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Editors: Tom Stone Carlson, Sanni Pajlakka, marcela polanco, and David Epston

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About This Release

We are excited to announce our next release of the Journal of Contemporary Therapy. This release has an interesting mix of original papers, a narrative autobiography, and author written reviews of two new narrative therapy books.

The first paper in the release is a practice story written by Sasha Pilkington entitled, “A story illustrating Narrative Therapy in a cross-cultural conversation with someone approaching death.”

The second paper is our second narrative autobiography written by long time narrative therapist, Jeff Zimmerman. You won’t want to miss Jeff’s retelling of his history as a narrative therapist and his hopes for its future.

The final two papers are a unique take on book reviews written from the perspective of the authors themselves. Here, the authors take us through their journey in writing their respective books, as well as their hopes and purposes for the contribution that they might have on narrative ideas and practices.

We hope you enjoy the latest release of JCNT.





A story illustrating Narrative Therapy in a cross-cultural conversation with someone approaching death (Revised)

Sasha McAllum Pilkington

Previously published in the New Zealand Journal of Counselling:

Pilkington, S. M. (2018). A story illustrating narrative therapy in a cross-cultural conversation with someone approaching death. *New Zealand Journal of Counselling*, 38(1), p. 39-49.

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Tēna koutou, tēna koutou, tēna koutou kātoa

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Thank you, Huia Swann, for your encouragement and feedback through the many iterations of this story.



Abstract

This paper uses ethnographic fiction to explore and illustrate the Narrative Therapy practices I might engage with when meeting with a Māori woman who has a life-threatening illness. In it, I seek to show how I, as a Pākehā counsellor committed to honouring Te Tiriti o Waitangi might go about a therapeutic conversation with a Māori woman for whom marginalising discourses and the colonisation of Aotearoa New Zealand have had a key role in shaping her experience of cancer. This teaching story illustrates the unfolding of deconstructive questioning and working with the impact of oppressive discourses to begin a process of re-authoring some harmful identity descriptions.

Keywords: Narrative Therapy, Māori, cross-cultural, palliative care, cancer

An unexpected beginning¹

It was a busy morning at the hospice. I made my way into the community team's office and was greeted with a buzz of activity. One of the nurses called me, and I turned to greet her. In her hand was a referral letter. "Sasha, I was wondering if you would see this woman for counselling? Her name is Louise and she has advanced lung cancer.² Louise is refusing all treatment. It seems someone thought she was 'in denial' but I saw Louise yesterday and she told me she's not having any chemo' because she doesn't think she's worth it. Louise is Māori, but she's refused cultural support. Could you see her?" she repeated, as she handed me the letter.³

¹ For those readers interested in the use stories to learn or teach narrative therapy see Carlson et al (2018) and Heath et al (2022). For additional examples of stories illustrating narrative therapy see Epston, 1989; Heath, 2015; Ingamells, 2014, Ingamells & Epston, 2016; Pilkington, 2014; 2016; 2021; 2022.

² This story was written with the permission of the person in it. All identifying information has been changed.

³ In Aotearoa New Zealand, Māori have a higher incidence of lung cancer and poorer survival rates than Pākehā (non-Māori). A number of barriers to early diagnosis and treatment have been identified including access to care, engagement with specialists, communication with specialist services and lack of culturally appropriate services (Kidd et al, 2021). Even though Louise's lung cancer was incurable, chemotherapy would offer her the chance of improved quality of life and an extended life span.

When someone responds in ways that others don't understand, it is common for judgements to be made from a position of "knowing best" what is right for that person. I find it more helpful to be curious about another person's world and to try and understand what is important *to them*. I also want to learn what they are taking into consideration that matters to them and is restraining them from taking a particular course of action. For example, what was Louise concerned about or prioritising that she had chosen not to accept chemotherapy? Often, when I have fully inquired into what matters to a person and what they are weighing up, their decision-making process and reasons becomes clear. At other times, the questions I ask can lead them to reconsider their decision and take another path. (See Chochinov, 2022)



“Of course,” I replied, disturbed by the thought that Louise didn’t feel she was worth treatment, but grateful the nurse had looked beyond the judgement that Louise was ‘in denial’ (Pilkington, 2017; Zimmermann, 2004). Before I could say any more, the nurse was summoned to the ‘phone and with a smile, I left to call Louise.

A few days later I pulled up in a beautiful driveway. Plants nourished by an attentive hand surrounded the house in front of me. As I got out of the car, I saw a slight woman emerge into the sunlight. Her dark hair gleamed as the rays of sun caught it and as I came closer, I saw she was smiling. Louise welcomed me warmly and, after I had removed my shoes, guided me into the house. We sat down at the kitchen table. Nearby stood a large kete⁴ filled with driftwood, each piece carefully placed to reveal a story. Woven mats hung on the walls and outside I could see clusters of red berries hanging below the fronds of a nikau palm. Artistry was evident in creating this home and I looked around with admiration.

After some further introductions, Louise eased herself back in her chair and looked at me expectantly. Tentatively I responded to her silent invitation with, “People are so much more than the illness they are living with and their current situation. Would it be OK to begin, maybe, with me asking you a bit about yourself... so that I might learn a little about who and what matters to you?”⁵ I

⁴ A kete is a basket usually woven from flax. Māori words are in common usage in Aotearoa New Zealand. I have chosen to leave such words in this text out of respect for the person in the story, and to uphold the mana of Te Reo Māori (the Māori language).

⁵ My intention in asking this question is twofold. I wanted to get to know Louise aside from the difficulties she was living with in ways that dignified her and brought forward her preferred stories of who she was. I also wanted to create space for culturally respectful ways of getting to know each other without assuming how she might wish to go about that. A broad question such as this one creates space for Louise to answer in ways that fit for her. In some instances, I may ask a person if there is a particular way they wish to begin, in order to create space for karakia (a ritual chant or prayer) or any other ritual that may be meaningful to them. Louise’s talk and refusal of cultural support led me to think such an invitation might be uncomfortable for her. I therefore held back on this occasion knowing I could raise it another time.

Building a relationship in ways that honour and create space for possible cultural identities a person may hold is important, especially if that culture has been oppressed. Such respect has effects on what kinds of conversations are made possible and can open up areas that are often overlooked. For example, acknowledgement of tikanga Māori (Māori cultural processes) can underpin the engagement of Māori in treatment (Kidd et al, 2021) and can be significant in generating a relationship in which stories of suffering can be told.

