Assessment and Treatment Strategies for Psychiatric Patients in the Emergency Department

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Objectives

• Recognize the importance of symptom management for psychiatric patients
• Gain understanding of psychiatric diagnoses and associated symptoms
• Identify patients at high risk for suicidality, self-harm and acting out behaviors
• Learn specific strategies for dealing with a variety of behavioral issues
• Identify characteristics of “special populations”
• Gain insight regarding therapeutic rapport, nonjudgmental attitude and alliance
THE IMPORTANCE OF SYMPTOM MANAGEMENT

• Anxiety drives many problematic behavioral symptoms
• Anxiety $\rightarrow$ Agitation $\rightarrow$ Aggression
• Symptom management reduces anxiety, acting out, need for restraints and enhances cooperation of patient and family
• Avoid the attitudes and behaviors that increase patient anxiety and frustration ... don’t REACT:

  **R**: restrict

  **E**: escalate

  **A**: avoid

  **C**: coerce

  **T**: threaten
The Importance of Symptom Management

- **Anticipation** of symptoms based on diagnosis and initial nursing assessment of pt.
- **Prevention** of symptoms by use of early intervention, building trust, conveying nonjudgmental attitude, establishing therapeutic rapport and alliance with patient
- **Management** of symptoms saves time, energy and resources; reduces chaos, noise; improves patient outcomes and satisfaction
- **Goal** is to keep patients and staff safe by enlisting cooperation of pt. to stay in control
Common Psychiatric Disorders

- Borderline Personality Disorder
- Bipolar Disorder (Manic Depression)
- Psychosis/Schizophrenia
- Depression (Major Depressive Disorder)
- Anxiety Disorders

**Symptoms can range from mild to severe.**
Borderline Personality Disorder

- Commonly occurs in individuals with traumatic childhood abuse or neglect
- Rigid or fixed perception of the world
- Characterized by poor self-image, chaotic personal relationships, "emotional dysregulation," intense reactions to situations, extreme fear of abandonment and ineffective coping skills in crisis
- Women are more often diagnosed with BPD (75%)
- Often occurs with co-morbidities e.g. eating disorders, substance abuse, depression
Borderline Personality Disorder

Behaviors/Thinking

- Manipulation, power struggles, passive-aggressive communication
- Tend to want you to know what they want, without telling you directly
- Unpredictable, “gamey” around safety issues, attention-seeking, dramatic, provocative
- Can be argumentative; have difficulty taking responsibility for behaviors e.g. may blame dissociation or “voices”
- High risk for self-harming behaviors
- Can be chronically suicidal with many “attempts”
- Black and white thinking
Borderline Personality Disorder

Emotions:

- Angry, labile, depressed, overwhelmed, needy
- Hypersensitive to “rejection,” criticism, negative attitude
- Easily frustrated, agitated
- Anxiety around being poorly treated, ignored, etc. is common trigger for acting out
Borderline Personality Disorder

Specific Strategies:
• AVOID POWER STRUGGLES!
• Give choices as often as possible; clear, reasonable limits
• Don’t react emotionally to behaviors, know your own “buttons”
• No punitive treatments, threats, ultimatums or excessive restrictions—they will give the patient a reason to escalate
• Spend time (if you can) talking with the patient to find out what they need and want; try to accommodate them if you are able (explain why if you can’t)
• Be aware of non-verbal communication
• Explain the process involved, try to decrease anxiety as much as possible
• Check back with the pt. often
• Expedite process of evaluation
“Who needs sleep????”

Bipolar Disorder

- Also known as Manic-Depressive illness, characterized by cycles of extreme mood swings and behaviors
- Involves disruption in normal brain chemistry, often with a familial component
- Not curable, can be managed
- Young, undiagnosed Bipolar patients often “self-medicate”
- Manic behaviors can result in loss of job, relationships, etc., which can increase instability
- High risk for “accidentally” or intentionally killing self
- May not be taking medications
**Bipolar Disorder**

**Behaviors/Thinking (manic phase):**

- Delusions of “grandiosity,” may feel invincible
- Impulsiveness with little regard for personal safety or consequences of actions; high risk behaviors
- Racing thoughts, tangential thinking make it difficult to follow directions or complete tasks e.g. giving UA
- Grandiose, delusional, paranoid, may see some psychosis; perceive themselves as being superior
- Poor boundaries, inappropriate language; loud, frequent change of subjects, interrupting
- Often have little intent to be disruptive or oppositional
- Poor sleep, hygiene and nutrition in acute manic phase
- Rapid, pressured speech
**Bipolar Disorder**

**Emotions:**
- Euphoric, energized, confident
- Labile, anxious, paranoid, feeling “invincible” to harm and superior to others
- Impatient, easily frustrated when process is slower than they think it should be
- Confusion as to why others are concerned about them
Specific strategies:

- Low stimulus, keep directions/statements short and simple (may have to repeat them)
- Don’t argue with the pt.; say “you’re right” as much as possible in order to make it easier to set limits when necessary
- Medicate early for agitation, get a reliable sitter
- New onset mania needs medical workup and probably hospitalization
- Assume pt. will be unpredictable and plan for it
- Check medication levels
“I think that doctor is from the CIA!”

