EMERGENCIES IN GENERAL PRACTICE

ACUTE PSYCHOSIS

BY

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Acute psychoses are not rare conditions. Statistics for admission to mental hospitals and observation wards indicate that the family doctor will be fortunate if he is not called on to deal with many such emergencies during his career. Few practitioners relish the responsibility of the acute mental case, for it can be among the most difficult of emergencies with which he is called upon to deal. There exists, of course, for the disposal of such cases a lay official known as the duly authorized officer (D.A.O.), who, as the law stands at present, has the authority and means to place the acute mental patient into a suitable hospital without the intervention of a doctor. In practice the D.A.O. will be found only too willing to accept the help and medical backing of the general practitioner; for the latter to deflect the whole responsibility on to a layman is never in the best interests of his patient.

When a doctor is called to see an acutely psychotic case he has to make several decisions of great consequence to the patient. The summons, "Please come at once; Mr. Jones has run amok," is not the only way in which an acute psychosis may come to the notice of the practitioner. Though violence, destruction, and general bedlam are the most striking manifestations, acute psychosis can, and often does, present in a far less dramatic way. Relatives can easily see the need to take action with the grossly excited, but it often needs medical skill and experience to recognize under the disguise of quarrelsomeness, peevishness, or physical complaints the acutely suicidal melancholic who is equally an emergency in general practice. Facile cheerfulness and jocularity may disguise a hebephrenic schizophrenia; egotism, callousness, and brutality towards the nearest and dearest may be the first indication of a senile psychosis.

Acute psychosis is not a disease entity but a global term applied to a group of grossly pathological disorders of behaviour and mental state. It is a medical equivalent of "insanity," which is a legal term implying that the patient is unable to care for himself or constitutes a danger to himself or others. The psychoses are distinguished in broad terms from less serious mental aberrations by the presence of one or more of the following criteria: loss of contact with, or marked distortion of, reality; severe and persistent disturbance of emotional expression; gross deviation from normal, socially accepted behaviour; sudden disintegration of the patient's former personality; rapid deterioration of the previous level of intellect and common sense.

Investigation of the Patient

Correct diagnosis is of paramount importance in medicine, and the acute psychoses are no exception. To reach the conclusion that the patient is of unsound mind is enough for the magistrate involved in certification, but the doctor must go further. In the diagnosis of the acute psychotic states, the history, with few exceptions, is far more important than

examination of the patient. Often prodromal symptoms of a psychotic breakdown have been present for some time, and so the doctor will have been prepared for it; alternatively he may be surprised by its appearance without warning in a patient whom he already knows well. If the case is new to him he should take the history from a relative or friend before the patient is seen; many acute psychotics are unable or unwilling to give a coherent account of themselves. The patient can then be seen with a clear knowledge of what to expect.

It is a good rule never to interview the relatives in the presence of the patient and to interview only one informant at a time. The members of the patient's family are not infrequently in a highly emotional state, and if seen all together they are more likely to confuse than to clarify the story by their interjections and interruptions. Spare relatives can be dispatched to watch the patient; for it is not unknown for the latter to run away or to attempt suicide on the arrival of the doctor. Under no circumstances should the patient be left alone. If it is impracticable to interview the relatives in the house or that of a neighbour, it is a good plan to take the history while sitting in the car with the informant in the front seat and the doctor at the back so that he is not embarrassed by having his notes read. It is sometimes possible to obtain a fairly full history over the telephone when first called, or in less urgent cases to persuade a relative to call at the surgery before the doctor visits the patient.

Once adequate information on the past history and development of the symptoms has been obtained, the doctor should proceed to interview and examine the patient. Prudence and common sense dictate that a doctor should not go by himself to examine a possibly dangerous patient. The history will brief the doctor on how much assistance will be required, and this should always be mobilized beforehand. It is often surprising how an acutely excited patient will quieten down and submit to examination when he sees that strength is not on his side. If when the doctor sees the patient he is properly briefed by the history and is accompanied by adequate helpers he has little to fear.

