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having lost a part of themselves, but also by having failed in what they perceive as their responsibility for the total feelings of their child. To provide mutual support, survivors of suicide groups have appeared throughout the United States, generally led by nonprofessional survivors themselves. Therapists who have lost patients to suicide comprise another survivor group—one too often ignored and unsupported, despite their own considerable suffering and sense of guilt and compounded by the specter of litigation potentially being brought to bear. REFERENCES Allen MH, Abar BW, McCormick M, Barnes DH, Haukoos J, Garmel GM, Boudreaux ED. Screening for suicidal ideation and attempts among emergency department medical patients: Instrument and results from the Psychiatric Emergency Research Collaboration. Suicide Life Threat Behav. 2013;43:313. Betz ME, Miller M, Barber C, Miller I, Sullivan AF, Camargo CA, Boudreaux ED. Lethal means restriction for suicide prevention: beliefs and behaviors of emergency department providers. Depress Anxiety. 2013;30:1013. Betz ME, Sullivan AF, Manton AP, Espinola JA, Miller I, Camargo CA, Boudreaux ED. Knowledge, attitudes, and practices of emergency department providers in the care of suicidal patients. Depress Anxiety. 2013;30:1005. Cha CB, Najmi S, Park JM, Finn CT, Nock MK. Attentional bias toward suicide-related stimuli predicts suicidal behavior. J Abnorm Psychol. 2010;119:616. Figueroa S, Dalack GW. Exploring the impact of suicide on clinicians: A multidisciplinary retreat model. J Psychiatr Pract. 2013;19:72. Kohli MA, Salyakina D, Pfennig A, Lucae S, Horstmann S, Menke A, Kloiber S, Hennings J, Bradley BB, Ressler KJ, Uhr M, Müller-Myhsok B, Holsboer F, Binder EB. Association of genetic variants in the neurotrophic receptor–encoding gene NTRK2 and a lifetime history of suicide attempts in depressed patients. Arch Gen Psychiatry. 2010;67(4):348. Nordentoft M, Mortensen PB, Pedersen CB. Absolute risk of suicide after first hospital contact in mental disorder. Arch Gen Psychiatry. 2011;68(10):1058. Patorno E, Bohn RL, Wahl PM, Avorn J, Patrick AR, Liu J, Schneeweiss S. Anticonvulsant medications and the risk of suicide, attempted suicide, or violent death. JAMA. 2010;303:1401. Sadock BJ. Inevitable suicide: A new paradigm in psychiatry. J Psychiatr Pract. 2012;18:221. Shirey KG. Suicide and HIV. In: Loue S, ed. Mental Health Practitioner’s Guide to HIV/AIDS. New York: Springer Science+Business Media; 2013:405. Simon RI, Hales RE, eds. The American Psychiatric Publishing Textbook of Suicide Assessment and Management. 2nd ed. Washington, DC: American Psychiatric Publishing; 2012.

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23.2 Psychiatric Emergencies in Adults

A psychiatric emergency is any disturbance in thoughts, feelings, or actions for which immediate therapeutic intervention is necessary. For a variety of reasons—such as the growing incidence of violence, the increased appreciation of the role of medical disease in altered mental status, and the epidemic of alcoholism and other substance use disorders—the number of emergency patients is on the rise. The widening scope of emergency psychiatry goes beyond general psychiatric practice to include such specialized problems as the abuse of substances, children, and spouses; violence in the form of suicide, homicide, and rape; and such social issues as homelessness, aging, competence, and acquired immune deficiency syndrome (AIDS). The emergency psychiatrist must be up to date on medicolegal issues and managed care. This section provides an overview of psychiatric emergencies in general and in adults in particular. Section 23.3 covers psychiatric emergencies in children. TREATMENT SETTINGS Most emergency psychiatric evaluations are done by nonpsychiatrists in a general medical emergency room setting, but specialized psychiatric services are increasingly favored. Regardless of the type of setting, an atmosphere of safety and security must prevail. An adequate number of staff members—including psychiatrists, nurses, aides, and social workers—must be present at all times. Additional personnel to help out in times of overcrowding should be available. Specific responsibilities, such as the use of restraints, should be clearly defined and practiced by the entire emergency team. Clear communication and lines of authority are essential. The organization of the staff into multidisciplinary teams is desirable. Children and young adolescents are best served in a pediatric setting (see Section 23.3). Unless there is a risk of behavioral problems or of their leaving the hospital against advice, they need not be sent to the adult psychiatric emergency service. Immediate access to the medical emergency room and to appropriate diagnostic services is necessary because one third of medical conditions present with psychiatric manifestations. The full spectrum of psychopharmacological options should be available to the psychiatrist. Violence in the emergency service cannot be condoned or tolerated. The code of conduct expected of staff members and patients must be posted and understood from the time of the patient’s arrival in the emergency room. Security is best managed as a clinical issue by the clinical staff, not by law enforcement personnel. Whenever possible, agitated and threatening patients should be sequestered from the nonagitated. Seclusion and restraint rooms should be located close to the nursing station for close observation. The entire staff must understand that patients in physical and emotional distress are fragile and that various expectations and fantasies, often unrealistic, influence their responses to treatment. For example, a man with impaired reality testing who is brought in by the police against his will may not understand that the clinician is interested in helping him. Other patients, influenced by previous unsatisfactory treatment experiences, may be hostile. A high percentage of patients believe that

