Crisis and Connection

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Abstract

Psychiatric interventions for crisis care lie at the center of the conflict between forced treatment and recovery/wellness systems in mental health services. Though crisis can mean completely different things to people who have the experience, the general public has been taught a unilateral fear response based on media representation. More and more this has led to social control but is erroneously still called treatment This does nothing to help the person and in fact further confuses people already trying to make meaning of their experience.

This paper offers a fundamental change in understanding and working with psychiatric crises. Rather than objectifying and naming the crisis experience in relation to the construct of illness, people can begin to explore the subjective experience of the person in crisis while offering their own subjective reality to the relationship. Out of this shared dynamic in which a greater sense of trust is built, the crisis can be an opportunity to create new meaning, and offer people mutually respectful relationships in which extreme emotional distress no longer has to be pathologized. The authors, who have had personal experience with psychiatric crises, have provided this kind of successful crisis counseling and planning and have designed and implemented peer support alternatives to psychiatric hospitalizations that support this model.

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Sarah had been a recipient of mental health services for most of her life. She had been diagnosed with bipolar disorder and because of her history she was told to expect periodic episodes of mania. She was so accustomed to this schedule that she virtually prepared herself for hospitalization every year. This year, at the beginning of August, she came to the local peer center. She described not sleeping, racing thoughts, images of death and blood, and an urgency about running into the woods with a knife. Rather than calling her case manager I talked with her about having often felt like this as well and told her how terrified I had been. We talked a lot about our images of death and blood and shared related experiences. We both talked about histories of past violence. She finally told me the story of an August where she had been kidnapped, held in an outhouse, and repeatedly raped. When she had finally been released she ran through the woods for a long time, not knowing where she was or what she should do. Many years later, just before August, when she finally brought it up to her case manager, she was told to put the past behind her. That's exactly what she did, always one step behind her. Out of her sight but not out of her experience.

The day we met we put both our pasts into the 'conversation.' We shared strategies and ideas. Mostly we built a relationship that was not based on assessment but rather on shared truths and mutual empathy. Each year since then Sarah has asked people to "wrap around" her in August. She talks to people and they talk to her. Her experience is not named, it is witnessed. She no longer has delusions, she has strong feelings. She doesn't see herself as out of control but rather in great pain. This pain now has meaning for her. It is her history and her experience and she has begun to transform it. She now helps others develop plans and strategies to move through crises differently or even to prevent them all together.

Mutual relationships have generally been extremely helpful in allowing people to reconstruct and rename their experiences and take control of their own recovery from mental illness (Mead et. al 2001). People are able to share their stories with each other and challenge the extent to which their "learned" stories have been based on social constructs or imposed "truthes" (Mead & Hilton, 2001). Rather than either person analyzing or assessing the meaning of the other's story, both people are engaged in a mutually enriching dialogue. From genuine connections with others, old patterns can be revealed and what previously felt out of control for one person is now part of the conversation (Evans & Kearny, 1996). When old patterns do arise both people can support each other's changes. Both people can offer perspective when either one seems stuck and each can offer support in a way that allows for mutual growth, shared risks, and an opportunity for mutual empathy and a deepening relationship. Through re-telling and sharing stories in community (as in peer support programs), people can begin to challenge the dominant discourse, come up with new language and finally create environments that offer supports for people without the more restrictive use of emergency based services.

Peer support programs have been at the cutting edge of exploring new practices. They are grounded in the knowledge that neither person is the expert, that mutually supportive relationships provide necessary connection, and that new contexts offer new ways of making meaning. Peer communities have demonstrated again and again that challenging traditional practices leads to personal, relational and cultural transformation as will be exemplified throughout this paper. This way of being with people can offer the field of mental health new ways of thinking about responses to crisis, both pro-actively and reactively.

Throughout this paper we will offer personal experiences we've had that model some of these changing practices. We will demonstrate that peer support is at the heart of new trends emerging in crisis interventions. More specifically, the paper will first focus on the importance of proactive planning, second, a new 'reactive' response to crisis and finally, some recommendations for evaluation and research.

