Katherine Maloy

A CASE-BASED APPROACH TO

Emergency Psychiatry

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EDITED BY KATHERINE MALOY, MD

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Introduction

The term *emergency psychiatry* has a wide range of meanings and implications, and how emergency psychiatric care is provided may take many forms. Patients may present to the emergency department with an acute psychiatric complaint, they may arrive as walk-ins to an urgent care setting needing referrals and medication refills, they may present for a real or perceived medical issue and have unmet mental health needs driving their presentation, or they may be in the community with an acute, severe behavioral disturbance. Depending on the volume of patients, local mental health laws, availability of trained clinicians, and the design of the emergency department itself, emergency psychiatric care can be delivered in many ways. Some systems rely on an on-call clinician, possibly a psychiatrist, but at other times on a social worker or advanced practice nurse, who provides an evaluation and recommendations for treatment. Other systems with high volumes of patients in need of psychiatric care have developed more comprehensive emergency department–based services that include aftercare, short-term inpatient treatment, and extensive supportive services.

Still other systems, with more severe shortages of practitioners or where travel to the patient's location is a challenge, rely on telepsychiatry to provide consultation. In many health care systems there is a long wait for outpatient care, and it can be particularly difficult to access without insurance, outside of regular working hours, or due to transportation issues. Emergency medicine physicians will also note that many patients who present for issues related to chronic medical conditions also have ongoing mental health needs that are either contributing to their current visit or to their overall difficulties in maintaining their health outside the hospital.

Although comprehensive emergency psychiatric services or crisis centers are a way of meeting many of the challenges in providing immediate evaluation, diagnosis, and referral to appropriate treatment, they are certainly not the norm. Particularly in smaller, low-volume health care settings, there may not be sufficient volume to provide such depth of service. Emergency psychiatric care may fall on the shoulders of an emergency medicine physician or nurse practitioner. The clinician working at an urgent care center may be the first person to evaluate someone with new onset of serious mental illness or the first person to notice a substance use disorder. These clinicians may not feel they have sufficient training to intervene, or they may not be as eager to look for something they feel ill-equipped to manage. Similarly, although psychiatric residents are frequently called upon to cover emergency department consultation as part of their training, without sufficient support

they may experience this work as overwhelming and unpleasant. Patients without adequate health care resources also disproportionately use emergency services over outpatient services, and thus the burden of comorbidity of medical problems, substance use disorders, and social issues such as homelessness or economic adversity may be high in the emergency setting.

Working in an emergency or urgent-care setting requires flexibility, a practical approach, and a broad range of knowledge. The ability to maintain calm in serious and confusing situations, to work in a team and as a consultant, to provide support and build an alliance not just with patients but with emergency department staff, and to make decisions with limited information are all important qualities. The work itself is rarely dull and provides the opportunity to keep up with one's "medical" training. Memorable cases can provide an anchor for clinical knowledge, whether for one's own education or for teaching. Toward that end, this book strives to draw on the authors' experiences as psychiatrists working in the emergency setting—but also their additional training in addiction, child, psychosomatic, and forensic psychiatry—to provide a case-based approach to problems that are frequently encountered in the emergency setting.

The cases in this book do not represent actual patients but are composites based on the experiences of the authors working in multiple settings. The situations described are designed to illustrate a range of issues, from more routine issues such as panic attacks and mild depression to more complex issues such as patients with severe personality disorders or neurologic issues that masquerade as behavioral problems. While many of the chapters deal specifically with groups of disorders—mood, anxiety, psychosis, personality, substance use, developmental disability—others delve into more complicated topics such as ethical obligations of the psychiatrist, working with patients in custody or who may commit crimes in the emergency department, or consulting to the medical emergency department about patients with somatization. The crossover between medical/neurologic illness and its behavioral manifestations is explored, as well as the impact of the clinician's own countertransference on evaluation and disposition. The case histories are punctuated by clinical tips and learning points that derive from the authors' experience, and they are followed by discussion that includes references to current literature and evidence-based practices. The topics covered should provide a broad knowledge base that clinicians working in emergency settings can refer to for clinical guidance in complicated situations and, we hope, spark an interest in this compelling and developing field.

