Psychiatric Consultation in Emergency Department: A Study from Kashmir

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ABSTRACT

Introduction: General practitioners serve as gatekeepers for specialist psychiatric care in Kashmir. A good number of patients seek emergency psychiatric consultation in Kashmir. Medicos posted in 'General Casualty' may not be efficient enough to handle psychiatric cases because of limited training in this subject and lack of specialized support. Also, psychiatric patients may not be easy to deal with as these patients are often uncooperative or aggressive and present with a wide variety of symptoms which are often difficult to diagnose by 'non psychiatrists'.
Material and Method: This was a descriptive study which was carried out for a duration of one month at Emergency Psychiatric Unit of Government Medical College, Srinagar. Sociodemographic variables and other relevant clinical data was recorded in a semi structured proforma. Patients were diagnosed on the basis of text revision of the fourth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR).
Results: Most of the patients were females (60.8%) belonged to age group 16-30 years (62%), married (62.86%), were from urban area (62.45%), nuclear families (74%), educated upto graduation (40.25%) and from 'Above Poverty Line' class (83.60%). Conversion disorder was the commonest emergency psychiatry problem (29.5%) followed by anxiety disorders (12.9%). Loss of consciousness (21.58%) and unexplained breathing problem (13.2%) were the commonest clinical presentations.
Conclusion: Emergency psychiatric services are sought for a wide variety of symptoms. Medicos posted in casualty need to have a basic understanding of psychiatric disorders for their proper referral and better management.

Keywords: Psychiatric Consultation, Conversion disorder, unexplained breathing problem

INTRODUCTION

Emergency service is a vital component of and is the gateway to different departments of a general hospital facility.[1] Currently, focus is being laid on Emergency Psychiatric services throughout the world.[2] Psychiatric emergency unit has become the primary entry point for patients having multiple problems (physical or Psychiatric).[3] Emergency psychiatry department is consulted by patients having either mental disorders or physical illnesses. American data has shown a greater increase in patients visiting emergency psychiatric disorders in the last decades probably owing to de institutionalisation movement.[4] Evaluation and management of patients visiting psychiatric emergency is frequently different from patients visiting OPDs, in view of the fact that consultations are sought for a wide variety of clinical variables ranging from side effects of medications to different psychological stressors.[2]

Psychiatric emergency is an acute disturbance of thought, mood, behavior and social relationship that requires an immediate intervention as defined by patient, family or the community.[5] Inattention to psychiatric emergency may endanger patient including people around him as well as increase the risk of damage to property, thus demanding a prompt intervention from the service providers.[6]

The Emergency Psychiatry Unit of Government Medical College Srinagar being located adjacent to general emergency Unit frequently receives patients in crisis, many a times with underlying medical illness. This unit is located in a Tertiary Care General Hospital (Sri Maharaja Hari Singh Hospital, Srinagar), catering to whole Kashmir valley, Ladakh and parts of Jammu region comprising a population more than 8 million.[7] This study was done to study the profile of patients attending this Emergency Psychiatry Unit.

MATERIAL AND METHODS

The study was carried out at Emergency Psychiatry Unit of Government Medical College Srinagar, Kashmir, India which is supervised by Department of Psychiatry. The study was carried out from 15th Dec 2016 to 15th Jan 2016. The patients were included irrespective of the diagnosis of any organic disorder, age, sex or mental retardation. Immediate symptom/clinical variable was also recorded. Sociodemographic variables were recorded in a semi-structured proforma developed in the Department. Socio economic status was assessed by possession of 'Ration Card' issued by Department of Consumer Affairs and Public Distribution, Jammu and Kashmir Government. Psychiatric diagnoses for axis I and II were made according to the text revision of the fourth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR).[8] Patients with physical illnesses were referred to the respective units and the diagnosis thereof was recorded. All the diagnosis were reported as per DSM Multi Axis System.

STATISTICAL ANALYSIS

The data was tabulated, categorized and appropriate statis-

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tically analysis (like Chi Square test) was done wherever needed using SPSS version,20. Difference was taken significant at *P* value of less than 0.05.

