety of causes).

(2) Severe infection.

(3) Cerebral or pulmonary emboli.

(4) Electrolyte disorders.

(5) Cancer.

b. Head trauma.

c. Hypoxia.

d. Personality disorders (for example, poor impulse control).

e. True neuropsychiatric illness.

(1) Paranoia. Paranoia is a form of psychosis characterized by delusions (of grandeur, of persecution, and so forth).

(2) Schizophrenia. Schizophrenia is a psychosis characterized by delusions and hallucinations marked withdrawal from interpersonal relations, severe deterioration of personal habits, and bizarreness of gestures and speech.

f. Senile dementia in elderly.

g. Suicidal crisis.

h. Substance abuse.

(1) Drugs (intoxication and withdrawal syndromes).

(2) Alcohol (acute intoxication and alcohol withdrawal syndrome).

i. Severe situational stress/anxiety.

5-4. ACUTE ALCOHOL INTOXICATION

a. Alcohol normally acts as a depressant. It dulls reflexes, dulls sense of awareness, decreases reaction time, and depresses one's inhibitions (therefore, sometimes thought of as stimulant).

NOTE: The acutely alcohol intoxicated patient may exhibit signs like patients with physical injuries or illnesses. Also, alcohol intoxication may mask signs and symptoms of underlying physical or psychological illness.

b. Acute disorientation can occur with varying levels of alcohol intake in an inexperienced drinker (young, elderly, and so forth). Normally, the average adult would have to drink enough to become sedated before becoming disoriented. Disorientation often occurs when alcohol is mixed with other drugs.

c. A drunken patient may show extreme behavior. He may exhibit aggression, destructiveness, belligerence, combativeness, paranoia, and/or inappropriate behavior.

d. Gross behavioral disturbance is often a sign of an underlying or additional problem besides ingestion of alcohol (for example, psychiatric illness, ingestion of hallucinogenics or stimulants).

e. Alcohol withdrawal syndromes occur in a person who is used to constant alcohol intake. When the supply is withdrawn, the patient may manifest alcohol hallucinations and/or delirium tremens.

f. Management of acutely alcohol intoxicated patient.

(1) Protect the patient from harming himself and/or others.

(2) Maintain the patient's airway and prevent him from aspiration.

(3) Monitor the patient's vital signs.

(4) Evaluate the patient for underlying illness and/or injury.

(5) Administer oxygen to the patient and start an IV with normal saline.

(6) Prepare to have the patient evacuated to the nearest medical treatment facility (MTF).

5-5. DISORIENTATION

a. Disorientation is a disturbed mental state characterized by confusion regarding one's relationship to physical surroundings, time, or person. It may be a sign of underlying illness, injury, or stressful situation--not separate disease state.

NOTE: It is always important to consider the underlying contributing factors/cause of the disoriented or confused behavior. Many similar conditions, illnesses, or injuries may contribute to or cause manifestations of disorientation, disturbed behavior, and/or violent behavior. It is essential, after reacting to the particular situation presented, that each casualty or patient be carefully evaluated both physically and mentally to determine the true physiological cause of any behavioral emergency.

b. Management of a confused/disoriented patient.

(1) Prevent the patient from harming himself and/or others.

(2) Use the patient's name frequently.

(3) Give frequent reassurance as to time, place, and situation.

(4) Explain any procedures or actions simply, but in detail.

(5) Decrease sensory stimulation by providing simplified environment (a quiet and well-lit room, and so forth).

(6) Evaluate the patient for the underlying illness or injury suspected to precipitate the disorientation.

5-6. VIOLENT BEHAVIOR

a. Violent behavior is behavior that is potentially hazardous to the patient and/or others. It also is not peculiar to any one type of diagnosis; however, there are certain conditions and situations that might indicate a potential for violence. Most of the factors that might precipitate other disturbed behaviors are also known to occasionally precipitate violence.

b. Potentially, violent episodes should be anticipated. Be aware that some (but not all) patients in stressful situations may pass through the four stages of crisis development. If you are able to recognize these stages, you may be able to intervene early and appropriately.

(1) Stages of crisis development.

(a) Anxiety.

(b) Acting out orally (patient may become defensive, argumentative, and possibly verbally belligerent).

(c) Acting out physically (patient may lose control and may assault you by grabbing, striking, and so forth; he may or may not use some type of weapon).

