EMERGENCY PSYCHIATRY

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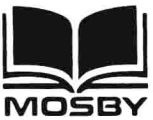

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To my parents

Carl and Caroline

D.A.R.

In loving memory of

Nadine W. Hutzler

1910-1983

J.C.H.

PREFACE

The purpose of this book is to enable the emergency physician to understand and deal effectively with patients who have psychiatric disorders. It is our firm conviction that recognition and management of psychiatric disorders in the emergency patient need not be inordinately difficult. The diagnosis of psychiatric disorders has been made far more straightforward with the American Psychiatric Association's adoption of clear clinical criteria for psychiatric illness in the 1980 version of the *Diagnostic and Statistical Manual of Mental Disorders* (third edition), the DSM-III. Relatively simple treatment regimens can be remarkably effective when applied in the proper circumstance.

The initial emphasis of the text is that of determining which mental and behavorial disorders are organic and which are not. The differentiation between these two categories of disorders is of major importance in determining the direction of further assessment and treatment and can usually be accomplished rather easily in the emergency department.

The next emphasis is to clarify psychoses, affective disorders, and personality disorders. These classifications of disease are often avoided by physicians who have in the past been confused, if not bewildered, by conflicting terminology, various "schools" of psychiatric thought, and imprecise diagnostic criteria for these clinical conditions.

The text also deals with several common problems in the emergency department from a psychiatric perspective: patient-defined emergencies; the violent or combative patient; psychiatric emergencies associated with death, suicide, anxiety syndromes, panic attacks, or somatoform disorders; and the patient who signs out or refuses treatment. The text concerns itself with therapeutic techniques, including both interpersonal and pharmaceutical therapy for psychiatric illness.

Our objective is to make emergency physicians as comfortable and adept with psychiatric disorders as they are with medical or surgical disorders and to ultimately improve the care of the psychiatrically impaired patient in the emergency department.

We are indebted to those who helped to make this book possible. Christine Dailey, Jacqueline Parris, Pamela McDougall, and Pam Furney created superior manuscript from our handwritten versions. Cathy Converse of The C.V. Mosby Company kept us amply supplied with professional advice and continuing encouragement. Catherine Khoury, Gerald Chever, Jim O'Harra, Debra Slusher, and William Lanier provided invaluable assistance in preparing our illustrations, and special thanks go to an incomparable Gary Smith for his facile display of mood and movement. Martin D. Keller,

Lee Jansen, and the American Red Cross furnished additional photographic material from their collections; Steve Moon rendered line drawings with his characteristic style; Ed Whitehead provided invaluable assistance in our library searches; Dr. Charles Whitfield helped us greatly in our thinking and in our presentation of alcohol syndromes; and Steven R. Schneir created a fine preliminary draft of Chapter 21.

Finally, we are indebted to our families who tolerated our preoccupation with this text during the long months of its preparation.

Douglas A. Rund
Jeffery C. Hutzler

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1 EMERGENCY PSYCHIATRY
the medical model

Psychiatric illness is remarkably common in patients who seek care in emergency departments. Psychiatric problems constitute the primary reason for 10% of the patients visiting one urban hospital.[1] The prevalence of active psychiatric illness in emergency patients seeking care for *any* reason was as high as 38% in a fairly recent study using standardized research criteria for psychiatric diagnoses.[2] This represents an enormous group of patients to be evaluated by emergency physicians.

The psychiatric disorder may not be apparent from the patient's chief complaint, and the immediate clinical problem may seem unrelated to an underlying psychiatric disorder. By contrast, the psychiatric condition may be so florid that it outshines all others, disrupting normal functioning of the department and the composure of the staff. Such conditions demand attention, and the emergency physician must act immediately to bring both the patient and the situation under control.

Some conditions are far more common than others. Substance abuse, depression, anxiety, and acute situational reactions are huge social and medical problems that appear regularly and predictably in emergency practice.

The emergency physician and psychiatrist are now able to collaborate on both the clinical management and investigation of these disorders far more easily than in the past because their respective disciplines are progressing. Emergency medicine is moving to identify and explore its clinical content; psychiatry is moving toward the medical model.

Both the science of psychiatry and the discipline of emergency medicine are on pathways that allow the development of a skillful and compassionate approach to the problem of the "psychiatric patient" in the emergency department (Fig. 1-1). To fully appreciate the developments that make this approach possible, we can briefly review the evolution of each specialty.

