

Treatment of Agitation and Aggression

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Assessment

- Agitation
- Aggression
- Anxiety
- Psychosis/Catatonic Agitation
- Mental Retardation
- Akathisia
- Dementia
- Delirium
- Mania

Rating Scales

- Young Mania Rating Scale
- Overt Aggression Scale
- Overt Agitation Severity Scale
- Brief Psychotic Rating Scale
- Hamilton Anxiety Scale
- Hamilton Depression Scale
- Agitated Behavior Scale
- AIMS
- Rating Scale for Aggressive Behavior in Elderly (RAGE)

Evaluation of Agitation

- Yudofsky's 4D's
- Determine the the etiology of the psychological/organic disorder that contributes to the agitation
- Delineate the bio/psycho/social context of the behavior.
- Document and rate the agitation with an appropriate scale
- Develop a multifaceted treatment plan

Assessment

- Initial medical evaluation including: Vital signs, Medical history, Visual exam of patient, Cognitive exam
- Determination of allergies/adverse reactions to medication
- Identify causal medical problems with appropriate evaluations (labs, scans, toxicology screen, etc.)
- Determine substance use history
- Screen for medications that cause agitation
- Determine history of prior interventions that worked
- Ask patients for their preferences in treatment

Other Causes of Agitation

- Medication including drug interaction, CNS toxic side effects, accidental misuse.
- Urinary tract infection
- URI
- Stroke
- Occult head trauma/ fall history
- Thyroid disease
- Caffeine abuse
- Metabolic disturbance
- Diabetes
- Respiratory disease
- CHF
- Medication withdrawal
- Infection
- Occult bleeding
- Emotional issues
 - Argument with peer/spouse
 - New caregiver
 - Sensory impairment or overload
 - Loneliness

Interventions

- Stage 1 = Behavior range from refusal to cooperate to intense staring
- Verbal interaction
- Try patient's self-reported soothing activities
- Offer unopened snack/beverage
- Offer other modes of relaxation
- Offer quiet time in room
- Offer voluntary medication (of patient's preference if possible)

Interventions

- Stage 2 = Stage 1 behavior plus motor restlessness and/or purposeless movement
- Rule out Akathisia (has pt received neuroleptics/antiemetics?)
- Verbal interventions from stage 1
- 1:1 with staff in quiet space away from milieu
- Encourage voluntary oral medication or IM if patient prefers

Interventions

- Stage 3 = Affective lability and loud speech (+/- symptoms from stage 1 and 2)
- Verbal interventions and remove from milieu to comfort/alternative room
- Require additional staff presence
- Strongly encourage oral/IM voluntary medication
- Designate staff monitor

Interventions

- Stage 4 = Severe irritability and intimidating behavior that is externally directed
- Verbal intervention away from milieu with other staff present (show of force)
- Require additional staff presence
- Consider security presence
- “I am going to give you some meds, do you want oral or injectable?”
- Give patient some space and consider clearing other patients from the unit.

Interventions

- Stage 5 = Aggression to property and/or verbally demanding and hostile
- Show of force with Security
- Stage 4 interventions followed by IM medication if patient refuses PO.
- Consider quiet room or seclusion if still threatening to self or others

Interventions

- Stage 6 = Directly threatening or assaultive
- Immediately stop any physical assaultiveness
- Security and appropriate staff
- Give PO or IM medication
- Open door seclusion if patient can de-escalate
- Closed door seclusion of patient does not de-escalate.

Medication Intervention for Alcohol Withdrawal

- CIWA protocol to assess agitation/withdrawal symptoms
- Withdrawal taper with benzodiazepines (lorazepam or oxazepam)
- Withdrawal coverage with valproic acid, carbamazepine or other anticonvulsant
- PRN high potency antipsychotics

Medication Intervention for Other Substances

- Stimulants Consider oral benzodiazepine or benzo + high potency typical antipsychotic first. Consider IM ziprasidone or IM typical second.
- Hallucinogens Consider benzodiazepine or benzo+high potency typical antipsychotic
- Opioids Consider clonidine or valium

Medication Intervention for Psychosis

- Determine stage in hierarchy of interventions
- Benzodiazepine alone
- Oral atypical/typical antipsychotic alone
- Oral antipsychotic +/- lorazepam +/- benadryl or cogentin
- If necessary administer above medications IM
- Avoid anti-cholinergics in patients over 65
- Give appropriate scheduled medications
- Consider OAS or psychotic rating scales to track response

Medication Intervention for Organic Brain Injury or MR

- Determine stage in hierarchy of intervention
- Offer oral antipsychotic and anticholinergic if needed
- If necessary administer IM
- Avoid benzodiazepines due to potential for paradoxical disinhibition
- Give scheduled medications
- Avoid anticholinergics in patients over 65
- Anti-androgens
- Consider OAS or OASS to track

Medication Intervention for Mania

- Agitation in Patient with Mania (no psychosis)
- Determine stage in hierarchy of intervention
- Offer prn oral lorazepam
- If necessary administer IM
- Oral antipsychotic +/- lorazepam +/-benadryl or cogentin
- Consider Valproic Acid loading (20mg/kg)
- Consider antipsychotic with indication for mania (olanzapine, clozaril) or agitation (ziprasidone)
- Consider Young Mania Rating Scale to track

Medication Intervention for Akathisia

- Decrease neuroleptic doses
- If not on neuroleptic consider reserpine, antiemetics, dopamine agonists, l-dopa as possible etiology
- Consider propranolol, benzodiazepines as first line to treat
- Anticholinergics generally not helpful
- Clonidine has some efficacy as second line agent.

Medication Intervention for Dementia

- Antipsychotics start with atypicals in low range of dosing. Haldol at 0.5-3mg is option. Be alert to akathisia.
- Anticonvulsants VPA and CBZ effective. Consider sprinkles for non-compliant pts.
- Acetylcholinesterase Inhibitors
- Benzodiazepines be alert for over-sedation, falls and disinhibition
- Lithium, anti-androgens, SSRI's, Trazodone
- Consider RAGE to monitor improvement

Medication Intervention for Delirium

- Treat underlying etiology
- High potency typical antipsychotic IV or IM
- Atypical antipsychotics

Chronic Aggression

- Beta blockers Propranolol best studied. Good for agitation due to organicity or non-specific etiology.
- Anticonvulsants Best for bipolar, personality disorders, PTSD
- Benzodiazepines Short term generally. Klonopin may be exception
- Antidepressants Best for agitated depression and anxiety
- Antipsychotics Second line for chronic aggression unless psychosis present or severe personality disorder
- Lithium Useful but not first line
- Buspar Useful, initially can increase agitation, delayed onset
- Anti-androgens Selectively useful in sexual agitation

Propranolol for Aggression

- Start at 20mg tid and increase by 60mg/day every three days. (No cardiac issues present)
- Stop titration if pulse <50 or systolic BP <90
- Target is 12mg/kg or control of agitation/aggression
- Doses greater than 800mg generally not required. 8 week trial before concluding there is no efficacy.
- Exclude patients with asthma, COPD, IDDM, CHF, angina, PVD, hyperthyroidism. Monitor carefully if patient has history of bradycardia or hypotension.