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Anxiety, Trauma, and Hoarding

KATHERINE MALOY ■

CASE 1: "I COULDN'T BREATHE"

Case History

Ms. D is a 26-year-old woman with no known prior psychiatric or medical history who presents to the psychiatric emergency department (ED) via ambulance after an episode of dyspnea on a train platform. The patient appears calm on arrival and does not understand why she has been triaged to the psychiatry side of the ED. She notes, "I couldn't breathe, what am I doing here in psych?" and states that she feels better anyway and needs to get to work.

The emergency medicine technician (EMT) accompanying the patient notes that when they arrived she was panting, flushed, and clutching her chest, stating she felt like she was going to die. Her lungs were clear, oxygen saturation was 100% on room air, and she denied any history of asthma, allergies, heart problems, or recent illness. A large crowd had gathered around the patient and so the EMTs rapidly moved her out of the train station and into the back of the ambulance where she could have some privacy. After a few minutes of controlled breathing directed by one of the EMTs, the patient's symptoms had resolved. She wanted to be transported to the hospital, however, because she was worried that something was medically wrong with her. When she arrived at triage with normal vital signs and no signs of distress, the nurse had decided that she had experienced a panic attack and sent her to the psychiatric side of the ED.

Clinical Tip

In a young patient with no signs of medical illness or comorbidity the likelihood that the patient is experiencing an acute MI or other medical illness is low, particularly since the symptoms resolved so quickly. However, once symptoms resolve, the patient may not wish to endure an evaluation in a psychiatric setting either, and may be reluctant to immediately identify his or her symptoms as psychiatric in nature.

Clinical Evaluation: The patient agreed to see the psychiatrist as long as she also is medically evaluated. On interview, the patient reports that she was on her way to work and thinking about her recent interactions with her supervisor when the symptoms began. She has been written up several times and is in danger of losing her job. She was already running late, and was anticipating getting "chewed out" by her boss once she got to work. She was running to catch the train and breathing rapidly. She has some financial problems already, and lives with her family as a result. She denied any depressed mood or other symptoms of depression but does note more difficulty concentrating at work and having over the past few weeks a few episodes where she begins thinking about all of her problems and "my mind just races and I feel like I'm going to pass out." She ate a good breakfast this morning, drank her usual one cup of coffee, and denies use of cigarettes, drugs, or alcohol. She saw her primary care doctor a few months ago and was deemed healthy but was advised to exercise more frequently. She denies having any history of suicide attempts, arrest, violence, or prior psychiatric hospitalizations.

On physical exam, no abnormalities are detected. Electrocardiogram is normal. Laboratory studies show no signs of metabolic problems, anemia, or thyroid disease. She submits urine for toxicology and no substances are detected. Urinalysis is normal. The psychiatrist reviews her chart and begins to think about how he is going to explain to Ms. D what happened to her.

"So, What's Wrong with Me? Is It All in My Head?"

While Ms. D is sitting in the psychiatric ED waiting for the results of her labs, a very agitated patient is brought by police in restraints. He is shouting, very malodorous, and accompanied by a crowd of police, EMS workers, and staff from the medical ED. Ms. D did not want to sit in the locked portion of the ED, so she is now sitting in the waiting area while the new patient is given sedating medications and restrained. The waiting area is suddenly very crowded. Ms. D begins to breathe rapidly and then gets up and is seen crying, stating "I've got to get out of here!"

Clinical Tip

Anxiety and panic can be precipitated by closed spaces, crowds, or stressful situations. Ms. D is likely having a panic attack precipitated by a situation not uncommon in a busy psychiatric ED.

Ms. D is moved to a quieter area, and one of the staff sits with her and helps her slow down her breathing. As soon as the acute crisis with the other patient is resolved, the psychiatrist meets with Ms. D to explain the likely diagnosis.