It was unusual for me to have this first meeting with Louise on her own. (It was Louise’s decision to do so.) I usually meet with many different constellations of families and most often see someone who is unwell with at least one other member of their family/ whānau. Louise introduced me to her family after this conversation and later brought different members of her wider whānau/ family in to see me when they visited from other parts of the country.



didn't name the illness as I didn't know what language she preferred to use or how she might wish to speak about her experience.

Louise responded immediately. "Sure! I'm married to Pete and we have three children. They're all really supportive, in and out of the house every day..."

Louise continued to share stories of her day-to-day life and I listened attentively, occasionally asking her questions so that I could learn more of what was important to her. I quickly learnt Louise was a hard worker and a committed parent. She made no mention of where she was from or her tīpuna.⁶

After a time, Louise paused and reached across the table to pick up a piece of paper. "Well, it's lucky you've come to see me on your own. I don't like groups because I lie in them. I'm a liar," she stated in a forthright tone, waving what I now realised was a support-group invitation from the hospice.

Struck by her honesty and trust in me, a stranger, I replied, "Would it be OK to ask what you mean when you say you lie?"⁷ In my mind was an awareness that some truths are more easily spoken than others, and for some people it was unsafe to voice or live their truth.

Louise responded, speaking in rapid buoyant tones, "Oh, I say what I think I should in groups...but then later I discover it would have been all right if I'd said what I really thought."

With all the respect I could convey, I replied, "What is your understanding of why you say what you think you should?"

Immediately Louise explained, "Oh, I tell a story to fit in."

I reflected that people usually have good reasons for what they do. "What is important to you about fitting in, do you think?"

Louise sat back in her chair looking thoughtful. "I like to fit in. When I'm in a community I'm proud of it. I like belonging to clubs. I wasn't brought up to do any sport or anything, so it means I can choose. I'm not tied to one thing."

⁶ The people Louise was descended from. For some Māori, this is an important part of forming a connection and getting to know each other.

⁷ This was a significant deconstructive question in our conversation. Deconstructive questions pull apart the threads of an idea so that a person can examine them. When we take up a stance of curiosity and ask a person about the particular meaning of common words and ideas to them, new therapeutic directions can open up.



Curious, I responded, “Would you mind me asking... how do you go about this fitting in?”

Louise paused. “I don’t know, but I’m really good at it,” she finally said.

“Are you a flexible kind of a person?” I offered.

“Sure am.” Louise nodded.

“Which kinds of communities or clubs do you like to fit in with?” I continued.

“I take the best of what’s around. People are good to me, kind,” Louise answered, as if she couldn’t quite believe her good fortune.

“Would you say you are someone who both accepts and appreciates the generosity and care of others?” I asked, noticing her gratitude.⁸

Louise began to tell me how she appreciated homemade gifts as opposed to bought ones. She elaborated on the care and effort in the presents people made and gave to her. Homemade fudge was so much better than a box of chocolates, she explained.

“Do you see the intention behind the gift, the love maybe?” I asked. Louise nodded as if this was obvious to her.

“What do you give to people in return when you accept their gifts, noticing the care and effort that has gone into making them?” I asked, highlighting the reciprocity in the way she received gifts.⁹

“They must feel the magic, because I do,” Louise answered matter-of-factly.

“People are kind,” she reiterated. “I have lung cancer. It’s an ugly cancer. I was so

⁸ As I learn more about Louise’s life, I am listening for *how* she goes about what is important to her and whether that way of living expresses Aristotelian ‘virtues’ that she values, such as for example; generosity, compassion, kindness, courage and love. I gather more stories of these expressions of *goodness* that are valued by Louise and these stories make up the backbone of the re-authoring process (White, 2007). I am mindful that ideas of what is important and considered virtuous sit inside cultural frameworks. Such themes of what people are engaged with in their life, and the virtuous ways they go about what engages them, are called “narrative values” by the philosopher Todd May (p. 73, 2015). May says it is these stories that can give a person a sense of living meaningfully. Such identity stories that describe valued qualities of a person are very helpful at the end of life. Not only do they lend meaning to a person’s life but they offer a way of responding to illness, treatment and dying that is not reliant on a well body. They can give a person a sense of agency at a time when they may be experiencing a lack of influence over their life (see also Pilkington, 2022).

⁹ Ideas that position a person who is unwell as ‘only receiving’ can lead them to feel a burden on others. I often inquire in detail into *how* a person receives the care of others and the experience they generate in the carer with the intention of highlighting the reciprocity in the relationship. The way we receive can give another person an experience of themselves as generous, kind, significant and worthy for example.



happy when they included me in the make-up day for women with cancer. I didn't think they would, what with me having a dirty cancer and them all having the pretty pink kind."

Taken aback, I responded, "Would it be okay to ask what you mean when you talk about your cancer as being dirty and theirs as a pretty pink kind?"

Louise lowered her head as she answered me. "My cancer is dirty because it's a smoker's cancer. It's my own fault."

Infusing as much respect into my voice as I could, I asked her in a quieter tone, "Would you mind me asking you some questions about how you began to smoke?" I reflected on how hard it would be to be a smoker with cancer and not afforded the support that other people living with cancer are offered. I tried to imagine being shamed at one of the worst moments in life, not allowed to feel sad or angry but being repeatedly blamed both vocally and silently.

"It was the 'in thing' to smoke," Louise explained. I nodded. Louise and I both came from a time when many people smoked.

"When I was 10, 11, 12 years old I pinched my mother's cigarettes for a naughty puff," she told me with a mischievous glint in her eye, evoking glimpses of childhood fun away from the surveillance of adult eyes.

"When you were 10, 11, 12 years old, do you think it was possible for you to realise the full implications of the naughty puffs?" I inquired, hoping to lessen the harsh judgement she extended towards herself alone.

"No. I didn't realise in my teens either. It wasn't 'till much later when I came to live around people who didn't smoke," she told me.

"How do 10-, 11-, 12-year-olds come to smoke, do you think? How do they come to think it's a good thing?" I responded.

"It's the way I was brought up. It was a hard life. It wasn't 'till I started playing sport that I realised there were different ways of living, that some kids had a bed each and enough to eat.¹⁰ My parents were hard people. They smoked and drank," Louise conveyed with a frown.

¹⁰ Moana Jackson vividly describes the processes of how colonisation robbed Māori of a sense of home in their own land and what was lost. "When you take away the whenua from a people who regard themselves as tangata whenua; when you take away their ability literally to touch the mountains; if you limit their ability to dream their own dreams; if you take away the earth upon which they stood with love; then you render them homeless in the



In my head I did a few calculations. Louise would have been growing up after the Second World War when many Māori were living in poverty. I thought about her family and wondered if Louise had a grandfather who fought in World War One. I knew of Pākehā returning servicemen who had been allocated a farm in the ballot after fighting in World War One, while my friend's *tīpuna*¹¹ who fought in the Māori Battalion returned to discover his ancestral lands had been confiscated. There were many possible reasons for why Louise's family experienced hardship.

