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Rapid tranquillisation

SIR: Pilowsky *et al* (*Journal*, June 1992, **160**, 831–835), in their survey of rapid tranquillisation, report that intravenous sedation with diazepam alone or in combination with haloperidol appeared to be more rapid and effective than other drugs given intramuscularly. Furthermore, staff expressed greatest satisfaction where a combination of an antipsychotic and a sedative were used. However, we are concerned about the dangers of intravenous injections in psychiatric settings. We note that one of the 60 patients in the study had a cardiorespiratory arrest, another collapsed with shallow respirations and a third had a transient tachycardia.

We would like to draw attention to the risks associated with emergency intravenous injections by describing two cases known to us. In the first, a general practitioner (GP) assessed an excited 23-year-old man threatening suicide after a furious row with his parents who objected to his bringing his girlfriend to the parental home at 3 a.m. He was given diazepam, 10 mg intravenously. As this apparently had no effect, the GP then gave chlorpromazine, 50 mg intravenously. The patient was brought into hospital unconscious, responding only to painful stimuli and with acute dyskinesias affecting his neck, trunk and limbs. It took two days for him to recover full consciousness. The ABPI data sheet compendium states that parenteral chlorpromazine can be administered only by intramuscular injection. Likewise, the British National Formulary (1991) and Gilman *et al* (1990) describe only intramuscular use. Martindale mentions that the injection can be given intravenously if it is diluted beforehand (Reynolds, 1989). How many doctors know this?

The second case involved a psychotic and disturbed young adult assessed at home by the GP and a psychiatrist. After intravenous injection of diazepam, 20 mg, and haloperidol, 20 mg, the patient had a fatal cardiac arrest. There was a history of drug therapy for asthma. Sometimes emergency treatment has to be started when the patient's mental state prevents the doctor taking an adequate history which would include details of past medical illness and recent drug (including illicit drug) use. Although these two cases occurred in the community we do not believe that hospitals confer immunity from catastrophe.

Finally, we would like to point out that estimation of dose is based largely on guesswork. Dr Pilowsky *et al* used small bolus doses to avoid oversedation and undertreatment. However, we are concerned that with aggressive patients who are being restrained by staff and need to have a needle kept in a vein, there is a powerful incentive to get the matter over with quickly. But as Gilman *et al* (1990) write of intravenous injections, "once the drug is injected there is no retreat". While the same might be said of intramuscular injections, the effects are not so sudden. We think that the issue of intramuscular versus intravenous rapid tranquillisation should be addressed by a prospective study with random allocation of patients to either intramuscular or intravenous treatment groups.

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SIR: We found the paper by Pilowsky *et al* (*Journal*, June 1992, **160**, 831–835) on the use of rapid tranquillisation in a general psychiatric hospital compelling reading.

While psychological, behavioural and therapeutic restraint are acknowledged as alternative ways of managing aggressive patients, we were dismayed that no mention was made of the use of continuous observations. Shugar & Rehaluk (1990) found that continuous observation provides the essential ingredients of reduced stimulation, protection, intensive observation, and an opportunity for therapeutic contact and that its use forestalls and manages self-destructiveness, violence and over-stimulation of psychiatric in-patients. Our own study confirmed these findings. We studied consecutive acute psychiatric admissions in the Nottingham Health District, and found 14 documented incidents in a 28-day period. However, there were no untoward incidents when patients were observed on the most intense level of observation. In Nottingham this entails a designated nurse being in visual contact with the individual patient at all times.

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We feel that a description of the observation levels used in their hospital might have explained why in 26% of incidents a second injection was required and that further physical methods to control behaviour were still required in 10% following all medication.

Shugar, G. & Rehaluk, R. (1990) Continuous observation for psychiatric in-patients: a critical evaluation. *Comprehensive Psychiatry*, **30**, 48–55.

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'Suicide prevention' by GPs?

Sir: Although Michel & Valach's suicide prevention programme among general practitioners (GPs) using a seminar seemed effective (*Journal*, June 1992, **160**, 757–760) it must be time to demolish the myth that GPs can prevent suicide. In an average list size of 1000 it will take eight years of consultations before a GP will consult a patient who will shortly thereafter commit suicide. If an average general practice surgery contains 20 patients, there are eight surgeries a week, and the GP works for 40 weeks in the year then he will have carried out 51 199 consultations with patients who are *not about* to kill themselves in those eight years. Evaluation of teaching GPs about suicide prevention would require enormous sample sizes with huge numbers of GPs over long periods of time and is quite unlikely to show any statistical difference unless there is an enormous difference in the efficacy of different methods. So, please, can we now have a moratorium on this idea that practitioners can prevent suicide?

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The cultural specificity of psychotherapy

Sir: The recent debate on the relative efficacy of psychotherapy with 'non-Western' populations (*Journal*, March 1992, **160**, 425; June 1992, **160**, 864–865; July 1992, **161**, 127–128) seems to have been conducted at a rather abstract level without any empirical data being offered. The question is surely not one to be decided by rhetorical argument alone; the results of psychotherapy, like those of any other psychiatric treatment, can be quantified and compared.

Exactly what 'Western' may mean in the present context is uncertain, but I assume it refers to those of 'Anglo-Saxon' culture or origin, or at least those who are urban Europeans.

At the Nafsiyat Intercultural Therapy Centre in North London, over 350 non-British and non-White patients have received individual dynamic psychotherapy over the last 10 years. A Department of Health grant has enabled two doctoral students from this department of psychiatry to assess its value. Using the 60-item General Health Questionnaire with one sample of 52 consecutive patients, the numbers in each of the following GHQ categories were initially as follows: below 12=7; 12–19=5; 20 plus=40. Numbers following a minimum of 12 therapy sessions were 38, 5, and 9 respectively. While 'non-specific' factors and spontaneous remission cannot be discounted in any evaluation of psychotherapy, it is noteworthy that a high proportion of patients had initial GHQ scores conventionally taken as indicating psychopathology which is not self-limiting. These patients were not the 'worried well': on initial interview with the Present State Examination, 42 fulfilled the criteria for the Syndrome Checklist category of simple depression, and 46 for other SCL depressive syndromes. Improvement was unrelated to ethnicity or place of birth (a quarter in the UK, a quarter in the Caribbean, a tenth in Africa and a fifth in South Asia).

The results are described more fully in two papers in preparation and in Moorhouse (1992). They indicate that dynamic psychotherapy appears effective for those who have been presumed not to benefit from it and who have traditionally been denied access to it (Littlewood, 1992). Whether this is for the explicit reasons favoured by the therapists themselves is a matter for future study.

Littlewood, R. (1992) Towards an intercultural therapy. In *Interpretation and Practice* (eds J. Kareem & R. Littlewood). Oxford: Blackwell.

Moorhouse, S. (1992) Quantitative research in intercultural therapy: some methodological considerations. In *Intercultural Therapy: Themes, Interpretation and Practice* (eds J. Kareem & R. Littlewood). Oxford: Blackwell.

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