A psychiatric problem becomes an emergency when a person's anxiety has increased to the point that immediate aid is requested. The phrase “psychiatric emergency” does not define a single clinical situation, because many different types of patients may be interviewed under emergency conditions. A person may experience anxiety himself and seek help, or he may elicit anxiety in a partner who labels the situation an emergency and seeks assistance for the patient.

Previous chapters have emphasized the artificiality of boundaries between the initial diagnostic and later treatment interviews. This is particularly true in emergency situations in which therapy begins with the patient’s awareness of the availability of treatment.

In all emergency situations—psychiatric, civil, military, and others—people do not know what to do. The clinician’s most important functions are to project the feeling that he knows what he can do and to assist the patient and those who accompany him in developing a clear notion of what they can do. These role definitions convert the emergency into a problem and allow the individuals involved to employ their own adaptive skills in mobilizing the resources of their environment. The patient is not always an ally in this endeavor. If he is convinced that he is helpless and unable to cope with his problems, he may actually conceal his own resources in an attempt to make the clinician take care of him. After the emergency has subsided, it is not uncommon to find that the patient failed to mention a close relative, a supply of funds, or a contingency plan that would have been invoked if the clinician had failed him.

The sense of urgency that permeates every emergency is analogous to pathological anxiety in other situations: It impairs effective adaptive
behavior and efficient utilization of resources. The clinician’s task is to avoid being overwhelmed by this urgency, thereby reducing its impact upon his patient. His most important tool is the aura of competent self-assurance that he maintains throughout the interview. The clinician should convey the feeling that he is interested and is capable of assisting the patient with his problem. This professional approach, together with the early definition of roles, reduces the disorganizing effects of the crisis and establishes a firm basis for treatment.

Psychiatric emergencies can best be understood by first classifying them according to three basic categories of presenting symptoms: intrapsychic, somatic, and interpersonal. A classification based on these three modes of presentation is initially more useful than the traditional diagnostic categories, since emergencies frequently require decisions and action before a diagnostic evaluation can be completed.

A central question in the psychodynamic evaluation of any crisis is Why did it occur now? or What has disrupted the patient’s previous functioning? An understanding of the stress that altered the patient’s psychological equilibrium and led to the presenting symptom is critical in managing the emergency. The precipitating stress may activate psychological conflicts directly, or it may operate at a physiological level, impairing the autonomous and executive functions of the ego. In either case, the individual will respond with characteristic patterns determined by his basic personality structure. Some individuals are crisis prone and frequently respond to stress with an emergency syndrome; others bind their anxiety more effectively and rarely experience crises.

The patient arrives not only with a presenting symptom and a precipitating stress but also with certain expectations concerning the treatment he will receive. These three factors determine the clinician’s approach to the emergency interview.

**Intrapsychic Problems**

The most common intrapsychic problems are depression, anxiety, and confusion.

**Depression**

The patient’s depression may stimulate anxiety either in himself or in a friend or loved one. The psychodynamics of depression have been discussed in Chapter 7, “The Depressed Patient.” It commonly results from the real or imagined loss of love and the lowering of self-confidence and self-esteem. The emergency aspects of depression frequently develop from the possibility of suicide. This danger must be explored
An acute grief reaction, the normal response to the death of a loved one, may present a picture that is quite similar to depression. The sadness and pain of grief, together with crying spells and insomnia, may bring individuals to seek emergency psychiatric help. The grief-stricken patient should be supported and given an opportunity to vent his feelings. He should be encouraged to accept help from others, to take medication if he has difficulty sleeping, and to rely upon friends and loved ones. Above all, the interviewer should make it clear that the patient’s response is normal and healthy, that it will end in a short time, and that the patient will then be able to resume his normal role. Regressive desires and dependent needs should be supported and gratified during the acute stress, and the patient should be helped to work through the grieving process by being allowed to discuss his loss and express his sadness.

Anxiety

Anxiety, the emotional response to danger, is a cardinal feature of any psychiatric emergency. When it occurs in the patient, it may be the major presenting complaint. In emergency situations, this usually occurs when 1) an event in the patient’s current life reawakens fears that have lain dormant in his unconscious or 2) the patient feels that his ability to control sexual or aggressive impulses is threatened, and he fears the consequences. He is rarely aware of the specific fear that has been aroused; instead, the patient feels an overwhelming sense of dread or panic. A common clinical example is the adolescent male who leaves home for college and is asked to share a room with another male for the first time in his life. Homosexual feelings become increasingly difficult to repress, and when he is under the influence of alcohol, his defenses are further weakened, and he begins to panic. Another typical emergency-department problem is the woman who becomes increasingly resentful of the burden of caring for her newborn infant. She becomes terrified that she will accidentally injure the baby, stick him with a pin, or drown him in the bath. Some patients will become aware of the feared impulses, but more often these impulses are denied, as in the postpartum woman, or projected, as in the male college student who responds to unconscious homosexual feelings by fearing that his roommate will attack him. In each of these situations, the balance between the patient’s
drives and his ego defenses has been disturbed, resulting in an acute increase in anxiety, which may be accompanied by new defenses.

Anxiety over the possible loss of control may disturb either the patient or significant figures in his environment, depending upon 1) whether the impulses involved are primarily transgressions against the patient’s inner standards or against social mores and 2) whether it is the patient himself or others who feel that it is likely he will act upon them. Both of the examples given earlier are of patients who fear that they will act on impulses that they themselves consider repugnant. The parents of the adolescent female who bring her to the hospital because she has threatened to run away with her boyfriend and the woman who brings her alcoholic husband because she fears that he may injure their children in one of his drunken rages are examples of emerging impulses that disturb the patient’s parents or partner rather than the patient himself.