psychiatrists can read minds or are only interested in admitting patients to lock them away. Such people see little point in openly discussing their problems. Many people have an inaccurate

understanding of their rights as patients. All clinical interventions must take those expectations and attitudes into account to minimize the possibility of misunderstanding and consequent problems. EPIDEMIOLOGY Psychiatric emergency rooms are used equally by men and women and more by single than by married persons. About 20 percent of these patients are suicidal, and about 10 percent are violent. The most common diagnoses are mood disorders (including depressive disorders and manic episodes), schizophrenia, and alcohol dependence. About 40 percent of all patients seen in psychiatric emergency rooms require hospitalization. Most visits occur during the night hours, but usage difference is not based on the day of the week or the month of the year. Contrary to popular belief, studies have not found that use of psychiatric emergency rooms increases during the full moon or the Christmas season. EVALUATION The primary goal of an emergency psychiatric evaluation is the timely assessment of the patient in crisis. To that end, the physician must make an initial diagnosis, identify the precipitating factors and immediate needs, and begin treatment or refer the patient to the most appropriate treatment setting. In view of the unpredictable nature of emergency room work, with many patients presenting both physical and emotional complaints, and in view of the limited space and the competition for ancillary services, a pragmatic approach to the patient is required. Sometimes, moving the patient out of the emergency room into the most appropriate diagnostic or treatment setting is best for the patient. Medical emergencies are generally better managed elsewhere in the system. Keeping the number of emergency patients in one place to a minimum reduces the chance of agitation and violence. The standard psychiatric interview—consisting of a history, a mental status examination, and, when appropriate and depending on the rules of the emergency room, a full physical examination and ancillary tests—is the cornerstone of the emergency room evaluation. The emergency room psychiatrist, however, must be ready to introduce modifications as needed. For example, the emergency psychiatrist may have to structure the interview with a rambling manic patient, medicate or restrain an agitated patient, or forgo the usual rules of confidentiality to assess an adolescent’s risk of suicide. In general, any strategy introduced in the emergency room to accomplish the goal of assessing the patient is considered consistent with good clinical practice as long as the rationale for the strategy is documented in the medical record. What constitutes a psychiatric emergency is highly subjective. The emergency room has increasingly come to serve as an admitting area, a holding room, a detoxification center, and a private medical office. Such medical conditions as head

traumas, acute intoxications, withdrawal states, and AIDS encephalopathies may present with acute psychiatric manifestations. The emergency psychiatrists must rapidly assess and distinguish the truly emergency psychiatric patients from those who are less acutely ill and from nonpsychiatric emergencies. A triage system using psychiatrists, nurses, and psychiatric social workers is an efficient and effective way to identify emergency, urgent, and nonurgent patients, who can then be prioritized for care (Fig. 23.2-1). FIGURE 23.2-1 Evaluation and treatment of psychiatric emergencies. In one model, every patient who comes to the emergency room is assessed by a triage nurse on arrival to ascertain the patient’s chief complaint, clinical condition, and vital signs. The psychiatrist then briefly meets with the patient and other significant people involved in the case—family members, emergency medical service technicians, and police—to assign the patient to one of the three categories—emergency, urgent, and nonurgent—or to refer the patient to an appropriate treatment setting, such as the medical emergency room. Having a senior clinician perform that task ensures rapid identification of the most urgent and troublesome cases, an appropriate allocation of resources, and an answer to the most common question heard

