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PRACTICAL PSYCHIATRY

Psychiatric Emergencies in General Practice

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Psychiatric emergencies used to be regarded as those acute and socially disruptive states calling for more or less immediate admission to hospital, usually under some kind of compulsory detention order. Today the notion of what constitutes an emergency has widened so as to embrace a number of other conditions which would not at one time have been placed in this category. The term psychiatric emergency does not, furthermore, imply that of necessity admission to hospital will be required. It does, however, denote a situation which calls for prompt attention, not because it contains an element of danger—which it may or may not do—but in order that prolonged morbidity may be prevented. Some psychiatric emergencies are clearly due more to intrinsic than extrinsic factors. These consist for the most part of acute psychotic states, rare on the whole in general practice. Others are more the outcome of an acute environmental or social crisis. It is not profitable to try to separate two categories, for, as Morrice¹ recently stated, this does injury to the total concept of psychiatric illness. Indeed, while problems which give rise to critical situations are familiar enough, those who respond to them by developing psychiatric symptoms are those who, owing to some pre-existing personality inadequacy, are unable to resolve them in a healthy fashion.

Very acute psychiatric disorders containing a real element of danger, which call for urgent admission to hospital, though possibly even rarer in practice than they once were, still occur. It is important therefore to know what positive action to take in such cases.

Use of Force

If, as happens occasionally, a patient, owing to confusion, delirium, paranoid panic, or some other acute psychotic state, is wildly uncooperative, then nothing short of force may be required. Here the golden rule is to have a sufficient number of persons to hand to deal adequately with the situation. Otherwise an unduly severe or prolonged struggle may bring harm both to the patient and to those who attempt to control him. It should also not be forgotten that most mentally disturbed patients tend to use violence only when frightened. In this respect they differ little from normal people. Initially, therefore, there should be no suggestion of force, and with due regard for safety the patient should be interviewed alone or in the presence of one other person, preferably a trusted relative. If, following this, forcible action has to be taken an effort should always be made to explain clearly and simply what course of action is proposed and why. Deception is to be avoided at all costs, even in the case of those who are so disturbed as to appear unable to comprehend what is going on.

Apart from force, sedation will often be needed. If so, sufficient should be given, for too small a dose may do no more than make a bad situation worse. As a whole barbiturates and paraldehyde are best avoided. The latter, although relatively

safe, is unpleasant; and it should be remembered that, although often given by injection, it is not sterile. Initially, and if there is nothing else to hand, a combination of morphine (15-30 mg.) and hyoscine hydrobromide (0.6 mg.) may produce a satisfactory state of tranquillity. Other drugs which may be both safe and effective are chlorpromazine (100 mg.) injected intramuscularly, or haloperidol (5 mg.) given intramuscularly or intravenously. In older people parenteral chlorpromazine may produce a fall in blood pressure and should be used with caution on this account.

Compulsory Admission

Compulsory admission to hospital can be effected only under the provisions of the Mental Health Act, 1959. Urgent admission is often effected under Section 29, which requires application either by a mental welfare officer or a relative of the patient and the recommendation of a single medical practitioner, preferably one who has previous knowledge of the patient. Agreement by a hospital to admit the patient under this section may also be needed.

Some are of the opinion that this procedure is often misused merely because it is easy to implement. Under less urgent circumstances admission for observation under Section 25 or less commonly admission for treatment under Section 26 is preferable. Both these, however, are more elaborate and time-consuming processes requiring the written recommendations of two medical practitioners. One of these should have known the patient previously and is likely to be the patient's general practitioner; the other must be a medical practitioner approved by the local health authority as having special experience in the diagnosis and treatment of mental disorder. Although Section 29 is probably not as widely misused as some maintain, there is no doubt that at times administrative convenience may override other considerations. This is regrettable. Furthermore, experience shows that a number of those admitted under this section could, given tactful handling, have been persuaded to accept informal admission. It has been said, however, that those on the receiving end may sometimes doubt the need for urgency unless the patient is admitted under some form of compulsion.