Surgical procedures and other physical threats to the body are a common precipitant of anxiety because they symbolically reactivate primitive fears of bodily damage. Academic examinations may represent more abstract symbols of the same type of danger. The therapist must understand the relationship of the anxiety to the unconscious imagined danger, since the patient will focus on the realistic threat to his safety, although simple reassurances directed to this end will have little effect.

Anxiety can lead to neurotic symptom formation. Patients may present with acute panic attacks, social phobia, conversion reactions, or hyperventilation syndrome. These patients usually request help themselves, although others may be involved before they reach the clinician. The psychotic individual may respond to anxiety by fears of ego disintegration and gross disorganization. This patient is often unable to seek aid himself, and he may provoke others to define the situation as a psychiatric emergency.

Confusion

The confused patient may not know where he is or how he got there. He has difficulty communicating intelligibly, and his thought processes are fragmented and disorganized. He feels that his senses are unreliable and may misinterpret sights and sounds in strange ways. Anxiety and depression usually result from stresses that threaten the psychological defenses of the ego. They indicate difficulty in resolving conflicts, controlling impulses, and maintaining dependency gratification. Confusion, on the other hand, relates to those areas of ego functioning that are
usually immune from psychological conflicts. These autonomous or conflict-free functions of the ego include memory, perception, and learning. They are impaired in brain syndromes and some acute functional psychoses. The patient is confused and bewildered. He is either frightened or so helpless that others are concerned about him, and often he passes through these two stages sequentially. For a more complete discussion see Chapter 15, “The Cognitively Impaired Patient.”

The acute precipitant of the emergency may be an event that did not directly impair autonomous ego functioning but that instead placed new or increased demands upon an already damaged ego. The move to a new apartment, with the many adaptive tasks it entails, can precipitate an acute psychiatric crisis in an elderly and slightly brain-damaged person. He is unable to find the bathroom, forgets the location of the telephone, misses his familiar neighbors, and becomes agitated and frightened. His poor memory and impaired spatial thinking were adequate for a familiar environment but are not so for a new one. The interviewer must seek information pertaining to practical aspects of the patient’s current life in order to evaluate what skills he retains and what type of assistance would allow him to utilize his remaining abilities most effectively. It may be quite unimportant whether an elderly man living alone knows the month and year or the name of the president, but it is crucial whether he remembers to turn off the gas or is able to find the grocery store.

This patient will usually be brought to the clinician by another person who is anxious to prevent the patient from acting irrationally or harming himself. Although the psychopathology is intrapsychic, the definition of the emergency and the plans for treatment involve interpersonal dynamics. A common error is to diagnose the underlying illness accurately (usually dementia) and to make appropriate recommendations, only to have the treatment plan fail because the needs and expectations of the emergency partner have been ignored.

**Somatic Problems**

Somatic symptoms that are based on psychological causes are easier to treat when the patient is aware of this relationship, or at least is aware of the existence of concomitant psychological problems. Unfortunately, in emergency situations this is seldom the case. The interviewer may quickly determine that the somatic complaint is only a symptomatic manifestation of a panic attack and thus focus the interview on the patient’s emotional conflicts. However, at the end of what he thought was a successful interview, the patient may surprise him by asking, “But
what about the pain in my chest?" Such experiences demonstrate that somatic symptoms must be treated as seriously and explored as thoroughly as any other psychological symptoms. Generally, the patient's medical examination and diagnostic studies have already indicated that he has not had a somatic crisis by the time the psychiatrist is summoned.

It is the patient whose symptoms include the somatic manifestations of anxiety or depression who is most likely to acknowledge the existence of emotional problems. Other psychiatric patients who complain of somatic problems will resist the suggestion of psychological conflict. Hypochondriasis, somatic delusions, conversion reactions, histrionic elaborations of physical symptoms, and psychosomatic reactions are usually not perceived by the patient himself as stemming from psychological conflicts. They are only seen as psychiatric emergencies when some other person feels that the problem is urgent and defines it as psychiatric (see Chapter 4, “The Histrionic Patient”; Chapter 13, “The Psychotic Patient”; and Chapter 14, “The Psychosomatic Patient”).

Somatic symptoms are often associated with extensive denial of emotional problems, and therefore the patient is resistant to seeing a psychiatrist. He fears that the clinician will tell him that the problem is in his mind and will ignore his serious physical symptom. This is further complicated if the referring individual or emergency partner is a physician or member of the health profession. Again, the symptom must be taken seriously, discussed in detail, and explored with the patient. It is not sufficient to ascertain from a hospital chart that the referring physician performed a complete physical examination. Usually, if such an examination reassures the patient, he is not referred to the psychiatrist. Furthermore, the precise details of the physical symptoms and their course are an important source of information about the psychological problems.

**Interpersonal Problems**

Interpersonal problems frequently involve one individual complaining about the behavior of another—the wife whose husband is alcoholic, the adolescent male who threatens to leave home, or the psychotically agitated man who is brought by the police. These situations are furthest removed from the traditional medical doctor-patient model and therefore are often difficult for beginning clinicians. It is important to search for appropriate psychodynamic points of intervention rather than to become a judge or referee. When the patient is psychotic this may be easier, but when the major pathology is a character disorder, it may take
some time to identify what the psychiatric problem is and which person (or persons) is best considered the patient.

A patient may be brought to the clinician by someone else because he is unable to recognize his own problems. The most obvious examples would be the very young or the very old—the child with uncontrolled aggressive outbursts whose parents frantically seek guidance or the elderly confused man brought by his family because he has been wandering aimlessly in the streets.

Whenever one person brings another—that is, whenever an emergency partner is involved—there is an interpersonal problem in the emergency situation, even if the basic psychopathology is intrapsychic.

