# PRACTICE AND MANAGEMENT OF PSYCHIATRIC EMERGENCY CARE

Edited by
Jacquelyne G. Gorton
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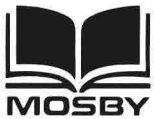


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# PRACTICE AND MANAGEMENT OF PSYCHIATRIC EMERGENCY CARE

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# Foreword

When crisis intervention theory was first introduced, it encountered much skepticism from psychiatrists because the theory did not fit the standard medical model of long-term, in-depth analysis of the client. Now skepticism has changed to acceptance. Today crisis intervention is recognized as an effective and viable therapy modality. It is no longer considered a "second-best" form of therapy or a "Band-Aid" but a very effective form of brief psychotherapy.

The acceptance of the concept of crisis intervention has contributed considerably to the growing importance of psychiatric emergency care. Public awareness of the broader concepts of mental health and the mental hospital deinstitutionalization movement have further contributed to the development of an increasing number of psychiatric emergency units.

The time has come for a comprehensive text dealing with the clinical components of psychiatric emergency care and crisis intervention as well as the administrative issues of unit management. Jacquelyne Gorton and Rebecca Partridge address this need with great skill and sensitivity. They have synthesized their extensive experience in psychiatric emergency care and administration, enabling them to compile a volume of practical, vital, up-to-date information. Recognizing that the most effective care is provided by the multidisciplinary team, they sought contributions from respected members of the fields of nursing, psychiatry, psychology, and social work. These contributions present the diverse perspectives inherent in this team approach.

Realizing that appropriate care can be provided only when the management of the unit allows it, the authors offer practical suggestions and guidelines for effective and efficient administration. The discussions of unit maintenance and functioning in today's complex institutions will prove invaluable to the novice as well as the experienced administrator or manager.

Gorton and Partridge have succeeded admirably in their intent to meet the needs of all professionals currently engaged in or wishing to enter the field of psychiatric emergency care or crisis intervention. This should be a valuable text to all professionals interested in modern methods of treatment of the mentally ill.

**Donna C. Aguilera, Ph.D., F.A.A.N.**

# Preface

The purpose of this book is to offer theoretical information and practical advice for professionals currently engaged in or wishing to enter the field of psychiatric emergency care or crisis intervention. Most books on psychiatric emergency care and crisis intervention focus on the clinical components of care and rarely discuss issues related to unit management. This book provides comprehensive discussions of clinical psychiatric emergency care and crisis intervention as well as administrative issues of unit management in one volume.

Part One, Practice of Psychiatric Emergency Care, describes the crisis intervention approach that provides part of the theoretical basis for psychiatric emergency care. The assessment process is reviewed in detail, and separate chapters are devoted to the most common psychiatric emergencies. Diagnostic criteria, treatment and intervention strategies, and disposition alternatives are presented for clients experiencing organic disorders, seizure disorders, schizophrenic disorders, affective disorders, borderline conditions, suicidal behavior, homicidal behavior, assaultive behavior, and substance abuse problems. Some unique needs of special clients in crisis are examined as they relate to children, victims of rape and battering, homosexuals, ethnic minorities, and the bereaved.

Part Two, Management of Psychiatric Emergency Care, offers practical suggestions and guidelines that are useful to the novice and the experienced staff leader, unit manager, or administrator. Unit organization and structure are analyzed with regard to theories and strategies for unit management, leadership, and use of the multidisciplinary team. Discussions of unit maintenance and functioning include the potential and actual impact of standards of care, legal rights and responsibilities of staff and clients, budgeteering, and interagency and intraagency collaboration.

Since psychiatric emergency care and crisis intervention involve clinicians representing a variety of disciplines, we have included among our contributing authors representatives from each of the following professions: nursing, psychiatry, psychology, and social work. The diverse perspectives presented by these different disciplines reflect the dynamic processes inherent in the use of the multidisciplinary team approach. Our intent was to prepare a book that would meet the needs of a wide audience, and we anticipate that this volume will be of interest to graduate students, faculty, and clinicians in many health care professions. In particular, those working in psychiatric emergency units, crisis intervention clinics, and medical emergency units will find that this book specifically addresses clinical and unit management issues they regularly confront.

Selecting the terminology that would provide structure and clarity for this volume was a difficult task. Particularly in the health care field, "it is well known that professional jargon helps to unite a group and to set it apart from strangers."* We have attempted to use terms that are understood by and are acceptable to most health care professionals. There were three issues of termi-

*From Blau, P.: Dynamics of bureaucracy, Chicago, 1963, University of Chicago Press, p. 106.

nology that required editorial fiat on our part, and we would like to take this opportunity to explain our decisions. The three issues concerning terminology were (1) the use of the phrases *psychiatric emergency care* and *crisis intervention,* (2) reference to individuals who seek or receive care as *clients* or *patients,* and (3) the use of gender-neutral pronouns or gender-specific pronouns.