in the emergency room: “When am I going to see a doctor?” The psychiatrist then assigns clinical responsibility for each patient to the appropriate personnel. As the evaluation often stretches over more than one shift, a careful procedure to transfer responsibility and to pass along information from tour to tour must be built into the system by using visual, oral, and written communications. A request for old records should be made automatically for every patient who is assigned to the emergency room. Each emergency should be judged on its own merits, but information from previous records and from workers in the field and family members can be of crucial importance in assessing patients, especially patients who are psychotic, frightened, or otherwise unable or unwilling to cooperate in giving a good history. A multilingual staff and a hospital language bank that lists bilingual staff members and other translation services should be readily available to the psychiatrist. The use of the patient’s friends or family members as translators is not desirable because of the possibility of unconscious or deliberate denial or distortion of the clinical picture stemming from their involvement with the patient. An initial assessment of the patient’s total biopsychosocial needs is optimal, but the patient’s emergency status, other patients waiting to be seen, and the constraints of the emergency room setting often make such a full assessment a moot point. At a minimum, the emergency evaluation should address the following five questions before any

disposition is decided on: (1) Is it safe for the patient to be in the emergency room? (2) Is the problem organic, functional, or a combination? (3) Is the patient psychotic? (4) Is the patient suicidal or homicidal? (5) To what degree is the patient capable of self-care? Table 23.2-1 provides a general strategy for evaluating patients. Table 23.2-1 General Strategy in Evaluating the Patient Patient Safety Physicians should consider the question of the patient’s safety before evaluating every patient. The answer must address the issues of the emergency room’s physical layout, staffing patterns and communication, and patient population. Psychiatrists must then take stock of themselves: Are they in the proper frame of mind to conduct an evaluation? Do any issues in the case spark countertransference reactions? The selfassessment should go on throughout the evaluation. The physical and emotional safety of the patient takes priority over all other considerations. If verbal interventions fail or are contraindicated, the use of medication or restraints must be considered and, if necessary, ordered. Careful attention to the possible outbreak of agitation or disruptive behavior beyond acceptable limits is often the best insurance against untoward occurrences.

Medical or Psychiatric? The most important question for the emergency psychiatrist to address is whether the problem is medical, psychiatric, or both. Medical conditions—such as diabetes mellitus, thyroid disease, acute intoxications, withdrawal states, AIDS, and head traumas—can present with prominent mental status changes that mimic common psychiatric illnesses (Fig. 23.2-2). Such conditions may be life-threatening if not treated promptly. Generally, the treatment of a medical illness is more definitive and the prognosis is better than for a functional psychiatric disorder. The psychiatrist must consider all casual possibilities. FIGURE 23.2-2 Bellevue Hospital emergency ward: a drug addict brought in after having taken an overdose. (Courtesy of Leonard Freed for Magnum Photos, Inc.) Once patients are labeled psychiatric, their complaints may not be taken seriously by nonmental health professionals, however, and such patients’ conditions may deteriorate, especially if they have a major Axis I syndrome. Because of such factors as deinstitutionalization, homelessness, and chronic alcoholism, the mentally ill are at great risk of tuberculosis, vitamin deficiencies, and other easily overlooked, but easily treated, conditions.

Symptoms such as paranoia, internal preoccupation, and acute psychosis can make a routine medical diagnosis exceedingly difficult. Each patient must be assessed for the possibility that an organic illness is combined with an underlying psychiatric illness. A young man who comes to the emergency room intoxicated or in alcohol withdrawal two or three times a month may one day come with a subdural hematoma as a result of a fall. Table 23.2-2 lists features that point to a medical cause

of a mental disorder. Table 23.2-2 Features that Point to a Medical Cause of a Mental Disorder SPECIFIC INTERVIEW SITUATIONS Psychosis Whether the patient is psychotic refers not so much to the diagnosis as to the severity of the patient's symptoms and the degree of life disruption. The patient's degree of withdrawal from objective reality, level of affectivity, intellectual functioning, and degree of regression are other important parameters. Impairment in any of those areas may lead to difficulties in conducting an evaluation. Agitated, assaultive behavior or failure to comply with treatment recommendations may also result. A paranoid, hypervigilant patient may misperceive a staff member's offer of help as an attack and may lash out in self-defense. Command auditory hallucinations may cause a patient to deny symptoms and to throw prescriptions in the garbage immediately after leaving the emergency room. The psychiatrist should be alert to the complications that can arise with patients whose reality testing is impaired and the psychiatrist should modify the approach accordingly. All communication with patients must be straightforward. All clinical interventions should be briefly explained in language the patient can understand. Psychiatrists should not assume that the patient trusts or believes them or even wants their help. Clinicians must be prepared to structure or to terminate an interview to limit the potential for agitation and regression. Depression and Potentially Suicidal Patients The clinician should always ask about suicidal ideas as part of every mental status examination, especially if the patient is depressed. The patient may not realize that such symptoms as waking during the night and increased somatic complaints are related to depressive disorders. The patient should be asked directly, "Are you or have you ever been suicidal?" "Do you want to die?" "Do you feel so bad that you might hurt yourself?" Eight of ten persons who eventually kill themselves give warnings of their intent. If the patient admits to a plan of action, that is a particularly dangerous sign. If a patient who has

