A survey of psychological techniques that have been applied in the psychiatric emergency service demonstrates their potential for meeting the increased treatment demands of this changing and challenging milieu.

Psychological Treatments in the Psychiatric Emergency Service

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The psychiatric emergency room has long been decried as an impersonal place with potential for strained relations between staff and patients (Gerson, 1980). Its role as gatekeeper, with an intense focus on legal responsibilities, social control, and medical problems, seems to militate against any therapeutic role. Historical forces, however, have conspired to place the PES at the front end of therapy (Fawcett, 1994). Medical economics has introduced a bias against immediate admission (Geller, 1991), while risk management considerations discourage quick and thoughtless discharge (Marcos, 1989). As PES staff struggle with competing priorities, both patients and staff suffer from the resulting inattention to the more personal, potentially rewarding therapy opportunities. In fact, the PES also has certain advantages, and the use of psychological treatments in the PES is destined to expand as inpatient stays shrink, outpatient services are modified or curtailed, and the PES attempts to meet new needs.

Stages of a PES Visit

The PES visit can be divided conceptually into three stages, with different needs and goals at each stage. In the *early stage,* the patient is triaged; symptoms and context of presentation are assessed; a tentative therapeutic alliance is built; and the patient confronts the reality of being in the PES. In the *middle stage,* most of the assessment and treatment occur; active intervention is often required; the patient may get a "trial of therapy." The *late stage* is characterized by active negotiations and treatment planning involving the patient, significant others, and treatment agencies or services.

Therapeutic Approaches

A number of therapeutic approaches have been developed over the last twenty years that might prove valuable to therapy in the PES, including crisis intervention, brief psychotherapy, psychoeducation, family therapy, and cognitive approaches. While each of the above treatments involve fairly specific criteria not applicable to a chaotic PES, in fact, many of these and other treatment approaches are already woven into each stage of PES work.

PES work is pragmatic and in a sense atheoretical; therapies are often used in combinations, sometimes producing new configurations. The goals of psychotherapy in the PES can differ from their classic outpatient counterparts. For example, a technique of therapy such as challenging a defense might be used more as a probe to assess readiness for discharge than as a reparative act.

Therapies are used eclectically and spontaneously to achieve short-term goals, and interventions may serve dual purposes. For example, small talk near the beginning of the interview can sometimes be used not only to informally assess mental status but also to build trust.

Crisis Intervention

Crisis intervention (CI) was developed in the early 1960s, harkening back to Lindemann's (1944) work with the Coconut Grove fire victims. Classical crisis theory conceptualizes the patient as being in a state of initial stability, which is disturbed by an event or series of events that disrupt the client's homeostasis and produce tension (Caplan, 1964). As the individual is unable to cope with the crisis, tension rises until there is a functional breakdown. The goal of CI is to actively restore the previous level of functioning using a range of interventions from inquiry to advocacy. Interventions may involve only the patient or include the family or others in the community (Hess, Rustler, and Roberts, 1990); ideally, they should take place before functioning is impaired. The CI model is indifferent to psychiatric diagnosis and can proceed without medicalization of a stressor. It is a useful tool when diagnoses are provisional and information is incomplete. In the PES, CI often has the effect of advancing the evaluation while illuminating patient defenses and pathology.

> A thirty-five-year-old unemployed male lost his job and could not sleep or eat. Six weeks later, he visited his estranged wife and had an argument about money. In the course of the dispute, he went to the bathroom and swallowed ten antihistamine capsules. His wife called an ambulance, and he was brought to the medical ER for treatment.

Early stage. When the patient arrived, he was depressed and withdrawn and declined to talk much to staff except for demanding to leave. The staff responded with short, supportive interactions, focusing on the availability of help and their concern about the patient's depressed mood and suicide attempt. The patient was placed in an observation bed.

