BEHAVIORAL DISORDERS: CLINICAL FEATURES: INTRODUCTION

Estimates of the proportion of emergency department patients who present with a psychiatric disorder range from a few percent to over a third. This variability is due in part due to differences in patient population and the community’s use of alternatives for psychiatric crisis intervention.

When patients are screened for mental disorders including substance abuse, many have unrecognized psychopathology that is relevant to their assessment and treatment in the emergency setting. Subgroups of the emergency patient population at higher risk for psychiatric disorders include those who are self-referred for nonurgent, nonspecific, vague medical or social problems, and the “after midnight” group of emergency department patients who have been shown to have a higher prevalence of psychiatric illness than those presenting during the daytime. Sometimes, psychiatric disorders clearly make up the primary reason for an individual’s presentation to an emergency department. In other cases, psychiatric disorders lead to injury and illness. In contrast, psychiatric disorders may form part of the current or past medical history of a patient, yet possess little importance for the immediate clinical condition.

In studies that report categories of psychiatric illness seen in the emergency department, the most prominent diagnoses are substance abuse, affective disorders, anxiety disorders, antisocial personality disorder, and severe cognitive impairment. Among repeat users of the emergency department, persons with schizophrenia are overrepresented.

DIAGNOSIS

In the assessment of patients presenting with psychiatric symptoms, as with other medical conditions encountered in the emergency department, promptly stabilize the patient’s acute psychiatric condition and evaluate the major complaint. Formulating a specific diagnosis is not as important as determining if the patient is harmful to him- or herself or others and needs hospitalization. The determination that an individual is suicidal and in need of protection and hospitalization, for instance, is more important than deciding whether that person suffers from schizophrenia or psychotic depression.

Nevertheless, provisional psychiatric diagnoses can be made in the emergency department. Recognition of specific behavioral syndromes can assist in evaluating the presenting complaint, pursuing associated symptoms, and determining treatment and disposition. Emergency physicians should be sufficiently familiar with commonly seen psychiatric illnesses to describe their predominant clinical features.

Structured Diagnostic Criteria

The current official diagnostic nomenclature, most recently published in 2000 by the American Psychiatric Association, is the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (text revision), commonly known as DSM-IV-TR. A copy of DSM-IV-TR should be available for reference in the emergency department, because it contains the list of criteria for each disorder and additional material on demographics, associated symptoms and syndromes, and differential diagnosis.

Multiaxial Diagnostic System

The DSM-IV diagnoses are made on a multiaxial system in which each axis refers to a different domain of information. This system aids in making a comprehensive assessment, organizing complex clinical information, and communicating between professionals. Axis I disorders comprise the clinical syndromes of mental disorders. Conditions listed under axis II are the personality disorders and developmental disorders, including mental retardation, which may underlie the more florid axis I syndrome. Axis III concerns general medical conditions. Axis IV consists of psychosocial and environmental stressors or problems. Axis V relates global, overall functioning (Table 288-1). Knowledge of this multi-axial system may
facilitate an understanding of medical records, psychiatric consultants' notes, and interaction with consulting psychiatrists or psychosocial personnel. For instance, a patient with previous medical records containing *DSM-IV* diagnoses of axis I (alcohol intoxication), axis II (antisocial personality disorder), and axis III (scalp laceration) should be recognized as likely to display features of the axis II personality disorder, although the patient's chief complaint may be a new problem.

