Part III
Fundamentals of Crisis Intervention and De-escalation

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

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Let's Watch a Very Quick (1 Minute) Video

The presenters will be:
- Scott A. Simpson, MPH, MD,
- Melanie Rylander, MD,
- Denver Medical Health Center
- (at) University of Colorado School of Medicine

- Are there any thoughts or comments about what you just saw?
- *I have one…at the point the guy threw something at the medical person…the de-escalation is over!*
- *It's time to call (at least) security and maybe the police if she was injured!*

OK, now let's watch it again, only this time we shall see it presented with a little more thought and authentic concern put into a successful de-escalation

According to the two Video Denver Medical Physicians, there are 10 Steps to Successful Deescalation of Crisis

Blue Front ***White Back***

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Denver Medical Health Medical Center 10 Elements of Deescalation
1. Respect Personal Space
2. Do not be Provocative
3. Establish Verbal Contact
4. Be Concise
5. Identify Wants and Feelings
6. Listen Closely to what the Patient is saying
7. Agree or Agree to Disagree
8. Set Clear Limitations
9. Offer Choices and Optimism about the Situation
10. Debrief the Patient and Staff

Tips: *Interacting with Someone who is in a Psychiatric Crisis*

- You should have a "card" listing the Denver Health Model for Interacting with Someone in Crisis
- You should also have two cards from Mary, find the one that has the (10) *Tips: Interacting…*
- The third and next part of our discussion will focus on me fusing the two crisis intervention models
- I will argue the 'Memphis Model' stuff used by NAMI to train Cops in CIT is the root of virtually all other Crisis Intervention plans, such as the Denver Medical Model.
- I will recommend you to use the Denver Medical Model to guide you as medical professionals
- I will advocate the 'MM' should be used for you to "backfill" the rationale of the Denver Medical plan thus in order to illuminate its rationale

(Take Home Point #2:) There exists some peril for those of whom who are attempting to deal with people in crisis!

- Any person who attempts to de-escalate a crisis, is/will also experience a *flight or fight* response, to one degree or another.
- *Howzat Tom?* Well…de-escalation does not take place in a vacuum, it is a mutual engagement – and it can be an acute traumatic event just as well as for Medical Practitioners.
- Hence, the professional must deal with the crisis suffering person certainly;
- However, it's done while wrestling with their own ForF response in the process
- In which case, the de-escalator is also under extreme stress and risks being (secondarily) traumatized!
- So, we have what is also referred to as Secondary Traumatic Stress or aka Vicarious Trauma or, Compassion Fatigue
- Its symptoms are those of Post-Traumatic Stress Disorder (PTSD), a Mental Illness (DSM 5).
- PTSD is not to be confused with 'burnout!' an *acute distress disorder*, these are two different things!

So, **Trauma Informed Care** (TIC) is (a) ***Treatment Framework*** but it is also (b) an ***Organizational Structure*** that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma Informed Care then emphasizes physical, psychological and emotional safety for both patients and providers, and helps everyone involved to rebuild a sense of control and empowerment.

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University of Colorado School of Medicine
Scott A. Simpson, MPH, MD,
Melanie Rylander, MD,
Haley Medlin, PsyD

1. Deescalation Element: Respect Personal Space

Main Points
- Clear the room of Obstacles
- Maintain a two arm's length space between yourself and the one in crisis

Question…?
- Why?

Indeed, do maintain the (an) appropriate distance from the Crisis Sufferer (but what's appropriate?)

- You must know (or learn[what are]) the culture based body space (proxemics) requirements all people have!
  - Including yourself!
  - YOU must determine what is an appropriate distance between you and the crisis sufferer --and be prepared to adjust that if the dynamics change!
  - It's a judgment call!
- Do not touch the subject in crisis unless you intend to restrain them!
  - Why?
- Be prepared to increase space or, "back pedal" physically and verbally from the crisis sufferer.
  - It's OK!
  - Remember your own ForF Response is activated too!
- Keep your hand off of (any) medical tools, paraphernalia or instruments!
  - These will appear to them as a weapons and/or convey a "threat message."

