

03 - 23.3 Psychiatric Emergencies in Children

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Few children or adolescents seek psychiatric intervention on their own, even during crisis; thus, most of their emergency evaluations are initiated by parents, relatives, teachers, therapists, physicians, and child protective service workers. Some referrals are for the evaluation of life-threatening situations for the child or for others, such as suicidal behavior, physical abuse, and violent or homicidal behavior. Other urgent but non-life-threatening referrals pertain to children and adolescents with exacerbations of clear-cut serious psychiatric disorders, such as mania, depression, florid psychosis, and school referral. Less diagnostically obvious situations occur when children and adolescents present with a history of a wide range of disruptive, aberrant behaviors, and are accompanied by an overwhelmed, anxious, and distraught adult who perceives the child's actions as an emergency, despite the absence of life-threatening behavior of an obvious psychiatric disorder. In those cases, the spectrum of contributing factors is not immediately clear, and the emergency psychiatrist must assess the entire family or system involved with the child. Familial stressors and parental discord can contribute to the evolution of a crisis for a child. For example, immediate evaluations are sometimes legitimately indicated for a child caught in the crossfire of feuding parents or in a seemingly irreconcilable conflict between a set of parents and a school, therapist, or protective service worker regarding the needs of the child (Table 23.3-1).

Table 23.3-1 Familial Risk Factors An emergency setting is often the site of an initial evaluation of a chronic problem behavior. For example, an identified problem—such as severe tantrums, violence, and destructive behavior in a child—may have been present for months or

even years. Yet the initial contact with the mental health system in the emergency room or private office may be the first opportunity for the child or adolescent to disclose underlying stressors, such as physical or sexual abuse. In view of the integral relation of severe family dysfunction to childhood behavioral disturbance, the emergency psychiatrist must assess familial discord and psychiatric disorder in family members during an urgent evaluation. One way to make the assessment is to interview the child and the individual family members, both alone and together, and to obtain a history from informants outside the family whenever possible. Noncustodial parents, therapists, and teachers may add valuable information regarding the child's daily functioning. Many families, especially those with mental illness and severe dysfunction, may have little or no inclination to seek psychiatric help on a nonurgent basis; therefore, the emergency evaluation becomes the only way to engage them in an extensive psychiatric treatment program.

LIFE-THREATENING EMERGENCIES Suicidal Behavior Assessment. Suicidal behavior is the most common reason for an emergency evaluation in adolescents. Despite the minimal risk for a complete suicide in a child less than 12 years of age, suicidal ideation or behavior in a child of any age must be carefully evaluated, with particular attention to the psychiatric status of the child and the ability of the family or the guardians to provide the appropriate supervision. The assessment must determine the circumstances of the suicidal ideation or behavior, its lethality, and the persistence of the suicidal intention. An evaluation of the family's sensitivity, supportiveness, and competence must be done to assess their ability to monitor the child's suicidal potential. Ultimately, during the course of an emergency evaluation, the psychiatrist must decide whether the child may return home to a safe environment and receive outpatient follow-up care or whether hospitalization is necessary. A psychiatric history, a mental status examination, and an assessment of family functioning help establish the general level of risk.

Management. When self-injurious behavior has occurred, the adolescent likely requires hospitalization in a pediatric unit for treatment of the injury or for the observation of medical sequelae after a toxic ingestion. If the adolescent is medically clear, the psychiatrist must decide whether the adolescent needs psychiatric admission. If the patient persists in suicidal ideation and shows signs of psychosis, severe depression (including hopelessness), or marked ambivalence about suicide, psychiatric admission is indicated. An adolescent who is taking drugs or alcohol should not be released until an assessment can be done when the patient is in a nonintoxicated state. Patients with high-risk profiles—such as late-adolescent males, especially those with substance abuse and aggressive behavior disorders, and those who have severe depression or who have made prior suicide attempts, particularly with lethal weapons—warrant hospitalization. Young children who have made suicide attempts, even when the attempt had a low

lethality, need psychiatric admission if the family is so chaotic, dysfunctional, and incompetent that follow-up treatment is unlikely.