been threatening suicide becomes quiet and less agitated than before, that may be an ominous sign. The clinician should be especially concerned with the factors listed in Table 23.2-3. Table 23.2-3 History, Signs, and Symptoms of Suicidal Risk A suicide note, a family history of suicide, or previous suicidal behavior on the part of the patient increases the risk of suicide. Evidence of impulsivity or of pervasive pessimism about the future also places the patient at risk. If the physician decides that the patient is in imminent risk for suicidal behavior, the patient must be hospitalized or otherwise protected. A difficult situation arises when the risk does not seem to be immediate but the potential for suicide is present as long as the patient remains depressed. If the psychiatrist decides not to hospitalize the patient immediately, the doctor should insist that the patient promise to call whenever the suicidal pressure mounts. Violent Patients Patients may be violent for many reasons, and the interview with a violent patient must attempt to ascertain the underlying cause of the violent behavior, because cause determines intervention. The differential diagnosis of violent behavior includes psychoactive substance-induced organic mental disorder, antisocial personality disorder, catatonic schizophrenia, medical infections, cerebral neoplasms, decompensating obsessive-compulsive personality disorder, dissociative disorders, impulse control

disorders, sexual disorders, alcohol idiosyncratic intoxication, delusional disorder, paranoid personality disorder, schizophrenia, temporal lobe epilepsy, bipolar disorder, and uncontrollable violence secondary to interpersonal stress. The psychiatric interview must include questions that attempt to sort out the differential for violent behavior and questions directed toward the prediction of violence. The best predictors of violent behavior are (1) excessive alcohol intake; (2) a history of violent acts, with arrests or criminal activity; and (3) a history of childhood abuse. Table 23.2-4 lists some of the most significant factors in assessing and predicting violence. Table 23.2-4 Assessing and Predicting Violent Behavior

Rape and Sexual Abuse Rape is the forceful coercion of an unwilling victim to engage in a sexual act, usually sexual intercourse, although anal intercourse and fellatio can also be acts of rape. As with other acts of violence, rape is a psychiatric emergency that requires immediate, appropriate intervention. Rape victims may suffer sequelae that persist for a lifetime. Rape is a lifethreatening experience in which the victim has almost always been threatened with physical harm, often with a weapon. In addition to rape, other forms of sexual abuse include genital manipulation with foreign objects, infliction of pain, and forced sexual activity. Most rapists are male, and most victims are female. Male rape does occur, however, often in institutions where men are detained (e.g., prisons). Women between the ages of 16 and 24 years are in the highest risk category, but female victims as young as 15 months and as old as 82 years have been raped. More than a third of all rapes are committed by rapists known to the victim, 7 percent by close relatives. A fifth of all rapes involve more than one rapist (gang rape). Typical reactions in both rape and sexual abuse victims include shame, humiliation, anxiety, confusion, and outrage. Many victims wonder whether they are partly responsible and somehow invited the assault. In fact, victim behavior is less important in precipitating a rape than it is in precipitating a homicide or a robbery. Rape and sexual abuse victims are often confused after the assault. Clinicians should be reassuring, supportive, and nonjudgmental. Inform the patient about the availability of medical and legal services and about rape crisis centers that provide multidisciplinary services. If possible, a female clinician should evaluate the patient, because the victim may find it easier to talk with a woman than with a man. The evaluation should take place in private. When rape or sexual abuse has not been acknowledged openly, it is usually because many victims hesitate to discuss the assault and thus avoid the topic. If the patient appears to be anxious when questioned about sexual history and avoids the discussion, it is important to validate the patient’s avoidance. Recognize that the rape victim has undergone an unanticipated, life-threatening stress. It is legally and therapeutically important to take a detailed and complete history of the attack. With the patient’s written consent, collect evidence, such as semen and pubic hair, that may be used to identify the rapist. Take photographs of the evidence, if possible. The medical record may be used as evidence in criminal proceedings; therefore, meticulous objective documentation of all aspects of the evaluation is essential.

