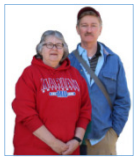
Part I: What is a Crisis and -
Part II: Crisis and Behavioral Emergencies

Presented by:
*Dr. Thomas P. Luzinski, Ph.D. and*
*Assisted by:*
*Mary Helen Luzinski, RN, BSN, MS,*
*President of:*



Introductions: Who are Tom and Mary



- Tom is a retired Police Officer
- Lieutenant, Mequon Police Department serving from 1970 to 1998.
- Started teaching in 1990 at Concordia-Mequon University in the Adult Education Department and also in the traditional Criminal Justice Programs.
- Completed a doctorate in 2004
- 2005 began full time teaching in Madison at Herzing University.
- Left Herzing in 2007 and became the Departmental Chair for the Criminal Justice Program at Marian University and
- Retired in 2014.

- Mary, is a retired Nurse
- RN, BSN, MS
- She is a retired after 44 years in 2012.
- She has worked in Aurora and Wheaton Franciscan system Hospitals in Milwaukee.
- She was an adjunct professor at Concordia-Mequon University
- She is currently the President of NAMI Ozaukee Chapter
- She is a member of NAMI Ozaukee CIT Steering Committee.

Tom and Mary are the parents of a son who successfully lives with mental illness and both are 25 year members of NAMI Ozaukee.

NAMI National Alliance on Mental Illness Ozaukee



Today's "Game Plan"

*My Assumption:* Perinatal clinicians as care givers are experiencing increased levels of crisis or "behavioral emergencies" in your patients and others associated in your caregiving. You may need some help understanding and dealing with this. That is why your organizing committee asked us back in 2019.

- *Class Objective 1*: We will examine some of the critical factors that drive that increase, to help you understand why that likely is.
- *Class Objective 2:* We will review the basics of the physiology associated with "behavioral emergencies." i.e. "human flight or fight response. This will be useful when we frame an understanding of the mechanics of a "behavioral emergency" and how to manage those. (*Psych 101 stuff)*
- *Class Objective 3*: We will examine dealing with a "behavioral emergency." We will learn the skills taught to police officers in accordance with the "Memphis Model of Crisis De-escalation." We will adapt that model to be useful to medical professionals. It is…what to do to de-escalate crisis and more importantly what not to do to not make it worsen! (*CIT and NAMI stuff)*



First a definition, What is a Crisis De-Escalation?

- De-escalation is "emotional first aid" which is designed to assist the person in crisis to return to "normal functioning." It is not "long term" care!
  - *Whyzat?* Well, something real and physiological is slowing down or even preventing their return to "normal functioning" (Whatever that may be!)
  - The focus of crisis intervention should be only on what's happening here and now!
  - This means…We can help, certainly! However, we can't do a whole lot -if anything- about the underlying condition!
- De-escalation is not like a recipe or a sequenced and stepwise formula –it's more like a flexible set of options.
  - There are no one single set of de-escalation skills
  - We have tried to put together a effective set of skills by borrowing from multiple approaches
- Our approach relies heavily on the best practices source model referred to as the "Memphis Model (MM)."
  - What does that mean?
  - It's what is taught to the Cops
  - We will adapt the 'MM' to clinical work and into a fusion of the two
  - De-escalation will usually but not always work in a behavioral crisis!



Part I:
What is a Crisis, *aka* 'Behavioral Emergency,' aka a 'Behavioral Crisis' or aka 'Psychiatric Emergency'?

- A crisis is an individual's human reaction based on his or her perception of an event or situation, as being an intolerable difficulty, that exceeds the resources and coping mechanisms of that person
- It's not a "hissy fit!"
- Crises will manifest in behavior which can be so out of control (passively or aggressively, or cyclically so) that the person becomes a potential danger to everyone.
- Unless the person obtains relief, the crisis causes severe behavioral malfunctioning.



The Usual Triggers for Behavioral Emergencies

- Medical conditions that can cause the type of behavioral emergencies include but are not limited to:
  - Low blood sugar related to diabetes or
  - Hypoglycemia, hypoxia,
  - Traumatic brain injury (TBI) or reduced blood flow to the brain
  - And central nervous system infections such as meningitis.
- Of course, behavioral emergencies can also arise due to substance abuse and/or related medical conditions.
- However, mental health issues will play a huge part in this issue!