### Table 288-1 Multiaxial Psychiatric Assessment

<table>
<thead>
<tr>
<th>Axis</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Axis I</td>
<td>Mental disorders</td>
</tr>
<tr>
<td></td>
<td>Clinical and other psychiatric conditions that may be a focus of clinical attention</td>
</tr>
<tr>
<td>Axis II</td>
<td>Personality disorders and mental retardation</td>
</tr>
<tr>
<td>Axis III</td>
<td>General medical conditions</td>
</tr>
<tr>
<td></td>
<td>Medical conditions that are relevant to the understanding or management of the case</td>
</tr>
<tr>
<td>Axis IV</td>
<td>Psychosocial and environmental problems</td>
</tr>
<tr>
<td>Axis V</td>
<td>Global assessment of functioning</td>
</tr>
</tbody>
</table>


### Psychiatric Syndromes (Axis I Disorders)

The major categories of axis I disorders covered in this chapter are listed in Table 288-2. A useful strategy for making a *DSM-IV* diagnosis is to classify the primary feature into a major category, consider possible nonpsychiatric etiologies for the complaint, and then use the decision trees in Appendix B of *DSM-IV* to identify the appropriate diagnosis. The decision trees guide the clinician who is unfamiliar with the intricacies of the criteria within a category to identify the features that distinguish closely related conditions. An example of the decision tree for evaluating acute psychosis is shown in Figure 288-1.

### Table 288-2 Axis I Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delirium, dementia, and amnestic and other cognitive disorders</td>
</tr>
<tr>
<td>Substance induced disorders</td>
</tr>
<tr>
<td>Mental disorders due to a general medical condition</td>
</tr>
<tr>
<td>Schizophrenia and other psychotic disorders</td>
</tr>
<tr>
<td>Mood disorders</td>
</tr>
<tr>
<td>Anxiety disorders</td>
</tr>
<tr>
<td>Somatoform disorders</td>
</tr>
<tr>
<td>Factitious disorders</td>
</tr>
<tr>
<td>Dissociative disorders</td>
</tr>
<tr>
<td>Eating disorders</td>
</tr>
<tr>
<td>Adjustment disorders</td>
</tr>
</tbody>
</table>

*Fig. 288-1.*
Delirium, Dementia, Amnestic, and Other Cognitive Disorders

This group of syndromes is characterized by a clinically significant deficit in cognitive or memory function due to a general medical condition. There are several distinct and common causes of organic brain syndromes in which the causative factor is known, for example, vascular dementia and alcohol withdrawal delirium. In these cases, the specific diagnosis is listed in DSM-IV. In other cases, the etiologic factor should be specified with the descriptor "due to [general medical disorder or substance]," for example, "delirium due to hepatic encephalopathy."

DEMENTIA

The essential clinical feature of dementia is a pervasive disturbance of cognitive functioning in several areas, including memory, abstract thinking, judgment, personality, and other higher cortical functions such as language. If clouding of consciousness is present, then the patient does not have solely a dementing illness but has delirium or intoxication. The presence of global cognitive impairment may be detected by a bedside cognitive examination, such as the Mini-Mental Status Examination (see Chap. 289), and additional confirmatory history should be gathered from an informant, such as a family member. Memory disturbance is usually the earliest sign to be apparent to others, and, unless it is very mild, it can be easily identified by examination. Such an examination asks the patient to remember three words (tree, pen, and book) and repeat them back immediately and in 5 min.

Patients with dementia may be brought to the emergency department after having been found wandering away from home or an institution. Because the onset of most forms of dementia is slow and gradual, presentation to the emergency department often occurs only when some acute worsening of mental status occurs, which may be the result of a superimposed medical illness, adverse drug effect, or environmental change. The demented patient's diminished
intellectual and physiologic resources allow abrupt worsening of function with the addition of such stressors.

Early in the course of dementia, anxiety, depression, or psychosis may dominate the clinical picture and obscure cognitive dysfunction. **For this reason, a high degree of clinical suspicion of dementia should be maintained when evaluating an elderly patient with no prior psychiatric history who presents with new psychiatric problems.** Demented persons are also prone to unrecognized physical illness, because of inability to perceive or describe symptoms. Careful examination and appropriate laboratory testing are always indicated in the initial and ongoing evaluation of such patients.