PSYCHIATRY: HIPPOCRATES TO DSM-III
Origins

The science of psychiatry is rooted in ancient observations of disordered behavior and thought. Hippocrates wrote of madness, delirium, and "fears and terrors (which) assail us, some by night and some by day. . . All these things we endure from the brain when it is not healthy."[3] This early viewpoint was a precursor of the "medical

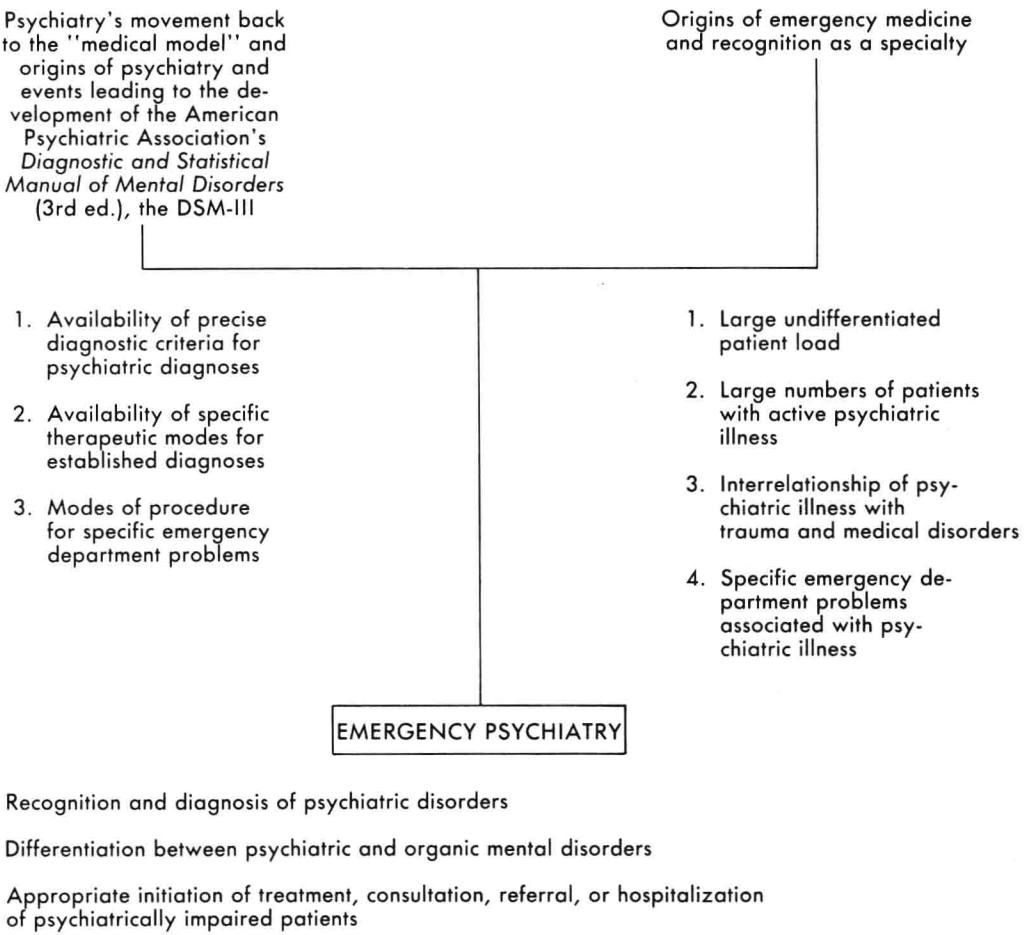

FIG. 1-1. Development of emergency psychiatry made possible by application of major advances in both psychiatry and emergency medicine.

model" concepts of psychiatry, which are most prevalent today; that psychiatric illness is similar to other types of medical illness. Psychiatric conditions can be evaluated rationally, can be defined according to their clinical characteristics, and can be treated with therapies that are indicated for a given diagnosis.

Dichotomy of mind and body

Plato is given historical credit for establishing the notion that mind and body, *psyche* and *soma*, were separate entities. The dichotomy of mind and body continued as the dominant concept through the middle ages and was fostered by religious scholars who viewed the human soul as separate and distinct from the human body.

After many centuries we once again view the individual as a whole. Biochemical processes that affect the body affect the mind, and disorders of thinking, behavior, and emotions certainly affect the body. This holistic concept builds bridges of understanding between the medical practitioner and the psychiatrist, and it forms a foundation that allows the emergency physician to understand current concepts of psychiatric illness.

