YOUTHS *in the* PSYCHIATRIC EMERGENCY SERVICE

Text by Dr Thanita Pilunthanakul

It was 4.30 am and I was sluggishly clicking through the emergency room (ER) waiting list. My lukewarm coffee had lost its aroma. Normally the crowd dies down around 2 am on night shift, but a new case popped up – a teenage girl. There had been an increasing number of child and adolescent cases in the ER this past month.

As a first-year medical officer in my third month of a psychiatric ER posting, my duty was to see the patient, then finalise the management plan with the child and adolescent consultant on duty. This also involves discussion with their parents for a corroborative account.

The teenage patient

The 15-year-old girl who turned up was not accompanied by family, but by police. She was sitting alone on the 17th-floor window ledge of her home. Neighbours noticed her dangling legs from across the building and called the police to rescue her. Like other teenagers that end up in the ER, she revealed that she had gotten into a verbal dispute with her parents that night, had ongoing issues with her friends and boyfriend and was stressed about crippling high expectations during recent examinations.

Before tonight, she described feeling as if a grey cloud floated over her head daily and that she did not deserve her loved ones. She felt body aches and tiredness every day, even on weekends when she slept in until late in the afternoon. She had not been able to wake up in time for nor stay awake in school. She felt her dream of becoming a scholarship student crumble when her grades dropped that semester. She no longer enjoyed her favourite Korean drama on Netflix and avoided going out for waffles and ice cream with her friends.

Later, we found out that though she did not share her troubles with her parents, they knew something was wrong – she frequently missed family meals, became irritated over minor matters and was often tearful unprovoked. Her "hellos" and "goodbyes" became curt, and her interactions became cold. They said it was as if the light in her had dampened.

Case management in the ER

To determine whether suicidal patients need urgent admission, we ask about current and past suicide attempts – the triggers, methods and last acts such as a written goodbye note. We explore their intentions behind the acts of deliberate self-harm, including overdosing on medications, cutting themselves and banging their heads against the wall as examples. If they do not want inpatient admission and prefer to be discharged, we will make sure that there is a safety plan in place with a family or friend (who is old enough) to watch over them in the next few days to one week (depending on our assessment) while they rest at home.

Some other common complaints we see in children and adolescents in the ER are panic attacks and hallucinations.

Panic attacks are usually manifested from emotional stress and involve a range of physical symptoms that reach peak intensity before dying down. These symptoms can be sudden and functionally impairing, often scaring the patient as they feel like they are about to die. An analogy would be feeling palpitations and nervousness anticipating a rollercoaster drop that evolves into a sustained chest-about-to-burst and stomach-clenching sensation during the drop. This uncomfortable experience can last up to 30 minutes. Panic attacks are also sometimes mistaken for real heart attacks or strokes and make such individuals rush to the emergency departments of general hospitals.

Hallucinations in children and adolescents can vary in nature and origin. The hallucinations can sometimes be imaginary friends

they never let go of, influenced by violent cartoons, manifested from unaddressed spirit-crushing stress, simply due to lack of sleep, or on rarer occasions, an indication of early psychosis. The last will need urgent admission and monitoring. Hallucinations are akin to having the perceptual experience where no real stimuli exists. The most common hallucinations are auditory in nature. In adolescents, we should be mindful that hallucinations occur frequently in mood disorders and may also be normal phenomena associated with sleep (hypnogogic and hypnopompic hallucinations).

Resolving the case

As for the young girl I saw at 4.30 am, she reported active suicidal thoughts in the consultation room, so we admitted her to the observation ward overnight. Her friends and parents came to see her in the morning. By the time she was reassessed, she was remorseful of her actions and regretted making the people around her worry. She felt touched by her friends visiting her despite the differences between them in the past. She showed eagerness to improve and sincerity in seeking help if she reached such an overwhelming state again. Antidepressants likely would have been prescribed to adults presenting with similar depressive symptoms that hinder their daily functioning; however, the black box warning of a temporary increase in suicidal ideation makes it less attractive for parents to give to their child or teenager. Understandably, her parents wanted to try lifestyle changes and close monitoring before considering medications at the next clinic review.

On discharge, she and her family were provided with a safety plan established by the medical social worker, a referral to a community youth support programme and an early appointment with a child and adolescent psychiatrist. A case manager would check in with them until their scheduled appointment.

A memo was also provided to the school counsellor for daily monitoring for the next few weeks, with an additional request to support her with school material she missed/felt she was not doing well in. Though we have short encounters with patients in the ER, we try our best to de-escalate the immediate risk and provide as much help as we can when they are discharged. I didn't care that my coffee lost its aroma or that I didn't get to sleep on shift – what mattered most was that she was safe. ◆

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What Can Doctors Do for Adolescent Patients?

- Check in with them regularly for any stress they may have with friends/relationships, family or school.
- Have a safety plan in place with them as well as yourself – knowing the helpline number (the Samaritans of Singapore can be contacted at 1800 221 4444) to call and where to go if they experience extreme distress.
- Engage a school counsellor to monitor their mood and be their soundboard when you aren't able to.
- Keep them socially active – exercise and encourage experiences that will improve their connectedness to friends, family and the community.