Dementia is not synonymous with the previous designation of "chronic organic brain syndrome," which implies irreversibility. Common causes of potentially reversible dementia include metabolic and endocrine disorders, polypharmacy, and depression. Often, especially in elderly patients, depression may present with prominent cognitive impairment, a condition erroneously labeled "pseudodementia," but more accurately called dementia of depression. A relatively acute onset, prominent mood changes, and vegetative disturbances such as loss of appetite and weight, sleep disturbance, or expressions of guilt or suicidal ideation point to depression as the cause. In these situations, treatment of the mood disorder may lead to resolution of the cognitive impairment, although recent studies indicate that many such patients have evidence of brain dysfunction and only partial treatment response.

**DELIRIUM**

Like dementia, delirium is characterized by global impairment in cognitive function but is distinguished from it in two major ways. In delirium, the patient has clouding of consciousness, a reduction in the awareness of the external environment (manifest as difficulty sustaining attention), varying degrees of alertness ranging from drowsiness to stupor, and sensory misperception.

The primary distinguishing feature of delirium is the course that is typically acute, with rapid deterioration in hours or days, rather than in months as with dementia. Also, the severity of delirium fluctuates over the course of hours; the patient may appear normal at one time and wildly agitated a few hours later. Extreme changes in psychomotor activity, ranging from restlessness and hyperactivity to stupor, are frequent in delirium but uncommon in dementia except in the later stages when a delirious state may be superimposed. Hallucinations, often visual, are common in delirium. They typically have a vivid quality to which the patient reacts strongly. The hallucinations contrast with the visual hallucinations seen by psychotic patients, which often are described and experienced indifferently.

**Substance-Induced Disorders**

**INTOXICATION**

When recent ingestion of a specific exogenous substance produces maladaptive behavior and impairment of judgment, perception, attention, emotional control, or psychomotor activity, and the patient does not display features of delirium, hallucinosis, or other organic brain syndromes, a diagnosis of intoxication is made. When the offending substance is known, it should be specified (e.g., alcohol intoxication or amphetamine intoxication). The specific features of intoxication syndromes commonly seen in the emergency department are described in greater detail in the section on toxicology.

As a general rule, the diagnosis of intoxication can be rather easy when laboratory analysis reveals the type and amount of intoxicant circulating in the system. The clinical features of alcohol intoxication are familiar to experienced emergency physicians and range from impaired judgment and coordination through ataxia, lethargy, and coma. When repeated episodes of intoxication occur within a brief period, the individual by definition has a substance abuse disorder, and the additional diagnosis is made. A urine toxicology screening test and a blood alcohol level are most useful in evaluating patients with new onset psychiatric symptoms and often are required as part of the evaluation assessment of patients admitted to psychiatric facilities.

**WITHDRAWAL**

Withdrawal can follow cessation or reduction in use of a substance of abuse. The category signifies a syndrome characteristic of withdrawal from that particular drug, when the clinical syndrome does not satisfy the criteria for delirium or another organic brain syndrome. For example, mild forms of alcohol withdrawal would be classified here, but if the patient is confused, hallucinating, and agitated, a diagnosis of alcohol withdrawal delirium is indicated. The diagnosis is made by identification of the withdrawal syndrome and evidence of recent use of the substance in a pattern sufficient to produce withdrawal when the amount ingested is decreased. Specific withdrawal patterns depend on the agent.
customarily used.

Alcohol withdrawal, for instance, includes up to four stages: autonomic hyperactivity (sweating, tachycardia; 6 to 8 h after cessation of drinking), hallucinations (24 h after withdrawal), major motor seizures (1 to 2 days), and global confusion (3 to 5 days after last use of alcohol). Some withdrawal syndromes, particularly from alcohol or barbiturates, can be life-threatening.

Mental Disorders Due to a General Medical Condition

The DSM-IV has implemented a major change in the classification of psychiatric symptoms caused by medical conditions. The previous terminology of "organic brain syndrome" and the subtypes organic mood disorder and organic delusional disorder, for example, have been eliminated, because of the implication that the "functional" mental disorders are unrelated to biologic changes in brain function.