Violent Behavior and Tantrums Assessment. The first task in an emergency evaluation of a violent child or adolescent is to make sure that both the child and the staff members are physically protected so that nobody gets hurt. If the child appears to be calming down in the emergency area, the clinician may indicate to the child that it would be helpful if the child recounted what happened and may ask whether the child feels in sufficient control to do so. If the child agrees and the clinician judges the child to be in good control, the clinician may approach the child with the appropriate backup close at hand. If not, the clinician may either give the child several minutes to calm down before reassessing the situation or, with an adolescent, suggest that a medication may help the adolescent relax. If the adolescent is clearly combative, physical

restraint may be necessary before anything else is attempted. Some rageful children and adolescents brought to an emergency setting by overwhelmed families are able to regain control of themselves without the use of physical or pharmacological restraint. Children and adolescents are most likely to calm down if approached calmly in a nonthreatening manner and given a chance to tell their side of the story to a nonjudgmental adult. At this time, the psychiatrist should look for any underlying psychiatric disorder that may be mediating the aggression. The psychiatrist should speak to family members and others who have been witnessing the episode to understand the context in which it occurred and the extent to which the child has been out of control.

Management. Prepubertal children, in the absence of major psychiatric illness, rarely require medication to keep them safe, because they are generally small enough to be physically restrained if they begin to hurt themselves or others. It is not immediately necessary to administer medication to a child or an adolescent who was in a rage but is in a calm state when examined. Adolescents and older children who are assaultive, extremely agitated, or overtly self-injurious and who may be difficult to subdue physically may require medication before a dialogue can take place. Children who have a history of repeated, self-limited, severe tantrums may not require admission to a hospital if they are able to calm down during the course of the evaluation. Yet the pattern, no doubt, will reoccur unless ongoing outpatient treatment for the child and the family is arranged. For adolescents who continue to pose a danger to themselves or others during the evaluation period, admission to a hospital is necessary.

Fire Setting Assessment. A sense of emergency and panic often surrounds the parents of a child who has set a fire. Parents or teachers often request an emergency evaluation, even for a very young child who has accidentally lit a fire. Many children, during the course of normal development, become interested in fire, but in most cases, a school-aged child who has set a fire has done so accidentally while playing with matches and seeks help to put it out. When a child has a strong interest in playing with matches, the level of

supervision by family members must be clarified, so that no further accidental fires occur. The clinician must distinguish between a child who accidentally or even impulsively sets a single fire and a child who engages in repeated fire setting with premeditation and subsequently leaves the fire without making any attempt to extinguish it. In repeated fire setting, the risk is obviously greater than in a single occurrence, and the psychiatrist must determine whether underlying psychopathology exists in the child or in the family members. The psychiatrist should also evaluate family interactions, because any factors that interfere with effective supervision and communication—such as high levels of marital discord and harsh, punitive parenting styles—can impede appropriate intervention. Fire setting is one of a triad of symptoms—enuresis, cruelty to animals, and fire setting—that were believed, some years ago, to be typical of children with conduct disorders; however, no evidence indicates that the three symptoms are truly linked, although conduct disorder is the most frequent psychiatric disorder that occurs with pathological fire setting.

Management. The critical component of management and treatment for fire setters is to prevent further incidents while treating any underlying psychopathology. In general, fire setting alone is not an indication for hospitalization, unless a continued direct threat exists that the patient will set another fire. The parents of children with a pattern of fire setting must be emphatically counseled that the child must not be left alone at home and should never be left to take care of younger siblings without direct adult supervision. Children who exhibit a pattern of concurrent aggressive behaviors and other forms of destructive behavior are likely to have a poor outcome. Outpatient treatment should be arranged for children who repeatedly set fires. Behavioral techniques that involve both the child and the family are helpful in decreasing the risk for further

