



Narrative Psychiatry and Family Collaborations: A co-created book of true stories and helpful guidelines

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Introduction

I want to introduce the book I have written on collaborating with families struggling with psychiatric illnesses. I have named it *Narrative Psychiatry and Family Collaborations* (Jørring, 2022). But before you read about the book, I want you to know of my gratitude towards 18 families that have helped me write the book.

As I began writing this book, I told some of the families I had worked with that I was going to write a book about our collaborations to teach future child and adolescent psychiatrists and everybody else working within the Child and Adolescent Mental Health Services. I asked them: “Can I use your story and the letters we sent you?” And: “What do you think is the most important message you want me to convey in the book?” Later I asked them: “Will you read what I have written, and correct it, so it is true for you and conveys the messages you want it to convey?”

I also asked my younger colleagues to read my manuscript and tell me what parts made sense and what did not. This way you will not just read my stories; you will read co-created stories. If these 18 families and my colleagues had not assisted me, it would have been a very different book.

The art of good questions

Good questions are questions that lead to ideas of multiple answers and even create more questions, way before you have the first one formulated inside your

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head. David (David Epston) just asked me such a question: Why did you write this book?

My mind immediately began racing ahead: Why did I write this book? What did I hope to achieve by writing a book? What shall the readers experience, learn, or even begin dreaming of while reading this book? Can this book provide better lives for families struggling with psychiatric problems? Can this book help change the taboo and stigma connected to mental health problems and psychiatric illnesses? What hopes did I have when I began writing? What hopes do I have today? How might this book influence the way our societies evolve? Might I be able to create similar dreams in you? I had to stop!

I can tell you this: It was not a one-shot idea. The book sneaked in on me through many different roads and avenues. I have decided to answer David's question by sharing some of my stories with you. Some are shorter than others, but they all contain plots that relate to the dreams I have for this book.

I wrote this book to honour all families struggling with psychiatric problems.

Imagine being that mother

I will start by sharing an experience I had when I was a very young doctor, just embarking on my training to become a child and adolescent psychiatrist. I also share this story in Chapter 1 of my book.

I was sitting in my tiny office as a young resident at the Child and Adolescent Psychiatric Hospital.

I was trying to keep track of what the mother, Sheila, was telling me. At the same time, I was desperately keeping an eye on her six-year-old son, Hans, who was climbing up and over the furniture and getting into everything.

The mother was describing the troubles Hans faced at school, the complaints about him from people in their residential complex, the difficulties in raising him, and her fears for his future, which she already foresaw being corrupted by crime and drugs.



By now, Hans had emptied the toys onto the floor and flipped the trash can so he could use it as a shed for farm animals and racing cars. He talked constantly about everything and nothing.

Despair invaded my brain, telling me that this mother was unfit, and her son was out of control. However, I tried to respond with empathy and common sense to invitations from Hans to play and, simultaneously, give my full attention to his mum.

Thoughts about the difficulties of my job were interrupted by other thoughts. How awful must it be for this mother and son here in my office? Does the mother expect me to see her and Hans as failures? What might they need most right now? Might their biggest need be respect and acknowledgement from a health professional like me?

Realising that I needed to show Sheila and Hans my respect and faith in both, I said:

"Do you know the story of Emil of Lönneberga (Lindgren, 1963)? I am reminded of Emil and his mother. Do you remember all the troubles Emil made?² Despite Emil's troubles, his mother loved him dearly and knew that his only goal was to make other people happy, even though his efforts often ended up all wrong. Emil's mother was the only person who understood him. Do you remember this?"

To my horror and surprise, I saw tears in Sheila's eyes. She sat silently and nodded her head.

Luckily, Hans intervened. He sat on the floor in front of his mother, gave her legs a hug, looked at her with big, shining eyes, and said, "I love you too, Mum."

I asked if they remembered what Emil became as an adult in the story. They did not. I told them: "He became chairman of the local council."

² Emil probably had ADHD, had the diagnosis existed then. <https://www.astridlindgren.com/en/characters/emil-in-lonneberga>.





My intention was to illustrate that I believed Sheila and Hans also had potential for creating a good life. As a doctor, giving and holding onto hope is a calling. I view “hope as a practice, rather than simply an emotion or a cultural attitude” (Mattingly, 2010, p. 6).

