An innovative and creative approach for reaching out to difficult at risk teenagers and their families using a combination of crisis containment, family intervention and story telling in a group program that has produced tremendous results.

Breaking Down the Barriers

Treatment of Adolescents at Risk of Self-Harm and Suicide

An Integrated Program of Crisis Intervention, Family Therapy and Therapeutic Storytelling Intervention (TSI)

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As his eyes became adjusted to the dimness, he realized he was not alone in this large dungeon. He gasped in amazement. The chamber was full of people sitting on benches, shoulders slumped, many with their faces in their hands. Some were moaning. Some were biting their bottom lips and wringing their hands, and a few were uncontrollable laughing, although the noise was not fun...

Everyone had given up. The boy sat up and looked from row to row. Finally, he screamed, "Let's get out of here!" No one even raised their head. "Well, I'm getting out of here!" The man next to him smiled and chuckled knowingly to himself...

The boy though, I'm still making bad choices. I'm here and I don't want to be here. This is not good for me... No, I will not give up, he thought. No way, man, no way!

(From Gem of the First Water, Ron Phillips, 1989)

Engaging and successfully treating youth at risk of suicide and self-harm has become a great challenge for mental health services throughout the world. It is recognised by many to be at a crisis level in New Zealand (cf,. Editorial New Zealand Herald Tuesday January 20 1998) with 15 to 24 year old males having the highest rate of deaths (Coggan et al 1995). The Ministry of Health is currently developing a National Youth Suicide Prevention Strategy to attempt to deal with this problem. Working with this clinical population has immense problems. It is easy for the clinician and the health system to be become despondent and feel hopeless. A positive framework for treating this group of clients has been developed through the work of Dr. Michael Rimm and Ron Phillips, and further enhanced by the team at Campbell Lodge Child and Adolescent Mental Health Service in South Auckland. South Auckland has a diverse population and an unacceptably high level of youth suicide.

This creative and successful means of treating at risk teenagers has been developed by bringing together Therapeutic Storytelling Intervention (TSI), based on the story Gem of the First Water by Ron Phillips, with a model of family therapy, crisis intervention and psychiatric approaches. It has become our adventure for finding creative alternatives for working with a difficult client group in innovative and challenging ways. This article is the story of our evolving work as we have treated this high risk group at Campbell Lodge.

Developing an Integrated Program for Suicide Intervention

With the challenge of the intense difficulties and needs of the suicidal adolescent in the South Auckland area we began to work on the development of an integrated therapeutic approach. It was clear that services in the area were not meeting the demand and the community needed a broader approach. We started with psychiatric assessment and systemic model of crisis management (as developed by Michael Rimm) combined with family therapy. The addition of Ron Phillips's Therapeutic Storytelling Intervention (TSI) added a new dimension to the work that was able to engage the 'at risk' adolescent and their families. The work of the Campbell Lodge team has enhanced, developed and implemented this into a coherent package.

Therapeutic Storytelling Intervention (TSI), used in a group program or individually, has created a means of engaging difficult and resistant teenagers who often have failed more traditional treatments. The use of this extended metaphor/story has given these teenagers a safe means to address their difficulties, which they had often not done previously.

This integrated program has had dramatic effects on working with the families where concurrent change is also needed to reinforce the changes of the teenager is making in the TSI groups and help the positive results to be sustained. TSI creates a 'window of opportunity' that gives the family in the therapeutic process some breathing space to work on their issues as the positive effects begin to work and they become empowered to maintain safety for their teenager. The family work has begun to utilise power of the story by linking the parents with the experience of the teenager.

It enables families and larger systems to make the shifts necessary to enable the teenager to be re-integrated back in the community with a safe and developmentally appropriate level of functioning. By working closely alongside a model of crisis containment and network consultation we are able to help families through the whole process. Underlying this program is a working knowledge of individual and family risk factors from the psychiatric literature on teenage suicides and self- harm that guides and directs our work.

