

Psychedelics in the Psychiatric ER

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Potential Causes of a Bad Trip

- Adverse environment
 - Noise, unpleasant music or lighting
 - Strangers/Needing to hide altered state
 - Difficult interpersonal issues between tripping people
- Large dose/ naïve subject
- Attempts to mentally resist the effect of the drug
- Surfacing of difficult and uncomfortable unconscious material or memories

Medical Safety

- Establish Vital Signs, especially temperature
- Determine what drug was ingested and when
- Other drugs (alcohol, E tabs) involved?
- Medical history of the patient (including allergies and Rx drugs on board)
- “Peaking” or not yet? (to determine timeline)

Classic instructions for treatment of psychedelic “overdose”

- Quiet, darkened room
- Minimize sensory stimulation
- Solitude
- Stress time-limited extent of the event
- “Talk Down”
- “Supportive” care (medical support)
- Sedatives
 - Benzodiazepines

–Antipsychotics (atypicals-better with PCP, ketamine)

Enlightened instructions for handling a psychedelic “emergency”

- Emergence can be therapeutic
- Create a safe space
- Sit, don’t guide
- Talk through, not down
- Difficult is not necessarily bad

When life gives you lemons, make lemonade. (Instead of squelching the experience, use it as an opportunity to midwife some very difficult emotional experiences into consciousness.)

Psychedelic emergency as growth opportunity (therapeutic potential of psychedelic-assisted psychotherapy)

Discuss limitations of average psych ER to do any real therapeutic work, but the importance of doing just that.

A patient in a psychedelically induced “crisis” is in need of empathy and connection, not just comfort and reassurance.

What is required is de-briefing, gently unearthing traumas and processing them, hopefully with a measure of acceptance of the history and compassion for the self.

A clinician who is experienced with and knowledgeable about psychedelics is invaluable. However, there is a dearth of teaching about psychedelics in medical school and in most psychiatric residencies.

Case of “Patient X”

Antisocial Personality Disorder, Alcoholic, PCP abuser who came to ER “intoxicated” with MDMA. Victim of significant childhood sexual abuse.

Many patients in the psych ER with psychiatric disorders (esp. PTSD, ASPD, substance abuse disorders) are victims of sexual abuse and

Case of “Patient Y”

s/p psilocybin ingestion, CoSM viewing, brought in by ambulance proselytizing on the street, giving away his wallet, watch, etc. appearing manic

Chemical similarities between manic episode, psychedelic experience, religious epiphany (enlightenment, kundalini explosion, mystical epiphany)

Objective Signs of Peak/Mystical Experience

Psychedelic Induced:

- Dilated pupils
- Sympathetic arousal –Increased temp, BP/HR, Decreased appetite,
Dry mouth
- Sleeplessness
- Fine tremor

Manic Episode

- Psychomotor agitation
- Loud, pressured speech
- VS minimally altered
- Pupils *not typically* dilated

Peak/Mystical Experience Subjective Effects

Psychedelic Experience

- Altered sense of time
- Altered sense of self
- Sense that “everything is connected”
- Sense of wonder/awe
- Labile affect
- Panic re: ego disintegration
- Loosening of associations

Manic Episode

- Inflated self-esteem/Grandiosity
- Sense that “everything is connected”
- Sense of wonder/awe
- Labile affect
- Racing thoughts

- LOA/flight of ideas

Peak/Mystical Experience Pharmacology

Psychedelics

- Serotonergic agonists
- 5HT2A agonism
- 5HT 1a and 2c agonism (likely modulatory)
- Adrenergic activation
- Dopamine agonism

Direct and indirect, likely via 5HT2a agonism

Manic Episode

- Hyperactivity of:
 - Serotonin
 - Dopamine
 - Adrenergic neurotransmitter systems
- Projections to the amygdala, VMPFC, DLPFC, Orbito-Frontal Cortex, striatum, thalamus, hypothalamus, and basal forebrain

Psychiatric Models

PCP Model of Schizophrenia

LSD/psilocybin Model of Schizophrenia

Discovery of LSD, serotonin, and serotonin hypothesis of schizophrenia somewhat simultaneously.

5HT2A activation produces psychotomimetic effects

5HT2A receptor abnormalities in brains of cps

Clozapine and Risperdal have 5HT2A antagonist properties

LSD/psilocybin Model of Mania ?

Enhanced serotonergic transmission as the basis of self-esteem spectrum, from enhanced self-confidence to grandiosity, as elicited by MDMA, psychedelics, and the manic state.

Feeling of “oneness” with the universe in manic, psychedelic, and religious epiphany states.

Using MDMA in the treatment of the acutely psychotic, unmedicated schizophrenic.

Pharmacologic Rationale

- MDMA is an acutely acting serotonergic agonist
- Secondary dopaminergic agonist
- Increased oxytocin release
- Abnormalities in serotonergic and dopaminergic tone in schizophrenia
- Increased oxytocin in adequately treated schizophrenics
- Oxytocin administration does improve symptoms in cps

Show “testimonials” from four people with schizophrenia who had therapeutic experiences with MDMA

Using psychedelics and MDMA in the psychiatric emergency room

Using MDMA in acutely suicidal, hopeless patient

Using MDMA in acutely psychotic patient

Using MDMA in mute patient

Ideas for future research:

MDMA and schizophrenia, autism spectrum

Oxytocin and MDMA

We need death midwifery w/ psychedelics

Get rid of recreational/therapeutic dichotomy

Designer Drugs – instead of designed one step ahead of the law, they should be optimally designed to maximize therapeutic potential and efficacy.

Universal Drug Scheduling with honest appraisal of risk/benefit analysis