Crisis Planning

Proactive planning is best in all circumstances. When people are allowed the time and the non-judgmental atmosphere to talk about the things they have been through, they can often begin to identify some of the things that helped them learn and grow from particular situations and they can also begin to identify the things that have kept them stuck in old patterns and old ways of relating to people. Crisis planning should be an interactive process. In this process the goal is for two people to try to understand how the other has learned to make meaning of their experience. In that, it is useful to ask questions that might lead to a new perspective for both people. Rather than the typical compliance and risk assessment kinds of questions for example, people might explore how they think others would describe their crisis (Pearce, 1998). This vantage point allows people to step outside of the traditional rhetoric and observe themselves "being" in crisis. Rather than assuming that symptom language has the same meaning for everyone, it is useful to think about what clinical terms mean for both people, or to stay away from pathology language altogether. Sharing similar experiences also helps to break down people's sense of isolation and supports the conversation towards moving past traditional constraints (guessing what to say to get what you need but not saying too much so you don't get locked up). Without this dialogic process, and this struggle to deeply understand the other person's lived experience, two people fall into the traditional rhetoric of illness and treatment (Bentz, 1989; White, 1990).

It was cathartic when I (S.M.) was able to tell a peer about my experience with cutting (a process I was tremendously ashamed of and secretive about). Instead of labeling it the other person said she had gone through similar kinds of things and had found ways to learn from it and consequently was able to express her pain differently. For the first time, I felt some hope. I felt like less of a "crazy person" with bizarre behaviors, and more able to think about gaining new resources toward change. It also allowed me to think about pain in a language that had a relationship to my past history of violence rather than pain as symptomatic. Over time this knowledge has led me to understand contextually some of the difficult experiences I've had. It has also supported my ability to be in relationship through crisis without falling into the patient role.

It is also relevant to set up some guidelines about how the relationship will work in this interactive interview process. These guidelines are useful to minimize power issues can be minimized (Ellis et al, in Hertz, 1997) and to ensure safety for both people. When people set up plans that are respectful of the relationship, difficult times (even when there are incongruent realities) can be negotiated. For example one person might see him/herself as entirely incapable of controlling their behavior when they're having a difficult time and the other person might remind her that it's hard to stay with someone if she's scaring you to death. Both people, talking from their experiences, can come up with some ideas about strategies they will **both** use to maintain the safety of the relationship and use it as a guideline if difficulties should arise. As trust builds in the relationship and both people feel valued, new ways of thinking and doing become possible.

This was exemplified when a young man who had a long history of hospitalizations around psychotic experiences wanted to get through these times without being in the hospital and without increasing his medication. During his interview, we talked in detail about the kinds of things we both were willing to sit with and what might feel intolerable. He was also studying eco-psychology and wanted to use our respite program as a structure for thinking about psychosis from that perspective. The unfortunate time did come when he needed to use the program. His doctor advised him that taking the risk of not increasing his meds might lead to involuntary treatment and he was told that he was much too vulnerable to be going through this with his "peers." In spite of this advice, my friend did use the respite program. He stayed up for 4 days straight talking to his peers; each person sharing their own similar experiences and unique perspectives. He and his peers also worked with the guidelines from his crisis plan so that they could remind each other of sharing in the responsibility. No one was afraid of "bizarre behaviors," or strange ways of thinking and no one told him what it meant. After nine days of respite (with several days just catching up on sleep) he left respite…without increasing his medications and without forced treatment. In fact he went back to school and wrote about his experience. Some of the things he said were very interesting. For instance, he (Crocker, 1998) wrote,

It was really terrific being with all different people who knew me in different ways and who all had their own versions of these kinds of experiences. Through all these conversations I could take the things that were important to me and throw out the rest as just "crazy" thinking. As I learn more about what happens for me and the kinds of things that feel important I can begin to understand what kinds of events might contribute to these situations and what kinds of things might help me take a different path.

He also stressed on another issue that is so important but overlooked in traditional care. He wrote,

What was really great was having had all these intense conversations, I could stay in touch with people and continue to work through some of the conversations. I could learn from some of the things they had each experienced and I could also be a new valued support person in their lives when they were struggling because we'd built up such reciprocally trusting and empathic relationships

Crisis Without a Plan

What happens when people are already in crisis? Here, engagement takes on an urgent need to interact in a way that helps people feel safe, connected, comfortable, and in the company of people who understand what is happening to them, but who may not be in

the same reality. In the absence of a pre-crisis negotiated plan, this supports the establishment of mutually responsible and respectful relationships that will be crucial to the ability for people to accept help or even engage in relationship. This process must:

- Be respectful of the "story" being told. Maintain non-judgment and listen deeply for themes that might allow for a mutually enlightening conversation.
- Maintain awareness of where fear/discomfort tends to push either person into power and control issues.
- Negotiate ways of being with the person to work towards safety for all (safety: feeling comfortable, supported and connected enough to get through emotionally charged experience).
- Make room the development of a new "shared" story. Build a relationship where the processes of both people contribute to a richer understanding of the experience without either person imposing their meaning. Create new ways of understanding (for both people) that leads to the development of a more trusting relationship and offers the opportunity to use the crisis as a growth experience.