The difficulty for the suicidal adolescent is that many of them present in crisis initially having made a suicide gesture or self-harm attempt. They are not willing clients who have defined and owned their problems. The containment and management of crisis enables these adolescents to be held and brought back into the combined TSI and family therapy process outlined above. By being able to move fluidly between the parts, we have been able to manage the seriously at-risk adolescents that would normally fail therapeutic programs in the community and are at high risk of completing suicide.

This integrated package, as three strands woven together, has demonstrated itself to be more effective than any one part of the program in isolation. We will examine the results of a clinical review that has evaluated the outcomes of this project over the last year. In the beginning this project has been developed as a result of the crisis created by the very limited resources in an over-stretched child and adolescent mental health clinic in South Auckland that has pushed us into more creative thinking and practice.

Therapeutic Storytelling Intervention - Engaging the Resistant Adolescent

The power and effectiveness of story telling has been well documented. Bruno Bettlelheim (1976) in his book The Uses of Enchantment: The Meaning and Importance of Fairy Tales explores the role that stories play in helping the child make sense of their inner unconscious struggles that may be too overwhelming to be verbalised or made conscious. As the children externalise these conflicts through the story they create a transitional space that firstly, validates and makes safe these unconscious struggles and secondly, creates a process through which these are resolved. The telling of the story by the adult enables the child to share and have affirmed the struggles they can not consciously talk about. The traditional fairy stories, such as those of the Grimm Brothers, that are still so popular today have emerged out of such a verbal tradition.

In the light of this it is not surprising that Ron Phillips found Storytelling to be a powerful intervention with adolescents, who had failed traditional approaches. He was inspired by his own experiences with Tolkien's The Hobbit and Lord of the Rings, as well as the stories of C.S. Lewis. In a similar vein he used a story format more relevant (than fairy stories) to the adolescent struggle and particularly those at risk adolescents he had worked with in twenty years of doing specialised foster care programs in California. He also discovered the fable, with it themes and images, is archetypal, not literal. It is effective cross-culturally; the boy is everybody regardless of gender, ethnic group or economic level.

Gem of the First Water follows the adventures of a boy who is angry and upset with his family and the world around him. As he is magically transported into the Land of Confusion, a fantasy world like that of Tolkien's Middle Earth, he faces many adventures that draw out the unspoken struggles of adolescents, particularly those at risk. He moves through different stages -

• confrontation with himself and his motives,

• the discovery of new behaviours and attitudes coupled with a new belief in his own self worth,

• failure and relapse and then

• success and integration.

The story invites the adolescent to join the journey of the boy. Ron found that in moving from a set of individual stories to a larger story or journey created a more powerful process that increased the overall effect more than the sum of the individual parts. The adolescent reading the story or participating in the group becomes part of the journey.

This story has connected powerfully with the struggles of the suicidal and at risk adolescent in the work of our service, both in the crisis intervention phase and ongoing treatment. It provides a safe vehicle for engagement and crisis intervention with adolescents who so frequently present unco-operative in the interview. The clinician, when stuck in a crisis assessment with seemingly no way forward, will bring out the story. By using a part of the story - like that of the dungeon scene (illustrated above) - a safe way is created to introduce dialogue to the situation in a way that does not seem to be possible.

"What in the world am I doing here Fox?" the boy asked emotionally.

"You are in the Land of Confusion," (said fox)... "It's your time. This is your destiny, boy. All kids who become adults make this journey. You either learn to stand alone or you won't. Simple as that. It will be a great adventure, my friend. You have my permission to make good decisions."

"... Your life could easily be one mixed up puzzle," (the fox continued). "This trek is your opportunity. If you think before you act and think before you speak, you'll conquer. If you continue to do these things backwards, you'll just get stuck."

K. is a 13 year old Samoan girl who was suffering from the effect of PTSD (Post Traumatic Stress Disorder) and depression. She was involuntarily admitted to an inpatient unit following her attempts to throw herself off a school building. Her family was unable to provide for her safety at that point in time. On visiting the inpatient unit she was electively mute and not making eye contact with anyone in the unit. She continued this behaviour with the clinician when he visited. He began by saying to her that he did not want her to talk, but to listen to a story. She looked up and said, "what do you want to do that for". As he began to read K lifted her eyes and began to engage. A conversation was now possible about her dilemmas and struggles.