But it is not only very acute psychiatric illnesses which give rise to critical situations. Conditions characterized by lack of judgement leading to inappropriate behaviour may also do so. While judgement may be impaired in almost any psychiatric illness it is particularly prone to be affected in organic states and in hypomania (that is, mania in its less florid form.) Old people with organic cerebral disease are prone to confusion and may come to harm thereby. Left alone they may wander away, particularly at night, when darkness may add some degree of sensory deprivation to an already blinkered awareness. Gas taps may be inadvertently turned on, and, if senile anosmia is present, may be forgotten about after a fruitless search for matches. Such old people living alone may seriously neglect themselves. Nutritional deficiency is not uncommon, and in

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winter weather a dangerous state of hypothermia can occur owing to failure to light a fire. Patients with organic brain disease, whether old or sometimes younger, are also occasionally liable to violent antisocial or untoward sexual behaviour, these again being the result of lack of judgement, disinhibition, and the release of tendencies which in the presence of intact cerebral functioning would probably have remained controlled.

Hypomania

Hypomania can present real difficulty. Unlike full-blown mania, in which a gross degree of mental disturbance is immediately apparent and which is now a relatively rare condition, in hypomania faulty judgement and a disturbance of behaviour may mask the true nature of the illness, though if something is known of the patient's premorbid personality he may be seen to be more active and over-talkative than usual. Elation is, however, by no means invariably evident. Instead some patients are sulky and irritable rather than elated. But it is the sudden onset of inappropriate behaviour which may be the most striking feature of the disorder.

A girl of 18 from a well-respected family was brought on a very hot day by her distraught mother to the consulting-room of a doctor who was a total stranger to her. Taking no notice of him, the first thing she did on entering the consulting-room was to sprawl outstretched in a chair, lifting her skirt to an electric fan so that cool air might play on her naked genitals. She was devoid of underwear.

This girl's action was completely foreign to her usual self. It is very easy to see how such patients, who may suffer from enhanced eroticism as well as a lack of judgement, could be taken advantage of by some unscrupulous person. Money is another problem.

An ex-naval officer, a bachelor, living on a retirement pension in a private hotel, who was normally regarded by the other residents as quiet and reserved, suddenly began to change in manner. Instead of a customary and somewhat terse good-morning at breakfast time he started by way of greeting to chuck some of the ladies under the chin. He then went out on a spree during which he spent several hundred pounds, much more than he could afford, in a number of dubious night-clubs. All this was quite foreign to his normal self.

Both these patients were admitted to hospital, the first voluntarily, the second much to his annoyance on a compulsory order. He had had previous hypomanic attacks and could, if he had been handled tactfully, have been persuaded to accept treatment voluntarily, as indeed he did a day or so after admission.

Attempted Suicide

Attempted suicide may present difficulty. This seems to be becoming increasingly common, not so much as a symptom of relatively clear-cut mental illness but as a response to a social crisis. Indeed, in many cases a suicidal attempt—in particular an overdose—can be seen not so much as an essay of self-destruction but as an appeal for aid, a method whereby inability to cope with some personal crisis is communicated to family, friends, or to others who might conceivably help. The matter presents no immediate problem when the patient is found injured or under the influence of drugs. As a rule no other course is open but to have him conveyed to the casualty department of a general hospital for resuscitation. Following this the underlying problem may be sorted out more or less at leisure and its seriousness assessed. If, however, suicide is only threatened, or the patient when first seen has already made an attempt but does not require resuscitation or has come to no physical harm, the doctor may be faced with a more difficult decision.

There are no hard and fast rules. Each case must be assessed on its merits. If other features of overt mental illness are evident—for example, depressive or schizophrenic symptoms—the threat of suicide must always be taken seriously, the more so if the patient is hypochondriacal, paranoid, or otherwise deluded. Alcoholics, epileptics, and those who are old, lonely, and physically infirm should also be regarded as at risk. But in the absence of any of these factors, when a suicidal attempt or threat is made apparently in response to a social or interpersonal crisis, this should not be too readily dismissed as not serious, despite the fact that there may appear to be very little real danger. Errors of judgement are easily made and there is little virtue in being wise after a fatal event.

