Practical Psychiatry in Medicine

Part 7. Suicidal Behavior and Other Psychiatric Emergencies

Psychiatric emergency refers to any mental or emotional disorder that requires prompt intervention. It is likely that the great majority of psychiatric emergencies that occur outside psychiatric hospitals are first seen by non-psychiatrist-physicians in their private offices and in the emergency rooms and inpatient services of general hospitals. It is therefore essential for the physician to be able to ascertain that a psychiatric emergency exists, to proceed with diagnostic evaluation to the degree necessary to develop at least an initial plan of management, and to implement the management plan while awaiting psychiatric consultation. As is true with any medical consultation, it is also the primary physician's responsibility to evaluate the opinions and suggestions of the psychiatric consultant and to decide if and when to transfer the primary care of the patient to the psychiatrist.

Psychiatric emergencies are characterized by one or both of the following: (1) behavior which is alarming to the patient or others, and (2) severe subjective distress.

1. There are many varieties of alarming behavior. One of the most common is that posed by the patient who has made a suicide attempt or who is judged to be in danger of doing so. Any kind of behavior which appears to threaten the well-being or vital interests of the patient or others may be acutely alarming to the patient's relatives or to the patient himself. In addition, behavior or symptoms which are interpreted as indicative of serious illness may be quite alarming even though there is little or no danger to the patient's life. For example, an acute, dramatic conversion reaction, such as sudden paralysis of the legs, is often quite frightening to the patient's family and therefore may require immediate attention.

2. The two major categories of acute, subjective psychic distress which may constitute emergencies are panic and severe depression.

For purposes of further discussion, it is convenient to consider the problems of suicidal behavior separately and to lump together other forms of alarming behavior arbitrarily under the rubric of "acute behavioral disturbances." The emergency situation sometimes posed by severe depression will be included in the section dealing with suicide. The emergency evaluation and management of panic will be discussed separately.

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The following chapters have been selected by the Publisher from its forthcoming book, *Practical Psychiatry in Medicine,* by John B. Imboden, MD, and John Chapman Urbaitis, MD, in the hope that they will have immediate usefulness to our readers.

Suicidal Behavior

Few occurrences in life evoke a more intense welter of emotions in relatives and physicians than does suicide. In fact, the physician, as a person dedicated to the alleviation of suffering and the preservation of life, often must come to grips with the intense ambivalence aroused in himself by a suicide attempt if he is to approach the patient with the same compassion and objectivity that he exercises in other medical emergencies.

Definitions

It will be useful to define three terms as they are used in this chapter.

Completed suicide means an act by which an individual has intentionally killed himself.

Attempted suicide refers to an act deliberately carried out by an individual against himself, by which he intends to endanger or end his life, or to give the appearance of such an intent, but which does not result in death. In many attempted suicides, the patient has conflicting feelings, simultaneously having a wish to live and a wish to die. In some instances, the death wish appears to be minimal, there being some other primary motivation, such as the manipulation of a spouse or the seeking of help. These have sometimes been referred to as suicidal gestures but are included here in the category of attempted suicide.

Potential suicide refers to the individual who, while not having made an attempt on his life, is thought to be in danger of doing so.

Completed Suicides

In the United States, the rate of recorded suicides is about 11 per 100,000 persons per year.[3,11] An unknown number of suicides go unrecorded, death being wrongly attributed to other causes. Among completed suicides the ratio of men to women is between 2 to 1 and 4 to 1 throughout the industrialized world. In men, the suicide rate increases with age until the mid-80s and in women it peaks between ages 55 and 65. The suicide rate is substantially higher among single persons, particularly the widowed or divorced, than among the married. The rate is higher among whites than blacks and somewhat higher among Protestants than Jews and Catholics.

Most persons who have committed suicide have made previous attempts or have threatened to attempt suicide or both. Retrospective studies indicate that most completed suicides occur in people who have a psychiatric illness, depression being the most common diagnosis made in this group.[10] Persons afflicted with incurable or fatal physical illness account for a small fraction of completed suicides.

