# GARY J. TUCKER

# PSYCHIATRIC EMERGENCIES

## *Evaluation & Management*

*American Handbook of Psychiatry*

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## Evaluation And Management

## Gary J. Tucker

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# Psychiatric Emergencies: Evaluation And Management

Phenomenologically a psychiatric emergency is a request by a person, family, or agent of society to *immediately evaluate* the behavior of an individual. Theoretically, an emergency is the occurrence of a "sudden change" and a crisis is a "turning point" that may have potentially adverse consequences. Defined in such a way, almost any disturbance of human behavior can confront the clinician as an emergency or crisis situation. Consequently, the skills and knowledge required to treat these varied problems may seem overwhelming. The emergency situation not only demands diverse knowledge but also implies intervention or action. This is true of any emergency situation, medical or psychiatric. The demands of making insulin and diet changes over a prolonged period in a known diabetic are very different from treating the same patient in diabetic acidosis. In the same way, a patient who has been in long-term psychotherapy for a depression becomes a very different treatment problem should he become acutely and seriously suicidal. While one can say that in these emergency situations everything must be known, the management of emergency situations is, in actuality, simpler. It is simpler because the time perspective needs only be brief, only those interventions which alleviate the immediate situation are necessary; although long-term goals and treatment can be aimed at, these facets of treatment may be reserved for some future time. This

chapter, of necessity, must deal with many disparate topics, but its intent is to deal with the discrete variables that have proved most useful in emergency situations. Although as noted, the emergent situation can encompass almost any aspect of human behavior, general guidelines for emergency psychiatric management can be clearly delineated. These guidelines, coupled with specific information of the more common emergency problems, can lend competence and skill to the management and treatment of these difficult and, for the clinician, frequently anxiety-provoking situations. However, all that any text can provide is a skeleton that must be fleshed out with experience, judicious judgment, knowledge, and a sense of humanity.

The psychiatrist has always been confronted with urgent situations, but until recently psychiatry, as a profession and a body of knowledge, has shown little cognizance of emergency and crisis situations. Sixty-nine percent of emergency psychiatric services in this country have been established since 1950 (Myers, 1965). Perhaps as long as most psychiatric care for seriously ill patients was undertaken in large, isolated rural state hospitals, there was little need for psychiatrists, unrelated to these hospitals, to concern themselves with emergency care. If the patient did not respond to immediate verbal intervention or sedation, the only resource for the emergency situation was the state hospital. Consequently, the major emergency intervention was hospitalization. In fact, one of the first articles that took cognizance and delineated some principles of emergency psychiatric management was by

Lindemann in 1944 (Lindemann, 1944-45), on a population not traditionally considered psychiatric, e.g., the bereaved families of the victims of a disaster situation. However, as the care of the psychiatric patients moved closer to the community it became apparent that neither our institutions nor theories were capable of handling emergency situations. From the early 1950s to the present, many new types of psychiatric facilities as well as a vast theoretical framework for the management of psychiatric emergencies have arisen (Morrice, 1968).

## The Rise of Psychiatric Facilities for Emergency Care

As the state hospital systems shifted their orientation from custodial to therapeutic, they, in part, forced the communities to develop facilities for care of discharged patients and outpatients, and soon emergency functions followed. In the middle and late 1950s, in order to treat the returning patients from the state hospitals, we saw the development of large outpatient clinics set up primarily as aftercare clinics. These clinics soon became inadequate for the demands put upon them. In 1959, Coleman and Zwerling noted that their clinic was soon overrun with demands for service (1959). They described the development of a six-to-twelve-month waiting list and, consequently, a marked inability to provide treatment when the person most needed it, that being during the crisis or emergency situation. They then go on to describe an "innovative" psychiatric emergency clinic that provided "a flexible way of

meeting community mental-health needs." Concomitantly, as general hospitals began to develop their own psychiatric units, the psychiatrist became available to general hospital emergency rooms. In part, the Community Mental Health Center Act of 1963 explicitly defined this increasing need by making emergency care one of the essential services of a community mental health center. Consequently, some type of walk-in or emergency psychiatric consultation is presently available in most communities (Blane, 1967).

Paralleling the geographic changes in the handling of psychiatric emergencies, one is impressed with the increasing variety of treatment modalities that have become available to the psychiatrist. The advent of the tranquilizing and antidepressant agents coupled as well with the theoretical developments of family and group therapies, brings an increasing range of effective treatment modalities and capabilities within reach of those treating psychiatric emergencies. However, for the psychiatrist to utilize these techniques great shifts in training were required.

In the recent past the major focus of psychiatric training has been on the development of individual psychotherapeutic skills. These skills emphasized the psychotherapeutic relationship, analyzing, over time, intrapsychic problems and the necessity for the relative exclusion of others from the treatment (Detre, 1970; Tucker, 1973). With this emphasis we developed a

generation of psychiatrists who seemed ill prepared to deal with emergency situations. When all the psychiatrist had to offer was an intense and prolonged delving into intrapsychic conflicts it became quite difficult for him to deal with the problems presented in an emergency situation. The dictionary definition of an emergency covers such things as "an unlooked for contingency," "a sudden demand for action," "a pressing need." An emergency requires both intervention and some action. The psychodynamic theories, as noted, offered little theoretical help in the handling of emergencies and crisis situations. Into this vacuum moved the theories of Lindemann (1944-45), Caplan (1961) and Erikson (1950), relating in varied ways to the concept of "crisis." Caplan defined a crisis as a state "provoked when a person faces an obstacle to important life goals that is, for a time, insurmountable through the utilization of customary methods of problem solving" (Caplan, 1961) Much of the early literature on crisis intervention was devoted to demonstrating that crisis management could be either reconciled or made relevant to psychoanalytic principles (Brandon, 1970; Darbonne, 1967; Jacobsen, 1965; Schulberg, 1968). Although subtle, this viewing of an emotional crisis as an "obstacle" to important life goals put the "crisis or emergency" into a conceptual framework that allowed the clinician to examine aspects of the emergency situation other than the intrapsychic. The therapist was now doing "crisis intervention work" during which it was legitimate to examine the social matrix of the situation and even temporarily rearrange it. The

person treating "the crisis" no longer felt that an intervention fell short of the mark unless it revised the person's total personality. However, with the advent of crisis theory the definition of a crisis and the areas of intervention were expanded greatly to allow almost any change in life, such as the "crisis of adolescence, early marriage, change of jobs, entrance into nursery school, retirement" (Caplan, 1967), to be viewed as an area in which to intervene. While these would certainly be classified as what Caplan has called primary prevention, they are not the usual emergencies with which a psychiatrist is confronted.

**Psychiatric Emergencies— A Perspective**

If one reviews the literature on the kinds of psychiatric problems that come to the emergency rooms of general hospitals, one is impressed with several things (Blane, 1967; Chafetz, 1966; Coleman, 1963; Muller, 1967; Schwartz, 1963; Senay, 1968; Tischler, 1966; Ungerleider, 1960). Although there are few such studies in the literature, it is clear that the emergency situation is most often defined by people other than the psychiatrist. The clinician charged to deal with the emergency can state after evaluating the patient that it is or is not an emergency, but the psychiatrist is not usually noted as the initiator of the emergency contact. In this country a high proportion of the patients seen as emergencies (55 percent) are referred by themselves (Muller, 1967; Ungerleider, 1960). This contrasts with England

(Brothwood, 1965) where only 35 percent of the patients are self-referred, and 59 percent come from general practitioners, which may in part reflect the low availability of primary medical care in this country for lower socioeconomic groups. The general proportion of psychiatric emergencies seen in emergency rooms varies from 3 percent to 12 percent (Chafetz, 1966; Ungerleider, 1960) of the total patients seen. About 50 percent of the psychiatric patients are seen between 8:00 a.m. and 5:00 p.m., 20 to 40 percent are seen from 5:00 p.m. to midnight, and about 8 to 12 percent are seen from midnight to 8:00 a.m. in large metropolitan centers (Muller, 1967).

A survey of psychiatric emergencies done by Muller, Chafetz, and Blane (1967), summarized data gathered on close to 5000 emergency psychiatric contacts seen in Helsinki, New Haven, Boston, and Cleveland. It noted that diagnostically the problems that present on an emergency basis are equally divided among: (1) psychotic, (2) neurotic, (3) alcoholic, and (4) personality disorders and situational reactions. These proportions varied slightly from location to location as do most studies that rely primarily on clinical diagnosis and, as such, are often difficult to interpret. However, if we look at the behavior manifested by these patients, we see consistent patterns that necessitate emergency psychiatric consultation. The kinds of behavior seen most often as emergencies primarily are agitation, suicide (both threats and attempts), episodes of excessive drinking, and emotional withdrawal or isolation. Contrary to the popular notion, assault and other forms of violence

were the least common patterns of behavior presenting for emergency consultations. The majority of the patients also represented episodic outbreaks of chronic problems. Of those seen in emergency rooms, about 23 percent had had prior inpatient treatment, and about 13 percent previously had had outpatient treatment. Unfortunately, there is almost no data on the types of emergencies handled by private practitioners. Descriptively, the patients necessitating emergency consultation usually manifest chronic problems, are often of a low social class, and are usually young adults. While this data may also be viewed as more representative of those who use emergency rooms of urban general hospitals, clinical experience seems to confirm that the nature of the presenting symptoms is similar in other populations and settings.

