What Crisis Response Can Teach Behavioral Health Leaders About Communication Under Pressure

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> *A seasoned law enforcement officer is standing outside a locked door. On the other side is a woman. A victim of sexual assault. He is talking to her, he's been trained for this, but something is happening. His words are coming faster. His voice is tightening. A trainer calls time and asks him: what's going on for you right now? He pauses. Then: "I'm desperate to help her and I can't get to her." The moment he named it, something shifted. His breathing slowed. His shoulders dropped. He went back into the scenario and this time, he could actually help. He had not forgotten his training. He had lost access to it. And the path back was not more technique. It was contact with what was actually happening inside him.*

The Pressure Problem in Behavioral Health

Behavioral health professionals are operating in conditions that would challenge anyone. High caseloads. Underfunded systems. Workforce shortages. Clients in crisis. And underneath all of it, an expectation that staff will remain calm, clear, and connected regardless of what is in front of them.

This is not a complaint about the field. It is a description of its reality, one that is producing measurable consequences. Research consistently finds that chronic workplace stress in behavioral health settings erodes the very capacities the work demands most: communication, empathy, and sound judgment.[1] The evidence is equally clear that interventions focused only on individual resilience, without addressing the conditions people work in, are insufficient.[2]

Leaders already know this. What they are still working out is what to do about it.

Why Communication Is Not Just a Soft Skill

When communication breaks down on a team, when a staff member misreads a situation or goes flat in a moment that called for connection, the instinct is to treat it as a training gap. More instruction. A corrective conversation. A refresher module.

But that instinct misses something important about how people actually function under pressure.

Neuroscientist Stephen Porges has spent decades documenting the Social Engagement System, the neural circuitry that enables clear communication, empathic listening, and nuanced response. His research shows that this system is not always accessible. It comes online when the nervous system registers sufficient safety, and goes offline — rapidly and involuntarily — when threat is perceived.[3]

> *When stress increases, even subtly, the nervous system shifts toward protection. Attention narrows. Tone changes. Habits override intention. Complex skills become harder to access. — Porges, 2022*

This is not a failure of professionalism. It is a predictable biological response. The prefrontal cortex, which governs nuanced judgment and flexible responding, is measurably impaired by acute and chronic stress.[4] Under pressure, people do not simply forget what they know. They lose neurological access to it. Communication is not a personality trait. It is a state-dependent skill.

What Crisis Response Settings Make Visible

Community crisis response programs, including co-responder models and non-law enforcement crisis teams, have become a real-world laboratory for understanding what happens to communication under pressure.

SonderWorx has worked inside one of these programs since its inception. Albuquerque Community Safety (ACS) — the City of Albuquerque's non-law enforcement crisis response program — launched in 2021 as one of the first municipal programs of its kind in the country, deploying trained civilian responders to behavioral health calls in place of police. SonderWorx has trained ACS field responders since the program began. That experience has been instructive not because crisis work is unique, but because the pressures it generates are unusually visible and immediate. It is hard to miss when a practitioner loses access to their communication skills in real time.

What these settings make visible is this: even skilled, well-trained, highly motivated practitioners lose access to their best communication in intense moments. Not because they don't care. Not because they weren't taught. But because the urgency, unpredictability, and emotional weight of the work activate the very nervous system responses that narrow empathy, reduce listening, and compress judgment.

Clinician Deb Dana, whose work translates Polyvagal Theory into practical application, describes this through the concept of co-regulation: the practitioner's own nervous system state matters enormously for the person in front of them. A dysregulated provider cannot offer the regulated presence that a crisis situation requires.[6] This is not a metaphor. It is neurophysiology. And Charles Figley's foundational research on compassion fatigue established that repeated exposure to others' distress without adequate support, produces measurable erosion of empathic capacity, judgment, and professional functioning.[7]

Crisis settings don't create these dynamics. They reveal them. The same processes are at work, less visibly, across every behavioral health team operating under sustained pressure.

What Organizations Often Miss

Most behavioral health organizations respond to communication problems the same way: more training, more content, more policy. The assumption is understandable; if staff know more, they will perform better. But knowledge is not the same as access. Under pressure, access is what determines behavior.

K. Anders Ericsson's research on expert performance makes the point plainly: professional experience alone does not reliably produce excellent performance. What produces it is deliberate practice — structured, effortful rehearsal under realistic conditions, with immediate feedback.[8] A training event is not deliberate practice. It is a starting point.

There is a deeper gap that most training designs miss entirely. Practitioners generally believe they know how they will respond under pressure. They don't. Not really, not in their bodies. A

clinician who has read extensively about the nervous system can still freeze completely during a high-stakes role-play, lose access to language, feel disoriented, and have no idea why. That moment of being caught by their own stress response — in a structured, non-judgmental setting that invites curiosity rather than shame — is often more instructive than hours of didactic content.

Deb Dana's concept of "befriending your nervous system" names what this kind of learning makes possible. When practitioners experience their own stress responses in a supported setting — and then reflect on what happened, what they felt, and what they needed — they develop a quality of self-knowledge that cannot be taught through information alone. They come to recognize their own early warning signs. They learn what regulation feels like from the inside, not just what it looks like on a diagram.

The group dimension matters as much as the individual one. When practitioners go through this process together, they witness each other's responses — the freeze, the shutdown, the over-talking — and something important happens: they develop genuine compassion for those responses in each other. The neurobiological reality that "this is what happens to all of us under pressure" stops being a concept and becomes a shared lived experience. Teams that have learned this way carry a fundamentally different culture into their work. They can recognize stress responses in colleagues in real time, name them without judgment, and offer the kind of co-regulation that crisis moments actually demand.

