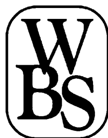

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Managing acute psychotic disorders in an emergency department

Lisa A. Jensen, MS, APRN, CS

Mental Health Clinic, VA Medical Center, 500 Foothill Boulevard, Salt Lake City, UT 84148

Emergency departments (EDs) frequently are faced with managing agitated patients experiencing episodes of acute psychosis. These situations can escalate quickly into a crisis, resulting in frustration for the staff members and a dangerous environment for patients, visitors, and staff. Effective, efficient handling of these conditions is crucial in maintaining a safe environment. This article reviews the definition of the term *psychosis*. Possible causes of psychosis, including differential diagnoses, also are considered. Treatment options and nursing interventions available in the ED are outlined.

Definitions

The term *psychosis* brings to mind various images for clinicians. In general, an individual in a psychotic state is thought to be experiencing an impaired sense of reality. The *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision* (DSM IV-TR) [1] lists an extensive definition of the term *psychotic* in the glossary. The most narrow definition suggests that the disorder is restricted to delusions or prominent hallucinations, with the individual exhibiting no insight into the hallucinations. Conceptually a psychotic patient is thought to have a loss of ego boundaries or a gross impairment in reality testing. Allen [2] defined *agitation* as "a temporary disruption of typical physician-patient collaboration." He said that treatment decisions regarding an agitated patient must be made without any input from the patient, which is an "undesirable situation for all concerned."

E-mail address: lisa.Jensen@med.va.gov

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An individual in a psychotic state can exhibit a variety of symptoms. Perceptual disturbances or hallucinatory experiences are often present in patients with schizophrenia or other psychotic disorders. The most common hallucinations are auditory, although patients also may experience visual, tactile, olfactory, and gustatory hallucinations. The auditory hallucinations or voices heard by a psychotic patient might be perceived by the patient as threatening, accusatory, or self-deprecating in nature. Moller and Murphy [3] described a type of hallucinations known as *command hallucinations*. These auditory hallucinations can be particularly dangerous, in that they may instruct the patient to do something harmful to himself or herself or to other people.

Delusional thinking is another hallmark of psychosis. This symptom can take a variety of forms. One of the most common delusions is that of paranoia, characterized by suspiciousness and perceived persecution. Delusions also may be somatic in nature, with the belief that there is a problem with the functioning of one's body. Patients experiencing somatic delusions likely could present in the ED. Delusions also may be related to control of one's thinking. Patients may believe that thoughts are inserted into their minds, that their thoughts are broadcast to others, or that other people are able to control their thoughts. Disorganized speech and behavior also frequently are apparent in psychotic patients. When these are present, the patient may laugh inappropriately while conversing, or he or she may dress in an inappropriate fashion.

Behavioral disturbances

Behavioral disturbances are common in psychotic patients. The most serious behavioral disturbance exhibited by the agitated psychotic patient is that of aggression. An aggressive patient has the potential to cause physical harm to other patients in the ED and staff and visitors. There is also the possibility the aggressive patient will harm himself or herself or damage the facility.

The behavior of a psychotic patient may escalate to physical violence. Nurses should be knowledgeable of what behavior may indicate potential physical disturbances. These behaviors would include pacing in the waiting area; speaking with a raised voice or shouting; demanding to be seen immediately; threats of violence, which may be verbal or nonverbal; and escalation of any of these behaviors.

Case example

Family members bring a 42-year-old white man to the ED. The family reports that the man has been acting "strange" at home. He yells at the television when the news comes on, mutters to himself frequently, and insists

on closing all of the blinds in the house during the day and night. The patient has a long history of psychiatric problems. He has been diagnosed in the past alternately as schizophrenic and bipolar. Now the patient is pacing about in the waiting area, looking down at the floor. His hands are at his sides, and he is clenching and unclenching his fists. He begins pacing at a quicker rate. He has been mumbling to himself. He now begins shouting a few words from time to time in addition to his muttering.

In this clinical example, immediate triaging and intervention with the patient are important for the safe management of this patient.