Of great significance is the fact that most persons who have died by suicide have a history of having consulted their physician within a year prior to death. Murphy found that of 32 persons who committed suicide by overdose of medication, 29 (91 percent) had consulted one or more physicians within six months or less of their deaths.[8,9] Further, 16 of these patients (50 percent) had obtained lethal quantities of hypnotic medication in a single prescription and in most instances the prescription had been filled within two weeks of the suicide. In the same study it was found that of 28 persons who suicided by means other than overdose of medication, 20 (71 percent) had consulted their physician within six months of death. In both groups of suicides, the physician last seen was not a psychiatrist in 75 percent of the cases. In the same study it was noted that there was substantial evidence of depressive illness in three quarters of the patients who had been seen by physicians but that the depressive illness was usually not diagnosed and therefore was rarely treated. The implications of these observations for suicide prevention are obvious. As Murphy points out, however, retrospective studies of completed suicides give no indication of the frequency with which physicians are successful in detection and management of suicidal risk.

The Potential Suicidal Risk

Among both completed and attempted suicides, the most commonly made diagnosis is depression. Therefore, it is important to be alert to the presence of a depressive syndrome in any patient and, if found, to assess the suicidal risk and to institute treatment

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promptly. It is not uncommon for a depressed patient to focus primarily on physical symptoms and to "explain" his depressed mood as being secondary to them. In such cases, the diagnosis may be easily missed.

In the assessment of suicidal danger, it is useful to determine (1) the severity of depression, (2) the presence of hopelessness, (3) a prior history of suicide attempts, and (4) the presence of current suicidal thoughts and suicidal intentions.[2,7]

Severity of Depression

In the general adult population the occurrence of mild, transient periods of depressed mood is extremely high, perhaps universal. A depressive illness of significant severity exists if the mood disturbance has lasted for a month or longer and is accompanied by several or more of the following symptoms: insomnia; anorexia; weight loss (in absence of dieting or organic disease sufficient to account for loss of appetite and weight); fatigue; agitation; slowness of speech or activity; difficulty in concentrating; loss of interest; impotence; or feelings of guilt, inadequacy, unworthiness, or hopelessness and a wish to die.

In persons suffering from affective disorders, the lifetime risk of suicide has been estimated to be 15 percent.[4] Although there are numerous exceptions, there is some correlation between severity of depression and suicidal risk. Paradoxically, however, apparent symptomatic improvement in the course of the illness does not necessarily mean that the risk of suicide has decreased. Some patients may seem to have improved because they have secretly made a decision to commit suicide while others, who had been functionally incapacitated by severe depression, may become better able to carry out a suicide plan as their depression begins to lift.

Hopelessness

The patient who feels that his future is bleak, his problems insoluble, his illness incurable, that he is not worthy of relief, or worthy of any other good fortune represents a greater suicidal risk than does a person who, though depressed, has a hopeful outlook regarding his future. A hopeful, but nonetheless depressed, patient may make casual reference to future plans thus implying that he intends to be around.

Prior History of Suicide Attempts

A history of previous suicide attempts increases the probability of another attempt.

Verbalization of Suicidal Thoughts and Intent

A common error in dealing with a suspected suicidal patient is that of failing to ask him directly about his wishes and intentions regarding death and suicide. It is likely that all depressed patients, at one time or another, feel a wish to die and have thoughts of suicide. However, it is important directly to ask the patient if he has been preoccupied with death and suicidal thoughts and if he has, in the present or recently, actually intended to commit suicide. If he says he has so intended, the patient should also be asked to describe the method contemplated, whether he has procured the means to carry out the act, and other details.