Ms. D is not totally convinced that there is not something medically wrong with her and reinforces several times to the psychiatrist that her heart was beating very quickly and that she "felt like my chest was thumping inside." Eventually she blurts out, "So I'm crazy? That's what it feels like, like I'm going crazy and I'm going to lose my mind and end up in the looney bin!"

The psychiatrist is able to reassure her that this does not mean she is in any way "crazy" and that the sensation of feeling "crazy" or out of control can in fact be a symptom of a panic attack. Ms. D is also able to recall some incidents from her late teens when she had similar symptoms. The patient was given referral information for treatment options, including cognitive behavioral therapy.

DISCUSSION

Panic attacks are a common precipitant for ED visits, particularly if patients do not understand what is happening to them, as the symptoms closely mimic an acute respiratory or cardiac problem. Rapid heart rate, rapid breathing, and the feeling of having "palpitations," being weak or faint, and of "impending doom" are all features that could be shared by many disorders. In a young and otherwise healthy patient with no comorbidities, the diagnosis of a panic attack can probably be mostly made by clinical history, most prominently by the fact that the classic symptoms should be self-limiting and resolve on their own.

Clinical Features and Epidemiology

Panic disorder is defined as recurrent, unexpected panic attacks that are either causing significant, distressing worry about having more attacks or leading to changes in behavior to avoid attacks for at least one month.[1] It is possible to have isolated panic attacks without meeting criteria for the disorder, as long as they are infrequent and not disabling. Median age of onset is 20 to 24 years, with new cases rarely diagnosed after 45 years of age.[2]

Differential diagnosis—apart from ruling out any acute medical causes of the symptoms—should also include an investigation into substance-related causes of anxiety symptoms and a thorough investigation into comorbid mood and psychotic symptoms. Patients may be more willing to report their symptoms as a "panic attack" than an adverse anxious or paranoid reaction to use of cannabis or stimulants. Withdrawal from alcohol or benzodiazepines can precipitate intense anxiety that may be identified by the patient as panic. Patients may also describe having "panic attacks" but their overall symptoms are more consistent with a generalized anxiety disorder. While it is difficult to make the diagnosis of a personality disorder in the ED, patients with borderline or histrionic traits may have episodes that they describe as panic or anxiety attacks when, in fact, they are more consistent with periods of emotional dysregulation.

The etiology of panic disorder is still not completely understood, but some researchers hypothesize a dysregulation of the normal fight or flight response to stressful stimuli and overactivation of a normal fear response.[3]

Panic Disorder and the Emergency Department

Although anxiety disorders in general are considered to be less serious than other mental disorders such as schizophrenia or bipolar disorder, panic disorder can be

disabling, may lead to withdrawal from daily activities, and is associated with higher risk of suicide attempts in patients who also meet criteria for depression.[4] Undiagnosed or unrecognized panic disorder can also lead to excessive use of emergency medical services, as patients may appear as though they are having an acute medical issue or may believe, despite multiple workups, that they are having an undetected medical problem.[5] Worry begets worry, and the fear of having a panic attack may become even more disabling than the attacks themselves. Patients may withdraw from society to avoid triggers such as crowds, bridges, or elevators or be unable to complete basic daily activities due to their intense worry about having an attack or being embarrassed by their symptoms.

Most patients with panic disorder will not have a history of physical or sexual abuse, but patients who exhibit panic symptoms should be screened for posttraumatic stress disorder (PTSD), as there may be other symptoms of PTSD that are going unrecognized. An episode of reexperiencing a trauma or flashback could look like a panic attack in terms of autonomic hyperarousal and anxiety. Patients should also be screened for comorbid depression, as well as substance use disorders.

The good news is that panic disorder is quite treatable and can frequently be treated without medications.[6] For patients who are fearful that they are "crazy," the news that a short course of manualized cognitive behavioral therapy might ameliorate their symptoms is frequently reassuring. Some of these techniques can even be introduced in the ED and rehearsed with the patient, such as controlled breathing and progressive muscle relaxation. The news that panic attacks are self-limiting and not fatal can itself be helpful in helping patients address the fear of the attack.