Our conversation about Emil of Lönneberga became instrumental to the success of our collaboration. The next time Sheila and Hans visited, Sheila handed me a huge pile of papers and said, "I have demanded and received access to all the records that the hospitals and social services have on me and Hans; here they are."³ My social worker is seeking authorisation to remove Hans from our home. Nobody in the social services department has ever believed in me. Please read these papers. Then you will see why I need your help."

The records contained medical notes from hospitals and procedural notes from social services and his kindergarten, dating from Hans' birth. Many interventions had been tried over the years. But the tone was the same throughout: judgmental, arrogant, and condescending. The notes were written by professionals whose role was to offer help. These people, in their professional roles, had great power over this family, who were dependent on them for help. No one deserves to be seen through that kind of lens.

I marvelled at Sheila's courage in sharing the records with me. As I read, I thought again and again, that help offered in such a condescending manner would not help.

I developed the deepest respect for Sheila and the battles she had fought. I felt terrified, imagining being in her position. I was certain that I would not have coped as well as her.

I assessed Hans with my colleagues and co-created an understanding with Sheila of his and her family's difficulties. Most importantly, we changed the narrative about Hans, from a boy being raised by a neglectful mother, to a boy whose

³ In Denmark, the municipalities and state are mandated to deliver all public records on a person, if they request it.





Attention-Deficit Hyperactive Disorder (ADHD) was making his parenting extremely difficult.

We arranged a family community meeting with the social worker, school psychologist, and teacher and initiated several forms of assistance. Hans was provided with support in school and extracurricular activities. Sheila received support with her job and education. I provided her with psychoeducation on ADHD, and she was eager to learn.

Months later I received a thank you letter.

Sheila wrote that she had been fearful before our first family community meeting. I had promised her there would be no surprises, and that I would say only what we had planned together. She had been sceptical, but I had kept my word.

Sheila also thanked me for seeing her as a mum of a child with problems, not as a mother causing the problems. She appreciated that I wanted to support her in creating a better life for her family and her son. I felt deeply humbled, receiving written appreciation for merely behaving like a decent person. All I'd done was to follow basic ethical principles of good conduct as a helper in a position that gave me great influence over another person's life.

Many years have passed since I met Sheila and Hans. I often share their story with younger colleagues and ask them to consider these questions:

Imagine being that parent; how would you feel?

Imagine living that parent's life; how tired would you be by now?

Imagine what life like that might do to your parental self-esteem?

When we do this exercise, we feel overwhelmed at how difficult life must be for the parents of children with psychiatric problems and humbled by the love these parents manage to keep alive.

This insight compels us to acknowledge that parents deserve our respect and support. Giving correct scientific treatment is not enough; we must also deliver



the treatment with the appropriate spirit. A respectful, curious, trusting, and hopeful spirit creates the foundation for a mutual relationship necessary for treatment to be effective, and the best it can be (Sælør, 2014; Turns, 2013).

A family-psychiatry empowering the entire family

When one person is struggling with a psychiatric illness, their family struggles as well. Therefore, the whole family together deserves help.

I do not believe in individual therapy for children. Imagine a child saying, “Hey Mum, I have learned these new things about myself, and I will act differently from now on. Therefore, I expect you to change your behaviour accordingly.” That situation would be impossible for a child. I believe parents are in a better position to change the way family members interact with each other and their problems.

I once overheard an older colleague explain psychiatry to a group of politicians this way: “Psychiatric illnesses are communicative illnesses, they are trying to tell somebody something, and we must listen!” I like this way of describing and understanding these problems. The person has a relationship with these problems, and the problems are trying to communicate. When we adopt this perspective, it makes no sense to treat only one person, without involving those people the messages are intended for, which most often are family members.

I trained as a child and adolescent psychiatrist and a narrative family therapist at the same time. This joint study had a profound effect on my future work aspirations. I imagined working in a mental health service that adhered to the ethics of caring and helping that I was taught in medical school and adhered to the ethical values of narrative therapy. These values embrace collaboration with my patients, based on respect, curiosity, trust, and hope, and consider patient and family wisdom as being of equal value to my medical knowledge (Madsen, 2007).

My hope is that we can expand our understandings and approaches to mental health so that we can help the families as well as the person with their problems, psychiatric illness, or mental health problem. The whole family is struggling, not only one person. Treating the child or youth alone, telling them to go home after



a session loaded with the responsibility to change the communication with their dear ones and their shared problems makes no sense.

I have a dream

Mental health problems and psychiatric illnesses take away your dreams. They tell you that you are not worthy to be in this world. That you are not allowed to live a good life. That you deserve no dignity. That is why we need to meet all people and their families first and foremost with respect, curiosity, trust, and hope.