"What is your understanding of how they came to be like that?" I asked.

"Maybe it's 'cos they grew up in the Depression.¹² It was a hard life, and they worked hard and partied hard. Yeah, they were hard people," she repeated.

"Hard lives can have people turning to cigarettes and drink to ease things, especially when there is trauma and hurt that comes with it," I commented.

"What do you make of there being cigarettes for sale when we all know they kill people?"

We pursued this line of questioning for a bit longer, with me seeking to broaden the responsibility for smoking into our societal context so that Louise wasn't left to shoulder it entirely on her own. However, I noticed myself beginning to labour a little in the conversation and started to wonder if I might be more interested in taking such a direction than Louise was. So, I listened harder for what was important to her.

"Yeah, well..." Louise pondered. "I left home at 13 to get away from it all. I knew I had to get out. The beatings, the life... My fault I smoked... Miracle I survived this far. The shame of it has been with me since I've had children."

"What was important to you that you knew you had to get out?" I wondered.

"I wanted to get away from the cigarettes and the booze..." Louise elaborated.

"Do you know what it was that was important to you that you wanted more from life, that you didn't just accept the cigarettes and booze?"

most complete sense (Jackson, 2022, para 25." (Whenua means land and tangata whenua means people of the land.)

¹¹ *Tīpuna* means ancestor in the Māori language.

¹² During the depression Māori were harder hit than Pākehā. Māori were often the first to lose work, and were paid lower unemployment benefits than Pākehā. The situation with benefits was only rectified in 1936 (Waitangi Tribunal, 2004, p. 659).



“I wanted a better life and to live it,” Louise explained.

“May I ask, what sort of better life did you want?”¹³

Louise told me how she wanted a home and security. “I wanted a bed of my own and to know where I was sleeping each night,” she explained.

“What steps did you take towards getting a better life?” I inquired.

“I went white.”

The words hung in the air, heightening my awareness that I, a privileged Pākehā, sat at her table. I wondered how I was selling her short.

Louise continued, “I knew I had to leave if I was to survive, so I hung around with my white friends. When I left, I got away from a lot. Not just the cigarettes. I made sure I fitted in, and it was my ticket out.”

“Would you say fitting-in saved your life?” I asked her.

“Definitely, I had to get away from the other lot.”

She watched me, seeming to wait to see how I would respond. I reflected on Louise calling her own people “the other lot.” I could hear the racist discourse ringing in my ears, inviting the harshness to be because they were Māori, rather than taking into account the devastating effects of colonisation on generations of Māori people.

“Could you help me understand a little more of what you mean when you say ‘the other lot’?” I inquired.¹⁴

“Māori,” she replied, sounding like she was repeating something rather than truly believing it.

Louise waited, her body tense and alert.

“Colonisation has been very hard on the Māori people,” I ventured, thinking of the decades of injustices Māori had endured. “Do you think that the drinking and smoking and what you went through was because they were Māori, or do you

¹³ I cannot assume I know what “a better life” means to another person.

¹⁴ My intention in asking this question was to make the racist discourse visible so that we could examine it together.



think it could have been because of the hardness of life and what it did to the family?”¹⁵

Louise’s shoulders dropped and she was quiet for a moment. “I’ve forgotten who I am,” she rasped sadly.¹⁶

Before I could respond, she ploughed on, seeming to contradict herself with what could have been growing pride in her voice. “I do all the old stuff: knitting, cooking, sewing, carpet-making. I paint.”

“Are you a creative person?” I asked her, smiling. “And the garden?”

Louise enthused about her garden.

“Are there threads of who you are in the old arts?” I asked her.

Louise considered. “Yes, I think there are.” She seemed to meditate on this for a moment, then looked me in the eye. The corners of her mouth crinkled up as a smile formed briefly. “But then I forget,” she added, looking shamefaced again.

“Colonisation can do that to people...get in the way of being connected to who you are... Not surprising when there were laws trying to do just that,” I said sadly.¹⁷ I reflected on the children who had been beaten in school because of laws that forbade them to speak Te Reo Māori and the efforts to suppress Māori cultural practices. “There can be a heavy cost when you are forced to turn ‘white’

¹⁵ Note the way I scaffold my question with a statement. Louise immediately recognised how I was positioning myself and responded. Consider the harmful impact if I had let the moment pass without addressing such an idea and one that included Louise in its judgements. We could ask, what was made possible in the conversation following these moments when I sided with her and her whānau against racist discourses?

¹⁶ This is an example of how Māori meanings can be lost in translation (Mutu, 2004). When Louise referred to who she was, she was not speaking of an individual internal construct of self but a relational self. Included in who she understood herself to be were her connections to her tīpuna, her whānau, the whenua (land) and moana (sea). In this conversation, Louise is considering the elements of whanaungatanga that she wishes to be connected to and that have been disrupted by colonisation. I, in turn, am referring to a relational self when I reflect on what has got in the way of her connecting to who she is. When I asked my colleague Barbara O’Loughlin of Marutūāhu and Ngāti Hauā, to describe her understanding of who she was, she answered me, “I whakapapa to the maunga (mountains), to the moana (sea), the awa (river), to my tīpuna, to my whanau and to te ao Māori (the Māori world), (personal communication, November 24th, 2022)”. There is no “I” or “self” that matches the construct shaped by dominant Western discourse in her understanding of who she is.

¹⁷ In the late 19th century and early 20th century, statutes were passed that suppressed Māori cultural practices (for example the 1907 Tohunga suppression act that intended to stop traditional healing practices), and forbade children from speaking te reo Māori (the Māori language) in school (Crocket, 2013).



to survive. Would it be OK to ask if there has been a cost for you?"¹⁸ I thought about what it might be like to forget who I was. Emotion stirred in my belly.

"I don't have a belonging," Louise confided. "I feel I'm a betrayer."

Deep sadness leaked into the air around us. It hovered, seeming to draw us together. We sat in silence.

After a time Louise gradually seemed to recover, and in a bright voice she said: "You know I'm Scottish. I identify as Scottish." I looked into her beautiful brown face, with its broad nose and dark brown eyes, framed by the sweep of almost-black hair.