The medical model presented emphasizes medical (organic) causes of abnormal thought and behavior. We recognize that biochemical and perhaps structural abnormalities of brain tissue produce syndromes of abnormal thought and behavior. In some syndromes (like schizophrenia) underlying pathology is not fully understood; antipsychotic drug therapy of the disease controls the symptoms (hallucinations, delusions) just as drug therapy for certain medical conditions controls the symptoms of pain or fever.

Clinical psychiatry

The clinical discipline of psychiatry emerged gradually in the eighteenth and nineteenth centuries and was intermittently influenced in one direction or another by individual theories, terminologies, and therapeutic methods. The impact of Freud, for instance, profoundly influenced psychiatry in the late nineteenth and early twentieth centuries.

Various Freudian theories that explained abnormal thought and behavior on the basis of "delayed oral gratification stage" or "inadequate development of superego" were barely comprehensible for practicing physicians. For many, these theories created mystery instead of understanding and resembled more an art form or a philosophical system than science or useful medical knowledge.

Psychiatry was finally recognized as a specialty in the United States in 1934 with the establishment of the American Board of Psychiatry and Neurology.[4] Since that time, psychiatry has moved deliberately into the medical realm. Becoming firmly established as a "medical" discipline, psychiatry has sharpened and refined its clinical science.

DSM-III

The American Psychiatric Association first adopted standardized nomenclature for psychiatric diagnoses in 1952. The publication of this nomenclature in the *Diagnostic and Statistical Manual of Mental Disorders,* (1st ed.)[4] provided the practicing psychiatrist and medical community with a set of established diagnoses. Ideally, patients given a specific diagnosis had certain clinical characteristics specific for that diagnosis. Communication could flow among all physicians about diagnosis, effects of therapy, and patient prognosis.

In 1968 a second edition, the DSM-II,[5] was published with a set of revised terminology. The need for even more precise diagnostic criteria and terminology for psychiatric illness remained, however. Feighner and his colleagues took constructive steps to formulate explicit criteria for psychiatric diagnoses that allowed reproducible psychiatric research and meaningful clinical communication especially between the psychiatrist and nonpsychiatrist.[6] They identified 14 psychiatric diagnoses with precise diagnostic criteria; most of the data needed for the diagnosis could be obtained at the bedside. The

illnesses identified in this early work were the following: primary affective disorders (depression and mania), secondary affective disorders, schizophrenia, anxiety neuroses, obsessive compulsive neurosis, phobic neuroses, hysteria, antisocial personality, alcoholism, drug dependence, mental retardation, organic brain syndrome, homosexuality, and transsexualism. The potential advantage of the emergency physician having precise terminology and clear-cut criteria for psychiatric illness was enormous. Physicians could now make clinical psychiatric diagnoses based on specific clinical criteria. Psychiatrists had developed the roots of a diagnostic nomenclature, which was as specific, or even more specific, than many other medical specialties.

The work of Feighner emphasized standardized terminology and clear criteria for psychiatric diagnoses. The collection of one cluster of symptoms and signs comprised one diagnosis, whereas a different cluster defined a different diagnosis. With increasing experience the psychiatric community further crystallized its diagnostic thought. The result was the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders,*[7] published in 1980. Commonly abbreviated as the DSM-III, the *Diagnostic and Statistical Manual* is available from the American Psychiatric Association, Washington, D.C., both as a full-sized textbook and as a pocket-sized reference with the essential diagnostic criteria for terminology and code numbers for psychiatric illnesses. It also has easy-to-understand flowcharts (or decision trees) to enhance rapid, bedside diagnosis.

EMERGENCY MEDICINE

Origins

The science of emergency medicine, in one respect, has its historical roots in the most primitive attempts to deal with acute injury, illness, and life-threatening events. The development of emergency medicine as a formal discipline, however, has a far more recent beginning. The enormous growth of emergency medicine in the last 20 years has been largely the result of changing societal behavior, changing social demands, and technological improvements in the immediate management of life-threatening conditions.

The economic basis for the increase in the number of hospital-based emergency physicians is the tremendous increase in the volume of patients seeking care in the emergency department. In 1958 the nation's hospitals reported 18 million emergency patient visits. In 1968 the number reported was 44 million,[8] and by 1977 the number had risen to 76 million[9] annual patient visits. The reason for the increase included a general societal drift away from stable relationships with providers of essential services, decreasing relative numbers and availability of general practioners and primary care physicians, and third-party payment policies that reimburse the fees incurred for hospital emergency services but not for office-based medical care.

