Introduction

The Clinical Impact of Agitation in Various Psychiatric Disorders: Management Consensus and Controversies

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Agitation is a behavioral symptom that manifests in a wide range of psychiatric illnesses. It is commonly seen in the psychiatric emergency setting as a presenting complaint of patients with psychotic illness (schizophrenia or schizophreniform disorder) as well as in those with bipolar manic or bipolar mixed episodes. For these patients, once acute agitation has been ameliorated and relative stability has been achieved, a lower level of chronic agitation may persist as the patient either commences inpatient hospitalization or resumes outpatient life. In many cases, the patient's acute agitation subsides only briefly, ultimately recurring with full-blown fury in a subsequent emergent presentation. Particularly for patients with bipolar mania, this threat of recurrence may be as high as 90%.[1]

As opposed to the dramatic acute agitation that is frequently seen in patients with psychosis or manic episodes, agitation in patients with Alzheimer's disease typically evolves slowly and insidiously. In early Alzheimer's disease, for example, agitation often manifests as mild, nonaggressive behaviors, such as pacing or repetitive questioning. Agitation can also be clinically manifested as overtly aggressive behaviors such as cursing, screaming, throwing objects, or physically striking out at others. It is often at this point that the patient's family—now faced with a loved one whose actions are perceived as threatening and uncontrollable—deal with the emotionally charged decision of whether or not to place "Grandma" or "Grandpa" in a nursing home. In this case, the onset of severe agitation represents not only a turning point in the nature and location of patient care, but also a major change in the patient's lifestyle and (possibly) the quality of interpersonal relationships among the family as a whole.

A family's decision concerning institutionalization of a loved one is an example of the tremendous, and often underestimated, burden of illness associated with the problem of agitation. First of all, agitation exacts a substantial emotional and psychological toll on the patient, whose illness may have transiently compelled him or her to act in a way that represents a frightening or embarrassing contrast to "normal" everyday behavior. For the patient's family, as well, there is an emotional and psychological burden, not only during episodes of acute agitation, but also after the episode has resolved. For example, family members who have witnessed a loved one in a state of acute agitation, especially in the context of overt aggression or violence, not only may worry about a recurrence, but also may find that apprehension regarding the patient's illness has now negatively impacted their ongoing interpersonal relationships. Lastly, agitation adversely affects health care personnel—a fact that is often underestimated, even in the medical literature. Specifically, while the immediate family members are the most common targets of aggression by agitated patients inside the home,[2,3] it is typically the nursing staff who are the most frequent and immediate targets in the hospital setting.[4] In particular, among emergency psychiatric services, where the prevalence of agitated or frankly violent patients may be as high as 10%,[5] an average of 6 assaults (range, 0 to 35) occur per site annually.[6] Of these assaults, 60% are severe enough to result in time lost from work by the emergency room staff.[6]

The last 5 years have seen an upsurge of interest in agitation as it manifests in patients with psychiatric illness. This interest may have been prompted, in part, by 1 or more of the following developments:

1. The recent introduction of safe, efficacious, and rapid-acting (intramuscular and oral) forms of atypical antipsychotics as treatments for acute agitation, especially in the psychiatric emergency setting;

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2. The increased off-label use of atypical antipsychotics as the de facto treatment of choice for agitation associated with dementia, especially that of Alzheimer's disease[7]; and
3. The April 2005 advisory from the U.S. Food and Drug Administration (FDA),[8] citing reports of higher death rates as compared with placebo among elderly patients with dementia who had been treated with atypical antipsychotics, often for behavioral symptoms such as agitation.

Recently, agitation—whether acute or long-term, mild or frankly violent—has been the focus of a number of highly respected journal publications and monographs that reach an international clinical audience. In addition, agitation as a behavioral symptom of schizophrenia, bipolar disorder, or Alzheimer's disease recently has been highlighted in several congress reports arising from the 2005 annual meeting of the American Psychiatric Association.[9,10]

In recognition of the current upsurge in interest regarding agitation as a psychiatric behavioral problem, the purpose of the present supplement is to do the following:

1. Present an overview of the incidence, putative pathophysiology, and clinical impact of agitation as it occurs in various mental illnesses;
2. Review the most widely accepted treatment strategies that are currently employed in ameliorating acute and longer-term agitation, particularly as they pertain to patients with schizophrenia, bipolar mania, or dementia; and
3. Review the impact of agitation on psychiatric illnesses and its current management strategies.

The ultimate goal of this publication is to provide the clinician with a solid foundation of information regarding the clinical impact of agitation as it occurs in various psychiatric disorders and offer a concise review of the current therapeutic consensus and controversy regarding the treatment of this challenging behavioral problem.

We hope you find the contents of this supplement helpful in your clinical management of agitation in psychiatric patients.

REFERENCES

1. Keck PE, McElroy SL, Arnold LM. Advances in the pathophysiology and treatment of psychiatric disorders; implications for internal medicine: bipolar disorder. Med Clin North Am 2001;85:645–661
2. Buckley PF, Noffsinger SG, Smith DA, et al. Treatment of the psychotic patient who is violent. Psychiatr Clin North Am 2003;26:231–272
3. Lehman AF, Lieberman JA, Dixon LB, et al. Practice Guideline for the Treatment of Patients With Schizophrenia, Second Edition. Am J Psychiatry 2004;161(suppl):1–56
4. Currier GW, Allen MH. Emergency psychiatry: physical and chemical restraint in the psychiatric emergency service. Psychiatr Serv 2000;51: 717–719
5. Huf G, Alexander J, Allen MH. Haloperidol plus promethazine for psychosis induced aggression. Cochrane Database Syst Rev 2005:CD005146
6. Allen MH, Currier GW. Use of restraints and pharmacotherapy in academic psychiatric emergency services. Gen Hosp Psychiatry 2004;26: 42–49
7. Hansberry MR, Chen E, Gorbien MJ. Dementia and elder abuse. Clin Geriatr Med 2005;21:315–332
8. US Food and Drug Administration (FDA). FDA Talk Paper: FDA Issues Public Health Advisory for Antipsychotic Drugs Used for Treatment of Behavioral Disorders in Elderly Patients. April 11, 2005. Available at : http://www.fda.gov/bbs/topics/ANSWERS/2005/ANS01350.html. Access verified April 20, 2006
9. Cummings JL, Tariot PN, Jackson-Siegel J. Agitation and psychosis in Alzheimer's disease and Parkinson's disease [symposium 31, pt 2]. Presented at the 158th annual meeting of the American Psychiatric Association; May 21–26, 2005; Atlanta, Ga
10. Mintzer JE, Marder SR, Sachs GS, Caine E. Atypical antipsychotics: treatment of agitation across mental disorders [symposium 34]. Presented at the 158th annual meeting of the American Psychiatric Association; May 21–26, 2005; Atlanta, Ga