I responded then, not as I would to a Pākehā with a question, but in the way of Māori (Lacey, Huria, Beckert, Gillies, & Pitama, 2011) who connect through the people and the land they come from, whanaungatanga.¹⁹ I adjusted my phrasing according to shades of tikanga Māori²⁰ and said, "The people I come from are Scottish. They belong to the clan of Callum. They come from the highlands of Scotland." My intention was to tell her we were connected, and in telling her this and in the way I phrased it, I wanted to say, "I also acknowledge your Māori side and it is beautiful," though this was implicit.

My disclosure resonated with Louise immediately. Laughing, she jumped out of her chair and rushed off to gather photos of all her grandparents who had died long ago. She introduced me to her Scottish grandmother, whom she loved dearly. "She taught me the old arts," Louise explained.

"Were you a willing learner?" I asked her.

"Yes, I took in what I wanted and spat out what I didn't."

¹⁸ How we step into questions can create space for new responses or directions. The acknowledgments leading into my question are important scaffolding in generating possible ways of responding from Louise.

¹⁹ Whanaungatanga is the practice of including, fostering, nurturing and developing a sense of belonging in family relationships. I understand whanaungatanga to be the honouring of a person's connections, that of family and social relationships in the broadest sense. This includes both people who are living and those who have died. Whanaungatanga stands in contrast to Western ideas of individualism.

²⁰ Māori processes/ protocols, in this case a process of introduction. I am speaking in English some of the words from my pepeha (my formal introduction in the acknowledgements section) at the beginning of this paper. A pepeha is a way of introducing yourself that tells who you are through the land, water and people you are connected too. Louise easily recognised my statements of where my people came from as respect for her Māori ancestry.



“May I ask what you value about your Māori side?” I inquired, appreciating that the photos were of both sides of her family.

“Māori love fully and unconditionally, no questions asked, no grudges.”

“How do *you* love?”²¹ I asked, hoping to make visible a thread of whakapapa²² (see Swann, Swann & Crocket, 2013).

Louise proudly announced: “I love like a Māori!”

Warmly, I responded, “Can you tell me some stories of how you show that knowledge of loving?” I wanted to strengthen Louise’s description of herself as having the ability to love fully. It stood out in contrast to her sense of not being worth chemotherapy.

Louise was off, taking centre stage. I listened, grinning, delighted by her rich and lengthy stories of such loving. I then asked her questions of how she came to learn such loving and we tracked knowledge of love through the generations in some long overlooked stories.

“Who in your life knows that you have this knowledge and way of expressing yourself?” I asked.

“All my friends!” Louise responded enthusiastically.

“Could it be that you have captured aspects you value from both worlds with your fitting-in ability?” I asked, after a moment’s reflection. Louise embraced this possibility seemingly for the first time. Her enthusiasm bubbled. We went over her mothering and loving of her children, with Louise adding details such as “...but the car is warranted.”

“Could it be you are not a betrayer if you’ve made the best of both your Māori and Pākehā sides?” I slipped in the word Pākehā, the Māori word for non-Māori, to give weight to Māori knowledge. “You’re right, I’m not,” she told me. Then, as she thought about it, her voice firmed. “No. I have been clever, I haven’t got off-

²¹ When people make broad generalisations, I often ask them a question that makes the statement personal and relating to them rather than getting into a discussion about the generalisation and how accurate it is.

²² *Whakapapa* means genealogy. It refers to a “framework that links all animate and inanimate, known and unknown phenomena in the terrestrial and spiritual worlds” (Rāwiri, accessed 2021). In this case I am seeking to link Louise to her Māori heritage in such a way that she feels connected to the mana (prestige) of those who have gone before her.



side with anyone. I have danced on both sides of the fence.” Louise smiled fully at me. It was a beautiful sight.

Smiling back, I continued, “If you were to think of yourself as a person who can dance on both sides of the fence, what difference might that make to how you are living your life?”

“Well, just everything,” she exclaimed exuberantly. Idea after idea quickly followed.

“If this ability you have to dance in two worlds was one that you kept in your mind, what might it keep you in touch with that is important to you?”

“That I’m OK. Sasha, it’s going to change my life!” Louise’s joy once again spilled over. I was overwhelmed. How generous she is, I thought.

“Do you think it will make a difference to how you live with cancer?” I asked.

A little later, I started to draw the conversation to an end mindful that we still had more to talk about.

“Sasha, I like this talking,” Louise exclaimed, with bouncing joy. “Today I discovered I’m not a liar!”²³

I drove back to the hospice with sadness stuck to me rather than her happiness. All I could think of was Louise...a Māori in a sea of Pākehā. I thought of the times when I have felt apart, out of step, disconnected and the only one. I tried to take myself there, but I knew it was not the same. When I arrived back at the hospice, I wondered what I might have missed, what I didn’t ask. Later, as I reflected with Niwa, my Māori colleague and friend, I was reminded of the bridges that friendship, love and respect can provide.

A few days later, I heard from the nurses that Louise had decided to have treatment for her cancer. Louise later explained to me, “I felt worth it after we talked.”

When Niwa and I met with Louise and her family a few weeks later, we heard the good news she was improving. A short time of respite from the cancer beckoned.

²³ Our identity descriptions don’t just speak to our past and to whom we think of ourselves as being, they influence our future decision making and what we think is possible for us. When Louise reached the conclusion she wasn’t a liar, new possible ways of responding became available to her. Louise told me later that she never again said things she didn’t really believe in order to fit in. Instead, she chose to use her fitting in ability in ways that honoured her past and more closely aligned with her values.



Postscript

This story illustrates one way a counsellor might go about such a conversation. It is not the only way to respond. I carry the knowledge that I have many blind spots, especially in conversations that are cross-cultural. I am also aware that I am the recipient of the kindness and generosity of the people with whom I meet. This story does not represent a 'right way' to practice but rather is written in response to a question I ask myself: "What does my commitment to the principles of Te Tiriti O Waitangi²⁴ look like in practice?"

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²⁴ The version of the Treaty of Waitangi that was distributed to Māori. The Treaty of Waitangi is Aotearoa New Zealand's founding document. There were two versions, one in English, The Treaty of Waitangi, the other in Te Reo Māori (the Māori language), Te Tiriti O Waitangi. The Treaty is an agreement between the Crown and 540 Rangatira (chiefs) that contained articles to guide the founding of a nation state and build a government of New Zealand. In the English version, Māori cede sovereignty of Aotearoa, while in the version Māori signed, they agreed to give the Crown exclusive rights to buy land in return for full rights of ownership to their land, forests, fisheries and other possessions. It was first signed on February 6th 1840.