The lack of availability of primary physicians has been most acute in inner-city communities and rural areas, and although the coming increase in physician supply may improve many problems of physician availability, the importance of emergency medi-

cine is not likely to diminish. The medical community and the public fully expect competent emergency physicians to be available at all times to provide initial management of acute medical, surgical, and psychiatric conditions in the hospital emergency department.

The proportion of patients with life-threatening illnesses in most emergency departments is no more than 5% to 10%, compared to 15% to 20% for those with illnesses and injuries that make hospitalization necessary. The most salient characteristic of emergency patients is that they often arrive in large numbers and have illnesses that run the gamut from the most minor to the most serious.

The early leaders in academic emergency medicine were originally from the discipline of surgery.[10] Therefore it was reasonable that an emphasis on the immediate management of trauma was felt early in the development of emergency medicine. Since the first automobile accident in 1899, the incidence of trauma had grown to become the leading cause of death in persons under 30 years of age, which also made the emphasis on early trauma management a reasonable expectation.

As the overall content of emergency practice is fully elaborated, however, conditions like psychiatric illness and substance abuse continue to surface as major problems. Many of the current leaders in emergency medicine are nonsurgeons or graduates of a residency program in emergency medicine. As they try to understand the problems that arise in their clinical practice, psychiatric conditions stand out as major dilemmas.

Specialty status

The American Board of Emergency Medicine was approved in 1979, and the scientific underpinnings of the discipline continue to emerge. In creating a new body of knowledge and a unique mode of clinical practice specific for emergency medicine, it has been necessary initially to draw heavily from established disciplines and create mutual approaches to shared clinical problems. Psychological disorders are specifically identified as an integral part of the Emergency Medicine Core Content.[11] Continued collaborative analysis of psychiatric problems in the emergency setting will undoubtedly be fruitful, and the general movement of psychiatry toward the medical fold facilitates such cooperation. It is with this collaborative approach in mind that we have written this text.

EMERGENCY PSYCHIATRY

The management of patients with abnormal behavior or thought processes in the emergency department is bound to be influenced by the setting. The pace is fast. The patient problem may be complex and often extremely serious. The pressure to make rapid decisions with minimal data is ever present and insistent, yet the physician must be able to evaluate each patient quickly and succinctly without significant loss of accuracy. Similarly, treatment and disposition must be accomplished in a concise fashion with reasonable certainty that the treatment will be effective and almost absolute certainty that the treatment will do no harm. Our presentation of emergency psychiatry

must then be relevant and applicable in the emergency setting. Some therapies involve medication, and some involve active listening and crisis intervention. These latter therapies are techniques that can be accomplished by a physician or a nonphysician.

The treatment of these patients is similarly influenced by the attitudes of the entire emergency staff. It is not secret that physicians, nurses, and clerical staff seem to dislike the confrontation with psychiatric patients. The disturbing behavior of such patients bothers us, and we often blame them as if they purposefully try to disrupt our emergency schedule. Some of the distaste for dealing with psychiatric patients can, in our opinion, be decreased with increasing knowledge by providing the emergency physician and team with effective diagnostic tools, straightforward management approaches to psychiatric illness, and perhaps most importantly of all, an understanding of the patient and his disease.

Our thesis is perhaps controversial. We feel that the emergency physician should be just as capable of initiating proper early therapy in psychiatric disorders as in those of the cardiovascular system. Similarly, just as the treatment of some cardiovascular disorders require consultation with a cardiologist and hospitalization, certain psychiatric illnesses are complex and time consuming; the physician should be able to recognize these disorders and seek the appropriate psychiatric consultation, psychiatric referral, or hospitalization for the patient.

Throughout this text certain fundamental principles of emergency psychiatric care are emphasized. The following are three of the principles of emergency psychiatric care.

1. Immediate stabilization of the patient and the situation is usually the physician's first management priority.
2. Recognition of medical conditions that cause the abnormal thought or behavior should be an early responsibility of the emergency physician.
3. Psychiatric consultation and/or mandatory hospitalization may be the only logical conclusion of the emergency physician's encounters with these patients.

Stabilization

Certain emergency situations require immediate stabilization. The violent patient must be brought under control immediately for the protection of everyone involved. Early restraint of such patients requires adequate manpower and proper techniques. The concept of stabilization applies to other psychiatric emergencies as well. Such emergencies may include a suicide attempt, a substance abuser, or a psychotic patient. The concept of stabilization is critically important in the practice of emergency medicine, since this is an environment where things happen quickly and unexpectedly. Throughout this text, the concept of early stabilization is applied to specific patients, situations, and problems that seem to involve psychiatric disorders.

