In this era of ED crowding, managing patients with behavioral emergencies can be quite challenging for even the best prepared, physically designed, and equipped emergency department. Challenges intensify because of limited beds for acute hospital admissions, decreased numbers of public and private psychiatric inpatient beds, and shrinking local, state, and federal government budgets for community-based mental health and drug treatment services. The 2008 National Health Statistics Report from the Centers for Disease Control and Prevention indicates that the rate of psychiatric-related visits has increased 19% since 2003. Overall, 6% of ED visits nationwide are psychiatric emergencies. Patients present with a spectrum of behaviors, from subtle changes in mental status to very physical aggression. Trying to find a safe, appropriate place in the emergency department for assessing, diagnosing, and providing a timely disposition requires rapid, astute decision making, which includes an awareness of all the factors contributing to the reason the patient has come to the emergency department to begin with. The collective literature continues to provide emergency nurses with valuable information and evidence to assess acuity, accurately identify cause, maintain safety, and initiate an appropriate plan of care in order to manage even the most puzzling or challenging behavioral emergency.

Categories of Behavioral Emergencies

The American Psychiatric Association defines a psychiatric emergency as a situation that includes an acute disturbance in thought, behavior, mood, or social relationship described by the patient, family, or social unit that requires immediate intervention. Other terms found in the literature, such as behavioral or psychiatric emergency, mental health, or mentally disturbed, are used interchangeably to mean patient presentations that include such symptoms as anxiety, depression, aggression, personality changes, delusions, and hallucinations. I suggest that the term “behavioral emergency” is the more accurate, objective term because psychiatric symptoms are commonly nonspecific and occur in medical as well as psychiatric disease. Patients with behaviorally related chief complaints can be placed in 1 of 4 categories:

- Strictly psychiatric in origin with no detectable underlying physical disease
- A psychiatric condition that is causing a medical problem
- Complaints appearing to be psychiatric in origin that may be manifestations of underlying medical conditions either exacerbating mental illness or co-existing with it
- Most importantly, complaints of medical origin with no independent psychiatric disorder

Dating back to 1936, psychiatrists suggested that psychiatric and behavioral symptoms often precede the full-blown development of medical illness. Nonspecific behavioral and mood alteration often represent the very first sign, and occasionally for prolonged periods, the one single and exclusive sign of an undetected physical illness. No single psychiatric symptom exists that cannot at times be caused or aggravated by various physical illnesses. Physical conditions that cause or exacerbate mental symptoms are not uncommon, and their detection is critical in providing appropriate care.

The ED Role

So what is the emergency team’s role when a patient presents with behavioral complaints? The role of the team is the same as with any patient entering the ED doors. While keeping the patient and others safe, emergency medicine physicians and nurses should provide a thorough and unprejudiced assessment, keeping an open mind about the presenting symptoms and their differential diagnostic possibilities.

How well do ED clinicians perform this task? A common term in the specialty of emergency medicine is to pro-
vide medical clearance or to medically clear someone. Differing definitions for medical clearance abound in the literature.\textsuperscript{11-15} Generally, the term is applied in at least 3 different situations when patients are referred to the psychiatric service. A patient being medically cleared means:

1. It is thought that no medical illness is present.
2. A medical illness is known to be present but is not thought to be the primary cause of the patient’s symptoms.
3. It is thought that the medical illness that was present no longer needs medical treatment.\textsuperscript{16}