David Epston speaks to these issues in the foreword and afterword that he has written in the book. He has invented the term “regrading” (Epston, 1989, pp. 111-119) to reference his and Michael White’s intention to seek counter-practices that will restore honour and dignity, and to capture their “moral character”: We were aware of how undignifying and dishonouring such pathologizing discourses were to those who suffered. Let me put this another way: how do professionals like us come to know those who seek our help and, by the same token, how do they come to know us?

I have met so many parents speaking about the problems of getting their worries about their child acknowledged. They have either been told not to worry, or that they are to be blamed. A research project in Denmark has shown that it takes on average five years from the time parents voice their worries until their child can be admitted to an outpatient clinic in Child and Adolescent Mental Health services (Hansen, 2021). This would never be the case with a somatic disease like a broken leg, cancer, or diabetes.

Stigmatisation works in so many mysterious ways. Parents are often regarded as the reason for their children’s predicaments and children are viewed as just attention-seeking. The relational effects of the problems make us all act in ways opposite to our intentions, both as professionals and family members. One mother, who had been struggling for years not only with her daughter’s psychiatric illness but also with the health and support system, wrote me this message for the book:



“I became the worst possible version of myself while my daughter was hospitalized. I wish the clinicians had met me before, so they knew my other, ‘better side.’ Then we might have been able to cooperate more readily.”

Somatic diseases such as leprosy, AIDS, and cancer used to be just as stigmatised as psychiatric illnesses. Finding the biological explanations for these diseases helped to de-stigmatise. But psychiatric problems cannot be explained the same way. We use the bio-psycho-social-model in psychiatry (Borrelli-Carrió, 2004). This helps, but I propose that we add the theory from social constructionism and the externalising language to speak about the problems, to counter all the stigmatisation. Because social constructionist theory explains how language, ideas, metaphors, and the understandings we give to different words determine how we live, i.e., how we experience ourselves as ill or not, as patients or not (Besley, 2010; Braiden, 2010; Brinkmann, 2020; Gergen, 1985). The externalising language helps demonstrate that it is not the child, nor the parents or the families, that are the problem. The problem is the problem.

I have a dream, that one day, people and their families affected by psychiatric illnesses will be met with the same respect and get the same proper treatment as people having somatic diseases.

Bringing a manual to life

In 2009, The Family Therapy Team was established in the Child and Adolescent Mental Health Centre of the capital region of Denmark. The purpose was to offer narrative family therapy to families so burdened by problems that treatment as usual had not been helpful. We wanted to do efficacy studies (Ejbye-Ernst, 2017; Jørring & Gjessing Jensen, 2018) and wrote a treatment manual with these visions (Jørring, 2014):

- Combining narrative therapy and the bio-psycho-social model used in the health care sector to address psychiatric problems.
- Taking a family approach, not an individualistic approach.
- Creating a team culture consistent with narrative ethics.
- Honouring and using the knowledge and wisdom of people who seek help in our services.





I began using our manual on Collaborative Family Therapy teaching trainees in Child and Adolescent Psychiatry. I received positive reviews, but also many complaints and demands. The trainees liked the structure and clear guidelines but wanted more examples on how to do it. They said, “It lacks those stories you tell us. We learn from those stories and carry them with us.” That feedback inspired me to start writing stories, and the idea to write this book was born.

This book contains many of the stories that I tell my younger colleagues, and that they then carry with them. The stories illustrate how helpful it has been for my personal and professional development to invite families to collaborate and to give advice about what is helpful for them.

I have realised over the years that I teach future child and adolescent psychiatrists to think and practice “family-therapeutic” in all situations. But many people think that family therapy is exclusively about the conversations that take place when the whole family is gathered together. This is the reason for the title of the book. I chose not to use Collaborative Family Therapy, as our manual is called, but Narrative Psychiatry and Family Collaboration, so the psychotherapeutic becomes an implied part of the whole.

The book’s chapters are organised according to ideas, values, and techniques. The initial focus is on family-oriented practices. The book then weaves through narrative collaborative practices, narrative psychiatric practices, and narrative agency practices.

You can read the book from start to end and read the stories in chronological order, or you can read the different chapters according to your interest. Some stories about the families stand alone. Other stories are woven into several chapters as they illustrate different aspects of our work.

Several stories include direct comments from the families. I want you to experience the same humbling effect as I have experienced when these families share their stories, ideas, and wisdom about what constitutes good treatments. I hope you also get a sense of what it is like to be on the receiving side of mental health services.



