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THE CORNER: NARRATIVE THERAPY IN CAMHS: CREATING MULTISTORIED TREATMENTS

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This article describes how clinicians are working on establishing structures that will enable research on and producing evidence for narrative family therapy with families struggling with psychiatric illnesses. The aim is to suggest ways for clinicians working in Child and Adolescent Mental Health Services (CAMHS) to implement collaborative therapies in a psychiatric setting that favors evidence-based practices. Pragmatism and the narrative theory of multistoried practices offer the means to both speak and theorize about such dilemmas and suggest practices that enable clinicians to grapple with these challenges. We hope that this article will be part of the growing inspiration for others to practice "narrative psychiatry."

FRAMING THE STORY

This article is a story about therapists in a small Child and Adolescent Mental Health Services (CAMHS) unit in Denmark who have set out on a journey towards better treatment for children with complicated or comorbid mental illness and their families. The therapists meet families who may have searched high and low for help and ways to deal with the suffering they have experienced by the various means available to them; this will have included school counselors, social workers, alternative practitioners and their medicines, and psychologists. When these families meet the CAMHS practitioners, together they are about to explore the possible pathways by which psychiatry might lead them towards more desirable yet unknown futures.

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This story could be about the way the therapists join the families on their journey, holding the torch for the family, exploring such pathways and how they accompany families through states of despair and doubt, support and strengthen their hopes, and assist them to see the potentialities. However, we have chosen to tell a very different tale: It is about the journey of the therapists themselves who, by staying in that same subjunctive mode and experiences that families go through, search for the possibility for the optimal treatment that psychiatry with all its standardization and evidence-thinking may bring about in combination with narrative therapy. We tell such a story for two reasons. First, we want to share our experience with our narrative therapist colleagues in the hope that it might inspire and increase the interest in doing narrative therapy in CAMHS venues. Second, we want to advocate for a pragmatic stance in the dialogue among narrative therapy, psychiatry, and evidence-based medicine. We believe that a pragmatic stance provides us the best platform to stand on as we investigate the consequences of bringing together in practice knowledge and ideas from psychiatry and narrative therapy.

There are so many tales that can be told about such an endeavor. Each of them positions the us/clinician in relation to the clinical material as well as to the academic and therapeutic communities. From the pragmatic platform, we can position ourselves as curious and creative thinkers guided by the multiple ideas that different ways of thinking bring about. We find this positioning more helpful when our goal is to be partners with the patients, as the philosopher Kirkegaard said: "If one is truly to succeed in leading a person to a specific place, one must first and foremost take care to find him where he is and begin there. This is the secret in the entire art of helping" (1859/1998, p. 45).

SETTING THE SCENE

Let us set the scene by introducing you to PTK, a psychotherapeutic clinic in a CAMHS center on the outskirts of Copenhagen, Denmark, that was opened in 2010. PTK offers family therapy to children, adolescents, and their families who are challenged by comorbidity or mental illness in other generations or are extraordinarily burdened. The aim is to assist the families to achieve more personal agency and alter the relationship with the psychiatric illness so that the child and the family experience themselves as more powerful/knowledgeable in regard to the illness. Our clinic engages with narrative and collaborative methods and theories in combination with psychiatric expertise ("Mental Health," 2003; "Mental Health and Families," 2008; "New Voices," 2007). We have a very specific engagement with William Madsen's collaborative family therapy (Madsen, 2007). It requires special skills to ask questions that will elicit answers about hopes, dreams, values, and preferences. By the same token, it requires special skills to ask questions that make it possible for a child to tell about psychiatric problems such as psychotic experiences and the pattern of a bipolar disorder (Angold, 2002; Hamkins, 2004;

Nylund, 2000). Last but not least, it requires special skills to treat children receiving psychotropic medicine, as do approximately 50% of the children attending PTK. The therapists at PTK are trained in all of these skills and knowledges and strive to combine them within the same therapy (Hamkins, 2010, 2013).