When people experience states of extreme emotional distress, regardless of cause, attempts to negotiate and engage are strained by the tear in usual use of language and communication (Pearce, Littlejohn, 1998). Understanding that crisis events are full blown flights of fright, no matter what the presenting story may be, grounds the supporters in understanding that the first priority is to help the person feel welcome, safe and heard. Contradiction, challenge or refutation build unhelpful power dynamics, and create relationships that are embedded in pathology and lead to secrecy and control. Rather, it becomes essential in the early stages of engagement to allow a person to talk about their perception of the experience in as much detail as is necessary without having it labeled, assessed, or interpreted. Loren Mosher, from the Soteria project (Mosher in Warner, 1995) describes this not as a "treatment or a cure but rather a phenomenologic approach, attempting to understand the psychotic person's experience and one's reaction to it, without judging, labeling, derogating or invalidating it" (pg.113).

 At the same time the support person is listening deeply, she/he must be willing to be engaged in critical self-reflection and notice the extent to which they really understand vs. interpreting or reacting. If the two people are unfamiliar with each other and their first interaction occurs when one is in crisis, it is crucial to build the basis for a relationship that doesn't foster old dynamics. Traditionally with 'expert/ patient' roles, both people end up stuck. The person in crisis may either feel alienated or dependent and the support person finds that they are no longer present but that their "skills" and book learning have taken over. The process of *stepping in* while *stepping back* is at the core of building new responses to crisis. It provides an opportunity to mutually explore the "essence" of the experience relationally while creating the groundwork for a meaningful relationship oriented towards the learning and growing of both people (Jordan, 1992).

An example of this occurred at an inpatient setting with a friend of mine who was working as a mental health worker. Over the course of a week, one of the patients had become more and more distressed over the light from the smoke detector in his room. He

told the staff that it was an FBI microphone and that he needed to swallow all his pills in order to "keep from talking." When he was relatively calm the staff would remind him that this was just a paranoid delusion. If he became agitated they would increase his medications and if they became frightened that he might overdose, they removed him from his room and put him in seclusion. These reactions only served to disconnect the man from everyone on the unit. The longer he was there, the more his stress increased. Finally, he was screaming much of the time about the fact that the red light was really from a space ship that wanted to carry him away. He was terrified and no matter how much medication he was given, his fear would not abate. Finally my friend had a shift on the unit. She'd been "briefed" about the gentleman and was clearly discouraged by the other staff from engaging with him. The staff, in fact, joked with her about the space ship and referred to him as "the alien." Though my friend wanted to "do" the right thing as a new junior staff member she was also keenly aware of what it was like to be invalidated and labeled. She had had her own experience with this kind of fear and knew that having her experience discounted had been damaging. When she finally got a chance to go in and visit the gentlemen, he was seriously distressed. He screamed at her to watch out for the space ship while virtually in tears from his terror. She sat with him; aware of her own discomfort but listened deeply and calmly and asked him questions about his experience. As he talked and was validated for his feelings, he began to calm down. He went on to explain that the light from the spaceship (or FBI microphone) made him feel unsafe. My friend offered a story of her own in which people had not listened to her and instead had named her fears as an over-reaction. Finally she suggested that together they cover up the light. He enthusiastically agreed. No increase in medications, no particular evaluation, but the beginning of a relationship in which negotiation and respect would frame their mutual progress. Bringing a sense of who you are to the relationship provides the other person with the sense that they are not in this alone. Building this mutuality and connection is the single most important aspect of fostering healing relationships. Judith Jordan (1992) writes, "when people feel the sense of safety that true validation elicits, they are able to make a connection with the support person that allows both people to impact the direction of the crisis (pg.9)."