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Professional Autobiography

Jeff Zimmerman

I am sitting in a medium-sized meeting room in Tulsa, Oklahoma, next to Gail Lapidus, the director of a Family Service agency that I consult with, and surrounded by the staff of that agency, gathered behind desks in a square that was open to one side. It is 1984... I think...OMG that is almost 40 years ago. We are awaiting an interview that is about to be conducted by some family therapist named Michael White from Adelaide Australia, who Karl Tomm had brought to the agency to show off the work that Karl claimed he had recently, “fallen in love with.” Karl had recently given a workshop to this agency and had asked if he could return with Michael, which would be Michael’s first US gig. I had recently completed an externship in Calgary and had met Karl during this process. And I had been supervising a therapist in Oklahoma City, Janet Adams-Westcott, in the Milan Family Systems approach. She was affiliated with this agency and had encouraged them, with my encouragement, to engage Karl in the first place.

Backstory

I had done a Post-Doc internship in Pediatric Psychology at the University of Oklahoma Health Science Center, a strange place for an East Coast boy, but they had one of the best Pediatric Psychology programs in the country. Indeed, the Psychiatry Department was dominated by psychologists for good old Oklahoma reasons (the daughter of a prominent politician would sit on the lap of the Governor when she was little, and she became a psychologist). Anyway, I was encouraged to apply for a faculty position (which I received) and became their family therapy “expert.” I was fortunate to receive family therapy training in graduate school, as at the time the systems thinking/family therapy thing was in its early days.

The agency had selected a client for Michael to interview. This woman, who was likely much younger than she looked, had an old-fashioned “Chinese restaurant menu” of diagnoses; you know pick one from Column A, one from column B, one from column C, etc. She had been at this agency for many, many years and had worked with a multitude of therapists over time. She was considered an agency lifer (a “teaching case” for interns), with a dismal prognosis; any attempt by her



to suggest any motivation to change was met with a roll of the eyes and a high level of exasperation.

She is now wheeling herself into the room followed by Michael. I can hear the staff whispering amongst themselves something like, "I can't wait to see this." I turn to Gail and share a knowing look, as we have discussed this client with the staff on more than one occasion. Michael asks her something about her wishes for her life; she responds with something about wanting to leave her Problems behind and move forward in her life. We are all rolling our eyes now. Michael is taking her very seriously and asking her questions that reflect both interest in her and his own genuine belief that she could do exactly what she is saying. I am watching this, and it seems clear, by her body language and affect, that she is beginning to believe she could do it as well. It was a life-changing moment for me.

That weekend began a relationship between Michael and Cheryl White with both Gail and with me. Humorously, after Michael gained some notoriety, people would wonder what it was about Tulsa, Oklahoma, of all places, that had Michael returning there with great frequency. At that time, it was all about relationships for Cheryl. Michael and Cheryl had made strong connections in a few places in the US, and in the early days, these were the places that they returned to (Chicago-Jill Freedman and Gene Coombs, Boston-Bill Madsen, Sally-Ann Roth and Kathy Weingarten, Mississippi-Melissa and Griff Griffin). I remember Cheryl giving me lessons on how to watch over Michael, anticipating that she would not be accompanying him on every trip. Watching over meant, in particular, paying attention for both of us when we were crossing streets, as Michael was colorblind.

I then began reading everything that Michael had written. My work had evolved from, what I referred to as Strategic–Structural therapy, to Milan work. I had been intrigued by Strategic ideas, and how they usefully undermined the traditional therapeutic approaches of the day. I was not, however, enamored with the amount of use of therapist directives in the work. After going to Calgary, I was introduced to the Milan world of complex questions, although I was left wondering if the work did enough to move things forward efficiently. After seeing Michael work, talking with him throughout the weekend, and then doing the reading (which was sparse at the time as far as things he had written), I became convinced that his approach



(not yet called narrative) both embodied what I believed to be the best of all the approaches I had been exposed to, and left behind what I did not think was useful. Primarily, his work left behind the pathologizing of persons, and the implicit endorsement by the therapeutic community of dominant specifications for personhood (although I did not have this language yet). Growing up, I was a shy adolescent whose ways did not fit into dominant ideas for how young men should be... and as a college-aged person in the early 70's, I was an anti-war protester (as was Michael), and very supportive of the suddenly evolving ideas of how gender influenced identity. Narrative ideas were a really good fit for my developing perspectives that were concerned with oppressive hierarchies and oppression of people. Not only the ideas, but also the way Michael interacted with me and with the others also fit my "preferred values" (these were new words as well at that point).

I spent some time with Michael and with Cheryl separately during that time. With Michael, I would try to pick his brain and discuss approaches. Michael was always careful not to accept invitations from me to define the relationship in a hierarchical manner. For example, when I asked Michael what he was reading, his response would be to ask me what I was reading. I also remember being in a bookstore with Cheryl and looking through books together and Cheryl saying to me, "When are you going to write a book Jeff?" and I thought something like, "yeah, right."

Cheryl seemed to enjoy finding "prospects" like me and propelling them forward in their careers; I reckon that she did the same thing at an earlier time for Michael and David. I will always be grateful to Cheryl for her pushes in the direction of me taking myself seriously and the effects that had on my development.

A Calgary MOMENT

Sometime in the next couple years, I traveled back to Calgary to attend a workshop that Michael was giving. I had no idea that it would lead to perhaps the most surreal moment in my therapeutic career. As part of one of Michael's live interviews, I was on the reflecting team, watching the pre-session discussion from behind a one-way mirror. A woman burst into the room and started yelling at the staff members; she was not a client of theirs nor related to the client they were about to interview. She picked up the clipboard and threw it... and Michael,



trying to be protective, unfortunately intercepted it with his head. From behind the mirror, it seemed to occur in slow motion and brought with it a great deal of shock for those in the room and behind the mirror.

One early misconception about Michael's work was that he would be accepting of anything, and so when he asked to file assault charges, we were all shocked. But Michael was all about accountability, and in fact was clear that instead of "anything goes," it was more about "nothing goes," at least without seeking accountability for the real effects of what had occurred. Lesson learned.

Fast forward to 1989

After teaching and supervising narrative work for several years in Oklahoma, I moved to San Francisco in 1988. In order to circulate locally, and to make connections, I called agencies, talked narrative, and offered to give talks and even do live interviews for free (I often joked that if you were willing to do interviews in front of an agency's staff, they immediately assumed you knew what you were doing). I became known as the local "narrative" person...well, actually, the only narrative person. In my "tours" of agencies, the name Vicki Dickerson kept coming up as a local Family Therapy teacher. Now, I knew that name as she was in the Calgary Externship with me one of the years I attended; we were in the "outlier" faction together (what a surprise as Vicki was prone to saying). So, I rang her up and we started getting together, with me sharing my excitement with her about these new narrative ideas. Vicki got it right away, and a decade long partnership was born.