A SHORT NOTE ON PRAGMATISM AND SUBJUNCTIVITY

When the CAHMS clinic was opened, we would explain to people both in and outside the clinic that we acknowledged the dilemmas we faced in bringing narrative therapy, psychiatry, and evidence-based thinking together, but that we intended to solve the dilemmas in practice. With this aim, we assumed a pragmatic stance on science and knowledge, much in line with Bem and De Jong (2006, p. 9):

> In our view, science is to be evaluated from a pragmatic perspective. . . . We think that there is no need for a single, fixed ahistorical canon of scientific method. Knowledge about the world comes in many varieties, and should be evaluated pragmatically, in the light of practice.

This epistemology stems from the idea that knowledge in itself is something that is and comes to life in interaction. According to the philosopher John Dewey: "Knowing is . . . a case of specially directed activity instead of something isolated from practice. Knowing is one kind of interaction which goes on within the world" (1929, p. 163). With this as our point of departure, we began to explore the many queries and insights that arose from psychiatric standards, evidence-based medicine, narrative theory, and collaborative ideas and practices. Each was in its own way directing our newly formed service. Our guiding principle for choosing which ideas to bring to the therapy and how to go about it in practice was the conceit of putting ourselves in the place of the families who come to the clinic and in the process guessing their responses. This provided us with fruitful reflections. But considered retrospectively, perhaps the most important thing to learn from the families was their subjunctivity and pragmatism.

The subjunctive mode is the mode of doubt, hope, will, and potential. It is the mode people are often engaged in when dealing with uncertainty and possibility (Whyte, 2005). From her ethnographic studies in Uganda, Susan Whyte paid attention to the fact that for people in the midst of suffering and uncertainty, confrontation with suffering is a practical rather than an intellectual exercise. Rather than simply recognize experience by assimilating it to lasting principles, people use meaningful modes of acting on the problem (Whyte, 2005). Their focus is on what actions may bring about. Whyte obviously was engaged with suffering people in Uganda; however, much the same approach to suffering characterizes the Danish families in our CAHMS clinic. For them, psychometric measures, externalization, evaluations, and obligatory treatment plans were all actions to be

valued (or disvalued) for what they "did" to them and for the potentials towards which they seemed to point.

EVIDENCE-BASED NARRATIVE THERAPY IN PSYCHIATRY AS A CONTRADICTION IN TERMS

Before turning to our learnings, let us pause and consider the paradox of bringing ideas grounded in very different "systems of thought," e.g., science and poststructuralism, together as we do. As it is, evidence-based narrative therapy in psychiatry can indeed be a contradiction in terms, not so much because of the incongruent epistemological standpoints of psychiatry, evidence-thinking, and narrative theory, but because of conflict rife in discussions in academia as well as between therapists working within and outside of psychiatry. In short, the positivist perspective entailed in evidence-based medicine and the way and means of the perspective underlying narrative therapy clash over and again in practice (Epston, Stillman, & Erbes, 2012; Redstone, 2004, Speedy, 2004).

There have been attempts to bridge these discourses (such as Stillmann, 2010), but as it is, we are still lacking an evidence base for narrative therapy that would qualify it as "evidence" and authorize it when health service policy makers are prioritizing and choosing among treatments that should be offered families struck by mental illness. In Denmark, this division is exacerbated by the fact that psychiatry and evidence-based medicine belong to the "health sector," whereas narrative therapy is mainly practiced in the "social sector" and in private practices. Therapists in the social and the health sectors often describe themselves as having "different cultures," "different languages," and "different understandings of what is a mental illness." So different in fact that cooperation is a challenge and prejudices are rife (Johansen, Larsen, & Nielsen, 2012).