Fear, Discomfort and Power

Implicit in our culture is the message that we should constantly move away from discomfort. We drug strong feelings, we try to "calm people down," and we only feel competent if we "make someone feel better." We are not a culture that has any tolerance for pain, difficult feelings or unusual affective expressions. In that, discomfort tends to compel us to eliminate difference, pull people into our worldview and see things as normal only when we ourselves are once again comfortable. A very common example is what happens in a public place when someone is acting "differently." People go out of their way to stay far away, ignore the situation or even call someone in authority to take care of it. This really hit home with me in the grocery store several years ago. A man was wandering up and down an isle, clearly talking to himself in a rather emphatic way. He seemed to be upset, but not violent. People avoided the aisle he was in like the plague. The whole tone in the store was tense. You could almost see people taking their children far away so as not to provoke any questions and you could guess that someone was already thinking about calling the police. Finally, I went up to the man and said that he

looked very upset. I asked what was wrong and if there was anything I could do. I also mentioned to him that I had had trouble in grocery stores. He started crying and said he didn't know what to do. He said that he needed to get out but didn't know how. I helped him find the door and locate his bicycle. Though I'm not sure where he went from there or what the outcome was, he thanked me and told me that he appreciated my concern. Although I couldn't help but worry, I could feel the connection that a simple act of caring elicited.

Although most support people don't go into a crisis situation determined to control the other person, their own sense of discomfort may make them become overly directive and controlling, driving the direction of the interactions while building a power-imbalanced framework for future interactions. At its worst crisis response is controlled by a fear of liability. Support workers may be more concerned with a lawsuit (or reprimands from a supervisor) than thinking about how to build a mutually enhancing relationship. Even when in good faith the person in distress is told that some treatment is "for their own good," or is asked to sign a safety contract, they are no longer part of the dialogue. They are seen as a walking liability and may even begin to see themselves as out of control, or they may disconnect completely. When relationships are entirely built on assessment of risk, they are by nature controlling and disempowering (White, 1995). It is crucial that support people maintain a rigorous self-awareness of their own need to "fix it," "do it right," or unilaterally determine the outcome. It is also crucial that the support person maintain an awareness of the inherent power dynamics in a helping relationship. Whether subtle or explicit, power dynamics create an imbalance and drive the direction of the experience while setting the stage for future power imbalanced interactions.

Safety and Risk

Clearly suicide or homicide are the ultimate risk and not surprisingly, events that evoke a sense of powerlessness and fear. I have found through years of training both peer support workers and professionals that, no matter how much people promote choice, that when it comes to the topic of suicide (even if they are just stated feelings) people tend to withdraw from the dialogue and start to analyze everything. Now when the person in crisis says she is feeling worthless and tired of it all, she is seen as being in imminent danger. When feelings are all seen through the lens of risk the support person screens her own comments fearing that the "wrong" thing will trigger a suicide response.   Whether there is a subtle shift in the power or whether someone is involuntarily committed, fear has driven the outcome. The relationship is no longer mutual and the possibilities for making new meaning of the experience are halted.

One of the more subtle ways of taking power is the use of the "safety contract." These documents are often mandated when a person talks about feeling suicidal or like hurting themselves but give the "impression" that there is still negotiation in the relationship. This author would argue that the document is really a means of controlling the support person's discomfort with the conversation. In other words, "I can't really engage with you unless you sign on the dotted line." To that end, the language of safety has strayed far from its intended meaning (feeling accepted and validated) and has turned into risk

management. The outcome, once again, becomes prescriptive and controlled by the support person, leaving the person with the concerns feeling unsure that she is capable of making good decisions. In spite of the fact that most people have felt suicidal (at least at one point in their lives), in the context of a "helping" relationship, talking about these feelings continues to be taboo. Interestingly, most people in the mental health system, having extreme histories of trauma and abuse find that suicidal feelings are congruent with the messages they received as children "(You should be dead." "You never should have been born, "I'll kill you if you tell," etc.). They have become a patterned, coping response to feeling out of control or powerless. Signing a safety contract rather than talking about the painful feelings is just another way of generating powerlessness.