The majority of patients studied were felt to be valid emergencies in that between 30 and 50 percent were immediately hospitalized. The remainder were referred to outpatient treatment of some sort, and under 10 percent were discharged as either not needing treatment or because the contact was sufficient. Those most likely to receive no treatment were patients who primarily manifested longstanding character problems.

## General Aspects of the Evaluation Process of Psychiatric Emergencies

A psychiatric emergency may then be defined by its components: (1)

either the patient or those surrounding the patient perceive that there has been a sudden change in the patient's behavior, or the consequences of this behavior; (2) there is a request made to a socially designated expert in behavior for assistance and evaluation of this behavior, and (3) the socially designated expert agrees or disagrees that this behavior or the resulting situation is one that needs immediate psychiatric intervention or care. In this sense, the clinician is frequently confronted with a patient whose *behavior* has been judged by others as either changed, disruptive, or deemed no longer appropriate to a specific setting. The person charged with evaluating this behavior is usually confronted with a person who has "done" something. It is the process of evaluation to determine what "is" happening to the person as well as what "is" disrupting the equilibrium of the patient's life and/or others' lives. Probably the most helpful parameters in evaluating behavior and most critical in determining the emergency status of the behavior are the *form, intensity,* and *frequency* of the behavior (Lebow, 1973).

Behavior by its formal characteristics alone can be deviant, repugnant, or serious. Consider a suicide attempt. A patient who has ingested three aspirin tablets is treated and evaluated differently than the patient who has shot himself in the chest. The intensity of the behavior relates more to the degree of control over the behavior the patient manifests, e.g., the difference between suicidal thoughts, a suicide plan, and an actual suicide attempt. The frequency of the behavior is the actual frequency of the occurrence of a

behavior and the context it occurs in, e.g., the constant occurrence of suicidal thoughts after any rejection or personal affront (it may at times also relate to the deficiency of behavior in specific contexts).

Behavior does not occur in isolation. There is a constant interplay between the individual and the social network surrounding him. This interactive process can also be affected by the presence of either or both psychopathology or impairment of biologic function. The request for an emergency consult can best be viewed as a disturbance in a "system" (Polak, 1971). While all the components of this system are constantly interacting, this interaction can be best evaluated by arbitrarily looking at its three major components. These are: (1) the psychologic status, (2) the social network surrounding the patient, and (3) the biologic functions.

The evaluation of the *psychological status* has often been considered the main task of the evaluation, but in the emergency setting it is only one component and in part often obtained from others. It encompasses the traditional mental-status examination and psychiatric history. It is here that knowledge of specific categorical psychiatric syndromes are necessary to the evaluation. Those aspects of categorical problems necessary for emergency evaluation will be dealt with subsequently. While the psychiatrist traditionally has gained this information from the patient himself, and this evaluation of the patient is of extreme importance, in an emergency situation

the examination is often confirmatory, in the sense that history and symptoms are frequently gained from those who requested the emergency evaluation, e.g., the family, the police, etc. The patient, for a variety of reasons, may be unwilling or unable to reveal the entire history, so it is often necessary to gather data from other sources about present and past psychologic status. For example, a fifty-eight-year-old man was seen as a walk-in patient for an initial interview. He manifested symptoms of a mild to moderate depressive reaction (both biological and psychological) but denied any suicidal ideation. Although the physician was somewhat concerned about the patient, he felt that it would compromise his relationship with the patient to consult anyone else, and when confronted by the patient's wife in the waiting room at the conclusion of his interview, he suggested that she might discuss some of her anxieties with a social worker at the next visit. By this time, the husband had left the waiting room and the wife, who had tried to be with the patient initially, asked the physician if he "had told him about the noose" (which the patient had not). The patient was sought out, but could not be located. Later that day he committed suicide.

While the psychological status may reveal little symptomatology during mental-status examination, the clue to the nature of an emergency situation is frequently gained by an evaluation of the social relationships surrounding the person. It is critical as part of an emergency evaluation to determine significant relationships in the person's life, particularly, patterns of

relationship and changes in these relationships. In several recent studies, one of the most critical life-stress factors noted was entrances and exits from the person's immediate life. Usually these were entrances and exits of significant people in the person's life (Holmes, 1970). The family is only one aspect of the person's life, the other important aspect is the work situation.

The evaluation of the biological status of the patient is perhaps the most crucial evaluation in the emergency situation. This evaluation is critical in that it is easy to overlook physical or biological causes of behavior when seen by those clinicians with primarily a psychological "set." Certainly, there are many organic syndromes (epilepsy [Slater, 1963], encephalitis) [Himmelhoch, 1970], prescribed and non-prescribed medications that can often precisely mimic primarily psychological conditions (Davison, 1969; Pincus, 1974). This distinction becomes even more difficult in patients who are seen for the first time and are relatively unknown to the person doing the evaluation. While these conditions, fortunately, are rare, they must be kept in mind when doing emergency evaluations, for it is easy to prescribe not only the wrong treatment but to overlook a potentially life-threatening situation.

It is also important to recognize that organic problems may not only coexist but contribute to emotional symptoms. Several studies of admissions to psychiatric hospitals have noted that anywhere from 18 to 44 percent of the patients were suffering from some form of physical disorder (Eastwood,

1970; Eilenberg, 1961). In one hundred patients seen as psychiatric emergencies, Eastwood et al. noted that 24 percent were suffering from physical disorders already known to the physicians and 16 percent had physical abnormalities that had not previously been recognized (Eastwood, 1970).

While in contemporary times there is much concern about the role and identity of the psychiatrist, it is in the area of emergency evaluations that medical knowledge is crucial. However, it does not mean these conditions cannot be determined by nonphysicians who are trained in evaluation but that the complete evaluation may necessitate physical examination and subsequent medical consultation. Several clinical observations may prove helpful in indicating that organic problems may be present: (1) there is an abrupt history of personality change, in that the patient's pre-morbid behavior and personality are in marked contra-distinction to the presenting behavior; (2) a good premorbid history of social functioning and achievement, and a family situation that is warm and supportive; (3) rapid or periodic fluctuations in behavior and mental status; and (4) the patient seems to struggle against the symptoms rather than giving in to or believing them. In addition to these, certainly any history of a recent central-nervous-system trauma such as a fall, head trauma, etc., or a history of drug use or abuse is critically important to the evaluation of many behavior disorders. A family history of central-nervous-system disease is also pertinent (Himmelhoch,

1970; Pincus, 1974).

The complexity of the evaluation process is further enhanced by the fact that the request itself is an important part of the psychiatric emergency. The request may simply be related to the fact that the behavior observed was either misunderstood or inappropriate to a specific situation. It may also be a request to remove an unwanted family member (frequently the aged) or label someone mentally ill (Smith, 1972). The request itself may have many meanings. In an evaluation of 200 patients requesting treatment from a "walk-in service," Lazare et al. (1972) defined four major types of requests from patients applying for immediate treatment: (1) *Support*—including such things as aiding self-control, reality contact, succor, institutional contact, confession, ventilation, and advice; (2) *psychotherapy*—a desire to clarify the recent events in their life or provide insight into some intrapsychic problem. (3) *request to an authority figure*—medical, administrative requests in order to meet and fulfill social needs; and (4) *miscellaneous requests*—related to community triage, e.g., where the person uses the clinic evaluation in order to be directed to what they really want —to no requests at all. The latter category, interestingly, includes patients frequently brought to the clinic against their will.

While the behavior, the psychobiologic aspects, and the meaning of the request for emergency evaluation can usually be determined through

interview and observation, the emotional aspects of the emergency may color this information.

**Emotional Aspects of Dealing with Psychiatric Emergencies**

As noted previously, the psychiatric emergency by definition and fact puts immediate emotional pressure on the person requested to do the evaluation. This pressure is related primarily to the necessity of making rapid decisions in what most often presents as a chaotic situation. Contributing to this anxiety and also affecting action sometimes is the threat of physical violence. Although relatively rare in psychiatric emergencies (Muller, 1967), the possibility or fantasy of violence is often present in the mind of the person doing the evaluation. Another factor that contributes to the anxiety of the person charged with dealing with emergencies, particularly those working in general hospital emergency rooms, walk-in clinics, etc., is the feeling of having very little, or actually no, control over what type of patients present themselves for evaluation. The consequent anticipation of problems that "could" present themselves often leads to great anxiety. In the face of the anxiety-provoking situation of dealing with psychiatric emergencies, particularly on a continuing basis, several aspects of the preparation of the staff are important. (It is probably important to recognize that some people will never be able to function well in these situations also.)