One chapter describes how we use wonderfulness interviews to find the magical wonderfulness in their intentions and actions to awaken our own curiosity. The chapter is called: 'I am not the problem! We are the heroes!'

Another chapter focuses on mattering and different mattering practices and explains why they matter. This chapter contains stories about three different families. The last story focuses on team mattering practices, and how making colleagues know how their work matters to the team and to the families we serve ensures our ability to matter to the families. In my experience, there is way too little focus on mattering the helpers.

I have several chapters on how we write our notes in collaboration with the families as a public note taking practice to honour their words and language, highlight their wisdom, and make visible what is most helpful. I also describe how we use this note-taking technique in other contexts such as conferences, assessments, anamneses, notes at meetings and supervision. I describe it step by step, focusing on different techniques, such as mapping the problem, tracking a story, using metaphors, different colours, and drawings. I especially like our "reach for the stars" technique to support the therapist to write the therapeutic letter.

You will find transcripts of therapeutic letters in almost all the chapters. One mother began writing her own stories to make sense of what happened to her family. Another mother wrote me back "between the lines", and you will follow her and her daughter's story through the book. You can also read another example of this technique for answering letters in another chapter that focuses on parent wisdom.

The stories show how the letter writing has been crucial for our development as a team of therapists and health professionals, and how this approach has improved our skills in asking good questions. David claims that we might be the only team in the world that writes therapeutic letters after every session. I do not know if this is true. But I do know that it is such an integral part of our work today that we would not be able to let go of it. When I supervise, my supervisees will often mail me their letters so I can suggest different questions they can use either in the



letter or in the next session. They also share their letters with each other. This empowering practice is a true joy to experience as a teacher and supervisor.

The chapters also describe how our team works between sessions. These practices are important in sustaining us in our daily practices as mental health workers.

Most of all, I hope the stories convey the immense joy we experience when working with families.

Building bridges or creating mutual worlds.

For many years I often experienced being the only psychiatrist practicing narrative therapy, or the only narrative therapist using medical science and psychiatric diagnoses. I often felt I was the odd one and I didn't like it. It seemed to me that most people wanted me to choose either to be a narrative therapist or a child and adolescent psychiatrist. I began dreaming of being able to offer narrative family therapy as a "mainstream" treatment, which means an evidence-based treatment at mental health services.

With my medical doctor-mind I listen to the Hippocratic Oath. It has been translated into many languages and looks very different, but in most texts, it says: "First do no harm" (Markel, 2004). For me, this entails that I must be able to tell my patients and their families about the treatment I am proposing. That it has been evaluated, what good effects we shall expect, and whether there are any side effects. There is some qualitative research on narrative therapy, and good narrative therapists also evaluate the process with the patient every time they meet, doing co-research on every single case. But in the medical world, we use a paradigm called evidence-based medicine, which is the "integration of best research evidence with clinical expertise and patient values" (Sackett, 2000). I believe that there has been so much focus on how to achieve the best possible research evidence that the two other aspects of this paradigm are often lost: the clinical expertise and the patient values. I believe this to be one of the main reasons there is so much dispute about the research on psychotherapy.



If there was a bigger emphasis on all three aspects of the paradigm, I do not think I would have been in such a dilemma when I began my quest for making narrative family therapy a viable treatment in the medical world. But it was a huge dilemma for me that there is no evidence base for narrative therapy. I had to produce this evidence (Ejbye-Ernst, 2017; Jørring, 2014).

When our Family Therapy Team was first established in 2009 some colleagues on my team were happy to embark on a project to write a manual and undertake efficacy studies. A manual would help them know what was expected of them and would provide clear guidelines and a checklist to help when an impasse occurred on whether to do this or that.

But the narratively trained colleagues were appalled. The word “manual” had a whole other meaning for them. They felt physically restrained. They were concerned that each family would become a number, where the research became more important than the individual family (Ejbye-Ernst, 2017, p. 49).

I asked David Epston and William Madsen for help. They really supported my dream of making narrative family therapy available to families seeking help in the mental health services. At first though they too were very sceptical of the dream of combining the medical and the social constructionist theories. They each came and visited, taught, and supervised our team. I still remember William Madsen standing in front of us with his feet planted very far apart, almost falling over. He tried to demonstrate how impossible it would be to build a bridge reaching two worlds so far apart.