First, the issue of psychiatric emergency care versus crisis intervention. Obviously, the term *psychiatric emergency care* suggests an illness-oriented medical model approach, whereas *crisis intervention* connotes a mental health approach to situational problems. The popular distinction is that *crises* refer to situations in which relatively healthy individuals are subjected to great environmental stress and that *psychiatric emergencies* are those in which the individuals have psychopathological conditions and in which socio-environmental factors are less important precipitants.

The crisis intervention approach originally developed as a lay effort to help people with special problems (youths with drug problems, rape victims, suicidal people) who were not being adequately dealt with by the professional community. Today crisis units remain community based but usually employ health care professionals to serve as clinicians. Psychiatric emergency units are usually affiliated with hospitals and urban medical centers but often solicit and maintain considerable community involvement.

Although the impetus and development of crisis units and psychiatric emergency units differed in their original perspectives and settings, in recent years the two approaches have begun to converge. No longer are the distinctions obvious. Some of the crisis intervention literature continues to assume a target population composed of relatively normal healthy individuals undergoing extreme stress; in actual practice crisis clinics often serve clients with marked preexisting psychopathological conditions. And conversely, persons without these conditions often seek help with situational crises in psychiatric emergency units.

We have chosen to use the term *psychiatric emergency care* as a generic one encompassing crisis intervention, and to this end we have included chapters that deal with helping people in crisis with problems of rape, battering, bereavement, homosexuality, and ethnic minority status. We define a psychiatric emergency as a crisis situation precipitated by an intrapsychic, intrapersonal, biological, or environmental change that potentially impairs the general functioning of an individual.

We recognize that the label of *psychiatric emergency* may not be preferred by all, but we found *crisis intervention* too limiting because of its emphasis on environmental precipitants and the narrow scope of the assessment process implied by a problem-solving approach. The primary shortcoming of the term *psychiatric emergency* is the social stigma it has traditionally carried. The phrase *psychiatric patient* has been particularly stigmatizing, which leads us to the issue of referring to recipients of care as *patients* or *clients.*

In keeping with the view that health care consumers have rights, responsibilities, and a participative role, we refer to individuals seeking or receiving care as *clients. Patient* has been the traditional term in medicine, but in recent years the nursing and social service literature commonly has used the term *client,* especially in reference to community-based health services. *Patient* conveys a proprietary attitude by the provider and generally assumes that the consumer is passive and relinquishes responsibility, that is, the role of the patient is subordinate to that of the care provider. We prefer the use of the term *client,* which suggests a reciprocal relationship between consumer and provider.

And finally, the issue of gender-neutral versus gender-specific pronouns should be considered. Many authors and publishing companies (including The C.V. Mosby Company) have adopted policies regarding the avoidance of the sexist connotations implied by the generic use of masculine pronouns. We wholeheartedly agree with this position. Using feminine pronouns promotes reverse discrimination and is therefore no remedy. So we have used the gender-neutral plural pronouns wherever possible. Writing in the plural form may seem awkward at first, but the process of changing old habits is always a bit uncomfortable. Strict grammarians may occa-

sionally object to the slight deviations from traditional literary customs that using the plural forms necessitates, but we believe that language is dynamic and its use should reflect the emergence of the gender-neutral values of our culture.

We wish to express gratitude to the many individuals who have directly or indirectly contributed to this book. To each of the contributing authors we owe a special thanks. Our appreciation also goes to the staff at Mosby: Mike Riley, in the early stages of the book, and more recently, Alison Miller and Suzi Epstein, who have been very helpful in guiding us through the later stages of the production of this volume. We also wish to thank Audrey Fitzgerald for ably handling our correspondence and typing many drafts and much of the final manuscript.

**Jacquelyne G. Gorton**
**Rebecca Partridge**

# Contents

# PART ONE

# Practice of psychiatric emergency care

**PART ONE OF THIS BOOK** deals with clinical issues of the practice of psychiatric emergency care and consists of three sections. Section A deals with the theoretical basis of psychiatric emergency care and includes two chapters on crisis intervention and assessment. Section B includes nine chapters devoted to the assessment and treatment of the most common psychiatric emergencies: organic disorders, seizure disorders, schizophrenic disorders, affective disorders, borderline conditions, suicidal behavior, homicidal behavior, assaultive behavior, and substance abuse problems. Section C consists of five chapters dealing with some of the unique needs of special clients: children, women who are raped or battered, homosexuals, ethnic minorities, and the bereaved.