The evaluation of emergencies requires not only skilled but knowledgeable decisions. One of the best general ways to prevent anxiety from unduly influencing decisions is to equip emergency personnel with clear guidelines for dealing with and evaluating many of the common problems they will confront. For example, many types of check lists for evaluating suicidal behavior have been developed and others should be (Litman, 1961; Mayfield, 1972; Murphy, 1972; Weisman, 1972). The need for guidelines relates more to a way of organizing knowledge and making sure that the person, while acting under pressure, will not leave out pertinent aspects of the evaluation. Certainly, the gathering of information in itself has a calming effect on everyone. The person who presents as an emergency frequently has been the focus of chaotic interactions with others in his environment. An attempt to sit down and clarify this situation often has a calming effect in itself. In this sense, it is best if the emergency can be evaluated in a calm surrounding. A crisis in a person's life is not best handled in the heart of the emergency ward or the halls of a psychiatric unit: there should be a private place in which to deal with the situation. The manner of the interviewer in terms of equanimity, calmness, and composure, even under the greatest stress, is important to the patient. The manner should also be sympathetic, firm, consistent, and reassuring. The person doing the evaluation should also try to convey that if the patient assists him he, the clinician, may be able to sort out some critical factors that will be helpful to the patient. In this sense,

the person doing the evaluation is certainly more active than the traditional psychotherapeutic "blank-screen" stance. He shows that he is willing to aid in the resolution of the problem as much as he can.

Hankoff (1969), in his book on the treatment of psychiatric emergencies, condenses the above into three phases of emergency treatment: (1) assessment of symptoms and the critical aspects of the patients life; (2) an exploration of the patient's environment either by interview, phone calls, or even a home visit; and (3) the relief of acute symptoms through either verbal communication or pharmacologic means. Perhaps a key to the assessment of the emergency situation is the question, "Why now?" Why is this patient here at this point in time? What has happened in his immediate life that has made this situation an emergency? Many of the interpersonal and social problems that present as emergency requests for consultation can be markedly alleviated, and much of the pressure of the situation removed, through the process of clarification and evaluation itself.

From the foregoing survey of emergency problems it seems clear that it is the patient's *behavior* or other people's reactions to that behavior that usually constitute the emergency, and that traditional diagnostic labels are not as valuable as one might think for either evaluation or intervention. From the same data it is apparent that three classes of categorical behavior appear to most frequently necessitate emergency consultations: (1) *behavior that*

*threatens life,* such as suicide, assault, or generally violent behavior; (2) *behavior that disturbs existing patterns of life,* such as depressive symptoms, overwhelming anxiety, interpersonal conflicts, or what would be considered classic psychopathology; and (3) *behavior that makes it impossible to negotiate life,* such as senility, toxic psychosis, or what would usually be considered organic disturbances of the brain. For most of these categories of behavior there are clear guidelines for evaluation and intervention. We intend to focus on those aspects of emergencies which are the most difficult to evaluate and manage and to spend less time on those aspects most familiar to the daily work of psychiatrists, other than to present some recent work in the more familiar area. These specific guidelines, blended with the above general guidelines, can facilitate emergency evaluation and treatment. (This process is summarized in Table 29-1.)

## Categorical Kinds of Behavior Necessitating Emergency Intervention

### Life-threatening Behavior

Certainly, the evaluation of life-threatening behavior such as suicide, assault, or even homicide are some of the most difficult and anxiety-provoking kinds of behavior confronting the clinician. Depending upon the findings of the evaluation, the decision will be made as to whether the patient can be treated as an outpatient or whether he should be hospitalized

immediately. The crucial decision is one of the few life-and-death decisions that confront those who evaluate psychiatric emergencies. Perhaps the most crucial, overall predictive factor in the evaluation of life-threatening behavior is the past history (Ervin, 1969; Farberow, 1961; Lion, 1969; Rubin, 1972). It has been demonstrated in numerous studies that those who have acted violently or suicidally in the past will have a higher incidence of such behavior in the future. It is also in this area that questions of morality and legality, in terms of the physician's responsibility to the patient and to society, may come into conflict with the civil rights of the patient. It is of interest that a court or judge cannot imprison someone as a potential criminal. The court of law must act on fact, including previous behavior, whereas, those who evaluate psychiatric emergencies often act in an opposite manner. The person evaluating the psychiatric emergency, if he feels there is a high potential for either violence or suicide related to emotional problems, can, in most states and countries, institutionalize or effect institutionalization as a preventative measure against life-threatening behavior. Certainly, this responsibility must be taken seriously and cannot be abused. However, it is also important to note that this responsibility and power is legislated by the society through the advice of the medical or psychiatric profession.
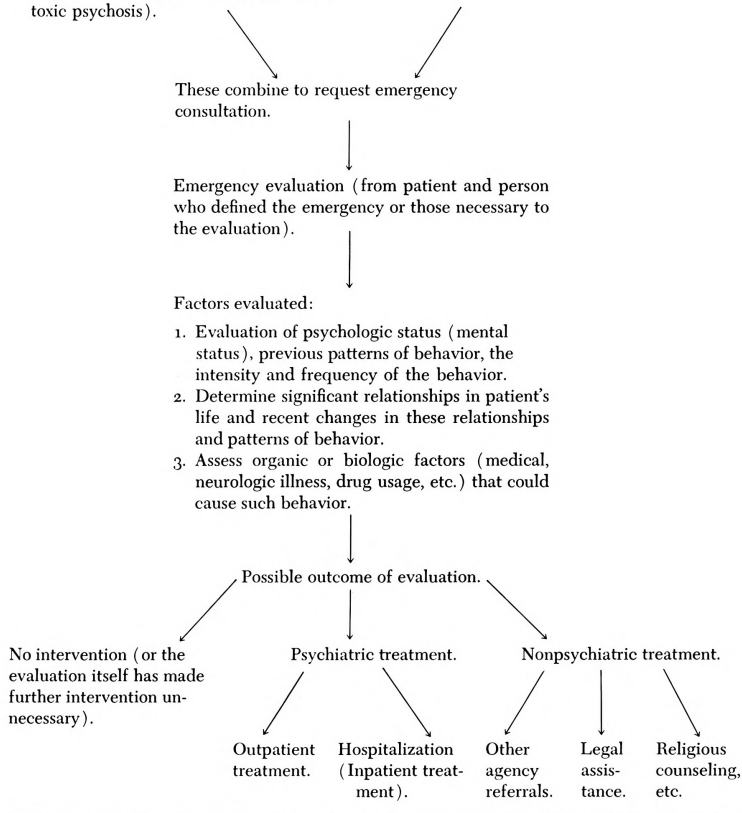
*Table 29-1. The Process of Evaluation of the Psychiatric Emergency*

| CATEGORIES OF BEHAVIOR THAT MOST OFTEN CONSTITUTE PSYCHIATRIC EMERGENCIES | THE EMERGENCY MAY BE DEFINED OR CALLED TO ATTENTION BY THE FOLLOWING |
| --- | --- |
| 1. Behavior that threatens life (e.g., suicide, assault).<br>2. Behavior that disturbs patterns of life (e.g., depression, overwhelming anxiety).<br>3. Behavior interfered with so that it is impossible to negotiate life (e.g., senility, toxic psychosis). | 1. Patient.<br>2. Family, friends.<br>3. Physician.<br>4. Social agencies (police, etc.) |

These combine to request emergency consultation.

Emergency evaluation (from patient and person who defined the emergency or those necessary to the evaluation).

Factors evaluated:

1. Evaluation of psychologic status (mental status), previous patterns of behavior, the intensity and frequency of the behavior.
2. Determine significant relationships in patient's life and recent changes in these relationships and patterns of behavior.
3. Assess organic or biologic factors (medical, neurologic illness, drug usage, etc.) that could cause such behavior.

Possible outcome of evaluation.

No intervention (or the evaluation itself has made further intervention unnecessary).

Psychiatric treatment.

Nonpsychiatric treatment.

Outpatient treatment.

Hospitalization (Inpatient treatment).

Other agency referrals.

Legal assistance.

Religious counseling, etc.

With regard to life-threatening behavior, there are usually two aspects: (1) there are patients who threaten such behavior, and (2) those patients who

have actually carried out such behavior. The other dichotomy are those patients who participate in life-threatening behavior while not in treatment and those who participate in such behavior while in treatment, either outpatient or inpatient treatment. Successful completion of life-threatening behavior while in treatment often relates to denial on the part of the therapist (Lion, 1968). However, at times, clues to these kinds of behavior are not clear. Regardless of these distinctions, a history of such behavior in the past remains as one of the best predictors.