Starting medications in the ED should ideally be avoided unless follow-up is immediately available. Although selective serotonin reuptake inhibitors are the first-line treatment for panic disorder,[7,8] they take time to be effective and any side effects in an already anxious patient can lead to early discontinuation or worsening of anxiety. A patient who has a less than ideal response to a medication prescribed in the ED may then be unmotivated to seek continued treatment or may doubt the accuracy of the diagnosis. While short-acting benzodiazepines are frequently used "as needed" for panic attacks, the onset of action of most agents, even alprazolam, is longer than the duration of most panic attacks. Short-acting benzodiazepines are also highly habit-forming and can cause rebound anxiety as they wear off. Comorbid substance use disorder greatly increases the risk of abuse of prescribed substances. There is also always a risk of patients who come to the ED endorsing panic symptoms specifically seeking benzodiazepines, as well as patients who are not in fact experiencing panic disorder but are experiencing anxiety in the context of withdrawal from abused substances such as alcohol, benzodiazepines, or barbiturates. Some patients may have also tried illicitly obtained benzodiazepines to ameliorate their symptoms, and they may be reluctant to reveal this information. For patients without comorbid substance use disorders who have intense fear of having another attack, simply having a small supply of a short-acting benzodiazepine available may have a positive effect in empowering them to not restrict their behavior in fear of having another attack. Patients should, however, be questioned about comorbid substance use disorders.

If a diagnosis of panic disorder can be made and conveyed to the patient effectively and the patient is able to engage in treatment, the result can be a great deal of

savings in unneeded ED visits, health care costs, and a greatly improved quality of life for the patient.

Key Clinical Points

- Although medical comorbidities should always be considered, in young, otherwise healthy patients, panic disorder should be a consideration for patients with a classic cluster of symptoms.
- Other issues—apart from medical causes—that should be considered in the ED evaluation of panic attacks include adverse reaction to illicit drug use, seeking of prescriptions, and withdrawal from benzodiazepines or alcohol.
- Providing education about panic disorder and available treatment options can be helpful in reducing patient anxiety, avoiding overuse of medical services, and improving quality of life. Some brief interventions can be taught in an ER setting.

CASE 2: "STALLED IN THE HIGHWAY"

Case History

Initial Presentation: A 28-year-old white man is brought by ambulance and police from the middle of a highway. He was found standing next to a stalled delivery truck in the middle of traffic in a highly agitated state. Police had been called to help tow the truck out of traffic; on their arrival, the patient had become combative—arguing with police, demanding their rank, and wanting to speak to their commanding officer. Additional police and an ambulance were called to the scene. The man was restrained by several officers for transport to the hospital. One of the police noted that "It seemed like he was talking to people that weren't there . . . he kept calling me Sergeant." On arrival, the patient was diaphoretic, highly agitated, and tied to the stretcher. He did not seem to understand that he was speaking with a doctor. He appeared to be hallucinating. He was reciting military terminology. He was given intramuscular haloperidol and lorazepam, transferred to behavioral restraints, and he eventually fell asleep. Vital signs were notable for tachycardia on arrival but quickly returned to normal after sedation.

Routine laboratory studies were normal; alcohol level was zero. He was admitted to emergency observation. Pulse and blood pressure remained within normal limits consistently after sedation.

Learning Point: Evaluation of Altered Mental Status

The patient arrived in a highly agitated state, with abnormal vital signs and appearing disoriented to person, place, and time. While he appeared to be a young, healthy individual and vital signs rapidly normalized after sedation —suggesting that agitation was primarily responsible for his tachycardia—his presentation is concerning for a non-psychiatric etiology of his behavior. Monitoring of vital signs, laboratory studies, EKG, toxicology, and careful physical exam are all important initial

interventions in this patient. A screening CT of the brain could be considered. Acute intoxication, particularly on a hallucinogenic compound or stimulant, would also be a leading diagnostic consideration.

Collateral Information: An hour after the patient arrived, a call was received from his employer, who had been notified by police. The patient had just begun a job as a delivery truck driver, and the employer noted he has a military background. The employer provided the patient's emergency contact number—that of his wife.

