

**Project:** Ghana Emergency Medicine Collaborative

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**Emergency Medicine Lecture  
Series: Topics in Emergency  
Psychiatry  
(8/24 & 8/31/2011)**

**Rachel Lipson Glick, MD  
Clinical Professor of Psychiatry  
Medical Director, Psychiatric Emergency  
Services**

# Relationships with Industry

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# Emergency Psychiatry Topics

- Approach to the agitated patient
- Evaluation of psychosis
- Suicide risk assessment
- Commitment laws
- Somatoform Disorders
- Anxiety Disorders
- Personality Disorders

# Approach to the Agitated Patient

- Agitation is a state of increased psychomotor and mental activity with heightened arousal and anxiety
- Treatment of agitation is challenging
  - Agitation is heterogeneous.
  - Agitated patients can be dangerous.
  - The agitated patient may not cooperate with treatment.
  - The agitated patient may require treatment before full assessment and diagnosis.

# Causes of Agitation

## Medical/Neurologic

- Delirium
- Acute Psychosis
- Substance Abuse/Dependence
- Any “Brain” Disease

## Psychiatric

- Schizophrenia and other psychotic illnesses
- Bipolar illness
- Major depressive disorder
- Anxiety disorder
- Personality disorders

# Causes of Agitation

In psychiatric illness agitation results from:

- Mania
- Disturbing thought content/delusions/  
hallucinations
- Disorganized thinking
- Intrusion of law or mental health workers
- Akathisia



# Survey of PES Directors

- 20 PES directors responded to a structured phone interview.
- 17 stated they intervene with medications +/- restraints before assessing severely agitated patients.
- 13 used the same medication regimen regardless of eventual diagnosis.

# Management of Agitation: Current State

- No national standard of care.
- Recent expert consensus guidelines
- Clinicians prefer IM high potency neuroleptics: perceived benefits of rapid drug delivery and onset.
- Impact of drugs given in PES/ED last longer than ED stay.
- Patient preference and future compliance must be considered.

# Expert Consensus Guidelines:

## Interventions for an Imminently Violent Patient

### Preferred initial interventions

Verbal intervention

Voluntary medication

Show of force

Emergency medication

Offer food, beverage, or other assistance

### Alternate Interventions

Physical restraints

Locked or unlocked

Seclusion

# Expert Consensus Guidelines:

## Factors Determining Initial Choice of Medication

- Availability of IM formulation
- Speed of onset
- Immediate effects
- Most experts still use lorazepam and IM haloperidol as medications of choice
- Oral liquid or orally dissolving formulations are also a highly preferred route of administration along with IM medication

# Expert Consensus Guidelines:

## Important Factors in Choosing Route of Administration

### Most Important Factors

Speed of onset

Reliability of delivery

### High Second-Line Factors

Interactions with other medications

Patient preference

# Expert Consensus Guidelines: Factors Limiting Use of IM Medication

Limiting factors in order of importance:

- Risk of side effects
- Mental trauma to patient
- Compromising patient-physician relationship
- Physical trauma to patient
- Exposure to contaminated needles
- Effects on long-term compliance

Allen MH et al Postgrad med Special Report 2001 (May): 1-90

# American College of Emergency Physician's Clinical Policy

## Evidence Based

### Level A recommendations:

- Accepted practices with large degree of clinical certainty

### Level B

- Strategies with moderate clinical certainty

### Level C

- Strategies based on preliminary, inconclusive or conflicting evidence, or if no published evidence, or if based on consensus guidelines

# American College of Emergency Physician's Clinical Policy

Level A – none

Level B –

- Benzodiazepine or typical antipsychotic alone in undifferentiated patient
- If rapid sedation required, consider droperidol
- If patient is known to have psychiatric illness for which antipsychotics are needed use a typical or atypical alone
- If patient cooperative use combination of benzodiazepine and oral antipsychotics

Level C –

- Combination of IM benzo and haloperidol may be more rapid in severe agitation



# Management of Agitation: Medications

- Antipsychotic Medications
  - \*Haloperidol
  - Olanzapine
  - Risperidone
  - \*Ziprasidone
  - Quetiapine
  - Aripiprazole
  - Asenapine
- Benzodiazepines
  - \*Lorazepam

# Treatment of Agitation: Recommendations

1. Assure the safety of the patient/others
  - diagnosis
  - history of violent behavior
  - present behavior
  - environment
  - family present
  - staff present
2. Non-pharmacologic approaches
  - decrease stimulation
  - set limits
  - have a calm, emphatic approach
  - offer oral medications
  - show of force
  - quiet room
  - offer food/drink
  - locked seclusion
  - restraints/IM medications

# Treatment of Agitation: Recommendations

3. If medications are needed, target arousal and aim for calm wakefulness or light sleep.
4. Treatment selection
  - Benzodiazepines appear at least as effective as antipsychotics in initial calming effects but are more sedating
  - Antipsychotics may have longer duration of action
  - Antipsychotics address underlying psychosis and mania
  - Medications available are probably equally effective. If appropriate, orals preferable to IMs but if IMs needed availability of IM atypical antipsychotics gives us new options.
  - Mode and ease of administration should guide choice
  - Large double blind trials comparing agents are needed to develop evidence based approach to agitation.