How huge? Let's focus on the Mental Health issues…

- Severe anxiety disorders (to include PTSD) can trigger behavioral emergency and often do.
- However, major mental illnesses i.e. depression, bipolar disorder, schizophrenia and personality disorders can all cause symptoms that can overwhelm the sufferer enough to lead them into a behavioral emergency,
- Especially if these conditions are undiagnosed or untreated or if the sufferer abruptly stops taking his or her medication, or is *self-medicating*.
- OK, so just how prevalent is the mental health issue involved in a crisis episode?



*Sez* the *National Alliance on Mental Illness* (NAMI)

- Their science posits - 1 in 4 (or 5) people in the US (*i.e.* 60 to 80/out of 325-Meg) have a diagnosable and treatable mental illness (MI).
  - Incidentally, the sufferers of MI prefer us to refer to them as Consumers (*i.e.* of MI services) We would be the Providers.
- It is not likely you will know for sure that a Crisis Sufferer has an underlying Mental Illness
  - We recommend you assume the crisis is driven –somehow- by an MI to be sure!
  - It can't hurt!
- As such, crisis triggering events can assimilate from many sources; the preponderant one for a crisis is likely some mental illness, which is generally characterized by the DSM-5 as:
  1. Thought Disorders
  2. Mood Disorders
  3. Anxiety Disorders (PTSD)
  4. Personality Disorders

Looking at the 'numbers,' one can expect that a rather high correlate exists for Consumers and Crisis



More triggers: Anxiety's Role in Behavioral Emergencies

- *Anxiety* is a common mental condition that can also lead to a behavioral emergency.
  - Approximately 10 percent of all adults suffer from anxiety, making it the most prevalent psychiatric illness.
- Symptoms of anxiety (and at the apex PTSD) include extreme uneasiness and worry, agitation and restlessness.
- Although the symptoms of anxiety are relatively easy to recognize, it is often misdiagnosed and/or not diagnosed
- People who suffer from anxiety can also have panic attacks, which are intense episodes of fear and tension that can overwhelm the sufferer and quickly lead to a behavioral emergency.
- The sufferer may lose the ability to concentrate, focus and rationalize feeling and body's responses to those feelings.
- They can even suffer "panic attacks" fearing they will have more panic attacks.

*Incidentally, this is referred to as agoraphobia which translated from ancient Greek means a "fear of an open marketplace."*

- Agoraphobia today describes severe and pervasive anxiety about being in situations from which escape might be difficult.
- Or, avoidance of situations such as being alone outside one's home, traveling in a car, bus or airplane, or being in a crowded area *or even medical places*.
- Hence, agoraphobia is a common cause of panic related crisis.

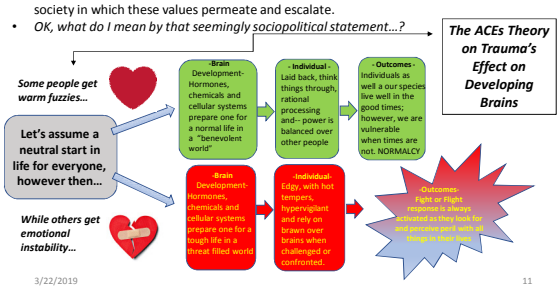
Also, Adverse Childhood Experiences (ACEs) are triggers…

- *What is that?* The term Adverse Childhood Experiences (ACE) refers to a number of potentially traumatic events, including episodes of sexual, physical or emotional abuse as well as exposure to hardships like parental divorce and parental incarceration.
- Such events can have negative and lasting effects on a child's well-being and have been linked to increased risks of obesity, alcoholism and depression, later on in adulthood, according to the research.
- *These people come to you as patients as adult!*
- From ACESs research, we know that twenty-two percent of children in the United States — more than 15.6 million kids total — have had two or more adverse experiences, according to the latest results from the National Survey of Children's Health. I will explain what this means shortly.
- Data on adverse childhood experiences also vary by race and ethnicity. American Indian (37%) and African American (34%) children are significantly more likely to have multiple adverse experiences compared to their White (19%) and Asian (7%) peers, according to the National Survey of Children's Health.