RESULTS

Sociodemographic variables

Most of the patients were young belonging to the age group of 16-30 years and 31- 45 years, together these groups comprising more than 81%. Less than 5% patients belonged to the age group of less than 15 years. Most of the patients attending emergency psychiatry unit were females (60.8% females vs 39.2% males). Patients from urban background more often visit the emergency psychiatry unit (62.45%). 62.45% patients belonged to nuclear family. More number of patients were from the married group (62.86%). Other important characteristics of the sample population are given in table 1.

Axis I and II psychiatric diagnoses

Maximum diagnoses were on Axis I and Axis II, together comprising more than 68%. The diagnosis were usually clinical corresponding the nearest possible DSM IV TR diagnosis. Single largest psychiatric diagnosis was conversion disorder (29.5%). It was a clinical diagnosis for such conversion patients where no obvious medical or psychiatric diagnosis was found at the time of assessment. Depressive disorders comprised 18% and bipolar affective disorders were seen in 4% of patients. Other diagnosis included anxiety disorders (12.9%), substance related disorders (9.3%) and psychotic disorders (3.1%).More than 10% patients presented with suicidal attempts/ thoughts/self harm. 3% of the patients attending emergency psychiatry had personality disorder and 1% of the patients had associated mental retardation. [Table 2]

Axis III diagnosis (general medical condition)

25% patients presented in psychiatry emergency with coexistent medical illness. Patients having disorders of digestive system, metabolic system and nervous system predominated the list; comprising 9.33%, 8.7%, and 4.6% respectively. About 13% patients attending the emergency psychiatry unit could not be assigned either a medical or a psychiatric diagnosis at the time or presenting in the unit.[Table 2]

Immediate clinical variables

Patients presented with varied complaints, commonest being loss of consciousness (21.58%), breathing problems (13.2%), pain symptoms (9.75%) and panic attacks (7.05%). [Table 3]

DISCUSSION

Emergency psychiatry unit is increasingly becoming the first contact service in general hospital unit and in consultation liaison psychiatry. As mental health problems are increasing day by day, the emergency psychiatry services deserve a due consideration.[9] Association with other illnesses, magnitude of their severity and prompt intervention call for importance of Emergency psychiatric services.[6] In the Casualty Department, recognition of psychiatric services is often complicated by the frequency of physical associations.

In our study young adult female patients have been the chief service users. There have been similar observations by Allen et al who found that population less than 40 years predominated among the service users in these units.[5] Moreover our population is predominantly young owing to the demographics in this part of the world.[7] In our study we found that most of the patients were from urban area. Although it is contrary to the population demographics, it could be because of the easy accessibility of urban residents to our hospital. Moreover, the emergencies in rural areas come in general units after being catered at peripheral emergency units. Nuclear families frequently visit the services which was observed by

Characteristics	Variable	Frequency(%)	Chi square	P value
Sex	Male	189(39.2%)	22.4	< 0.01
	Females	293(60.8%)		
Age (yrs)	<15	22(4.56%)	438.69	< 0.01
	16-30	276(57.26%)		
	31-45	117(24.28%)		
	46-60	46(9.54%)		
	>61	21(4.36)		
Domicile	Rural	181(37.55%)	29.87	< 0.01
	Urban	301(62.45%)		
Marital status	Married	303(62.86%)	31.9	< 0.01
	Unmarried/ divorced/widowed	179(37.14%)		
Occupation	Unemployed	249(51.66%)	74.8	< 0.01
	Employed	129(26.76%)		
	Student	104(21.58%)		
Education	Illiterate	97(20.12%)	62.18	< 0.01
	Upto Middle	109(22.62%)		
	Upto Graduate	194(40.25%)		
	Above graduate and Others	82(17.01%)		
Family type	Nuclear	301(62.45%)	28.98	< 0.01
	Joint	181(37.55%)		
Socioeconomic Status	Above Poverty Line	403(83.60%)	217.9	< 0.01
	Below Poverty Line	79(16.40%)		