The potentially suicidal patient may have an illness other than primary depression. In fact, any condition or situation that has resulted in a feeling of hopelessness may be associated with the danger of suicide. For example, persons confronted with public exposure of unethical behavior or evidence of incompetence, or individuals with progressive, incurable disease may choose death in preference to a future which they perceive as laden with unbearable misery. The schizophrenic patient may attempt suicide in a moment of despair or in response to an hallucinated command. The delirious patient, while not necessarily intending suicide, may seriously or fatally injure himself in a variety of ways, such as leaving the room via a window. The presence of alcoholism, especially if associated with depressive illness, increases the risk of suicide.

Management

The management of the suicidal

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patient consists of taking those steps necessary to protect him from self-destructive impulses and of treating the associated illness, usually depression, which is causing the patient to be suicidal. The practical importance of effective management of the suicidal patient is underscored by the fact that in most cases the patient remains actively intent upon suicide for only a limited period of time, eg, until there has been alleviation of the feeling of hopelessness. On the other hand, it may be impossible to prevent suicide by the person who keeps his despair and suicidal intent secret, or who persists in intention for suicide in spite of efforts to assist him with his emotional problems, or who suddenly acts on impulse.

If the physician has judged that there is grave and imminent risk of suicide (such as in the case of a depressed patient who feels hopeless or who is preoccupied with suicidal thoughts), he should discuss this openly with the patient and his next of kin. Psychiatric consultation should be obtained without delay. If psychiatric consultation is not immediately obtainable or if the circumstances otherwise warrant it, the physician may decide upon immediate hospitalization and institution of suicidal observation. The latter consists of the patient being constantly accompanied by a responsible person until the danger of suicide is considered to have abated. In addition, environmental opportunities for self-destruction are reduced to a minimum. This includes the provision of an unbreakable, locked window and the removal of objects, including medicine, with which the patient may harm himself. In severe depression requiring psychiatric hospitalization, electroconvulsive treatment may be indicated if the suicidal risk is judged to be especially grave or if the depression does not respond to chemotherapy and psychotherapy.

In many instances, the primary physician or the treating psychiatrist elects to treat the depressed person on an outpatient basis. This is done when the suicidal risk, though not entirely absent, is thought not to be overwhelming or imminent. Treatment with one of the tricyclic antidepressants in combination with supportive psychotherapy is usually indicated for depressive illness of moderate severity. In the outpatient management of depression it is wise to avoid the use of barbiturates or other potentially dangerous hypnotics and to manage the insomnia by administering most or all of the tricyclic antidepressants in the evening. If a hypnotic is necessary, flurazepam (Dalmane), or some other mild hypnotic which is relatively unlikely to be lethal if taken in overdose, may be used. It is of course unwise to attempt to bolster the mood of the depressed patient by cheerfully telling him that everything will be fine or by some other superficial "reassurance," for this is apt to create a feeling of not being understood and thus only add to the patient's despair. It is helpful, however, to let the patient know (1) that the physician realizes how real is the suffering of depression; (2) that often there are moments when any depressed patient doubts that he will ever feel well again; (3) that though the patient may have doubts about it, experience shows the chances for remission of the depression are very good; and (4) there is apt to be a "lag period" between initiating treatment and the beginning of substantial improvement.

The Suicide Attempt

In addition to the immediate medical or surgical management necessitated by the attempt itself, the physician must assess the seriousness of suicidal intent. To assist him in carrying out this assessment it is advisable, for both clinical and legal reasons, to obtain the assistance of a psychiatric consultant.

It would be impractical and probably unwise to routinely advise psychiatric hospitalization in every case of attempted suicide. The incidence of attempted suicide is conservatively estimated to be more than ten times that of completed suicide.[12] In contrast to the latter group, the rate of attempted suicide is higher among women than men and reaches its peak in the third decade of life. These statistical differences, coupled with the fact that most completed suicides have made previous attempts, suggest that the attempted suicide group is a heterogeneous one that partially contains those who will eventually compose the completed group, ie, as the attempted suicide group grows older it contributes substantially to those who complete suicide. It has been estimated that the risk of suicide in the attempted group is approxi-

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mately one to two percent per year.

