In Response

A Practical Approach to the Assessment and Management of Psychiatric Emergencies

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I would like to respond to the article entitled "A Practical Approach to the Assessment and Management of Psychiatric Emergencies" (*Jefferson Journal of Psychiatry,* Vol. 7:81–91, 1989). The authors are to be congratulated for their concise distillation of the major clinical problems encountered in emergency psychiatry. However, there are several aspects of this review which require further amplification and clarification.

The authors tend to emphasize drug therapy. While drug treatment is an integral part of emergency psychiatry, an understanding of the psychodynamic issues related to violence, suicide, and adjustment disorders can frequently facilitate a psychological reintegration for the patient and reduce or obviate the need for medication. Furthermore, in the treatment of personality disorders, substance abuse patients and depressed and/or suicidal patients, and geriatric emergencies, timely family intervention by enlisting the help of the patient's support network can frequently attenuate the emergency, minimize medication and avert hospitalization. The irony of emergency psychiatry is that like all emergency medicine, the emphasis is generally placed on rapid intervention and disposition. Paradoxically in emergency psychiatry, "tincture of time" is often a powerful treatment intervention. Obviously, the ability to employ psychotherapeutic interventions is dependent on space and staff availability.

Specifically addressing several issues raised by the authors, I was curiously struck by the statement that "the psychiatrist should never take part in any patient restraint, but rather give orders and direct the action." It is not quite clear to me why psychiatrists should never take part in any patient restraint. There is no evidence to indicate that such interventions would disrupt a therapeutic relationship. Assuming that a psychiatrist is knowledgeable in restraint procedures and adept at this technique, I believe that the psychiatrist should actively involve him/herself since part of his/her task is to role-model appropriate treatment interventions for other staff. At other times, the psychiatrist may in fact be the most ill-equipped member of a team to give orders and direct action and frequently psychiatric technicians or nursing staff are more experienced and skillful in restraint procedures. I think that the involvement of

a psychiatrist is a variable which is dependent on the level of training, skill and knowledge of this procedure.

In the discussion of violence, the authors state that the technique of rapid neuroleptization has recently been questioned since high dose neuroleptics may serve to increase sedation and the risk of toxicity without shortening hospitalization. The concept of rapid neuroleptization needs to be further expanded and clarified so the reader will not be mislead. Rapid neuroleptization is a technique that was proposed in the early 1970's. This technique employed high doses of antipsychotic medications in the first several days of hospitalization with the goal of rapidly attenuating the patient's symptoms and shortening the hospitalization. This technique is quite different from rapid tranquilization (RT) which is a procedure used in emergency psychiatry. In RT, patients are given modest doses of antipsychotic medication in brief intervals of time (30 to 60 minutes) to attenuate psychotic, agitated, threatening, potentially destructive behavior. RT is a circumscribed procedure and most patients respond to several doses of medication. The safety of RT has been documented repeatedly, often with seriously medically ill cardiac and cancer patients.

The authors state that neuroleptics should be used prudently because "they may exacerbate muscle spasm and the intrinsic anticholinergic activity of PCP," and that benzodiazepines are the medication of choice for PCP. I do not believe that this treatment approach is well substantiated in the literature. The cornerstone of treatment is enhancing PCP excretion through acidification of the urine. Benzodiazepines may be effective with mildly agitated patients. However, with patients that are moderately to severely agitated, antipsychotic medication remains the preferred treatment. Despite early assertions that antipsychotic drugs may increase anticholinergic activity, no published clinical reports substantiate this notion.

In the discussion of substance abuse, the authors note that IV diazepam or lorazepam should be considered for the control of agitation secondary to cocaine abuse. It is unclear to me why this is the only recommendation being made. Other authors have recommended antipsychotics since antipsychotic medications would directly block the effects that cocaine has on the amine system.

The discussion on geriatric emergencies is a timely one and the authors make a critical point by stating that medical evaluation is the single most important intervention that can be provided in the emergency room. This is one area of psychiatry where psychiatrists *must* maintain a knowledge of general medicine. Too often psychiatric or geriatric patients are prematurely referred to the psychiatric emergency service because of their aberrant behavior, the stigma of being a psychiatric patient or the feeling that "the patient is demented and there is not much that can be done." Psychiatrists working in psychiatric emergency services must always maintain a high index of suspicion for medical illness. The mental status evaluation can often be an important tip-off to delirium and as a rule patients with clouded consciousness, illusions, visual

hallucinations, abnormal vital signs, patients over the age of 40 with no previous psychiatric history and patients with a sudden change of mental status should always be considered to have an underlying organic problem until proven otherwise. This problem becomes more complex in older patients who experience a delirium superimposed on an underlying dementia.

Finally, Wernicke-Korsakoff syndrome may be one of the most misdiagnosed syndromes in the emergency department. Too often these patients are prematurely triaged to the PES. The confabulation, the memory impairments coupled with the occasional aberrant behavior frequently leads to misdiagnosis. A thorough understanding not only of alcohol withdrawal but all alcohol syndromes is essential for the psychiatrist practicing emergency psychiatry.

There are only a few syndromes that the emergency psychiatrist is called upon to treat. Yet he/she must have a broad-based indepth knowledge of all psychiatry. While stressful, the diagnostic challenges in emergency psychiatry coupled with the ability to rapidly impact and attenuate severe illness makes the practice of emergency psychiatry a gratifying, intellectual challenge.