EVIDENCE-BASED NARRATIVE THERAPY IN PSYCHIATRY AS A REWARDING DIALOGUE THAT OPENS UP NEW POSSIBILITIES

In such a context, full of such enacted and re-enacted contradictions, the therapists we tell about here may indeed be at risk of being caught up in frustrating and unsolvable paradoxes (Madsen, 2007). In such circumstances, the pragmatic stance and a subjunctive mode have proven to be of considerable assistance. Whenever this paradox was felt to be too overwhelming by someone on our team, the way out appeared when someone else began to insist upon our shared hopes and aspirations for the combination of psychiatric expertise and narrative therapy. We have been discussing and searching for practical solutions and combinations of thoughts and ideas over and over again. And today, three years after the clinic was opened, we continue to do

so. We would be misleading if we gave you the impression that all our dialogues on doing evidence-based narrative therapy in psychiatry are rewarding from beginning to end. However, we insist on the basic narrative idea that curiosity and multistoried experience may bring about new possible paths towards desirable solutions (White & Epston, 1989). We have decided that narrative therapy must be our foundation and point of departure, but from this standpoint, we should be curious about any ideas and practices that can contribute to an effective collaborative treatment.

As has been pointed out in different ways by a variety of thinkers from the early pragmatic philosophers (Dewey, 1929; James, 1907) to the narrative thinkers of today (Mattingly, 1998), past experience is central to our abilities to understand and act in the present and see possible desirable goals. In line with this, our dialogues are, when they are most rewarding, filled with references to former experience, what we have learned from our families about the experience of parenting children with mental illness, as well as scientific and theoretical knowledge stemming from many sources, much in line with the proposals propounded by Madsen (2006). To offer the reader insight into our dialogues and the pragmatic practices we are developing, we will present three short examples to show (i) how we improved our collaborative work by talking about "effect," (ii) how we as a group became more proficient therapists by collectively working on and writing a manual, and (iii) how we employ narrative practices in clinical conferences. While each vignette is a story with its own point, together we hope these examples might illuminate the variety of forms that narratively based dialogues in psychiatry may take.

Talking About "Effect"

As we originally approached the question of "effect," we did it mostly to engage our group of therapists in preparations for a study of effects. However, the dialogues also made the therapists work on and improve aspects of their narrative therapy that they had formerly not paid much attention to—and that in our circumstances became particularly relevant—that of practicing transparency, with the aim of sharing expectations with the families and giving the families realistic platforms on which to stand when choosing to embark on a specific treatment. Evidence-based medicine asks important questions: It forces us to compare therapies and find means for such comparison. Provocative as standardized measurements and randomized controlled trial (RCT) designs may seem to a narrative therapist, they still are one way to look at effects across and beyond individual therapies and their internal logics. And moreover, evidence-based medicine helps us ask those questions the families are dying to ask: Will this work for us? What effects can we expect? It also insists on searching for what works for whom on a more generalized level and, furthermore, help us acknowledge that certain treatments are better than others for certain people (Carr, 2008).

Evidence-based medicine has a twin, which metaphorically has played an important role in our dialogues: shared decision making (SDM). SDM insists that

families be informed about the likely outcome of their treatment as well as potential negative effects. Evidence is required to be shared with families because they must be actively involved in decisions about which kind of treatment is best for them (Edwards & Elwyn, 2009). Up until we "met" SDM, we might have thought that it was the politicians and managing directors alone who wanted to know about evidence before deciding which kind of treatments we should offer patients in CAMHS. We increasingly accept it as a premise that patients and families will and shall be in a position to make those choices themselves; for them to do so, we need to be able to engage in a dialogue with them on known negative and positive effects. This demand for transparency forced our group of therapists to scrutinize our practices of talking outcome with families and ways of introducing the therapy itself. In some of our first sessions after meeting one another, we agreed that transparency and giving the families a real choice were in harmony with narrative practice, but for some who had been highly trained in certain traditions of psychology, it had not been common to work with transparency in the manner required by SDM.

And after all, what effects could we, with sufficient certainty, tell the families about and insist upon? In psychiatry we may strive for certainty; in narrative therapy we take the not-knowing stand and stay curious. We asked ourselves questions like: Can we be curious about the many possible changes that therapy may bring about and at the same time talk of effects with certainty? What are the consequences of not talking about effects with the families? A professional insecurity also sneaked into the dialogues: What if we did not personally have the competences necessary for creating effect? After all, it is well known that the abilities of the therapist are decisive for effect and the degree of trust that therapist and the family have in one another is one of the most significant effects of therapy (Hubble et al., 1999). Our experience working with families attacked by anorexia was brought into the dialogue. This helped us to see possible consequences of talking expectations of effect with families. When we work with these families, we tell them from the beginning that we know this treatment is effective from evidence and from our own experience as therapists. Families seem to benefit from this. As phrased by one family: "We knew we could trust you from the very first day. You were so certain that you knew what to do, so we believed you. You were the mountain we could lean on, until we ourselves became the mountain our daughter could lean on."