This process provides the valuable containment needed for both the adolescent and their family with such difficulties. This process often leads to a vital shift in the adolescent's mental status needed to work towards developing safety with their caregivers. It provides both the adolescent and family with a means of externalising overwhelming feelings and struggles, giving a conceptual map in metaphorical language, of what paths they could follow to move forward.

The story works for adolescents at multiple levels. Firstly, it operates at an overt level, using many cognitive/behavioural techniques as it works to restructure the links between the actions and sense of responsibility. The influence of William Glasser's Reality Therapy (1965) on the TSI program is very clear. It is a process that gently brings the participant into an honest relationship with their motives, actions and intent and successfully challenges the young person's ingrained denial and projection. Secondly, the story works at a covert level using psychodynamic principles, speaking to the underlying unconscious processes. It reflects and works with the internal struggles that fuel the negative behaviour of at-risk adolescents. It speaks to the inner (unconscious) attitudes from which the adolescent's projections arise. The unspoken process of the story is a powerful one, which we are only just beginning to understand and articulate.

There are four processes inherent in the story telling intervention (which have been adapted and modified from the introduction in Gem of the First Water).

• Externalisation. As the boy in the story is magically transported from the real world into the land of confusion, the listener is taken with him into the fantasy of the story. The adolescent sees the boy as being like him: angry, upset and confused by the events and relationships around him. As these troubles are too dangerous to be approached directly in the real world, the story removes him or her from there and externalises it in fantasy and magic. When the conflict is too close to reality the adolescent can say to themselves outwardly that "The boy is not me", while at the same time they can work with it in safe manner.

• Identification. By identifying with the boy in the story, the adolescent can compensate for all the inadequacies of him or herself. As the conflicts are validated and owned they can be identified with. "I am like the boy and I can feel like that as well. I can struggle with these troubles in this way."

• Internalisation. As the conflicts are validated and made safe in the story, the boy through the story can be internalised. "These are my struggles which I can resolve too". These are taken in at both overt and covert levels.

• Transformation. Achieving integration and taking control of one's life. This is the process where by the adolescent is able to experiment with the new behaviours in the outside world. They can own their feeling and intentions.

TSI is used either individually or in a group program. The story is read by the clinician over a period of 16 to 20 sessions. Discussion about the story follow which begins to link the story to the individual's own life. No one is required to answer a question (they are allowed to pass), though it is requested that they answer honestly. Questions and discussion, following the telling of the story, begin to connect the experience of the adolescent with the story and challenge them to work with the principles in their lives. The ability of the clinician to embody the power of the story, and bring it alive in the process of telling, is one that engages the adolescent. As we are able to safely contain the strong feelings that the 'at risk' adolescent generates in the group, this gives them the safety to enter the journey with us. The power of peer feedback in the group is also a powerful process that greatly assists change.

One of the challenges of working with the "at-risk" suicidal adolescent is that they often lack a language or form to communicate their experiences to others. The TSI process creates a language which becomes a safe, TSI is used either individually or in a group program. The story is read by the clinician over a period of 16 to 20 sessions. Discussion about the story follow which begins to link the story to the individual's own life. No one is required to answer a question (they are allowed to pass), though it is requested that they answer honestly. Questions and discussion, following the telling of the story, begin to connect the experience of the adolescent with the story and challenge them to work with the principles in their lives. The ability of the clinician to embody the power of the story, and bring it alive in the process of telling, is one that engages the adolescent. As we are able to safely contain the strong feelings that the 'at risk' adolescent generates in the group, this gives them the safety to enter the journey with us. The power of peer feedback in the group is also a powerful process that greatly assists change. One of the challenges of working with the "at-risk" suicidal adolescent is that they often lack a language or form to communicate their experiences to others. The TSI process creates a language which becomes a safe, shared domain between the therapist and the adolescent, and then the family and adolescent. In the group, the story provides a safe means of exploring the adolescent's difficulties. They can start talking about the boy "out there" in the Land of Confusion and this makes it easy to begin exploring their own

difficulties. The adolescent is engaged. The silent responses that often characterise such adolescents have been broken through. Vicariously, through the story, the group is able to share the commonality of their experiences, validating the struggles they all share together. No longer is the suicidal adolescent alone in their internal trauma. The family can now be engaged with the adolescent and their own risk to themselves is reduced.