Assessment and diagnosis

Many psychiatric diagnoses can present as a threat of violence in the ED. An accurate diagnosis is essential in dealing appropriately with these patients. An agitated patient who is in a state of acute intoxication is treated differently than a patient experiencing an acute exacerbation of chronic schizophrenia. It is important to determine the cause of the psychosis before determining the most practical and effective treatment.

Brief psychotic disorder

The DSM IV-TR [1] defines *brief psychotic disorder* as a disturbance involving the sudden onset of positive psychotic symptoms. The so-called positive symptoms include delusions, hallucinations, disorganized speech, and grossly disorganized behavior. Kaplan and Saddock [4] reported that characteristic symptoms of brief psychotic disorder may include intense mood swings, strange dress or behavior, screaming or muteness, and impaired short-term memory. Patients presenting to the ED with these types of symptoms potentially could create a situation that results in violence.

Schizophrenia

A patient with an acute exacerbation or first psychotic episode of schizophrenia often presents with similar positive symptoms as those exhibited by a patient experiencing a brief reactive psychosis. Of particular concern for the staff in the ED, as mentioned previously, is a patient with schizophrenia who is experiencing command hallucinations. The patient may hear voices telling him or her to harm specific types of people (ie, men with beards or young attractive women). The patient may believe he or she should direct that aggression toward people in general. The schizophrenic patient with psychotic symptoms also could be experiencing visual hallucinations that may lead to violence. The patient might see another person as "the devil," which the patient perceives as a threat to be defended against or destroyed.

Bipolar disorder, manic phase

During a manic episode of bipolar disorder, the mood displayed can be expansive, irritable, grandiose, or elevated. The patient may present with an unusual appearance, in terms of clothing, grooming, and makeup. Speech may be loud and rapid, to the point that the listener is unable to understand the patient. Patients experiencing a manic phase describe the sensation of racing thoughts, which are not under their control. The heightened irritability often observed in the manic patient can result in violent behavior, particularly if the patient believes that he or she is being thwarted in attempts to obtain something or complete his or her perceived task.

Schizoaffective disorder

Patients showing symptoms indicative of a mood disorder in addition to psychotic symptoms are defined as having schizoaffective disorder. The mood symptoms seen in this disorder could be that of a depressed mood or manic symptoms. The DSM IV-TR [1] delineates that during an active phase of this illness, the diagnostic criteria for schizophrenia are met and the criteria for a major depressive episode or a manic episode.

Psychotic disorder resulting from a general medical condition

A patient presenting with a diagnosed medical condition who also is experiencing psychotic symptoms could meet the diagnostic criteria for psychotic disorder resulting from a general medical condition. The psychotic symptoms seen here are prominent hallucinations or delusions. Further criteria, according to the DSM IV-TR [1], are evidence that the psychotic symptoms are a direct result or consequence of a general medical condition. Medical conditions that may result in a psychosis include, but are not limited to, cerebral tumors, epilepsy, migraine headaches, infections, endocrine and metabolic disorders, and hepatic or renal diseases.

Acute intoxication

Individuals present to the ED in various states of intoxication, with a variety of intoxicants. Phillips [5] found, through a literature review, that patients with schizophrenia often use substances in attempts to self-medicate their symptoms. A patient in a psychotic state also may present while acutely intoxicated with alcohol, as an attempt to control his or her symptoms. Phillips [5] stated that psychostimulant drugs often are used to reduce negative symptoms, such as social withdrawal, whereas benzodiazepines and alcohol may be used to suppress temporarily positive symptoms, such as hallucinations.

A person who is acutely intoxicated with alcohol may be belligerent and irritable on presentation. Patients undergoing detoxification may present to

the ED with psychotic symptoms. Hallucinations, particularly visual and tactile, are common in individuals experiencing delirium tremens. Alcohol withdrawal symptoms, or delirium tremens, may occur within 1 week after the patient has stopped drinking, and the patient may not be acutely intoxicated. Assessment of alcohol intake and alcohol blood level is important because the treatment of an intoxicated patient is different from that of a patient who is acutely psychotic without having ingested any alcohol or mood-altering drugs.