Focus on the Present

Psychodynamic formulations rely heavily on developmental material, understanding the patient's conflicts by tracing them to his early experiences and his habitual modes of coping and relating. In an emergency, the patient's attention is directed to his current crisis, and time is usually limited. Therefore, it is necessary to focus on his means of coping with this stress, on his feelings and conflicts now. One must construct a formulation of the acute crisis rather than of the lifelong personality pattern. After the emergency has subsided, more developmental material can be obtained and a more complete psychodynamic explanation attempted. It is an error to concentrate on obtaining childhood historical material from a person with panic disorder—the focus of inquiry must always be on that which is immediately emotionally meaningful to the patient.

It is important to determine early in the interview which symptoms are acute and which have been present for a considerable time. More recent symptoms are more easily understood and provide clues to the problems and conflicts involved in converting a chronic problem or lifestyle into an acute crisis.

MANAGEMENT OF THE INTERVIEW

Emergencies seldom occur at convenient times or in convenient places. In spite of this, the traditional amenities of the interview should be maintained as far as possible. These include a quiet, comfortable place to sit and talk without a sense of hurry and a minimal number of interruptions.

The emergency interview invariably requires more time than the
beginner anticipates. He should realize that even the most experienced
clinician often devotes several hours to such problems. Otherwise, he
will become dissatisfied with his own performance and annoyed with
the patient. Furthermore, these patients are often unable to express ap-
preciation for the clinician’s efforts, and the clinician must obtain satis-
faction independent of the patient’s gratitude.

The exploration of the patient’s problems follows the major outlines
that have been discussed for nonemergency situations. A special char-
acteristic is the increased emphasis on the precipitating stress and on
the expectations of all persons concerned. In addition, the interviewer
must structure the interview to include areas that are crucial for imme-
diate therapeutic decisions.

**Determination of Who Will Be Interviewed and When**

If someone has accompanied the patient, the interviewer must decide
who will be taken into the consultation room first. The customary pro-
cedure is to begin an interview by speaking to the patient alone. There
are situations in which it is preferable to begin by jointly interviewing
both the patient and the person accompanying him. The decision to in-
clude the partner in the interview is made when both the patient and
the partner either verbally or nonverbally indicate their desire for a
joint interview. If the patient seems reluctant to leave the partner, then
both should be invited into the consultation room. This usually indi-
cates that the person accompanying the patient is emotionally involved
in the emergency and therefore must be considered in its management.
If the initial portion of the joint interview reveals that the companion
inhibits the patient’s communication, he can then be excused. If, on the
other hand, the patient leaves his partner in the waiting room and then
seems unable to describe his problem, the partner could be invited to
join the group.

Sometimes the person accompanying the patient will ask to speak
with the clinician first, alone. Usually, it is a mistake to allow this, be-
cause the patient may no longer perceive the clinician as his ally. The
interviewer can indicate that he is interested in what the companion has
to say, but that he first wants to see both the patient and companion
together. If the patient objects to this, the interviewer should see the
patient alone. If the companion insists on a private interview, the inter-
viewer should still see the patient first. Later in the interview, the pa-
tient usually agrees to a separate interview with his companion.

In a family or group crisis, there are actually multiple patients, and
the entire family may be interviewed and given emergency treatment.
One individual often becomes the focus of pathological interactions in a family, the scapegoat for family conflict. It is important to broaden this family's notion of who is in trouble, so that appropriate help may be made available to others.

The selection of the initial interview group is important, but it does not limit the clinician's freedom to change the membership of this group as the interview progresses. It is customary to ask the partner to wait outside after he has related his views of the problem. It may be useful to ask the various persons concerned to enter or leave the consultation room during the interview. This enables the clinician to obtain new information while mobilizing the interest and involvement of others. The establishment of direct relations with anxious family members is vital for the effectiveness of the treatment plan.

If the patient's companion is not included in the initial consultation, he should be asked to remain nearby in case the clinician should wish to speak to him later. This will also facilitate the patient's transportation home or, if necessary, to a hospital. The failure to make this request explicit may result in the clinician spending an hour or two attempting to reach the patient's husband, who has returned to his night job at a hard-to-locate factory, or otherwise struggling to make practical arrangements that the companion could have handled with little difficulty.

The Opening Phase

The more formal portion of the interview begins, as always, with a discussion of the issue of greatest concern to the patient—his chief complaint. While exploring this presenting problem, the clinician attempts to determine the following: 1) Who felt the need for help? 2) How was the problem identified as psychiatric? and 3) What was the precipitating stress? The first two questions are of crucial significance in assessing the patient's awareness that his problem is psychiatric; unless he has at least partially accepted this idea, it is unlikely that he will follow the interviewer's treatment plan.

Who Felt the Need for Help?

The need for help may have been felt by the patient, his family, friends, a social worker, a physician, or some other person. Mental health clinicians tend to be more accepting of self-referred patients, since they are more likely to have intrapsychic symptoms and to express emotional suffering in psychological terms. Beginners find them easier to engage psychotherapeutically and generally prefer them. Patients with somatic symptoms may be preferred by the general physician, but he becomes
discouraged if their symptoms have no organic basis and the patient's complaints are not relieved by his therapeutic efforts. Such patients often antagonize the referring clinician with their clinging dependence, and a psychiatric referral may be as much an attempt to dispose of a problem as to solve it. Patients with interpersonal complaints may be self-referred but are more often accompanied by a family member or referred by a social agency. Such patients may quickly sense that the clinician prefers patients who are self-referred and who seek psychotherapy. In order to please the clinician, the patient may alter his history. It then becomes necessary to explore the details of the search for help carefully in order to identify the actual referring source.

