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Types of psychiatric emergencies seen in general practice or in a hospital emergency setting are defined, along with recommendations for handling. Also discussed are P.E. in children, methods of detecting the potential suicide and some conclusions based on a 2562 patient survey in one hospital.

"A cry of distress is a summons to rescue" — Justice Cardozo

Introduction — It is agreed in the psychiatric literature that there is no agreement on what constitutes a psychiatric emergency (P.E.).[1] Several months of exploration by the joint information service of the American Psychiatric Association and the National Association for Mental Health suggested a definition may be almost as illusive as that of alcoholism.[2]

Those who try to delineate psychiatric emergencies generally confine themselves either to statutory definitions ("a person dangerous to himself or others") or to the patient's own representations about his need ("any one who presents himself"). Goshen attempts to bridge these extremes by equating P.E. with human emergencies — as complicated as a homosexual panic to as commonplace as a child's nightmare.[3]

One of the more widely quoted definitions is that of Miller: "Any individual who develops a sudden or rapid disorganization of his capacity to control his usual personal, vocational and social activities".[4] This leaves out of account his subjective distress not manifesting itself in disturbed behavior. Cohn sees the P.E. as a disturbance of homeostasis either intrapsychically or interpersonally.[5]

Families or other nonmedical persons are often the ones who react to a problem as an emergency, making it difficult at times to determine which member of the family is most disturbed.[9] A P.E. can arise in people with any kind of illness from mental retardation to psychoneurosis; or even in the normal person, if subjected to sufficient

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sudden stress.[6] As stress increases the person goes through the stages of "alarm and mobilization" (with a determined effort at self control) to the stage of "resistance" (with consequent exaggeration of ego defense mechanisms) till finally the stage of "exhaustion" has been reached.[7] As these stages advance, the P.E. becomes manifest.

The common denominator in the origin of the P.E. is *danger. Danger* to biological or social existence, real or imagined, *danger* to self or others. The idea that danger confronts one gives rise to fear or alarm. Fear often engenders anger directed toward whomever or whatever we believe is threatening us. The situation can be further complicated since anger itself can lead to fearful ideas of the consequences of one's anger.[3]

With these thoughts in mind I diffidently suggest that a P.E. might be defined as: *A sudden, serious, psychological or psycho-social disturbance which renders the individual unable to cope effectively with his life situation, his interpersonal relationships, and/or his intrapsychic conflicts.*

I will spend most of this paper on those aspects of or conditions considered under P.E. which are either not covered or inadequately covered in the standard textbook of psychiatry.

The P.E. As Seen in General Practice

The P.E. can be among the most disturbing and dramatic experiences encountered in general practice. How these cases are handled may have profound effects on one's reputation. Hence the general practitioner should be prepared. A suggested list of equipment includes drugs such as sedatives, narcotics, tranquilizers; equipment for resuscitation; and such mundane things as money for telephoning and the phone numbers of sources of assistance or referral.[32]

In the P.E. the patient or family often demands immediate action which can lead to many errors of management. An unhurried approach with a calm and, if necessary, firm attitude seems best. Interest, sympathy, understanding, calmness and deliberation properly exploited are the keys to successful management. The physician should not be too hasty with either a sedative or hospitalization, as both often can and should be avoided.[3,33]

Excitement

A number of conditions can produce the picture of the noisy, disturbed and potentially violent patient. The most common cause of this picture is acute intoxication, either with alcohol or sedative drugs. The diagnosis is usually not difficult because of clear evidence of ingestion of such an agent. Staggering gait, slow speech, characteristic odors, flushed face, and injected conjunctiva are obvious in acute alcoholism. Closer examination reveals nystagmus, tremors, and a degree of clouding of the sensorium.[34]

Reassuring conversation may calm the patient, but it is good to remember that a disturbed patient with an alcoholic history who is in good physical condition may require larger than expected doses of barbiturates to produce sedation. If this is necessary, parenteral (i.v. best) administration is advisable. Barbiturates, chloryl hydrate, and paraldehyde all have their advocates. The only clear-cut advantage is that barbiturates can be given i.v. allowing immediate control of dangerous behaviour.