Patients taking illicit drugs also can present in an agitated, psychotic state. These patients may not have a history of a psychotic disorder. Use of cocaine can result in a state of intense paranoia. The use of hallucinogens often results in the experience of intense hallucinations. Friends or family members, who could be unaware of any drugs that have been ingested, may bring patients to the ED. Patients may be unwilling to admit to the use of the drugs because of their illicit nature. With any patient in whom there is a suspicion of drug use, a toxicology screen is indicated.

Differential diagnosis

Determining the correct diagnosis when treating an agitated psychotic patient is essential in deciding on the most appropriate treatment. Delirium often can be the cause of perceptual disturbances experienced by patients. Delirium usually is noted by a sudden onset of symptoms. The DSM IV-TR [1] describes delirium as being "a reduced clarity of awareness of the environment." Patients experiencing a delirium generally present with confusion and disorientation, hallucinations, and often unusual behaviors. The delirious state may be interposed throughout the day with periods of lucidity.

There are many possible physiologic causes of delirium, including an infectious process in the body, arterial disease, metabolic disorder, or a nutritional disorder. Patients with other medical disorders also may present to the ED in an agitated state. A patient with a closed head injury could be agitated, anxious, and possibly experiencing hallucinations. Determining the cause is important in selecting the most appropriate treatment and management.

Treatment and interventions

The nurse in the ED plays a central role in the identification of a psychotic, agitated patient and the safe management of that patient. The assessment process starts with observation of the presenting patient's behaviors. This observation begins as soon as the patient enters the ED, including his or her behavior while in the waiting area. The psychotic patient may become agitated while waiting to be seen. A patient who is pacing about the waiting area, speaking loudly, or behaving in a bizarre manner

needs to be evaluated before further escalation of his or her behavior. The patient may wander about the waiting area, march about or in place, or walk with an unusual gait; the patient may dress and undress; or the patient may stand in a posture, such as with one arm extended outward. Observation can give clues regarding the presence of hallucinations. A patient who suddenly turns and looks behind himself or herself may be responding to a voice. Documentation in the medical record should include the manner in which the patient arrived at the ED and any unusual behaviors observed before being seen and during the assessment. Also included in the medical record should be a description of the patient's general appearance, including dress and grooming, and any abnormal movements or psychomotor activity.

The interview with the patient is the next step. The interview should take place in a private area that affords confidentiality but does not jeopardize staff safety. Direct questions are asked regarding the presence of hallucinations. In the case of auditory hallucinations, information should be elicited regarding how many different voices are heard; whether or not they are recognized; the content of the message; and the frequency, intensity, and duration. The presence of other types of hallucinations is evaluated in the same way, drawing out information regarding frequency, intensity, duration, and content. The patient's perceived emotional response to the hallucinations also should be noted. Moller and Murphy [3] pointed out that successful intervention with a patient experiencing hallucinations includes practicing active listening skills and careful observation.

Safety

Provision of a safe environment is a primary consideration when an agitated psychotic patient is receiving treatment in the ED. Nurses play a principal role in ensuring the environment is safe. Being respectful of the patient's personal space helps ensure the safety of staff approaching the patient. An agitated patient who believes he or she is being threatened may strike out to protect himself or herself. The patient needs to be approached with a calm manner and voice. The nurse should not face the patient directly when talking with him or her, but rather stand at an angle, which allows for a quick escape from the situation should the need arise. If a staff member is alone in a room with the patient, the staff member needs to be closer to the door. Items that can be picked up easily and thrown about the room should be removed or kept at a minimum.

