Chapter 16
PSYCHIATRIC EMERGENCIES

Learning Objective

- Health workers can diagnose and manage common psychiatric emergencies.

DEFINITION

A Psychiatric Emergency is a disturbance in thought, mood and/or action which causes sudden distress to the individual/others and sudden disability or death, thus requiring immediate management.

COMMON PSYCHIATRIC EMERGENCIES

- Suicidal attempt, deliberate harm to self or others.
- Acute psychotic episode with excited behavior and violence.
- Alcohol & drug withdrawal syndrome & delirium tremens.
- Depressive stupor or catatonic syndrome.
- Acute stress reaction with dissociative conversion disorder.
- Panic disorder with panic attacks.
- Dystonic reaction due to psychotropic drugs.

Assessment of Psychiatric Emergencies

History - Obtain detailed history from both the patient and the informants as far as possible.
Examination - Conduct detailed general physical and systemic examination to rule out or diagnose any organic problems such as head injury and/or delirium tremens.
Mental Status Examination - Do Glasgow Coma Scale to determine level of consciousness if required. Do Mini Mental State Examination to determine level of mental functioning. Assess suicidal or homicidal intent as soon as possible. Formulate psychiatric diagnosis. Rule out any pre-existing psychiatric disorders. Determine overdose or withdrawal of drugs and or alcohol.

Mental State Examination

Appearance and behavior:
Level of consciousness- Fully conscious/ stuporous/ comatose/ confused.
Dress- Appropriately/ shabbily dressed/ overdressed.
Psychomotor activities- Normal/ increased/ decreased.
Cooperativeness- cooperative /un-cooperative.
Rapport- Good/poor.
Speech- Quantity of speech: Normal/ increased/ decreased. Relevance: Relevant/ irrelevant, Coherence: Coherent/ incoherent. Continuity: Present/absent.
Mood- Subjective (what patient describes) Objective (what the interviewer observes)
Perceptions: Illusions/Hallucinations: Present/absent. Details with examples should be noted.
Thoughts: Delusions: present/absent, goal directed/loosening of associations, logical/illogical

Cognitive functions:
Attention and concentration: Normal/ impaired.
Orientation to time, Place, Person: Normal/ impaired.
Memory: Immediate: Normal/impaired, Recent: Normal/impaired.
General information and intelligence: Adequate/ inadequate.
Judgment: Intact/impaired.
Insight: Present/Absent.

GENERAL MANAGEMENT

- **Secure safety of patient**: As patients are at high risk for suicide and violence, health workers should always take appropriate measure to prevent them. Keep family as attendant if available. Otherwise, mobilize hospital staff or other patients to closely observe the patient or restrain them.

- **Nutrition and hydration:** Patients are at high risk of dehydration and starvation due to self-neglect. Therefore, health workers should ensure that patients receive adequate hydration and nutrition.
- **Psycho-social support**: Educate the patient and family about the illness and your plan of management so that they understand the disorder and cooperate with you.
- **Medication:** to be given as per the need.
- **Investigation:** Do investigation as needed.
- **Notification:** Inform patient's family, hospital administrator or other agencies as necessary.
- **Inform:** police if case is medico-legal
- **Consult a senior colleague**: if in doubt
- **Refer if necessary**: after giving psychological first aid and medical treatment.

Criteria for Involuntary Treatment in Consultation with Patient's Family

Unlike patients with physical disorder, psychiatric patients pose a unique challenge as many do not accept treatment or admission in hospital due to lack of insight. Nevertheless, following conditions warrants treatment:

- Presence of a mental disorder (as defined by internationally accepted standards) and in need of treatment.
- Loss of insight and unable to provide for own basic needs.
- Serious likelihood of immediate or imminent danger to oneself (suicide) or to others (homicide).

SPECIFIC MANAGEMENT

To keep this manual brief and user friendly, detailed signs and symptoms of each disorder and their management are not discussed here. Readers may refer to the Mental Health Manual 2011 and other sources of information such as google if they require detailed information.

Suicidal Attempt, Deliberate Harm to Self or Others:

Determine method of suicide attempt. Is it due to overdose of drugs, poisoning, hanging, cut injury, or other methods? Attend to the physical needs of the patient first. Determine if patient is conscious or unconscious. Manage patients according to the method of attempt, its consequences and condition of patient.

When the patient's general physical condition stabilizes, do a quick mental state examination to rule out causes of suicide attempt such as depression, psychosis, alcohol, drugs abuse, acute maladaptive response to stressful situations or other causes and to determine if the patient is still actively suicidal (Refer to Pierce Suicide Intent Scale).

If the patient is actively suicidal, admit patient for further treatment or refer. If patient is not actively suicidal and you are able to determine the cause of the problem, either start appropriate treatment or refer.

Acute Psychotic Episode with Excited Behavior and Violence:

Symptoms include delusions and or hallucinations, disorganized thinking and behavior, and incongruent mood. Rule out drug or alcohol intoxication with a quick history and assessment. Do mental state examination and confirm if patient has psychotic disorder or manic episode. Start anti-psychotic drug treatment immediately. Make sure that you have enough support

before you give the injection. Mobilize at least 3 other people to restrain the patient if patient refuses injection. Do not try to do it on your own. Give injection haloperidol 10 mg IM stat and injection chlorpromazine 50 mg IM stat. Also give oral chlorpromazine 300 mg stat and at bed time, Risperidone 2 mg stat and t.i.d. and trihexyphenidyl 2 mg stat and t.i.d. Ensure that patient is observed all the time and does not fall off the bed. Oral or injection diazepam 10 mg can be added later if patient does not settle down with above treatment. After patient settles down behaviorally, decide whether to admit patient or refer.