Middle stage. Within a day, the patient was more verbal and reluctantly discussed more of the context in which he came to the PES. Interventions included *assessment, family involvement, agency involvement,* and *telephone contacts.* Assessment revealed that recent job loss produced financial stress such that he could not give his wife money for his two children. She now threatened to prevent him from visiting his children. The family became involved when the patient's brother was contacted. The patient's whereabouts had been unknown for days; the brother was encouraged to visit the PES. Agency involvement came about as the dimensions of the patient's interpersonal problems were appreciated; a suitable clinic with a low fee scale was identified that had evening hours compatible with the patient's potential work schedule. Now feeling more motivated, the patient was able to contact a friend who was aware of a job opportunity.

Late stage. The brother arrived with other family members and friends and spoke to the staff and patient; his wife remained distant. The patient planned to stay with his brother until he found work and agreed to attend an outpatient clinic where he will receive psychotherapy and assessment for an underlying depression. A new homeostasis has been established. On a deeper level, the patient has accepted the assistance of professionals. The stage has been set for the patient to enter treatment.

Brief Psychotherapy

Brief psychotherapy (BP) was introduced as a modification of psychoanalytic psychotherapy (Marmor, 1980). While taking a number of different forms, it emphasizes a time-limited, active approach focusing on alleviating distressing symptoms. Treatment typically ranges from five to forty sessions with some cases requiring only one session. Proper patient selection is a key component in its success (Burke, White, and Leston, 1979).

BP is relevant to PES work for several reasons. First, many PES patients are suitable candidates for BP, and the decision to recommend it is often made in the PES. Second, BP emphasizes the rapid building of the therapeutic alliance (Bellak and Small, 1978, pp. 56–67; Davanloo, 1990), which is believed crucial to the success of PES work (Rosenberg and Kesselman, 1993; Rosenberg, 1994). Trust established soon after the patient arrives is particularly helpful in difficult situations. Third, the assessment of ego functions, what Bellak and Small (1978) call a structural assessment, is done during the initial phase of BP. This is an important component of the middle phase. And fourth, a measured trial of therapy, which is sometimes the first step of BP (Davanloo, 1980, pp. 99–128), can be performed during the middle phase, yielding important information and furthering the therapeutic alliance.

> A man in his twenties was brought to the emergency room by the police on a mental health warrant taken out by his mother. He had pushed her as he tried to grab her pocketbook for crack money. He refused to answer questions upon arrival. He demanded to leave and was mildly agitated.

STAFF: Do you feel that it would help to talk to someone about your problems?
PATIENT: There is nothing wrong with me.
STAFF: You say that nothing is wrong, but your mother says you pushed her and she had you brought here.
PATIENT: She lies!
STAFF: Precisely. Then you are having difficulty getting along with your mother. Perhaps we can help you.
PATIENT: Will I get to leave?
STAFF: It would help us a lot if we could work together to figure out what happened and what we should do. Is crack a problem?
PATIENT: Well, maybe . . . I mean, why?
STAFF: Perhaps we could help you with that problem too.
PATIENT: Yeah. I need to get into a [rehab] program.

The patient calmed during the exchange and did not threaten the staff or become agitated or disorganized. He did not walk away angrily or ask to leave the room. This has significance for diagnosis, PES course, and therapy selection.

Assessment of ego functioning. Assessment of ego functioning, especially reality testing, judgment, sense of reality, object relations, thought processes, adaptive regression, and stimulus barrier are important in the early phases of the PES visit. The patient demonstrated good reality testing, sense of reality, and intact thought processes but problems with object relations and adaptive regression are suggested. This observation informs treatment. If this patient becomes agitated and requires medication, the clinician might avoid neuroleptics. Even in the first few minutes, information gleaned from the dynamic interaction directs the course of subsequent events.

Other ego functions such as autonomous functions, synthetic functions, and mastery competence often occur at a somewhat later stage of the PES visit. It is at this middle stage with a patient who is not psychotic or grossly disorganized that a "trial of therapy" may be attempted. Sometimes the patient initiates this trial rather than the staff.

The ability to deal with unconscious material is seen as important in the assessment of BP therapy potential (Davanloo, 1980). Avoidance of unconscious material in a crisis is somewhat like ignoring fallen tree branches while walking through the woods. Some common staff reactions to the raw material in PES presentations are also countertherapeutic and potentially dangerous. In their review of physical attacks on residents, Black, Wilson, and Wetzel (1994) note that irritable and confrontational staff members are more likely to be attacked and that certain situations such as forced (or denied) admissions may bring on an attack. The PES may provide an opportunity to deal with forbidden material if the staff is able to do so.