Incidentally, body space requirements in westernized (rich culture) societies is 18" to 36"

Personal space also means do not attempt to make a (psychiatric or medical) diagnosis of the Crisis!

- People in crisis modes cannot intellectualize much of anything!
- *Remember*…Their thinking brains are "hijacked" by their emotional limbic systems!
- Also, if done you run the risk of Projection Fallacy or the 'projection' of our own ignorance, negative behaviors, traits and impulses on someone else!
- The world is not how we alone see it!
- In the end, you will be wasting time that could be allocated to the de-escalation!
- The interaction and de-escalation techniques we will show you have broad applicability.
- Incidentally Empathy is considered the reverse form of Projection.
  - More on this later!

2. Deescalation Element: Do not be Provocative

Main Points
- Calm Demeanor, Manage Voice
- Body Language, Adjust Posture
- Don't Argue with Patient
- *So- Be nonthreatening…*
  - OK Tom…so just how does one not do or be that?

So, if no danger is present, approach in a "Nonthreatening Manner"

- Nonthreatening means…not likely to cause fear, worry or anxiety in others.
- *To begin -start with your Posture…*
  - Stand straight and relax your hands and keep them at belly or chest level and observable
  - Raise Eyebrows and Cock your head to one side!
  - Indeed, it's maternalistic!
  - More on this one later!
- If two or more Medical Professionals (MPs) are involved, then only one does the talking, the other(s)preserves the integrity of the situation! (CIT recommended)
  - What does that mean?
  - Many people talking to/at the crisis suffer can be threatening!
- Be prepared to switch roles, the dynamics can change!
- MPs may phase in and out and change roles due to changes in the circumstances, rapport and people.

Hands, Hands and Hands! (Did I mention…HANDS?)

- You can learn much about a person by looking at their hands.
- Despite the "smile on your face and the song in your heart," your hands will betray you intentions every time you interact if you do not control them!

Do maintain eye contact, *but*…do not engage in STARE-DOWN!

Eye Contact can be Threatening!
- So, glance to the side as you maintain a conversation
- Reestablish brief eye contact but do not hang onto it too long
- However, breaking eye contact too soon you risk appearing untrustworthy or overly nervous. (this is a cultural not physiological affect!)
- Hold eye contact a hair longer especially during/if a handshake. (i.e. 3 seconds)
- Yes, it's an art form! It's developing a "comfort level" with ambiguity!
- *Note:* In westernized society, not making or not maintaining "eye contact" is unconsciously interpreted as an indicator of deceit!

3. Deescalation Element: Establish Verbal Contact

Main Points
- Patients in crisis suffer a narrowed range of attention
  - That would mean "tunnel vision"
  - And they also suffer from "auditory exclusion"
- Sight and hearing are a human's main sources of sensory input about the world we live in.
  - However, people in crisis with the ForF response active, will key-in to the sights and sounds of potential danger and little else.

Concerning verbalization, manage your tone of Voice and Volume!
However…nonverbals???

- An ignorance of the effects of any communication can threaten building rapport!
- So, do speak respectfully…of course.
- OK to tell them your first name, ask for theirs!
  - USE IT OFTEN!
- Politeness is not necessary, however Courtesy is!
- *What's the difference*? Politeness is (almost a) ritual response.
- Courtesy is behavior displaying persistent regard for others in all aspects of one's interactions.
- Thus, it may be possible to be polite, while still not being courteous.
- This will be hard to do if the person is verbally abusive to you
- Learn the cultural dimensions of nonverbal communication!

Concerning Verbalization: Refrain from asking Crisis Suffers "Why" questions.

