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Handling Psychiatric Emergencies in School

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With all the details a teacher must address and prepare for in the classroom, some of the most important may be those that are least likely to occur. With the increase in violence in our society in general as well as the more obvious examples of shootings in schools in the past decade, it is clear that professionals in the field of education must address emergency situations. For teachers in particular, handling emergencies involving students should be a part of preparation and training. Given the high stress environment for adolescents in school, psychiatric emergencies should be expected. This essay gives a background of psychiatric emergencies in our society, breaks down their sequence and possible underlying problems, and gives guidelines for handling them successfully. It can be applied to many fields, but the focus here is the classroom setting.

Before addressing psychiatric emergencies and how they should be handled, there should be an operational definition of the term. Broomhead (2004) defined a psychiatric emergency as a psychiatric situation (disturbance in thoughts, feelings, or actions) that demands immediate attention and control because it presents either real or perceived danger to the client or the public. This is general enough to apply to various scenarios and in various environments, so it will serve well as the definition for the remainder of this essay. The term “patient” will refer to the student, and the teachers or administrators will be assumed to be making the intervention.

When confronted with a psychiatric emergency, all the actions that one takes should be directed toward a clear goal. Different scholars identify the goals of handling a psychiatric emergency differently, but the general themes are the same. Joel Foxman (1990) gave the very simplistic goal of moving the patient from an involuntary or hostile point to a voluntary and cooperative one. A more thorough description by Rocca (2006)

stated that the primary short-term goal of a behavioral emergency is to act as quickly as possible to keep violence from escalating and finding the quickest way to get the situation under control with the maximum safety for everyone using the effective method that is least severe. The priorities in these situations are to act quickly, defuse violence, prevent harm, and stabilize the situation. Any action taken to intervene in a psychiatric emergency should seek to meet the stated goals, keeping the interests of the patient as well as all others involved in mind.

The importance of knowing how to handle psychiatric emergencies as a teacher is apparent when one considers the role of educators in society and the social context that all of us operate in. The school system is an important tool in the assimilation of children into society. In addition to educational progress, schools are also important places for students to learn how to interact with others in the world, and school is vital to the growth and development of social skills. At times this aspect of education may be more difficult than the subject matter. When problems in social interactions arise, it is important that teachers can address them and work with students to solve them.

Psychiatric emergencies are extreme cases in which a personal crisis can threaten the well-being of others, and unfortunately school is a likely setting for such situations. In the last couple of decades, as our society has generally become more violent, violence and injury to the self has also increased. The greatest rise in suicide in this time period has been in children and adolescents (Foxman, 1990). Likewise, in the last decade there has been a general increase in the rate at which children and adolescents report to emergency departments with mental health complaints (Goldstein, 2005). Robert Olympia (2005) noted that pediatric emergencies are likely to occur in school, simply due

to the fact that children spend so much time there. The correlation between the school year and more frequent child and adolescent mental health emergencies is more striking, and Amy Goldstein (2005) argued this is likely due to the way in which the school year exacerbates childhood problems in general.

These trends indicate that children are becoming more prone to suffer psychiatric disturbances that can lead to severe problems, and that school is a likely setting for such episodes. The risk factors involved in these situations give a better picture of who might be susceptible, though they are often specific to the particular type of emergency. For suicidality, risk factors include a history of self-harm, substance misuse, anxiety, and depression. Violent behavior is likely to come from individuals with a low tolerance for anxiety or tension, those who favor physical action over verbalization and whose relationships are limited, superficial, and ambivalent. Violence-prone individuals are also characterized as having distrust and paranoia, self-centeredness, and being prone to morbid fantasies (Foxman, 1990). Being a racial minority and a female are additional risk factors for suicidality, as is being a young male for aggressive and oppositional episodes (Peterson, 1996).

Before a situation reaches the emergency stage, there is generally a series of steps that lead to it. The patient may or may not have the action planned out, he or she is likely to have practiced the violence beforehand, and there will likely be a crescendo – such as agitation, depression, or reclusiveness. The patient may even seek help before a psychiatric emergency develops. In addition, there is always a triggering event to one of these emergencies (Foxman, 1990). If a teacher were to witness the events that lead up to

an emergency situation and address the problems of the student, it is much more likely that a disaster could be avoided.

