From Isolation to Community:

Collaborating with children and families in times of crisis

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This article offers a narrative and anthropological framework for working with children and families in crisis. Psychiatric crisis can invite practitioners to prioritise their own ideas about problems and solutions above collaboration. The article argues that practices of collaboration are crucial when responding to these kinds of crises, and offers a framework for remaining in collaborative and hopeful positions. A range of clinical examples are also provided.

Keywords: psychiatric crisis, narrative therapy, children, families, collaboration, sociocultural drama

OUR CONTEXT

In our part of the United States, during the last ten years, there has been an increasing trend towards psychiatrically evaluating and hospitalising children who are acting in intensely angry, sad, or violent ways. This trend dramatically increased during the school shootings that occurred in the late 1990s. Schools and mental health professionals that were often quick to make a referral for psychiatric evaluation in times of crisis began to access these services more frequently (Wong 1999) in the hope of preventing another tragedy.

At that time we were newly graduated social workers in Massachusetts and were working in a variety of psychiatric and mental health care settings including inpatient psychiatric hospitals, short-term home-based family therapy teams, and in emergency rooms. In these settings we found ourselves pressured to produce evaluations that could 'guarantee' children would be safe in their communities. This pressure, and the impossible responsibility that it generated, often made inpatient hospitalisation the only available option for the children and families with whom we were working.

Many of these children and families were struggling with the effects of intergenerational poverty, family and community violence, racism, sexism, heterosexism and/or substance abuse. They frequently lived in small spaces where children had little safe space to play, and where poverty, violence and hunger were daily experiences.

They were also families with tremendous skills of resiliency. They had survived trauma, loss and injustice and had continued moving forward in their lives. The parents in these families were working to make connections with their children and to provide them with alternatives to despair. The children in these families were working to explore, to learn and to understand how to proceed even after difficult and painful events in their lives.

Many of these skills of resiliency became invisible when children were seen in emergency rooms, admitted to inpatient hospitalisations, or when viewed through standard assessment protocols. During these moments, children were not seen as acting in opposition to unfairness or oppression in their lives, were not seen as working to survive or hold onto hope, but instead were viewed as pathological and unsafe.

Traditional crisis literature posits that assessments are neutral, information gathering tools (Eaton & Roberts 2002). As social workers interested in post-structuralism and narrative ideas, we believed differently; that our actions, including our assessments and interventions, had profound effects on the lives of the children with whom we were working. More particularly, we believed that our assessments were having unintended negative effects on children. These negative effects included minimising skills of resiliency, hopes and values, and the highlighting of pathology and diagnoses.

What follows is a story of our journey to generate alternative practices. We will present an anthropological lens we found helpful in rendering visible some of the unintended effects our work was having. We will propose alternative practices we believe satisfy institutional concerns about safety while attending to children's and families' preferences. Finally, we will end with some questions for therapists to consider when doing this work. We are assuming that the reader has some basic knowledge of narrative ideas and practices (Morgan 2000; White & Epston 1990; Freedman & Combs 1996; Madsen 1999).

AN ALTERNATIVE LENS

In reflecting on our work with children and families in crisis, we had been encouraged by others interested in narrative ideas to look outside psychology and social work for an alternative view. Anthropologist Victor Turner's (1974) description of 'sociocultural dramas' – public occasions where a significant crisis emerges and is resolved – radically shifted how we thought, taught, and conceptualised our work with children and families in crisis. Turner's colleague and fellow anthropologist, Barbara Myerhoff (1978), had this to say about sociocultural dramas:

> *The drama begins when a threat to collective life is perceived. Often this happens when someone in the group violates an important rule or custom. The mechanisms that operate to contain or dispel conflict fail and the difficulty spreads, drawing in more and more members until it constitutes a genuine crisis. Some mending, some action that restores order and redresses the violation is called for and this occurs … the last part, the*

conclusion, achieves an equilibrium and often is accompanied by a realignment of social relationships where dissident factions or individuals are reintegrated into the group. This final stage of the sequence is often accomplished through symbolic displays of unity or ritual performance that affirm members' widest or most basic beliefs … (these events are) *definitional-ceremonies, performances of identity, sanctified to the level of myth.* (Myerhoff 1978, pp.31-32.)