**Psychosis/ Schizophrenia**

- Characterized by disorganization in thinking, delusions/hallucinations and some emotional “flatness”
- Schizophrenia onset typically late adolescence, early 20’s
- Psychosis can be drug induced or related to other disorders such as Bipolar or depression
- Typically don’t realize that their thinking is delusional or irrational; may not understand what is happening to them
- New onset vs. established diagnosis?
- New onset: families can often be in denial
Psychosis/Schizophrenia

Behaviors/Thinking:

- Paranoid, hyper-vigilant, responding to voices, religious references, delusions
- May extend their paranoia to include staff
- May believe that others are reading their thoughts, secretly plotting against them
- Socially withdrawn, focused on delusions
- Not typically violent/aggressive to others
- Could be self-harming or suicidal, if having command hallucinations
- May be uncooperative with an aggressive approach
Psychosis/ Schizophrenia

Emotions:
• Can be very frightened, anxious
• Emotionally withdrawn, suspicious, paranoid
• May not be willing to share what they are feeling; affect may be blunted
Psychosis/ Schizophrenia

Specific Strategies:

- Approach slowly, using non-threatening body language
- Don’t feed into delusions, but don’t directly contradict them either e.g. “That sounds very frightening.”
- Ask about voices, what they are saying, how the patient feels about them (some are “friendly voices”)
- Assess cognitive functioning to determine level of disorganization
- If the patient is there due to safety issues, ask what would be helpful to them to feel safe in the ER
- Low stimulus, medicate for agitation, consider medical etiology if new symptoms
- New onset? Plan for hospitalization and family education
Depression

• Acute vs. chronic (Major Depressive Disorder, dysthymia)

• MDD can be a progressive illness; if left untreated can lead to SI with “loss” of ability to perceive situations in rational, objective way

• Multiple stressors, recent trauma (especially with PTSD issues), perceived loss of control, difficulty in relationships, medical issues can be precipitants

• Genetics, personality, environment can make a person more susceptible

• Physical symptoms e.g. fatigue, headaches, nausea
Depression

Behaviors/Thinking:

- Usually cooperative in the ER, especially if no other psych issues involved (e.g. personality disorder, substance abuse)
- Tend to not ask for what they need/want, believe they are a burden or that they can’t trust others to care for them
- May or may not have intent to hurt self, may or may not want hospitalization vs. being set up with services
- Poor sleep/hygiene, inability to function, impaired judgment, lack of motivation, difficulty making decisions
- May be trying to please others vs. caring for themselves; may not assert themselves around getting the care they need
- Negative, unrealistic thinking
Depression

Emotions:

• Affect can be flat, sad, tearful
• Overwhelmed, anxious, scared, guilty, sad, insecure, hopeless
• May be angry at someone, usually don’t take it out on us
• Can easily shut down if they perceive negativity from staff
Depression

Specific Strategies:

• Ask what they need from ER visit, explain options e.g. connect with services
• Assess extent of depression to avoid excessive restrictions
• Be kind, explain what is happening; give reassurance that you want to help them
• Offer food, warmth, comfort; may need to ask more than once
• Ask about stressors, supports, therapists, allow family/friends if patient wants them
• Ask about SI (vague thoughts vs. plan with intent, can help pinpoint how far the depression has progressed)
Anxiety sets off a cascade of physical, emotional and cognitive symptoms that can overwhelm pt.

Anxiety is a more difficult emotion to handle than anger or depression

Patients often self-medicate with drugs, etoh

Panic attacks, phobias, PTSD-related anxiety can quickly become medical problems if not managed

During panic attacks, patients are unable to process what is being said to them

Anxiety is a strong component of many other disorders e.g. depression, schizophrenia

Physical symptoms can include nausea, chest tightness, dizziness, headache etc
Anxiety/Anxiety Disorders

Behaviors/Thinking:

- Repetitive, irrational thoughts; inability to control anxious thoughts
- Difficulty concentrating or making decisions
- Can be difficult to redirect, restless, impatient
- May escalate if physical symptoms are dismissed or negated
- Impulsive, poor judgment; avoidance as coping
- May react out of proportion to staff’s interactions
- Excessive worrying, may repeatedly ask the same questions
Anxiety/Anxiety Disorders

Emotions:
- Feelings of dread, sense of impending doom
- Irritable, edgy, preoccupied with physical symptoms
- “Anxious about being anxious”
- Overwhelmed, easily frustrated, feeling of powerlessness; lack of trust in staff
- Frightened, may feel like they are “losing control”
- Can escalate to anger, which may be easier for them to tolerate
Anxiety/Anxiety Disorders

Specific Strategies:

• Recognize, treat the physical symptoms as real
• Assess the pt.’s understanding of what is happening
• Offer reassurance e.g. “I know you are frightened but we are going to take care of you.”
• Specifically ask what would be most helpful to them
• Needle phobias, hyperventilation
• Ask what has worked for them in the past when dealing with their anxiety
• Family/friends involvement
• Humor, distraction are helpful with mild-moderate anxiety
Assessing Suicidal Risk