Table-1: Sociodemographic variables of the sample

Axis I (307)	Conversion Disorder	142 (29.5%)
	Anxiety disorders	62 (12.9%)
	Bipolar Affective disorder	22 (4.6%)
	Unipolar mood disorder	88 (18.2%)
	Substance related disorder	45 (9.33%)
	Schizophrenia and other psychosis	15 (3.11%)
	Suicide/ deliberate self-harm	52 (10.78%)
	Others	10 (2.07%)
Axis II (25)	Personality disorders	18 (3.73%)
	Mental retardation	7 (1.4%)
Axis III (122)	Central Nervous system	22 (4.6%)
	Digestive system	45 (9.33%)
	Metabolic/endocrine	42 (8.7%)
	Cardio-vascular system	21 (4.36%)
	Skin/musculo-skeletal	12 (2%)
	Infection/malignancy	9 (1.86%)
	Respiratory system	05 (1.03%)
	Gynae/obstetrical	16 (3.3%)
No Diagnosis / Diagnosis not conclusive		63 (13.07%)
*More than one diagnosis/ immediate clinical variable were present in some patients.		

Table-2: Clinical diagnosis*

Lossofconsciousness	104(21.58%)
Seizure/pseudoseizure	31(6.43%)
Suicidal/homicidalbehavior	37(7.67%)
Unexplainedbreathingproblem	64(13.2%)
Intoxication/drugoverdose/substancewith-drawal	27(5.6%)
Suddenlossofspeech	32(6.63%)
Confusionalbehavior	14(2.9%)
Fearfulness	32(6.63%)
Disinhibitedbehaviorirrelevant/abusive/exces-sivetalk	28(5.80%)
Severeanxiety/panicattack	34(7.05%)
Generalizedweakness/hemiparesisothers	32(6.6%)
Painabdomen,chestpain,headacheetc.	47(9.75%)
*More than one diagnosis/ immediate clinical variable were present in some patients.	

Table-3: Immediateclinicalvariables*

other researchers as well. It also reflects the vulnerability of nuclear families towards psychiatric emergency.[2,5,6]

The diagnosis of patients attending psychiatric emergency units has varied from researcher to researcher. Substance-related problems and psychotic disorders predominated over somatoform, anxiety and neurotic disorders as observed by Kropp.[10] Similarly more than thirty percent had substance related disorders in a study by Breslow et al.[11] Contrary to this, behavioral problems predominated in another study.[6] In our study the main diagnostic groups were conversion disorder, mood disorders, anxiety disorder and suicidal behavior whereas personality disorders, psychotic disorders and mental retardation were least represented. Similar results have been observed by other researchers in Indian subcontinent.[2,6] Pertinent to note is that the representation here is not an indicator of the prevalence of these disorders in the general population. The utilization of emergency services is governed by the demographics, symptom profile, accessibility, stigma, social and cultural restrains.[12]

Twenty five percent patients had a coexistent physical diagnosis with or without a psychiatric diagnosis. This reflects the existence of a close interlinking pathophysiological mechanism leading to most modern lifestyle illnesses with symptoms both in physical and psychological domains. However, the presentation of physical disorders in the emergency psychiatry unit could also be due to over-sensitivity or inadequate knowledge about mental illness in the non-psychiatric medical professionals.[13]

Conversion symptoms including loss of consciousness, pseudo-seizure and loss of an organ function predominated the symptom list. Since most presentations to psychiatry emergency are 'cry for help', these symptoms predominate in view of acceptance of the seriousness of these symptoms along with the requisite gain.[14] Similar results have been seen in another Indian study.[2] Thirteen percent presenters could not be assigned a diagnosis. This is because the emergency setup demands a prompt action and quick results and it is not possible to use a diagnostic tool in the emergency setup.[15] This limitation could be overcome by engaging more manpower and conducting more prospective research.

CONCLUSION

We conclude that emergency psychiatric consultation is sought both for mental and physical disorders. The predominant population is from nuclear families being young females. Conversion symptoms are frequently encountered by the emergency psychiatry staff. More prospective studies need to be carried out to study this area.

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