We believe that the kinds of crises Turner was describing, while not intended to describe psychiatric crisis work, can be a powerful aid in understanding what children, families and providers experience during a psychiatric crisis. Consider the four stages outlined by Turner:

1. Threat
2. Spreading Crisis
3. Mending
4. Realignment/definitional ceremony[1]

1) THREAT

Threat in a child psychiatric setting is understood as originating from the child. These threats include suicidality, homicidality, self-harm, aggression that results in violence, or altered states where a child experiences voices or visions. These actions and ideas are seen as threats to the individual child and to the collective health of the family. They are often terrifying for the family and child to experience and can un-nerve professionals.

2) SPREADING CRISIS

As the crisis becomes more pronounced, more and more professional helpers are brought in. This might start with an outpatient therapist, but could grow to include an emergency evaluation done by a crisis team or an emergency room. It could further expand to include a stay at an inpatient hospital, with the expanded group of professionals there (nurses, psychiatrist, social worker, occupational therapist, mental health workers, and more). At these moments, parents and their knowledge can be disenfranchised as their children become increasingly seen as the responsibility of helping professionals.

3) MENDING

Mending in these kinds of crises typically involves psychiatric treatment. Treatment at these moments can involve an inpatient stay, medication, individual, or family counselling. It might involve isolating the child from his/her family; increased observation by professionals; or entering residential treatment.

Almost all of these mending strategies rest on the idea that professionals have a better understanding of the 'root causes' of the crisis than the family, and will generate a plan that allows the child and family to best respond to it. The degree to which a child and family follows this plan determines whether they become seen as 'co-operative' or 'resistant'.

4) REALIGNMENT/DEFINITIONAL CEREMONY

As the crisis is resolved there are a number of rituals in which identity descriptions are given to children and families. When a child has been hospitalised, this occurs when children are discharged and understood to be 'stable' with a DSM IV (APA 2000) diagnosis. This label becomes a part of how the child and family understand themselves. If this is a first encounter with the psychiatric system, a new identity as a 'mental health patient' is assigned to the child. Parents are instructed to be vigilant about following the (often professionally made) plan.

This practice particularly concerns us as the knowledge and skills of children and parents are virtually erased by these identity descriptions. Having their children defined as 'mentally ill' invites parents to separate themselves from ways of being that they had previously found helpful ('Will what I used to do work for a child with bipolar illness?') and makes children's perceptions suspect.

A COLLABORATIVE APPROACH TO CRISIS

Examining our work through Turner's lens and inspired by the work of Michael White, David Epston, Sallyann Roth, Kaethe Weingarten, William Madsen, and a host of other clinicians and theoreticians[2], we began to ask ourselves a series of questions:

- How could we work with children and families in crisis so that they experienced us as doing things *with* them in an ethic of collaboration

(White 1997) as opposed to doing things *to* them in an ethic of control (Welch 1990)?

- How could we and the people we work with move away from holding 'simple' stories of crisis (single-voiced, dichotomous, and totalising) and invite the possibility of holding richer, more complex understandings of children and their actions?
- How could we act in accordance with our belief that problems do not solely rest 'inside' of people, but are the product of history, culture and discourse?
- How could we use externalising conversations to playfully engage (Freeman, Epston & Lobovits 1997) the creativity of children, families and clinicians in moments that seem to call for serious responses?
- What kinds of identity conclusions and self-understanding do children and families leave our work with? And what options for actions – what choices – are they then able to access as a result?

The practices that follow arose from our attempts to answer some of these questions. We see these practices not as a complete description of the ways one could collaborate with children and families in crisis, but as a starting point for thinking about this work. We have used Turner's ideas about crisis as socio-cultural drama as the basis for developing a framework for our work. The four elements of this framework are:

1. Threat/Transparent orientation.
2. Spreading crisis/Expanding the preferred audience.
3. Mending/Externalising conversations.
4. Realignment and definitional ceremony/Community celebrations.