It is not surprising that difficulty arises in communication and patient handoff during the consultation and referral process when this term is used if no real consensus exists among psychiatrists and emergency medicine physicians regarding what it really means or what the screening consists of.\textsuperscript{7,8,11,12,15,16} The term and process of medical clearance is plagued with conflict and confusion,\textsuperscript{17} and the resolution of this issue is relevant to current practice because it can affect ED crowding, patient throughput, and the cost of health care.\textsuperscript{8} Medical screening commonly consists of obtaining vital signs and a medical history, performing a review of systems and a physical and mental status examination, and then performing diagnostic tests.\textsuperscript{13} Throughout the years, research studies have been done on ED patients to determine which factors contribute to the erroneous attribution by emergency physicians of the alteration of behavior to psychiatric illness when the patient actually has a medical problem.\textsuperscript{11-13,18,19} The total sample size from all the studies is 625 patients who presented to the emergency department with what seemed like isolated psychiatric complaints. The studies showed a wide range of concomitant medical disorders (7% to 63%) in ED patients with behavioral emergencies, depending on the definition and thoroughness of the study design.\textsuperscript{13} Medical disorders were considered causative of psychiatric symptoms if they abated significantly with medical treatment, if medical symptoms seemed clearly related to the onset of psychiatric symptoms, or if the presence of a medical disorder, even though untreatable, explained the patient’s symptom pattern.\textsuperscript{19}

Table 1 summarizes the initial psychiatric diagnosis for these 625 patients who presented to the emergency department with isolated psychiatric complaints. Note that the italicized diagnoses, depicting trends in medical conditions like diabetes, thyroid, cardiovascular, and infectious conditions as common reasons for psychiatric symptoms, can be seen clearly. The widest variety of major medical illnesses mimicked the broadest assortment of psychological manifestations.\textsuperscript{9} The percentage of patients who had previously unrecognized medical illnesses that either caused or exacerbated their psychiatric illness ranged from 19% to 63%, and once the medical illness was treated, the psychiatric illness went away. The researchers concluded that most alert, adult patients presenting to emergency department with new psychiatric symptoms will have medical etiology\textsuperscript{11} and that

<table>
<thead>
<tr>
<th>Initial psychiatric diagnoses</th>
<th>Eventual medical diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis (schizophrenia [paranoid, chronic undifferentiated, schizoaffective, acute, borderline, acute])</td>
<td>Folic acid deficiency, hyperthyroidism, hypothyroidism, hepatitis, severe anemia, chronic anemia, hypoglycemia, Wilson’s disease, neuropsychitis, diabetes mellitus, epilepsy, hypertension, acute peptic ulcer, stroke, Pick’s disease, Addison’s disease, arsenic poisoning, malnutrition, Hashimoto’s thyroiditis, G6-PD deficiency, polycystic ovarian disease, acute central anticholinergic syndrome, digoxin intoxication</td>
</tr>
<tr>
<td>Neurosis (anxiety, acute anxiety reaction, depression [major, minor])</td>
<td>Diabetes mellitus, hyperthyroidism, epilepsy, hepatitis, parathyroid adenoma, hypertension, post-concussive syndrome, hypoglycemia, chronic brucellosis</td>
</tr>
<tr>
<td>Manic-depressive illness (manic, bipolar, depressive type)</td>
<td>Hyperthyroidism, thyroid storm, syphilis, hypothyroidism</td>
</tr>
<tr>
<td>Personality disorder (antisocial, hysterical, borderline, unspecified)</td>
<td>Diabetes mellitus, hypothyroidism</td>
</tr>
<tr>
<td>Medical brain syndrome</td>
<td>Epilepsy, toxic encephalopathy, impending delirium tremors, lead poisoning, malnutrition, dehydration</td>
</tr>
</tbody>
</table>

Data from references 10, 11, 13, 17, and 19.
most medical conditions were identified solely by the triage nurse or resident during the history of present illness interview. ED study results also have shown that evaluation should not stop after one positive test because several patients had multiple medical diagnoses. For example, alcohol, cocaine, and diabetic ketoacidosis; alcohol, gap acidosis, and a subdural hematoma; and hyponatremia, acute renal failure, and meningitis were common mutual diagnoses. The most important finding from these studies is that a high number of these patients’ conditions were strictly medical with no independent psychiatric disorder.