In assessing suicidal danger, the same principles apply which were discussed in the preceding section. In addition, it is helpful to take into account (1) the lethality of the attempt, (2) the circumstances surrounding the attempt, (3) precipitating factors, and (4) consequences.

Lethality of the Attempt

Lethality of the attempt refers to the danger to life posed by the act itself regardless of any mitigating circumstances. For example, the ingestion of a large number of barbiturate capsules and self-inflicted gunshot wounds to the head or chest are highly lethal acts, whereas an overdose of chlordiazepoxide and superficial lacerations are not. If the attempt is judged to be highly lethal, ie, if death probably would have ensued in the absence of timely intervention, it is best to presume that the suicidal intent was extremely serious and remains so in the immediate post-attempt period. This is a practical policy even though it is recognized that an occasional patient may not be aware of the relative degree of danger inherent in one type of attempt as opposed to another, eg, the lethality of barbiturate versus chlordiazepoxide overdosage. Obviously, the converse is not true. Low lethality does not necessarily point to low seriousness of intent.

Surrounding Circumstances

The following circumstances are positively correlated with seriousness of intent: (1) being alone at time of attempt; (2) actively taking precautions against being discovered; (3) the rescue of the patient could not reasonably have been foreseen by the patient; and (4) evidence of premeditation such as a suicide note, recent increase in life insurance, recently written will, or deliberate acquisition of material or equipment specifically needed for the attempt.

Precipitating Factors

The attempt may have arisen out of hopelessness and despair as part of a depressive illness or in association with some other illness or life situation. Not infrequently, however, the patient makes a suicide attempt, even a dangerous one, in order to bring about a change in his life situation. For example, the attempt may well be a "cry for help," an effort to arouse sympathetic concern in others or to change the direction in which an important relationship has been going. The attempt may be designed to punish someone, symbolically or actually, by evoking guilt. It may be an attempt to punish oneself.

It is, therefore, important to review with the patient what was going on in his life and in his mind at the time of the attempt. The patient should be asked if he had felt that the attempt would result in death. Had he thought that he might live, but that his life would be different? If so, how? Had he been angry and wanting to "get even" with someone? Had he felt guilty and that he deserved to be punished? Had he wanted to die?

Consequences

A key question is: does it appear that the suicide attempt will be followed by significant changes in the patient or in his circumstances? If the physician has been able to gauge the patient's original purposes, feelings, and expectations prior to the attempt, he may be able to ascertain the psychologic and interpersonal results of the attempt.

For example, if one infers that the patient had sought to be less isolated, to be more accepted by family, to get help for his problems or his depression, does the attempt promise to succeed in his substantially achieving these goals? Does the patient seem unsurprised, perhaps even glad, that he is still alive? Does he seem to feel less guilty than before the attempt? Did the suicide attempt achieve nothing as far as the patient is concerned? Does he now feel even less adequate and more isolated than before? Did he "wake up" to find a sullen, resentful spouse and an emergency room staff too harried with "real" emergencies to be very concerned with him?

All of the above categories of factors have to be weighed in forming a decision as to the seriousness of intent and the continuing danger of suicide.

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Management

It is prudent to obtain psychiatric consultation and to institute suicidal precautions until psychiatric evaluation indicates that this is no longer necessary. The essential principles of management are the same as those discussed in the preceding section. It is often and properly decided that the patient who has made a suicide attempt does not require psychiatric hospitalization. In that event, it is mandatory to recommend outpatient psychiatric observation and treatment. Unfortunately, a substantial percentage of suicide attempters for whom psychiatric treatment has been arranged fail to keep their appointments or drop out of treatment prematurely. This fact underscores the importance of thoroughly discussing the need for treatment with the patient and with important members of his family.