Not too much reliance should be placed on the method of attempt. A patient who takes a small and relatively harmless overdose may well have believed that its effects would be serious if not fatal. Nor does the admitted intention necessarily indicate the seriousness of an attempt. Thus a statement that an overdose of sleeping tablets was taken “in order to get a good night's sleep” may be mere dissimulation. In any case many patients seem after the event to be remarkably unclear as to their intention at the time.

Attempts made in the face of an acute social crisis call for detailed evaluation of family relationships. It may then appear that the patient is not the only family member requiring help, nor necessarily the most severely disturbed. Cases such as these need to be distinguished from those in which the precipitating factors are more intrinsic than extrinsic—that is, contained more within the patient than within his environment. Both, however, must be evaluated. Variations on this theme are “acting-out” by attention-seeking personalities whose suicidal attempts are often somewhat histrionic and may be construed as a type of emotional blackmail; certain other dubious happenings which are apparently but not convincingly accidental; and “short-circuit” reactions in those with explosive, psychopathic tendencies. In the latter alcohol often plays a part.

Even where suicide has not been attempted or threatened the possibility should always be borne in mind and raised during an interview with an emotionally disturbed patient. It is a sobering thought that a considerable number of those who actually commit suicide visit their doctors on some or another pretext a short time before. It is as if they give warning of the event, not directly but in a disguised form. While it is difficult to prove, there are grounds for believing that discussing the possibility of suicide with a patient may reduce the risk. It certainly does no harm. It should also not be forgotten that a depressed patient who is apparently not particularly suicidal can become so quite suddenly. In such cases reliance must be placed on relatives who have been warned of this, though they should not be allowed to become unduly alarmed at the prospect. In addition, therefore, to the nature and severity of his depression an estimate of the extent to which relatives can be relied upon will clearly govern the decision whether a patient should be admitted to hospital or not.

Bereavement

Other psychiatric emergencies arise out of certain environmental happenings which may be regarded as more or less critical according to the predisposition of those exposed. Such crises may produce severe and prolonged psychiatric reactions if not dealt with promptly. Bereavement heads the list, as it affects nearly everyone to some degree. As Caplan and others² have pointed out, the acute need is for the bereaved person “to bury the dead” in a psychological sense, by actively resigning himself to the impossibility of ever again satisfying his needs through interaction with the deceased. Such active resignation implies frank admission that the deceased really is dead and will never return. This admission is assisted by a show of grief, as in mourning.

From the practical point of view, therefore, the need is to help the bereaved person to show grief rather than conceal it and in showing it to come to terms with the real facts of the matter. At the same time a grief reaction should not be allowed to become excessive, as this may call into play defences, in particular a denial of reality, which can give rise to a prolonged and morbid psychiatric reaction. In the face of overwhelming distress, particularly when accompanied by sleeplessness, adequate sedation should be given.

The fact that a denial reaction can occur explains how some adults who appear to cope best with bereavement, seeming to take this often unduly calmly, may a year or more after the event break down and suffer a prolonged and sometimes fairly intractable depressive illness. A remarkable preservation of the deceased's personal effects in their customary place and manner as if waiting for him or her to come home sometimes provides good evidence of this denial of reality. Pseudo-hallucinations, which lie somewhere between images and true hallucinations, and by means of which the deceased's voice is heard, his face seen, or his presence felt, are also not uncommon. Such false perceptions are not indicative of a true psychosis but arise once again out of a failure to adjust to bereavement.

Bereavement reactions are not, of course, limited to adults. Children may also be acutely affected.

A boy aged 7 years, the eldest son of a professional man, was told that his father had died suddenly. This led to uncontrollable screaming and disturbed behaviour, during which he insisted that his father was not dead and that his mother was lying. After 24 hours of this his mother was advised to let the boy see his father's corpse. This done, the boy wept, his behaviour became appropriate, and no further difficulties ensued.