On occasion the clinician is called to see a patient when there is no valid indication for a psychiatric referral. For example, a surgeon requests a consultation after repairing the lacerations of a young man who was involved in a barroom brawl. The patient greets the clinician with protests that he was "only having a fight" and that he has no need to see a psychiatrist. If the clinician persists, asking if such incidents have occurred previously, the patient may answer, "Yes, so what?" The inexperienced clinician attempts to convince the patient that he must have emotional problems. However, the problem really concerns the interviewer, who is unsure of himself, reluctant to discharge the patient without completing a formal examination, and also reluctant to tell his surgical colleague that no consultation is indicated, because the patient has no awareness of a psychiatric problem and will not profit from the interview. This patient should be told, "You don't have to talk with me if you don't want to," and then should be given an opportunity to respond to this statement. The clinician's willingness to terminate the interview may stimulate the patient's desire to continue. If not, the therapist merely advises the patient of the availability of future psychiatric help if he changes his mind. For further discussion of this issue, see Chapter 17, "The Hospitalized Patient."

How Was the Problem Identified as Psychiatric?

The patient may be certain that his problem is psychiatric, he may tentatively consider the possibility, or he may be certain that it is not psychiatric. Often he has made some effort to obtain help prior to the interview, consulting a doctor, psychologist, minister, teacher, or social worker. He may have studied books on psychology or turned to prayer. His description of these attempts and their meaning to him will reveal his initial view of his problem and the way in which it came to be defined as psychiatric.
If the patient himself did not define the problem as psychiatric, he may have been referred to a psychiatrist for varying reasons. The referring physician may not have been able to fit the somatic complaints into a classical clinical syndrome, or he may have sensed underlying emotional problems. Occasionally, factors extraneous to the immediate emergency, such as past history of emotional illness, will determine the psychiatric referral. Understanding the reason for the referral and the patient's feeling about it will help in evaluating his attitude toward psychiatry and toward treatment.

A college student was referred to a psychiatrist by a family physician, who was also a close personal friend of his parents. The parents were devoutly religious and were greatly disturbed by their son's rejection of the church and its teaching. They were unable to see this as other than a symptom of illness and had enlisted the aid of the family doctor, a member of the same church, in reviving their son's faith. The young man was well aware of their feelings and saw the psychiatrist as just another agent of parental control. In fact, he was acutely troubled, but not over religion. His girlfriend had recently told him that she was pregnant, and he had become panic and depressed and had contemplated suicide. He felt unable to discuss this with his family, and the religious issue kept them at an emotional distance. He was able to tell the story only after the clinician had clarified his role, explaining that he had no preconceived idea of what the problem was or of how it could be resolved but was willing to discuss whatever the patient thought was disturbing him and see if he could help.

**What Was the Precipitating Stress?**

The "Why now?" question considers what has happened in the patient's life that has disrupted his previously operating system of defenses. The changes may be in the intrapsychic, physiological, interpersonal, or external environment. Such information is usually not volunteered, and often not even conscious, but it is essential that it be elicited and understood early in the initial interview.

A direct question of "What brought you here today?" is often met with "Things just got to be too much for me" or "I couldn't take it any more." The interviewer should pursue the matter further. He might ask, "How did you select this hospital?"; "Have you sought help from anyone else?"; or "Did something happen that was the last straw?"

A detailed description of the events of the past week and particularly the past 24 hours is often illuminating. Important events in the patient's life or changes in his role are considered. Anniversaries and holidays lead to emotional reactions based on their symbolic meaning—for example, depressions can regularly recur on the anniversary of
the loss of a loved one, and major holidays are common times for acute depressive reactions.

The clinician asks questions based on knowledge of the psychodynamics involved in specific symptom complexes. For example, if a depressed patient does not spontaneously report a loss, the interviewer inquires in this area. Similarly, if a patient is anxious about becoming psychotic, one can investigate recent experiences in which he feared losing control. One of us has had several emergency consultations with college students fearing impending psychosis without apparent cause. In response to specific inquiry, they revealed that the recent use of Ecstasy or marijuana had triggered their panic attacks. Such an episode will lead a patient to seek help, but his shame or fear of its significance may make him reluctant to reveal the crucial features of the history. He seeks reassurance but wants to avoid exposure. The clinician’s direct questions not only elicit the specific information but also reduce the patient’s anxiety by assuring him that the interviewer is familiar with this kind of problem and knows how to deal with it.

Specific Syndromes

In this chapter, only the emergency aspects of the specific syndromes are considered. For a discussion of these interviews in greater depth, the reader is referred to the appropriate chapters.

Depression and Suicide

When interviewing depressed patients in emergency situations, the most obvious area of structured inquiry is the exploration of suicidal risk. The patient should be asked about this directly. If the clinician is anxious about the topic or employs euphemisms such as “doing something to yourself,” the patient feels inhibited. The interviewer determines the patient’s thoughts and impulses, his attitude toward them, and the actions that have resulted. For example, if the clinician asks, “Have you had thoughts of suicide?” or “Have you wished to be dead?” the patient may reply, “Yes, I’ve felt that I should just end it all.” An appropriate response from the clinician would be, “Did you go so far as to plan how you would do it?” If the patient replies, “No, the thought was too upsetting,” and further inquiry reveals that he had not acted on impulses in the past, the risk would seem small. Another patient might reply to the initial question, “I had some thoughts of suicide last week, but not today.” The alert clinician inquires further, “Did you think of how you would do it?” The reply “I wondered about shooting myself;
in fact, I bought a gun and some ammunition a few days ago” would suggest a serious risk. If the clinician then asks, “Were you frightened?” and the patient replies, “Oh, I don’t know; I think everyone would be better off if I were dead,” immediate protective measures would be indicated.

