



AMERICAN PSYCHOLOGICAL ASSOCIATION

Division 12 – Society of Clinical Psychology

Section VII – Clinical Emergencies and Crises

# Management of Mental Health Emergencies

A PAMPHLET OF INFORMATION FOR  
CLINICAL PSYCHOLOGISTS AND  
OTHER MENTAL HEALTH CLINICIANS

Emergencies and crises occur in the practice of every mental health clinician, often without warning. The experienced clinician may have some notion of potential danger with certain kinds of patients, however, those with histories of violent and/or self-harm or destructive behaviors require special handling.

Education and training in the evaluation and management of such patients is often minimal and may even be inconsistent. Due to the complexity of human behavior, especially these kinds of behaviors, being prepared, with knowledge and some plans, provides needed structure for managing most clinical emergencies.

This pamphlet provides some helpful information. It cannot and does not offer all the answers, but it will offer some structure for making more accurate assessment, and subsequent decisions, for management and treatment.

# For Violence:

Even the most passive or compliant person may be violent.

- 1 Be alert and observant, especially when the patient looks and acts differently. A view of the entire patient is vital to reveal hand movements, restlessness and changes in eye contact. Note slurred speech, marked changes in grooming, posturing, voice tone, tempo and intensity of speech. Be especially alert for psychomotor restlessness and agitation, particularly if the person does not respond to redirection or to your calming efforts. Are there any indications of recent drug or alcohol abuse?
- 2 Check for recent negative life change (e.g., rejection, failure, betrayal, need to 'get even' or 'pay back').
- 3 Develop good rapport, based on mutual trust. Emotional lability may indicate loss of rational cognitive functioning. Good rapport should maximize candid expression of feelings.
- 4 With adolescents, being victimized may result in the need for payback. Histories of poor impulse control, temper outbursts, or suppressed anger are important indices of potential violence, especially with adolescents who feel isolated. At any age, loneliness needs prompt attention.
- 5 Ask about possession of weapons, history of weapons use and recent efforts to make weapons more available. Also, does the person have known enemies who continue to threaten? Whether actual or fantasies, such a scenario may require outside intervention.
- 6 Be careful about trying to calm someone. If the person is under the influence of drugs, calming efforts may be futile or dangerous. Do not try to use physical strength or direct confrontation. Instead summon help immediately. Any history of previous police interventions?
- 7 Safety-proof your office. Do you have a 'panic button' to summon security or the police? Are there small, heavy objects within reach of the person? A sound-proofed office can be a danger in such situations, and a plan in calling for help, or quick exit, is important.
- 8 Establish a personality diagnosis. Antisocial, Borderline, Paranoid/Delusional Disorders, Agitated Depression, Bipolar (especially in a Manic phase), and any drug/alcohol abuse, all have elevated risk for violent behaviors. When anger/rage have been suppressed/repressed for a long time, with no outlet, any form of negative life stress can trigger violent behavior. Finding an outlet for pent-up emotions is an immediate task for the clinician. Any outlet that can reduce the rising tide for anger, aggression, rage, whatever, is an immediate goal.

If attempts at reducing these emotions cannot be accomplished, then notify others (family, police, etc.). Protect others as well as the person. Confidentiality issues are secondary in such situations.

# For Self-Harm & Self-Destructive Behaviors:

Many of these recommendations can also apply to the suicide-prone person. The better you know the person, the more solid the rapport and mutual trust, the more likely you are to detect potentially destructive behaviors. An interview focused on the areas below is recommended.

- 1 Major, unexpected negative life changes, such as loss of one's health, relationships, failure, financial reversal, rejection, are especially problematic when the personality structure is rigid, and/or the negative life change is a first-time happening, including disclosing one's gay, lesbian, or bisexual sexual orientation to others and experiencing loss of friends, or stigma/discrimination.
- 2 History of prior suicide/self-harm attempts. Past behavior is the best predictor of future behavior. Also, consider race/ethnicity: Native Americans have an especially high rate in the U.S., as do elderly white men (see Diversity Fact Sheet for more information).
- 3 Both intent and ambivalence must be explored for assessing the risk for current suicidal ideation. The level of lethality, the risk of rescue, the chance of reversibility, should all be explored, as well as the degree of medical injury from any prior attempts.
- 4 Depression or sudden mood shifts. Once a person has made the decision to die, and has a defined plan, relief may actually lead to a positive affect.
- 5 The loss of hope is a vital correlate to explore.
- 6 The loss of future time perspective, especially when coupled with a heavy involvement in the past (wishing for the "good old days"). The existence of negative feelings about the present, and the loss of hope for the future, comprise a significant time profile.
- 7 A rigid personality structure, especially when combined with OCD, may mean that the person lacks the resilience to adapt to change, or to develop new coping skills, when new stress occurs.
- 8 Panic attacks have a high correlation with suicidal behaviors.
- 9 When anger, rage or aggression become internalized, the risk for suicidal behavior often increases.
- 10 When such anger is coupled with impulsivity, reckless behaviors may emerge. These need exploration as correlated of suicidal behavior and may also relate to ambivalence and intentionality.

- 11 Guilt and shame need to be assessed. Also, Religious strain, including religious fears and guilt and beliefs in having committed an unforgivable sin, are associated with greater levels of suicidal ideation,
- 12 A feeling of not belonging to another person, family, occupation, or even to oneself (identity) is an important area for investigation. Loneliness or feelings of alienation are common consequences.
- 13 Certain diagnostic entities correlate highly with suicidal behavior, especially Schizophrenia, Borderline, Manic phase of Bipolar, acute Depression, especially agitated, OCD, chronic dysthymia, Substance abuse, and Impulse Control disorders.
- 14 Serious decline in physical health, ongoing physical or psychological pain, serious illness of significant others, all need to be explored.
- 15 “Slow” suicide intent may be reflected by the continuation of known self-harm behaviors, such as alcohol abuse, heavy cigarette use, consumption of high calories foods by an obese person and “forgetting” to take life-sustaining medication. All may be related to an underlying indifference to maintaining health, or even to life itself.
- 16 Extreme carelessness and indifference need exploration.
- 17 Sudden withdrawal from favorite activities, giving away valuables, becoming economically deprived, especially in old age. and feeling increasingly isolated or alienated, all require investigation, as potential precursors of suicidal behavior.
- 18 Self-harm behavior may be fatal. Although intent to die may not be expressed, explicit intentions of self-harm must be viewed seriously.

Finally, the use of appropriate additional assessment techniques may help to quantify clinical judgment derived from a focused interview. Such additional techniques may also help quantify the level of potential lethality in terms of the intention and ambivalence factors, and determine whether hospitalization is needed.

An experienced clinical psychologist can best use these techniques, if you are personally not equipped to do so. If clinical judgment is still not clarified, consultation with other professionals who encounter clinical emergencies may be helpful in the assessment of risk and subsequent management.

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Past President of Section VII,  
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