Using DSM-IV, when there is evidence that a psychiatric disturbance is a direct physiologic consequence of a general medical condition or substance, the mental disorder is specified as "due to" the medical problem, for example, "major depression due to hypothyroidism."

Schizophrenia and Other Psychotic Disorders

Schizophrenia and related disorders are marked by the presence of psychotic symptoms, primarily delusions and hallucinations. Delusions are defined as fixed false beliefs that are not amenable to arguments or facts to the contrary and that are not shared by others of similar cultural background. Common delusions are of several types. Persecutory delusions are those in which one believes that one is being attacked, followed, harassed, or conspired against. Grandiose delusions are those that involve themes of special powers or abilities. Bizarre delusions are those with patently absurd content, such as believing that one's thoughts are controlled by extraterrestrial beings. Hallucinations are false perceptions experienced in a sensory modality and occurring in clear consciousness. Auditory hallucinations are the most common, followed in order of prevalence by visual, tactile, olfactory, and gustatory; the presence of the latter, nonauditory hallucinations suggests a medical, not psychiatric, cause of psychosis (such as alcohol withdrawal). The most prevalent psychosis is schizophrenia, described in detail in the next section. The other psychotic disorders, discussed briefly, are less common. A decision tree helpful in evaluating psychotic symptoms is presented in Figure 288-1.

SCHIZOPHRENIA

Schizophrenia is one of the most serious public health problems in the world, affecting just under 1 percent of the world's population. The essential features are a deterioration in functioning, characteristic active-phase symptoms (hallucinations, delusions, disorganized speech, disorganized behavior, and catatonic behavior), negative symptoms (blunted affect, emotional withdrawal, lack of spontaneity, anhedonia, or attentional impairment), cognitive impairment manifested by loose associations or incoherence for at least 1 month, and the relative absence of a mood disorder. Research has established the importance of genetic factors in its cause, and schizophrenia is most likely a group of disorders of different etiologies that shares a final common pathway, much as is the case with mental retardation. It is a brain disease, and there is no evidence that psychosocial stressors or poor parenting is responsible for the cause of the illness, although these may have a profound effect on the patient's adaptation to this usually chronic disorder.

Symptoms of schizophrenia usually begin in late adolescence or early adulthood, although the onset can occur at any age. The childhood history of schizophrenics often is marked by shyness, oddness or eccentric behavior, school difficulties, or paranoid behaviors, but such features are not always present. A prodromal phase, in which a gradual deterioration of function is noted, usually precedes the development of active delusions or hallucinations. Such deterioration usually includes the worsening of social withdrawal or the new onset of social withdrawal, odd behavior or speech, and difficulty in functioning in school or work. Patients or their families rarely seek care until the onset of the active phase of psychosis. Schizophrenics seldom seek care at all, because they lack insight; they do not realize that their perceptions, thoughts, and behavior are abnormal.

Typical, or older, antipsychotic drugs (such as haloperidol) usually reduce the severity of positive symptoms (delusions and hallucinations). Other manifestations of schizophrenia less responsive to typical antipsychotics include negative symptoms (lack of volition, blunting of emotion, anhedonia, and inattention). Such symptoms result in lasting impairment in self-care, work, and social relations. Newer, "atypical," antipsychotic agents (such as risperidone, olanzapine, clozapine
and ziprasidone) seem to have a greater effect in improving the negative and positive symptoms.

Disorganization of thinking and behavior characterizes schizophrenia. Disheveled appearance and grooming, bizarre behavior, poor judgment, and loosening of associations indicate such disorganization. *Loosening of associations* refers to a loss of the normal logical connections between one thought and the next; the schizophrenic patient's speech is often vague, rambling, disjointed, or nonsensical. Fantastic experiences and bizarre ideas are described in an indifferent manner and unchanged facial expression.