- It tends to be interpreted by them as Judgmental!
- They are not unintelligent, they are sick and most know it!
- If you persist in asking WHY, all you will get are irrational answers!
- Remember…if in crisis, they cannot process intellectually!
- Your firmness is necessary, do not concede to them if/when they make irrational demands of you.
- *Also:* If hallucinating…do not play into their hallucinations, this only validates those to the Crisis Sufferer.
  - You may say things such as: "No, I do not see the little man in standing the corner;' however, I do believe that you do!" etc.

Also train yourself not to ask (close ended) questions in which the answer will not be a Yes or No.

- For instance…"Would you tell me what is wrong?"
- "Are you experiencing problems today?"
- "Can you tell me your name?"
- Do not ask multiple (rapid fire) or complex questions!
  - Allow longer than usual time for a mentally ill person to respond to your question.
  - It takes them longer to process you!

4. Deescalation Element: Be Concise

Main Points

- Keep verbal communication slow and steady
- Keep verbal communication simple and be prepared to repeat messaging
- *Why*:
  - Because a person in crisis is likely only able to process 1 our of every 7 words that are being spoken to them!!!
- So YES, be concise but also keep it REAL for them!

Take Home # 3: How to keep it real: Do not speak to them in the Abstract!

- Abstract thinking is the grasping of a fundamental principle in which its concept and/or meaning (or both) is translated from one context to another. For instance, the term "Mental Illness" is an abstraction!
- For Crisis Sufferers to understand their crisis by you connecting it to an abstraction, i.e. the corresponding DSM-5 psychiatric designation occurring in their body; is terribly difficult for them to process! So…don't say that kind of stuff to them!
- *At this point you haven't a clue as to what I am talking about do you? Well, it's because I am purposely speaking to you all in the abstract!*
- It can help people for yo to talk about their emotional experiences and find ways to recognize and respond when their emotions are disturbing.
- For instance, a *crisis sufferer* may not be able (or willing) to talk about their mental illness or, the crisis but they can talk about how they 'feel sick' or pain.
- Accordingly, MPs need to ask questions like 'Where do you feel that pain?' or 'How do you feel that pain in your body?' to help the person identify what they are feeling, where and when.

Keep it real, this also means refrain from using another abstraction i.e. metaphorical speech!

- A metaphor is an exaggerated figure of speech which makes an implicit, implied or hidden comparison between two things or objects, that are poles apart from each other but have some characteristics common between them.
- Huh…*Wha*…Tom?

Keep it real, do not speak to them in the abstract… i.e. Euphemistically (e.g. "sugar coat")
More on Metaphors

- They have great difficulty processing and thinking in the abstract.
- They interpret things and issues literally (they don't understand "our" funny!)
  - This is not physiological but part of their social stigmatization
- Abstract thinking is the use of concepts to make concrete points or to problem solve.
  - For instance, *you look sicker than a dog…*
  - *Lady, you are really green around the gills!*
  - *You look like the weight of the world is on your shoulders!*
  - *Looks like you are in some real "deep doo-doo" Dude!*

(Take Home Point #4) Do make simple Requests and Give Clear Instructions

- Speak very slowly and repeat what you say! Repeat it again.
- Repeat it until it begins to register!
- (Very Important!) Even if you are alone with them, you will likely <u>not be the "only person"</u> in dialogue with and/or talking to the crisis sufferer!
  - They often are 'hearing voices' and seeing people they imagine.
    - Auditory Hallucinations
    - Visual Hallucinations
  - These 'imagined people' are monopolizing the crisis sufferer's attention.
- Hence, you are in competition for the Crisis Sufferer's attention!

This means that if you immediately start ordering or commanding this person to do something…you are likely to be interpreted as just another antagonist by him or her!

(Deescalation Elements 5 & 6 Go Hand in Hand)

First:

5.Identify Wants and Feelings

Main Points

- The patient will likely tell you exactly what they want

and secondly…

6. Listen closely to what the patient is saying…

- Agitated Patients have difficulty in expressing themselves
- It's OK to validate their wants
  - However, it may not be OK to actually enable those!