Consequently, we have asked ourselves: How we can make narrative therapy a mountain to lean on, while at the same time staying curious to unknown future possible outcomes? For the time being we focus on transparency and open talks regarding effects and patient choice. As a result, we have written an information pamphlet about our clinic detailing collaborative family therapy, our vision for collaboration, and what to expect if partaking in a therapy with us, i.e., better quality of life and a life where the illness has less negative effects on the child and on his or her family. We say that the effects are highly individual, and we are more than willing to detail the effects that other families have experienced when we have their consent to do so. We recommend that the child or the parents ask

us questions, and we are only too happy to provide them with suggestions for any relevant literature we know of. After having tried it, one therapist reflected that giving families a choice and a realistic idea about effects made her feel much better about offering the therapy. Another reported that it made her feel much more at ease when the family refused our therapy. In the future, after we have conducted our planned effect study, we will be able to provide families more extensive and precise information on outcome, allowing for more judicious choices on their part. By then we expect to have taken a new turn in the ongoing dialogue among ourselves. We must learn a hybridized language to talk about effect in a way that not only bridges the "language" of narrative therapy and that of evidence but also makes it possible for families to receive answers to their most pertinent questions: Will this work for us? Is this therapy in fact the best choice for us when compared to the alternatives?

Developing a Manual

As we began to create a manual of collaborative therapy for psychiatric multistressed families, we admit to having our doubts about such a project. To some of us, the very word "manual" conjured up images of professionals who behaved and asked questions in a very restricted manner, with the very vocabulary one used and the sequence of questions prescribed and packaged in the manual, allowing no room for flexibility or creativity. However, when we put the manual into action, we were to learn that not only was it possible to some degree to stay flexible, but the manual also helped the therapists to not deviate from what they know to be helpful practice for the families who have sought our assistance.

It is well known in research on psychotherapy that the specific technique of any particular school of therapy plays a small role in the outcome (Hubble et al., 1999). When we began to look more closely at the other effective factors (the common factors), we realized that many of these are based on the core approaches and core techniques that we find in collaborative practices. This led us to an important decision: We would conduct an effect study that investigated whether the very essence of narrative therapy, that is, producing knowledge in collaboration with the families, has healing effects. In order to show effect, one must, within the paradigm of evidence-based medicine, conduct a randomized controlled trial and have a manual.[1] An RCT demands a manual that is fixed and therapists who adhere to the model (Smith et al., 2006). Narrative therapy demands a therapist who is continually curious and is willing to use any new knowledge acquired in collaborating with the family (Madsen, 2007). Despite this, we decided to face the challenge and pragmatically search for a solution that would be acceptable within both traditions.

[1]The issue of finding the right psychometric measurements for this and how to administer them will be described in another paper (in progress).

We decided to create a manual based on the best knowledge on effective narrative and collaborative approaches and techniques and integrate these with the obligatory procedures, accreditation standards, and regulations of psychiatry. We gathered them, taught them, trained them, discussed them—and created a principle-based manual. The manual has a number of intended purposes. It serves as:

- A description of the commonly defined foundation on which the therapists base their work: the theories, the language, and the intentions.
- A snapshot of the knowledge and experience of the therapists.
- A source of inspiration when a therapist needs ideas as to what can be done in a therapeutic conversation.
- A checklist when a therapist needs to remember what he or she must do to meet hospital standards (not all the "ingredients" are described in this "recipe," only those that were found to be relevant for the therapeutic work).
- A tool for quality assurance and development of family therapy at the PTK Clinic.
- The practical foundation for a research project to examine the effect of collaborative family therapy.

One of the main principles in narrative therapy is that the therapists learn continuously by acquiring knowledge from the families (Redstone, 2004). This means that new knowledge must be added to the manual regularly. We therefore make use of the possibilities inherent in having a digital manual.