The speech and manner in which the doctor approaches the acute psychotic patient will do much to help his examination. Patients who are apparently quite out of touch with their surrounding may nevertheless be aware of how they are approached. The patient will certainly remain quite inaccessible if talked down to as if he was a child. A hectoring approach may arouse fury and resentment, while a timid and fearful manner may provoke a like response. Generally the acute psychotic should be talked to in the same friendly manner as if he were sane. It is uncommon for these patients to lie to simple straightforward questions, and it is unwise for the doctor to try to trick his patient into admitting delusions and hallucinations. It is equally important to listen well as to question well. If the doctor does most of the talking he will learn little of the patient. During the interview much can be learned from the patient's appearance, gestures, and general behaviour, as well as from what he says and how he says it. Physical examination should be carried out wherever possible, but this is not always practicable in the acutely resistive patient. In a surprising number (around 10%) of acute psychotics admitted to observation wards the mental symptoms are secondary to underlying physical conditions.

Differential Diagnosis: The Symptomatic Psychoses

Possibilities to bear in mind during physical examination are the acute toxic psychoses that follow the administration of drugs. Dilated pupils and a dry mouth suggest the possibility of an acute belladonna psychosis. Similar reactions may follow the use of other drugs such as bromides, amphetamine, cortisone, and some industrial poisons. The history of recent medication should clarify the matter. Other organic conditions which are not as rare as might be expected are the acute psychoses occurring in epilepsy, such as twilight states and other psychomotor symptoms; in myxoedema; in the vitamin-B deficiencies, with acute infections (pyrexia gives the lead here); and following operations and childbirth. Though rarely seen nowadays, G.P.I. can present as a dangerous excitement or as just the opposite. Acute alcoholic psychoses may be suspected from an array of empty bottles, and may be combined with other abnormalities such as head injury, epilepsy, etc. Roughly speaking, the acute psychoses which are symptomatic of some underlying physical disease should be thought of when there is clouding of consciousness, restlessness, visual hallucinations, and paranoid ideas which fluctuate during the day and night.

Excluding the acute symptomatic psychoses, one is left in broad terms with the differentiation of acute schizophrenic psychoses from affective conditions (manic and depressive), from psychotic reactions in epilepsy or in arteriosclerotic and senile illness, and from psychosis-like outbursts in hysterical and psychopathic personalities. The following pointers, though oversimplified, may be helpful in the recognition of these conditions. The differentiation depends almost entirely on the clinical picture and history as a whole, and very rarely on single or groups of symptoms.

Hysteria and the Affective Psychoses

Hysterical outbursts may occur in relatively normal persons under exceptional stress—for example, loss by sudden death of a close relative or an accumulation of unlucky events. If they happen after minor mishaps, it is usually in patients of obviously hysterical or psychopathic personality; there is invariably a history of instability and maladjustment dating back to childhood or adolescence. There is also often a history of similar episodes, so that the relatives are not taken by surprise at the outburst. The hysterical explosion is tinged with melodrama, threats, and over-demonstrativeness. The more reactive the audience the greater the show. It is well to remember that such hysterical outbursts may mask an underlying physical disorder such as cerebral tumour or encephalitis which if undetected will become a monument in the doctor's practice. Both psychopath and hysteric remain clearly in touch with their audience.*

The affective psychoses (manic-depressive psychosis and involuntal melancholia) are characterized by a pronounced and persistent change of mood. These patients may have shown marked mood swings for years before the acute breakdown, but are otherwise stable individuals. A gradual onset is commonest, though the doctor is often not called until an acute exacerbation of symptoms sets in. The depressive psychoses are characterized by a marked melancholy of mood, slowing of responsiveness, self-reproach, feelings of guilt, delusions of persecution, and agitation. There are often suicidal tendencies, insomnia, anorexia, and preoccupation with bodily function. Suicidal ideas in these cases must be taken seriously. In the manic psychoses there are excitement, elation, hyperactivity, and an uninhibited flow of talk. Such patients are often irritable, laughing and crying at the same moment, and readily distracted from what they are doing by any chance stimulation. Rarely, acute mania and depression present as stuporous

states with the patient mute, inaccessible, and refusing to eat. Unlike the symptomatic psychoses, the affective psychoses occur in a setting of clear consciousness.

Acute Schizophrenia and Other Psychotic Reactions

The differentiation of the affective psychoses from acute schizophrenia may be difficult, but, broadly speaking, the behaviour of the manic or depressed patient is related to his prevalent mood. The behaviour of the schizophrenic is, on the other hand, often incongruous to his mood, which vacillates irregularly and lacks the expressive quality of the affective states. Schizophrenics show a wide variety of bizarre forms of behaviour and mannerisms. The inability of the examining doctor to feel with his patient and to understand his train of thought, even though it sounds superficially plausible, is highly characteristic. A state of immobility lasting for minutes or hours, and perhaps interrupted by unexplained overactivity when disturbed, may be an early sign of catatonic schizophrenia. The history of a patient with acute schizophrenia often discloses prodromal symptoms of gradual social withdrawal, falling off of activity and interest, and increasing remoteness.