The patient's wife was contacted to attempt to obtain medical and psychiatric history. She reported no prior psychiatric history and was extremely concerned about his presentation. She noted that he had recently finished two years of military service in Iraq and that he had had difficulty finding a job. As a result the couple was under a great deal of financial stress. She denied that he uses drugs or alcohol, noting, "He's been looking for a job and every job requires a drug screen. He wouldn't mess that up."

Further Observation and Follow-Up: The patient woke overnight and was confused about his whereabouts but was calm and in control when informed of what had happened. He submitted urine for toxicology, which was negative for cocaine, barbiturates, opiates, phencyclidine, and THC but positive for benzodiazepines, which had been administered on arrival. He did not require any further sedation and his wife was notified at his request of his current condition. A CT scan of his head was obtained that did not reveal any space-occupying lesions, acute bleeds, or structural abnormalities.

Clinical Pearl: Reliability of Urine Drug Screens

Many patients conceal their use of drugs or alcohol for fear of judgment by providers, fear of prosecution, reporting to employers or child welfare officials, or simply due to stigma and shame. Despite reassurances from providers and sensitive, confidential interviewing, it may not be possible to obtain a fully honest substance use history. Some patients who are acutely intoxicated may be simply unable to provide any information. Toxicology screening for illicit substances can therefore be a useful tool when used in combination with clinical history. However, the types of screening available vary widely by hospital or laboratory, and turn-around times are not always rapid enough to be useful in the ER setting. Specimens are usually not obtained in an entirely secure manner; patients may be able to adulterate their urine with water or, in some extreme cases, switch it with that of another patient to avoid detection. Clinicians should also familiarize themselves with the expected window of time of a positive test for various substances and possible causes of false-positives (e.g., reports of dextromethorphan testing as phencyclidine), as well as false-negatives (e.g., some synthetic opioids not testing positive on a routine "opiates" screen).[9] Newer "designer" drugs are usually ahead of commercially available tests, as they are sometimes designed specifically to avoid commercially available testing (for example, synthetic cannabinoids or "bath salts").

The patient was re-interviewed in the morning by a psychiatrist and social worker. He was calm, polite, and deferential to staff, and he was extremely embarrassed

about his behavior the day before. He insisted he was fine and denied all psychiatric symptoms; his thought process was linear and organized. He was quite fearful that he would lose his job as a result of this episode and wanted to leave as soon as possible to present to work and attempt to explain his behavior to his employer. There was no evidence of paranoia, thought disorder, or hallucinations. His wife came to the hospital to meet with the team and continued to deny witnessing any behavioral changes at home preceding the event. Both were reluctant to discuss any possible precipitants for the previous day's events, focusing instead on how important it was for the patient to stay employed.

On more extensive questioning, the patient discussed his military history. He spoke about driving a truck in Iraq and being constantly afraid of mines and ambushes. He spent most of his two years of service in situations where he was on constant alert. He had difficulty recalling the events of the day before, but he did recall being stuck on the bridge after his truck stalled, particularly the noise of the traffic, people in other cars yelling at him, and his feeling of intense panic that he was surrounded and could not get away. He had not been injured while in the military but had witnessed injuries to members of his company as well as hearing numerous stories of soldiers who were maimed or killed in situations similar to his. Since returning home, he admitted to having periodic nightmares, from which he wakes in a state of intense agitation. He reported difficulty remembering that he is no longer in Iraq, as well as times when he feels as though he is reexperiencing certain situations. He noted that he sometimes withdraws from his wife and does not speak to her about what he is experiencing, noting that he already feels guilty for their financial problems and does not want to burden her with his difficulties.