1) Threat/*Transparent orientation*

Through the lens of this framework, the moment of the crisis may look very similar to the description above – a child engaging in suicidality, homicidality or altered states. Additionally, we have come to see how these threats against the self are understood also as threats to the norms of our larger society. One thirteen-year-old young woman we worked with had this to say about her experience of that phenomenon:

> *What you do to your body should be your business, but especially when you are a 'child' that is not a right given to you. If you drink or cut yourself, or are promiscuous, that's enough to get you into a hospital … they are completely unconcerned with the happiness of your life, making me wonder half-seriously if this whole system is meant simply to preserve bodies …* (Aria Boutet 1999)

In American culture, professionals who do not take action to 'guarantee' safety are open to liability and sanction. Families are often unaware of these and other professional norms. Therefore, we have found it critical to make transparent to families and children, especially at moments of crisis, the discourses that we are subject to and the range of actions possible.

This transparent orientation we do with children and families begins as soon as possible and includes clinicians discussing how the evaluation will occur. We describe to parents, children and other people important to the family, what choices are possible, and what choices institutions and laws may constrain.

For example, one of us (PD) has begun to say to all children and families in crisis: *My name is Philip Decter, and I have been asked by the emergency department to come down and ask you a few questions about what's been going on today. Before I begin though there are a few things I want to tell you about how things work here, what questions I am going to ask you, and what I am going to do with what you tell me. I want to let you know what choices you have, and what choices you may not have. I also want to give you a chance to ask me questions about why I am asking the questions I am asking, or anything else you want to know.*

Additionally, we have learned from our work with adolescents struggling with despair, self-injury, and thoughts of suicide, that the idea that professionals are solely responsible for assuring safety can be an obstacle to understanding and working together.

A fourteen-year-old young woman named Alycia[3], *who was strongly considering suicide, told one of us (EB) upon reading the 'How we learnt that scratching is really self-abuse' article (Nosworthy &*

Lane 1996), 'They got it right – everyone always thinks they can keep me safe, but only I can keep myself safe.' This opened up conversations about ways that I had been letting fear get between us in our therapeutic relationship, and radically changed my practice with people engaged with self-injury.

Now I ask: 'How should we handle this, if fear begins to get hold of me about the idea that you might harm yourself? What should we do if it gets hold of your mom (or other family members)? How can I act in accordance with your wishes, if despair has hold of you in such a way that suicide seems your only choice? Can you tell me if I seem to be holding too much responsibility for your safety? I promise to let you know if this is putting me up against my legal or ethical responsibilities. Would that be okay?'

2) Spreading crisis/*Expanding the preferred audience*

At these moments we work to expand the audience for children and families to include more of the people they would prefer to be present. Some of these people may be able to participate in a collaborative evaluation (Madsen 1999) directly, on the telephone, or in re-membered ways (White 1997). It has been our experience that as the people in the room begin to reflect the preferences of the child and family, so the availability of local knowledge, family ideas, wisdom and solutions increases.

One of us (PD) was called to evaluate Lisa, a fourteen-year-old girl brought to the emergency room on a Saturday afternoon. She was brought to the emergency room by a cousin who had located her after she had been missing from her family's home for more than a month. The cousin was concerned that Lisa had been engaged in prostitution and using drugs, and that she was depressed and potentially suicidal. She had brought her to the emergency room for medical attention, and the nursing staff, concerned for Lisa's well-being, called the child psychiatry team to evaluate her. The threats were seen as running away from family, possibly engaging in prostitution and drug use.

I met with Lisa, who was very quiet, making little eye contact, and appearing sad. She stated that she wanted to go home, and said that she had not been taking drugs, or engaged in prostitution, but her cousin remained concerned. I was concerned that Lisa might need a 'safe space' where she could meet and talk with her family before returning home. This was influenced by a fear I had that Lisa might be at risk of running away again. I proposed a short stay on the inpatient unit as an option for her – a 'pause' before returning home. The cousin stated she was concerned about this plan and asked if she could call her mother, Lisa's aunt.