# Acute Psychosis

- A symptom, not a diagnosis
- Potentially life threatening causes of psychosis:
  - Hypoglycemia
  - Meningitis or encephalitis
  - Decreased oxygen to the brain
  - Hypertensive encephalopathy
  - Wernicke's encephalopathy
  - Intracranial bleeding
  - Drug withdrawal or intoxication
- Other medical causes of psychosis:
  - Metabolic disorders
  - Neurologic disorders
  - Nutritional deficiencies
  - Industrial exposures
- Drug related causes of psychosis
  - Intoxication
  - Withdrawal
  - Toxic reactions
- Psychiatric causes of psychosis

# Acute Psychosis: Key points to remember

- The brain and the body are connected.
- History is the most important information
- Most psychiatric illness presents in younger patients.
- Most psychiatric illness has gradual onset.

# Suicide Risk Assessment

38% of patients in Psychiatric Emergency Services have suicidality/Assessing suicide risk is what we do!

## Estimating Suicide Risk

- The presence of a psychiatric illness is the most significant risk factor
- Medical illness is also associated with increased risk of suicide

# Suicide Risk Assessment: Psychiatric Illness

- Patients with a history of current or past major depressive episode were at a greater risk for suicide attempts
- Rates of suicidal behavior were found to be high across a broad spectrum of patients with psychotic disorders.
- Leading cause of premature death in schizophrenic patients is suicide: Most likely within the first 6 years of hospitalization

# What Increases Risk?: Previous Attempts

- The population that tends to make multiple low-lethality suicide attempts generally have lower risk
- The individual's risk always increases with each previous attempt (especially attempts within the previous two years)



# What Increases Risk?: Current Psychiatric Symptoms

- Anhedonia
- Impulsivity
- Anxiety/panic
- Insomnia
- Command hallucinations

# What Increases Risk?: Alcoholism

- Consumption of 6 or more drinks daily was associated with 6 fold increase in suicide risk
- Lifetime risk of suicide among alcoholics is approximately 7%. This makes the risk of suicide in alcoholics higher than risk in schizophrenia.

# What Increases Risk?: Medical Problems

- Nervous System: Multiple Sclerosis, Brain/Spinal Cord Injuries, Huntington's Disease
- Malignancies
- HIV/AIDS
- Kidney Failure/ Dialysis
- Chronic Pain
- Functional Impairment
- COPD

# What Increases Risk?: Other Factors

- Age/Sex/White Race
- Gay/Lesbian/Bisexual
- Childhood Traumas
- Access to Firearms
- Substance Intoxication
- Unemployment
- Domestic Violence
- Family suicide history
- Family mental illness
- Lack of social support

# Factors Associated with Protective Effects for Suicide

- Children in the home/Pregnancy
- Sense of responsibility to family
- Life satisfaction/Good social support
- Religiosity
- Positive reality testing, coping and problem-solving skills

# **Suicide Risk Assessment/The new approach: Mitigating risk by addressing risk factors**

While many patients who have suicidal thoughts or have made an attempt must be hospitalized, addressing risk factors allows PES clinicians to do more than just triage.

# Suicide Risk Assessment: Mitigating risk by addressing risk factors

While some % of patients assessed will require hospitalization for safety, other possible interventions include:

- Treat underlying mental illness/current symptoms
- Teach coping
- Mobilize supports
- Remove means (guns especially)

# Commitment Laws

- Danger to self, others or inability to take care of basic needs.
- Every state has laws, but process varies state to state
- MI: 3 step process:
  - petition (you may be asked to do this, do NOT put home phone #)
  - first certificate (EM physicians often complete these),
  - second certificate (must be completed by a psychiatrist) followed by court hearing within 72 hours.



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# Somatization: Malingering, Somatoform disorders, factitious disorder

**Somatization:** The process by which a person consciously or unconsciously uses the body or bodily symptoms for psychological purposes or personal gain.

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| <u>Disorder</u>         | <u>Mechanism<br/>of Illness<br/>Production</u> | <u>Motivation<br/>for Illness<br/>Behavior</u> |
|-------------------------|--|--|
| Somatoform<br>Disorders | Unconscious                                    | Unconscious                                    |
| Factitious<br>Disorder  | Conscious                                      | Unconscious                                    |
| Malingering             | Conscious                                      | Conscious                                      |

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# Malingering

- A disorder in which the patient intentionally produces symptoms for some sort of secondary gain. The patient knows that he or she is producing the symptoms, and knows why he or she is doing it.
- Vague, unverifiable history, symptoms do not correlate with objective findings
- Associated with antisocial personality and substance use disorders

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# Malingering: Management

- Diagnosis of exclusion, must r/o medical and psychiatric illness
- Malingerers often refuse testing
- Interview for acute precipitant: Why is patient here now?
- Careful mental status exam, especially affect, guardedness, observation when patient does not know they are being observed