(d) Tension reduction (in this stage patient becomes rational again and realizes that he has done something wrong).

(2) Although there are no fail-proof predictors of violence, awareness of the following behaviors may help you anticipate and/or prevent violent episode:

(a) Past history of violence, violent family life, and/or child abuse.

(b) Body language that includes clenched fists, rigid posture, and/or tautness (strained or tight).

(c) Verbalization of hostile threats or anger.

(d) Increased motor activity.

(e) Overt aggressive acts.

(f) Suspicion of others.

c. Procedures for managing an unarmed violent patient are given below.

(1) A violent, agitated patient must be controlled before you attempt to diagnose or make referral.

(2) Verbal control should be attempted first. The following verbal techniques are applicable to any situation in which a patient exhibits confused/disoriented, disturbed, or potentially violent behavior.

(a) Talk calmly.

(b) Do not threaten.

(c) Provide reorienting information about who you are, where the patient is, and how you can help.

(d) Ask the patient questions relating to why he is agitated. This often gets the person thinking rationally, as well as giving you information. It is often sufficient to calm someone who is not in a panic anxiety state, and is even sufficient for most psychotics.

(3) If verbal control succeeds, continue to reassure and provide orienting information while reinforcing a "medical care image."

(a) Example--"Good. You're looking calmer. I should check your pulse and blood pressure now."

(b) If patient accepts this, the patient is agreeing to sit still. Keep talking and reorienting the patient while preparing to do further procedures or while awaiting assistance.

(4) If verbal control is not successful, the patient must be brought to a horizontal position on the floor to ensure safety of both the patient and staff.

(a) Prefer a minimum of four to five attendants. There should be one attendant to each of the patient's extremities and one to the patient's head to prevent injuries.

NOTE: It is better to wait until there is enough help, unless danger demands high risk intervention.

(b) Action should be quick and decisive rather than ambivalent (uncertain as to which approach to follow).

(c) Spectators should be cleared from the area. Spectators seldom understand and usually misinterpret what is happening.

(d) When the patient is on the floor, a stretcher can be placed under him and sheets or cuff restraints can be used to maintain secure control (or use double litters in field environment). Put patient in prone position with head turned to side. Refer to Lesson 3, Apply Restraining Devices to Patient.

(e) When the patient is on the floor, medication may be given to help the patient regain his own control. However, it is best to wait until the cause is known since some drugs interact with some medical illnesses to produce unwanted side effects (which may be underlying causes of violence). If medication is used, careful follow-up is necessary.

(f) Convey an attitude that you believe the patient is a decent human being who is struggling to control difficult thoughts and feelings.

(g) Assure the patient that no harm will come to him, nor will he be allowed to harm anyone.

(h) Expeditious transfer of the patient should be arranged to a MTF for workup. Transfer the patient to a psychiatric facility only if sure origin is psychiatric.

(i) Continue to evaluate the patient while transporting or while awaiting transport. Observe for underlying or precipitation illness or injury.

5-7. MANAGEMENT OF ARMED, VIOLENT PATIENT

Procedures for managing a violent patient who is armed are given below.

a. Leave the area quickly, if possible.

b. Warn all personnel to clear the area and notify authorities (for example, MPs).

c. If you are unable to leave the area:

(1) Keep talking to the patient, allowing no prolonged silences to develop. Try saying things such as:

(a) "You can do a lot of harm if you want to, even without the gun."

(b) "You look frightened and I feel frightened."

(c) "I'd like to help you, but I'm concerned you might do something you can't take back with that gun. Could you please put it down, or let me hold it for you until we can finish talking about what it troubling you?"

(2) Make no abrupt movements--if the patient will not give up his weapon, he may at least be willing to put it into his pocket or into a nearby desk drawer.

(3) Offer free access to exits.

(a) Ask if he would feel better leaving the room or staying there.

(b) Stand away from the doors. The patient may have mixed feelings. He may feel comfortable and cooperative or trapped and cornered.

(c) The behavior of patient may depend on your position and reaction.

(4) If the patient leaves the room, alert all personnel and police (or MPs).

d. After your encounter with a violent patient (armed or unarmed), meet with the staff or unit personnel and inform them what was done and why.

