

Psychiatric Emergencies in the Casualty Department

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P psychiatric emergencies are difficult to define. The medical definition of psychiatric emergencies is situations in which, on account of an abnormal mental state or behaviour, the life of a patient, or someone else, is in jeopardy.

However this definition would exclude the commoner situations encountered in casualty which are characterised by severe dislocation in psychological or social functioning and often accompanied by their high nuisance value.

In order to remedy this limitation I shall also use the concept of "crisis" to include those situations when there is a reduction in coping ability to external stress.

Epidemiology

Only about twenty five per cent of "complaints" refer to psychiatric conditions in the conventional sense. This figure reflects the current social use of psychiatry. Sorrows and conflicts, many not caused by psychiatric illness, are brought to the Casualty Department and treatment demanded. This has expanded the boundaries of psychiatry and reflects the development of new views on mental health, the growth of a mental health industry in the welfare state and a loss of skills in handling emotions. Casualty departments cater for many who are not ill in the conventional sense. Perfunctory physical examinations and hurried discharges are not therefore sufficient; indeed they are counterproductive in that a population of "repeaters" may be created. On the other hand fifteen per cent of psychiatric emergencies may be accompanied by unknown severe physical disease.

Classification

Psychiatric emergencies may have:

(i) organic

- (ii) functional
(iii) social causes.

The three are often found combined and are difficult to tease apart. I shall not present you an aetiological approach but rather a syndrome-orientated one which is more helpful in the prediction of management.

Acute Confusional State — Organic (ACS)

"Clouding of the sensorium" is the primary psychological effect of acute brain insult. Hallucinations, paranoid ideations and emotional changes are often added. Delirium is the most florid state of acute confusional states.

ACS becomes an emergency when:

- (i) onset is acute
(ii) aetiology is unknown on admission
(iii) there is the threat of loss of behavioural control.

In most cases the degree of emergency is that of the causative illness, whether neurological, metabolic, endocrinological, cardiovascular or iatrogenic in cause. Sometimes increased motor activity or lack of patient cooperation add to the seriousness of the case.

When clouding, i.e. disorientation is absent, the cause may still be organic.

The following characteristics may be helpful identifying signs:

- abrupt personality change when there is good premorbid social functioning and family support.
- fluctuation in behaviour and mental state such as worsening in the evenings.
- catastrophic reactions; that is irritability, inability to recover from stress, lowered adaptive capacity, aggressive or violent behaviour in situations of ordinary stress may also be indicative of hidden organic pathology.

Management

- Sedation must be withheld until clearly indicated, as this may mask or distort neurological signs.
- Nursing care is the most important first line of treatment; therefore a well illuminated side room is required as well as reassurance during lucid intervals by the same staff if possible.
- If sedation is required (eg. patient becomes aggressive, suicidal, paranoid, pulls out drip etc.) phenothiazines are the drug of choice. If hypotension, hypothermia or marked sedation are severe, thioridazine or haloperidol may be used instead of chlorpromazine. Benzodiazepines may increase confusion by reducing the level of arousal, but may be used in status epilepticus.

Once the decision to medicate is taken, adequate doses should be prescribed regularly and not prn which is disorientating and upsetting. Dystonia or pseudoparkinsonian side effects may be controlled with procyclidine (Kemadin) 10mg iv.

If the patient demands discharge or tries to leave the pertinent sections of the Mental Health Act may be used to keep him in hospital provided that his mental state warrants such action. The Act may not be used to treat physical illness alone.

Functional Psychiatric Emergencies

- (i) Excitement
(ii) Stupor
(iii) Panic Attack
(iv) Hysterical Fugue
(v) Destructive behaviour towards others
(vi) Destructive behaviour towards self

(i) Excitement

This is characterized by motor

hyperactivity accompanied by disturbance of thought, perception, mood and insight. Some Acute confusional states may be considered as organic excitements.

Functional excitements are of various types:

- (i) Catatonic (rare)
- (ii) Manic
- (iii) Paranoid
- (iv) Non psychotic: hysterical acting out personality disorders insufficient behavioural control drug intoxications

Catatonic excitement is rare, dramatic, unmotivated and may threaten life as in "lethal catatonia". Insight is lost and patients need restraining and sedation.

Manic excitement is meaningful, less progressive in onset and develops in the context of contagious jollity, pressure of speech, flight of ideas and grandiosity. Occasionally it is punctuated by dysphoria, irritational aggression and an overbearing quality. Mixed states may be found with both hyperactivity and angry despondency. Rarely, secondary mania may develop in the wake of physical disease or drugs.