Common reasons for persons with schizophrenia to come to the emergency department include worsening of psychosis resulting from stress or noncompliance with medication, suicidal behavior, violence (often as a result of paranoid thinking), and extrapyramidal side effects of neuroleptic drugs. Schizophrenics constitute a large share of the chronic homeless population and may be brought in by authorities, in a confused state, obviously unable to attend to their basic needs. Their poor judgment and disorganization may lead to disregard for medical problems, so attention must be given to their physical status and the psychiatric problem.

**SCHIZOPHRENIFORM DISORDER**

*Schizophreniform disorder* is diagnosed when the patient meets the criteria for schizophrenia but the symptoms have been continuously present for less than 6 months. A rapid onset over a few days and good premorbid functioning are more common than in schizophrenia.

**BRIEF PSYCHOTIC DISORDER**

Some individuals may become acutely psychotic after exposure to an extremely traumatic life experience. If such a psychosis lasts for less than 4 weeks, it is termed a *brief psychotic disorder*. Precipitants of the psychosis include the death of a loved one or a life-threatening situation such as combat or a natural disaster. Emotional turmoil, confusion, and extremely bizarre behavior and speech are common.

**Mood Disorders**

The mood disorders are the most prevalent of the major psychiatric disorders, affecting about 10 to 15 percent of the general population at some time in their lives. Depressive disorders are the major cause of completed suicide. An unsuccessful attempt may bring the patient to the emergency department. Mood disorders, substance abuse, and anxiety disorders are the most common psychiatric diagnoses in emergency patients.

Mood, or *affective*, disorders differ from the normal extremes of sadness and happiness in that characteristic clusters of psychological and vegetative symptoms (depressive or manic syndrome) are present, and functioning is impaired. Any of the features of schizophrenia such as delusions, hallucinations, or disorganization may be present, but if a full depressive or manic syndrome exists, a diagnosis of a psychotic mood disorder is required. Another important characteristic of affective disorders is that they tend to be episodic, with periods of remission and normal function.

**MAJOR DEPRESSION**

The essential features of *major depression* are a persistent sad or depressed (dysphoric) mood or pervasive loss of interest in usual activities lasting for at least 2 weeks. Associated psychological symptoms include guilt over past deeds, self-reproach, feelings of worthlessness or hopelessness, inability to experience pleasure, and recurrent thought of death or suicide. "*Vegetative symptoms*” involve physiologic functioning and include loss of appetite and weight, sleep disturbance, fatigue, inability to concentrate, and psychomotor agitation or retardation. The depression may begin gradually or rapidly but usually will have been present for several weeks before the patient comes for treatment.

When the patient complains of the full spectrum of depression symptoms, the diagnosis of major depression is easy to make, but when the chief complaint is a single symptom such as insomnia or fatigue, it will be necessary to elicit the other symptoms of major depression to make the diagnosis. Somatic complaints such as vague pain or weakness may be part of major depression, as may generalized anxiety. A useful screening mnemonic is presented in Figure 288-2.

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**Fig. 288-2.**
In SAD CAGES. A screening mnemonic for major depression. (Reprinted with permission from Rund DA, Hutzler JC: *Emergency Psychiatry*. St. Louis, Mosby, 1983.)

Major depression is more common in women, persons with a family history of depression or suicide, and individuals with medical or other psychiatric illnesses. When a medical disorder or drug produces a depressive syndrome through a presumed biologic effect on the brain, the diagnosis should be "depression due to [the offending condition]." Major depression is often superimposed on other mental disorders such as substance abuse, personality disorders, and anxiety disorders; and such conditions are frequently comorbid conditions. Depression in the elderly may go unrecognized by the emergency physician. Screening tools for depression recognition in the geriatric population can be helpful in diagnosis.

Primary mood disorders tend to display more biologic features, are more familial, and respond better to somatic antidepressant treatment than do mood disorders due to medical disorders. The lifetime risk of suicide in patients with major depression is 15 percent, so prompt and aggressive treatment is strongly indicated. Major depression is often recurrent, so certain patients must be maintained on long-term treatment to prevent relapse.