fire setting, as is positive reinforcement for alternate behaviors. Child Abuse: Physical and Sexual Assessment. Physical and sexual abuse occurs in girls and boys of all ages, in all ethnic groups, and at all socioeconomic levels. The abuses vary widely with respect to severity and duration, but any form of continued abuse constitutes an emergency situation for a child. No single psychiatric syndrome is a sine qua non of physical or sexual abuse, but fear, guilt, anxiety, depression, and ambivalence regarding disclosure commonly surround the child who has been abused. Young children who are being sexually abused may exhibit precocious sexual behavior with peers and present a detailed sexual knowledge that reflects exposure beyond their developmental level. Children who endure sexual or physical abuse often display sadistic and aggressive behaviors themselves. Children who are abused in any manner are likely to have been threatened with severe and frightening consequences by the perpetrator if they reveal the situation to anyone. Frequently, an abused child who is victimized by a family member is placed in the irreconcilable position of having either to endure continued abuse silently or to defy the abuser by disclosing the experiences and be responsible for destroying the family and risk being disbelieved or abandoned by the family. In cases of suspected abuse, the child and other family members must be interviewed individually to give each member

a chance to speak privately. If possible, the clinician should observe the child with each parent individually to get a sense of the spontaneity, warmth, fear, anxiety, or other prominent features of the relationships. One observation is generally not sufficient to make a final judgment about the family relationship, however; abused children almost always have mixed emotions toward abusive parents. Physical indicators of sexual abuse in children include sexually transmitted diseases (e.g., gonorrhea); pain, irritation, and itching of the genitalia and the urinary tract; and discomfort while sitting and walking. In many instances of suspected sexual abuse, however, physical evidence is not present. Thus, a careful history is essential. The physician should speak directly about the issues without leading the child in any direction, because already frightened children may be easily influenced to endorse what they think the examiner wants to hear. Furthermore, children who have been abused often retract all or part of what has been disclosed during the course of an interview. The use of anatomically correct dolls in the assessment of sexual abuse can help the child identify body parts and show what has happened, but no conclusive evidence supports sexual play with dolls as a means of validating abuse. Neglect: Failure to Thrive Assessment. In child neglect, a child's physical, mental, or emotional condition has been impaired because of the inability of a parent or caretaker to provide adequate food, shelter, education, or supervision. Similar to abuse, any form of continued neglect is an emergency situation for the child. Parents who neglect their children range widely and may include parents who are very young and ignorant about the emotional and concrete needs of a child, parents with depression and significant passivity, substanceabusing parents, and parents with a variety of incapacitating mental illnesses. In its extreme form, neglect can contribute to failure to thrive—that is, an infant, usually under 1 year of age, becomes malnourished in the absence of an organic cause (Figs. 23.3-1 and 23.3-2). Failure to thrive typically occurs under circumstances in which adequate nourishment is available, but a disturbance within the relationship between the caretaker and the child results in a child who does not eat sufficiently to grow and develop. A negative pattern may exist between the mother and the child in which the child refuses feedings and the mother feels rejected and eventually withdraws. She may then avoid offering food as frequently as the infant needs it. Observation of the mother and the child together may reveal a nonspontaneous, tense interaction, with withdrawal on both sides, resulting in a seeming apathy in the mother. Both the mother and the child may seem

depressed.

FIGURE 23.3-1 A 3-month-old baby suffering from failure to thrive secondary to caloric deprivation. Weight is only 1 ounce over birth weight. (Courtesy of Barbon Schmitt, M.D., Children's Hospital, Denver, CO.) FIGURE 23.3-2 The same infant as in Figure 23.3-1, 3 weeks later, after hospitalization. (Courtesy of Barbon Schmitt, M.D., Children's Hospital, Denver, CO.)

A rare form of failure to thrive in children who are at least several years old and are not necessarily malnourished is the syndrome of psychosocial dwarfism. In that syndrome, marked growth retardation and delayed epiphyseal maturation accompany a disturbed relationship between the parent and the child, along with bizarre social and eating behaviors in the child. Those behaviors sometimes include eating from garbage cans, drinking toilet water, bingeing and vomiting, and diminished outward response to pain. Half of the children with the syndrome have decreased growth hormone. Once the children are removed from the troubled environment and placed in another setting, such as a psychiatric hospital with appropriate supervision and guidance regarding meals, the endocrine abnormalities normalize, and the children begin to grow at a more rapid rate.