Medical conditions

Certain abnormalities of thought and behavior are caused by medical conditions, obvious physical alterations in brain tissue, or abnormalities in brain function as a result

of exogenous or endogenous substances. When abnormal thought or behavior is caused by such conditions, the disorder is labeled *organic*. Such abnormalities of thought or behavior are called *organic mental disorders*. The specific mental disorder created by a "medical" condition is labeled according to its presumed cause. Examples of organic mental disorders include *hypertensive* encephalopathy, *hepatic* encephalopathy, *drug* intoxication, *alcohol* intoxication, and *alcohol* withdrawal.

Medical conditions that commonly cause abnormalities of thought and behavior are often missed by the medical doctor because of the rush to get the psychiatric patient *out* of the emergency department and *into* the hands of a psychiatrist. It is estimated that up to 30% of patients referred to psychiatrists have medical disorders that cause "psychiatric" symptoms. Paradoxically it is the psychiatrist who then must evaluate the patient to discover the responsible "medical" pathology.

For the emergency physician, the consideration of organic mental disorder must be paramount in the approach to the psychiatric patient. Some of these medical disorders may be life-threatening, and the only early clue to their presence may be bizarre behavior, hallucinations, or "crazy" speech. Some of the life-threatening conditions include meningitis, encephalitis, poisoning, hypoxia, or hypoglycemia.

In this text two broad categories of illness are considered. The terms *organic* and *functional* are used. Organic, as mentioned previously, refers to disorders that have underlying medical or structural pathology. Functional disorders are those for which the medical, structural, or chemical cause is unknown and for which the ultimate treatment is often within the province of the psychiatrist. These "functional" disorders include schizophrenia, generalized anxiety disorders, and personality disorders. When there is no underlying medical cause, the affective disorders (depression and mania) are also considered to be in the functional category. Some functional disorders respond to psychotherapy and/or psychoactive medications. Both of these broad classes of therapy constitute some of the special skills of the psychiatrist. The principles and limited application of these therapies can be learned by the emergency physician.

Consultation and hospitalization

Questions that frequently arise in the emergency care of the psychiatric patient (and one that invariably arises at 3 o'clock AM) are where to obtain immediate psychiatric consultation and where to hospitalize the patient, even against his will.

The general answer is that consultation is called for if there is doubt and that hospitalization is necessary if there is a danger of harm coming to the patient or others if he is not hospitalized. More specific recommendations with guidelines for consultation and hospitalization are presented as particular disorders are considered.

SUMMARY

Throughout this text we deliberately use the terminology and diagnostic criteria of the DSM-III. It is our firm belief that this allows the emergency physician to begin the study of emergency psychiatry at "square one." The terminology is current and new,

explicit and concise, and, in our opinion, it enables the emergency physician to be an accurate psychiatric diagnostician.

Though we recognize that the DSM-III is not accepted by everyone and will undoubtedly be revised again in the future, it does provide a starting point for colloboration. It offers a common vocabulary and a common conceptual framework for understanding psychiatric illness. In our opinion, it forms an excellent basis for the presentation of emergency psychiatry.

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2 APPROACH TO THE PATIENT

The patient with grossly abnormal behavior or thought is easily recognized by virtually everyone involved in his care. The patient's first words to the emergency staff may sound the alarm: "The underground psyches keep coming out and biting me," or "The radios are telling me to kill myself."

Alternatively, the circumstances of the patient's police arrest or the summoning of an ambulance may provide the obvious clues: "He was standing on the corner with his pants down shouting at everyone," or "She was found unconscious with several empty pill bottles and a suicide note near her bedside."

When the abnormal behavior is not so obviously deviant and the disorder of thinking is subtle, the patient may enter the emergency department with a variety of midleading, obscure, or nonspecific complaints, including the notorious "sick all over" complaint frequently associated with an affective disorder (like major depression). A history of trauma or a complaint primarily related to injury is frequently related to alcoholism, substance abuse, or antisocial personality disorder.

The stages in the management of psychiatric patients in the emergency department are as follows:

Recognition of abnormal behavior or thought
Stabilization of the patient and the setting
Alertness for medical emergencies
Interview
Physical examination
  Vital signs
  Head and neck
  Further examination as needed and/or tolerated by the patient
Testing
Consultation if needed
Admission or discharge

It cannot be emphasized too strongly that patient stabilization and the search for an organic mental disorder are fundamental skills for the emergency physician.

STABILIZATION

As in the management of any medical disorder, the first priority in the emergency management of psychiatric disorders is the stabilization of the patient and the situation.