Acute Behavioral Disturbances

Often, the patient who engages in aggressive, inappropriate, bizarre, or otherwise disturbing behavior does not seek medical attention on his own initiative because he is either unaware of the pathology of his behavior or is unconcerned about it, or both. Therefore, he frequently comes to medical attention at the behest of a concerned member of the family or a friend. Because of the patient's own lack of insight into his condition, the concerned relative may be perplexed as to "how to get him to the doctor" and may decide upon some sort of deceptive ruse such as telling the patient that he himself needs to see the physician and wishes to have the patient accompany him. It is unwise for the physician to go along with any subterfuge designed to trick the patient into seeing the doctor, for the loss of trust resulting from such a deception will often make further work with the patient impossible. The family should be advised to discuss the patient's condition directly, but gently, with him and to insist firmly upon the necessity of medical examination.

Acute behavioral disturbances may be characterized by one or more of the following: (1) recent development of behavior that is "out of character" for the patient such as acting impulsively, showing poor judgment, or seeming to be unresponsive, distant, uncaring; (2) aggressive or violent behavior; (3) excessive activity, verbal or nonverbal; (4) inactivity, withdrawal; (5) bizarre, silly, or "crazy" behavior; and (6) behavior characterized by evidence of confusion or amnesia.

It is essential to have the best informed and most responsible members of the family accompany the patient to the place of examination. If the pre-examination contact with the family indicates that there may be a problem in controlling the patient's behavior, it is wise to arrange for the examination to be in the hospital emergency room or other suitable location rather than in one's private office. The examination of the patient should include a mental status examination and a careful physical and neurologic examination as soon as the patient's behavior permits.

The Violent Patient

Although the diagnostic considerations that arise in the evaluation of violent behavior do not essentially differ from those of other kinds of disturbing behavior, the violent patient does require that certain immediate steps be taken. As with acute anxiety or panic, diagnosis and therapeutic management go hand-in-hand.

The excited, threatening, or combative patient instills fear in everyone in contact with him, including the physician. As Lion points out, it is useful to assume that the violent patient is afraid of losing control of his own aggressive impulses.[5,6] Thus, the physician has two immediate objectives. First, he should establish verbal contact with the patient and reassure him that he will be effectively helped to control his aggression, that he will not be allowed to translate his feelings into destructive behavior. Second, he should encourage the patient to talk freely about his current feelings including his fears and anger. This is done not with the objective of getting the patient to reveal what precipitated his disturbance but simply to help him substitute verbalization of feelings for action.

An excited, belligerent patient will often begin to grow calmer as the physician quietly explains that

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he wishes to help the patient, that he would like to talk with him about his feelings and problems, and offers the patient an opportunity to be interviewed alone. However, if the physician is fearful for his own safety, he should not make such an offer but should instead talk with the patient in the presence of two or three attendants or in a room with the door open and with assistants standing nearby. The presence of several assistants may in itself help to calm the patient who fears loss of control.

The focus of the interview should be primarily upon the patient's current feelings and thoughts. It is important to avoid promising the patient not to hospitalize him. The physician should simply indicate that the objective is to try to understand the patient's feelings and that the interviewer and his staff will help him to avoid loss of control of his impulses or angry feelings. In the initial stages of the evaluation, it is wise not to probe into the circumstances or issues which may have precipitated the rage, since this may provoke exacerbation. Such exploration, while important, can be done later. For example, if one suspects that the rage is covering homosexual panic, it would be unwise to "fish" for material to support that hypothesis.

Occasionally the excited, violent patient will not respond to the approach described above or will be too disturbed to allow the physician to attempt such an approach. In this event, physical constraints are necessary. The application of them, such as devices to immobilize the patient's arms and legs, should be done by several attendants under the supervision of the physician. Once the patient is restrained on a stretcher or bed, the administration of a suitable drug is often indicated. Chlorpromazine, 50 to 100 mg intramuscularly, may be given and repeated hourly until control is obtained. In an elderly patient, or a patient in whom there is special need to reduce possible hypotensive side effects, a benzodiazepine may be preferred: 50 to 100 mg of chlordiazepoxide intramuscularly or 10 to 20 mg of diazepam intramuscularly may be given and repeated hourly as necessary. Vital signs, including blood pressure, should be frequently monitored. Haloperidol, which is somewhat less sedating and has less hypotensive effect than chlorpromazine, may be administered in doses of 4 to 6 mg intramuscularly and may be repeated once or twice at hourly intervals if necessary.