However, if in administering sedation one merely wishes to help calm the patient, the voluntarily accepted injection of tranquilizer such as chlordiazepoxide is useful, though others may prefer chlorpromazine or related drugs. In a personally treated series of 25 successive disturbed patients presenting to the emergency department, only one failed to become adequately calmed and controlled with a voluntarily accepted injection of chlordiazepoxide. The dose ranged from 75-150 mg. intramuscularly in a single injection, which was given after a short private conversation with the patient. It wold seem to me to be wise to avoid tranquilizers if the patient does not accept the medication voluntarily. Very large doses might be necessary and would risk changing a P.E. to a medical emergency.

Any condition producing transient brain anoxia can produce the psychologic and psychomotor responses described. Examples are insulin shock, high fever, sensitivity to medication, and focal or diffuse brain involvement, whether due to infection, trauma or vascular disturbance.

Delirium

Delirium differs from the above picture in that the prevailing emotional tone is of apprehension; the sensorium is clouded; hallucinations are present, usually visual and they are influenced by the immediate environment. The confusion may vary from hour to hour and violent responses to misinterpretations may occur. Self-injury is more likely than aggression.

Again treatment varies somewhat with diagnosis and is ideally directed at ridding the patient of the offending toxic agent or febrile state. Tranquilizing drugs have a real place, but sedative drugs must be cautiously used, if at all, since they can increase the confusion and lead to aggravation of the patient's behavior. Restraints are seldom necessary if there is adequate supervision, aided by the continual presence of a reassuring person known to the patient. The patient's anxiety can be intensified if perceptual stimuli are diminished or absent, or conversely, if they are greatly intensified. Thus a lighted room simply structured is the best.

The Actively Hostile Patient

The actively hostile patient may be seen occasionally in the above conditions, but is more likely the result of: acute mania; catatonic excitement; paranoid schizophrenia or alcoholic hallucinosis when the patient has turned on his supposed persecutors; acting out in the unstable psychopath; epileptic furor.

Again certain principles obtain: Observe, listen, evaluate, and obtain a history. Be interested in, listen to, watch and talk to the patient. Use drugs only after accurate

appraisal and after having explained the reason further to the patient. Be firm, have adequate personnel, use appropriate explanation and only in the last resort use any physical force. Gentle restraint by a friend is advised first.

If one needs to subdue the patient physically, one person per limb is a recommended minimum and a sheet can be useful. This is to keep the damage to the patient at a minimum. Kennedy adds these words of advice: "Once it has been decided to restrain the patient, the party should be restricted to those actively involved, but if the affair is visible to the public, champions of the liberty of the subject may appear from the local public houses or the patient may successfully appeal to Irishmen or other minorities to support his cause."[32]

Electro-convulsive therapy may become the treatment of choice in the refractory delirium, the excited schizophrenic or the acute manic.

Panic States

In the panic state the patient is overwhelmed by the predicament, cannot discuss the situation, and is either immobilized by fear or frantically overactive. Suicide attempts are not uncommon in this state. The panic may result from a real, external challenge like bereavement; but most often it is caused by conflicts within the organism, e.g., unconscious homosexual conflicts. It is best regarded as a transitory acute disorder with a good prognosis and treatment is first directed to control the panic. Reassurance, tranquilization and only later exploration into the psychodynamics is a reasonable order of procedure.

Hysterical Character

The physician is sometimes called upon to treat an acute exacerbation of an hysterical character disorder. He is faced with a patient having much emotional feeling of a very labile quality which is felt to be not quite genuine. The patient's behavior is both impulsive and attention-seeking. There is a deficiency of inhibition and a flair for the dramatic. The patient has an underlying purpose to focus attention upon herself and to manipulate the persons about her. The varied clinical manifestations are best handled much like the panic states.

Other Conditions

Other conditions sometimes regarded as P.E.'s in general practice have included the emotional problems associated with pregnancy, e.g., hyperemnesis gravidarium, or the post-partum depression with thoughts of infanticide. Recognition of the condition, allaying of the patient's anxiety and specific drug therapy are usually the best way to manage the problem.