Learning Point: Differential Diagnosis

Upon ruling out a non-psychiatric medical etiology of the patient's presentation, as well as acute intoxication, more information must be gleaned about his recent history. There was no evidence of a prodromal period of worsening function, decline in self-care, or social withdrawal. There was no evidence either from the patient or his wife of an onset of hypomanic or manic symptoms. Although the patient admitted to feeling worried about his financial situation and sad at times when thinking about friends he had lost, he did not meet full criteria for a depressive episode or generalized anxiety disorder; there was no evidence of discreet panic attacks. Given that he had a very brief period of psychotic symptoms, brief psychotic disorder would be a consideration. However, brief psychotic disorder is characterized by a period of psychotic symptoms that lasts more than one day but less than one month, and it is characterized by at least two of the following: delusions, hallucinations, disorganized speech, or grossly disorganized behavior. The patient's symptoms lasted less than a few hours, and so he does not meet full criteria.

Once he was willing to discuss how his military service might be affecting him on a day-to-day basis, the patient more clearly met criteria for PTSD, with this episode representing a very dramatic and frightening flashback.[10] He described ongoing fear of loss of life for two years of service in war, as well as witnessing deaths of friends and close colleagues. He reported avoidance of situations that reminded him of his service, emotional numbing, distancing himself

from family, and persistent negative cognitions about his difficulties and his service. He had experienced nightmares and hypervigilance with increased startle reflex. Stuck on a crowded bridge surrounded by noise, trucks, and angry drivers, he became overwhelmed. The patient's intense fear of losing his job and shame about his difficulties made it difficult to engage him in the evaluation and left him reluctant to seek treatment.

Disposition: The patient had no health insurance. He did not want to apply for veteran's benefits coverage, as he expressed fear that simply walking into a Veteran's Administration (VA) hospital to apply for benefits would cause intense anxiety and distress. He accepted a referral to follow-up onsite and was open to the idea that he may have experienced a flashback that was related to his prior military service and triggered by stress. He accepted a note clearing him to return to work, but he did not want anyone to contact his employer directly to discuss his symptoms.

DISCUSSION

Epidemiology and Clinical Features

PTSD is heterogeneous in its course and presentation and can masquerade as other psychiatric syndromes, as it can present with features of irritability, depressed mood, anhedonia, anxiety, panic, and even at times psychosis.[10,11] Onset can be delayed, and presence or absence of an acute stress reaction immediately after a trauma is not a reliable predictor of development of PTSD.[11,12] Risk factors include history of prior trauma, comorbid substance abuse, and preexisting psychiatric disorders.[13] Women have a higher rate of PTSD than men, one possible explanation being a higher rate of exposure to interpersonal violence and sexual assault.[14] In a study of a large community sample, PTSD was uniquely associated with disability, suicidality, and poor quality of life after correcting for other mental disorders.[15] Patients may not want to report symptoms due to stigma, fear of losing employment, avoidance of reliving the experience, fear of disclosure of comorbid drug or alcohol use, or simply due to the negative cognitions that can be part of the syndrome itself, that is, a belief that this is all the patient's own fault to begin with. In this case, the patient's fear of triggering traumatic memories coupled with his negative beliefs about his service in the military had led him to avoid a potential source of help, the VA Hospital.

Trauma-Related Disorders and the Emergency Department

The ED setting—as well as events leading up to arrival, such as police involvement, involuntary transportation by EMS, lights, sirens, loud vehicles, crowds—can all be factors in acutely worsening the condition of a patient with a history of trauma, regardless of whether they meet full criteria for PTSD. The setup of a

psychiatric emergency setting can be specifically counter-therapeutic: EDs are frequently loud, other patients may be agitated, and staff who are attempting to maintain safety may be perceived as intrusive or aggressive. Patients with a history of trauma may not be able to verbalize their internal experience and may not effectively communicate their needs. For a woman with a history of physical or sexual trauma, for example, being in a confined space surrounded by male patients can be terrifying. Being placed in restraints or in a seclusion room is a last resort for patients who are acutely dangerous, but with someone with a history of physical or sexual trauma or forced confinement, it can precipitate symptoms such as flashbacks or intense panic. Patients who have been incarcerated before, and who have suffered trauma during their incarceration, are particularly triggered by locked doors and by many of the safety procedures that a psychiatric emergency service may consider routine, such as requirements for search, giving up clothes, going through metal detectors, metal detecting wands, body pat-downs, or in some settings, even strip searches. For the patient discussed in this case, the acute environment of police response to his stalled vehicle and arrival to the hospital surrounded by police, EMS, hospital workers and staff most likely worsened his acutely fearful state.