TREATMENT OF EMERGENCIES Psychotherapy In an emergency psychiatric intervention, all attempts are made to help patients’ selfesteem. Empathy is critical to healing in a psychiatric emergency. The acquired knowledge of how biogenetic, situational, developmental, and existential forces converge at one point in history to create a psychiatric emergency is tantamount to the maturation of skill in emergency psychiatry. Adjustment disorder in all age groups may result in tantrum-like outbursts of rage. These outbursts are particularly common in marital quarrels, and police are often summoned by neighbors distressed by the sounds of a violent altercation. Such

family quarrels should be approached with caution, because they may be complicated by alcohol use and the presence of dangerous weapons. The warring couple frequently turns their combined fury on an unwary outsider. Wounded self-esteem is a major issue, and clinicians must avoid patronizing or contemptuous attitudes and try to communicate an attitude of respect and an authentic peacemaking concern. In family violence, psychiatrists should note the special vulnerability of selected close relatives. A wife or husband may have a curious masochistic attachment to the spouse and can provoke violence by taunting and otherwise undermining a partner's selfesteem. Such relationships often end in the murder of the provoking partner and sometimes in the suicide of the other partner—the dynamics behind most so-called suicide pacts. As with many suicidal patients, many violent patients require hospitalization and usually accept the offer of inpatient care with a sense of relief. More than one psychotherapist or type of psychotherapy is frequently used in emergency therapy. For example, a 28-year-old man, depressed and suicidal after a colostomy for intractable colitis, whose wife was threatening to leave him because of his irritability and their constant altercations, may be referred to a psychiatrist for supportive psychotherapy and antidepressant medication, to a marital therapist with his wife to improve their marital functioning, and to a colostomy support group to learn ways of coping with a colostomy. Emergency psychiatric clinicians are pragmatic; they use every necessary mode of therapeutic intervention available to resolve the crisis and facilitate value exploration and growth, with less concern than usual about diluting a therapeutic relationship. Emergency therapy emphasizes how various psychiatric modalities act synergistically to enhance recovery. No single approach is appropriate for all persons in similar situations. What does a doctor say to a patient and a family experiencing a psychiatric emergency, such as a suicide attempt or a schizophrenic break? For some, a genetic rationale helps; the information that an illness has a strong biological component relieves some persons. For others, however, this approach underlines a lack of control and increases depression and anxiety. All feel helpless because neither the family nor the patient can alter the behavior to minimize the likelihood of recurrence. Some persons may benefit from an explanation of family or individual dynamics. Others only want someone to listen to

them; in time, they reach their own understanding. In an emergency situation as in any other psychiatric situation, when a clinician does not know what to say, the best approach is to listen. Persons in crisis reveal how much they need support, denial, ventilation, and words to conceptualize the meaning of their crisis and to discover paths to resolution. Pharmacotherapy The major indications for the use of psychotropic medication in an emergency room include violent or assaultive behavior, massive anxiety or panic, and extrapyramidal reactions, such as dystonia and akathisia as adverse effects of psychiatric drugs. Laryngospasm is a rare form of dystonia, and psychiatrists should be prepared to maintain an open airway with intubation if necessary. Persons who are paranoid or in a state of catatonic excitement require tranquilization. Episodic outbursts of violence respond to haloperidol (Haldol), βadrenergic receptor antagonists (β-blockers), carbamazepine (Tegretol), and lithium (Eskalith). If a history suggests a seizure disorder, use clinical studies to confirm the diagnosis and an evaluation to ascertain the cause. If the findings are positive, anticonvulsant therapy is initiated or appropriate surgery is provided (e.g., in the case of a cerebral mass). Conservative measures may suffice for intoxication from drugs of abuse. Sometimes, drugs such as haloperidol (5 to 10 mg every half-hour to an hour) are needed until a patient is stabilized. Benzodiazepines may be used instead of, or in addition to, antipsychotics (to reduce the antipsychotic dosage). When a recreational drug has strong anticholinergic properties, benzodiazepines are more appropriate than antipsychotics. Persons with allergic or aberrant