Diagnostic Evaluation of Acute Behavioral Disturbances

As enumerated above, from a descriptive viewpoint, a variety of behavior patterns may alarm the patient and family and prompt them to seek immediate medical attention. A useful diagnostic approach is to determine if the acute behavioral disturbance is (1) organic or (2) functional, and then to proceed toward a more specific diagnostic entity.

1. In general, acute disturbances of behavior in which organic factors play a major etiologic role are associated with evidence of impaired intellectual functions such as one or more of the following: disorientation, memory impairment, difficulty in comprehension and abstract thinking, rambling and incoherent speech, and drowsiness. In the hallucinating patient, a predominance of visual hallucinations favors an organic basis although it may be a feature of early, acutely developing schizophrenic decompensation.

Careful review of the alcohol and drug history is extremely important because of the frequency of intoxication and withdrawal syndromes. The type of drug or drugs, dosage, frequency of usage, and length of time since last dose are essential data for diagnosis and management. History of abusing one drug should arouse suspicion that other drugs also have been taken, knowingly or unknowingly. There may be associated physical signs such as pinpoint pupils, slow respiration, venous thrombosis and scarring in opioid intoxication; dilated pupils, flushed and dry skin, urinary retention in intoxication with atropinelike drugs; tremulousness, sweating, restlessness, and seizures in withdrawal from barbiturates or other CNS depressants; goose flesh, yawning, rhinorrhea, abdominal cramps in opioid withdrawal; drowsiness, slurred speech, and ataxia in intoxication with alcohol and other CNS depressant drugs.

Other aspects of the medical history also must be carefully reviewed. In addition to drug intoxication and withdrawal, organic brain syndromes may be associated with head trauma, metabolic disorders, febrile conditions, and any intracranial or systemic disease that alters cerebral structure and/or function. A history of "spells" or

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repeated, discrete episodes of behavioral disturbance, with or without amnesia, especially if associated with automatic or stereotyped behavior, olfactory hallucinations, micropsia, or macropsia, should arouse suspicion of seizure disorder.

Evidence in favor of an organic condition may indicate a variety of diagnostic procedures such as prompt chemical determination of blood and urine, skull x-ray, EEG, and repeated neurologic examinations.

2. Functional disturbances are usually not associated with the type of intellectual impairment that produces defective recent memory and disorientation. Careful examination and judgment, however, may be required in order to determine that the patient has a clear sensorium. For example, the schizophrenic patient may give a bizarre response when asked to state where he is though later indicating, in response to a more oblique inquiry, that he is clearly aware of his location. The severely depressed patient, or any patient who is self-absorbed and preoccupied, may appear to have a poor memory for recent events. For example, he may not recall what he had for breakfast because he was too preoccupied for it to have registered.

Most functional behavioral emergencies are associated with schizophrenic, manic, hysteric, or situational disturbances. The diagnostic characteristics of these conditions will be described in later chapters.

The importance of careful examination in making a psychiatric diagnosis is illustrated by the following case.

A young adult woman was rushed by ambulance to the hospital in the company of her acutely worried husband. Two hours before her arrival, she experienced the rapid onset of paralysis of the legs. Hurried examination in the emergency room revealed complete paralysis of both legs, marked weakness of the arms, and total anesthesia from the level of the umbilicus to the toes. Within an hour, the upper level of anesthesia had moved upward to the level of the thyroid cartilage. Her respirations were rapid but shallow. In anticipation of respiratory embarrassment, an emergency tracheostomy was done; this procedure was accomplished without administration of a local anesthetic since the incision was made below the upper level of anesthesia produced by the patient's illness. Following tracheostomy, the patient was transported by stretcher to the floor where she was to receive respiratory assistance as needed. On her way to the floor, the patient regained use of her extremities and the anesthesia markedly receded. The original examining physician subsequently recalled that during the paralysis and anesthesia, all tendon reflexes were present and plantar responses flexor. The diagnosis was conversion hysteria.