The Family and The Adolescent Suicide Crisis

The study of mental disorders began as a study of individuals, and only gradually did it become the study of individuals in the social environment. As a result of this approach, it has become increasingly apparent that the mental health - or ill health of each member is inextricably bound up with that of other members, influencing it and being influenced by it both favourably and unfavourably. (Aspects of Family Mental Health in Europe WHO 1965 quoted in The Family in Clinical Psychiatry, Bloch et al, 1994)

The adolescent in crisis is not primarily about the individual's mental state (though this dimension is also critical to assess). It is mainly about a breakdown in the caregivers' capacity to contain and manage of difficulties they are facing. As Leenaars et al (1995) suggests "the family system and its functioning is a central factor associated with suicide and suicidal behaviour" (p.63). One of the key tenants of our approach is that an individual's behaviour is understood within their developmental and social context (Minuchin, 1974). The primary context for the adolescent, but not the sole one, is their family relationships and the network of significant others. The family is required to give cohesion, stability and structure to its members, as well as flexibility and opportunities for developmentally appropriate change for its members. This gives coherence and containment to individuals that enables them to negotiate the changes and difficulties they are facing in their lives, both developmental and situational.

At each developmental stage, the family finds an "equilibrium" within itself. This is a balance, firstly, between flexibility and cohesion and, secondly, between the different roles, rules, boundaries and processes that enable the family to maintain the structures functional to the members for their particular stage of development. Regular and familiar patterns of interacting are formed that become the modus operandi or family map in which behaviours are manifested across different contexts.

External and internal factors create a pressure for change. If the family process is not able to adapt to the change of one or more of it members, then the pressure becomes intolerable and family patterns may become more rigid in an attempt to avoid change. The failure of the family, and the network of relationships, to adjust to both the developmental and situational challenges can result in the development of a symptom or crisis. As Joselevich (1988) states:

"Crises are felt by family members as periods of intense instability and impending change because of loss of the previous relational patterns and the lack of new ones to replace them.... A system (in crisis is) in an unstable situation, in the process of transition between order and disorder." (p. 274)

The adolescent's crisis (i.e. suicide or self-harm) is firstly, a symptom of a larger system (family) crisis and secondly, a symptom that both the adolescent's and family's threshold of

coping has been reached. An adolescent with severe risk factors for suicide indicates just how unbalanced this process can become. The crisis situation usually brings forth a re-enactment of the family regular and familiar patterns of interacting. The family's dynamics are often exaggerated by the crisis, which in turn exacerbates the very problems that they need to solve. This becomes part of the cycle of events perpetuating the problems and becoming a self-reinforcing pattern that can exist separately from the original etiological factors. Even when the original causal factors subside the problem will still continue under it own steam.

Assessment and Management of the Suicide Crisis

The information required during the assessment focuses on clarifying the presence of known risk factors (i.e. prior attempt, psychiatric disorders, substance abuse etc) and clarifying roles in order to account for reduction of risk factors. According to the DSM IV guidelines a psychiatric disorder is a "multi-axial" phenomenon that requires a multi-level assessment, including psychosocial (familial) factors and the Global Assessment of Functioning Scale. As the presence of a psychiatric disorder is a known risk factor, specific treatments (i.e. medication and psycho-education) are a common part of our work. Treating only the psychiatric disorder is not enough.

Safety is ensured, not only by assessing their individual symptoms, but also through understanding them in the context of the family's capacity to manage and contain them. The family is empowered to re-organise their roles, task and responsibilities towards each other. Seriously "at-risk" adolescents can be managed with the support of an adequate functioning network of significant others and/or family. Where the family is overwhelmed they may need additional respite help at this point. Caution is needed however as isolation and loss of family coherence work against the family's capacity to perform in the manner needed to meet the demand of the crisis, and probably adds to increased risk of self injury and suicide.