**Suicide and Suicide Attempts**

Recently, a whole range of kinds of suicidal behavior has been delineated. Groups of patients who threatened suicide have been contrasted with those who have successfully committed suicide, as well as those patients who have made multiple suicide attempts (Clendenin, 1971; Maxmen, 1974; Shneidman, 1961; Tucker, 1967). All categories of suicidal behavior are higher in patients who have primary diagnoses of depression (Farberow, 1961) and alcoholic problems (Maxmen, 1973), as well as some schizophrenic patients in the posthospital phase (Farberow, 1961). With the recent interest in suicide, it is easy to overlook the fact that suicide is a symptom and its occurrence is usually related to the above diagnostic entities. The typical suicide attempt is by a person described as a white, female, twenty to forty years of age, who ingests pills, usually after an interpersonal conflict. The

successful suicide is usually forty-five years of age or older, male, white, often separated, widowed, or divorced, who lives alone and may be unemployed or retired. Historical factors of poor physical health, and medical care within the past six months, some evidence of psychiatric disturbance as noted above, and a previous history of attempts or threats are usually cited as being more common in those who have successfully committed suicide (Shneidman, 1961). However, it is of note that there are many people who fit these demographic characteristics who have no suicidal behavior.

In the evaluation of patients immediately after suicide attempts, several scales have been devised that attempt to predict the lethality of suicide. One study delineates the risk of the attempt by evaluating the method and actual damage done (Weisman, 1972). Specific factors looked at are the agent used, whether these resulted in impairment of consciousness, the lesions or toxicity produced, the reversibility of the method used, and the treatment required. The more severe and irreversible these factors, the higher the risks. The other component is the rescue factor. This is based on whether the suicide attempt was made in observable circumstances and how available resources for rescue were at the time of the attempt. The latter include such things as location of the suicide attempt, the people around to initiate rescue, the probability of discovery, and the accessibility and delay until rescue. Other psychological factors have been delineated. Probably the most pertinent are the following (Fawcett, 1969): (1) interpersonal capacity— the person's

ability to relate to other people, and the quality of their relations. Interestingly, this interpersonal capacity probably relates also to the occurrence of other violent acts, as well as suicide attempts; (2) marital isolation; (3) the use of distorted communications; and (4) help negations—the person that feels that no help is available and also goes out of his way to negate any help. Stengel has talked about the Janus-faced quality of suicide wherein one part of the person actually wants to die and the other part is looking toward life (Stengel, 1967). But, in part, all of this comes down to the most critical factor—*the patient's explicit intent to die.* After assessing this factor by means of the above guidelines, one can then institute a treatment program for the patient. However, it is important to note that patients who are seen during the immediate post-suicide-attempt period may manifest a brief (hours to several weeks) period of lifting of a depressive reaction. So, the evaluation must be made on the previous depth of symptoms and lethality as well as the immediate clinical status, with an awareness that the presenting clinical picture maybe short-lived. It is also important at this point to assess the presence of any factors of an organic nature in the mental status that may have resulted from the suicide attempt (Davis, 1968). While most of these are acute, their presence may affect the immediate disposition and if chronic, the long-term disposition as well.

Certainly, in the process of the evaluation of the suicidal patient, an attempt should be made to establish a relationship with the patient. It is also

essential to gather information from people in the person's environment. As a critical part of the assessment includes the evaluation of the type of suicidal plan, e.g., the use of a gun, pills, etc., one should then attempt to remove these agents of destruction from the person's environment. An attempt should also be made to reduce the isolation of the patient in terms of involving friends and family, and even through hospitalization.

The suicidal patient usually feels helpless and is somewhat in an inert or anergic state. Some attempt to break this inertia can be achieved by giving the patient specific tasks such as to call at certain times, take specific medications, etc. A follow-up during this period is crucial and a contact should be maintained with the patient both over the phone and at frequent, short intervals in person. Some therapists attempt to discover any reason at all that the patient has for living and use this in their dealings with the patient. With respect to medication, no more should be given than a brief supply, and, certainly, the maximal lethal dose should not be exceeded (Brophy, 1967). It is also important to institute treatment for any other associated symptoms, e.g., depression, alcoholism, schizophrenia, etc.

### Violence

Violent and impulsive behavior in general can be defined as threatening or destructive acts or ideation to animate or inanimate objects (Ervin, 1969).

While violence is no stranger to psychiatrists, it is probably less of a problem in psychiatric populations than one would expect. Violence is not an exclusive problem of the emotionally ill, and, in general, it is more prominent in those who are not emotionally ill than those who are. Kalogerakis noted recently that in a survey of psychiatric inpatients violence against the staff was a most uncommon phenomena (1971). Messinger noted that less than 5 percent of all major crimes are committed by people with overt psychosis or mental retardation (1958). Brill and Malzberg are frequently cited to demonstrate that the crime rate for psychiatric patients was lower than that of the general population (Brill, 1962). Recently, Rappeport and Lassen noted that for some serious offences (robbery and rape) there is a higher incidence in discharged male psychiatric patients than in the general population (1965). For discharged females, aggressive assault was higher than in the general population (1966). This is of some interest, for one must recognize that this is only for discharged patients and not those still hospitalized. Still, the majority of violent people, which includes most criminal offenders, reckless and drunken drivers and so on, will not be seen by the psychiatrist (Ervin, 1969).

Several studies have been done on emergency-room psychiatric patients, seen primarily for violent behavior (Lion, 1968, lion, 1969; Tuason, 1971). These patients were almost exclusively male (94 to 98 percent). Their age range was between fifteen and forty-five years and their social class conformed to usual emergency-room populations. Aside from these

demographic factors, the most consistently cited predictive factor is a *past history of violent or impulsive behavior.* The sociologic factors cited in many studies are of interest, but of less use to the clinician. Recently, Rubin (1972) delineated some of the more pertinent psychologic historical patterns in violent patients: (1) their life experiences have created bitterness or resentment; (2) they have frequent quarrels with family members; (3) their associations with significant figures who are violent are greater than usual; (4) there is generally an absence of a source of self-esteem and a defective self-image; (5) interest in weapons; and (6) violent fantasies and daydreams. Specific symptoms that have also been correlated with violent behavior (but are also found in nonviolent patients) are such things as temper tantrums, hyperactivity, stuttering, and holding of breath. The specific constellation of pyromania, enuresis, and cruelty to animals has also been noted to be predictive of adult crime (Hellman, 1965). Typical family constellations that have been noted in violent patients are those marked by parental hostility and overt violence and/or seductiveness. Alcohol and drug use are factors indicated in a large number of violent episodes (Ervin, 1969).

As with any life-threatening behavior, it is no diagnostic feat to determine that an act has been committed. However, it is crucial to try to predict during an emergency consultation who will, in the immediate future, engage in such activity. It seems clear that there are at least two major groups that engage in violent behavior. One is a group of patients that has lifelong

histories of acting out aggressively and violently in response to varied, and often any, stress. The other comprises a smaller group (Detre, 1972). It is those who act aggressively in relation to the onset of some clear-cut emotional disorder, such as psychosis, affective disturbance, etc.

Violence or violent thoughts are either diffusely directed or directed at a specific person. Those with diffusely directed violence are frequently more difficult to treat as to finding a focus for immediate psychotherapeutic intervention. The self-referred patient who comes about questions of self-control or loss of control should be taken quite seriously in that he perceives himself to be a definite danger (Lion, 1968). Mental status is of some assistance in evaluating violent patients. Particularly noteworthy are the following: acute anxiety, fears of loss of control, ambivalent feelings toward those in the environment, and undisguised, straightforward hatred and anger. The more severe these symptoms are the more possible is the occurrence of violent behavior (Ervin, 1969).

It has been noted in prison populations and in those with impulsive behavior that there is a high incidence of EEG abnormality, but the exact role of neurologic factors in violent behavior is relatively unclear (Monroe, 1970; Tucker, 1965). Certainly, many physiologic factors have been shown to be a contributing factor in violent behavior, such as brain injury, seizure-like behavior, and even some of the recent genetic defects such as XYY (Ervin,

1969; Mark, 1970). While these can be contributing factors in lowering impulse control, the part they play in the immediate treatment plan is minimal other than in the utilization of specific medications for seizure disorders, etc. The majority of the patients seen for violent behavior are hospitalized, at least briefly, for further evaluation and many have previously been hospitalized for similar complaints (Lion, 1968; Tuason, 1971).

In general, the treatment of these patients involves some attempt to clarify the precipitants of the violent behavior, and to increase their capacity to tolerate stress and depression. Stress tolerance, at least in the acute state, can be increased pharmacologically. Many of these patients require immediate sedation in order to even further evaluate (see Table 29-2). Ervin recommends developing a type of institutional cathexis so that when the patient is under stress, he can either return to the emergency room or call the physician who saw him initially. Most violent acts are directed at family members, or those with whom the patient has close contact. Some assistance in alleviating the stress can be gained by treating the recipient of the violent behavior either alone or with the patient, and clarifying what is stressful and what isn't stressful. In most studies, continued contact with these patients is of some necessity and seems to be helpful (Ervin, 1969).

In the initial phase of treatment, when an agitated patient is brought to an emergency room, it is important to convey that he is in a place where he is

safe and can be controlled and will be able to do no harm. In this respect, restraints, although distasteful, are often useful initially, for a brief period of time.

For the very agitated, a "show of force" is recommended as a very calming influence. As an example, a manic patient who was reluctant to either take medication or remain in the hospital, and was quite dangerous to himself and others, was being restrained, not too successfully, by some of the psychiatric staff when a security guard entered who was at least six feet four inches and 250 pounds. The patient, who had been struggling violently and had assaulted one of the staff members, looked at this man, put out his hand, and said, "Hello. I'm Joe. Would you like to play chess?" and was quiet and took his medication.