SECTION A

# The theoretical basis of psychiatric emergency care

There are two chapters in this initial section. The first chapter, Crisis Intervention, discusses the utilization of crisis theory in psychiatric emergency care. The composition and characteristics of the crisis state are discussed in detail, and very practical guidelines and techniques of intervention are suggested. Step-by-step advice is offered to the clinician on strategies for developing a therapeutic alliance, gathering information, and problem solving. The authors point out some common pitfalls that should be avoided.

Chapter 1 offers very practical and clinically relevant information. The reader is reminded that although a theoretical distinction is sometimes made between crisis intervention and psychiatric emergency care, in reality clinicians in both settings are faced with the task of helping clients with and without psychopathology.

Chapter 2, The Assessment Process, offers clinicians a practical approach to the complex task of assessment. The authors remind the reader that it is important to guard against the common tendency to dismiss threats of violence or self-destructive behavior as idle talk. Because one of the paramount concerns in assessment is the determination of the potential for dangerousness, several other chapters are devoted specifically to assaultive, suicidal, and homicidal behavior. The assessment process is reviewed sequentially and includes realistic clinical strategies for assessing a client's appearance, psychomotor activity, affect, speech, thought processes, thought content, perception, consciousness, intellectual functioning, and availability of resources. The chapter concludes with a discussion of treatment planning.

CHAPTER 1

# Crisis intervention

*Mark W. Rhine, M.D.*
*Michael P. Weissberg, M.D.*

*Refuse to directly treat the presenting problem. Offer some rationale, such as the idea that symptoms have 'roots,' to avoid treating the problem the patient is paying his money to recover from. In this way the odds increase that the patient will not recover, and future generations of therapists can remain ignorant of the specific skills needed to get people over their problems* (Haley, J., The art of being a failure as a therapist, Am. J. Orthopsychiatry **39**:691, 1969).

No aspect of mental health care is more demanding than the psychiatric emergency. Clinicians are required to deal with severely disturbed clients* whom they have never seen before and to take action with a minimum amount of information under severe time constraints, never knowing who may come in the door next. Anxiety levels are high in the client and the clinician. Additionally, the clinician may have to deal with friends, family, and health care providers as well as a variety of community resources. There is a common misbelief that because crisis therapy is shorter than long-term therapy, it must therefore be easier. Nothing is further from the truth. Clinicians must be able to work fast; they cannot be passive listeners but must be active in gathering information, knowing what to look for and what is irrelevant. They must be able to formulate hypotheses quickly, sorting out potential medical problems from psychological problems, and then take steps to help clients solve their problems,

*NOTE: Although the authors of Chapters 1 and 2 prefer the use of the word *patient*, the word *client* is being used in keeping with the terminology of the other chapters.

often with a minimum of training and support.

In the past it has been customary to put the most inexperienced personnel into the psychiatric emergency clinic and then to provide them with minimal supervision. This may have been a reflection of the medical custom of putting the junior intern into the emergency room, of viewing emergency care as a service obligation, and of the anxiety of the more experienced staff who wished to avoid working in this setting. This practice was curious, because the psychiatric emergency clinic represents the chief link of mental health with the public and other health systems. This is where the tone is set for treatment. In fact, treatment can begin and end here. Fortunately this tradition of understaffing emergency services is changing, and now the best psychiatric emergency and crisis services use experienced clinicians. The more experienced staff bring the personality characteristics best suited to crisis work: confidence, ability to work independently yet to recognize when they need help and to seek it out, resourcefulness, activity, ability to function in an unstructured situation under stress, assertiveness, flexibility, and a healthy sense of humor. There has been a move away from the mere "disposition" and triage of clients to active treatment. The value of the emergency clinic for training has become appreciated, and it has been recognized that with proper support the emergency clinic, though stressful, can provide a magnificent learning experience for all health professionals (Zimet and Weissberg, 1979). Crisis theory has provided the framework for this shift in psychiatric care.

## WHAT IS A CRISIS?

Among the important psychological needs of every human being are the needs to feel loved, worthy, and appreciated, to feel strong and secure, and to feel that one is good, not bad. Life is a succession of crises, a series of problems that must be overcome lest they threaten these important psychological needs. If these crises are mastered, then self-esteem is bolstered, whereas failure leads to self-doubt. Sometimes the stresses of life seem overwhelming: the woman who has been raped at knife point, the father of five who has been laid off his job, the couple whose child has developed a life-threatening illness, or the soldier entering combat are all experiencing threats to their psychological homeostasis. Often overlooked, however, are the stresses that are involved in less dramatic, more joyful situations such as marriage, pregnancy and birth, promotion, or a move to a new city. For some, a crisis may be as small as a broken dishwasher or television, especially if the latter is used to occupy the children.