5-8. USE OF RESTRAINTS

a. Use restraints when a patient is violent, refuses to go to a medical or psychiatric facility for evacuation, is hallucinative or delusional when being evacuated by

air, or when having a substance abuse reaction (severe alcohol or barbiturate withdrawal).

b. How to apply restraints will vary with the patient and the situation. Be able to apply standard restraining devices or field expedient restraints (mixed equipment restraints or double litters with litter straps). Refer to Lesson 3, Apply Restraining Devices to Patients.

c. Record and report any restraining action taken.

(1) Use of SF 600, Chronological Record of Medical Care, in a MTF, and DD Form 689, Field Medical Card, in the field.

(2) Include the following data:

(a) Date and time restraint was applied.

(b) Type of restraint applied.

(c) Patient's tolerance of the procedure.

d. Hazards of restraints. Restraints could result in:

(1) Damage to tissues under restraints.

(2) Damage to other parts of the body.

(3) Development of pressure areas if the patient is restrained for long period of time or if the patient does not have frequent position changes.

(4) Nerve damage if restraints are applied too tightly or if restraints become too constrictive after application.

(5) Injury or death during fire or other occurrences.

5-9. CLOSING

As a medical specialist, your ability to manage a disturbed, disoriented, or violent patient, whether in the field or hospital, is of vital importance to you and the patient. Your ability to work with stressful situations could be worthy of preventing injury or death to the patient, other personnel, or yourself.

Continue with Exercises

EXERCISES, LESSON 5

INSTRUCTIONS: The following exercises are to be answered by marking the lettered response that best answers the question or best completes the incomplete statement or by writing the answer in the space provided.

After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers.

1. _____ is a feeling of apprehension, uncertainty, and fear with no identifiable cause.

2. All of the following situations could produce changes in the cerebral chemistry or tissue EXCEPT:

   a. Cancer.

   b. Depression.

   c. Severe infection.

   d. Personality disorders.

3. Alcohol is sometimes thought to act as a stimulant.

   a. True.

   b. False.

4. _____ is often a sign of some underlying or additional problem besides consumption of alcohol.

5. What type of behavior is potentially hazardous to the patient or others?

   _____

6. List the steps of crisis development.

   a._____

   b._____

   c. _____

   d. _____

7. What is the first method of control to be used to manage an unarmed violent patient?

   a. Staring at the patient.

   b. Restraining the patient.

   c. Verbal (talking to the patient.)

   d. Threatening to harm the patient.

SPECIAL INSTRUCTIONS FOR EXERCISES 8 THROUGH 15. Match the definitions in Column A with the correct term in Column B.

COLUMN A		COLUMN B	
____ 8.	Irreversible deterioration of intellectual faculties with emotional disturbance and disorientation	a.	Delirium
____ 9.	A sensory impression that has no basis in external stimulation	b.	Hallucinations
____10.	The affect of a drug or alcohol to the point where a person loses physical and mental control	c.	Delirium tremens
____11.	To be troubled emotionally or mentally	d.	Intoxication
____12.	A form of psychosis characterized by delusions	e.	Disturbed
____13.	A state of mental confusion and excitement, disorientation for time and place	f.	Disorientation
____14.	A disturbed mental state characterized by confusion regarding one's relationship to either physical surroundings, time, or person	g.	Dementia
____15.	A serious manifestation of the alcohol withdrawal syndrome with restlessness, fever, confusion, agitation, disorientation, and hallucinations	h.	Paranoia

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 5

1. Anxiety (para 5-2b)

2. b (para 5-3a)

3. a (para 5-4a)

4. Gross behavioral disturbance (para 5-4d)

5. Violent behavior (para 5-6a)

6. a. Anxiety
   b. Acting out orally
   c. Acting out physically
   d. Tension reduction (para 5-6b(1))

7. c (para 5-6c)

8. g (para 5-2e)

9. b (para 5-2h)

10. d (para 5-2i)

11. e (para 5-2g)

12. h (para 5-3e(1))

13. a (para 5-2c)

14. f (para 5-2f)

15. c (para 5-2d)

End of Lesson 5

LESSON ASSIGNMENT

LESSON 6	Identify the Physical and Emotional Characteristics Associated with Death and Dying.
TEXT ASSIGNMENT	Paragraphs 6-1 through 6-4.
LESSON OBJECTIVES	After completing this lesson, you should be able to:

6-1. Identify the reactions of health care personnel toward terminally ill or injured patients.

6-2. Identify the psychological responses to the dying process.

6-3. Identify how the medical specialist copes with death and dying in combat environment.