A symptom-related finding from these studies points to an important clinical pearl. Visual hallucinations, distortions, and illusions were the symptoms most discriminative of medically induced psychiatric disorders; 23% of persons with a medically induced psychiatric disorder experienced visual hallucinations compared with only 0.5% of the population having psychiatric symptoms that were not thought to be medically related. This finding strongly suggests that in patients who complain of visual hallucinations or distortions, medical impairment should be considered until proven otherwise.

A disease-related finding that surfaced was that diabetes mellitus was present with such a remarkable frequency and was overlooked at such an alarming rate. Diabetes mellitus is frequently misdiagnosed as a psychiatric condition, despite the fact that it is relatively easy to detect. Researchers state that this misdiagnosis occurs because early stages of diabetes mellitus easily can become a cause for psychiatric problems, and the psychosocial consequences of the symptoms may result in a misleading clinical presentation. The comorbidity of mental and physical disorders such as diabetes mellitus is a complicated issue, and the exact nature of the relationship between them is still unclear. Further research is certainly required.

An age-related finding from the literature is that the mean age of patients with a supposed psychiatric diagnosis is in the range of 35 to 47 years. However, studies of U. S. children demonstrate that more than 20% of 9- to 17-year-olds have a diagnosable but seldom treated mental disorder. Another clinical pearl highlighted by the research was that as the patient’s age increases, there is increased incidence of significant medical illness when the patient presents with psychiatric symptoms.

Ethical and Legal Significance

The phenomenon of declaring that patients have a psychiatric condition when they really don’t has many ethical and legal ramifications. The high incidence of functional psychoses as the psychiatric diagnosis is prevalent in the literature and needs to be noted, because this diagnosis carries with it the implications of long-term drug therapy, potential hospitalization, and possible changes in the patient’s legal status. In the majority of the patients whose condition was diagnosed as functionally psychotic, the psychiatric symptoms that brought them to seek help rapidly cleared with appropriate medical treatment, and the patients remained healthy. Thus a medical cause, not psychoses, was the reason for their behavior. Misdiagnosis and the application of psychiatric labels to medically ill patients reduces their chances of improvement and may result in worsening of their physical health, inappropriate hospitalization in a psychiatric facility, and social stigmas. Another significant consequence of failing to recognize a medical reason for changes in behavior is that a characteristic of people with serious mental illness who do have a medical disease is the high rate of serious co-morbid medical conditions and increased risk of premature death. All these examples underscore the ethical and legal importance of identifying medical conditions in patients with behavioral emergencies.

Implications From the Literature for Emergency Nurses

Table 2 lists general approaches that emergency nurses should take when assessing patients with behavioral emergencies. Presentation of certain behaviors should not automatically lead to the assumption that the patient’s problems are caused by a psychiatric disorder. The nurse should not plant the seeds of the psych label in other colleagues’ minds, which then could influence their overall assessment of the patient.
patient. The triage system has been listed as a limitation in studies of why emergency medicine physicians miss a medical condition and diagnose the patient as having a psychiatric condition, because the chief complaints are first obtained by a nurse, which can possibly bias patient assessment by the doctor.\(^8\,20\) The location of treatment should be carefully considered, because in some emergency departments, this can begin the journey down the *psych road*, which, as the data show, is inappropriate for many patients.

**Conclusion and Recommendations**

The literature highlights that issues and challenges related to managing behavioral emergencies have been with ED clinicians for decades, and they continue in today’s practice setting. Performance improvement initiatives are needed to improve the care provided to patients with behavioral emergencies. The ENA’s newly formed Psychiatric Patient Work Team is organizing this effort by initially developing educational programs and promoting clinical guidelines to improve the quality of care.\(^24\) Emergency nurses need to eliminate bias around patients with behavioral emergencies and incorporate evidence-based knowledge into their clinical practice. The emergency nurse should seriously consider medical causes for every patient who presents with a change in behavior, because patients have no obligation to describe their symptoms in compliance with the current textbooks—to the contrary, being laypeople, they are free to judge and evaluate their symptoms and presumptions entirely subjectively. Not so the clinician.\(^21\)

**REFERENCES**