Crises occur to everyone, no matter what their previous level of psychological functioning. As important as the crisis event itself is the nature of the person who is experiencing that event; a stress that may be readily handled in a better-adjusted individual may be overwhelming to someone who is only marginally compensated. Incidentally, some of the crisis intervention literature assumes the clients are relatively normal and healthy individuals undergoing extreme stress, whereas in actual practice crisis clinics tend to receive individuals with marked preexisting psychopathology, making the therapeutic task more difficult and the goals more limited than some of the literature may imply.

When one is unable to handle a particular stress, a variety of unpleasant symptoms develop which characterize the crisis state. Gerald Caplan (1961), a pioneer in crisis intervention, described crisis as a state that occurs when one's usual ways of coping are inadequate to deal with the stress. A period of disorganization and upset ensues during which abortive attempts at resolution may be made until a new equilibrium is reached. The solutions to crises may or may not be in the best interest of the individual or the environment. The following vignette illustrates some of these principles:

**Case vignette #1**

A couple who had recently celebrated their fortieth anniversary consulted a divorce lawyer and were referred to a crisis clinic for counseling. At the interview their frustration was obvious as they hurled complaints and accusations at one another. They were at a loss to explain why things had gone so sour, because they agreed they

had long enjoyed an "ideal marriage." Insistent questioning by the clinician clarified that their troubles had begun only 6 months earlier when the husband had retired from his railroad job. No longer did he travel 5 days a week but spent all his time at home in their small trailer, dirtying the ashtrays and, as the wife put it, driving her "crazy." The clinician recognized that the couple had established an equilibrium over the years which had been disrupted because the retirement had forced them into an unaccustomed closeness. Therapy was directed toward reestablishing the old equilibrium, with the husband being encouraged to take up pursuits that would get him out of the home for most of the day. At follow-up a year later the couple was again enjoying their marriage, and the husband was devoting his time to a model railroad club and to fishing and hunting.

This couple had functioned comfortably for years until they encountered a stress that they were unable to master in their usual manner. The wife took pride in having everything in order and maintained a meticulous household, a feat that she achieved by virtue of having her husband out of the home for most of the week. Now he dirtied the ashtrays and strewed the newspapers around the living room, and the wife's sense of orderliness and mastery over her environment was upset. A period of disorganization ensued in which the couple, not really understanding the source of their intense feelings, yelled and screamed at one another in futile attempts to solve their problems. Finally they went to a divorce lawyer, another unsuccessful attempt at resolution that, in view of their 40 years of marriage, could be considered a maladaptive one. Ultimately, through therapy, they were helped to utilize their usual methods of coping, namely, to keep distance from one another. A new and more adaptive equilibrium was reached.

Interest in crisis and in crisis intervention began to flourish in the 1940s. In 1943 Dr. Erich Lindemann had the opportunity to work with the survivors of the tragic Coconut Grove nightclub fire (Lindemann, 1944). As he worked with these people, he discovered that some were more able than others to deal with their grief. This led him to formulate the concept of emotional crisis and to develop an interest in studying what enables some individuals to successfully master a stress while others succumb and develop chronic difficulties.

At the same time the military was interested in the rehabilitation of troops with combat neurosis. During World War II and the Korean War the military developed for such casualties the concept of immediate treatment close to the battlefield so as to return the soldier to his unit and prevent chronicity. The value of abreaction, support, and reassurance in the rapid resolution of these traumatic neuroses was recognized. When these military psychiatrists returned to civilian life, they continued their interest in the short-term treatment of clients.

## CHARACTERISTICS OF THE CRISIS STATE

When individuals are unable to solve some significant problem in their lives, they begin to experience tension and anxiety. They can feel helpless and unable to take action on their own, which may lead to depression. Overall functioning decreases. They develop a variety of somatic symptoms, including various aches and pains, dizziness, easy fatigability, and difficulty sleeping and eating. They may experience intense feelings, perceptual changes, sometimes even hallucinations, which make them feel that they are "going crazy." There is a sense of urgency and immediacy, which may lead the individual to contact the clinic at all hours. There may be a frantic search for new solutions. There is an impairment of impulse control, which may be further compromised if the individual turns to drugs or alcohol to help alleviate the intense feelings. Behavior may appear childlike and regressed. They are frequently isolated from their usual sources of help. These feelings may be infectious, and friends, relatives, even therapists, may become caught up in the panic.

It is relatively easy to recognize clients in crisis when they enter the clinic with characteristic symptoms of anxiety or depression and