Our treatment has three phases: clarification of the Problem, collaborative work, and terminating phase. Each phase consists of certain "must do's" and a number of "can do's," along with any number of valuable experiences from which to draw inspiration. Hence, in our manual, each chapter has these three sections and a digital "treasure chest":

- "What and why" section: The underlying theories, ideas, and intentions of the actions mentioned below that in our opinion constitute important parts of collaborative family therapy.
- "Must" section: Actions to be taken by the therapists that must be included in all therapies. These are common requirements defined by us to ensure that what we conduct can be termed "collaborative family therapy" and at the same time meets the common guidelines of the Centre; these are the same collaborative practices whose effect we want to examine in our research project.
- "Can" section: Actions that the therapists can choose to take based on their therapeutic relevance. These actions can also become the object of research on their effect.
- Treasure chest: The digital manual has a treasure chest attached, where all therapists can store stories, videos, and verbatim quotes from families about

what was useful for them and good advice as to what they believe would be useful for future families. This section also contains more specific teaching and explanation of techniques.

The manual intends to help the therapists do what William Madsen calls disciplined improvisation: "The improvisation of accomplished jazz pianists sits on years of practicing scales that has led to the development of muscle memory. Similarly, principle-based practice is disciplined improvisation aimed at developing a rigorous practice foundation" (2011, p. 530). Our goal is that this manual will contain instructions on how to handle your instrument, how to play the scales, and how to improvise and create music. As such it is hoped that it supports rather than prohibits the playful improvisation that marks the practice of the most acknowledged narrative therapists. It is also our aim to incorporate knowledge from the "treasure chest" in the annual revision of the manual. As such, our manual will never be fixed and finished once and for all. It is a document stable enough to be a steady structure with solid principles and flexible enough to also provide for our collective development of evidence-based narrative therapy in psychiatry. We expect this will lead to continuous refinement.

The manual has become a meeting point for our discussions regarding how to provide the best practice. In the words of the therapists, it has become: (i) "A crutch for therapists new to narrative therapy," (ii) "a constant with techniques and practices to lean on, when the narrative language and thoughts appear as too distant ideals," (iii) "a structure and framework helping the therapist to stick to those practices that are 'must do's,'" and (iv) "last but not least, a place to revisit when one realizes that we, without having reflected about the reasons for it, are drifting away from the practices that are at the core of treatment at our clinic and thereby reviving our attempts to practice collaborative, multistoried treatments in accountable and documentable ways."

Narrative Practices in Clinical Conferences

As Madsen writes: "Efforts to help families envision preferred directions in life, identify supports and constraints to preferred lives, and draw on their resourcefulness to address those challenges can be best supported by following a parallel process in clinical discussions" (2007, p. 335). Though this in practice may be an exercise rife with dilemmas (Luhrmann, 2000), we also believe evidence-based narrative practices in psychiatry should be part of the organization and working culture in order to flourish. To give you an example of what this work entails, we will tell about our clinical conferences.

Clinical conferences are a core activity in hospital settings. This strong tradition upholds high-quality standards and sharing of knowledge as (younger) clinicians present new cases and their concerns and problems that arise and the (older) clinicians in charge give advice by way of a tradition of consultation and

sanction when necessary. We also have clinical conferences. At the beginning, we strictly followed the tradition of bringing up cases when they were new and when problems arose. However, inspired by Madsen, we have decided to give them a new format. According to Madsen (2007), we can identify two types of clinical meetings: determination meetings, in which there are efforts to generate a particular direction in the work, and formulation meetings, in which helpers, or helpers and a client, attempt to develop or clarify their thinking about the client's situation. We strive to combine these two goals at our clinical conferences, thereby broadening the focus compared to what happens in a classical psychiatric clinical conference, the aim of which is to find the correct direction for complicated treatments. In addition, we have adopted from Madsen and narrative practices the importance of reflecting on those things that go well and thicken stories that remind us of our forgotten competences.