Certain P.E.'s have a more obvious social component such as mania where the patient is carrying on business unwisely or in the case of a female, is involved in promiscuous sexual behavior. Fairly rapid action is demanded not only by the patient's

condition but also because of the possible deleterious social consequences of the patient's behavior.

The application of emergency psychotherapy is seen in those sudden serious exacerbations of psychosomatic illnesses, such as ulcerative colitis.

The final group of emergencies which can be included in this section are those which result from psychiatric treatment, such as electro-convulsive therapy, insulin coma or any of the psychiatric drugs. I do not intend to discuss these as by their nature they are medical emergencies.

P.E. As Seen in the Hospital Setting

The two main responsibilities of the P.E. clinic are: First, rapid psychiatric evaluation of patients and secondly, undertaking responsibility for the correct allocation of patients to available services. Add to these, if necessary, the assumption of clinical responsibility for the patient until referral is effected or the problem brought under control.[8]

The proportion of patients presenting to an emergency department who are suffering primarily from a psychiatric illness range from 2 to 52%.[1,10,11,12,13] This wide difference appears to be mainly accounted for by how hard the doctor looks for psychiatric illness, balanced by public awareness that emotional problems are readily tolerated and well treated.

In a survey of a general hospital emergency department in a small city in Ontario, which involved 2562 patients, 3% presented primarily with a clearly recognizable psychiatric syndrome.[11] This figure is typical, I feel, of most emergency departments. When particular facilities and personnel for emotional problems are provided, the percentage quickly rises to nearer 10%. Figures well beyond this represent highly specialized centers and/or inclusion of emotional problems presenting concomitantly with physical illness and trauma.

The psychiatrist is asked to see the patient in the emergency department most often as a result of the patient's asking for such a consultation. The second commonest reason is for administrative (medical-legal) reasons. If the condition is a more subtle psychiatric syndrome, the patients are seldom referred to psychiatrists by the house officer.[14]

Who is the typical patient presenting to the emergency department with psychiatric problems? She is a female, married, in her late thirties, from the lower socio-economic classes. Fifty-five percent (55%) or more of these psychiatric patients are female; 50% married; 25% single; 20% divorced or separated and 5% widowed.[15] (My figures were 62%, 26%, 18% and 4% respectively.[11]) About 50% are from social class 4 and 5. Seven percent of patients were in the adolescent age range.[15]

The most common age has been quoted as 35-40 with a normal distribution.[15] The author's study had a bimodal distribution, peaking in the 30's and 50's. The latter peak is not surprising to me, considering the older age of alcoholics and the additional stress at the menopausal age. However, what is more important to note is that the most common age for non-psychiatric adult patients presenting to the emergency department is in the 20-29 age group.[11,48] Thus, the psychiatric patient in this setting is significantly older than other patients.

Many patients are repeatedly seen and at least one-third have been hospitalized previously for a psychiatric condition often with inadequate or no follow-up. Thus the emergency is frequently an exacerbation of a chronic mental illness.

The presence of physical illness in these patients is significant with up to 25% having a physical disorder requiring treatment. However, in only one-third of these cases does the condition directly relate to the problem with which the psychiatrist is asked to deal.[16,17] These figures do not, however, reflect the increasing medical and surgical problems resulting from attempted suicide, drug abuse and alcoholism.

The source of referral depends on the relationship of the particular emergency department to community agencies, the police, and the general practitioners. Generally 20 to 35% of referrals each come from two sources, from the patient himself and from relatives and friends of the patient. The police account for from 5 to 30% and general practitioners 10%, on the average, in North America but a much higher percentage in England.[15,13] The author's figure for general practitioners was 30% — a figure which I expect is becoming more typical, as practitioners increasingly are referring unexpected patients to the Emergency Department rather than making a house call or interrupting a busy office.[11]

The P.E. has been commonly believed to present itself in the early hours of the morning. But this isn't correct. Sixty percent occur between 8 A.M. and 5 P.M.; a further 35% occur between 5 P.M. and 12 A.M., whereas only 5% present between 12 A.M. and 8 A.M. Monday has been found to be the most common day except for alcoholics who come most frequently on Tuesdays and Fridays.[15,18] This offers support for a "blue Monday" but not for the "Saturday night drunk".