"Listen closely to what the patient is saying…"
Denver Medical

- Concerning their statement if you "listen closely" per the Denver Medical recommendation…
  - Then I have a question? What if the crisis sufferer is/or may be hallucinating and <u>*seeing and/or hearing/and reacting*</u> *to* things that are not really there.
  - Also, if they are hallucinating…what might they be hearing, or seeing or both?
- For instance, let's listen to this recording made by the <u>National Empowerment Center</u>,
  - A consumer/survivor/ex-patient run support and advocacy group that depicts auditory hallucinations

If you challenge their reality, you will be/or are competing with imagined people or things and for the crisis sufferer's attention…

- Most hallucinations are auditory.
- They are often hearing abusive, threatening and sometimes horribly frightening things
- So, do not join 'that litany' and become just another source of abuse or danger to them by being an another aggressive antagonist.
- To succeed in a de-escalation, you must find a way to make yourself more humanely compelling to Crisis Sufferers thus to (re)focus their attention on you!
- So, instead offer them safety and protection!!!

Take your time!

- Yeesh, but of course Tom!
  - Yet, this is easier said than done!
- Crisis/Psych emergencies are extremely emotionally and physically taxing on mentally ill people (as well as MedPros).
- Physiologically speaking, a crises can last from 10 to 60 (18-20 being normal) minutes and it usually "peters-out" because the sufferer simply becomes physically exhausted
- In which case, you should see them profusely sweating, sitting, asking for water and generally 'fizzle out' do the extreme exertion.
- If done…you should see them open themselves to your patience, genuine concern and offers of help.
- Maintain your supportive and appropriate voice tones in the process
- *Question: What are the real world cautions or even problems with the time issue? Especially if you are a supervisor or manager?*
- Beware of a crisis condition called "*Excited Delirium,*" which is a Medical Emergency.

What pray tell, is Excited Delirium? (aka Medically Significant Behavior)

- It is the "Flight or Fight response on steroids!"
- It is defined as a medical emergency and has been associated with death in certain scenarios.
- Is the sudden onset of aggressive and violent behavior and autonomic dysfunction, typically in the setting of acute on chronic drug abuse or serious mental illness
- What we believe now is that Excited Delirium occurs most commonly in males with a history of serious mental illness or, acute or chronic drug abuse, particularly stimulant drugs such as cocaine, psilocybin, crystal meth and MDPV (Methylenedioxypyrovalerone, i.e. *Bath Salts*)
- Alcohol withdrawal or head trauma may also contribute to the condition.
- A majority of fatal cases involved men.
- The signs are symptoms of Excited Delirium are:
- Extreme paranoia, disorientation, dissociation, hyper-aggression, hallucination, incoherent speech, seemingly superhuman strength and profuse sweating
- You will often see them stripped naked, in an attempt to cool the elevated body temperature, which can rise to lethal levels if not treated.

For a long time, medical experts thought the Medically Significant Behavior (i.e. Excited Delirium) onset was just due to the effects of electronic control devices, such as Tasers and misused by the Police.

7. Deescalation Element: Agree or Agree to Disagree

- Main Points
  - According to the Denver Health video, if you opt for this tactic, this means you are at an impasse and you need some sort of an "icebreaker."
  - So, agree to disagree, and the best you can get is a temporary consensus.
  - Remember, you can give a little but you may not compromise on safety issues.
  - Ah, No! I don't know where this comes from!
  - I disagree and I can't recommend that you proceed with this rationale!
  - There really isn't a corresponding tactic in the MM that recommends this.
- *On Slide 9, I proposed:*
- Be prepared to switch roles, the dynamics can change!
- MPs may phase in and out and change roles due to changes in the circumstances, rapport and people.
- If you are faced with a "road block" this serious –i.e. to the extent that you cannot make progress…it's time to change the lead person(s) in the de-escalation!