**BIPOLAR DISORDER**

Bipolar disorder, previously termed *manic-depressive illness*, is characterized by the occurrence of mania cycling with periods of depression. A full manic syndrome is one of the most striking and distinctive conditions in clinical practice. The essential disturbance in mood is one of elation or irritability. Manic patients feel "on top of the world," expansive, and energetic. The state is precarious, however, and the patient may quickly become argumentative, hostile, irritable, and sarcastic, especially when their plans are thwarted.

The vegetative signs of mania are a decreased need for sleep, increased activity, rapid pressured speech, and racing thoughts. Manics may have grandiose ideas, such as unrealistic plans to start a business or run for public office, and if the grandiosity reaches delusional proportions, such patients may believe themselves to be famous, fabulously wealthy, or blessed with special powers and abilities. Poor judgment in spending money and sexual behavior may lead to problems that prompt manics' families to seek treatment for them, because manics usually lack insight into their abnormal condition and deny that anything is wrong. For this reason, reports from informants such as relatives often reveal important information to substantiate the diagnosis. Because patients who have had a manic episode almost invariably have depressions at some time (the other "pole" of bipolar disorder), a history of depression also may help in diagnosis.

The disorder is equally common in men and women, and the onset is usually in the third and fourth decades. Complications include suicide, substance abuse (excessive alcohol use is common during the manic phase), and marital and occupational disruptions. The course of bipolar disorder is episodic, with the duration, frequency, and regularity of the episodes varying greatly. Depressive episodes are more frequent than manic episodes.
DYSTHYMIC DISORDER

Dysthymic disorder is a more chronic and less severe form of depressive illness and was previously termed depressive neurosis. Depressed mood must have been present most of the day, more days than not, for at least 2 years. Psychotic features are not seen, and these patients often have a life-long gloomy, pessimistic outlook. Women are affected more often than men, and the onset is typically in childhood, adolescence, or early adulthood.

Associated personality disorders and substance abuse are common. When vegetative symptoms are present, they are usually less severe than with major depression. Major depression may be superimposed on dysthymia, often in association with stressful life events. When major depression complicates dysthymia, the patient may be brought in for evaluation, because of the severity of symptoms or treatment after a suicide attempt.

Anxiety Disorders

The anxiety disorders are mental disorders in which apprehension, fears, and excessive worry dominate the psychological life of the individual. Pathologic degrees of anxiety are accompanied by different degrees of autonomic activity (sweating, tachycardia, or dizziness) out of proportion to any real danger or threat. Because anxiety is a ubiquitous condition and frequently associated with medical illness, depression, neurologic syndromes, and psychoses, a diagnosis of a primary anxiety disorder should be made by exclusion of other causes.

Anxiety disorders are diagnosed in 4 to 8 percent of the general population and are diagnosed more often in women than in men. Because of the physical nature of certain symptoms associated with anxiety disorders, patients often seek treatment and evaluation in medical rather than psychiatric settings.

PANIC DISORDER

Patients who experience recurrent attacks of severe anxiety are said to suffer from panic disorder. For detailed discussion, see Chap. 292. A panic attack consists of a sudden extreme surge of anxiety and dread accompanied by autonomic signs, including palpitations, tachycardia, shortness of breath, chest tightness, dizziness, sweating, and tremulousness. The symptoms develop over a few minutes at most and may be unprovoked or occur with a phobic stimulus, such as a crowded store. After the attacks begin, some patients start to avoid situations that seem to precipitate the panic (phobic avoidance). When activities are severely limited, the complication of agoraphobia is diagnosed. In agoraphobia, the patient tends to avoid situations where ready escape or assistance during an attack is not possible. The frequency and severity of panic attacks wax and wane, but the illness is generally chronic.