Communications relating to suicidal impulses are frequently nonverbal or indirect. If a depressed patient arrives in the emergency department with his bag packed, he is asking to be hospitalized; if he has left the door of his home unlocked, spent his last few dollars on a good meal or a phone call to a distant friend, or is unconcerned about the time or place of the next visit, he may not expect to be alive very long. These messages indicate his ambivalence about living or dying. If someone cares enough about him, that person may succeed in tilting this ambivalence in the direction of life. Persons who have had a close relative or friend who committed suicide present a greater risk, as do patients with a personal history of previous attempts at suicide. If the patient has recently made a will or straightened out his financial affairs, he may plan to die. A belief in life after death or the fantasy of reunion with a dead person that he loved is another important piece of information. A variety of demographic, ethnic, and social factors have a demonstrable relation to suicide risk.

The interviewer inquires who would remain behind if the patient killed himself. He may save the patient’s life by convincing him that suicide would inflict great pain and suffering upon someone the patient loves. In the case of the suicidal patient who is physically ill, is elderly, and has no loved ones and no money, the clinician could say, “I can understand how badly you feel and how little you have to live for, but I have seen others who felt just as you do, who were then helped by treatment and recovered. You have nothing to lose by giving yourself a chance to get well.” Beginning clinicians often attempt to reassure the patient with statements such as, “Don’t worry—we won’t let you kill yourself.” This invites the patient to relinquish his own controls and to rely upon the clinician to arrest his self-destructive drive, and it is a promise that the clinician can rarely keep. The clinician may instead ask the suicidal patient if he would like to come into the hospital, where he may feel greater ability to resist his suicidal urge, until he is better. If hospitalization is not indicated, the clinician should let the patient know exactly where he can be reached, day or night, and whom the patient might call if the clinician is unavailable. Obviously, the person whom the patient can call must be told about the patient in advance.
Anxiety Attacks

The patient with acute panic attacks and hyperventilation syndrome may respond dramatically to direct explanation of his symptoms. This must, of course, be geared to his capacity to understand. An unsophisticated patient can be told, “When someone is frightened, he breathe very rapidly without knowing it. Fast breathing can cause many of your symptoms.” The patient might be further convinced by asking him to hyperventilate deliberately and then showing him how to control his symptoms by regulating his respiratory rate.

Clinical Situations

The Anxious Patient

Patients with overwhelming anxiety have already been told by others to relax. If this had been helpful, the patient would not be seeking further assistance. The clinician should avoid repeating such advice and should instead reassure the patient that his problem will at last be understood rather than simply suppressed.

Simple reassurance is of little value to the patient who is afraid of going crazy. Rather than telling him that he is not going crazy, the clinician finds out what the word “crazy” means to him. This reveals the significance of his fears and allows exploration of the sources of his anxiety. The clinician can inquire, “What do you mean by ‘crazy’?” or “What do you think it would be like to go crazy?” The patient can then be asked if he has ever seen anyone who was considered crazy, and what he observed at that time. Finally, the clinician finds out how the patient thinks people will respond to his craziness. Frequently the patient with an acute panic attack expresses fears concerning aggressive or sexual impulses. Once the specific fears are uncovered, the clinician’s reassurance will have much greater impact.

The Confused Patient

The clinician is sometimes asked to see a patient who at first appears to be completely out of contact with his surroundings. The scene is the emergency department of a general hospital; the patient is lying on a stretcher, difficult to arouse, and disheveled. He does not respond to questions or mumbles incoherently without looking at the examiner. The first impression suggests the aftermath of a major neurological catastrophe. Patients with confusional syndromes need a constant input of sensory stimuli and orienting information in order to maintain
their attention and contact with the outside world. The clinician should introduce himself and briefly assess the situation. He may then encourage the patient to sit up and, if possible, conduct the interview with the patient in a chair. The interviewer can initially structure the discussion by focusing the patient's attention on his immediate life situation. The response may be dramatic; on occasion it is possible to obtain a history and make a detailed evaluation of the patient's problem.

The Intoxicated Patient

One of the most difficult of the brain syndromes is seen in the alcoholic who is acutely intoxicated. This condition has many potential complications, some with a significant mortality. In addition to the medical complications of delirium tremens, hallucinosis, or pathological intoxication, the patient's emotional controls are weakened, and he is often depressed. Suicide or other impulsive behavior is a problem. The clinician must determine why the patient is drinking and whether this episode is different from previous ones. The interviewer will have little success in attempting to conduct an interview while the patient is acutely intoxicated, because the alcohol provides a chemical barrier that impairs effective communication. The patient has usually lost his emotional controls and is either belligerent and uncooperative or morose and depressed. If he can be observed for a few hours, a bewildering clinical picture often clears considerably, and a more careful evaluation is possible.

The Patient With a "Pseudo-Coronary"

The patient who is convinced that he is having a heart attack is a common emergency department problem. As with any patient with somatic symptoms, a careful medical history is indicated. The interviewer uses his questions in order to demonstrate the connection between symptoms and emotions. Someone who would be annoyed at a question like "Did you think the chest pain might have been because you were frightened?" will respond quite comfortably to "You must have worried a great deal about your chest pain." It is often useful to perform the physical examination personally; it provides an air of authenticity for later assurances about physical illness. Certainly if this patient proffers the affected portion of his body for examination, an examination should be performed. He wants to show his problem, and if this doctor appears disinterested he will seek another.