Using concepts and techniques from a variety of family therapy approaches, we work towards enabling the family and the significant network around the adolescent to contain and manage the crisis. This is part of a re-organising process to help the family develop a new modus operandi to deal with new challenges. In the relative safety of the clinic, the family can begin to "step back" from the crisis and begin to formulate new ways of helping change the situation. Both support and challenge is needed here. They will need to be supported to deal with many of the overwhelming feelings that the suicide crisis has created. However, this is not enough and may inadvertently support the family to continue the same structures, roles and processes that underlie the current difficulties. This would still leave the adolescent at risk. The family needs to be gently, but firmly, challenged to re-organise their processes in order to keep the adolescent safe.

For example: J (age 15) had taken an overdose, which had resulted in her admission to hospital. Both parents, who were separated, had attended the initial interview. The tension in the room was almost overwhelming as the parents sat in stony silence. J was the one person who was able to mediate between the parents and felt torn apart by the accusations that each parent directed at the other, sometimes with J as the messenger. It only took a few minutes for this to be re-enacted in the interview room. The clinician called "time out" to the parents as they could hardly stop arguing. Using the seriousness of the recent crisis, both parents were given responsibility by the clinician for not involving J in their parental conflict. Follow

up sessions focused on working with "ring fencing" the parental subsystem and their marital separation problems away from J. This defined and gave each parent a role 'as a joint parent' for J.

The crisis process can be the leverage for the family to change and the family may then take a leap to a new form of functioning by creating the new roles and structures necessary to accommodate to the new context or developmental stage. They can begin to work towards new patterns of interacting and the family map is changed. It is essential to understand such processes in order to begin developing a plan for risk management and effective intervention. The experience of parents having nearly lost their loved child is powerful one and can open up possibilities for painful self-examination and restructuring of the "family map" that would not usually occur otherwise.

The initial stage is to join with the family and adolescent to define and frame the nature of the crisis and different people's perception of it. Information is gained on the individual and the recent suicide attempt. This behaviour is a powerful form of communication to signal their distress, because they have not been able articulate it. The risk factors for the individual are considered, which includes the seriousness of the attempt, intent, lethality, built in rescue etc. The frame is widened to examine the contextual/relational aspect of the distress that the attempt represents. The risk factors for the family are also considered, which may include how seriously they have taken the event, their ability to give specific structure and limits to the adolescent and the level of emotional connectedness etc. The crisis provides a powerful process to engage families in ongoing work needed to effectively move beyond an ongoing crisis mode into more functional behaviour. Many of these families would not present for therapy in their own right.

We work towards assessing the family dynamics. This is about finding out about the roles, responsibilities and tasks of each family member or person in the significant network. This is gathered in two ways. Firstly, we examine content information, which is what the family describes to us. Secondly, we take in the process information, which is how the relationships and roles are re-created or displayed in the assessment. Where there is significant discrepancy between the two, we become more concerned about the level of risk for the adolescent. Some of the areas we consider, but not exclusively, are:

• ability of the family to respond (give cohesion and structure) to the adolescent;

• relationship binds and difficulties that the adolescent is caught in;

• blurred roles and boundaries within the family functioning;

• role of past traumas and problems on family functioning;

• the effect of the current suicide event in either paralyzing the family from using its own coping resources or how the crisis may exaggerate the usual pattern of interacting and acting.

Case Example - The boy who did not care about himself

V was a 15 year old boy who was brought in with grave concerns because he just did not care about anything, particularly himself. His recent history was one of being out of control where he would be off running to the streets, into small time offending, tagging and drug use for prolonged periods of time. He left his parents messages such as "you won't see me ever again", "I don't care about living, I don't care about life, nothing matters to me anymore".

It was clear that V was a teenager with significant risk factors for suicide or serious self-harm. He was a "shut down kid" at his initial assessment. He would not speak, answering questions only now and again and then only mono-syllabically. He sat slumped in his chair, not responding to anyone, including his parents as they voiced their fears and concerns for him. He spoke with a negative attitude saying "you cannot touch this, you cannot touch me", "this won't do any good" and "I don't want to be here, I'd rather do time if I get caught". He went on to say, "regardless of how much energy and time you spent, this isn't going to make any difference to my life."