The alcoholics as a group seem somewhat distinct. They are more likely male (about 75%); have a higher rate of marital disturbance (35%); are less likely to be accompanied by relatives or friends but more often brought by police; and are older (40 to 45) than other patients except acute brain syndromes (45 to 65) and chronic brain syndromes (over 65).[13]

The presenting problem is most commonly a psychotic break (20%), followed closely by a suicide threat or attempt (19%) and symptoms of depression (18%). Feelings of anxiety (7%) disorientation (6%) and disturbance of consciousness (4%) are other fairly frequent presenting problems, with all the rest accounting for 19%.[15]

The diagnosis corresponding to these presenting problems is most commonly a psychosis (20 to 35%) 30%*; a neurosis (20 to 55%) 25%; personality and behavior disorders (10 to 20%) 15%*; alcoholism (2 to 20%) 10%*; acute brain syndrome (2 to 10%) 5%*; chronic brain syndrome (5 to 8%) 5%*.[13,15,18] The most common diagnoses in the adolescent age group were: first, adjustment reaction of adolescence, second, depressive reaction, and third, hysterical character disorders.[15]

Emergency departments generally lack adequately trained staff to handle psychiatric disorders. In addition the existing personnel frequently lack the time and/or the inclination to treat these patients. Consequently the competence of treatment varies rather markedly. Twenty percent or more are given some drug therapy and the remainder, if treated at all, have a form of psychotherapy. Those admitted to a psychiatric bed (30 to 50%) average 40%. (About 65% of psychotics and only 10% of neurotics are admitted.) The admitting diagnosis in these cases agreed with the discharge diagnosis in only about 50% of the cases. Referral to an OPD clinic was made in (15 to 45%) 30%* of the cases, 20%* (15 to 30%) were discharged, and referral to the other agencies occurred in (5 to 15%) 10%* of the cases.[13,15,18]

The percentage of cases considered true emergencies depends nearly entirely upon the definition of a psychiatric emergency with a quoted range of 37 to 100%. The most rigid criteria required a "real" suicidal risk or that the mental state be such as to cause a social crisis; the other extreme being anyone coming to the emergency department whom the psychiatrist was asked to see.[19,20,21] Using the criteria implied in the author's definition I considered 61% of my cases to be true emergencies.

P.E. in Children

In one of the few papers on emergencies in child psychiatry Kenyon found a mean presenting age of 9.5 years with a range of 0-12 years. He noted a trend for emergencies to be referred less by family doctors and social agencies and more from other doctors, psychiatrists and the parents themselves than with the usual routine cases. The referral was precipitated by exclusion from or refusal to go to school in 28% of cases; by acute exacerbation of existing symptoms in 26%; by acute diagnostical problem in 14%; by suicidal threat or attempt in 12% and as a result of parental illness or threat in 7%.

The presenting symptoms in about one half of cases involved threatened or attempted violence; poor attendance or difficulty at schools. In about one-quarter of cases the patient showed anti-social behavior. About one-sixth of cases involved disturbed sleep; disturbed elimination; fits of depression or "always crying". About one-tenth showed disturbances of eating, threatened or attempted suicide; general backwardness, masturbation, somatic symptoms or overeating. As judged from the above there was a considerable over-lapping of symptoms.

The diagnosis reached was a primary behavior disorder in 60%; neurotic syndrome in 23% and mental subnormality in 7%.

*Average percentage.

The disposal of his cases involved three avenues: Admission in 33%, OPD treatment in 54% and discharge in 10%.

Kenyon felt only about two thirds of his cases were indeed emergencies, but he didn't state his criteria.