Although this case is unusually dramatic it is not uncommon for hysterical patients to have surgical procedures done to themselves.

Management

It is wise to obtain prompt psychiatric consultation in all cases of acute behavioral disturbance, including those in which an organic component is strongly suspected.

If the acute behavioral disturbance is based upon an organic condition, hospitalization is mandatory in order to safely manage the patient while the specific nature of the organic or toxic factors is being determined. The patient's behavior may necessitate the temporary use of chemotherapeutic agents in order to allow further examination to proceed. Delirious patients must be carefully observed. Confusion and the likelihood of panic can be reduced, especially at night, by keeping the room well lighted when the patient is awake, having a trained person in constant attendance, addressing the patient in clear, simple terms, and otherwise avoiding ambiguous environmental cues.

Usually it is also wise to hospitalize the patient with acute functional psychosis. However, if such a patient is not suicidal or homocidal, responds well to the intramuscular administration of antipsychotic agents while under observation for a period of several hours, and has one or more responsible relatives to care for him, it may be feasible to offer psychiatric treatment in an outpatient setting in which he is seen initially on a daily basis.

Special Cases

We have discussed emergency situations arising from acute behavioral disturbances. Occasionally, however, a chronically ill patient may present a type of emergency because of the particular life cir-

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cumstances in which his illness developed. For example, the patient with an organic brain syndrome, even in the absence of an acute disturbance of behavior, requires immediate, active management if he is a practicing physician or is in any other position in which the welfare of others is gravely jeopardized by the effects of his illness.

Panic

Regardless of their cause, all states of acute, severe anxiety or panic are characterized by intense fear, restlessness, and various other symptoms and signs such as palpitations, a feeling of suffocating, blurring of vision, tachycardia, pallor, and sweating. Commonly, the patient's fear becomes localized or specific such as fear of death through suffocation or cardiac arrest, or of going crazy. Sometimes the source of danger is projected onto the external world.

The most common conditions associated with panic are (1) anxiety neurosis, (2) a "bad trip" with an hallucinogenic agent, (3) the acute phase of a schizophrenic illness (including homosexual panic), (4) amphetamine or cocaine intoxication, and (5) delirium.

Diagnostic and therapeutic management of the acute attack must be done in parallel. Having established the presence of acute anxiety, the physician should matter-of-factly discuss the fact with the patient. While acknowledging the patient's extreme discomfort, he should reassure him about specific fears, eg, that his condition will not cause his heart to stop and that his fearfulness itself has momentarily affected his judgment. Usually, a neurotic patient will respond to sympathetic attention, reassurance, and an opportunity to discuss his feelings with the physician; in the process of symptomatic abatement, it becomes evident that he manifests no evidence of psychosis. In anxiety neurosis, the patient may have a history of previous attacks.

If the panic state is part of a psychotic condition, the patient does not usually respond to psychologic support as readily as does the neurotic patient. As a general rule, acute schizophrenic illness and amphetamine intoxication are associated with a clear sensorium. The latter closely simulates paranoid schizophrenia and can only be diagnosed with confidence by obtaining a history of excessive amphetamine ingestion. The "bad trip" resulting from ingestion of an hallucinogen may be associated with extreme anxiety. The patient will often reveal his drug history, particularly if the importance of doing so is explained to him. He may or may not be disoriented. Delirium may be associated with extreme fear.

Management

Psychiatric consultation should be obtained. Chemotherapeutic intervention is often necessary in panic associated with psychosis, whether functional or toxic. The choice of drug is based upon considerations similar to those mentioned in management of the violent patient. Phenothiazines are usually not employed in treating intoxication with hallucinogenic substances. If the anxiety state is associated with an organic or toxic psychosis, hospitalization is indicated. In the event of functional psychosis, the decision to hospitalize is based upon the same factors discussed in the management of acute behavioral disturbances.

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