Anyway, the AAMFT convention was in San Francisco in 1989, as was the infamous big earthquake during the World Series between our 2 local teams, the Giants and the Athletics. Michael would later joke that whenever he came to present in the Bay Area disaster would strike, as on a subsequent trip the Berkeley fires were going on.

Michael had been invited to do a live interview at the conference. As an AAMFT member, and being the local narrative person in SF, Mary Herget (who later joined several of my groups, and sadly died recently) reached out to me as she was involved in local conference planning. She wanted to discuss several possible "cases" for Michael's interview; it seemed to me that AAMFT wanted to select situations that were unusual and filled with as many Problems as possible (it made for better sales of video recordings). I kept assuring Mary that it really



wouldn't matter to Michael as he will do what he will do, a concept that seemed to me to be foreign to the way AAMFT thought about things at that time.

I was asked to be a member of the reflecting team, as was David Epston, who I believe I met for the first time (he was also presenting at the conference). Other team members included Karl Tomm, Jill Freedman, Irene Esler (who my kids also enjoyed having as a houseguest) and Margie Lim, a therapist who was working with me at the time. This was one of narrative's and Michael's biggest stages so far.

As I suspect that most of you have seen this classic video, you know that the interview worked out quite well. What I remember most, though, was how nervous we all were beforehand. I can even vividly picture the scene in the stairwell area where we were waiting to be called to come in. It was a big stage for all of us as well!

(OK, I can't resist. Our brains tend to remember most events that are the most emotionally evocative to us. It often represents them in pictures, as the part of the brain that mediates affective arousal tends to operate in images and not words. This seems to occur unless the event is too traumatic, and then instead gets locked up in special synapses and outside of conscious awareness, while unfortunately still retaining its influence).

BAFTTA

Vicki and I formed Bay Area Family Therapy Training Associates in September of 1990, becoming the first narrative therapy Center in North America. We offered therapy, ongoing training, consultation, and internships in the schools. We also gave workshops, and offered a program of guest workshops. Michael was, of course, a regular presenter.

Some little stories here:

Michael would stay with my family, and not surprisingly, he and his famous jellybean briefcase were an instant hit with my young children. Michael would always take time to interact with them, showing interest in their thoughts and ideas in a way few adults did. My older daughter, Stephanie, when given a Thanksgiving assignment to share her experience of a person in their life to be written on the body of a turkey that they drew...picked Michael, her favorite



turkey if you will. We were a bit aghast, but, of course, Michael loved it and put it up on the door of his office of his therapy room at Dulwich. Later, when they were teenagers and worked at the neighborhood recreation center giving swimming lessons, they would take Michael over there so he could swim laps. My daughter, Meg, who would later play water polo in high school and college, was once spontaneously “interviewed” at home by Michael after her swim team practice as to her swimming knowledges and practices (water polo players were not always fond of the swim team portion of their training program).

Once, when Vicki and I were watching a World Series game with him during one of his visits, Michael, with a smile and an innocent air, asked, “What countries play in the World Series?” I also took Michael to a baseball game when Barry Bonds was chasing the home run title and, despite his usual diet, he wanted a hot dog, and would repeat the 'Barry, Barry, Barry,' chant for the rest of his visit.

Vicki and I eventually gathered up the courage to ask Michael if we could co-present with him at one of these workshops. Deep down I was terrified as I knew what would happen. Michael would want one of us to do the interview and I knew it would end up being me doing the interview. It was one thing to teach with Michael, it was another thing doing an interview with him watching. At first, I apparently asked the same sort of question several times before settling down, but I learned so much from reviewing the interview with Michael. He was so artful in acknowledging the useful things I did while subtly opening space for me to see other possibilities. This experience not only helped me with my therapeutic work, but also offered up a model for “narrative supervision.”

I traveled to “Mecca,” aka Dulwich Centre, in 1991 to give a workshop in couples therapy and to see clients with Michael. The work I was doing with couples would be the basis of two articles on couples therapy that I would publish with Vicki in 1993. I was so tense that when I went swimming in the ocean with Michael the day before I strained my back, a timing that couldn't be worse. I also remember outlining my ideas on couples work to Michael, who said, “That's a really good way to do it.” I was pleased, but I also heard him say that there were many possibilities in this work.

Vicki and I, along with John Neal, taught a 9-month externship at MRI in Palo Alto in narrative therapy, from 1989-1997. This externship co-existed with the one given by some of Family Therapies founding fathers on their version of “brief



therapy.” Early on, I was asked to give a narrative teaching to them and their staff. OMG, I am now in the room with the legends whose work I grew up reading in graduate school...more terror. In attendance were the founders of the Brief Therapy Institute, Dick Fisch, John Weakland, and Paul Watzlawick. Art Bodin was there as well, and I believe a before EMDR Francine Shapiro was also there. When I sat at the head of the large table, I was struck by the fact that the men sat on one side and the women on the other side, and my finely honed by Cheryl White gender issues radar was beeping loudly. I was thankfully pre-warned that Paul Watzlawick did not look at presenters when they were talking, and so I didn’t take it as a bad sign when he didn’t. But imagine the sinking feeling in my stomach when, during my discussion of the importance of gender (and other dominant social constructions) in the work, he turned to me and said in his Austrian accent, “I am reminded of a quote by Gregory Bateson that ‘the name is not the thing,’” quickly turning away again after he spoke. I may have had a lot of anxiety to manage in those days, but I was pretty good conceptually and so was able to respond with something like, gender may be a construction, but it was one that had very real effects on all of us.

What happened next was fascinating. The women, all to my right, mumbled loudly enough to be barely audible, but not loud enough to be commented on (this group was the outgrowth of the “communication school” spearheaded by Watzlawick after all), something to the effect that these men don’t really allow us to be in any position of power and authority.

Conference time

Vicki and I also gave workshops/trainings together outside of BAFTTA from about 1990-1999. Often these were at conferences, both non-narrative (e.g., AAMFT, AFTA) and narrative/post structural (e.g., Narrative Ideas and Therapeutic Practices, Therapeutic Conversations).

In the mid-nineties, Vicki and I, sometimes with various combinations of colleagues, including Bill Lax, Stephen Madigan, Bill Madsen, Jill Freedman, Gene Combs, and Janet Adams Westcott, gave workshops together, primarily at AAMFT. We were often met with a great deal of resistance by the audience, who generally worked from a systemic model. We even did a 2 full days block introducing narrative therapy at AAMFT. It was mostly great fun for our merry band of rebels despite all the contrary comments and questions we received.