In general, the assessment of the violent patient probably depends upon three main factors: (1) the previous history of violent behavior; (2) the type of violence either contemplated or actually undertaken; and (3) the degree of control that the patient manifests both verbally and physically during the interview. When all of these kinds of behavior are clearly present and not well-controlled, the likelihood of violence is high. It also behooves the psychiatrist to recall the statement of Rubin; "The term dangerousness to others cannot be simply a way of singling out anyone who we would prefer not to meet on the streets. Possibility of injury is not enough, it must be likely,

and the threatened harm must be substantial . . . thus, the psychiatrist must define 'likely' as meaning 'virtual certainty' rather than mere chance" (Rubin, 1972).

## Homicide

The problem of homicide may be considered as a difference of degree in relation to violence. However, there are some aspects of the evaluation that are different. The demographic data reveals that the typical person who commits homicide is a male between the ages of eighteen and forty-three years. It is interesting that risk of committing homicide decreases with age unlike the suicide rate, which increases with age. The male to female ratio is five to one. While there is a higher Negro to white homicide rate, this seems more related to the American culture than to racial distinction, in the sense that the homicide rate of the American Negro is several times higher than that of the African. Certainly, the great majority of homicides is not related to classic psychiatric illness. However, MacDonald has stated that acutely psychotic schizophrenic patients and delirious patients who make homicidal threats should be hospitalized. The chronicity of paranoid delusions should provide the clinician with no assurance against homicide in that the paranoid delusions of those who actually assaulted or killed someone were present for at least four and a half years (MacDonald, 1968).

Among the many factors associated with homicide potential are: (1) parental brutality, (2) parental seduction, (3) arson, (4) cruelty to animals, (5) enuresis after age five, (6) arrest record, (7) arrest for assault, (8) alcoholism, and (9) attempted suicide. MacDonald, in an attempt to evaluate these predictors, studied a group of patients who made homicidal threats and compared them to a group of patients who had actually committed homicide and to a group of nonviolent psychiatric patients. None of these patients studied was psychotic, and each was matched for age, sex, race, and social class. While there was evidence that parental brutality, parental seduction, childhood arson, cruelty to animals, and enuresis were slightly higher in the actual homicide group, the groups could not be statistically differentiated. The only parameter that was significant was attempted suicide in the homicide-threat group. The study concluded that "the risk of homicide is higher in the absence of attempted suicide. Those who have attempted suicide are more likely to kill themselves than to commit homicide." A follow-up study of 100 patients who were admitted to a hospital for homicidal threats found that the subsequent rate of homicide or suicide was more than 7 percent during the five-year, follow-up period. This study indicates that the incidence of life-threatening behavior is much higher in the group that makes these threats than in the general population (MacDonald, 1968).

*Table 29-2. Types and Doses of Medications Frequently Prescribed for Psychiatric Emergencies\**

1. Acute Agitation—no organicity—usually psychotic

    A. Severe—immediate sedation desired, patient usually not arousable post-drug

        a) Sodium Pentothal, 250-500 mg. IV

        b) Sodium Amobarbital 200-800 mg. IV

        c) ECT

    B. Severe—sedation desired rapidly, usually within 1 hour—patient usually arousable post-drug

        a) Chlorpromazine: male (70 kg.) 100 mg. p.o. every 30 min., or 50 mg. IM and repeat in 45 min.

        b) Haloperidol: 3-5 mg. IM every hour

        c) Perphenazine: 5 mg. IM every hour

    C. Moderate—oral doses of above, tranquilizers and minor tranquilizers with regular maintenance schedule if indicated

    D. Prolonged Sleep Treatment (Dauerschauf)

        a) Chlorpromazine: 150 mg. p.o. and 150 mg. every 4 hours

        b) Sodium Amobarbital: 500 mg. p.o. and 250 mg. p.o. every 4 hours if awake

2. Acute Agitation—organic etiology

A. Toxic psychosis secondary to hallucinogenic drug use (sedation seems the most important factor)

a) No marked anticholinergic symptoms

1) Chlorpromazine as above depending on severity of agitation

2) Sodium Pentothal or Amobarbital, as above depending on agitation

3) Diazepam: 10 mg. IM or IV and then 5-10 mg. every hour, or 20-40 mg. p.o. and then 10 mg. every hour

4) Chlordiazepoxide: 100 mg. IM or p.o. every hour until sedated and p.o. or IM every 4 hours

B. Presence or suspicion of anticholinergic like drug or symptoms of —do not use phenothiazines

a) Diazepam, as above

b) Chlordiazepoxide, as above

c) Barbiturates, as above but smaller doses

d) Paraldehyde, as stated

e) Physostigmine salicylate, 2-4 mg. IM or p.o. and then p.o. every hour

3. Drug Withdrawal

    A. Alcohol—Delirium Tremens

        a) Paraldehyde 10 cc p.o. or IM and every 2-4 hours; chloral hydrate (may be added) 0.5-1 gm. every 4-6 hours

        b) Chlordiazepoxide, as stated

        c) Chlorpromazine, as stated in slightly smaller doses

        d) ECT

    B. Barbiturate and other central nervous system depressants

        a) Re-intoxication with 200 mg. pentobarbital, (see text for dose schedule)

    C. Narcotic Withdrawal

        a) Acute intoxication—can be treated with Nalorphine 2-10 mg. every 2 hours to restore mildly depressed respirations

        b) Withdrawal with 10-20 mg. p.o. Methadone in divided doses to a total of 40-60 mg. daily with gradual reduction (10%/day)

4. Organic Brain Syndromes

    A. Minimal initial doses of major tranquilizers either p.o. or IM with careful observation of effects, and gradual increasing of doses as needed.

While the above-cited parameters of controlled studies do not differentiate those who are homicide prone from those who will actually kill someone, they should alert the clinician to the person's potential for violence. As with suicide, one should not hesitate to ask questions about either homicidal thoughts, potential, plans, or past history when the potential for violence to others is suggested by a patient's history or clinical examination. As homicide seems to involve those the patient sees regularly (85 percent of murder victims were known by the murderer) there is reason for not only evaluating patients but the family as well and even treating them together (Ervin, 1969). While all patients who make threats cannot be hospitalized or detained for long periods, when there is a history of violent behavior—a patient agitated enough by mental-status examination to engage in such acts, with a history of poor impulse control—hospitalization is indeed indicated until the situation is mitigated or the patient is further evaluated. Lion (1968), Ervin (1969), MacDonald (1968) and others who have had a great deal of experience with such patients, all note the value of long-term follow-up and accessibility of a therapist for patients who manifest such problems, so that they might talk out rather than act out their feelings.

**Behavior that Upsets the Patterns of Life**

Many of the problems that constitute psychiatric emergencies are perceived by the patient or others. What is perceived is that something different, or some dramatic change, has occurred. Into this area fall most major categories of acute and chronic psychiatric illness, particularly psychosis. While there is no intent to review every major psychiatric syndrome, it is acknowledged that general guidelines of management exist. Any change in the behavior of even a chronic patient that is perceived as markedly different by the patient or others often leads to an emergency psychiatric consultation. In actuality, the problems that most often present in this manner can be grouped into four categories: (1) primary symptoms of conceptual disorganization (usually schizophrenia); (2) primary symptoms of affective disturbance (depression, manic depression, etc.); (3) primary symptoms of anxiety (panic); and (4) primary physical or somatic symptoms (conversions). These conditions are considered together, as they usually represent disruptions in the life of the patient; these disruptions effect almost all systems (social, family, and work) with which the patient has contact. The patient usually presents as the focus of a chaotic situation and the emergency consultation often provides a structured forum whereby some of the chaos can be mitigated. In dealing with these particular psychiatric problems, it is often easier to group them into the above categories instead of in diagnostic categories. In the emergency situation, one is mainly interested in the target symptoms and the primary complaint of the patient. At this point the

diagnosis may not be at all clear. The short-term focus of the emergency situation allows one to focus on immediate alleviation of symptoms and precipitating events, and to initiate treatment. As many organic conditions can mimic these states, organicity must be considered and ruled out before the institution of any medication. While there is great diversity in the clinical picture of the above conditions, there are some overall principles of management that are generally useful. Sedation and tranquilization may be necessary in order to even evaluate the patient. Specific attempts should be made to clarify the situation with regard to any activity of the patient or family that may be adding to the chaos. There is some value, in the initial phase of contact with the patient, in attempting to instill some hope with respect to a resolution of the situation. The interpersonal aspects of the relationship during the initial interview are extremely important. Perhaps most helpful is the acknowledgement on the part of the interviewer of the degree of distress or discomfort the patient feels. Statements such as "how upsetting" or "how frightening these experiences are" are much more useful than attempting to confront the patient, particularly the psychotic patient, with reality (Bullard, 1960). It is not reassuring to the patient to try to deny his discomfort or unhappiness. Perhaps the most important message to convey to the patient is a spirit of collaboration. While the decision to hospitalize such patients is often easier than continued outpatient treatment, the major factor that seems to determine the choice of intervention relates to

the structure and accessibility of environmental supports and treatment facilities (Maxmen, 1974; Mendel, 1969; Wood, 1960). Even the most psychotic patient can often be sent home to a supportive family, while someone less ill may need to be hospitalized because he has no supports in the community. Particularly, one should be careful about sending a heavily medicated patient out of the emergency room without supervision except when his response to the medications is known.