SUGGESTION After completing the assignment, complete the exercises at the end of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 6

IDENTIFY THE PHYSICAL AND EMOTIONAL CHARACTERISTICS ASSOCIATED WITH DEATH AND DYING

6-1. GENERAL

Just as being born is a natural process, dying is also a natural process. Death is inevitable no matter how we may want to prolong life. Death is a dreaded and unspeakable issue that is avoided by most people by every possible means. It reminds us of our human weaknesses in spite of all of our modern advances. Death is the last and loneliest experience for all of us, thereby making it difficult to help others. As a medical specialist, you will be faced frequently with the reality of another person's death. This can be very painful and stressful. It is only natural for fears of death and personal concerns to intensify whenever you are in contact with someone who is dying.

6-2. REACTIONS OF HEALTH CARE PERSONNEL TOWARD TERMINALLY ILL OR INJURED PATIENTS

To effectively work with a dying patient, you must recognize and understand the individual's needs, feelings, or tension and discomfort. Coming to terms with yourself will be your greatest asset.

a. **Denial**. Some personnel may tend to deny the reality of death or try to avoid patients who are terminally ill. Death is seen as a failure because it cannot be prevented. Some personnel may even "tune out" or "tune off" terminally ill patients by maintaining an objective, professional approach.

b. **Common Inappropriate Actions/Responses to Terminally Ill Patients Who Wish to Talk about Death**. The medical specialist should avoid the following expressions.

(1) Reassurance. "Everything will be all right."

(2) Denial. "You're not going to die."

(3) Fatalism. "We all have to die sometime."

(4) Changing the subject. "Let's think of something else to talk about."

c. **Appropriate Actions/Responses to Terminally Ill Patients**.

(1) Gentle discussion. Be aware of how you talk to the patient.

(2) Exploration of feelings. Allow the patient the time and opportunity to ventilate his feelings.

(3) Active listening. Be attentive when the patient talks.

6-3. PSYCHOLOGICAL RESPONSES TO THE DYING PROCESS

There are five basic stages of dying: denial, anger, bargaining, depression, and acceptance. A patient may or may not follow these stages in a fixed pattern. He may stop, regress, or not even get beyond the first stage. If family members are present, they too will usually pass through the same stages as the patient, but not necessarily at the same time.

a. **Denial**.

(1) Patient reactions. The patient may:

(a) Seek opinions of other physicians.

(b) Request a repeat of certain tests.

(c) State that the test results belong to someone else.

NOTE: These actions are usually characterized by "No, not me!" "It can't be true!" or "There must be some mistake!"

(2) Health care provided by the medical specialist.

(a) Listen -- do not contradict the patient.

(b) Reinforce prescribed medication/diet routine as prescribed by the physician.

(c) Respect the patient's wish to deny impending death.

b. **Anger**.

(1) Patient reactions. The patient may:

(a) Replace denial with questions, feelings of anger, rage, resentment, and envy.

(b) Blame, complain, find fault, and be extremely critical of the care he is receiving.

NOTE: These actions may be characterized by "Why me?" or "Why should this be happening to me?" or "What did I do to deserve this punishment?"

NOTE: The patient may attack the health care worker or his family physically or verbally. Be aware of these negative feelings of the patient and do not take them personally.

(2) Health care provided by the medical specialist.

(a) Have patience and tolerance.

(b) Acknowledge to the patient that you understand how he feels.

(c) Allow the patient to express anger and other feelings.

(d) Respect the patient's need to rave against his fate. Do not take the attack personally.

c. **Bargaining**.

(1) Patient reactions. This stage may be quite short, intermittent, or even not apparent. The patient may:

(a) Bargain to postpone death, seek reward for good behavior, or exchange places with someone else.

(b) Replace the previous question of "Why me? to "Yes, it is me, but ...." or "Why now?"

NOTE: This stage may be done privately.

(2) Health care provided by the medical specialist.

(a) Understand that bargaining is helpful to the patient.

(b) Keep the patient comfortable.

(c) Listen and be available.

d. **Depression**.

(1) Patient reactions. The patient:

(a) May be anxious to put affairs in order.

(b) Sense a great loss--(income, business, hair, limb, function, life).

(c) Have feelings of sadness and guilt over not having provided for family. He may make a will or update one.

(2) Health care provided by the medical specialist.

(a) Allow the patient to mourn, cry, and talk about losses.