responses to antipsychotics and benzodiazepines are treated with amobarbital (Amytal; mg orally or intramuscularly [IM]), paraldehyde, or diphenhydramine (Benadryl; 50 to 100 mg orally or IM). Violent, struggling patients are subdued most effectively with an appropriate sedative or antipsychotic. Diazepam (Valium; 5 to 10 mg) or lorazepam (Ativan; 2 to 4 mg) may be given slowly intravenously (IV) over 2 minutes. Clinicians must give IV medication with great care to avoid respiratory arrest. Patients who require IM medication can be sedated with haloperidol (5 to 10 mg IM). If the furor is caused by alcohol or is part of a postseizure psychomotor disturbance, the sleep produced by a relatively small amount of an IV medication may go on for hours. On awakening, patients are often entirely alert and rational and typically have complete amnesia about the violent episode. If the disturbance is part of an ongoing psychotic process and returns as soon as the IV medication wears off, continuous medication may be given. It is sometimes better to use small IM or oral doses at half-hour to 1-hour intervals (e.g., haloperidol, 2 to 5 mg, or diazepam, 20 mg) until the patient is controlled than to use large dosages initially, which can result in an overmedicated patient. As the disturbed behavior is brought under control, successively smaller and less frequent doses should be used. During the preliminary treatment, a patient’s blood pressure and other vital signs should be

monitored. Restraints Restraints are used when patients are so dangerous to themselves or others that they pose a severe threat that cannot be controlled in any other way. Patients may be restrained temporarily to receive medication or for long periods if medication cannot be used. Usually, patients in restraints quiet down after a time. On a psychodynamic level, such patients may even welcome the control of their impulses provided by restraints. Table 23.2-5 provides a summary of the use of restraints. Table 23.2-5 Use of Restraints Disposition In some cases, the usual option of admitting or discharging the patient is not considered optimal. Suspected toxic psychoses, brief decompensations in a patient with a personality disorder, and adjustment reactions to traumatic events, for example, may be best managed in an extended-observation setting. Allowing the patient additional time in a secure environment can result in sufficient improvement or clarification of the issues to make traditional inpatient treatment unnecessary. It can also spare the patient the trauma and stigma of a psychiatric admission and can free up bed space for needier

patients. Crisis intervention for victims of rape and other traumas can also be done in an extended-observation setting. When the decision is to admit the patient to the hospital, it is preferable to do so on a voluntary basis. Allowing patients that option gives them a sense of control over their lives and of participation in the treatment decisions. Patients who clearly meet involuntary admission criteria on the basis of dangerousness to themselves or to others cannot leave the hospital without further review and can always be converted to involuntary status if warranted. Because the initial evaluation is often inconclusive, definitive treatment is best deferred until the patient can be further assessed in the inpatient unit or in the outpatient department. When the diagnosis is clear, however, and the patient’s response to previous treatment is known, nothing is gained by delay. For example, a patient with chronic schizophrenia that has decompensated after discontinuing the usual regimen of antipsychotic medication is best served by prompt resumption of treatment. Even if patients feel comfortable coming to the emergency room in times of need, the emergency psychiatrist should always direct or redirect them to the most appropriate treatment setting. Patients in the psychopharmacology clinic who have missed their regular appointments should be given only enough medication to sustain them until they can be seen in the clinic. Feedback to

others treating them should be a matter of course. The emergency room is often the gateway to the department of psychiatry or the general hospital. First impressions carry a great deal of weight. The kind of attention and concern shown to patients on arrival in the emergency room strongly affects how they will respond to staff members and treatment recommendations and even their treatment compliance long after they have left the emergency room. Documentation In the interests of good care, respect for patients' rights, cost control, and medicolegal concerns, documentation has become a central focus for the emergency physician. The medical record should convey a concise picture of the patient, highlighting all pertinent positive and negative findings. Gaps in information and their reason should be mentioned. The names and the telephone numbers of interested parties should be noted. A provisional diagnosis or differential diagnosis must be made. An initial treatment plan or recommendations should clearly follow from the findings of the patient's history, mental status examination and other diagnostic tests, and the medical evaluation. The writing must be legible. The emergency physician has unusual latitude under the law to perform an adequate initial assessment; however, all interventions and decisions must be thought out, discussed, and documented in the patient's record. Specific Psychiatric Emergencies Table 23.2-6 outlines common psychiatric emergencies in alphabetical order. Readers are referred to the index and to specific chapters of this textbook for a thorough

discussion of each disorder. Table 23.2-6 Common Psychiatric Emergencies

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