While the above initial pharmacologic and psychotherapeutic guidelines are appropriate for most major emergency behavioral disturbances, specific behavior requires differentiation. Although by no means comprehensive, the following summary lists the pertinent symptoms and historical factors that are useful in determining the emergency management of these problems, particularly with regard to medications. Also cited are the more important conditions they must be differentiated from.

### Primary Symptoms of Conceptual Disorganizations

The symptoms most often noted are those of bizarre and idiosyncratic speech, delusions, hallucinations, without disturbances of orientation or memory. Also absent are primary or noticeable affective symptomatology. Certainly, the major condition that presents in this manner is the acute schizophrenic reaction. However, such entities as sleep deprivation (Luby,

1960), gross-stress reactions (Grinker, 1963), and particularly hallucinogenic-drug reactions (Freedman, 1968) can present in this manner, so a careful history must be taken to differentiate these conditions. The history should provide precise information on premorbid social functioning, family history, and the immediate precipitants to the episode. The predominant pharmacologic intervention for disorders that present with the above picture are the major tranquilizers (Klein, 1969).

## Primary Symptoms of Affective Disturbance

The most common symptoms associated with these conditions are depression, retardation, manic or hypomanic behavior, guilt, hopelessness and self-deprecation. These conditions, particularly retarded depressions, can often be mistaken for organic states, especially in older patients. Conversely, the organic dementias and senility can often be mistaken for severely retarded depressions. In this instance, it is especially important to perform a neurologic examination in cognitive and motor-retarded patients. A careful history of premorbid functioning will often assist in differentiating a dementia from the onset of a depressive reaction, the former being more gradual and slow, and the latter usually being more distinct at its onset. Certainly, there is very little difficulty in recognizing hypomanic and manic conditions, again being careful to differentiate them from various types of hallucinogenic-drug ingestions and other self-medications. Strokes or

cerebrovascular accidents can often present in either manner, e.g., either depressed or hypomanic. When this is suspected a neurologic examination is often of use. Almost as a subgroup of these reactions are acute grief reactions, as described by Lindemann (Lindemann, 1944-45). This includes symptoms of somatic distress, preoccupation with the image of the deceased, guilt, hostile reactions, and, in general, loss of usual life patterns. In these conditions, while initial medication for agitation may be necessary, the major pharmacologic interventions are those that affect mood, e.g., antidepressants, lithium, etc. (Klein, 1969).

### Primary Symptoms of Anxiety

In these instances, we see the patient expressing symptoms mainly associated with anxiety, such as feeling nervous, tense, an inability to concentrate, along with various symptoms of autonomic-nervous-system arousal—palpitations, diaphoresis, and an inability to focus attention. These symptoms may be treated by the minor tranquilizers or, if the agitation is severe, the major tranquilizers for immediate sedation (Klein, 1969).

In this section it might also be useful to discuss the group of reactions seen in survivors of a disaster situation (Lowenberg, 1952; Menninger, 1952; Tyhurst, 1950). While natural disasters such as fires, floods, and earthquakes, etc. are rare, the survivors of these occasions are frequently seen en masse in

emergency rooms and psychiatrists may be called in as part of a general medical mobilization. While major psychiatric problems are rare, there is a typical pattern of emotional response to be aware of. The crucial factor most of the survivors of disaster situations experience is an abrupt shift from a familiar environment to a strange or unfamiliar environment. In disaster situations, 12 to 25 percent of the patients remain calm and collected, and can be used for various leadership roles. Another 10 to 25 percent will react in an inappropriate, hysterical, and overwhelmed fashion. This group usually represents the majority of the psychiatric casualties. These patients are best managed by sedation. The majority of survivors of disaster situations, usually about three-quarters, will act in a stunned, bewildered, confused fashion, and, in fact, often appear sedated. They are usually passive and compliant. They respond to simple directions and clarification of rumors. After the initial shock phase of the disaster situation, there is usually a desire for compulsive talking and repetition of the story. However, this is accompanied, frequently, by physical fatigue and lassitude. At this time, leadership and direction are important, as well as rumor control. The whole cycle takes place in twenty-four to forty-eight hours, with complete recovery in most cases (Rubin, 1972).

*Primary Physical or Somatic Symptoms*

These patients frequently present with conversion reactions, paralysis, hysterical blindness, somatic symptoms such as nausea and vomiting,

amnesia, and fugue states. While these are not classically considered psychiatric emergencies they often present to emergency rooms or as emergency consultations. Certainly many of the patients who have these symptoms may belong to other diagnostic groups as well, but, in terms of the emergency management, these are the primary-target symptoms that need alleviation. In these patients interview and clarification often are more helpful than medication.

### Management of the Above Conditions—The Use of Medications

All of the above conditions, depending on their severity, may necessitate varying amounts of medication. These amounts may range from none to a great deal of parenteral medication. The criteria for the administration of medication usually depend upon the severity of the symptoms, but more particularly on the severity of what can be termed "biological symptoms." Biological symptoms we would consider are: (1) psychomotor disturbance in terms of either extreme agitation or extreme retardation; (2) extreme conceptual disorganization; (3) marked symptoms of anxiety; and (4) sleep disturbances that are protracted. While any of these symptoms may be present, they frequently are present as an admixture of all of them. Depending on the severity of symptoms and the capacity of the patient to be interviewed and evaluated, one may use these medications rapidly or at a gradual pace.

Although the phenothiazines and other tranquilizing agents have been in use for close to twenty years, there is very little in the way of prescribing or directions for the emergency use of these medications. The major psychotropic agents have most often been prescribed for the target symptoms of agitation, excitement, anxiety, ideas of persecution, and hostility (Goldberg, 1965; Klein, 1969). While the phenothiazines have become one of the most useful pharmacologic agents in the psychiatrist's armamentarium, there are still other agents such as barbiturates, paraldehyde, chloral hydrate, and minor tranquilizers that are useful in sedating agitated patients (see Table 29-1).

The decision to use medications is based on the level of biologic symptoms of the patient and his response to the interview attempts. For example, if the patient calms down appreciably during the interview, then sedation may not be necessary at that point but may be necessary if the patient is to return home. However, if the patient either remains very agitated during the interview or is initially so agitated that he cannot be interviewed, then medications are certainly in order. While medication should not be administered without examining the patient, in rare instances the patient will be so agitated that physical examination is difficult. At this time, pertinent history must be gained from either the patient or most often from others as to possible organic causes and, specifically, as to drug ingestion. An attempt should be made to take at least the vital signs. While the systolic blood

pressure is often high in an agitated, struggling patient, the diastolic is usually not that elevated. If the history is clear and there are no organic findings in the physical examination to contraindicate, then medications should be instituted, usually by the parenteral route. With regard to the major tranquilizers, the use of chlorpromazine (parenteral dose range 50-100 mg.), perphenazine (parenteral dose 5 mg.) or haloperidol (5 mg.) are all effective in initially sedating the patient (Detre, 1971; Klein, 1969; Ritter, 1972; Shopsin, 1969). If there is no response or diminishing of excitement, the dose may be repeated at thirty-to-forty-five-minute intervals until the patient is either asleep or calm enough to talk (see Table 29-1). At times, the very act of giving medication parenterally calms the patient. Aside from its pharmacologic effect, it signifies to the patient that safeguards or external controls have now been instituted to stop his behavior. In cases of extreme agitation, where the patient needs immediate sedation, intravenous sodium amobarbital in ranges from 400 to 800 mg. IV slowly, is also quite effective. The proper dose is enough to sedate or calm, and most problems relate to not giving enough of the medication (Klein, 1969). In prolonged contact it is important to continue the medication orally after the time of effectiveness of the intramuscular dose is over ( Detre, 1971).16 It is important to remember that the prior state of the organism, where the level of excitement or arousal is quite high, will usually allow the person to tolerate much higher doses of medications than he would in a less agitated state. In other words, 100 mg. of

sodium amobarbital may be used as a hypnotic for a person in a normal state, and the same person in an agitated state may take close to 800 mg. of sodium amobarbital to produce the same soporific effect (Wilder, 1958).