Paranoid excitements show disorganised and frightened behaviour. This may be sporadically replaced by defensive aggression, as delusional beliefs and persecutory ideas are acted out.

Hysterical excitement results from deficient behavioural control and episodic disorganisation of emotional and cognitive behaviour. Because of the secondary gain involved it is self perpetuating.

Personality disorders of the explosive or aggressive type when under pressure may develop states of disorganisation, incoherence, terror or aggression. This sudden release, often sensitized by alcohol or drugs of so-called psychopathic tension may generate marked antisocial behaviour.

Management

Catatonic excitement responds to high doses of intramuscular haloperidol (30-50mg). As it has a long half life, two injections daily are usually sufficient. Electroconvulsive therapy (ECT) is indicated in patients nearing exhaustion and who are not responsive to drugs.

Mania and Paranoid excitement respond to large doses of neuroleptics but ECT may also be indicated.

Hysterical and psychopathic excitements respond well to benzodiazepines and supportive psychotherapy.

(ii) Stupor

There are both neurological and psychiatric stupors. Twenty per cent of these are organic.

Therefore psychiatric stupor should only be diagnosed if tests for the function of the cerebral hemispheres and brain stem are normal and caloric tests produce nystagmus and not tonic deviation of the eyes. An EEG should also be carried out.

Psychiatric stupor is of three main types:

- (i) catatonic
- (ii) depressive
- (iii) hysterical

Management

Functional stupor compromises life by interfering with eating, drinking and defaecation. Those resulting from psychotic illness respond well to ECT. Hysterical stupors respond to any treatment but determined efforts should be made to identify their meaning and secondary gain. Patients only abandon this symptom if provided with an alternative means of coping.

(iii) Panic Attacks

These are characterised by a sudden increase in free floating anxiety with or without signs of autonomic overstimulation. There may or may not be accompanying fears of death or impending disasters including themselves or others. Such panic attacks are common in patients with agoraphobia, anxiety states and obsessional illnesses.

Panic attacks are also seen in organic states such as SLE, thyrotoxicosis, phaeochromocytoma, hypoglycaemic states, carcinoid syndrome, acute intermittent porphyria or acute schizophrenia.

Management

This should be of the underlying disease. Situational panic attacks settle down in the casualty room as do many other psychiatric disorders. This does not mean that they are "hysterical" or "unimportant".

Panic attacks are often prolonged by the hyperventilation paraesthesia and tetanic response which feed the patient's fears.

If all relevant medical investigations are found to be negative, benzodiazepines eg. diazepam 10mg iv may be

administered and psychiatric referral organized — not necessarily as an emergency.

(iv) Hysterical Fugues

This is a dissociation produced by a stressful situation and consists of a "motivated" or "psychogenic" loss of memory. Organic states account-for amnesia must be ruled out.

Management

Admission to St. Luke's Psychiatric Unit or Mount Carmel Hospital is advisable in order to organize management and protect the patient from potentiated danger.

(v) Destructive Behaviour Against Others

Anyone who during a crisis breaks the television set, attacks another person without motive, or demonstrates some other sort of destructive behaviour is likely to be brought to the Casualty Department. The incident must be assessed in terms of its circumstances, the patient's premorbid personality and contributing factors such as alcohol, drugs, mental illness and organic confusion. It must be decided whether aggression is alien to the aggressor, when organic or serious psychotic causes may be important, or if it is a feature of his subculture or personality disorder.

Sometimes violent behaviour may continue in hospital and it serves no good purpose to be heroic. The police should be called even if the patient eventually proves to be a psychiatric case.

In the case of assaultive behaviour due to alcohol intoxication, do not interview the patient alone, approach slowly and carefully in a firm and reassuring manner and talk down. If sedation is required use only benzodiazepines, phenothiazines and haloperidol.

Always be on the look out for an unsuspected subdural haemorrhage.

(vi) Destructive Acts Towards Self

Suicide and parasuicidal behaviour are a common psychiatric emergency. Patients who have made genuine suicidal attempts are usually admitted to a psychiatric ward as about ninety-three percent of these suffer from mental illness.

The parasuicidal patient requires psychiatric help and social worker support of a different kind.

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Social Psychiatric Emergency

These are behavioural disturbances resulting mainly from breakdowns in family communication which, in the absence of specialised crisis intervention services are dealt with as conventional psychiatric emergencies.

St. Luke's Psychiatric Unit functions also as a crisis intervention centre as psychiatrists, psychiatric social workers and psychologists are available. However the Centru Hidma Socjali could be a more appropriate source to refer to as this agency deals with such clients on the social model rather than a medical model.

A social worker is on call twenty four hours.