Amy Edmondson's research adds the systemic dimension: team psychological safety — the shared belief that it is safe to speak up, ask questions, and acknowledge mistakes — is the primary organizational condition that enables learning to transfer into practice.[10] The culture of the team either supports or undermines the skills that training is trying to build.

Many behavioral health systems expect staff to demonstrate excellent relational skills under pressure while providing them with one-time training, minimal reflective supervision, and no shared language for understanding their own stress responses. This explains a pattern leaders encounter repeatedly: capable, caring staff who still struggle to communicate effectively when it matters most.

> *In another scenario, a skilled clinician is responding to someone in distress. Textbook knowledge intact. Good intentions fully present. But the more the person expresses their feelings, the faster the clinician moves toward solutions. The role-player grows more agitated. The clinician works harder. The conversation spirals. Called to pause, the clinician is asked what was happening. The answer came slowly: "I was uncomfortable with how much pain they were in. I wanted to stop it." The clinician knew not to rush to problem-solving. Every training said so. But their nervous system had its own agenda. When they returned to the scenario — regulated, slower, more present — they discovered something: the person wasn't concerned about the problem the clinician had been trying to solve. They needed something else entirely. The knowledge had been there all along. What changed was access.*

What Helps

The research converges on a set of practices that build communication capacity that holds under pressure.

Realistic practice. Skills need to be rehearsed in conditions that resemble actual pressure. Deliberate practice research is unambiguous on this: feedback-rich repetition under realistic conditions builds durable skill. Exposure to content does not.[8]

> *One participant — confident, experienced, the kind of person others look to in a crisis — entered a scenario and went completely blank. Words left him. The conversation stalled. The person he was meant to help grew guarded and closed. He had no idea what was happening. With support, he regulated himself. He went back in. This time, something was different — quieter in him, more present. The person he was responding to began to open up. A real connection formed. He was able to help. At the end of the training, he said his confidence had skyrocketed. Not because he had learned something new. Because he had learned something true about himself, and discovered that he could work with it.*

Reflective debriefing. Structured reflection after difficult interactions, not as punitive review but as learning practice, builds professional judgment over time and is linked to reduced staff stress and stronger engagement in human services settings.[11]

Shared language around stress and regulation. Teams with a common framework for understanding how pressure affects performance are better positioned to support each other and recognize early warning signs in themselves and colleagues. This shared language is both a clinical tool and a team culture intervention.

Supervisor modeling and organizational design. Leaders set the regulatory tone of their teams. How a supervisor responds to mistakes and difficulty is the strongest predictor of team learning culture.[10] Caseload size, debrief opportunities, and norms around self-care are not peripheral to clinical quality, they determine it. A resilience training study published in *JAMA Network Open* found that structured organizational programs significantly improved staff wellbeing and reduced burnout, with effects sustained over time.[12]

Why This Matters for Workforce Sustainability and Care Quality

There is still a tendency in behavioral health to treat workforce sustainability as a human resources problem and care quality as a clinical one, as if they were separate domains. The research suggests otherwise.

When practitioners are chronically dysregulated, they cannot offer the attuned presence that therapeutic work requires. The quality of the provider-client relationship, consistently among the strongest predictors of clinical outcomes, is not simply a function of training or technique. It is a function of the practitioner's nervous system state.[3] Google's Project Aristotle, which studied over 180 teams across multiple industries, found that psychological safety was the single strongest predictor of team performance on every outcome measure.[13] The parallel for behavioral health is direct: supported staff communicate better, learn more, and deliver more consistent care.

When organizations invest in helping staff function well under pressure — through realistic practice, reflective support, shared language, and culture-level reinforcement — they are not simply being kind to their employees. They are making a structural investment in the quality and consistency of the care those employees deliver.

The question is not whether pressure exists in behavioral health. It does, and it will. The question is whether organizations are building systems that help people stay connected to their best skills when pressure rises.

A Practical Starting Point

Understanding where your team currently sits, what strengths are already in place and where the gaps are most likely to show under pressure, is the foundation of any useful intervention.

SonderWorx has developed a short, free assessment for behavioral health leaders: **How Ready Is Your Team to Perform Under Pressure?** It takes about five minutes and is designed to help leaders identify where their team's capacity is solid and where it is most at risk when stress rises. No sales process. Just clarity.

About the Author

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References

1. Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience. World Psychiatry, 15(2), 103–111.

2. Tang, Y-L., Raffone, A., & Wong, S. Y. S. (2025). Burnout and stress: New insights and interventions. Scientific Reports, 15, 8335.

3. Porges, S. W. (2022). Polyvagal Theory: A science of safety. Frontiers in Integrative Neuroscience, 16, 871227.

4. Woo, E., Sansing, L. H., Arnsten, A. F. T., & Datta, D. (2021). Chronic stress weakens connectivity in the prefrontal cortex. Chronic Stress, 5.

5. Goleman, D. (1998). Working with emotional intelligence. Bantam Books.

6. Dana, D. (2018). The polyvagal theory in therapy: Engaging the rhythm of regulation. W. W. Norton.

7. Figley, C. R. (1995). Compassion fatigue. Brunner/Mazel.

8. Ericsson, K. A. (2008). Deliberate practice and acquisition of expert performance. Academic Emergency Medicine, 15(11), 988–994.

9. Schön, D. A. (1987). Educating the reflective practitioner. Jossey-Bass.

10. Edmondson, A. C. (1999). Psychological safety and learning behavior in work teams. Administrative Science Quarterly, 44(2), 350–383.

11. British Journal of Social Work. (2023). Rapid review of reflective supervision in social work, 53(4), 1945–1963.

12. Yi-Frazier, J. P., et al. (2022). Assessment of resilience training for hospital employees. JAMA Network Open, 5(7), e2220677.

13. Rozovsky, J. (2015). The five keys to a successful Google team. re:Work with Google.