Management. In cases of child neglect, as with physical and sexual abuse, the most important decision to be made during the initial evaluation is whether the child is safe in the home environment. Whenever neglect is suspected, it must be reported to the local child protective service agency. In mild cases, the decision to refer the family for outpatient services, as opposed to hospitalizing the child, depends on the clinician's conviction that the family is cooperative and willing to be educated and to enter into treatment and that the child is not in danger. Before a neglected child is released from an emergency setting, a follow-up appointment must be made. Education for the family must begin during the evaluation; the family must be told, in a nonthreatening manner, that failure to thrive can become life-threatening, that the entire family needs to monitor the child's progress, and that they will receive some help in overcoming the many possible obstacles interfering with the child's emotional and physical wellbeing.

Anorexia Nervosa
Anorexia nervosa occurs in females about ten times as often as in males. It is characterized by the refusal to maintain body weight, leading to a weight at least 15 percent below the expected weight, by a distorted body image, by a persistent fear of becoming fat, and by the absence of at least three menstrual cycles. The disorder usually begins after puberty, but it has occurred in children of 9 to 10 years of age, in whom expected weight gain does not occur, rather than a loss of 15 percent of body weight. The disorder reaches medical emergency proportions when the weight loss approaches 30 percent of body weight or when metabolic disturbances become severe. Hospitalization then becomes necessary to control the ongoing process of starvation, potential dehydration, and the medical complications of starvation, including electrolyte imbalances, cardiac arrhythmias, and hormonal changes.

Acquired Immune Deficiency Syndrome Assessment. Acquired immune deficiency syndrome (AIDS), which is caused by the human immunodeficiency virus (HIV), occurs in neonate through perinatal transmission from an infected mother, in children and adolescents secondary to sexual abuse by an infected person, and in adolescents through intravenous drug abuse with an infected person or through intravenous drug abuse with infected needles and through sexual activities with infected partners. Child and adolescent hemophiliac patients may contract AIDS through tainted blood transfusions. Children and adolescents may present for emergency evaluations at the urging of a family member or a peer; in some

cases, they take the initiative themselves when they are faced with anxiety or panic about high-risk behavior. Early screening of high-risk persons may lead to the treatment of asymptomatic infected patients with such drugs as azidothymidine (AZT) and possibly other new medications that may slow the course of the disease. During the assessment of the risks for HIV infection, an educational process can be initiated with both the patient and the rest of the family so that an adolescent who is not infected, but exhibits high-risk behavior, can be counseled about that behavior and about safe-sex practices. In children, the brain is often a primary site for HIV infection; encephalitis, decreased brain development, and such neuropsychiatric symptoms as impairment in memory, concentration, and attention span may be present before the diagnosis is made. The virus can be present in the cerebrospinal fluid before it shows up in the bloodstream. Changes in cognitive function, frontal lobe disinhibition, social withdrawal, slowed information processing, and apathy constitute some common symptoms of the AIDS dementia complex. Organic mood disorders, organic personality disorder, and frank psychosis can also occur in patients infected with HIV.