In CAMHS, we often experience an overwhelming load of complex and troublesome cases. Hence, we can easily spend almost all the time we have available for intra-professional dialogue on those matters that go wrong or those situations where the therapist feels stuck. In practice, we have found that a slight transformation in the traditional clinical conference does the trick. The transformation is structural and communicative. We have simply decided that all cases shall be presented at structured intervals: (i) at the beginning, (ii) after stock-taking sessions, and (iii) at the end of treatment. The communicative frame is a variant of narrative witnessing, as will be clear from the description below. In addition, by using Collaborative Helping Maps, inspired by Madsen (2009, 2011), we look for the organizing vision, obstacles, and supports for the family and the tentative plans they have made.

When therapists present a case at the beginning or after stock-taking, their colleagues become witnesses of the work done. Nobody is asked to give advice nor is it sought. The witnesses speak about the phrases, sentences, or matters by which they have been most inspired or that have made a significant impression on them while listening to the case. Some will tend to be inspired by the resources and relations in the family; others have come to think of children they have known before who suffered seriously from certain symptoms; and some come to reflect on signs of psychopathology. The presenting therapist(s) then talk with each other about what they have heard that they think can be useful for them in the next phase of their work with the families. This frame opens up reflection and learning possibilities for all present at the conference.

Had we been working from a social constructionist perspective solely, we might have stopped the session here, satisfied with the widened perspectives that the session has brought about. However, being in psychiatry, we also acknowledge a more positivist thinking about mental illness and our treatment; we value the responsibility of the psychiatrist in charge for finding the best treatment and not overlooking more serious illness irrespective of the path that therapists and families have agreed to follow. Hence, the psychiatrist in charge may have a last word in

the witnessing session—and at times she will insist that a child be screened for certain psychopathologies.

The thinking that some approaches are better than others for certain illnesses and that it is the task of psychiatry also to detect illnesses not seen and perceived by people who are struck by them is a positivist thinking crucial for psychiatry. It is also one that, from our pragmatic perspective, can be fruitfully combined with that of social constructivism (Marks, 1992). Framed from a pragmatic perspective, we would say that illnesses must be evaluated for their potential consequences alongside the perceptions of them that we socially construct.

At presentations of terminating cases, the therapists reflect on what actions they and the families did that brought positive effects, and they will tell their colleagues of the advice they have gotten from the families regarding what worked for them in therapy. This way, knowledge from the families becomes common knowledge to be shared and to be stored in the hold of the "treasure chest" in the digital manual for anyone's use in the future. This little example is in no way revolutionary. It simply shows how a pragmatic stance helps us find ways to practice narratively in psychiatry. We do not introduce revolutions. We simply, day after day, try out the paths and possibilities that different knowledges seem to promise and evaluate them for their consequences in practice.

CONCLUSIONS

This is a journey that we have embarked on just three years ago. It is close to impossible not to be seized by the promise of things to come from what we have experienced so far. We are encouraged as we see empowerment becoming an established part of psychiatry and CAHMS in Denmark and as we see interest in several places around the world in doing research in narrative therapy. And as we see families profiting from our pluralistic approach, we become eager to continue our endeavor of bringing narrative therapy and CAMHS closer together in a partnership, or a relationship where reciprocal respect and curiosity is the foundation for creating new and better possibilities for helping families that struggle with psychiatric illness and problems.

The treatment world is pluralistic, and hence we believe the future lies in exploiting and engaging with pluralism. We must be able to include those stories that at first glance might be problem stories (nonnarrative or non-psychiatric). They often hold some truth. Deconstructing these stories has helped us find out that none are only problematic; they all hold good intentions and some good effects. So, being transparent about our life and work within a system that can contain multiple knowledges, ideas, and beliefs has become one of our tools to help families. Families with children with mental illnesses have to walk through so many different doors into so many different systems (hospital, school, social services, family networks, etc.) with different beliefs, dreams, norms, and languages. If we are to meet the families

where they stand (Kierkegaard, 1859/1998), we must be able to step in and out of those different contexts, speak different languages, be open and curious, and strive to find what works in every new context. We hope that by insisting on multistoried treatment within our clinic, we support families on their multistoried journey in life.

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