It should go without saying then…

- If you are experiencing what seems like an increase in patients in crisis, then one's ACE score might also factor into the increase.
- We live in a trauma society of which a growing number of people are affected by crisis.
- Childhood trauma can lead to long term consequences for the person who experienced the injury.
- It makes sense that they seem to be increasing in numbers as they are a product of a society in which these values permeate and escalate.
- *OK, what do I mean by that seemingly sociopolitical statement…?*






The Visible symptoms of a crisis, or behavioral emergency include, but are not limited to…

- Extreme agitation, i.e. threatening to harm one's self or others. Or…expressed ideation or suicidal intentions
  - If so… then you likely may have a §Chapter 51 Wisconsin Statutes concern, which may require an alternative response!
- Yelling and/or screaming, lashing out, irrational thoughts, throwing objects and other volatile behavior.
- The person will seem intensely angry, irrational, out of control and unpredictable. *OR* -
- In some cases they will just go "blank," and withdraw to the point of being noncommunicative.
- The unpredictable nature of either type of emergency can lead to injuries to you, the crisis sufferer and or bystanders if the sufferer reverts to violent behavior during the episode.
- Mood swings can (and will) change the crisis from hot to cold, and then cycle back and forth!

The Physiological Symptoms of an mental illness, anxiety or special circumstances behavioral crisis:

- Racing or pounding heartbeat
- Heart palpations or an irregular heartbeat
- Dizziness, lack of focus, loss of ability to concentrate, cognitive process deficit (i.e. can't reason with them)
- Tingling or numbness of the fingers and mouth
- Lower GI discomfort and issues
- Uncontrollable shaking as though the person is very cold and teeth chattering
- Shortness of breath
- *Incidentally all of these symptoms correlate with the activation of the "flight or fight" response all humans are genetically hard-wired with!*



Part II:
Behavioral Emergency and the Fight or Flight (ForF) (or Freeze) Response

- ForF is the fundamental physiologic human response which forms the foundation of modern day Stress Medicine.
- It is our body's primitive, automatic, inborn response that prepares the body to "fight" or "flee" from perceived attack, harm or threat to our survival.
- In addition to NAMI, Modern Stress medicine also posits that a person in "human crisis" suffers some extreme and/or prolonged activation of the ForF response which can be attributed to/or triggered by:
  - A Psychiatric/Psychotic Break
  - Drug Use or Abuse
  - An acute or chronic Traumatic Event
  - Or any/some combination of the above
- Let's watch a quick video will depict the physiology of FF or F response



Fight or Flight: What happens to us when we are under excessive stress?

- A complex Sympathetic Nervous System response is triggered.
- This response is hard-wired into our brains and represents a genetic wisdom designed to protect us from bodily harm.
- Central to the process, the area of our middle brain called the Amygdala, automatically activates by a neural response the Hypothalamus and Hippocampus, which occurs when we encounter a threat
  - The threat emanates from input via one of the five senses, normally sight.
- Together, (Amyg/Hypo/Hippo) drive a sequence of nerve cell firing that causes a chemical release of stress hormones that prepares our body for fighting or fleeing.
  - The three major stress hormones being Cortisol, Adrenaline and Norepinephrine

The problem is…and contrary to the video…once the base line "anxiety level" is set to a new high anxiety position, it does not get "reset" as the video portrays, back to "the normal position."

1:10



So, the Amygdala is combo "radar and smoke detector"

- It is 24/7 scanning the environment for danger, like radar.
- If danger appears, (usually by sight) it activates the "flight or flight" response in the human being
- Stimulation of the amygdala takes only .05 seconds; whereas, reasoning and recognition takes .75 second, or it's delayed for .7 second.
- The amygdala can "hijack" the executive control of the prefrontal cortex of 'reasoning' to the otherwise (*THIS IS PROBLEMATIC!*)
- When done, it causes intense emotion, such as aggression or fear or even "freezing" as chemical consequences for the body.
- Unless suppressed and "quieted" with reasoning (Parasympathetic)!



When neurochemicals like adrenaline, noradrenaline and cortisol are released into our bloodstream...