Most of us preferred the position of being on the outside, given our lives and histories. I also remember a “participants workshop” that Vicki and I organized at BAFTTA, attended by some local AFTA members, where one such person wanted to know why we used such new and complicated terminology in our work. This was amusing to me as systems/cybernetics language was a whole lot more complicated in my opinion.

Stepping outside the box...

But now that we are in the 90’s, it’s time to step out of this narrative and talk to you, the audience.

A number of times in this story you have read that I experienced terror, nervousness, tension, etc. These occurred during events where it was not unusual to have these feelings; events that offer the potential for evaluation to create a context where Fear has an easy time grabbing hold of us. In those days, for me, however, the situations that were fraught with “real danger” and, consequently, that I had a hard time managing, were the social ones. I remember being with some of the group of people referenced above (and others) at a conference in the early 90’s, (before I got to know anyone, it might have been a Therapeutic Conversations conference). I can picture a big table in a restaurant and being overwhelmed with Anxiety, noticeably, as I found out later, and wanting to run out the door.

This was not an unusual experience for me then, but I was usually able to avoid being in that sort of spot. Here I could not, as my goals for myself kept me hanging in there, and at least coming to a stalemate with Anxiety. Still, I couldn’t wait to escape.

Actually, this Problem had a hold of me most of my life up to that point. In contexts where I was very familiar with people, I would be gregarious, a leader/organizer, but when in unfamiliar interpersonal territory I was the kid in school who knew all the answers but was too uncomfortable to raise my hand.

I worked at a summer camp yearly starting at age 16 and was always great with the kids and did lots of cool stuff, but when it came to socializing with the other counselors...at some point someone told me people thought I was arrogant; I would have killed to feel that way. What I felt was the Anxiety that kept me apart from others.



I share this with you to give you a taste of what the Problem was, and I apologize to anyone that felt I was uninterested in them. Situations where people were consuming anti-anxiety agents were, understandably, more comfortable for me. Starting to practice what I thought of as “self-narrative therapy” had helpful effects; I lessened the grip of extreme self-evaluation by noticing my “victories” (including the fact that despite the “bigness” of the Problem I was able to make things happen), and by cutting myself a bit more slack when things did not go as well. But the Problem still often had the upper hand until...well, we will get there later in this story...

I’m going back to the timeline now...

In 1993, I presented at Stephen Madigan’s first Narrative Ideas and Therapeutic Practices conference. On the boat ride that Stephen had arranged for the presenters (where I was predictably uncomfortable) I wandered out on the deck and found a group of people who are dear friends to this day. I can picture this scene as well (our brain also remembers events laden with positive affect, it just takes more of it to have the effect that negative affect does). How did this happen so easily for me? We bonded around my then current non-professional obsession, the Grateful Dead. It turned out that Bill Lax, Colin Sanders, and Stephen were all Grateful Dead enthusiasts, and that made for an easy, actually passionate conversation. These boys have remained among the most lasting friendships in my life.

As an aside, it would be impossible for me to communicate just how important going to Grateful Dead shows had become at that point in my life. It was a refuge from the context of self-induced pressures and demands...a no evaluation zone...and provided me with an expanded sense of community. A funny Michael/Cheryl story here. One time in SF they met someone who “made” them listen to the Grateful Dead and danced/jumped around while doing so. They didn’t know quite what to make of this. Maybe they were even a bit aghast. When they shared this story with me, I just smiled and didn’t tell them that I had been to over 100 shows. The Grateful Dead was an acquired taste that one could only acquire by attending live performances. Michael would later be taken to a post-Jerry Dead show in DC and said to me afterwards that he got it “a bit,” and appreciated that there was little “body-discipline” among attendees.

Some of us were a bit wild in those days partying wise; we worked hard,



were passionate about these ideas, and then liked to blow it out.

These were the heydays of narrative therapy as far as I was concerned. The crowds got bigger, and Michael was in great demand. Our work was all of a sudden bordering on mainstream, at least as far as the larger group of outliers of traditional psychotherapy practice were concerned. I used to say we were the left wing of the left wing of the therapy world. I presented at Stephen's conference through 1997 with many of the same presenters and have so many beautiful memories of both the teaching and the not teaching times during those days. For example, I have a vivid memory from a Therapeutic Conversations conference in Denver in 1996. A large group of presenters were having drinks around a very large table, telling stories and joking around. At some point we all started singing together, including songs from Broadway shows. Kiwi Tamasese, I think Charles Waldegrave, and maybe Wally, were there (the Family Center from New Zealand had so much to do with shaping narrative ethics during those times). David Marsten, who had attended trainings from Vicki and I, was also there, and it turned out he had a great stage voice. Some of the others in attendance were Dave (the Rock) Nylund who also had learned some narrative from me, Stephen Madigan, my dear friend Liz Colt, and my wife D'Ann who has always been so supportive of me. I share this story as an example of one of the many beautiful moments of camaraderie I had working and playing with this group.

As the nineties went on and we became more mainstream (you know this story I'm sure, as soon as you become more established and less at war with the outside world, then the infighting begins), I became more and more concerned with the hierarchy battles that were beginning to brew, naively imagining it wouldn't happen to us. For me professionally, the real turning point came at the first Dulwich conference in Adelaide in 1999. There was trouble in Camelot it seemed. I was already disenchanted with what was happening and this made it all the worse. I can picture myself sitting at a table (here I go again) having lunch with other presenters, all of us going "what is going on here?" (And yes I'm leaving out the specifics).

Personally, I was also in a quandary. My children, with whom I was very involved, wanted me at home more and not traveling around the world to present. I was tired of dealing with all the pressures and anxieties (although I was better at this point as I knew people) and tired of seeing clients (I started taking film writing and directing courses) and dreamed of a different work life. I wanted to grow



more on a personal level as well. I tried being half in and half out of my usual role to see if I could do what I was doing and try evolving personally, but it wasn't working...

My last presentation with Vicki was in New Zealand in 1999...and I would go on to present at the second Dulwich conference in Atlanta in 2002, but at that point I was pretty out of, as I jokingly called it, the "famous family therapist" business. I would not present again for 5 years.

I had settled into a slightly different life that was family, friends, and self-focused (I was still seeing clients but had made my peace with that). I was also going to a lot of live music and attending festivals. But my main project at this point was becoming a better husband, father, friend, person, and being kinder to myself. I still wasn't, however, able to get past Anxiety enough to be connected to myself and others in the way I preferred.