Family Therapy

Interpersonal conflicts frequently generate PES visits. One survey of a large urban PES discovered that 25 percent of all visits involved explicit interper-

sonal conflicts with significant others. When confined to those presenting with suicide attempts or suicidal ideation the percentage rose to 35 percent (Rosenberg, 1995). The availability of family also affects disposition. One study reported a higher discharge rate on a three-day crisis unit when family was available (Dubin, Ananth, Bajwa-Goldsmith, and Stuller, 1990). It would seem that elements of family therapy can play an important part in all phases of a PES visit.

Casework with families involves psychological, psychodynamic, and sociological dimensions (Mitchel, 1961). Of particular importance to the work of the PES are issues of denial. "In the family interview process, what one parent conceals, the other reveals" (Ackerman, 1961, pp. 62–63). In addition, when anxiety reaches a certain threshold even conspiracies of silence are broken, and the PES staff learns of aggression, psychotic symptoms, drug abuse, sexual misconduct, and more. These data are valuable in the early stage for assessment and diagnosis; they become the material the patient must confront in the middle stage and help set the goals for discharge planning in the late stage.

The experience of the PES itself generates anxiety and in some ways a benign ordeal for the family. This secondary crisis of a PES visit can sometimes enhance the willingness of family members to compromise. A sister who was assaulted by the patient, her brother, said "I'm not going to keep quiet anymore! You beat me! You're sick! You need help!" The PES visit became an opportunity to examine this patient's behavior.

Sometimes significant others rather than the natural family help in breaking therapeutic impasses in the middle phase.

> A twenty-six-year-old male was brought to the PES by an ambulance. The man had called the ambulance himself after a dispute with his mother, with whom he lived. He had been released from jail a few months before and had befriended a woman who had a bad temper and would threaten people with knives. The mother disliked the girl and did not want her to visit. The patient—her son—became enraged, went to the bathroom, took an overdose of erythromycin, and called 911.

In the early phase, the patient was hostile, agitated, and actually requested medication to calm down. After a day and a half of observation, during which the patient was withdrawn and avoided talking to staff, he began to demand discharge. His mother had been contacted but declined to visit or even speak to the patient on the telephone. She said, "He can't come here. He needs help." The mother wanted the patient to be admitted. The patient's girl friend appeared and was distraught. "Can't he leave? He's not crazy!" Soon the patient was banging on the door shouting: "Let me out! Let me out!" The following dialogue then took place:

> STAFF: Why are you shouting?
> PATIENT: I want to leave.
> STAFF: Why are you here? Didn't you try to kill yourself?

PATIENT: No. That was just to get at my mother.
STAFF: Is there anything wrong with what you did?
PATIENT: What do you mean?
STAFF: What if I did what you did? What would you think of me?
PATIENT: That's stupid! (The patient turns away and looks at a TV in the room.)
STAFF: (persisting) Don't you think it's difficult adjusting to getting out of jail?
PATIENT: (grudgingly) Yes. I wish I had my own place.
STAFF: Maybe we could help?
PATIENT: No. I'll be all right.
STAFF: Can we talk with your girlfriend?
PATIENT: Yes.
The girlfriend joins the interview.
STAFF: I spoke to your boyfriend. He wants to go, but I think he needs treatment at a clinic for his bad temper and depressed mood.
GIRLFRIEND: Yeah. He goes off at times.
STAFF: Do you have a bad temper?
GIRLFRIEND: (giggling) Yeah. I go off too!
STAFF: Would you help us?
GIRLFRIEND: What do you mean?
STAFF: Would you go with him to a clinic visit?
GIRLFRIEND: Yes. Maybe I could talk to someone too.
PATIENT: No (addressing the girlfriend and ignoring the staff member). I don't need that. I'm okay.

The girlfriend was left alone with the patient. Thirty minutes later, they emerged, both with tears in their eyes, the patient said: "There's nothing wrong with me, but I'll go to the clinic for my girlfriend. Is that okay?"

