
Psychiatric Emergencies IN PEDIATRICS

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Psychiatric Emergencies in Pediatrics

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YEAR BOOK MEDICAL PUBLISHERS, INC.
CHICAGO • LONDON

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Library of Congress Cataloging in Publication Data

Khan, Aman U

Psychiatric emergencies in pediatrics.

Includes index.

1. Crisis intervention (Psychiatry). 2. Child psychiatry. 3. Psychiatric hospitals—Outpatient services. I. Title.

RJ504.4.K47

362.7'8'21

79-17978

ISBN 0-8151-5029-6

PSYCHIATRIC EMERGENCIES IN PEDIATRICS

**To my family (Jadine, Kamal, Aleisha and Jason),
whose support, affection and encouragement
allowed me to create and complete this book**

Preface

IN THE LAST DECADE, hospitals have been forced to reexamine their outpatient services because of the increasing number of patients who have been using these facilities. In 1972, 95% of the hospitals in the United States reported more than 222 million outpatient visits. Of 7,105 hospitals with outpatient services, general hospitals provided 90% of the services and reported 213 million outpatient visits. The number of emergency room visits has increased at a faster rate than either hospital inpatient admissions or outpatient visits. The number of patient visits to emergency rooms tripled (increased by 40 million) during the 10-year period between 1962 and 72. Although separate data are not available for children and adolescents, it is estimated that at least 30% of these outpatient and emergency room visits are made by persons under 18 years of age.

This increase in utilization of outpatient services has also forced hospitals to employ full-time physicians to provide medical care in emergency rooms and other outpatient clinics. It is estimated that at least 10% of all hospital-based full-time physicians (approximately 2,500), as well as some 5,000 interns and residents, are providing full-time services in emergency rooms and other acute care clinics. In addition, a large number of nurses (approximately 40,000) are involved in these services, as are a growing number of medical social workers, psychologists and psychiatrists.

Data from emergency rooms and other acute care clinics indicate that clear-cut psychiatric diagnoses amount to about 2–5% of the total diagnostic categories. These figures are deceptive, however, and greatly underestimate the presence of psychiatric problems in emergency rooms. The low figures are attributable to the reluctance of physicians to make a psychiatric diagnosis and to the busy schedule of emergency rooms, which rarely permit the physician an opportunity to explore the emotional aspects of the medical problems he treats.

This book is designed to help physicians understand and manage the psychiatric problems commonly encountered in emergency rooms and acute care clinics. It treats the dynamics of these problems and provides step-by-step directions for their management.

Although some of the information contained in these pages may be found in various books and journal articles, this is the first book to describe these psychiatric problems in a practical and succinct manner for those profes-

sionals working in emergency rooms and acute care clinics. Several chapters contain original material drawn from long clinical experience in this field.

It is my hope that this book will serve as a handy reference for physicians, nurses, social workers, psychologists and psychiatrists working in emergency rooms and acute care clinics and that it will help to improve the psychiatric aspect of pediatric care.

I gratefully acknowledge the assistance provided by Joseph Cataio, who contributed considerably to the organizing, editing and proofreading of this book.

I would also like to thank Mrs. Irma Wallner and Ms. Cindy Lee, who were extremely helpful in the typing and preparation of this manuscript.

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1/Hospitalism, Hospitalization and Day Care

HOSPITALISM has been defined as “a vitiated condition of the body due to long confinement in a hospital . . . the evil effect of institutional care of infants from an early age” (Spitz, 1945). This definition is very restricted, since there are few institutions today that provide long-term care to infants without attempting to meet their psychological needs. At present, most institutions caring for young children attempt to monitor and evaluate the psychological effects they have on their patients.

It is important to distinguish between hospitalism, a condition resulting from long-term hospitalization in infancy in an emotionally cold and sterile environment, and short-term hospitalization of children of all ages.

Day care centers for infants and children present yet another situation where children are separated from their parents and are cared for by persons who are initially strangers. These institutions, although rapidly increasing in number, have been the subject of much social debate regarding their possible adverse psychological effects on children.

The following section describes the historical events that led to the discovery of the phenomenon of hospitalism and to an understanding of the problems associated with separation and maternal deprivation.

Attachment

In the early part of this century, disastrous mortality rates brought institutional care of infants under severe attack. Chapin (1915a, b) enumerated 10 asylums in large American cities in which the death rate of infants admitted during their first year of life varied from 31.7% to 75%. In the same year, Knox (Chapin, 1915b) stated that in the child care institutions of Baltimore, 90% of the infants died by the end of their first year of institutionalization.