Other Methods of Handling Psychiatric Emergencies in a Hospital Setting

An innovation of P.E. service was introduced by Querido in Amsterdam.[28] This consists of sending a psychiatric team out to the home when a family reports that one of its members is seriously disturbed. This has, as its aim, immediate treatment and full assessment of the crisis situation. The purpose is to reduce the need for psychiatric hospitalization and its consequent loss of social self, loss of family contact and tendency for further regression to occur. This technique has been copied in many North American communities, even to the extent of associating psychiatric personnel with the police department.[29,30,46]

Coleman[23] has a method which he believes increases the efficiency of handling emotional problems which present in an emergency department. He has stationed either a social worker or a clinical psychologist in the emergency department on a 24-hour basis. These see patients referred by the house officer. By utilizing a technique of dynamically oriented supportive psychotherapy they attempt to help the patient during the crisis situation. A psychiatrist, of course, remains on call to handle the problems requiring a more detailed assessment. However, by having a therapist immediately available certain psychiatric emergencies are effectively handled and other situations are prevented from developing into P.E.'s Rosenthal has suggested that all hospital emergency departments should have on staff specially trained psychotherapists because their intervention is more beneficial than traditional supportive and comforting methods, both immediately and on a long-term basis.[24]

Bellak and others have gone a stage further and established walk-in clinics. Here the patient is encouraged to come in with any problem. People come just to talk things over and thus many quasi-medical and non-psychiatric problems are presented. The title "Psychiatry" is purposefully avoided so as to not discourage patients from using the facilities. Most cases are handled in a single interview although occasionally two or three are needed.[21,44] He feels that this approach prevents many crises from advancing to full blown P.E.

These "troubleshooting" clinics see themselves as providing the first echelon of medical care for people with bruised feelings or emotional disturbances, as well as more serious psychological complaints.[45] They feel they can handle effectively most minor problems allowing OPD clinics to concentrate on the more seriously disturbed patients.[25] Follow-up studies have shown a 60% successful treatment rate after 6 to 12 months. Seven to 12% of the cases are referred for more intensive psychotherapy.[26]

The British have been making use of observation wards to assess and treat psychiatric emergencies on an intensive short-term basis. Any patient sent by a physician is admitted and kept up to seven days before disposal to other facilities is mandatory. This is combined with domiciliary treatment and the utilization of ward nurses to assist in handling behavioral disturbances of patients previously in hospital on their wards. This three-pronged approach is reported to be effective in reducing emergencies.[16,27]

Roper has described a method of treatment of acute psychotic patients (frequently with suicidal and/or homicidal ideas) without hospitalization by a substitution of a day hospital. The treatment essentially consists of two "Page Russell" electroplexy treatments on the first two days, and one "Page Russell" treatment on the third and fourth days with subsequent treatments given at the rate of three standard single shock treatments a week. A minimum of drug therapy is used, the majority of cases receiving only night sedation.[31] The advantage of this as a means of treatment, aside from avoiding hospitalization, is not as yet established.

Suicide

Suicide has been termed a P.E. par excellence, as well as having been called the most common psychiatric emergency. Therefore, it deserves special coverage. An extensive topic itself, I will confine my remarks mostly to the evaluation of the suicide risk. This is appropriate since the P.E. consists in the imminent danger of suicidal action. A suicidal crisis is a psycho-social event. It represents a complicated synthesis of mental illness and social living problems. In a sense, self-destruction reflects the relationship of the individual to his community and his civilization.[35]

One approach to finding and aiding the suicidal patient has been that of the suicidal prevention telephone service in Los Angeles. The method used when the patient calls is aimed at maintaining the contact, evaluating the situation, and motivating the patient to further constructive action. The rapid development of a dependent relationship is first encouraged; then the relationship is used to sustain the patient's interest in living.[36]

The importance of immediate evaluation of a suicide risk has recently been emphasized by Seager who notes that in Bristol 4% of suicides were patients who knew that psychiatric OPD appointment had been made for them.[37] Thus, one must evaluate the risk on first contact with the patient and take appropriate action. One suggested form to achieve this assessment is Litman's Emergency Evaluation of Self-Destructive Potentiality.[35]

Case History

a) Age and sex

b) Nature of onset of self-destructive behavior; chronic, repetitive pattern, recent behavior change. Any prior suicidal attempts or threats?

c) Method of possible self-injury; availability, lethality.
d) Recent loss of loved person: death, separation, divorce?
e) Medical symptoms: history of recent illnesses or surgery?
f) Resources: available relatives or friends, financial status?

Evaluation

a) Status of communication with patient.
b) Kinds of feeling expressed.
c) Reactions of referring person.
d) Personality status and diagnostic impression.