(b) If possible, help patient take care of putting affairs in order.

(c) Provide emotional support.

e. **Acceptance**.

(1) Patient reactions. The patient:

(a) Is prepared to die.

(b) Is at peace.

(c) Is tired.

(d) May withdraw from all except a special loved one.

NOTE: The patient wants to be left alone or have someone sit near, but in silence. Family often needs more support than the patient. This is the time when it is too late for so many words, and yet the time when relatives cry the hardest for help--with or without words.

(2) Health care provided by the medical specialist.

(a) Respect the patient's need for quietness and offer reassurance by being there as much as possible.

(b) If the patient is unresponsive, do not discuss the patient in his room--hearing is the last sense to cease function.

(c) If the patient does not want to talk, communicate nonverbally to indicate a sense of caring and concern.

(d) Keep the patient as comfortable as possible.

(e) Maintain emotional support for the family.

(f) Communicate to the patient that he will not be forgotten.

NOTE: The medical specialist can be of great help during those final moments if he can understand the family's conflicts at this time and help select the one person who feels most comfortable staying with the patient. Those who feel too uncomfortable can return home knowing the patient will not die alone, yet not feeling guilty for having avoided the moment of death which, for many people, is so difficult to face.

6-4. COPING WITH DEATH AND DYING IN A COMBAT ENVIRONMENT

Health care provided by the medical specialist includes the following.

a. Make the casualty as comfortable as possible.

b. If possible, find someone who can sit with the soldier (hopefully, a buddy from his unit).

c. Offer to take care of unfinished business or notify family, if possible.

NOTE: The buddy of the deceased, or whomever is with the casualty at the time of his death, can provide feedback to include when the soldier died and where the soldier died.

d. Encourage the casualty to express feelings of grief.

e. If possible, make time for a brief service of some sort, however simple.

NOTE: The expression of grief is important to prevent post-combat psychological problems of those who saw their buddies killed in action. Many of the mental health professionals now treating combat veterans with post-traumatic stress disorders feel that too often the soldiers didn't allow themselves to grieve for their buddies at the time (or soon after), and so are still haunted by them today.

Continue with Exercises

EXERCISES, LESSON 6

INSTRUCTIONS: The following exercises are to be answered by marking the lettered response that best answers the question or best completes the incomplete statement or by writing the answer in the space provided.

After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers.

1. Health care providers of terminally ill patients should avoid the following types of expressions when talking to the patient:

   a . _____.

   b. _____.

   c. _____.

   d. _____.

2. List the five basic stages of dying.

   a . _____.

   b. _____.

   c. _____.

   d. _____.

   e. _____.

3. A patient may or may not follow through all of the five basic stages of the dying process.

   a. True.

   b. False.

4. Appropriate responses/actions to terminally ill patients include:

   a. _____.

   b. _____.

   c. _____.

5. As a health care provider of a terminally ill casualty in a combat environment, you should:

   a. _____.

   b. _____.

   c. _____.

   d. _____.

   e. _____.

6. When a terminally ill patient is prepared to die, is at peace, and is tired, he is experiencing which of the following phases of dying?

   a. Denial.

   b. Bargaining.

   c. Depression.

   d. Acceptance.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 6

1. a. Reassurance--everything will be all right.
   b. Denial--you are not going to die.
   c. Fatalism--we all have to die sometimes.
   d. Changing the subject--let's talk about something else. (para 6-2b)

2. a. Denial.
   b. Anger.
   c. Bargaining.
   d. Depression.
   e. Acceptance. (para 6-3)

3. a. (para 6-3)

4. a. Gentle discussion.
   b. Exploration of feelings (allow patient to ventilate).
   c. Active listening. (para 6-2c)

5. a. Make the casualty as comfortable as possible.
   b. Find someone (hopefully a buddy from his unit) to sit with him, if possible.
   c. Offer to take care of unfinished business or to notify family, if possible.
   d. Encourage the casualty to express feelings of grief.
   e. Make time for brief service, however simple, if possible. (para 6-4a-e)

6. d (para 6-3e(1))

End of Lesson 6

LESSON ASSIGNMENT

LESSON 7	Provide Postmortem Care.
TEXT ASSIGNMENT	Paragraphs 7-1 through 7-3.
LESSON OBJECTIVES	After completing this lesson, you should be able to:
	7-1. Identify the procedures to provide postmortem care in a hospital environment.
	7-2. Identify the procedures to provide postmortem care for battlefield casualties.
SUGGESTION	After completing the assignment, complete the exercises at the end of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 7

PROVIDING POSTMORTEM CARE

7-1. GENERAL

When a patient dies in a hospital, the physician is responsible for examining the body, declaring the patient legally dead, and notifying the next of kin. You, as the medical specialist, are expected to perform postmortem (after death) care. When you are providing this care, remember to conduct yourself so as to preserve the dignity and respect of the body and family members.