Conditions improved by the fourth and fifth decades. Bakwin (1942) reported a mortality rate of less than 10% for Bellevue Hospital in New York City. While these and similar results were being achieved both in this country and in Europe, physicians and administrators were faced with a new problem: they discovered that institutionalized children frequently developed subsequent psychiatric disturbances—delinquency, mental re-

tardation and other psychiatric problems. The high mortality rate in preceding years had obscured these consequences. Now that the children survived, other drawbacks of institutionalization became apparent.

Several reports of the psychiatric consequences of institutional care of infants in their first year have appeared (Durfee and Wolf, 1933; Lowrey, 1940; Bender and Yarnell, 1941; Goldfarb, 1943). The psychological injury suffered by these infants was attributed to two primary factors—lack of stimulation and the absence of the infant's mother. It was emphasized that a home-reared infant always received more stimulation than a nursery-reared infant and that mothers provided more intensive stimulation than did nursing personnel. Those institutions in which mothers were available to care for their infants had lower infant mortality levels than institutions where only trained pediatric nurses were employed.

Spitz (1945) studied 164 children during their first year of life, of whom 130 were institutionalized and 34 home-reared. The institutions were categorized as "nursery" and "foundling homes." The nursery was in a penal institution where delinquent girls were sequestered. These girls delivered their babies in a nearby hospital and then cared for their children in the nursery of the penal institution, where they spent a great deal of time loving and cuddling their children under the supervision of the nursery staff. Foundling homes were very sterile, unstimulating medical environments with daily medical rounds and a nursing staff. The home-reared infants and nursery infants did significantly better than foundling home infants on all measures of development. In addition to developmental retardation, foundling home infants showed, from the third month on, an extreme susceptibility to all kinds of infection and illness.

Bowlby (1946), in a retrospective study, demonstrated that maternal deprivation was a common factor in the background of juvenile delinquents. More recent studies (Barry, 1949; Brown, 1961) support some of Bowlby's findings. Glueck and Glueck (1950) studied 500 persistently delinquent boys in their early teens. As a control, each delinquent boy was matched with a nondelinquent boy for age, intelligence, national origin and residence. They found that delinquent boys had significantly more losses in their childhood than had the children in the control group. The losses included parental death, divorce, separation, desertion and prolonged absence due to illness or imprisonment of the parents.

Some of the implications of Bowlby's work were accepted uncritically for many years and were interpreted to mean that any separation of the infant from the mother resulted in emotional deprivation. However, once the shock of his findings wore off, investigators began to ask more specific questions:

Why does the infant become so attached to his mother?

What is there in the mother-child relationship the deprivation of which caused such a disastrous effect?

The traditional interpretation of the close relationship between an infant and his mother assumed that the relationship was based on a conditioning process in which the mother, through association with such rewarding stimuli as food and warmth, became a rewarding stimulus herself in much the same way as the buzzer becomes a sign of food and a rewarding stimulus for dogs in a Pavlovian conditioning experiment. If the initial feeding experience was not rewarding, it was believed the infant would develop an unsatisfactory attachment to the mother.

This conditioning model of social learning has been refined by ethological experiments, especially those of Lorenz (1960) and Harlow (1962). These researchers contend that the attachment between infant and mother is not merely the result of the mother's attention to and care of the infant, but that there are additional factors inherent in the biologic nature of the infant that govern this attachment. Lorenz (1935) demonstrated that little ducklings soon after hatching will follow a moving object. Usually, this is the mother duck, but this following behavior can be elicited by any moving object, whether a wooden toy or a human being. This behavior is inherent in the newborn duckling and serves the purpose of species survival. It takes about 13 hours for the ducklings to become strongly attached to their first moving object, as demonstrated by the ducklings' avoiding any other moving object or expressing fear of other moving objects. In one of Harlow's experiments (1966), infant monkeys were fed from a milk bottle attached to a wire-mesh structure (wire-mesh mother). A similar structure was covered with terrycloth to provide soft, cuddly touch sensations (terrycloth mother). The infant monkeys spent most of their time cuddling the terrycloth mother and went to the wire-mesh mother only when hungry. The terrycloth mother seemed to make the infant monkey feel secure, as was inferred from an experiment in which a large wooden spider was placed in the room. The infant monkey looked frightened and ran to the terrycloth mother and not to the wire-mesh mother. These findings are interpreted as evidence of a strong inherent need in infant monkeys to cuddle (much like the ducklings' inherent need to follow). The infant monkey is born with a strong grasping reflex. In the natural environment of the jungle, the young monkey clings to the hairy undersurface of his mother for several months after birth. The infant monkey thus becomes attached to those objects that best simulate the tactile sensations received from clinging to the mother.