When the somatic symptom is pain, the interviewer never challenges its being real. Pain is a subjective sensation, and only the person experiencing it can tell whether it is present. This does not mean, how-
ever, that the clinician must accept the patient’s explanation of its cause, because that is a medical matter. The clinician can say, “What you describe is certainly painful, but we need more information to determine the cause of the problem.”

*The Substance-Abusing Patient*

One of the most difficult differential diagnostic problems in emergency psychiatry involves the patient suspected of malingering pain in order to obtain narcotic drugs. Although most patients with pain want medical treatment for their underlying condition, the patient with severe pain may initially seek only relief from his symptom. He will rarely specify how this is to be given, whereas the substance abuser who is malingering may have a specific drug and dosage in mind.

*The Patient With an Interpersonal Crisis*

The patient with an interpersonal crisis will initially tend to blame someone else for his difficulties and may indicate that he wants only environmental manipulation. As the clinician would not tell the patient with psychogenic pain that it is all in his mind, he similarly would not make massive assaults on this pattern of defenses. The interviewer who asks, “Why do you continually get into such messy situations?” may feel that he is searching for the origins of a psychological problem, but the patient will experience it as an accusation. Consider the adolescent female who is brought to the emergency department by her distraught parents after she has ingested 10 aspirins in a dramatic suicidal gesture. She has been fighting with her mother about her late hours and her current boyfriend. The mother is obviously controlling her rage as she asks whether her daughter is all right. She then adds, “We have tried to bring her up right, but we can’t do anything with her.”

The clinician finds himself torn between the patient’s plea for sympathy and independence and the parents’ frustrated helplessness. He is tempted to interpret either her manipulative coercion or their overcontrolling domination, thereby taking one side or the other. Instead, he can explore the events that precipitated the emergency. The process of discussion will provide the family with an alternative to the pattern of dramatic scenes and uproar that has been their characteristic mode of interaction.

*The Assaultive Patient*

The management of an interview with an assaultive patient is always a problem. If the scene is a hospital emergency department, by the time
the clinician arrives he may find the patient lying on the floor, forcibly restrained by several attendants. Usually this demonstration of force will suffice to help the patient regain control over his aggressive impulses. The clinician can kneel beside the patient and ask him, "What is all the commotion about?" As the restrainers relax their grip, the clinician can quickly ascertain whether the patient plans to renew the struggle. If not (and this is usually the case), the clinician can ask, "Wouldn't you rather sit in a chair and talk with me?" and then help the patient to rise while the other personnel are dismissed. The interview continues with an immediate inquiry of "What happened?" and a discussion of the patient's loss of control. On some occasions, usually with organic psychoses, the patient must be kept in restraint while the clinician administers tranquilizers parenterally. When the medication becomes effective, the interview continues as it would under other circumstances.

Beginning interviewers are concerned that if they ask the wrong thing the patient will again become violent. Usually the patient is even more concerned about this than the clinician, and he should be asked to tell the interviewer if he feels his assaultive impulses recurring.

Some patients have not actually assaulted anyone, but they are on the verge. They may seem to be unaffected by the clinician's calm manner and continue to pace the floor in a state of great agitation. These patients are offered medication before continuing the interview. The therapist can remain with the patient while the medication takes effect and should not increase the patient's fear of being trapped by placing himself between the patient and the door. Such fears may provoke either aggression or flight.

If the clinician arrives to see the severely agitated patient just a few minutes too late he may find himself trying to interview someone who is heading out the front door. He should firmly but gently say, "Just a minute," and, if the patient stops, continue the interview wherever they are located, even if it is outdoors on the sidewalk. Rapport can be best established by exploring the patient's great haste to get away. Once this step is accomplished, the clinician suggests that the interview be continued in a more comfortable setting and proceeds as with other cases.

The assaultive patient is reassured by the confidence that the experienced clinician feels and exhibits. The same patient is quick to detect simulated confidence concealing fear, and he may react to the clinician's fear with assaultive behavior. If an inexperienced clinician continues to fear the patient, he should administer medication or utilize auxiliary personnel to control the patient so that he can conduct the interview more comfortably.
The Patient's Expectations

The patient comes to the clinician with expectations about the outcome of his visit. Such expectations are both conscious and unconscious, both positive and negative. They must be considered by the clinician early in the interview and reevaluated at its termination. Frequently, it is possible to help a patient modify his expectations during the course of the interview, after he has first gained an awareness of them. The clinician can demonstrate the inappropriateness of certain expectations while strengthening and supporting others that he can reasonably hope to satisfy. If the patient has not been able to formulate any realistic expectations, the clinician must do this for him. If the clinician fails to do so, the patient will be dissatisfied by the interview and will seek help elsewhere.

The patient should not be asked what kind of help he hopes to receive too early in the interview. He may interpret this as the interviewer’s refusal to accept responsibility for ascertaining his difficulties or as a hostile rebuff. Nevertheless, once rapport has been established, this question can reveal a great deal. Inquiry regarding previous attempts at finding help is also useful. A patient who has sought the police before arriving at the emergency department often expects controls to be imposed. With patients who have sought help from religious advisors, one should inquire into the specific kind of help requested. The patient who sought the name of a psychiatrist has different expectations from the one who sought help through prayer. A difference even exists between the patient who prayed for strength in coping with a situation and the one who prayed for a solution through omnipotent intervention.

When there is an individual in the patient’s life who would have been an obvious source of help but whom the patient avoided, questions concerning the avoidance may reveal some of the fearful expectations he has brought to the interview. The interviewer might also inquire directly concerning negative expectations. Such inquiry is not always successful, but the patient’s feelings may be revealed indirectly through stories of his family’s and friends’ experiences with mental health practitioners, anecdotes about the hospital, jokes, and so on. If a patient starts the interview by joking, “Where are the men in the little white coats that cart you off to the insane asylum?” this reveals not only some ability to maintain a sense of humor but also fear of being seen as crazy, with all of the many possible unconscious implications.