Alcohol and Drug Intoxication, Withdrawal Syndrome and Delirium Tremens:

Rule out other causes of delirium such as head injury or other organic brain syndromes. Confirm alcohol or drug intoxication or withdrawal syndrome from history and symptoms. Time lapse from last intake of alcohol or drugs will determine whether intoxicated or having withdrawals symptoms. Delirium is an acute, usually reversible brain disorder characterized by clouding of consciousness (decreased awareness of environment), a reduced ability to focus and maintain attention, and altered perception.

Symptoms often develop rapidly and may change from hour to hour. Intensity of symptoms varies through the day and is usually worse at night. Common symptoms are confusion, clouded thinking or decreased awareness, often accompanied by poor memory, emotional upset, tendency to wander, withdrawal from others, suspiciousness, agitation, disorientation, hallucination, illusions and disturbed sleep.

Alcohol Withdrawal seizures are often mistaken for epileptic seizures and treated wrongly. Start oral diazepam detoxification regimen immediately: 20 mg t.i.d x 2 days; 15 mg t.i.d. x 2 days; 10 mg t.i.d. x 2 days; 5 mg t.i.d. x 2 days and 5 mg HS x 2 days. Give inj. Diazepam 10 mg IV slowly stat and as required if patient develops withdrawal seizures or becomes very agitated and violent. Give thiamine 100 mg IV stat before starting any IV fluid. No specific regimen for drug withdrawal syndrome. Determine types of drug abused and give symptomatic treatment such as non-opioid pain killers for pain, antispasmodic drugs such as dicyclomine for intestinal cramping pain or non-addictive major tranquilizers such as chlorpromazine and tricyclic antidepressant amitriptyline for insomnia.

Depressive Stupor and Catatonic Syndrome:

Depression is a mood disorder characterized by depressed mood, loss of pleasure or enjoyment and/or decreased interest and associated with physical symptoms such as change in body movement, bowel functions, appetite or psychological symptoms such as feeling helpless, hopeless or decreased self-esteem. In depressive stupor or catatonia, patient has extreme slowing of psycho-motor functioning and social withdrawal.

There is risk of starvation and severe dehydration as these patients will refuse to eat or drink. They will also refuse oral medication. Start IV fluids as required. Pass NG tube and feed through it. Oral anti-depressant and anti-psychotic drugs medications can be crushed and feed through the NG tube as well. Give amitriptyline 100 mg stat and once a day. Give chlorpromazine 100 mg stat and once a day if the patient also has psychotic symptoms. Admit patient until condition stabilizes and vital parameters reach normal level. After that decide whether to continue treatment or refer.

Acute Stress Reaction with Dissociative Conversion Disorder:

Dissociative Conversion Disorders are characterized by the presence of physical or psychological symptoms in the absence of physical pathology. When patients are confronted

with overwhelming psychological conflicts or stressors which are difficult to be resolved, they dissociate themselves from the psychological conflicts or stressors subconsciously and convert them into physical symptoms.

Although this is not a life-threatening condition, nevertheless, it causes so much fear and confusion in patients and their relatives that this condition is one of the most common problems presenting to the emergency department. Usually common in adolescent girls, presentation can be from the simplest presentation like hyperventilation and tetany to the most bizarre such as sudden loss of consciousness, seizures or paralysis without significant clinical findings. Management includes calming down the patient and escorts, finding out a stressor or psychological conflict which may have triggered the symptoms and giving appropriate psycho-education and explaining of symptoms and reassurance. Teaching patient positive adaptive techniques like muscle relaxation, abdominal breathing exercises, mindfulness practice and positive self-talk are useful for prevention of similar symptoms in the future. Very rarely, short course of anxiolytic drugs like diazepam is required.

Panic Disorder with Panic Attacks:

This is also not a life-threatening condition. But again, the symptoms of panic disorder mimic so much like an ischemic heart attack or serious medical condition that it causes so much fear and distress in the patient and his relatives. Therefore, it is another common problem presenting to the emergency department.

Panic Disorder is characterized by a white-knuckled, heart pounding terror that strikes with the force of a lightning bolt, without warning. Some people feel like they are going mad, devoured by fear, dying of heart attack. Because they cannot predict these attacks, many experiences persistent worry that another attack could overcome them at any time. Most panic attacks last only a few minutes but could last up to ten minutes in rare cases.

Management includes a brief but relevant history and examination, investigation to rule out an IHD or other serious physical condition. If panic attack is suspected or confirmed, calm the patient and relatives. Explain the symptoms and reassure patient that this is not a heart attack or life-threatening condition. Teach breathing and relaxation exercises and positive self-talk. Very rarely, short course of anxiolytic drug like diazepam is required.

Dystonic Reaction due to Psychotropic Drugs:

This is an acute adverse extra pyramidal effect to use of anti-psychotic drugs like haloperidol and chlorpromazine. Dystonic reactions are characterized by intermittent spasmodic or sustained involuntary contractions of muscles in the face, neck, trunk, pelvis, and extremities. Though these reactions are becoming rare these days with the use of newer anti-psychotic drugs like risperidone and olanzapine, nevertheless, when they occur, they are frightening and distressing to patients and their relatives. Dystonic reactions are rarely life threatening.

Management includes taking relevant history to confirm prior anti-psychotic drug intake or overdose and brief examination. Treatment is extremely effective and motor disturbances resolve within minutes. Give either injection diazepam 10 mg IV stat slowly or injection Phenergan 10 mg IM stat. The condition usually subsides with these injections. For prevention of similar events in the future, oral trihexyphenidyl tablet 2 mg t.i.d. can be added or review and revise anti-psychotic drug regimen.

References

1. Mental Health Manual
2. Glasgow Coma Scale
3. Mini Mental State Examination
4. Mental State Examination
5. Pierce Suicide Intent Scale