GENERALIZED ANXIETY DISORDER

When anxiety attacks are absent but the patient complains of persistent worry, tension, or free-floating anxiety, a diagnosis of generalized anxiety disorder should be considered. This condition lasts at least 6 months and is characterized by apprehensive worrying, muscle tension, insomnia, irritability, restlessness, jumpiness, or distractibility. Muscle tension may be so severe that the patient actually experiences diffuse muscular pain. Associated autonomic symptoms include the cardiopulmonary, gastrointestinal, and neurologic symptoms seen in panic attacks. In generalized anxiety disorder, such symptoms occur more continuously and chronically than in panic disorder.

PHOBIC DISORDERS

Phobic disorders, other than agoraphobia, are an unusual cause of self-referral to the emergency department. In phobias, the anxiety symptoms are recognized as excessive and occur when the patient is exposed to, or anticipates exposure to, a specific situation, which then leads to avoidance of the stimulus to a degree that it interferes with the patient's life. In social phobia, the situation involves having the attention of others drawn to the patient. Such activities as public speaking or meeting strangers create a fear that the patient will be embarrassed in some way. Specific phobias are quite common; they involve fear of a very specific stimulus, such as animals, heights, dark, or flying.

OTHER ANXIETY DISORDERS

Posttraumatic stress disorder is an anxiety reaction to a severe psychosocial stressor, usually life threatening, such as military combat, fire, rape, or natural disaster. Symptoms involve repetitive and intrusive memories of the event, nightmares, emotional numbing, survivor guilt, and different degrees of depression and anxiety. Substance abuse appears to be a frequent complication.

Obsessive-compulsive disorder is a mental disorder in which the patient experiences intrusive thoughts or images that cannot be eliminated from the mind. Typical thoughts involve images of graphic violence to self or others, contamination,
or perverse sexual behavior that the patient would not carry out but nevertheless obsessively fantasizes about. To control the obsessive thoughts, the individual may engage in compulsive behavior or rituals, such as excessive washing, repetitive checking, or counting. When the obsessions and compulsions occupy a great deal of time, the patient may become significantly disabled and seek psychiatric attention. The sense of helplessness and the impairment can lead to the development of depression, which also leads the patient to seek help.

**Somatoform Disorders**

Many patients have particular complaints or symptoms for which no medical explanation can be identified. When a physical cause has been clearly eliminated, and the complaint is not delusional or occurring in the context of a depression or anxiety disorder, somatoform disorders may be considered. When the complaint involves a loss of function, usually in the neurologic system (e.g., paralysis, blindness, or numbness) and psychological factors are deemed etiologic, a *conversion disorder* may be present. Conversion disorders are much more common in culturally and psychologically unsophisticated persons. This diagnosis should be made with extreme caution, if at all, in the emergency department, because studies indicate that many patients diagnosed with conversion disorder eventually develop signs of a physical disorder explaining the symptom. For further discussion, see Chap. 293.

Some patients have a wide variety of complaints and long complicated histories of medical problems that have no apparent medical cause. Such individuals may have *somatization disorder*, a disorder beginning in the teens and twenties, usually in women, and leading to considerable unnecessary diagnostic and surgical intervention. The prototypical patient is a middle-aged woman who describes a "positive review of systems" in a dramatic and confusing way. As with conversion disorder, a firm diagnosis of somatization disorder should not be made on the basis of one visit to the emergency department, but the identification of somatizing behavior is useful for future reference, because patients frequently make repeated contacts with medical providers.

*Hypochondriasis* may be diagnosed when the patient is preoccupied with fears of serious illness, fears that persist despite appropriate medical evaluation and reassurance.

When pain is the sole complaint and the intensity and secondary disability are unexplained by a known physical ailment, a diagnosis of *pain disorder* may be considered.

