Patients with Repeated Admissions to a Psychiatric Emergency Service

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ABSTRACT: *Psychiatric emergency treatment units traditionally care for patients with acute psychosocial crises and are not ordinarily concerned with providing long term follow-up treatment. Nevertheless, a significant percentage of patients continues to utilize emergency treatment services repeatedly rather than become involved in other more definitive and durable treatment programs. These patients, as well as the nature of their intermittent and recurrent emergency treatment contacts, are described. It is postulated that psychiatric treatment on an emergency basis may be an effective mode of treatment for those patients who are prone to recurrent crises and are unable to establish more stable treatment relations.*

An increasing number of psychiatric treatment facilities have recognized the growing need for making emergency care readily available to the community (Atkins, 1967; Bellak & Small, 1965; Coleman & Zwerling, 1959; Errera, Wyshak, & Jarecki, 1963; Schwartz & Errera, 1963; Jacobson et al., 1965; Frankel, Chafetz, & Blane, 166; Chafetz, 1965). Clinics have been established, often as part of the general hospital emergency room, which function to provide rapid diagnosis and management of the acute psychiatric casualty. This type of emergency clinic (Acute Psychiatric Service) is in operation at the Massachusetts General Hospital and has been described previously (Frankel et al., 1966 Chafetz, 1965) as a walk-in clinic in which all patients are admitted on an unselected basis. A large proportion of persons who have sought treatment have done so because of psychosocial crises of a more or less acute nature.

Acute crises have been observed in patients who may never have experienced previous overt psychiatric disturbance as well as in chronically ill persons whose acute problems are superimposed. Ninety percent of patients with acute symptoms manifested chronic psychopathology (Muller, Chafetz, & Blane, 1967). Management of such patients includes a brief, but thorough, evaluation of their psychiatric, social and general medical condition which provides the basis for therapeutic intervention aimed at resolution of the crisis. In addition, after treatment of the immediate crisis, further care following the patient's discharge from the Acute Psychiatric Service may be required. Such longer term treatment plans are carried out by other psychi-

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atric facilities within the hospital or by community agencies rather than in the emergency clinic where emphasis is placed on the acute phase of management.

There is a large group of chronically ill patients who appear repeatedly at the emergency service instead of utilizing the various forms of follow-up therapy obtained for them. These patients who draw heavily on the resources of the emergency service will provide the focus for this paper.

The psychiatric patient who presents himself repeatedly for treatment as an emergency is not unique to our experience. Ungerleider (1960) in a study of psychiatric emergencies, has commented on the existence of a number of patients who obtained repeated admissions to an emergency facility. Seven percent of the patients presented as psychiatric emergencies more than once in the six-month period of study. Another 7% had already sought emergency treatment prior to the study.

Fifteen subjects examined by one or both of us at least once in the course of their admissions to the emergency service comprise the study group on which our results are based. Data have been obtained from our examinations as well as from the extensive records of the treatment which these patients received in the course of their multiple admissions to the emergency service.

DESCRIPTION OF PATIENTS

Patients who repeatedly represented themselves as psychiatric emergencies wished for immediate and drastic intervention by the clinic staff. They assumed the attitude of helpless persons who are victimized by powerful external forces and placed the solution to their problems entirely in the hands of the physician. The presenting crisis ranged from the vague and nebulous complaints of some patients along a spectrum which included chronic, diverse, and recurrent emotional and somatic symptoms to the highly specific requests of other patients for hospitalization or medication. For example, the initial complaints of a 33-year-old housewife on 4 separate occasions were: "I am falling apart," "I am afraid of becoming an alcoholic," "I don't want to live," and "I don't know why I am here." A few chief complaints of a 24-year-old homosexual man were: "I want to kill my wife," "I am going to kill myself," and "I want nerve medicine." A 40-year-old woman complained of "depression," "awful feelings," and "headaches." All of these patients evaluated in the emergency service expressed a sense of urgency about their problems, often manifested by repeated threats of suicide and/or homicide. Each patient made such a threat at least once.