Epileptic furor and twilight states may closely mimic certain schizophrenic states. There is, however, a history of fits and clouding of consciousness. Mental defectives are prone to psychotic episodes which clear up, leaving the patient in his previous state. Here the history of backwardness should clinch the diagnosis. It is not unknown for patients who are expecting legal prosecution to feign psychotic behaviour, but in these cases the picture is only a replica of the patient's idea of madness, and the well instructed is rarely misled to diagnose psychosis.

An acute psychotic episode may be the first indication of senile dementia. These patients are restless, often delirious, and invariably disorientated. They cannot answer questions on their whereabouts, the time of day, and the date. With an ageing population these cases are becoming increasingly frequent.

Management

Acute psychotics are often dangerous to themselves and others, so certain precautions should be taken. It is better to take too many precautions than too few. If the patient rejects tactful handling and persuasion, which should always be tried first, force must be used in his own interests. The mere presence of three or four other persons may make any physical coercion unnecessary. If dangerous and armed, the help of the D.A.O. and police should be sought immediately, but no more force than is necessary to restrain the patient should be used. It is not unknown for relatives to relish the chance of getting their own back on an overpowered patient who in earlier episodes of his illness may have been an annoyance. Psychotic patients, particularly catatonics, react with great sensitivity to their environment. They are often relatively quiet until interfered with. It is therefore wise to avoid all unnecessary interference and to reserve force for the moment of real necessity—for example, when giving an injection or removing the patient to the ambulance.

Constant vigilance is the only sure way of preventing suicide. The patient should be kept on the ground floor to prevent jumping from a height. He should be undressed, shoes being removed first, and, if delay in removal to hospital is unavoidable, placed on a mattress on the floor, and kept warm between blankets. Sharp objects, penknives, scissors, etc., should be removed, together with belts, pyjama cords, and medicine bottles, which might be used for suicidal attempts. The patient should be accompanied to the lavatory. If he will take fluids, they should be given liberally to avoid dehydration.

Adequate sedation is essential. For patients who can swallow their medicine, 6 gr. (0.33 g.) of sodium amylobarbitone may be given by mouth, but it often proves

*See also Dr. Gerald Garmany's article in this series, "Acute Anxiety and Hysteria" (July 9, p. 115).

ineffective in an excited patient. Paraldehyde up to 3 dr. (11 ml.) is reliable and acts quickly, but its taste is repulsive. If intravenous injection is possible, 5–10 ml. of a 10% solution of hexobarbitone sodium, injected slowly, 1 ml. a minute, will serve the purpose. Most cases of this kind, being restless, obstructive, and uncooperative, require sedation by hypodermic injection. The most useful and well-tried combination for the uncontrollable patient is 2 ml. of morphine and hyoscine injection (*N.F.*), which contains $\frac{1}{2}$ gr. (22 mg.) of morphine and $\frac{1}{75}$ gr. (0.86 mg.) of hyoscine. If this is not effective, one-half of this amount can again be injected one hour later. Although the morphine multiplies the sedating effect of hyoscine in this combination, it should be remembered that morphine in itself is not a sedative and has almost no calming effect on the psychotic patient, but may lead after admission to hospital to retention of urine often difficult to overcome.

A relatively harmless but very helpful measure is two injections of paraldehyde injection (*N.F.*), 5 ml. deeply into each buttock. This can also be repeated in hourly intervals until adequate sedation is achieved. The stoutest needle available should be used.

Disposal

Treatment of the acute psychotic patient in the home is generally impracticable, and it is therefore in the best interests of all concerned to have the patient removed to an observation ward in a general or a mental hospital. Having excluded transient mental upsets, such as occur in drunkenness or psychopathic reactions—for example, in hysterical states—which are likely to settle rapidly at home with some mild sedation, the doctor is faced with the problem of how admission can be best arranged.