**Dissociative Disorders**

The dissociative disorders comprise a group of uncommon and poorly understood conditions in which the central feature is a sudden alteration in the normal integration of identity and consciousness. The dissociation often occurs under severe stress and may or may not be recurrent, although it is rarely permanent. The forms of dissociative state relevant to emergency practice are *psychogenic amnesia*, a temporary loss of memory for important personal details that is not due to an organic cause, and *psychogenic fugue*, in which a similar loss of memory and assumption of new identity are accompanied by travel away from home. Dissociative disorders are difficult to distinguish from *malingering*, in which the individual in pursuit of a clear goal, such as avoiding incarceration or military duty, may consciously feign amnesia. As always, organic causes, such as drug intoxication, or loss of memory, such as that resulting from transient global amnesia, must be ruled out.

Other conditions in this category include *multiple personality disorder* and *depersonalization disorder*.

**PERSONALITY (AXIS II) DISORDERS**

*Personality* refers to an enduring pattern of perceiving, relating to, and reacting to one's environment and interpersonal relationships. When a pattern of behavior is lifelong, not limited to periods of illness, and causes significant impairment in social and occupational functioning or considerable distress, a *personality disorder* is present. Some individuals are painfully aware of the consequences of their behavior but are unable to alter these fundamental ways of dealing with their world. Most patients who are seen clinically in medical and psychiatric settings who are diagnosed with a personality disorder lack a clear awareness of how their behavior alienates others or aggravates their own stress. Even when such insight is possible, actual personality change is unlikely.

The patient presenting with a personality disorder often may be recognized by the characteristic effect the interaction has on the physician and medical staff. Antisocial patients, for instance, are disliked immediately; they seem to be in control.
of their behavior, unlike psychotic or depressed patients, but nonetheless have repeatedly engaged in maladaptive behavior. The patient may be seen as using the emergency department for some vague, or obvious, goal. These disorders are the most common secondary diagnosis in the malingering.

The emergency physician seldom needs to decide which of the personality disorders relates appropriately to the patient. General categories of personality disorders are grouped in Table 288-3. When such features are present and seem to be interfering with some important aspect of the patient's life, personality disorder can be suspected. The presenting complaint should be evaluated appropriately, because patients with well-established character disorders still develop bona fide medical illnesses.

Table 288-3 Behavioral Characteristics That Suggest Various Clusters of Personality Disorders

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Personality Disorder Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eccentric, odd, isolated, withdrawn, suspicious, inhibited, no friends, overly sensitive</td>
<td>Paranoid, schizoid, schizotypal</td>
</tr>
<tr>
<td>Emotional, dramatic, angry, seductive, impulsive, erratic</td>
<td>Antisocial, histrionic, borderline, narcissistic</td>
</tr>
<tr>
<td>Anxious, fearful, nervous, cautious</td>
<td>Dependent, avoidant, obsessive-compulsive</td>
</tr>
</tbody>
</table>


The personality disorder that constitutes a disproportionate share of emergency visits is antisocial personality disorder. The patient shows a continuous pattern of maladaptive behavior displaying disregard for the rights of others in a variety of ways: criminal behavior, fighting, lying, abuse and neglect of dependents and spouses, financial irresponsibility, recklessness, and inability to sustain enduring attachments to others.

The sociopathic behavior begins before the age of 15 years, but the diagnosis may not be made until after the age of 18 years. Sociopathy is much more frequent in males, in lower socioeconomic classes, and in relatives of alcoholics and sociopaths. Alcohol and drug abuse, imprisonment, multiple divorces, traumatic injury, accidental and violent deaths, and poor medical compliance are common complications.

Management of the antisocial patient in the emergency department is often frustrating, but anger toward the patient can be minimized and the interaction hastened along by setting firm limits on behavior, focusing on the chief complaint, and providing the patient with necessary information about the medical problem at hand. No effective psychiatric intervention can be forced on the patient, although certain patients may benefit from substance abuse treatment, psychotherapy, or organized religion when motivated to make changes in their lives. Fortunately, the most violent and disruptive behavior of many antisocials seems to "burn out" in the late twenties or after, although their adjustment to society often continues to be marginal.

REFERENCES