Evaluating psychiatric patients in the ED setting should include screening for a history of trauma—including sexual and physical abuse, interpersonal violence, and exposure to traumatic events—as well as military history. Although it may not be appropriate to delve into details of past abuses, it is nonetheless information that is an important part of diagnostic evaluation and a context in which to frame interventions for the patient. Interventions for managing the patient's behavior can then incorporate this information. For example, a woman with a history of sexual abuse might be provided with a more private space during evaluation away from male patients, or a patient who has an exaggerated startle response to loud noises might require a quieter setting or a voluntary stay in seclusion to de-escalate when feeling triggered. Evaluating for and responding to a patient's history of trauma is an important facet of providing patient-centered care.

Evidence-Based Treatment and Disposition

In terms of disposition and referral to aftercare, treatment of PTSD can be effective, but most patients still do not receive appropriate care.[16] Pharmacotherapy options include medication for depressive and anxiety-spectrum symptoms, as well as use of antipsychotic medication as augmentation if psychotic symptoms are persistent or prominent and specific anti-adrenergic agents to prevent the physiologic response to nightmares and improve sleep.[17] Psychotherapeutic interventions include cognitive-behavioral therapy, focusing on exposure and response prevention.[18] Prolonged exposure therapy has been shown to be efficacious, as well as reduce health care utilization in VA populations.[19] However, systematic reviews have been less conclusive in patients with chronic PTSD symptoms.[20,21] In this patient, who was reluctant to consider any medications, stressing psychotherapeutic, cognitive-based interventions may have been a way of engaging him in treatment. This patient had a supportive spouse and an employer who was aware of his military history and

invested in hiring and retaining veterans—both positive prognostic factors in terms of being able to maintain financial independence and employment.[22]

Key Clinical Points

- Acute agitation can be caused by or worsened by a history of trauma, even if a patient does not meet full criteria for a trauma-related disorder.
- The ED setting itself can worsen or provoke symptoms in patients with history of physical, sexual, or emotional abuse and combat- or incarceration-related trauma. Providers should be vigilant about screening for history of trauma or abuse and attempt to provide accommodation for patients that minimizes triggers while still maintaining safety.
- Negative self-perceptions and cognitive distortion are part of the syndrome of PTSD, and may lead to difficulty reporting symptoms and minimizing triggers and shame, thus further limiting access to treatment.

CASE 3: "AN UNLIVABLE SITUATION"

Case History

Ms. B is a 66-year-old white woman who is brought by ambulance with police and adult protective services escort from her apartment a few blocks away from the hospital. She is angry and combative, wearing only a bathrobe and slippers despite cold temperatures outdoors and slapping at police who are attempting to bring her into the ED. Emergency medical services (EMS) workers escorting the patient state that the patient was "removed" today from her apartment by "social workers" and that the apartment is "unbelievably disgusting." They do not know her medical or psychiatric history because she has refused to cooperate with any assessment, including vital signs. They do not know what precipitated the removal today, as they were summoned by police on the scene after the patient refused to open her door. The lock was drilled to gain entry.

Once Ms. B arrived at the ED, she did cooperate with initial vital signs, which were not grossly abnormal: blood pressure of 142/80, pulse of 90, respirations of 16, and temperature 98.8. The patient even agreed to have a finger-stick glucose measurement which was 94. She denied having any chest pain or any other somatic symptoms but was angry and yelling, so psychiatry was called to evaluate her.

The patient cooperated with laboratory studies, which were all normal.

On interview, she does not have any idea why she is in the hospital and wants to return to her apartment immediately, as she notes that the people who "kidnapped" her today have moved some of her valuable antiques and may have caused damage to some of her important items. She refused to provide contact information for any friends or family. She is fully oriented to person, place, and time but refused any detailed cognitive screening.

Past Psychiatric History: The patient denies ever seeing a psychiatrist. There are no prior visits at the hospital where she is being seen.