His despair was compounded by the fact that he had a loving caring family. They had come to feel hopeless and helpless. V recognised that he was letting them down. The more he felt this the more he acted out, and the more he acted out the more he felt that he was letting his parents down. This had set up a self-reinforcing negative cycle that continued to unintentionally exacerbate the problems both directions.

V clearly needed stronger containment in order to break the cycle. The CAT (Crisis Assessment and Treatment) team was used to provide input through the support of a psychiatric nurse in the home to help the family maintain the safety, care and protection needed for their son. The situation was at total breaking point. His parents were worn out from his behaviours, but they wanted him maintained at home in the family, rather than in hospital or in foster care. This respite was effective and managed to contain his behaviours for a short while. While this was being managed the therapists introduced V and his parents to the TSI program and begin concurrent family work. Initially, like most adolescents he was skeptical and needed some encouragement to give it a try, which he did.

The materials in the TSI program provided a safe and common space for dialogue which had previously broken down. As V and his family entered the "Land of Confusion" in the story, they found together the opportunity to externalise his (and their) difficulties and discover a safe language for communication again. V had missed a substantial amount of schooling through his problems and was not a strong or confident reader. He was soon engaged in the group, where the story was told. He began to get interested for himself, wanting to read more of the Gem himself and to look to his parents for support and guidance. V clearly enjoyed each session, remembering exactly where the last session had left off and reminding the therapists where to begin the next adventure. He took on the principles and personalised them, making them his own.

Concurrent family work used structural and systemic family therapy interventions. It became apparent that there were significant stresses between the parents. As V experienced these stresses, he would take off to the streets or act out, thereby focusing their energy onto him and away from themselves. His problems seemed to serve a function or purpose for the family. As these stresses between the parents were being dealt with V's situation began to change.

V. went from being a street-wise kid to the boy his parents said they recognised again. He became more caring of himself and of others around him. He developed a sense of self worth and showed it in his day to day life. No longer was he attending sessions with his baseball cap over his eyes. He began to open up in many ways, in his presentation to others physically and emotionally. His need to abscond and the continual running away ceased. He found himself an apprenticeship with a plumber on paid working experience. This contrasted to his initial statement where he said he believed he would drop out of school and amount to nothing, as he could not deal authority or the academic work.

Just prior to writing V had a relapse where he began to slide back again, but not nearly as seriously as before. For example, V was no longer considered a suicide risk. The parents quickly returned for some extra sessions. The Gem again provided a means of working on these difficulties, which enabled his quick recovery and reconnection to his family. The parents again continued to work on their stresses. V's life had begun to turn around and his family was able to respond more effectively.

This work has it ups and downs. The process is rarely smooth yet we have seen significant results in many of the families we work with. Through our plans for ongoing research we intend to put this claim to closer scrutiny.

We then develop both individual and family/systemic formulations to form the basis for ongoing intervention. This goes beyond a description of the individual symptoms to an understand of the relationship of the symptom with the family functioning. This will involve both psychiatric and therapeutic dimensions for providing a basis to develop a plan of action for the crisis intervention.

We work with the family in developing a safety plan. Depending on the level of risk, the family are required to supervise the adolescent, often 24 hours a day, until both we and the carers are satisfied the adolescent is now safe. Often family members need to be empowered to take charge in the development of this safety plan. For one reason or another, they have often lost their ability or position to act in the way they used to know. The family needs the clinician, and often other supports, to convince them that they can, in fact, shift their roles to maintain safety, even if they themselves feel out of control. This creates a powerful message for the adolescent, giving a feeling of safety and control.

The development of a safety plan with the family can become a prime space for helping (or challenging) the family to re-structure or re-organise itself. This is more than just containment - the subtleties of such work are critical. It is not as easy as it sounds as parents are often required to challenge old patterns that have become their modus operandi. This crisis may shock the family into being prepared to try alternative patterns of relating which may have been too alien previously. The crisis intervention is often the beginning of an important process of treatment. It can open up possibilities that are more acceptable to explore under the stress of the crisis and may be more difficult to begin engaging with once planned ongoing treatment has begun.