They were demanding, provocative, and manipulative in their communications to the emergency staff. This mode of expression was not reserved for the professional staff alone, but was also noted by the ancillary personnel. When patients did not receive the responses from the staff which they desired, they frequently reacted in a negativistic manner. They increased

their demands, emphasized their dependency needs, and in some instances their behvaior became openly hostile and threatening. Anger pervaded all of their communications. One patient became physically aggressive toward various staff members, others were verbally abusive, and some left the emergency service abruptly—to return at a later date. This was particularly true when treatment programs were proposed which were at variance with the patient's expectations. They could not accept therapeutic approaches which did not provide an immediate resolution on their terms. Patients desiring hospitalization, for whom hospitalization was not indicated and therefore denied in favor of other treatment modalities, found it extremely difficult to accept the alternatives offered. They consistently expressed the accusation that special or unique treatment was being withheld or that all which could be done for them was, in fact, not being done. When faced with frustrations on numerous occasions they continued to return to the emergency service for help in spite of their feelings of resentment and hostility.

Each patient was seen in the course of numerous visits (from 7 to 30 in one year) by a variety of physicians, psychologists, and social workers. The diagnostic category to which they were all repeatedly assigned was that of the borderline personality. However, five patients were also diagnosed as chronic schizophrenics and two were considered psychopathic on at least one occasion. The assessment of borderline function was based on the patient's personal history and mental status which revealed such characteristics as a disruptive life style in which emotional experience is shallow and illusory, an impaired capacity for meaningful object relationships, and tenuous ego functions. The patients had chronic and severe difficulties in coping with themselves and their environment in a way which is adaptive and commensurate with reality.

MOTIVES FOR EMERGENCY VISITS

The event which precipitated any specific admission to the emergency service was quite similar to that which had prompted previous visits in spite of the varied presenting complaints mentioned above. Patients persistently sought treatment each time they had acted upon or anticipated acting upon impulses which aroused anxiety or guilt. Four patients consistently visited the emergency service following indulgence in alcohol or homosexual acts. They also appeared when the anticipation of such actions generated extreme anxiety. Five patients who were in psychotherapy utilized the emergency clinic when, in the course of therapy, their hostile or erotic transference feelings became a manifest threat to them. Two of these threatened suicide whenever their anger became unbearable.

Patients sought treatment when they felt isolated, lonely, depressed, and overwhelmed by their life situation. They returned again and again when in the midst of beginning a new job or personal relationship, when suffering from a disappointment or frustration of their wishes, or when overburdened

with personal responsibility. One patient became terrified each time her husband went away on business and left her home alone with her children. She was anxious and obsessed by fears of being attacked, and by thoughts of suicide or of hurting her children. In addition to frequent emergency clinic visits during such crises, the patient made numerous daily phone calls. Another patient came with the request for a referral to a new therapist each time her own therapist returned from a vacation and she became frightened by her anger at him for leaving.

These precipitating events were experienced by patients as overwhelming crises which tended to exert upon them a disproportionately severe degree of disorganization requiring the assistance of an external agency to prevent disaster.

During these periods of disorganization, patients interacted with the emergency staff in a dependent and passive manner. "I want to be hospitalized" was a frequent expression of this attitude. Patients stated quite readily that they needed "someone to depend on," that they wished "to be taken care of," that they "just could not cope any more," or that they were "exhausted."

The goals and limitations of emergency treatment had to be made explicit because patients hoped that their most unrealistic wishes would be gratified. A patient stated that he had a "sense of well being" when he was at the emergency clinic because he believed that the psychiatrist would "take care of everything."