- Our respiratory rate increases.
- Blood flow is redirected away from our digestive tract and redirected into our muscles and limbs, which require extra energy and fuel for running and fighting.
- Our awareness intensifies, our pupils dilate, our sight sharpens (tunnel vision), our hearing adopts auditory exclusion
- OK, so our impulses quicken, threshold and perception of pain diminishes.
- Also, our immune system mobilizes in preparation for injury.
- We become prepared—physically and psychologically—for fight or flight.
- We scan and search our environment, "looking for the enemy."
- *Rather easy to find here, I think!*



OK, quick questions on the 4 short videos…

- Premise: Given the (a) the TV dude and the lizard, the (b) TV lady and the idiot, the (c) lady attempting to cook the crabs and (d) the dude attempting to avoid being eaten by the 200# cheetah…
- My first question is, what good would it be to ask any of them at the precise moment they veer into the deepest throes of a limbic system response to the danger they perceive, i.e. *"What's wrong?"*
- Do you think there would be any rational response from any of the three at that very time?
- Do you think it might be better to wait until the crisis passes physiologically speaking, show them the videos and then talk to them about their reactions—after they naturally (parasympathetically) calm down?
- Now, apply this hypothetical rationale to crisis de-escalation.
- *Assume a person is locked in "fight or flight" response by their limbic system; which is "hijacking" their brain's executive and reasoning functions.*
- *This keeps them in crisis, i.e. unable to naturally shut down the flow of stress hormones*
- *Question: What good would it do for us to try to reason them out of it, if they cannot be reasonable?*

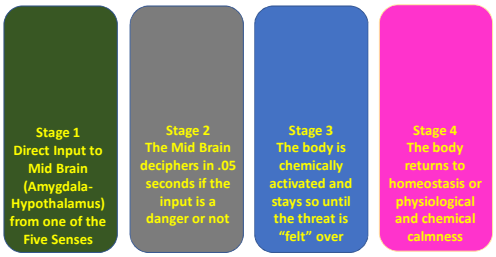
Answer: Probably not to much!

So, given a genuine behavioral emergency or crisis, what exactly are we dealing with?

- We are dealing with a person whose ForF response 'shuts out' their rational mind—the place where one's reasoned thought out beliefs exist—and cycles them into either an "attack" mode or a life preservation mode.
- Under ForF, people cannot be reasoned with!
  - *Why?:* Because this state of alert causes us to perceive almost everything in our world as a possible threat to our survival!
  - As such, we tend to see everyone and everything as a possible enemy.
  - Like airport security during a terrorist threat, on the look out for every possible danger.
  - We may overreact to the slightest comment.
  - Our fear is exaggerated. Our thinking is distorted.
  - We see everything through the filter of possible danger.
  - We narrow our focus (i.e. tunnel vision) and listen (i.e. auditory exclusion) to/only those things we sense pose a harm to us.
  - Accordingly, fear becomes the lens through which we see the world.
  - We sorta become like "werewolves!" *Did you ever try to talk to a werewolf*?



In Summary: Fight or Flight for all humans is a 4 Stage Process:




*Onset* -> Sympathetic Nervous System to *"Cool Down"*-> Parasympathetic Nervous System



A crisis ensues when the body cannot or does not perceive the threat no longer exists…

- And remains chemically active and in Stage 3.
- The prefrontal cortex is not (or can not) "tell" the Limbic brain" that the threat is over and safety has returned. It is dysregulated!
- This can leave undischarged tension and prevents homeostasis (or referred to as a DSM-5 *Dysregulation Dysfunction*) *aka* PTSD if/when permanent!
- Crisis De-Escalation or Intervention is doing something to bring about the homeostasis
- Or, not doing something that (unintentionally) prolongs the natural onset and calming of tension (i.e. Sympathetic yielding to the Parasympathetic Nervous System) release

Take Home Point #1: The deeper the crisis the less you will be able to reason with the sufferer! If a person is cycling in a *Stage 3 Crisis*, you cannot reason with them! The executive and rational functions of their brains have been and remain 'hijacked' by the Limbic System via activation of the ForF response. The person is still being flooded with Stress Hormones such as Cortisol, Noradrenaline and Adrenaline!
*You have to find a different way to quiet them!*



So, "The Whole Goal of Crisis Deescalation is to (ONE) 'get-around' a person's flight or fight response."

- So Sez: Dr. Christian Conte, Ph.D.
  - Licensed Professional Counselor,
  - Certified Anger Management Specialist
  - Certified Domestic Violence Counselor
- We will see more and hear from him later.
- And TWO, the "getting around" a person's fight or flight response entails the "helping person" engaging an "crisis activated person" by using *"rhythmic and repetitive motion"* in the process!
- This means – Employing calming actions (i.e. verbal) directed to soothe the crisis activated person's middle or limbic brain.