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# Malingering: Management

- Avoid hospitalization
- Confrontation, limit-setting, coordination with other providers
- Document carefully, include history of exaggerating symptoms, how affect changed during interview (? avoid the term “malingering”)
- Manage countertransference

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# Management of Somatoform Disorders

- Provide care, rather than aiming for cure - focus on the psychosocial problems not the physical ones
  - Do not try to completely eliminate symptoms
  - Focus on coping and functioning strategies

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# Management of Somatoform Disorders, continued

- Minimize the use of psychotropic drugs
  - No medication has been shown to be useful in Somatoform Disorders
  - These patients may tend to become dependent upon drugs easily, particularly sedative-hypnotics
  - Do provide psychotherapy

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# Management of Somatoform Disorders, continued

- Minimize medical diagnostic tests and procedures to reduce expense and iatrogenic complications
  - Review old records before ordering tests
  - Consider benign remedies



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# Conversion Disorder

- A disorder characterized by neurological symptom(s) that cannot be explained by a known neurologic or medical disorder. Psychological factors must be associated with the initiation or exacerbation of the symptom(s).

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# Conversion Disorder: Epidemiology

- Annual incidence as high as 22/100,000
- Ratio of women to men as high as 5 to 1
- Onset most often in adolescence or young adulthood

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# Conversion Disorder: Epidemiology, continued

- More common in:
  - Rural populations
  - Those with little education
  - Lower socioeconomic groups
  - Medically unsophisticated
- Commonly associated with:
  - Major Depression
  - Anxiety Disorders
  - Schizophrenia
  - Personality Disorders

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# Conversion Disorder: Differential Diagnosis

- Medical or neurological disease:
  - 15-50% of patients initially thought to have Conversion Disorder are eventually found to have a “real” illness
- Other Somatoform Disorders
- Factitious Disorder or Malingering

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# Conversion Disorder: Course and Prognosis

- In 90% of cases symptoms resolve in a few days or less than a month
- 25% have a recurrence at some point
- Longer the symptoms last, the poorer the prognosis for ever recovering

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# Conversion Disorder: ED Management

- Work-up the symptom (s). Remember many patients eventually found to have a “real” cause
- Hospitalize if you have to
- Try to find the psychological reason for the symptom
- Reassure patient as tests are negative, but don't disregard the symptom or the patient's distress

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# Conversion Disorder: ED Management (cont)

- Be optimistic and confident “these symptoms will get better even if we don’t understand them”
- Referral for psychiatric services to help cope (and ultimately try to understand reason for symptoms), and treat associated Axis 1 disorders
- Monitor your negative countertransference and remember the symptoms represent suffering.

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# Factitious Disorder

- A disorder in which the patient intentionally produces signs of illness and misrepresents his or her history to assume the patient role. The patient is aware that the behavior is intentional, but the motivation for the behavior is unconscious, and not easily controlled.
- Vague, evasive with inconsistent (but extensive) history, false reports, deliberate self injury, scars
- Presentation to ED where they are unknown is common, often late at night when more junior clinicians are present.
- Not bothered by prospect of invasive, painful procedures



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# Factitious Disorder: Management

- Recognition (hard in ED)
- Verification of past medical history (hard in ED)
- Minimize procedures
- ? Confronting the patient
- Psych consultant's main role may be in helping medical staff deal with their own counter-transference to these patients
- Careful but accurate documentation

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# Anxiety Disorders

- Anxiety vs. anxiety disorder
- Anxiety disorders are common, and patients with them seek medical attention more than those without anxiety.
- True medical emergencies make patients anxious. Rule these out before labeling the patient.
- Anxiety can be life threatening: increased suicide risk.
- Benzodiazepines do have a place in treatment of acute anxiety, but long term treatment is usually SSRIs and focused, time-limited psychotherapies
- PES can help

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# Personality Disorders

- 3 Clusters: Odd/Eccentric, Erratic/Dramatic, Anxious/Fearful (DSM-IVR...DSM-V will be different)
- Odd/Eccentric: often brought by someone else, distrustful (can get paranoid) and are vague poor historians, uncomfortable in ED setting, few social supports
- Erratic/Dramatic: most often in ED for SI/HI/ attempts, intoxication, by police (if antisocial)

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# Personality Disorders

- Anxious/Fearful: Complaints are often anxiety induced, reassurance that physical concerns are not life threatening can be most helpful intervention.
- All groups have overlap with other psychiatric disorders.
- All groups are difficult. Let PES know if we can help.

# Emergency Psychiatry

- Questions? Cases?

- Suggested texts:

1. Riba M, Ravindranath D (eds), Clinical Manual of Emergency Psychiatry. American Psychiatric Publishing, Inc, Washington, DC, 2010.

2. Glick RL, Berlin JS, Fishkind AB, Zeller SL (eds), Emergency Psychiatry, Principles and Practice. Lippincott Williams & Wilkins, Philadelphia, 2008.

3. Zun LS (ed), Behavioral Emergencies: A Handbook for Emergency Physicians. To be released in 2012 by Cambridge University Press.