### Management of Above Condition—Psychotherapeutic Goals

With regard to psychotherapeutic interventions, many of the objectives of the emergency interview have already been listed. Depending upon the severity of the symptoms of either conceptual disorganization or affective disturbance, the primary intervention is medication. After a period of sedation and some alleviation of symptoms, the scheduling of psychotherapeutic sessions can be done at a more leisurely pace, either on an outpatient or inpatient basis. This is in contrast to the situation where symptoms of anxiety, and the physical and somatic symptoms predominate. Then talking and psychotherapeutic intervention are almost the main intervention, especially in mild cases, and medications are adjunctive. Lindemann's principles for the treatment of acute grief reactions are useful in many emergency situations other than grief reaction (Lindemann, 1944-45). He outlined that in acute grief reactions psychotherapeutic intervention should focus on: (1) a sharing (of the grief work); (2) reviewing the relationship with the important people in the environment (deceased); (3) accepting the pain of the grief as well as working through and mobilizing some of their own feelings and fears about such things as insanity, anger, etc.;

(4) acquainting the patient with their own present alteration of modes of emotional reaction; (5) attempting to establish some acceptable formulation of future relationships (to the deceased) and, in general, to others in the environment; and (6) finding new persons around whom the patient can develop new patterns of contact. In the emergency situation many of these topics can only be touched on, but they do provide good guides for inquiry. The gathering of information and the reflection back to the patient of the implications of the information go a long way to reassuring the patient that there is not only a cause for the state he is in but a possible solution. The use of insights gained in these contacts may be superficial, but they are often perceived by the patient as the beginning of a helping process. Interestingly, for some they may even be lastingly effective, becoming "rules of life" for their future activities.

**Impairments to Performing Effective Behavior**

While previously we looked for classic symptoms of emotional illness, in this section the class of symptoms that are manifested primarily are those considered to indicate organic brain dysfunction. Disturbances of memory, orientation, and level of awareness arc the most frequent symptoms that one would note. In other words, we are dealing with phenomena that interfere almost mechanically with the person's ability to negotiate life. In most instances the emergency situation that will confront the clinician relates

primarily to three areas: (1) specific central nervous system damage, (2) too much of a drug (intoxication) or too little of a drug (withdrawal) or (3) drugs with primary-behavior-altering properties or idiosyncratic reactions to drugs or toxins. Whatever the cause, the symptoms usually manifest themselves as some type of cerebral dysfunction either in the form of a delirious state or in classic-acute or chronic-organic brain syndrome (Lipowski, 1967). When the mental-status examination reveals evidence of cerebral dysfunction, it is almost mandatory that the patient have a detailed physical examination, looking for such things as pneumonia, subdural hematoma or cerebral laceration, meningitis, diabetes, and any of the other myriad metabolic conditions that can cause delirium and even psychosis (Himmelhoch, 1970; Pincus, 1974). Of contemporary concern would be noting, in the physical examination, evidence of injections of various drugs, particularly narcotic drugs. The vital signs (temperature, blood pressure, and pulse) are also of critical importance in the evaluation, particularly temperature. The other most important part of the examination of patients with any type of evidence of cerebral dysfunction in the mental status is a detailed exploration of the history for past drug use and abuse as well as current medications, both prescribed and self-prescribed.

The majority of these problems can be grouped into the following three categories: withdrawal reactions from chronic use of some pharmacological agent, toxic or idiosyncratic reactions, and, lastly, cerebral dysfunction related

to traumatic, vascular, infectious, metabolic, or neoplastic disease of the central nervous system.

### *Withdrawal Reactions*

The classic withdrawal reaction is that usually associated with the use of alcohol. The syndromes (all of which may present for emergency evaluation) associated with the abuse of alcohol have been most clearly delineated by Victor" (1966) He noted: (1) *alcohol intoxication,* which is simple drunkenness and includes such entities as pathological intoxication. Pathological intoxication may be defined as an abnormal, psychoticlike reaction related to small amounts of alcohol. Some people have felt this is related to temporal-lobe epilepsy; (2) *abstinence or withdrawal syndrome,* including tremulousness, hallucinosis, "rum fits," and delirium tremens; (3) *nutritional diseases* associated with alcoholism, such as Wernecke Korsokov syndrome, neuropathies, pellagra; and (4) *degenerative diseases* of uncertain pathogenesis. The syndromes related to abstinence and withdrawal are those most commonly seen as psychiatric emergencies. Alcoholic hallucinosis may present without tremulousness and may be seen as a withdrawal symptom or while the patient is still drinking. However, its close association with the ingestion of alcohol and the lack of a history of schizophrenia make it a fairly distinct entity (Victor, 1958). The classical syndrome of delirium tremens, with increased motor and autonomic activity, confusion, disorientation,

hallucinations and illusions, is familiar to most physicians. The syndrome is classified as a medical emergency. Its treatment necessitates proper hydration as well as vitamin supplementation. The pharmacologic management of this entity has changed in the recent past, initially being treated by the phenothiazines when they first became popular, moving to chlordiazepoxide (Librium) when it became available; now there has been a return to paraldehyde and chloral hydrate in the treatment of these alcohol withdrawal syndromes. In the sixties, a study by Golbert demonstrated that paraldehyde and chloral hydrate were the most effective and best-tolerated drugs in the treatment of patients with delirium tremens (1967). With the use of these drugs, there were fewer complications noted in terms of pneumonia, convulsions, and hypertension. The schedule recommended in the regimen was 10 cc. of paraldehyde orally, and 0.5 to 1 g. of chloral hydrate orally. The paraldehyde could also be given intramuscularly. The paraldehyde was given at four-hour intervals and the chloral hydrate at six-hour intervals. If the agitation increased, the 10 cc. of paraldehyde could be given every two hours, and a gram of chloral hydrate every four hours until the patient was sedated. Librium in doses of 50-100 mg. every hour until sedation was reached has also been recommended as adequate treatment. The onset of the withdrawal syndrome occurs, usually within the first twenty-four to forty-eight hours, but may occur as long as seven to ten days after the cessation of alcohol. However, this is rare. Eighty percent of the cases will respond within three

days of treatment (Ungerleider, 1960). A few years ago, Dudley presented data that a single ECT was also often effective in the treatment of delirium tremens (1972).

Barbiturate withdrawal, or for that matter any central-nervous-system-depressant drug, can present frequently with either seizures or psychotic symptoms as part of the withdrawal syndrome (Ewing, 1967; The Medical Letter on Drugs and Therapeutics, 1970). In fact, of those taking more than 900 mg. of barbiturate a day about 80 percent will have seizures and the majority psychotic symptoms upon abrupt withdrawal. The barbiturate addict (also found in patients addicted to other types of central-nervous-system depressants) may present in an intoxicated state. Usually, they are ataxic (often they show bruises on legs and body due to ataxia) with slurred speech and slowed and confused mentation. The intoxicated patient is often brought in by his family or friends. They say that the patient's behavior has changed and that he is either acting differently now or sleeping most of the time.

While an addict of central-nervous-system depressants, in the intoxicated state, may present as a diagnostic problem, the patient, in withdrawal, may present as a self-referral for treatment, for partial treatment to make his habit cheaper, or because he has run out of drugs. Physical signs that often confirm barbiturate-addiction withdrawal are insomnia,

blepharospasm, nystagmus, and postural hypotension with a pulse rise on standing of greater than twelve to fifteen beats. Seizures do not usually occur before thirty-six hours. The usual treatment of the withdrawal state from depressant drugs is by re-intoxication with a depressant drug. Ewing has suggested a demonstration of drug tolerance with the use of a test dose of 200 mg. of pentobarbital orally on an empty stomach (Ewing, 1967). The patient is then observed in one hour, and if he shows no sign of intoxication at the end of this hour, there is probably indication of extreme tolerance (addiction of more than 1000 mg./day) to barbiturates; if the patient is asleep but arousable, there is probably no dependence on these types of drugs. There is a great deal of cross-tolerance in these drugs and even though the patient may be addicted to such things as meprobamate, glutethimide, etc., the patient may be withdrawn with pentobarbital or phenobarbital on a decreasing schedule of 10 percent a day until withdrawal is complete. With regard to opiate use, the withdrawal usually starts thirty-six to seventy-two hours after cessation of drug use, with symptoms progressing from a craving for drugs and anxiety to yawning, perspiration, lacrimation, mydriasis to goose flesh (pilomotor erection) etc. The withdrawal can usually be tolerated without substitution of other drugs. However, the addiction may be mixed and one then must withdraw the patient depending on the addiction. While pure opiate withdrawal is not life threatening, most physicians will use methadone for withdrawal (The Medical Letter on Drugs and Therapeutics,

1970). It is also important to note that many drug abusers are addicted or use many different drugs so that both withdrawal and intoxicated states may present confusing clinical features. Consequently, in any patient with drug-abuse problems multiple drug use should be considered.

### *Drugs That Alter Behavior. Toxic and Idiosyncratic Reactions to Drugs*

Of interest today are the reactions to hallucinogenic drugs. In the past decade the increase in number and availability of compounds that have hallucinogenic effects has been nothing short of remarkable (Table 29-3) (Freedman, 1968; Gowdy, 1972; Kramer, 1967; Leff, 1968; Lieberman, 1971; Ullman, 1972). Tim willingness of people to take unknown compounds, which may or may not be adulterated and may have any number of unknown contaminants, is no less astounding (Freedman, 1968). The effects of these drugs, often taken in varying combinations and routes of administration, are dramatic. However, some indication of what drug the patient has taken can often be obtained from some of the physiological symptoms (see Table 29-3). The confused, highly anxious, often fearful, hallucinating youth, with a history of hallucinogenic drug use, often surrounded either by his frightened family or by friends who may be in a similar condition, has been all too common in our emergency rooms. Lately, this trend has seemed to diminish. However, these reactions are still common and, as our pharmacological armamentarium increases, so are behavioral and toxic reactions to a wide

variety of new and old compounds.