Indeed, agreement requires full duplex communication…

- So, Yes! Do initiate only *Relevant Conversation*, but if you have nothing relevant to say, it's OK
- However, remember…Silence and slow progress can be a powerful allies
- *Why so Tom?*
  - Because, use of silence can be a tactic!
- How to be Tactically Silent Part 1
  - Give the "lull" a while.
  - The first few seconds of silence are easy, but the next ten to twenty can be hard to get through without cracking.
  - It's worth it to choose to keep yourself silent though --because that's usually when they will feel most compelled to start the talking again.

Tactical Silence -2: Remain Quiet but Stay Engaged

- Use body language that indicates you're paying attention: face the other person and look at them.
- If possible…take notes – use a clipboard, notebook, etc. (*i.e.* very neutral accouterments- and not tools)
- Try not to stare at your shoes or turn your body away from them.
- If you can't look at them for the full amount of time you're silent, focus on the notes you may have been taking during the conversation.
- Pick up your pen and examine and --then visibly annotate something new (anything) to what you've written.

Tactical Silence -3:

- If you feel the urge to speak, avoid explaining yourself, even if so asked.
- Instead, ask questions or use short phrases to encourage the other person to keep talking. "Uh-huh," "OK" and/or "Tell me what you mean by that question," are all helpful phrases.
- These interludes are referred to as "minimal encouragers."
- If you go blank, repeat the last thing that they said and pose it back to them as a new question.

8. Deescalation Element: Set Clear Limitations

Main Points

- Limitations will likely pertain and conform to legal constraints on you and/or your corporate safety policy and protocols.
- Do not offer or agree to improbable solutions to the crisis sufferer.
- Set acceptable limits to behavior in a nonconfrontational manner
- I would recommend keeping high level administrators away from the de-escalation!

So, in any event do not give them multiple alternatives

- In reality, there is only one alternative and that is to peacefully cooperate with you!
- Therefore, you must identify the element(s) of the choice they have and on your terms!
  - "I can not leave you alone…"
  - (Therefore) "Please feel free to leave, or, you can remain in the hospital, or you can go home with your friend or your sister, or your Uncle Fred…"
- Detail that choice and the consequences of bad choice making.
- Repeat it as long is it is necessary to get the compliance you demand.
- Keep refocusing them back onto the problem (i.e. they are distressed and they need your help) if they start to delude again.
- Keep them fixed on your point! Restate, restate and restate it is as much as necessary!

9. Deescalation Element: Offer Choices and Optimism about the Situation

Main Points

- Create the means for Empowerment
- (Note) Empowerment means transferring your authority to someone.
- Become empathetic, your empathy will empower the receiver every time!

Work on your Empathy …so ah, What's Empathy?

1. Shared Emotion (*Not Projection*!)
- Empathy is not Sympathy, or feeling sorry for someone.
- Empathy is about sharing an emotion (not projecting your own) with someone, or feeling the way they feel, even if you aren't in the same situation.
- When you feel an emotion along with someone, even if you aren't directly affected by whatever is causing their situation, that's empathy.

2. Neurological research confirms that humans and other social animals, especially primates, we are equipped with "mirror neurons,"
   1. These give us the capacity to display, read and mimic emotional signals through facial expressions and other forms of body language.
   2. Mirror neurons help us share emotional experiences and become more and naturally empathic toward others.

3. Sharing Perspective and Mirror Neurons
- OK, this is all good, but what happens if you are not an Empathetic Person by nature?
- Well you can try to at least know what it is and attempt to "show it!"

- The five keys of "showing empathy" are:
  1. Giving the person your genuine and undivided attention;
  2. Being nonjudgmental;
  3. Focusing on the person's feelings, not just psychiatric facts as you may interpret them;
  4. Allowing the/for silence;
  5. Using restatement and minimal encouragers to clarify your messages.
     - Non-verbal minimal responses such as a nod of the head or positive facial expressions, finger sign OK
     - Verbal minimal responses such as "Uh-huh" and "I hear what you're saying"
     - Brief invitations to continue such as "Tell me more"

Major Minimal encourager: Do ask them how you can help!