Therapeutic alliance

The formation of a therapeutic alliance is necessary to manage the psychiatric patient effectively. The relationship formed with the patient is the primary intervention tool that is used. A high level of trust is necessary for the patient to open up to the nurse and reveal symptoms being

experienced. Psychotic patients as a rule understand that what they are experiencing is unusual. They may be reluctant to share information for fear of being humiliated. The paranoid suspicious patient may believe that he or she can trust no one or may think that he or she has information that can be shared only with particular individuals. Approaching the patient with a nonjudgmental attitude is crucial to the formation of a therapeutic alliance. Arguing with a patient about his or her paranoid thoughts, delusional thinking, or hallucinations may increase anxiety and agitation and interferes with establishing a trusting relationship. The best approach is to acknowledge the patient's experience and ask the patient how he or she is feeling emotionally about the symptoms from which he or she is suffering.

Case example

A 27-year-old woman comes into the ED complaining of abdominal pain. She is agitated and pacing about in the examination room. She tells the nurse that she believes she has a large parasite in her abdomen and insists that a surgical procedure be performed immediately to remove the parasite. An appropriate response for the nurse would be to say, "I understand you must be in a great deal of pain; it must be very scary for you. Let's have you sit on the examination table so the doctor can take a closer look at what's going on."

It is important to remember that the patient who is experiencing a psychotic episode finds this experience frightening. The patient recognizes that the experience is not normal. Providing a calm, safe environment for the patient is beneficial in helping him or her to become more relaxed.

Provision of a calm environment

Providing the agitated, psychotic patient with a quiet, calm environment is essential in the practical management of the patient. Placing the patient in a private examination room, if available, is indicated. Having the same staff members interact with the patient decreases confusion for him or her. Farrell and colleagues [6] encourage the use of direct, simple messages and nonconfrontational feedback. The use of limited choices is suggested (ie, "would you prefer to sit in this room or lay on the exam table?"). Offering choices gives the patient a sense of control in the situation. Minimizing the noise level also contributes to calming the patient. Available family members may be able to assist in placating the patient. Family members and caregivers also may contribute to the agitation of some psychotic patients. The patient's response to the family needs to be observed and considered when deciding on the family's level of involvement.

Use of medications

Many medications are indicated for managing agitated psychotic patients in the ED. Medications used most frequently in the ED fall into two classes of drugs: the sedative-hypnotics or antianxiety drugs and the antipsychotics

or neuroleptics. The antianxiety drugs used most in the ED are the benzodiazepines. These drugs have many advantages. They are absorbed quickly and have a rapid onset of action. The benzodiazepines most often used for agitated patients include lorazepam (Ativan) and clonazepam (Klonopin). According to Currier [7], lorazepam is absorbed within 15 to 30 minutes and has a half-life of 6 to 20 hours. This medication often is used in combination with haldol, an antipsychotic medication. The typical dose of lorazepam is 2 mg. Clonazepam also is absorbed quickly, although it has a longer half-life than lorazepam. It also is given in combination with an antipsychotic, at doses of 0.5 to 2 mg. Diazepam (Valium) is another benzodiazepine that was popular in the 1970s and 1980s, but it is no longer a treatment option for agitation because it has a long half-life (>20 hours), which can lead to a cumulative effect if given in repeated administrations [7].

The typical antipsychotics, such as haloperidol (Haldol), are used infrequently in mental health to treat psychotic disorders because of their undesirable side-effect profile and long-term side effects, such as tardive dyskinesia. They are still used successfully in emergency settings, however. According to Currier [7], this is due to their availability in parenteral form. Oral absorption of the typical antipsychotics is slower and leads to less predictable blood levels than the parenteral form. Haloperidol is available in oral, intramuscular, and intravenous preparations. The onset of action for the oral or intramuscular preparations ranges from 30 to 60 minutes.

Droperidol is another antipsychotic agent that often is used in emergency settings. According to Glow [8], an advantage of droperidol (Inapsine) is that it can be used in an intravenous preparation, which has a shorter onset of action than that of intramuscular haloperidol. Another noted advantage is the shorter half-life of droperidol, allowing faster reevaluation of patients. This medication is particularly useful in the management of stimulant-induced psychosis. Droperidol has been issued a "black box" warning by the Food and Drug Administration. This is the most serious warning for a Food and Drug Administration–approved drug. The warning addresses the potential for cardiac arrhythmia during drug administration. Another serious side effect of droperidol is orthostatic hypotension; patients should be monitored carefully for this effect after administration and cautioned when they are discharged from the ED.