Apparently, each species has a special set of responses that can be brought forth at birth or very soon afterward. These responses are more complex than simple reflexes. They are elicited by the first appropriate

stimulus that the environment provides, and the objects eliciting these responses usually become the objects of attachment for the young animal.

Animals who are deprived of appropriate attachment relationships with caring mothers of their species become isolated and do not learn to interact appropriately (socially or sexually) with other members of their species. The monkeys raised by terrycloth or wire-mesh mothers, although physically sound, would not play or mate well with other, normally raised, monkeys.

Ethological theories thus conclude that: (1) young animals are born with specific innate reactions, which (2) help them to survive and to develop an attachment to the appropriate members of their species, and (3) this attachment is considered essential for the later development of appropriate social and sexual behavior and relationships.

Are human infants born with such innate responses?

Bowlby (1946) has suggested that there are five such responses in the human infant: sucking, babbling, visual scanning, crying and smiling. They help the infant to survive, as well as promoting interaction between the infant and the mother, thus facilitating attachment. Sucking and crying have strong survival value, while babbling, visual scanning and smiling serve the purpose of promoting interaction with the mother.

The babbling that occurs during the first 6 weeks in human infants is an innate response. After the first 8 to 10 weeks, the environment seems to affect the frequency and variety of these sounds. Children raised in homes in which mother and child engage in reciprocal vocal play vocalize more and with greater variety than do infants from homes where such exchange is minimal.

There are two types of smiling responses: endogenous and exogenous. Endogenous smiling is present at birth. It is a spontaneous response associated with a specific EEG pattern within the rapid eye movement (REM) stage of sleep. It tends to occur in bursts and does not decline over successive REM periods. It is present even in microcephalic newborns and is more frequently displayed by premature infants. It is postulated that this form of smiling is mediated by brainstem structures and becomes inhibited by subsequent maturation of the cerebrum.

Exogenous smiling is not present at birth. It begins as an irregular response to external stimuli at the end of the first postnatal month. It promotes the interaction between the mother and the child, such interaction normally increasing the frequency of smiling.

Although there are normal variations in the frequency and strength of these innate responses, some infants are born with abnormally weak or intense innate responses which are likely to have a significant impact on the rearing practices of some parents. For example, an infant who does

not cuddle or smile easily is likely to be ignored and neglected by the adults around him.

It has been postulated that the psychological problems of a deprived infant are the result of an unsatisfactory or nonexistent attachment to the mother. It takes a human infant about 6 to 8 months to recognize his mother, as manifested by the appearance of stranger anxiety. Fear of strangers appears at about 6 months of age in American infants, shows a peak frequency at 8 months, then gradually vanishes by the time the child is 12 to 15 months old.

Is the biologic mother necessary for the development of attachment?

It seems reasonable to hypothesize that the biologic mother is the best person with whom to develop this attachment relationship but that a surrogate mother could also develop this bond as long as she elicited the infant's primary reactions and provided food and physical comfort. Data on the rearing of adopted infants generally support this hypothesis.

It has not yet been established whether continuous care of an infant by one adult exclusively is more conducive to better social and sexual development than care by multiple parties. This is a very controversial issue. Some experts feel that excessive attachment to one set of parents may eventually result in overly individualized and aggressive behavior. Other investigators believe that mothering by several caretakers is detrimental to the development of normal social and emotional relationships.

Hospitalism

The term "hospitalism" is generally restricted to extreme cases of emotional deprivation in early infancy. Although such extreme deprivation most frequently occurs in institutions that provide long-term care to infants, this condition is also seen in home-reared infants. It is not uncommon to observe many such deprived children admitted to childrens' hospitals every year.

