Unpacking agitation in practice: a call for greater precision

Key points

• Agitation is a term often used but no unified conceptualisation prevails.
• The term agitation covers a broad range of behaviours.
• The information relayed is not accurate enough to properly assess or treat a patient.
• The term often signifies a value or even moral judgement.
• We propose that clinicians avoid the imprecision of the term agitation in complex clinical scenarios.

Agitation is a term often used by health professionals to describe patient behaviour that is regarded as problematic or disruptive. What constitutes agitation has been a topic of debate, and no unified conceptualisation prevails. Rather like terms such as ‘indigestion’, agitation may refer to completely different things when used by different clinicians. Or as famously said by Humpty Dumpty in Lewis Carroll’s Through the Looking Glass: ‘When I use a word it means just what I choose it to mean—neither more nor less’.

A consensus statement by the International Psychogeriatric Association (IPA) [1] proposes that specific behaviours (excessive motor activity, verbal aggression, physical aggression) associated with ‘emotional distress’ have to be present for at least 2 weeks before a ‘diagnosis’ of agitation is made. This definition of agitation is limited to patients with mild-to-severe cognitive impairment, in particular dementia. Disruptive patient behaviours that are attributable to other psychiatric disorders (e.g. psychosis), medical conditions or inadequate care do not fall under this definition of agitation. Remarkably delirium, commonly associated with agitation, is not mentioned in that statement. Perhaps this is not all that surprising as delirium is a somewhat invisible condition at bedside and organisational levels [2].

The question remains therefore how patient presentations excluded from the IPA definition—i.e. that are more short-term in nature or in ‘response to another disorder’ [1]—should be termed when they are frequently referred to as agitation in clinical practice? Furthermore, is it possible to definitively ascertain that agitation is predominantly caused by the neurocognitive disorder itself and not a reaction to unmet needs?

In contrast with the IPA statement, it has previously been argued that discomfort [3] or pain [4] may lead to agitation. Also contrariwise, restlessness, a term frequently used in association with agitation, has been argued to be an expression of agitation as well as a separate entity not to be confused with it (Cummings et al. [5]). We would further argue, in line with the Need-Driven Dementia-Compromised Behaviour model [6], that restlessness may also be a functional response to a physiological state, for example, a full bladder. Restless behaviour, in this case, is not caused by agitation as such but by the full bladder and potential difficulties to reach the bathroom due to the person’s medical conditions or the hospital environment. Assessing the context is therefore essential.

While the IPA made a great effort to define agitation in a way that resembles a diagnosis, usage of the term is far from precise in clinical practice. Behaviours covered by the consensus statement encompass a broad range, from someone climbing out of bed to someone furiously throwing a fire extinguisher. In both examples, agitation serves as a surrogate term for a health risk either to the individual patient (e.g. risk of falling) or someone else (e.g. being hit by a heavy object). But, while it serves to alert clinicians to a (potential) problem, it does not relay information specific enough to properly assess the individual person and situation and initiate an appropriate response beyond prescribing sedatives. Equally, some assessment measures, such as the Richmond agitation–sedation scale [7] have sedation and agitation on a continuum, which also inadvertently may promote that the goal of treating agitation is sedation, not clear sensorium without agitation.

Unpicking this further, we propose that agitation is arguably a loaded term, signifying not only a value judgement about a situation (e.g. dangerous to the patient or someone else) or a patient’s behaviours (e.g. distressing to the patient) but also potentially a moral judgement of the patient [8]. It may indeed have become shorthand for the need to actively and rapidly intervene, bypassing comprehensive assessment. This could lead to too hasty use of pharmacological strategies, rather than this being an option of last resort. At best, therefore, the term ‘agitation’ may alert staff to potential danger, at worst it may lead to inappropriate sedation, which then may even be continued in error. Because of the urgency often associated with the
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short-hand term ‘agitation’, it sidetracks clinicians from further investigation of underlying causes which is so crucial to optimal management of patients with delirium. On balance, therefore we propose it may be best to reject the way this term is used in clinical practice as a catchall for a multiplicity of patient behaviours and reserve it to those occasions that meet the criteria put forward by the IPA.

When these criteria are not met, we should develop the eloquence of our clinical vocabularies and use far more specific, meaningful terms that help guide the most appropriate, targeted and person-centred clinical response. Replacing ‘agitation’ with a patient’s intention to get up and walk may lead to interventions aimed at optimising physical exercise, ambulation and sensorium, while the throwing of objects may warrant measures to increase staff and patient safety primarily, e.g. by removing dangerous objects and then continuing to investigate underlying causes for the behaviour.

In sum, we propose that clinicians avoid the imprecision of the word agitation in complex scenarios. Rather we call for greater distinctions of the diverse behaviours they see in their patients. The benefits are that if specific behaviours of the patient are assessed and potential causes are identified, the pathway to safe and effective intervention becomes clearer. All too often non-pharmacological approaches are abandoned too quickly in patients, particularly those who are delirious, because of the lack of nuanced description of the behaviours being played out, the contexts within which they exist and an understanding of what might be triggering ‘agitation’ in a vulnerable frail patient. Importantly, replacing ‘agitation’ with more precise terms and descriptions might lead to a reduced emphasis on medication and sedation as a go to treatment approach when pressures on the ward become unsurmountable.

Ultimately, Humpty Dumpty’s ‘When I say’ approach towards terminology has no place in clinical care. To understand what is truly occurring for each patient at each point in time involves better communication, assessment, expertise and awareness of our values, attitudes and practices towards patients most at risk.

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References