

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



"I don't have an attitude!"

THE IMPORTANCE OF SYMPTOM MANAGEMENT

- Anxiety drives many problematic behavioral symptoms
- Anxiety → Agitation → 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



"What's YOUR problem?"

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.***



"Can I leave, so I can go home and kill myself?"

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

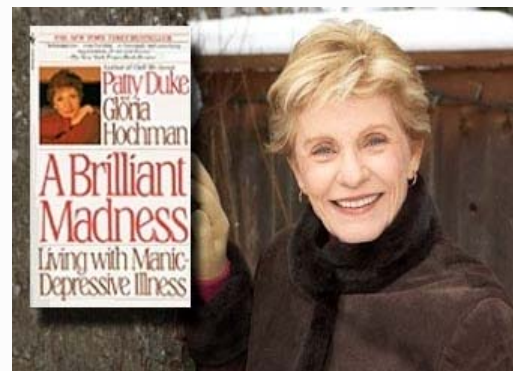


Bipolar Disorder



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





Bipolar Disorder

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 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



"I really think my kids would be better off without me...."

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)



"I'm pretty sure I'm having a heart attack!"

Anxiety/Anxiety Disorders

- 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**

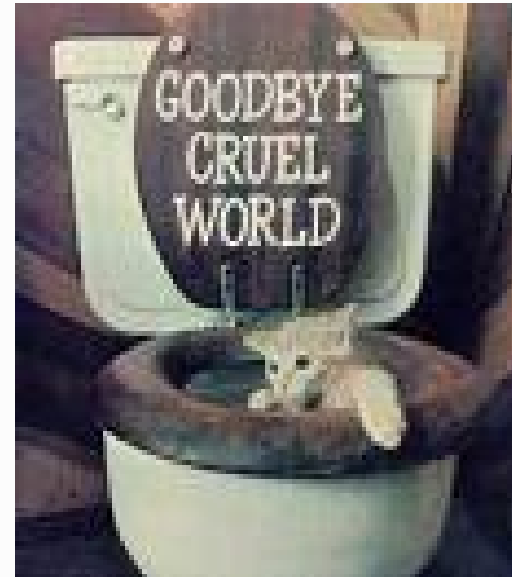




Assessing Suicidal Risk

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
- Can not 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)



Special Populations

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



The Therapeutic Relationship

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..."*



Summary

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...

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