URGENT NON-LIFE-THREATENING SITUATIONS School Refusal Assessment. Refusal to go to school may occur in a young child who is first entering school or in an older child or adolescent who is making a transition into a new grade or school, or it may emerge in a vulnerable child without an obvious external stressor. In any case, school refusal requires immediate intervention, because the longer the dysfunctional pattern continues, the more difficult it is to interrupt. School refusal is generally associated with separation anxiety, in which the child's distress is related to the consequences of being separated from the parent, so the child resists going to school. School refusal can also occur in children with school phobia, in which the fear and the distress are targeted on the school itself. In either case, a serious disruption of the child's life occurs. Although mild separation anxiety is universal, particularly among very young children who are first facing school, treatment is required when a child actually cannot attend school. Severe psychopathology, including anxiety and depressive disorders, is often present when school refusal occurs for the first time in an adolescent. Children with separation anxiety disorder typically present extreme worries that catastrophic events will befall their mothers, attachment, or themselves as a result of the separation. Children with separation anxiety disorder may also exhibit many other fears and symptoms of depression, including such somatic complaints such as headaches, stomachaches, and nausea. Severe tantrums and desperate pleas may ensue when preoccupation that a parent will be harmed during the separation is frequently verbalized; in adolescents, the stated reasons for refusing to go to school are often physical complaints. As part of an urgent assessment, the psychiatrist must ascertain the duration of the patient's absence from school and must assess the parents' ability to participate in a treatment plan that will undoubtedly involve firm parental guidelines to ensure the child's return to school. The parents of a child with separation anxiety disorder often exhibit excessive separation anxiety or other anxiety disorders themselves, thereby compounding the child's problem. When the parents are unable to participate in a treatment program from home, hospitalization should be considered.

Management. When school refusal caused by separation anxiety is identified during an emergency evaluation, the underlying disorder can be explained to the family, and an intervention can be started immediately. In severe cases, however, a multidimensional, long-term family-oriented treatment plan is necessary. Whenever

possible, a separation-anxious child should be brought back to school the next school day, despite the distress, and a contact person within the school (counselor, guidance counselor, or teacher) should be involved to help the child stay in school while praising the child for tolerating the school situation. When school refusal has been going on for months or years or when the family members

are unable to cooperate, a treatment program to move the child back to school from the hospital should be considered. When the child's anxiety is not diminished by behavioral methods alone, tricyclic antidepressants, such as imipramine (Tofranil), are helpful. Medication is generally prescribed not at the initial evaluation but after a behavioral intervention has been tried.

Munchausen Syndrome by Proxy Assessment. Munchausen syndrome by proxy, essentially, is a form of child abuse in which a parent, usually the mother, or a caretaker repeatedly fabricates or actually inflicts injury or illness in a child for whom medical intervention is then sought, often in an emergency setting. Although it is a rare scenario, mothers who inflict injury often have some prior knowledge of medicine, leading to sophisticated symptoms; the mothers sometimes engage in inappropriate camaraderie with the medical staff regarding the treatment of the child. Careful observation may reveal that the mothers often do not exhibit appropriate signs of distress on hearing the details of the child's medical symptoms. Prototypically, such mothers tend to present themselves as highly accomplished professionals in ways that seem inflated or blatantly untrue. The illnesses appearing in the child can involve any organ system, but certain symptoms are commonly presented: bleeding from one or many sites, including the gastrointestinal (GI) tract, the genitourinary system, and the respiratory system; seizures; and central nervous system (CNS) depression. At times, the illness is simulated, rather than actually inflicted.

OTHER CHILDHOOD DISTURBANCES

Posttraumatic Stress Disorder Children who have been subjected to a severe catastrophic or traumatic event may present for a prompt evaluation because they have extreme fears of the specific trauma occurring again or sudden discomfort with familiar places, people, or situations that previously did not evoke anxiety. Within weeks of a traumatic event, a child may re-create the event in play, in stories, and in dreams that directly replay the terrifying situation. A sense of reliving the experience may occur, including hallucinations and flashback (dissociative) experiences, and intrusive memories of the event come and go. Many traumatized children, over time, go on to reproduce parts of the event through their own victimization behaviors toward others, without being aware that those behaviors reflect their own traumatic experiences.

Dissociative Disorders Dissociative states—including the extreme form, multiple personality disorder—are believed most likely to occur in children who have been subjected to severe and repetitive physical, sexual, or emotional abuse. Children with dissociative symptoms may be referred for evaluation because family members or teachers observe that the children sometimes seem

to be spaced out or distracted or act like different persons. Dissociative states are occasionally identified during the evaluation of violent and aggressive behavior, particularly in patients who truly do not remember chunks of their own behavior. When a child who dissociates is violent or self-destructive or endangers others, hospitalization is necessary. A variety of psychotherapy methods have been used in the complex treatment of children with dissociative disorders, including play techniques and, in some cases, hypnosis.

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