David Epston wondered if a manual would kill the very soul of the narrative ethics. How can a manual sustain the clinicians in being able to question and be in opposition to the establishment? The idea that something that is mainstream is also frozen in time and cannot evolve is a very strong narrative. I still remember feeling like a petulant child, stomping my feet, banging my head, and screaming at the top of my lungs. I tried to argue my point: No truth holds all the truth and nothing but the truth. One must meet every person with curiosity and an open mind, seeking to find their good intentions. No matter how their actions might compel us to disregard their points of view, a narrative therapist will seek to



understand their point of view, find their good intentions, and seek to co-create a mutual understanding. David Epston and William Madsen became the greatest supporters of our team. I hope you will be able to see their influence from all their visits all through the book.

Our team used a lot of time addressing the different discourses, the different interpretations of the word “manual,” our stories, training, and values. This work helped us co-create a team founded on our shared values; we co-created a multi-storied team with multi-storied treatments, and we found ways to embrace both of these worlds (Jørring, 2014).

It was a process from trying to combine, then to bridge, to eventually find ways where we truly experience that we can combine the very best from the two worlds into one mutually narrated world (Ejbye-Ernst, 2017; Jørring, 2014). We found the word “cookbook” served as a metaphor to describe the purpose for our manual. Since we all liked to cook and bake, we had the shared experience and knowledge of following a new recipe closely at first, when unfamiliar with the recipe, then later when confident and familiar with the principles, starting to improvise with knowledge based on the results of our experience. Our aim was to continuously improve the outcome. In this way the word “cookbook” resonated for us in creating and using our treatment manual.

The manual did not become frozen in time and, if you want to use it, you can find it on ResearchGate (Jørring, 2013, 2018). We suggest that you remember that as all other treatment, it is context-based. So do as we do: Ask the families at the last session, the “saying-good-bye conversation,” for advice. We tell them that they are our best teacher and ask them: “Will you use some time on helping us? Imagine that we are meeting a new family very much like yours next week. What do you think we shall do more of, less of, and what shall we change to help this new family the best we can?” We record their good advice, and we change the manual accordingly.

As we worked with the families, we also came to realise that the academic discussions among us were not problems for the families. One of my colleagues, Ditte, interviewed the families about filling out questionnaires and our research



project. They were all eager to help us become better at treating their ailments and helping them live lives closer to their aspirations. They saw no problems in filling out questionnaires and participating in qualitative interviews. It became obvious to us that the families all knew deep in their hearts that their problems could not be explained in any simple terms, and the more knowledge we all can obtain through as many channels as possible, the better we become at helping (Ejbye-Ernst, 2017, 2015).

If I had only one dream with this book, it would be that the discussions between psychology, or social constructionist on the one side and biology or medical science on the other side, will abide. That it will no longer be as in the book *Of Two Minds* (Luhrmann, 2001), where the patients have to choose between psychology and psychiatry when they seek help.

My vision for this book

My vision is helping families with complex psychiatric problems by seeing and meeting the families and the family members as the best versions of themselves before we see and address the diagnoses.

This is what I have written on the back cover of the book: Imagine a young child with severe psychiatric problems, and that not only the child, but the whole family was provided with collaborative help and support by professionals. Imagine that you were the one suffering, and your whole family was invited to receive help. How would that make a difference to you?

Imagine that:

Professionals and families are collaborating with each other with respect, curiosity, trust, and hope, and that they all share the same goal of the family being able to live the best possible life.

That you conduct treatment, clinical conferences, and meetings in ways that make all members of the family experience being heard and seen, understood and empowered, and able to participate on equal ground.



That you talk about problems, diagnoses, and difficult family experiences so that they become manageable, and the family members can free themselves from the negative influences of those problems.

That your patient's family are your collaborators. You are in it together.

I have devoted the final chapter to the subject of daring to weave personal and professional values into a patchwork of narratives about who we want to be. When witnessing people as the best possible versions of themselves, we experience the transformations that occur within their lives, and we become better people ourselves (Carlson, 2016; Greenhalgh, 2010; Hastrup, 1992; Sælør, 2014; White, 2002).

I want to inspire you to become the best version of your professional self. During the writing process I've imagined that I am telling stories to younger colleagues and trainees who work with families struggling with mental health problems. The narrative approach to teaching has inspired me for many years, especially the concept of exemplary tales (Carlson, 2016; Carlson, 2017; Epston, 2018, 2016; Ingamells, 2016a, 2016b). I hope my stories can become such tales and be applied in this way. Do dare to care!

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