Many years ago I called a crisis hotline. I was feeling really horrible, had moved into my patterned response of wanting to cut and wondered how bad it would be if my life just ended now. I'd had a hard time driving home and had lost my way, only getting home to remember that my children were due to arrive in a couple of hours. I had called the local hotline to do some venting so that I would be in better shape when my children arrived. Not knowing the crisis worker, I was careful with my choice of words but it wasn't long before she started the standard suicide risk protocol. Do you feel safe? Are you thinking about suicide, do you have a plan? I said that I always had suicidal feelings and that I was calling so that I wouldn't keep obsessing with thoughts of self-harm. The hotline worker never even asked what was going on in my life. Never bothered to find out that I was in a heated custody battle, that my psychiatric records were being used as a threat, or that I was a full time graduate student working ½ time and single parent of three young kids. To her I was just "at risk." She asked me to contract with her around my safety. I immediately began to shrink from the conversation. I began to wonder if my feelings were more dangerous than I knew. I began to wonder if I was being naïve and this woman knew something I didn't. I agreed to contract with her knowing that she would probably call the police if I didn't and assured her that I was fine and would call her if I felt distressed later. I thanked her profusely, got off the line and fell apart. What was simmering before had turned into a full boil and I thought I might surely die. Now there was no place for the feelings to go and I became further convinced of my inabilities. She had a contract that I'm sure made her feel like she'd done a good job and I was left carrying the affect for both of us.

Rather than reaching for safety contracts we need to become more able to "sit with discomfort." I wonder for example, what would have happened if this woman had started the conversation with "what happened?" vs. "what's wrong?" or if she had been able to look for the metaphor in my urges to cut and simply "be" with my pain. I wonder how it would have been different if this woman had said that she was scared but would hang in there with me. And finally I wonder what would have happened if she crossed that ever-rigid boundary and said that she had had a similar experience and had had similar feelings. Even when people don't have shared experiences, building mutually empathic relationships is the only way that people can build a "new, shared" story.

Building Mutuality, Creating New Outcomes.

Narrative theorists (White, 1990, 1995) have used the concept of "re-storying" for many years and with much success. More than a cognitive restructuring exercise, this practice uses the framework of the relationship to negotiate new meaning for people's experiences. Considering that all of us have patterned and predictable responses to our experiences, it is only through relationship that new ways of perceiving can begin to question our historic assumptions (McNamee & Gergen, 1999). This process is most dramatic in crisis when one person is teetering between total disconnect and chaos, and yet it is the most crucial time. It is a time of potential transformation. Judith Jordan (1992) writes: "Unlike resilience, transformation suggests not just a return to a previously existing state, but movement through and beyond stress or suffering into a new and more comprehensive personal and relational integration (pg. 9)."

One of the methods of supporting a new story is the narrative approach of externalizing the problem (White 1990, 1995). Even in extreme states of emotional distress, most people find that connecting with others through a process of dialogue enables a different vantage point to the current situation and offers an opportunity to take action against the "problem" rather than being controlled by it. White (1990) offers example after example of situations in which people in crisis are asked to look at the influence of the problem on their lives right now. The dialogue is oriented towards what the support person and the person in crisis can do to not let the problem 'win' (White, 1990, p.?). From this perspective people may be able to muster the ability to separate themselves from the problem and its power over them, doing something on their own behalf, and coming out of the situation with what White (1990) refers to as a "unique outcome (p. 15)."

White (1995) also invites people to explore the meaning of the problem within a socio-political context. He writes, "the discourses of pathology make it possible for us to ignore the extent to which the problems for which people seek help are so often mired in the structures of inequality of our culture, including those pertaining to gender, race ethnicity, class, economics, age, and so on…(1995, pg. 115). This new framework allows both people to analyze the extent to which these messages affect whole populations of people and promotes an advocacy approach to the elimination of the problem rather than the traditional approach of simply analyzing and medicating the person.

This really hit home for me recently when I was asked to spend some time with a woman labeled with schizophrenia who was being threatened with involuntary treatment. As she wrung her hands and literally wailed as a reaction to the demeaning voices, I listened to the shame and guilt that was driving her "crazy." The voices were telling her that she was a horrible mother and that everyone knew it. The message was that she should kill herself before she could infect her children anymore. Furthermore, her experience in the most recent voluntary hospitalization had included daily 10 minute rounds with a team of doctors and medical students who all tried to convince her that she must accept her illness, take all the medications they prescribed (without telling her anything about the side effects) and suggested that perhaps she was too "fragile" to be a parent at this stage in her life. When she became afraid that the prescribed medications would only further infect her children, the doctor's suggested involuntary treatment with forced medication.