The emergency partner will also have expectations, and these may be similar to or different from those of the patient. When the partner has initiated the request for help, his expectations must also be considered;
otherwise the search will continue, regardless of the effectiveness of the interview with the patient.

**Unconscious Expectations**

The unconscious expectations of the patient are closely related to the psychodynamics of the precipitating stress. The most common unconscious expectation is that the clinician will directly resolve the patient's conflict. For example, the depressed patient wants his loss replaced, and an important early task is to shift this desire to a hope that his pain will be comforted and his diminished self-esteem restored. In the case of a man who is depressed following the loss of his job, the clinician inquires why the patient blames himself. By pointing out the discrepancy between the patient's critical attitude toward himself and his successful functioning in other areas of his life, the clinician focuses on his current adaptive skills and his desire to find a new job rather than his lost hopes and his fantasy that the clinician will somehow get his old position back for him.

Another situation is illustrated by the depressed woman who is angry with her husband but is fearful that he will leave her if she ventilates her rage. She feels that she is a martyr but is afraid to rebel. When she asks, "Do you think it is fair that I have to live like this?" she is seeking permission to act. This patient may become depressed if the clinician does not grant this permission, but she may be even more threatened if he does. It is important first to establish a trusting alliance and then to search for alternate patterns of behavior that may allow some gratification of her impulses without dire consequences.

**Conscious Expectations**

The conscious expectations of emergency patients include hospitalization, medical treatment, medication, environmental manipulation, psychotherapy, reassurance, no effect at all, and actual physical or psychological harm.

Hospitalization may be seen as a protection from the threat of inner impulses or as a means of influencing the environment. For example, a woman sought help a few weeks after giving birth to a child because of obsessive fears that she would drop or otherwise harm the infant. When the clinician inquired further, she said, "I hoped you would put me in the hospital or take my baby away before I kill him." She was seeking control. The very act of seeking control implied that some inner controls were working, and these had to be found and strengthened. The patient herself was the best ally.
If the patient views treatment as a means of controlling others, he may first insist that he be hospitalized and then be equally insistent that he be discharged 1 or 2 days later. A patient who loudly protests against hospitalization, while at the same time acting crazy, may actually be requesting hospitalization but refusing to accept responsibility for it. His expectation is that he will be forced into a hospital against his will, and he may become more upset if his expectation is not met.

A patient may fear that the clinician will select the wrong alternative in treating an impulse problem. Thus a religious patient who is concerned about sexual feelings may wish to remove or suppress them and may fear that the clinician will encourage sexuality. If his hopes and fears are made explicit, the patient can be helped. The clinician might say, “I have the feeling that you’d like to eliminate your sexual feelings and that you fear I may only make things worse by encouraging them.”

Patients with little psychological sophistication and those with somatic symptoms will want medication. These patients may request medication early in the interview, and beginning therapists often comply much too quickly. The problem may appear different at the end of the interview, and advice concerning medication can wait until that time, even when the clinician feels confident that drugs will be necessary. If the patient feels that all the clinician can do is to prescribe medication, he loses interest in the interview once he receives his prescription, and what follows is anticlimactic. In an emergency situation, the prescription should be for only enough medication to last until the next visit. If the clinician reassures the patient that things will soon be better and then provides a 3-month supply of medicine, the patient may not trust the clinician’s words. A beginning dose of medicine, supplied directly by the clinician and perhaps taken in his presence, has special value. It carries the magical power of the clinician’s personal tool of therapy. A patient with whom the clinician is not thoroughly familiar should never be given a potentially dangerous quantity of medication. Even if the patient is not suicidal, he may feel that the clinician is either careless or unconcerned about his welfare.

The clinician often makes recommendations that involve manipulating the patient’s environment. He may recommend a home helper or a leave of absence from school or a job. In doing this, he distinguishes between the patient who must be encouraged to relinquish his pathological sense of obligation and the patient whose tenuously maintained self-esteem is dependent upon his continued functioning. For example, the suggestion of a home helper could upset a mother who, despite her depression, takes pride in her continuing ability to care for her children. In this situation, the clinician recognizes the patient’s devotion to her
family, treats her depression, and asks the patient, “Is there a family member who can assist you in your responsibilities while we treat your depression?” If the patient has no helpful relative or friend but is open to the concept of accepting temporary assistance, a “personal helper” could be suggested.

The patient with interpersonal problems will often want the clinician to alter the environment and therefore remove the problem. Thus a woman might complain that her husband beats her and want the clinician to remove him from the home. The clinician might reply, “Only the police can do that, and you have told me that you have been to them many times. However, I might be able to help with the troubles that lead to his drinking, or your uncertainty about leaving him, if you are also bothered by those problems.” The patient may already have some awareness of these considerations, and this can sometimes be elicited by comments such as, “If you only wanted someone to straighten out your husband, you would not have come to a psychiatrist.” In this way the clinician is reinforcing the patient’s more realistic expectations.

Psychotherapy is more likely to be expected by patients who are better educated or are from a higher social class and whose symptoms are psychological in nature. However, a patient’s awareness of psychological problems does not mean that he will not need medication, direct guidance, or hospitalization. This patient’s distress, like that of the patient with somatic symptoms, may be an indication for medication. Indeed, an acutely heightened awareness of inner conflicts is often indicative of the too rapid breakdown of defenses.