Lisa agreed to have her cousin call her aunt and before long I was meeting with Lisa, two aunts, a cousin, and an elderly grandmother. The family gathered with Lisa, asked her concerned questions, teased her, and brought her out of her quietness. I spoke with Lisa's grandmother, who gently stated: 'You seem like a nice man, and this pause idea is interesting – but this is our daughter, and we know how to care for her.' I understood at that moment that nothing would be gained from forcing a plan from my agenda, however helpful I might be trying to be, and together with the family, created a plan that allowed us all to feel Lisa could go home, to be cared for as their daughter rather than admitted as a psychiatric patient.

3) Mending/*Externalising conversations*

As our work continues at these moments of crisis, we utilise externalising conversations. Amongst other things, these conversations seek to explore: (a) any positive intentions, however obscured, that the child or family member was hoping would come of their dangerous action; (b) the potential values and commitments the child or family member held during the moments they took the dangerous action; and (c) any possible negative effects the child or family member is now finding. These conversations do not condone or endorse dangerous actions, but we work from a belief that there are always values, commitments, intentions and hoped-for purposes even in children's acts against themselves and others.

One of us (PD) met with a child in the emergency room who had taken an overdose of over-the-counter medication. During the conversation I asked her: 'What were you hoping would happen as a result of this overdose?' She looked at me quizzically. 'I was hoping I would die.' 'And what' I asked her, 'would be different then that would make such an action worthwhile to you?' She began to cry. 'I just want the fighting with my mother to

stop', she said. This conversation, witnessed by her mother, was able to help her articulate this hope, offering new options for them both.

This is when we talk to the gathered community and extended family about what they know about this particular crisis, and what they know about how it might be resolved. A primary feature of these conversations is our belief that children, families and their communities have expert knowledge about their own lives. Finding ways to elicit this knowledge can create effective plans for safety that draw on and access local resources.

One of us (EB) was referred to work with Joe, a six-year-old boy who had been admitted to the local inpatient unit after threatening to stab another child in the eye with a pencil at school. Joe was very engaging and lived with his mother, two younger sisters and his father in a small apartment next to a park. His youngest sister has severe disabilities, and his mother was struggling to care for her while also caring for Joe and his sister. The family was also living in poverty, and Joe's father had to work two jobs. Both his school and his family were concerned that Joe's 'anger' was out of control.

In our conversations, I asked Joe what he wanted to call this problem, and learned he preferred to call it 'the angries'. Following this naming, I learned that Joe was a child deeply concerned about fairness and committed to keeping the angries from harming his family, although this was difficult for him to master. He told me that at times he was so afraid the angries might harm his family that he thought he might need to run away or die.

We began to create playful ways (Freeman, Epston & Lobovits 1997) of 'disappearing' the angries, including drawing a picture of the angries chained up in a dumpster! As we did this, Joe, in a six-year-old way, began to talk about how much he loved his sister and parents, and how much he did not want to engage in violence. Over a three-month period, with many conversations between Joe and his whole family, he began to have more success against the angries both at home and school.

While I no longer see Joe for counselling, and he has struggled in the years since, I have occasionally seen him. In our last encounter, he pulled me aside and said: 'They are still in that dumpster, you know'. This stood out to me as evidence that these conversations centered on children's understanding, knowledge and abilities have considerable value, and are not easily dislodged.

4) Realignment, definitional ceremony/
Community celebrations

In taking up the call to consider therapy as a definitional ceremony (White 1995) that can have positive or negative effects, we have begun to be increasingly thoughtful about how we use the rituals of our everyday work. We plan meetings in which children and adults tell their chosen community what they are learning about themselves, what they are learning about the effects of the problem, what their hopes are for the future, and how they are moving toward that future. These community gatherings often turn into raucous celebrations (Nichols & Jacques 1995) even while discussing serious and difficult problems. We encourage families and communities to respond to what they see changing for the family, and how they can contribute to ongoing change.

Sarah's community celebration. One of us (EB) was working on an inpatient unit and met Sarah, an eighteen-year-old art student who had been admitted the evening before after attempting suicide. In our conversation, Sarah and I spoke about the effect that depression was having in her life, her fatigue with it, and the solace she found in her art. Sarah felt that understanding depression as something she has a relationship with was a radical idea for her. She had previously understood it as comprising a major part of her identity. Sarah and I wrote a letter to depression, where Sarah expressed her anger that depression had tried to take her life, which she valued.