7-2. PROVIDING POSTMORTEM CARE IN A HOSPITAL ENVIRONMENT

a. **Obtain Special Instructions**.

(1) Ask your supervisor for any special instructions in caring for the deceased.

(2) Consult your MTF standing operating procedure (SOP).

NOTE: This step is vitally important in providing postmortem care. Each institution has its own procedure to be exercised in the care of deceased patients. These procedures vary because of local mortician preferences or state and local laws. Despite the difference in procedures, many elements in caring for a deceased patient remain essentially the same. The supervisor will give specialized instructions in caring for the deceased patient.

b. **Perform Initial Postmortem Care**.

(1) Place screens around the bed, draw the curtains around the bed, or close the door to provide privacy for the body.

(2) Close the patient's eyelids by applying light pressure downward with the fingertips.

(3) Adjust the bed to a flat position. Remove all pillows except one under the head of the body.

CAUTION: Leave one pillow under the deceased person's head to prevent blood from being pooled in the head region of the body, thus preventing discoloration of the face.

(4) Use gloves to inspect and wash soiled areas of the body; change patient's gown.

(5) Align body in natural anatomical position with body on back, arms alongside, and palms turned toward thighs--poor alignment may cause irregular body formations.

NOTE: The body should be placed in alignment and in as natural position as possible. Poor alignment will result in deformities as a result of rigor mortis (profound stiffening of limbs and body as a result of death).

(6) Replace soiled bed linen and straighten top linen.

(7) Remove, clean, and replace dentures, comb hair, close or support patient's mouth, if applicable.

NOTE: The mouth may need to be closed or supported by using rolled ABD pads to prevent the lower jaw from sagging.

(8) Clean patient's area and remove all unnecessary equipment.

NOTE: Viewing of the body by relatives is done at this time, if desired. Be supportive and compassionate.

(9) Perform a patient care handwash.

c. **Perform Final Postmortem Care**. This care begins after the viewing of the body. It is done in preparation to transfer the body to the morgue.

(1) Obtain equipment.

(a) Obtain prepared death pack. The death pack, which may vary from one hospital to another, includes wrapping or mortuary sheet, absorbent cotton or some type of underpads, gauze or bandage rolls (ties), safety pins, death tags, and various forms (hospital report of death, authorization for autopsy, disposition of body, local forms, state death worksheet, and form for organ donor).

(b) Obtain additional needed equipment and supplies such as clean sheets, chux, basin of warm water and soap, clean gloves, paper bag, acetone, stretcher, two litter straps, laundry hamper/bag, comb, washcloth, and towel.

(2) Provide privacy for the body by placing screens around the bed, draw curtains around the bed, or close the door.

(3) Don clean gloves (if applicable).

(4) Remove the following items:

(a) Top bedding except for a drape sheet.

(b) Pajamas/gown.

(c) Jewelry and personal articles (get-well cards, eyeglasses, religious articles, and so forth). Return these items to the family in the presence of a witness.

CAUTION: Never leave valuable articles unattended.

(d) Remove soiled dressings and discard them in the contaminated wastes.

(5) Tie off, remove, or clamp all drains and tubes as directed by supervisor. Tubes are generally left in body for an autopsy.

(6) Wash body and remove adhesive markings from the skin (if applicable) with solvent (acetone) as prescribed in the SOP.

(7) Apply new dressings over wounds. Use a minimum amount of tape and dressings.

(8) Pad anal and urinary areas with perineal pad or abdominal pad IAW local SOP. The perineal pad is placed to absorb feces and urine that are expelled as the sphincters relax and to absorb drainage.

(9) Remove gloves.

(10) Secure ankles and wrists.

(a) Cross right ankle over left ankle, place ABD pad between ankles and secure with gauze roller bandage or according to local SOP.

(b) Cross right wrist over left wrist, place ABD pad between wrists, and secure with gauze roller bandage or IAW local SOP.