As I listened to her story I felt her intense pain. There is not much worse for most mothers than being threatened with the loss of their children, and there is not much more damaging than being told you are a bad parent. We began to wonder together (as I learned more of her recent experiences) how it is that single mothers who work are blamed for neglecting their children and are accused of abusing the system if they don't. We wondered how this oppressive message had been internalized and what she might do now to stand up to it. As she began to think about actions to take, I told her a story similar to her own in which staff on a psychiatric unit told me that I was in denial of my illness and that the stress of parenting was triggering my symptoms. I shared with her how it almost killed me until I realized that much of what had kept me alive and energized was being with my children. We began to cry together, about our pain, our shame and guilt AND our gift of having wonderful children. A week later she was back home and beginning to venture back out into her community with the support of myself and another single mother. The transition between hospital and getting back into life, which is considered as the most dangerous time for people in the psychiatric system (Warner, 1995), may have less to do with moving out of the "safe environment" of a hospital and more to do with negotiating both the internalized and external stigma of being labeled with a mental illness.

Creating a new, shared story involves a willingness to take risks in relationship even when we are uncomfortable with the situation. In that we must realize that we come into a situation not only with our own "stories" and our own perceptions but also with a prescribed role that tends to reinforce further imposition of meaning on the other person (e.g diagnosing or pathological interpretation) (Gergen, 1991). Finally if we can both go back and have a discussion after the crisis is over about what it was that we both learned we can develop a new "crisis" plan that will contribute to preventing future crises and offer us more opportunities to learn and grow together.

Research and Evaluation

Research in the arena of mental health has been heavily influenced by research in all the "natural" sciences. We are desperately seeking "cures" for biological defects and trying to find causal relationships between biology and "symptoms" and then "treatment" and "symptoms" Rather than thinking about multiple levels of systems (as some of the other human sciences are doing) we are looking at genetic predisposition, cognitive functioning and symptom management. As with the rest of the positivist/naturalist debate, there is little to no interest (or corresponding funding) in understanding the meaning certain actions and behaviors have to individuals, families or communities, there is no consideration to the context within which the meaning is made, and there are no indicators for changing cultural practices or beliefs (Bentz & Shapiro, 1998; Bleicher, 1982; Bray et al.2000; Denzin, 1997; Fetterman et al., 1996; Gergen, 1982; Holstein & Gubrium, 2000). Further, for many people who are subjects of the research symptom reduction is only what is visible to the outside world. What becomes hidden from the discussion is the extent to which medications leave people with virtually no feelings, a sense of numbness and more insidiously, the reinforcement of the identity of a mental patient. In other words, rather than working towards transformation and recovery our research continues to support maintenance and social control.

Among some of the methods that attempt to study change from an ecological or systemic vantage point are ethnography, hermeneutic, phenomenological, narrative and action research. I became particularly interested in ethnographic study many years ago when I read Sue Estroff's, *Making it Crazy* (1981). As opposed to the clinical research I'd read on mental illness, Estroff lived and participated in a community mental health program. Her conversations and interactions were with clinicians *and* recipients of services with the goal of understanding the mental health culture. She worked at developing a deeper understanding of the context in which relationships took place, the extent to which that context had meaning for all involved, and the difference between people's conversations when they were role dependent (e.g. clinician/recipient or recipient/recipient). Further, she was very mindful of how her relationships changed with each of the participants as there were interpretations and reinterpretations made of her role and her assumptions about the project. In this powerful example, Estroff shows us that through building an understanding of the cultural dynamics, not only was she able to engage in discussions with people about what she saw, she was able to document her own changes and perceptions about mental health treatment and outcomes.

 This kind of study has tremendous implications for evaluation of alternative crisis responses. Not only does it provide a birds eye view of mental health culture, it allows practitioners, recipients and researchers to engage in a dialogue about system's change. Recipients can reflect on how their own interpretation and consequent actions have changed in relation to their previously told "story," clinicians can reflect on their changing assumptions and practices and both can share changes they've experienced based on their new relational dynamics. This conversation offers challenges to the whole "boundaried" professional practices that have kept people locked into action/reaction responses. Finally, as these mutually responsible relationships become more normative we may find dramatic shifts in the ways in which the general public understands psychiatric crisis.

It is clear that there are tremendous advantages to practicing alternative approaches to what is labeled psychiatric crisis. Judith Jordan (1992) eloquently writes,

Joining others in mutually supporting and meaningful relationships most clearly allows us to move out of isolation and powerlessness. Energy flows back into connection, joining with others is a powerful antidote to immobilization and fragmentation. It is thus an antidote to trauma. Moreover, the ability to join with others and become mobilized can further efforts towards a more just society (Pg. 9)

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