The form of treatment for the patient who has taken these drugs usually consists of: (1) decreasing the stimulation in the immediate environment: treating the person in a quiet room out of the mainstream of the emergency room or hospital activities; (2) attempting to establish some type of verbal contact with the patient with a minimum use of tranquilization; (3) reassurance and attempts to make reality concrete with repetitive, simple statements; and (4) reassuring the patient that the temporary waxing and waning of his mental status is typical. As a last resort, sedation is often necessary. If the agitation is severe, the phenothiazines in moderate doses have been quite effective parenterally or orally as an initial intervention. If there is some evidence that the patient has taken a drug with a strong anticholinergic component, then diazepam (Valium) 10 mg. intramuscularly (I.M.), repeated every thirty to forty minutes usually brings about sedation. (The use of phenothiazines with patients who have taken drugs with strong anticholinergic components may bring on a central, hypotensive crisis.) In general, the treatment guidelines for these reactions, when medications are indicated, are sedation. In this respect, either phenothiazines, barbiturates, paraldehyde, or diazepam have all been noted to be effective (Taylor, 1970; The Medical Letter on Drugs and Therapeutics, 1970).

However, there are a wide variety of toxic and/or idiosyncratic

behavioral reactions that can occur with any type of central-nervous-system stimulant or depressant, anticholinergics, tranquilizers, halogenated hydrocarbons (glue, gasoline, cleaning fluids) and commonly used medicines. Thus, the possibility of their use should never be ruled out (Lamy, 1971; Lamy, 1971). This is especially true if neither the past history nor clinical picture are consistent with typical diagnosis categories. Careful questioning about drug use is extremely important as patients may not only be reluctant to reveal regular use but may also have taken a drug for so long that it has almost become a way of life. Any medication the patient is taking, including digitalis, aspirin, even antidepressant medication and phenothiazines, can cause toxic, confusional-type syndromes by themselves or through electrolyte imbalance (Lipowski, 1967). The majority of these reactions can be treated simply by withdrawing or omitting the offending agent, and sedation. The history of any current drug use is often important. Even a person who has stabilized a drug habit may show evidence of withdrawal with intercurrent infections, changes in tolerance to the drug, or a less potent new drug supply. All can cause some type of behavioral reaction.

*Table 29-3. Physiological Effects\* of Drugs that have Acute Behavioral Effects*

| DRUG | CONSCIOUSNESS | SKIN | PUPILS | TEMPERATURE | PULSE |
|------|---------------|------|--------|-------------|-------|
| **Stimulants** | | | | | |
| Amphetamines Methylphenidate, etc. | Hyper-aroused, hallucinations | Sweating, dry mouth | Dilated, reactive | ↑ | ↑ |

**Hallucinogens**

| | | | | | |
|---|---|---|---|---|---|
| LSD Mescaline | Hyper-aroused, visual hallucinations, often no confusion | Slight sweating | Dilated, reactive | ↑ | ↑ |

**Anticholinergics**

| | | | | | |
|---|---|---|---|---|---|
| Scopolamine Atropine Methapyrilene, trihexyphenidyl | Confused, hallucinating, memory impairment | Flushed, dry, hot, mucous membranes also dry | Dilated, unreactive | ↑ | ↑ |
| **Marijuana THCl** | Clear, distorted perceptions, drowsy | Dry mouth | Normal, conjunctive dilated vessels | → | → ↑ |

**Opiates**

| | | | | | |
|---|---|---|---|---|---|
| Intoxication | Depressed, slight | Warm, sweating | Pinpoint unreactive | → ↓ | → ↓ |
| Withdrawal | Alert, anxious | Sweating, gooseflesh | Dilated, decreasingly reactive, lacrimation | → ↑ | ↑ |

**Barbiturates**

| | | | | | |
|---|---|---|---|---|---|
| Intoxication | Drowsy, confused, slurred speech | | Normal, nystagmus | → ↓ | → |
| Withdrawal | Anxiety, psychosis, delirium | Sweating | Blepharospasm | →↑ | → ↑ |
| **Halogenated hydrocarbons** | Giddy, tinnitus | | Diplopia, dilated, reactive | | → ↑ |
| **Phenothiazines** | Drowsy | Dry, mucous membranes dry | Dilated, reactive | ↓ | → ↓ |

| Tricyclic antidepressants ǂ | Confusion, disorientation, hallucinations | Dry, mucous membranes dry | Dilated, unreactive | →↑ | ↑ |

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*\* Physiological effects may be mixed due to multiple simultaneous drug injections.*

*ǂ Tetrahydrocannabinol. ǂ High doses or idiosyncratic responses. Legend: → = Normal; ↑ = Elevated; ↓ = Decreased*

When there is a clear history of drug use that could explain the clinical picture, the clinician tends to drop the diagnostic process. In any intoxication it is important to remember that head trauma is a distinct possibility, either from the patient falling or from attempts at "sedation" by those accompanying the patient. An adolescent, who had jumped through a ground floor window while under the influence of LSD, was brought in by his parents with a history of the father having to "hit" the patient to quiet him. When routine skull x-rays revealed a depressed skull fracture, it was then noted by the father that the "hitting" was done with a hammer.

### Cerebral Dysfunctions

Disturbances of memory, verbal ability, spatial psychomotor functioning, numerical ability, and fluctuating or diminished levels of consciousness are usually taken as symptoms of the presence of cerebral

dysfunction (organic-brain syndrome). As these conditions are discussed more fully in Volume 4, Chapters 2-9, they will only be touched upon here.

Etiologically, organic-brain syndromes unrelated to drug reactions are usually associated with fever, bacterial toxins, or other cerebral insults such as cerebrovascular accidents, trauma, etc. In general, the diagnosis of these conditions rests again on getting an accurate history, particularly an accurate medical history. The treatment rests on dealing with the underlying causes. It is important, also, to assess the electrolyte balance, hydration, nutrition, and vitamin supply of the confused patient.

Treatment of organic-brain syndromes consists of: (1) treatment of underlying condition if possible; (2) attempts to orient the patient through regular, simple sensory inputs by staff, stating at each contact who they are, what hospital the patient is in, etc. Also such things as clocks and calendars for time orientation; even a radio tuned to a station with hourly news breaks is helpful; and increasing lighting so visual illusions are not as possible due to shadows or indistinct objects; and (3) sedation with a major tranquilizer in small doses may be helpful for the more agitated patients (Detre, 1971; Senay, 1968). The use of cortical depressants such as barbiturates should be avoided because they may exacerbate the condition.

*Repetitive Behavior Patterns*

In many of the studies of psychiatric emergency rooms, patients with personality disorders who manifest chronic patterns of behavior that cause themselves and those about them repeated difficulties are a small percentage of all patients seen. These patients are usually discharged from the emergency room with no follow-up arrangements. The diagnostic labels of psychopath, antisocial personality, or behavior disorder are most frequently used for these patients. While they may manifest acute symptoms of anxiety or depression, what is most prominent in their histories is a prolonged story of consistent maladaptive responses to stress. Usually after or during the interview, it becomes apparent why they have come at this particular time, and their enthusiasm for further treatment usually depends on the response of the interviewer in promising or offering some type of help for the immediate situation. Most often treatment or prolonged contacts are broken off as soon as the acute situation is over, and these patients tend to return only at times of a repeated stress. Although their behavior is more of a pattern, they do, at times, have difficulty in negotiating their lives due to these repetitive patterns (MacDonald, 1966).

## Conclusion

From the foregoing it is quickly apparent that the psychiatric emergency can encompass almost any behavior. To write comprehensively on each topic would require a complete textbook of psychiatry. However, the problems that

constitute the emergency can usually be treated by careful evaluation and judicious decisions. In many settings staff (nonpsychiatrists) have been trained to do at least the initial screening, using psychiatric consultation as needed (Hankoff, 1971; Mendel, 1969). As soon as standardized interview schedules and rapid computer analysis become available, it would seem that more nonpsychiatrists will be doing the emergency evaluations.

What is also apparent is that the evaluation of the psychiatric emergency is often the initiation of the treatment process. As such, the place where emergency evaluations are performed should be part of a system for continued care with a diversity of facilities, e.g., hospital, outpatient, day care, etc. If facilities are not provided for whatever follow-up is necessary from the emergency consultation, then the quality of service is distinctly compromised (Rhine, 1971; Thomas, 1970; Weisman, 1969). It would also seem important that if an emergency consultation service or walk-in service is to function efficiently, then it should have facilities for medical and diagnostic consultations.

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