(11) Attach two body tags, DA Form 3910 (Death Tag), to the body.

(a) Obtain three completed and signed death tags from supervisor.

(b) Tie death (body) tag to right great toe.

(c) Tie death (body) tag to left wrist.

CAUTION: Do not tie the tags so tight as to cause severe skin discoloration.

(12) Wrap the body.

(a) With assistance, roll the body to the side of the bed.

(b) Place one clean sheet diagonally under the body.

(c) Roll body back to the center of the sheet.

(d) Fold the upper corner of the sheet loosely over the head and face. Fold the lower corner over the feet.

(e) Fold the right and left corners over the body.

(f) Fasten the sheet corners with a safety pin.

(13) Attach signed exterior body tag (third tag) to outside of sheet near anterior portion of head or upper torso of body.

(14) Transfer the body to wheeled litter (stretcher).

(a) With assistance, lift the wrapped body onto the stretcher.

(b) Secure the body to the stretcher with straps at the chest and just above the knees.

(c) Cover the wrapped body with a clean sheet.

CAUTION: Avoid using any pressure that will cause discoloration of the skin.

(15) Prepare for transfer of body to morgue.

(a) Obtain from supervisor all records and forms for accompanying body to morgue.

(b) Notify morgue or appropriate supervisory personnel IAW local SOP that body is ready for transfer to morgue and transport IAW local SOP.

(16) Perform a patient care handwash.

d. **Clean the Deceased Patient's Area**. Give the patient's area a terminal cleaning. Follow the principles of medical asepsis and local SOP.

e. **Report the Procedure**. Report completion of postmortem care to your supervisor.

7-3. PROVIDE POSTMORTEM CARE FOR BATTLEFIELD CASUALTIES

a. Field postmortem activities are conducted by Graves Registration (GRREG) IAW FM 10-63. The medical specialist may be called upon to assist with the following procedures.

b. Tag with DD Form 1380, Field Medical Card.

(1) CRO--"Carded for Record Only."

(2) Complete appropriate blocks.

NOTE: Record 8-digit grid coordinates--if corpse is left. Ensure readable carbon copy for later use on battlefield.

c. Remove sensitive items (weapons, classified materials, radios, maps, Vinson keys, communications-electronics operating instructions (CEOIs), and so forth).

(1) Turn in removed items to the platoon sergeant.

(2) The medic will secure the items if the platoon sergeant is unavailable.

(3) All other personal items and valuables will remain with corpse.

d. Place corpse in a body bag or other suitable shrouding material.

e. Evacuate to the unit resupply point. Supply personnel will evacuate the body to the GRREG collecting point.

f. Potential problems to avoid:

(1) DO NOT transport killed in action (KIA) with casualties, if at all possible.

(2) If the unit resupply point has moved and the new site unknown, DO NOT leave KIAs at old point. Find out where the new point is.

(3) DO NOT move KIAs to airfields. They cannot evacuate them.

(4) DO NOT commit air evacuation of KIAs within forward line of own troops (FLOT) areas. Use ground transport at this level.

(5) If litters are used to evacuate KIAs to unit resupply point, DO NOT leave your litters with the corpse if you cannot get a one-for-one exchange.

Continue with Exercises

EXERCISES, LESSON 7

INSTRUCTIONS: The following exercises are to be answered by marking the lettered response that best answers the question or best completes the incomplete statement or by writing the answer in the space provided.

After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers.

1. How would you position a deceased patient's body?

   _____

   _____

2. How many death tags will be attached to a deceased patient's body?

   a. One.

   b. Two.

   c. Three.

   d. Four.

3. Why would you place screens around a deceased patient's bed?

   _____

4. Poor alignment of a deceased patient's body may cause _____.

5. Where would you place DA Form 3910 on a deceased patient's body?

   _____

   _____

6. What would be used to secure a deceased casualty's body in the battlefield.

   _____

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 7

1. Align in natural anatomical position with body on back, arms along sides, and palms turned toward thighs. (para 7-2b(5))

2. b (para 7-2c(11))

3. To provide privacy for the body. (para 7-2b(1))

4. Irregular body formations. (para 7-2b(5))

5. Tied to right great toe.
   Tied to left wrist. (para 7-2c(11))

6. Corpse placed in a body bag or other suitable shrouding material (para 7-3d)

End of Lesson 7