COURSE OF EMERGENCY ADMISSION

Patients who were not already engaged in treatment received referrals for continued therapy in other psychiatric clinics. In some instances, when indicated, hospitalization was arranged. Definitive follow-up treatment was made available to virtually all of the patients, and yet they seemed to prefer returning to the emergency facility when they needed treatment. They did not believe that treatment between emergency visits when they felt well was necessary. Thus, the majority were unable to become involved in anything other than emergency clinic treatment in spite of frequent and energetic referrals. Those few who were being treated in other settings utilized the emergency clinic as often as those who were not in treatment.

Patients were seen by many different staff members during the course of their multiple visits. This was due to the frequent rotations of the professional members of the clinic team. The occasions on which definite follow-up appointments were agreed upon constituted the exception to this general procedure. Frequently patients did not keep appointments and returned at an unscheduled time to see a new physician or social worker. They seemed quite content with this arrangement and none complained that he was unable to consult the same staff member on subsequent admissions.

COMMENT

Patients attending psychiatric emergency services are quite painfully aware of an urgent need for relief of distress (Coleman and Errera, 1963). Unlike patients who seek treatment by appointment, they seem less able to tolerate any delay in treatment. In addition, their wish for an immediate problem solution is intense. These observations are particularly relevant to the plight of the borderline patient who has a low tolerance for other than minimal levels of tension (Brody, 1960). The threshhold is quite regularly exceeded, and the resulting tension prompts him to return repeatedly to the emergency clinic.

The borderline patient is primarily concerned with the present. The notion of future-oriented solutions to problems is one with which he is unprepared to cope. This attitude coupled with the inordinate inability to withstand tension and frustration, as well as the rather chaotic and chronically disturbed life style of the borderline, culminates in the precipitation of frequent psychosocial crises for which emergency intervention is sought. Crisis appears to be an inextricable aspect of the borderline's adaptation to life. His own available resources for coping with repeated crises are so limited and maladaptive that a sense of urgency is created which results in a propensity for seeking emergency treatment.

Although the patients were quite unaware of the nature of the crisis with which they were dealing, what usually constituted the major impetus to obtain treatment was an increased disorganization of ego functions. The ego deficits of the borderline patient make it especially difficult for him to maintain adequate control of disruptive drives (Schmideberg, 1959; Knight, 1953). He must often enlist the aid of an external agency in an attempt to contain them.

These patients sought emergency treatment with the expectation that they would find an immediate and definitive solution to their problems by placing themselves passively in the hands of the physician whom they had endowed with omnipotence. The concept of the emergency service assumed this aspect for them as well. Modell (1963) believes that the borderline patient relates to object as separate and distinct from himself but tends to invest objects with qualities of his own. Since he continues to believe in his own omnipotence, he attributes this same quality to others, including the physician.

The borderline patient has a great deal of difficulty in achieving closeness in interpersonal relationships primarily out of a fear that such closeness can be dangerous and possibly destructive (Modell, 1963). Such a view of object relations results in a need to increase the emotional distance between himself and others. This need may well determine his propensity for the impersonality inherent in emergency room treatment. The emergency facility becomes a place where temporary stabilization can be obtained when necssary without suffering the danger of closeness. The generally negativistic manner in which patients interacted with emergency clinic staff is suggestive

of an attempt to further increase interpersonal distance. The few patients who were engaged in psychotherapy elsewhere took refuge in this more impersonal atmosphere on occasions when involvement in therapy became a threat to them. The remaining patients who were entirely unable to tolerate psychotherapy or other long term assistance limited their treatment to frequent emergency visits.

The immediately available treatment which provides both a reliable source of reality testing and the reassurance of external control as well as a means for reestablishing ego boundaries and a sense of identity without engendering intense transference is attractive to these patients. Although we have not assessed the effectiveness of their psychosocial adaptation between emergency visits, it appears that these patients are able to achieve and maintain a steady state of competent function until a crisis precipitates emergency admission. Emergency psychiatric treatment that can restore psychic equilibrium may be a worthwhile, practical, and realistic therapeutic modality for these patients who have been unable to benefit from the more ambitious goals of other treatment programs.

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