Variations in Suicidal Ideation:

- Chronic vs. **acute**
- Fleeting vs. vague vs. **specific**
- No intent vs. passive intent vs. **clear intent**
- Impulsive vs. **planned**
- Self-harm vs. gesture vs. **attempt**
Assessing Suicidal Risk

RED FLAGS:
• Planned attempt, no regret
• Did not tell anyone
• Unhappy about being alive
• No “future” plans
• Very irrational thinking
• Specific plan, with means
• Lethality of attempt
• Cannot contract for safety
Assessing Suicidal Risk

Specific Strategies:

• Assess level of SI

• Do not minimize/dismiss lethality of attempt or patients’ stressors, feelings

• Do not attempt to “talk pt. out of it”

• Avoid backing suicidal pt. “into a corner”

• Listen in a nonjudgmental way, avoid offering “advice”

• Check with pt. before allowing visitors, phone calls

• ? Safety contract

• Explain to pt. what the process involved in formal assessment
**Special Populations**

**Geriatric Patients:**

- Assess past history of mental health issues
- Unlikely to develop personality disorders, bipolar disorder or schizophrenia past age 60
- High risk for depression/suicide, esp. males, but depression is not a normal part of aging
- Illness, losses, financial problems, caring for incapacitated spouse may increase risk of mental health issues (either exacerbation of chronic or new onset)
- May have difficulty identifying their own depression, or asking for help
- Ask “What is most difficult for you right now?” to begin discussion
- Evaluate support systems, access to services, changes in level of functioning
**Special Populations**

**Adolescents:**
- Rapport with parent and patient is crucial to management; avoid authoritarian approaches
- Assess safety, ability to cooperate with and understand process, relationship with parents
- Common stressors for teens that lead to SI include parental divorce/conflict, relationship breakups, bullying, school problems
- Speak to adolescent first; avoid asking about what you already know
- Separate parents from kids when appropriate; do not “take sides” with parent or adolescent
- Ask about self-harming, SI without parent present
- Allow adolescent to “save face,” have some control, modesty
- Avoid taking behaviors personally
- Remember, bribery (aka “negotiation”) is underrated
Special Populations

Medical-Psych

- Both medical and psych illnesses can exacerbate each other; important to maintain awareness
- Assess psych illness with pt.'s cooperation, e.g. ask about effectiveness of medications, sleep, stress level, supports; “Please let us know if anything changes”
- Medications/NPO status
- Educate patients about mental health issues that may result from medical illnesses
- Avoid dismissing physical symptoms as part of psych illness, without appropriate assessment
- Consistency among shifts with difficult pts. (?need for care plan)
Substance Abusers:

- Can be high risk for self-harming, suicidal behaviors
- May have co-morbid psych illnesses, which will complicate treatment (e.g. bipolar disorder, borderline personality)
- Self-medication for anxiety, depression, anger issues
- Assess "how far" pt. is into addictive process; ask about effects on supports, functioning, finances
- Avoid judgmental attitudes and behaviors
- Avoid "direct" suggestions e.g. AA
- Explain sequence of "tolerance, dependence, addiction"
- Limit education to "most important thing"
- Educate family about caring for themselves, when necessary (e.g. Alanon, CODA, Alateen)
The Therapeutic Relationship

Main components:

- Therapeutic Rapport: consistency, reliability, confidentiality, safety, trust, respect
- Nonjudgmental attitude: acceptance, validation, compassion, empathy
- Alliance: support, meeting of needs, working “with” pt. to achieve goals

**Establishing a therapeutic relationship does not mean condoning, allowing unhealthy or problem behaviors**
Establishing a therapeutic relationship is KEY to symptom management

- Nonverbal communication
- Appropriate humor
- Physical needs e.g. pain control, warmth, food
- Respect: avoid stripping, cathing, threats, ultimatums
- Clear, reasonable, enforceable limits; give choices
- Educate vs. lecture; timing is important
The Therapeutic Relationship

What not to say:

- “If you’re going to act like a child, I’ll treat you that way.”
- “I’m going to call the police if you don’t stop that, here I go. See? I’m heading to the phone.”
- “I know how you feel.”
- “I don’t have time for this.”
- “I have worse problems than you and I’m not suicidal.”
- “You have a lot to live for.”
- “You’re causing your own problems.”
- “Are you here again?”
The Therapeutic Relationship

And what to say instead:

- “That sounds like it is really scary/difficult/overwhelming for you.”
- “I’m sorry this is happening to you.”
- “You’re right” or “I agree with you.”
- “What can I do to help you while you are here?”
- “What would be most helpful to you?”
- “What is worrying you the most right now?”
- “It sounds like you made the right decision to come here.”
- “These are your options...”
Both patients and staff benefit when we:

- Understand psychiatric diagnoses
- Anticipate, manage and prevent symptoms
- Avoid punitive, controlling strategies
- Increase cooperation by establishing a therapeutic rapport and alliance

Questions or comments...
And finally...

References:


- National Alliance for Mental Health, www.nami.org

- Psychiatric Services, www.psychservices.psychiatryonline.org


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