**Negative Expectations and the Unwilling Patient**

The patient with negative expectations anticipates no help and may expect further injury and humiliation. When depressed, he is likely to be suicidal; when paranoid, he will probably be belligerent and combative. He does not accept psychiatric intervention. These negative expectations must be openly discussed if there is to be any hope of engaging the patient’s cooperation in a treatment plan. When discussing this patient’s unconscious expectations, it is crucial that the clinician ally himself with the patient’s unconscious hope rather than his unconscious fear.

It may be necessary to force treatment against a patient’s will in order to protect him or others around him. This must be done openly. It is better to tell a patient, “I will have to send you to the hospital even if you don’t agree to go,” than to conceal this by saying, “We’ll have to arrange for another consultation in the building across the street.” The
patient will ultimately appreciate the clinician’s honesty and directness, and his attitude toward other clinicians will be favorably influenced.

Before involuntarily hospitalizing a patient, the interviewer should exhaust every possible means of convincing him to go voluntarily. This process begins by explaining the therapeutic rationale behind hospitalization at this time—usually the need to supply the patient with external assistance in controlling suicidal or assaultive impulses. If the patient did not wish to have these impulses curbed, he would not have allowed himself to be interviewed and would have kept their existence a secret until he was free to act upon them. This should be explicitly pointed out to the patient.

Few judges will force a commitment against the wishes of the patient’s relatives unless he has committed a crime. Patients have been hospitalized repeatedly only to be signed out, against medical advice, by a relative on the following day. Therefore, it is necessary to gain the relatives’ support when the clinician is recommending hospitalization. Frequently a relative, friend, priest, or someone else whom the patient trusts can exercise greater influence in helping the patient to accept hospitalization than can the clinician.

A careful discussion of the patient’s fears of hospitalization is essential. He may think that he cannot obtain his own release when he no longer feels the need for hospitalization, or there may have been previous unpleasant experiences with psychiatric hospitals. Alternate plans that would provide assistance in controlling his impulses should be discussed. Sometimes this may convince the clinician that hospitalization is not the only way to cope with the emergency. The clinician should then feel free to alter his recommendation. Finally, when a patient indicates reluctance about accepting hospitalization, he should not be left unsupervised after the subject has been mentioned and especially not after a positive decision has been made.

The Treatment Plan

As the interview draws to a close, the clinician begins to formulate his suggestions and plans for further treatment. These must be conveyed to the patient in a way that will help him to accept them. The patient’s own treatment plans are to be explored first. How has he handled similar problems in the past, and what were the results? If his plan differs radically from the clinician’s, has he considered alternatives? If he indicates that he has already rejected the clinician’s plan, one can point out that he thought of it himself, and at least considered it as a possibility. The interviewer finds the patient’s own reasons for and against it, and deals
with his arguments rather than with those of the clinician. If he has not considered the specific alternative that the doctor has in mind, it is suggested to him and he is asked to consider it during the interview. If he reaches the same plan as the clinician, he is far more likely to follow it than if he is simply informed of the clinician’s thoughts.

For example, an acutely depressed college student sought help in the week of his final examinations. He had never had a similar episode in the past. He described his problems, and the clinician inquired as to his plans. He replied that he expected to take his exams, but that, in his current state, he was sure that he would fail. The clinician asked, “Have you considered any alternatives?” The patient said, “Yes, I thought of asking to be excused from the exam, but the professor would probably say no, and anyway, it wouldn’t be fair.” The clinician asked, “Could you tell the professor that you weren’t feeling well, and ask if you could make up the exam when you were better?” The patient had not considered this because, like most depressed people, he did not feel that he would get better. He replied, “Well, I don’t know, I don’t want the professor to know I’ve seen a psychiatrist. He would never understand.” The clinician was then able to explore his reaction and to demonstrate that the patient’s fear had no foundation in reality but was instead based upon his diminished self-esteem and consequent assumption that others would be intolerant of him. This sort of discussion will help the patient to employ the clinician’s recommendation, although initially he was quite resistant to it.

If the emergency partner has initiated the consultation, he too must be considered in the treatment plan. If the clinician does not reduce his anxiety, he will continue to pursue other avenues of help. It is not sufficient to merely acquaint him with the treatment plan if he was not present during its formulation. His expectations must also be made explicit, and any discrepancies between these and the actual plan must be discussed.

Closing the Interview

Because the emergency patient does not know the length of the appointment, the clinician should always indicate that time is drawing to a close when there are still a few minutes of the interview remaining. He can say, “We will have stop in a few minutes” or “Our time is almost up now.” This provides the patient an opportunity to add more material or, more important, to ask questions. The clinician can ask, “Is there anything we have not talked about?” or “Is there something else you would like to tell me, or something you would like to ask me?” The patient’s choice will reveal what he considers to be a crucial problem or
major anxiety. Occasionally he will reply, “There is nothing.” This reply does not necessarily mean that the patient is satisfied. The interviewer does not stop at this point but pursues discussion of an area that was not fully explored earlier. The topic can be one that, although affectively charged, was not developed because it was tangential to the emergency. The patient who has no questions to ask is provided an opportunity to reveal additional material through his trend of associations.

In closing the interview, it is preferable to give the emergency patient a specific appointment rather than suggesting vaguely that he come back later. If the problem was severe enough to precipitate an emergency, it should be reevaluated in a second interview. If he does not have a specific appointment, the patient may have to create another emergency in order to return.

CONCLUSION

The psychodynamics of emergency behavior encompass all of the specific clinical syndromes, but there are special considerations added by the emergency situation. An understanding of these additional dynamic issues will enable the clinician to utilize his existing knowledge most effectively. His systematic approach to the problem will allay his own anxiety by protecting him from the crisis atmosphere produced by the patient and partner. This allows the clinician to reduce the patient’s anxiety, and as a result, the patient can mobilize his own adaptive skills to cope with his problems.