Although males commit suicide more often than females (particularly in urban centers), suicidal attempts are more common in females. The rate of suicide per 100,000 persons increases with age, but the greatest number of suicides occur in the 50 to 59 age group in Britain and likely before that in North America. Up to 80% of persons who commit suicide discuss the act with doctors or relatives.[47]

It is likely, Schmidt points out, that if the physician is aware of the possibility of suicide and asks about it the patient will readily tell him about his suicidal thoughts.[39] An extensive review of the literature does not reveal a single reference to support the oft-mentioned caution that asking the patient about suicidal ruminations might put the suggestion in his mind and actually increase the suicidal danger.[40] One should be particularly careful to ask the patient regarding suicidal thoughts when he shows symptoms of depression, marked recent change of personality and life habits, a severe anxiety state or especially when the patient perceives his life situation as overwhelming, his conflicts as unsolvable, and his suffering inexorable. The latter negative feelings increase the suicidal danger.

The most reassuring reply is a qualified denial.[41] Frank denials, indignation, or anger in a patient whom one otherwise considers a suicidal risk should be viewed with suspicion.

Fatigue, illness or excessive environmental demands diminish the person's ability to cope with life and thus increase the danger. Conversely, positive relationships and meaningful involvement with friends, family plus professional responsibilities, life goals and cultural or church groups diminish the danger of suicide.

Wahl has emphasized the role of suicide as a magical act, "activated to achieve irrational, delusional and illusory ends". He may desire to punish another by inducing guilt over the injury he intends to do to himself. He does not recognize the fact that, if he should die, he will be dead and gone. This concentration on the magical solution to life conflicts increases the danger.[42]

Death of a parent before or during adolescence is seen four times as frequently in the seriously suicidal group versus the control group. There is a 25 to 30% incidence of previous suicide in the immediate families of patients who commit suicide.

"When the manifest content of the dreams becomes increasingly violent and destructive, or replete with themes of dying and death, or the affective component of the dreams increasingly depressive or anxious, or the expressed attitude one of giving up or surrendering, or the content increasingly morbid, the suicidal danger is often greater".[40]

As psychomotor retardation of the depressed patient lessens, the suicidal danger increases. Suicide *during* a course of electro-convulsive therapy is unusual, but much less unusual *following* a course of treatment, and is thus felt to represent a relapse in the initial condition. Similarly, the initial home visit and the first few months at home following hospitalization for suicidal thoughts or attempts are the most dangerous suicidal times.

The mild to moderate risk patient can usually be managed with environmental manipulation and appropriate drugs outside of hospital. Serious risk patients should be hospitalized. An overriding importance with all patients is that "a psychotherapeutic relationship be established early and maintained consistently during the suicidal crises, so that the patient is able to appeal for help and so that the therapist is able to perceive and respond to the appeal until the suicidal urges have abated."[35]

Patients with Low Suicidal Potential

This is seen most commonly in immature, passive dependent, passive aggressive, self-dramatizing persons. They simulate a suicidal mode of action in order to gain a point or manipulate a person. They act impulsively usually in close proximity to other persons, often when anger would have been appropriate. Suicide occurs only by accident or miscalculation. Frequently there is a history of chronic unstable interpersonal relationships. These cases are best handled by family counselling and case work in social agencies as well as psychotherapy.

Moderate Risks

The risk of death depends upon the outcome of a very close disturbed, ambivalent, interpersonal relationship, the patients are ambivalent: want to die but also want to be rescued and live. They endanger their lives severely in suicidal attempts but also make provision for being rescued. They leave it up to the gods, as it were, to choose for them life or death.

High Risks

These occur in severe depressives, restless schizophrenics and alcoholics who have exhausted their emotional resources. The action is seldom a matter of impulse. When suicidal danger is evaluated as high, there is no substitute for the safety and other therapeutic advantages of a psychiatric ward.

In conclusion I would like to note some of Litman's findings in assessing "successful" suicides. He found that certain masochistic perversions can and do lead to suicide

by asphyxiation or hanging; that persons who are taking large amounts of barbiturates over any extended period of time are living on the very edge of death and often slip over without quite meaning to; and that most people who play Russian Roulette—cheat.[43]

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