Sarah felt that she should have her family witness this new idea about her relationship with depression and they were invited to the inpatient unit that same afternoon. Sarah and her family had a long conversation in which she shared her new understandings about depression and asked for her family's support. The family enthusiastically agreed, and shared Sarah's anger that depression might have taken her from them. Sarah went home with her family that same day with a new understanding of herself as an artist in relationship with depression, rather than as a 'suicidal patient'. I then wrote Sarah a letter, recording this

conversation, which also went into her chart at the hospital.

Joe's community celebration. At the end of our work with six-year-old Joe, described above, we asked him how he would like to let his family and community know about his successes against the 'angries'. He thought it would be important to have a party, with balloons, pizza, a cake, his family, friends and teachers. He wanted this party to be at his house. He was also clear that he wanted a trophy – a big one, recognising him for his skills in putting the 'angries' in a dumpster, and for playing basketball.

We invited his teachers, family, friends, neighbours, school counsellor and the staff of the inpatient unit, to his house for a 'Joe disappeared the angries' party. His instructions were followed to the letter, and he performed, with one of the clinicians, a skit to show his family how he had worked to 'disappear the angries'. He received a trophy, and his whole family received certificates for their contribution to his efforts and successes. His community was invited to share with him, and with each other, the efforts and successes they saw Joe making.

Our colleague, William Madsen, watching a video of one such event, commented that such ceremonies seemed more like 'anti-discharge meetings', where instead of the identity of 'patient' being confirmed, children are embraced and celebrated as members of their communities. We are particularly interested in how such ceremonies can help parents to reclaim *their* knowledge of their children as of equal or of more value than professional ideas.

CONCLUSION

Using an anthropological lens to describe psychiatric crisis work has helped us to better understand our preferences in our work with children and families in crisis. We have been able to see some of the unintended effects our work can have, and the possibility narrative practice holds for assisting us in collaborating with children who engage in dangerous acts.

These practices include: rendering visible institutional and mandated constraints on our conversations, consulting families about their preferred audiences for evaluation and assessment, engaging in externalising conversations and seeking to better understand the values and commitments that underline dangerous acts, helping families to embrace complexity, and co-creating opportunities to celebrate success.

As clinicians, we have found working from this frame has allowed us to more easily hold onto our collaboration, curiosity, and willingness to share risk at moments of crisis, while also assisting us in identifying discourses that might lead us towards practices of control. These practices not only keep us more in line with our preferred values, but also help us to keep children in their home communities rather than using costly extended hospitalisation or residential treatment. We have found that working in this manner opens up new possibilities for ourselves, for our creativity and, most importantly, for the families and children that consult us at such important times in their lives.

ANCHORING YOURSELF: AN EXERCISE TO CONSIDER YOUR RELATIONSHIP WITH CRISIS

In our crisis work, we have found that the following ideas and experiences can come between us and our best intentions:

- Crisis can try to convince us that we are solely responsible for the safety of others. This is supported by cultural ideas about professional liability. This means that we often experience fear for the children, their families and for ourselves.
- Crisis works to convince us to respond to it with urgency, seriousness and speed.
- Crisis works to convince us that we need to understand the 'truth' of a situation.
- Crisis introduces a heightened degree of pressure to 'fix' or 'solve' a dangerous situation.
- Crisis works to pull us into certainty about what needs to happen for a child or family, and leaves us vulnerable to fear if we resist these efforts.

The following exercise was originally written by Robert Kegan of Harvard University and has been adapted at various points by Jeffery Kerr and William Madsen at the Family Institute of Cambridge. It can be performed as a self-visualisation or with a group.

YOUR RELATIONSHIP WITH CRISIS

1. Imagine a moment of crisis, in your life or in your work, which has worked out well. This should be a moment where you were able to stand up to any negative effects of Crisis and prevail.

2. What did you know about yourself and your work at this moment?

3. Now, imagine a time you were involved in a crisis, in your personal life or in your work, and things did not go as you wanted them to.