- Authentically, offer them safety and protection and a way out of the danger they are delusionally experiencing.
- Reinforce that, let it become your "mantra" with Crisis Sufferer.
- To do this you must speak slowly, reassuringly and in very simple sentences; so they can process each one --above the turmoil they are hearing and seeing.
- The '*One-Out-of-Seven' Rule*! Is in force! *Wha…Huh*?

10. Deescalation Element: Finally, debrief the Patient and Staff

- A debrief is a simple, yet powerful tool that enables a team to self-correct, gel as a team, and enhance their performance.
- During debriefs, team members reflect upon a recent experience, discuss what went well and identify opportunities for improvement.
- Debrief and Trauma Informed Care:
  - Many clinicians/nurses/support persons experience symptoms of compassion fatigue at some point in their career, which can lead to burnout, job dissatisfaction and PTSD.
  - PTSD/Compassion fatigue (or worse) may be prevented by engaging in proactive, planned reflective debriefs after critical events.
  - Health care leaders who advocate for planned activities to promote resiliency among their medical/nursing/support staff can increase retention and morale.

Components of Debriefing

- All forms of debriefing have a shared structure that involves setting the stage followed by three operational phases including (1) Descriptions and/or Reactions, (2) Analysis, and (3) Application (i.e. improvement(s) for next time).
- To be effective, a debriefing must be conducted in a manner that supports learning, not reprimand.
  - Therefore, the purpose is not to identify error and assign blame, but to understand why actions of debrief and that the decisions that made sense to clinicians in the moment.
  - Such a focus increases the probability that positive performance can be reinforced, and new options can be generated for changing performance that was incorrect or otherwise below the desired standard.
  - This requires establishment of psychological safety for participants regardless of the type of debriefing conducted.
  - Whether engaged in a clinical debriefing lasting 3 minutes or a simulation debriefing lasting 30 minutes, the tone set by the leader and the leader's management of the discussion are both critical to maintaining psychological safety.

Deescalation in Three Easy Steps by Dr. Christian Conte

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CIT

Conte's 3 Point
Model of De-escalation

1. Validate the Person, acknowledge how they feel without judgment.
2. Help the Person find appropriate options to empower them.
3. Allow them to choose from the options.

Take Home #5: An Example of a (CIT) Preferred Intervention

The first minute of this video during the opening is a depiction of the way in which to **NOT TO DO** an Intervention. (Watch Closely)

My only criticism of this otherwise excellent video is that the NOT TO DO part should have been elaborated upon a little more.

The rest of the video depicts an intervention that in "Memphis Modelling" is the appropriate way to humanely deal with a Consumer in Crisis

The "MM" fusion with the Conte Technique here is apparent!

In summary and in a Crisis…

- The likelihood you can resolve this issue without force or, some "authoritarian" solution is quite high!"
- Seek the peaceable resolution as the solution.
  - It will take some time up front
- Remember, these are distressed and/or sick people, they are not unintelligent!
  - They can start to intellectually process your instructions (only) after you 'quiet' them with empathy.
- But - In the crisis mode, they are not rational
  - You as the rational adult in the room must define the appropriate behavior for them
- You have a homework assignment!
  1. Investigate Trauma Informed Care (TIC)
  2. Investigate ACE (Adverse Childhood Experience) Research
  3. Investigate effects of Cultural Verbal and Nonverbal Communication
  4. Find out more about Excited Delirium

Thank you for your attention

Contact Dr. Tom and Mary Luzinski
tpluzinski@gmail.com & marhelu@wi.rr.com
Home: 262-242-6492
Visit: namiozaukee.org