This case provides an example of how prompt and appropriate action brought about a rapid resolution of a seemingly uncontrollable crisis situation. Wrongly handled prolonged difficulty might have occurred, as the following example demonstrates.

A boy of 6 years was not told that his father had died, but heard about this 3 weeks later accidentally at school. Following this he was separated from his mother for 3 years, returning to live with her after she had remarried. At the age of 12 he developed a severe depressive episode. During the course of treatment he expressed much hostility towards his mother and fantasy about the cause of his father's death.

Had the manner of breaking the news to the boy of his father's death been correctly and promptly dealt with in the first instance it is likely that his later depressive illness might not have occurred. In addition separation from his mother was almost certainly an important factor. Children other than those in the two examples quoted may also be affected. Indeed, a number of recent studies have suggested that there is a significant relationship between bereavement under the age of 15 and the occurrence of a depressive illness in later life. Suicide is also known to be commoner in these cases.

Apart from actual bereavement there are other forms of loss which may precipitate more or less acute psychiatric reactions in vulnerable persons. These include material loss, loss of status, loss of a job—particularly a long-standing and seemingly secure one—failure to pass an important examination, or to achieve expected and much hoped for promotion. Divorce or marital separation is not far removed from bereavement. A broken engagement comes almost into the same category, as does the distress an over-possessive mother may experience when her son marries a girl of whom inevitably she does not approve. A common theme runs through all these disasters—something has been lost and with it the self-esteem of the sufferer. Those

who are the most vulnerable therefore are those who are basically insecure. Not being self-sufficient their security is overdependent on material things, on worldly success, and on the unqualified approval of others. If they are suddenly deprived of support, some form of collapse, depression, or regression into a state of neurotic dependency is apt to occur.

But vulnerability is not necessarily constant. There are certain times when a person is more at risk than at others—for example, during adolescence, late middle-age, or as the senium approaches. Vulnerability may also be increased following accidental happenings. Thus psychiatric illnesses are apt to follow certain physical illnesses—for example, influenza, jaundice, and virus infections, also surgical operations and accidents, in particular those which may lead to disfigurement or some disability threatening security and earning power. In many women the puerperium is undoubtedly a critical and vulnerable period. While florid puerperal psychoses are not rare, other quite serious disturbances of a more neurotic nature are commoner still, and can give rise to much unhappiness and considerable disability which may in turn have adverse effects on other family members, particularly children.

Help for Relatives

Under any or all of these circumstances relatives may be in need of considerable help. To have a member of one's family taken acutely mentally ill and admitted precipitately to a psychiatric hospital can be a most disturbing experience. The reaction to this may take several forms. Apart from overt anxiety, demanding reassurance and explanation, some relatives may behave in a most difficult and seemingly uncooperative fashion. However irritating this may be, it should be realized that such reactions may be the outcome of a wish to deny the realities of the situation, perhaps to play it down, this in turn being derived from feelings of guilt and shame which, being hard to bear, tend to be projected. The doctor may well be the recipient of such projected feelings. How he handles the situation will depend on the degree of his understanding.

Perhaps nowhere is conflict seen so clearly as in acute adolescent crises, which appear to be on the increase. The difficulty here is to deal with exasperated parents on the one hand, who obviously want the doctor to exert the authority which they have failed to exert, and on the other to cope with a sullen, rebellious adolescent who trusts no one but who is clearly searching for an identity of his own and perhaps experimenting dangerously in the process. Somehow a respect for the needs of both parties has to be established in both their minds. This can be a most difficult and daunting task, the need in the first instance being to try to banish recrimination. It is helpful if parents can be helped to remember what they were like as adolescents. It may be helpful also if a young person can be brought to realize that the seeming inflexibility of his parents is not altogether deliberate but an outcome of a genuine impossibility of keeping abreast with change, at least in terms of how one feels about things. Indeed, in view of the possible long-term effects, adolescent crises may be numbered among the more important psychiatric emergencies with which a general practitioner may have to cope both now and for some time to come.

REFERENCES

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- ² Caplan, G., *Principles of Preventive Psychiatry*, 1964. London.