4. If Crisis had a voice at this moment, what was it that Crisis was trying to convince you of about your work? What was it trying to convince you of about yourself?

5. What did Crisis try to make invisible about you or your work at this moment?

6. If you could talk back to crisis, about what you know about yourself, your abilities, how you are helpful to families, what would you say? This might be several sentences, but try to make it into one or two sentences that begin, 'Crisis, I know_____.'

CONSIDERATIONS IN CREATING COLLABORATIVE PRACTICES IN RESPONSE TO CRISIS:

Transparent orientation:

What do families need to know?

We've found it helpful to address questions we imagine children and families might be holding before we begin talking about the crisis. This orientation serves to ground the context of our work, makes institutional discourses and laws that hinder choice visible, and offers up a map of what we might do together to begin talking about the current problem.

Imagine families have asked *you* the following questions and create an introduction/orientation to yourself that answers them:

- Who are you?
- What is your role?
- What is going to happen to me (now)?
- What is going to happen to me (in the longer term?)
- What are the purposes of our meeting?
- How long is this going to take?
- Am I going to need to leave my family/child?
- Am I going to have to go to a hospital?
- Do I have to listen to what you are saying?
- Who else can participate in our conversation?
- What if I don't want to talk?
- Can I leave if I want to?
- Who else knows about what I say here?

Questions to ask families:

- What can I do that would be most helpful to you here today?
- What should we make sure that we talk about?
- What would I most appreciate about you if we met in a moment when crisis was less present?

CONSIDERATIONS IN CREATING COLLABORATIVE PRACTICES IN RESPONSE TO CRISIS:

Expanding the preferred audience:

Who should we include in this conversation?

Believing as we do that knowledge and identity are inseparable from relationships, we try to be purposeful about who clients have in the room during our conversations. When practicalities make it impossible to have particular people present, we inquire about who would be important to have in the room in re-membered ways (White 1997).

Some questions you can ask children and families to incorporate community members into the conversation:

- Is there anyone else who should be here for this conversation?
- Who else, even if it is not possible for them to join us, would you like to have here?
- Who in your life, real or imagined, alive or dead, appreciates you the most?
- Who in your life, real or imagined, alive or dead, might have ideas about what to do in this situation? What might those ideas be? What do those people know about you that would lead them to have these ideas?
- Who knows the most about you?
- What might they understand about this situation and about your abilities that I might overlook meeting you here, at this moment?

Externalising conversations:

These are conversations where we are working to understand and connect children and families to their values and preferences for living. We assume that all acts are purposeful, and that actions sometimes have unwanted effects.

Ask families and children:

- What would you call this [problem]?
- What is this [problem] doing to you? Your family? Your life?
- Is this your preference? Why or why not?
- What were you hoping would happen when you took this step?
- Why is that important to you?
- Is this how you want things to be?
- Why, or why not?
- How would you prefer things instead?
- What does it say about what is important to you that you prefer this?

Community Celebrations:

In creating celebrations, we seek to create opportunities for the ritualised performance of the identities that the child and family prefer. We work to be as creative and fun as possible in following the family's plan for these celebrations.

Ask families and children:

- What do you think is most important about this (difficulty or achievement) that you want others to understand?
- What would you like them to recognise or witness about you?
- What kind of formal recognition would you want to receive from us (professionals)?
- What kind of recognition would you want to receive from your family and community?
- Who should be invited?
- Who will be unable to be there whom we should be sure to include?
- What kinds of food or decorations should be there?

NOTES

[1] It was not and is not our intention to see these ideas as a traditional 'stage theory', with the decontexualised assumptions of universality that follow. Instead we see Turner's work as a lens to help us reconsider our own practices.

[2] In particular, we would also like to acknowledge Christiane Kolberg, Ann Rita Gjertsenm Hanna Nyvoll, Aasta Myhre and Wenche Marie Jensen's (1999) article, 'Creating conversation in times of crisis'.

[3] I (EB) would like to gratefully acknowledge the radical difference that Alycia Vivian has made to my work with adolescents regarding safety conversations, and creating safety plans.

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