In the event that a psychiatric emergency does occur, there are general guidelines for handling the situation and protecting the safety and well-being of all concerned. It is important to recognize that all situations are specific to the individuals involved in the emergency as well as to its underlying causes. With that caveat, the following principles are basic and practical guidelines for addressing most psychiatric emergencies.

First of all, it is best for a team to intervene, preferably a male and a female. Collaterals, which include family members or significant others, can also be helpful, depending on the relationship they have with the patient (Foxman, 1990). It is possible that these people could worsen the situation if the relationships are troubled, so determine the relationship status beforehand. If one must intervene in a situation where he or she does not have a strong relationship with the patient, they may be viewed as a stranger or an intruder. Acknowledging this and discussing it can be an important first step in developing trust with the patient (Foxman, 1990).

After considering the people involved in the situation, the environment should be evaluated. It is important to be aware of the patient's comfort zone. Patients in a state of panic become very territorial, and their space is very important to them. One should not invade that space without permission. It is also essential to find exits from the area and to identify possible weapons nearby. If personal safety becomes threatened, it may be necessary to withdraw from the situation. When approaching the patient, it is best not to stand face-to-face, but rather to stand at an angle, both to avoid possible attacks and to seem less confrontational (Foxman, 1990). Entering the situation with an awareness of

the surrounding environment and making the approach in a non-threatening manner are crucial early steps.

To solve the dilemma, one must reduce the patient's tension and emphasize the positive over the negative. In order to work with the patient towards a solution, one should engage in a working relationship with mutual trust. Patients tend to become violent when they feel frightened, hopeless, deceived, betrayed, or belittled. With this in mind, it is important to listen to what the patient has to say and to make it clear that you understand their feelings. Building the self esteem and sense of worth in the patient is also very important to handling a psychiatric emergency. Patients who feel weak and powerless may seek to prove their power by being violent, so one should avoid the power struggle at all times. The best alternative is to present the patient with choices, acknowledging their power while guiding them to nonviolent decisions. Verbally acknowledging their power can also prevent them from feeling that they need to prove it. It may be helpful to shift blame away from the patient or to help them direct their anger at something outside of themselves that will not cause harm to others. If a situation becomes grim, it may be necessary to confront the death wish of the patient, since they may not have considered the grave consequences that could result from their actions. De-romanticizing death can also prevent the patient from harming his/her self or others (Foxman, 1990).

The most important thing that one can do to help a hopeless patient is to induce hope. While raising the hopes of the patient, it is also important to be truthful and realistic, because they will most likely pick up on lies or impractical suggestions. Deception will reduce the trust in the relationship and may provoke anger in the patient.

Reminding them of positive possibilities in life can often lead them to change their mind, especially if their focus has been primarily on the negative (Foxman, 1990).

If violence can be avoided and the situation is defused, the follow-up is also crucial. It is important to involve the patient's support system, whether that be family, friends, or a significant other. A contract outlining expectations for behavior and establishing responsibility for one's own actions is another suggestion. The contract may include responsibilities for the teacher or administrator as well as for the student. Referring the patient to specialized care is recommended, and following through on promises and responsibilities is a must in order to preserve trust with the patient.

Teachers should be aware that school is a high-stress environment, and that adolescence is a stressful time in life. When complicated further by issues such as poverty, instability at home, and struggles with academic achievement, the stress in a schoolchild's life can understandably boil over. When psychiatric emergencies do occur, they are complex, and the details depend on the particular situation and the individuals involved. There may be preexisting conditions like oppositional defiant disorder, attention deficit hyperactivity disorder, post traumatic stress disorder, drug or alcohol abuse, physical abuse, or sexual abuse that affect an individual situation. It is important that the focus is not on labeling or classifying the students into categories based on risk factors or past behavior, but rather on handling situations that arise in a manner that protects the student, the teacher, and the learning environment. The general themes outlined above are applicable to psychiatric emergencies and seek to defuse violence while stabilizing the situation so that it can be referred to a specialist and more

thoroughly addressed. The teacher must protect the learning environment and thus be prepared for any situation that is a threat to that objective.

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