The use of haloperidol or droperidol requires monitoring of possible side effects. Extrapyramidal side effects (EPS) are common with these medications. The EPS of concern in this setting include dystonia, akathisia, and parkinsonism symptoms. Dystonia encompasses a wide array of symptoms, such as acute contractions of muscles in the tongue, face, neck, and back. Spasms of the jaw, tongue, and neck also are a common presentation of dystonia. Other signs include oculogyric crisis, in which the eyes are locked upward; laryngospasm; and a tightening of the entire body. Parkinsonism symptoms include stiffness, masklike facies, and a shuffling gait. Common complaints of patients with akathisia include inner

restlessness; jitteriness, and fidgeting. EPS are most likely to occur during early treatment or rapid titration of neuroleptic agents.

When neuroleptics are administered in the ED, the nurse must monitor patients for possible EPS. Often akathisia is misdiagnosed as psychotic agitation, and the patient is treated with an increased dose of neuroleptic medication, which leads to further symptoms of akathisia. The symptoms of EPS can be treated quickly and effectively with diphenhydramine (Benadryl) or benztropine mesylate (Cogentin). These medications can be administered intramuscularly or intravenously to treat acute EPS.

The atypical antipsychotics, so named because of their side-effect profile, which is vastly different from the typical antipsychotics, include risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), and ziprasidone (Geodon). The atypical antipsychotics are considered the first line of maintenance treatment for psychotic disorders today within the mental health arena. They are used less frequently, however, in the emergency setting because of a lack of availability in intramuscular form. It is expected that parenteral forms of olanzapine and ziprasidone will be available in the United States in the near future.

Seclusion and restraint

Seclusion and restraint are options that at times must be used with an agitated psychotic patient. Hamolia [9] defined *restraint* as "the use of mechanical or manual devices to limit the physical mobility of the patient." Hamolia [9] indicated that *seclusion* involves the use of three therapeutic principles: containment, isolation, and a decrease in sensory input. Most EDs are not equipped with a seclusion room, in which case physical restraints become necessary. The Joint Commission for Accreditation of Healthcare Organizations has specific guidelines and regulations that must be followed when seclusion and restraint are used. These guidelines include written orders, which are time limited and cannot be "as needed"; frequency and type of observation; frequency with which the patient will be reassessed; and frequency with which the restraints must be loosened or released.

If seclusion and restraint are used, the staff must receive training in the appropriate and safe use of these devices. A lone staff member should never attempt to place a patient in seclusion or restraints. These interventions must be implemented through a team approach. The charge nurse usually is designated as the team leader. The choice of who will be the team leader should be made in advance. According to Hamolia [9], the team leader has many roles in managing a crisis situation, including obtaining assistance to handle the situation, which may involve members of the institution's security personnel; balancing the need to act quickly with the need to be well organized; and ensuring the safety of other patients in the area and staff and visitors. Currier and Allen [10] pointed out that there is much debate about the use of physical restraints in the health care setting. The use of restraints

may be necessary to ensure an orderly, therapeutic environment for the patient being treated and other patients in the immediate area. Winship [11] suggested that the physical holding of a psychotic patient may be involved in the process of reestablishing an intact ego for that patient. Winship [11] also suggested that patients involved in the restraint process have an increased sense of safety and containment if the restraint is delivered with care and insight by the staff involved.

Debriefing staff members

The use of restraints historically has been controversial. Putting an individual in restraints can be a traumatic experience for all involved. A short debriefing session can be a meaningful component of the intervention. Debriefing gives the staff time to express their feelings and reactions to the situation. It also allows the team an opportunity to discuss what went right and what could have been improved on during the intervention.

Dealing with an agitated psychotic patient in the ED can be a challenging experience. Making an accurate assessment initially assists the staff in selecting the most appropriate disposition for the patient. Providing care to these patients in a safe manner is also an important element in their treatment. Nurses in the ED play a key role in ensuring the safe, efficient treatment of the psychotic, agitated patient.

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