An appointment was made at the crisis clinic. The patient was discharged with his girlfriend. They both came the next morning to the clinic where the patient began to accept the idea of treatment, for himself. The girlfriend was functioning as the patient's family for now. A strategic alliance with a significant other resolved an impasse in the PES.

Psychoeducation

Psychoeducation grew out of family therapy work and is an attempt to educate families to recognize patient symptoms and participate in relapse prevention. Although relatively new, this approach has been shown to be of value in a variety of patients including substance abusers (Wallace, 1992), high-emotional expressive (EE) families of schizophrenics (Hogarty and others, 1992), and bipolar manics (Van Gent and Zwart, 1991). It is a valuable tool in the late stage of the PES visit for preventing future relapses and has been used with families as well as patient groups. Families are encouraged to bring the patient to the PES when warning symptoms emerge. Blaming, introspection, and psychological mindedness are avoided; collaborative action is emphasized.

STAFF: How can you tell when your son is getting sick?
MOTHER: Every day he likes to go to the store for me. But when he gets sick, he stays indoors and shouts at me to leave him alone.
STAFF: Then what happens?
MOTHER: He eats less, refuses to change his clothes, and stays up more at night and plays the radio real loud.
STAFF: Then?
MOTHER: Then the neighbors complain. He shouts at them. He wants to wander the hallways. Soon they call the cops.
STAFF: So you know when he doesn't want to go out that something is wrong.
MOTHER: Yeah. Usually he hasn't been taking his medication.

Cognitive Therapies

The cognitive model of illness postulates that between internal and external stimuli and affective and behavioral responses lie certain thought patterns that interpret stimuli and plan responses (Beck, 1976). Direct modification of these thought patterns leads to productive changes in behavior and affect. Psychological mindedness is not usually a prerequisite, but some degree of cognitive capacity and coherence of thinking is usually required. Conversely, applying these techniques with PES patients may demonstrate areas of strength or weakness. While cognitive work can take place at any time in the PES visit, rapport must have been built first.

A clearly defined problem such as suicidal ideation or anxiety about a situation is usually assumed. Underlying the affect of a person in a depressed or anxious mood lie automatic thoughts at the fringe of awareness that interpret stimuli or events and presage negative behavior or affect. Thoughts such as 'You are useless,' or 'You can never succeed,' or 'You are doomed' are typical. The therapist's role is to identify these thoughts and challenge them.

An eighteen-year-old woman with no psychiatric history made a suicide attempt after performing poorly on an examination. She related that her mother told her that she was lazy.

STAFF: So, your mother says you are lazy.
PATIENT: Yes, I guess so.
STAFF: How do you spend your time?
PATIENT: Cleaning the house, shopping.
STAFF: What else?
PATIENT: I watch my brother and sister.
STAFF: It sounds like you do a lot for your mother. That doesn't sound lazy to me.
PATIENT: You're right. I do a lot for her.

New, more positive thoughts are substituted for older, pathological ones:

STAFF: Do you deserve to die because you had trouble with an exam?
PATIENT: I guess not.
STAFF: Aren't you allowed another chance?
PATIENT: Yes. Can I go home now? I didn't know this would happen.
STAFF: So what do you think now?
PATIENT: What I did was stupid. I overreacted.
STAFF: Stupid? Can we find another word?
PATIENT: Wrong. It was wrong. I was just trying to get my mother's attention. It was wrong to pull a stunt like this.
STAFF: Yes. It was not wise to hurt yourself to get your mother to pay attention.
PATIENT: Yes. It was not wise.

Here, the staff modified unproductive self-attacks (You are lazy. You are stupid.) to a more appreciative, reflective, and remorseful tone (I am useful. What I did was wrong, that is, unwise.).

Cognitive work can be done on an individual basis or it can lend itself to group or family formats. For example, in the case above, cognitive therapy work might be even more effective if performed in front of the patient's mother with the patient practicing self-assertion.

Future Directions

As the use of therapy techniques in the PES becomes more appreciated, research techniques will emerge to refine and combine them. In time, new theories of emergency psychological care and new techniques that fuse aspects of older psychotherapies in innovative ways will help meet the acid test of therapy on the front lines.

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