Infants who have experienced extreme emotional deprivation are listless and lethargic. They do not smile or babble. They often look at the passerby with wide open eyes and without any expression of feeling on their faces. They do not feel as much pain as normal infants do. Once these infants are recognized by the staff and are given a great deal of attention and care, however, they begin to change for the better. Initially, they become irritable and respond to strangers with anxiety and fear. They seem to feel more pain and cry more often. But they do manifest some attachment to the adults who spend a great deal of time with them, and if the special attention and care are continued, more pleasant emotions develop, which are expressed by smiles and babbling. Unfortunately, many of these in-

fants are not recognized early enough by health care professionals, and their continued deprivation results in permanent damage to their emotional and intellectual faculties. Many of these children function at a retarded level as they grow older.

It should be noted that children born with a high threshold for stimulation do not benefit from normal levels of environmental stimulation and may appear to be behaviorally similar to and thus mistaken for emotionally deprived children.

Hospitalization

Tommy, an 8-year-old boy admitted to the hospital for the first time with acute abdominal pains of 2 days' duration, rings the nursing station every 5 minutes with various complaints. He is driving the nurses crazy and seems to demand everybody's attention. Are his complaints exaggerated or attention-seeking in nature?

Another boy, Jerry, 6 years old, has been admitted to the hospital for the fourth time since the onset of his first acute asthmatic attack 8 months earlier. He appears very quiet and withdrawn and does not relate much to the nurses, doctors and other children. Is he emotionally healthy?

Children admitted to hospitals react in varying ways. These psychological reactions have become a matter of genuine concern to most health care personnel, since they are likely to influence the child's response to subsequent medical care and certain aspects of the child's personality development.

As hospitals become more complex by virtue of ever-changing technology and new procedures which the layman does not understand, specific efforts must be made to simplify hospitals for parents as well as for children.

Children's hospitals formerly had limited visiting hours and were very restrictive of the parents' presence, even during minor surgical procedures. It is only since the early 1960s that visiting hours and parental involvement in the care of the hospitalized child have been liberalized. Although there are many physicians and nurses who feel uncomfortable caring for a child in the presence of parents, the parents' involvement is generally regarded as psychologically beneficial for the child as well as for the parents. There are some obvious exceptions when exclusion of the parents is warranted, however, such as when the parents are abusive, are magnifying the child's fears, or are unable to tolerate minor surgical procedures.

What is there about hospitalization that psychologically upsets children?

At least 3 factors can be recognized as contributing to a child's upset:

1. Separation from his home, parents and all his cherished belongings
2. The strangeness and unfamiliarity of the hospital
3. Fear of hospital procedures, pain, operations and mutilation

Hospitals arouse many fantasies of injury, mutilation and death in children. Some children feel they are sick because they have been bad. The sickness may thus be interpreted as punishment and abandonment.

Gellert (1961) studied 102 hospitalized and nonhospitalized children, 4 to 16 years of age. They were shown a picture of a child in bed and were asked several questions related to how the child became ill. About two thirds of the children felt that the child in the picture had been bad and had done things contrary to the expectations of his parents. These fantasies were more common among young children and children with limited intellectual capacity.

Age plays an important role in the degree of upset experienced by children, with children under 5 years old being the most upset by hospitalization because of their proneness (especially during the first 2 years of life) to stranger and separation anxieties. In addition, the young child's poor comprehension of time exaggerates the effects of a brief separation.

Every separation from the parents may create a crisis for the young infant, who may experience a severe anxiety attack when his parents leave his hospital room. This reaction is at times misinterpreted by hospital personnel, who believe it stems from the parents spoiling the child and who, accordingly, try to curtail the parents' visits to the child. These upsets usually decrease during hospitalization, however, so no curtailment of parental visiting is necessary.

The nature of the parent-child relationship also influences the child's reaction to hospitalization. Children who trust their parents are able to trust other adults, doctors and nurses. A poor and untrusting relationship between the child and his parents decreases the child's ability to trust other adults and enhances his upset when hospitalized.

The parents' own response to the child's illness is still another factor in the child's reaction to hospitalization. Many parents feel guilty about their child's illness and may overprotect him to the point of treating him as if he were an infant. A high level of parental anxiety interferes with effective psychological preparation of the child for hospitalization or surgical procedures. The lack of full comprehension of the disease or a diagnostic procedure, lack of trust in the doctor and unfamiliarity with the hospital routine are some of the contributory factors to the parents' high level of anxiety. Parental anxiety is easily communicated to the child, who, lacking understanding of the situation, may become more apprehensive than his parents.

Johnson (1955) studied the relationships between parental attitude to-