What is done depends largely on whether the patient is willing or unwilling to enter hospital. Nowadays a high proportion of acute psychotics are admitted and treated as voluntary patients, and, if this is at all possible, it is certainly in the patient's best interests. If the patient agrees to voluntary treatment, the doctor should telephone the duty medical officer of the hospital in the district where the patient resides to see if a bed is available. Hospital catchment areas vary considerably in different regions. Precise information on local arrangements can be obtained from the D.A.O., whose telephone number is usually under the borough or county health department. Some patients, having consented to enter hospital voluntarily at first, change their mind when they reach hospital and refuse to sign the voluntary form. This is a risk that has to be accepted.

When dealing with the unwilling patient the procedure differs according to whether the relatives wish for treatment under the National Health Service or whether they are willing and able to pay the fees for a private hospital. In the former case the procedure is easy and consists in telephoning the D.A.O. and informing him of the position. The doctor will be well advised to leave the legal side of the admission to the D.A.O. He should remember that the precise procedure to secure admission rests with this officer, who is legally responsible and can act at his own discretion. D.A.O.s are usually co-operative and helpful, and, as mentioned before, they like to have their decisions backed by the general practitioner. In the case of a "Three-Day Order" they like a note (not required by law) saying, in effect, that the patient is in urgent need of observation to determine his soundness of mind.

The best and most convenient procedure for the non-voluntary private patient is by an Urgency Order, which is not identical with certification. It lasts for seven days, allowing sufficient time for further appropriate action to be taken. Having ascertained if the selected hospital can take a private patient, the nearest relative available signs as petitioner and the doctor completes one medical certificate stating the reasons for the patient's urgent admission. A magistrate is not required. The relative who signs must

have seen the patient within two days and must complete a statement of particulars. Urgency Order forms are self-explanatory and can be obtained from a law stationer.

If the doctor acts with good faith he has little to fear about later legal repercussions; in case of doubt about any legal point concerning the admission of the unwilling patient, the D.A.O. is a good source of information. In Scotland the emergency, whether in a private or National Health Service patient, can be dealt with simply by a Certificate of Emergency (one medical certificate and a petition), which allows the patient to be retained in hospital for three days.

The procedures mentioned, though not the only ways, are the most convenient and frequently used for getting cases of acute psychosis into hospital. Once in the hospital the psychiatrist will take responsibility for arranging further treatment as a temporary, certified, or voluntary patient.

Dealing with the Relatives

In dealing with a case of acute psychosis the doctor has to cope not only with the patient but with his relatives and friends, who are often nearly as distraught as the patient himself. Many of the difficulties in dealing with these cases are created by the relatives, who envelop the house with an atmosphere of alarm and mystery. By adopting a quietly confident manner and getting all to regard the patient as somebody who is sick and needs treatment, he can do much to dispel their unfounded fears and dreads. He should resist attempts by anxious relatives to introduce himself to the patient as the "insurance man" who has just dropped in, or by some similar subterfuge. The doctor should always tell the patient who he is and why he has come.

Relatives prefer to be told that the patient is mentally ill rather than insane, and welcome a plainly reasoned statement of the action needed in the patient's best interests. Undue pressure from relatives to have a mildly confused senile patient put away should be resisted, particularly if there is reason to suppose that the condition is only transitory, accompanying an infection. Conversely the need for hospitalization of the acutely suicidal depressive should be stressed to reluctant relatives. The interests of the patient always take precedence over those of his relatives. Sometimes the relatives of these patients prove to be particularly difficult, in which case a firm but tactful attitude is essential. As a last resort one can point out that it is the doctor's duty to inform the D.A.O. of the emergency and of the relatives' refusal to abide by medical advice. In borderline cases a domiciliary visit by a psychiatric consultant may be a way out.

The relatives often ask for a prognosis, but in only a few cases will even the specialist have sufficient information to predict the likely outcome after one interview. The best line is to explain that with recent advances in treatment the outlook is much more hopeful than is commonly supposed, and that only by full investigation in hospital can a definite prognosis be made. It is unwise to hazard a guess about the kind of treatment that will be given in hospital. Not infrequently difficulties arise when relatives have been told by the family doctor that some special therapy will be applied, and they find out from the specialist that it is not indicated. It is unfortunate that once in hospital the family doctor all too often loses sight of the patient until his discharge. Acute psychotics do often recover, and on leaving hospital need the support and encouragement of their own doctor during convalescence.

The worst mistakes arise from failure to recognize the acutely suicidal depressive, or when the doctor takes only one anxious peep round the front door and without further ado arranges for admission to hospital.

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