In narrative therapy, we talk about following our client's experience. I always followed maps really well and was really good at maintaining and articulating conceptual frameworks. Michael used to kid me that I taught Michael better than he did; my retort was that it was because I had a simpler understanding. But following the client's experience as we thought of it in narrative was one thing and being able to be emotionally inside a client's experience and inside my own emotional experience at the same time was another thing for me. At that point in time, I didn't have the words to describe what I was looking for (but now I do, and it's PRESENCE).

Back to the future

A couple of years or so down the pike, I became thirsty again for learning something new. I started asking around, and doing some general reading, and discovered that the two hot topics of the day were attachment theory and neurobiology. I knew a fair amount about attachment theory as Mary Ainsworth was on my school's faculty both in college and graduate school. I actually almost did my dissertation in attachment theory, but I decided I preferred to get out of graduate school in a timely manner instead. At that point in time, I didn't really like how mainstream psychology was using attachment ideas, more as criteria for pathologizing and specifying personhood than as a developmental metaphor, which often resulted in taking a corrective approach. I was, however, taken with neurobiology (I was a biology major for a while in college) and the more I read



the more I was fascinated with the way that neurobiology surprisingly supported a lot of the ideas in narrative therapy (except, of course, the immense importance emotional systems play in neuroscience thinking).

The truly important development for me in my life, however, was the beginning of a meditation practice. Living in California, I knew a number of people who engaged in meditation. And my dear friend Bill Lax had written a paper on Buddhism and Narrative Therapy, a seminal work in that literature. Foolishly, I had chalked meditation mostly up to California sensibilities. However, I became struck with the number of neurobiologists who were engaged in meditation practices. I was very influenced by the work of Daniel Siegel and was taken with his Wheel of Awareness practice (I later did an intensive with Dan and was impressed with the loving way he approached all of us and the importance to him of trying to make a difference in the world). So, I began meditating. At first, I complained to the meditators in the groups I led that I felt like it made my mind buzz worse. They laughed, and said I was just noticing it more. I said "no, it's worse." Of course, they were indeed correct. What I was not prepared for was the real effects of meditating on my connection to myself and others. It was like I was suddenly and almost magically opened up. I couldn't believe that this kind of practice had effects that you didn't see with sometimes years of psychotherapy, including narrative therapy. I was starting to get a handle on presence, something I was reading about in the neurobiology literature. Amazingly, one effect for me was that I was significantly more comfortable with other people and with social situations. One year, when my wife asked me what I wanted for my birthday I told her it was for her to start a meditation practice. This opened her up more and opened the door to increased closeness for us as a couple.

I began discussing these neurobiology ideas with both of the ongoing groups I led in the East Bay. The participants were very interested in what I was saying as they had done some neurobiology reading as well and were enthusiastic to hear about how I was combining these ideas with the narrative ones that we had been discussing. After about a year or so of doing this, I began to discuss some of these ideas with my intern training group at BAFTTA. Marie Natalie Beaudoin, who I had hired to be our training director (Vicki had long left our center at that point), eventually became interested in my new focus, and began doing some reading herself.

So, in 2007, when Rick Maisel (another Deadhead) told me that he was



presenting in Cuba at the invitation of David Epston and wanted to know if I would like to present with him, I told him, borrowing a line from the movie Jerry Maguire, "You had me at Cuba." I thought this was a good test for my newfound ability to manage Anxiety and hold onto my own presence. It all went shockingly well for me, and I felt it was a major turning point in my life. While our presentation was not focused on the exciting new neurobiology ideas I had been teaching and letting influence my practice, I gained some enthusiasm for maybe presenting them in the future.

Neuro-narrative therapy

The next few years found me continuing to do a ton of reading and beginning to do presentations on what I would eventually call Neuro-Narrative therapy. Marie-Nathalie was taking notes at these presentations and eventually began doing some writing herself. I, however, was still reluctant to get back into the writing game. I had written a book with Vicki (Zimmerman & Dickerson, 1996, *If Problems Talked: Narrative therapy in Action*), and I/we had been involved with another 15 articles on narrative therapy (see bibliography). I had even done some writing prior to that as well but, unlike teaching, writing comes hard to me, and I wasn't sure I wanted to get back to doing it again. Nevertheless, when Marie-Nathalie approached me with a draft of an article that covered some of the basics of my work and asked if I wanted to be involved, I agreed, and that would become the basis of an article we published in 2011. We also presented at the Dulwich conference in Brazil in 2011. We would write another article (Zimmerman & Beaudoin, 2015, *Neurobiology for your narrative: How brain science can influence narrative work*). I eventually wrote another article on my own (Zimmerman, 2017, *Neuro-narrative therapy: Brain Science, narrative therapy, poststructuralism, and preferred identities*). So, I then had the courage to say yes when Norton approached me about writing a book. In my heart, I knew it would be a different kind of torture.

I agreed to write the book for several reasons, some good and some bad. In doing workshops at Therapeutic Conversations 10 (2012) and 11 (2014), I was met by very enthusiastic audiences, many of whom were into narrative as well as the neurobiology they were reading or learning in school. Many came up to me after these presentations and whispered, "Is it ok to experiment with this? Can we



Speak about this out loud? What about the ‘narrative police’?”¹ This was also true after my 2014 presentation in Adelaide at the Dulwich conference, although the people there who were interested in my work had to be much more discreet about their interest given the local atmosphere towards anything not officially sanctioned. I thought, “Wow, has narrative therapy become subject to such a harsh a set of rigid specifications, that students have become so fearful and subjugated?” I have a lot more to say about the operations of power behind this, and its real effects on the future of narrative therapy...

Back to the book. So, one reason that I wrote it was for all those who attended my workshops and wanted more, specifically something to read. I was also encouraged by several colleagues whose work I impacted. For example, the South African narrative contingent was very interested in what I was doing...Elise Morkel in Capetown, as well as Chene Swart in the Johannesburg area, who has become a treasured friend. I was invited by them to do a couple of workshops there in 2015.

The bad reason for agreeing to do the book, however, was pride and hubris. These Problems got in my way from saying no to a project that I was not sure I wanted to take on at that point in my life.

Working on the book, as I suspected it would, had a huge and not so good impact on me. I put on weight, had meltdowns, and was moody. All of this was complicated by an increasing but unrelated visual disturbance I was experiencing that made reading and writing more difficult and was opening the door to a lot of fear about my future. These were not ideal book writing conditions. Lots of coffee and more frequent and longer meditations eventually got me through it. The book was published in 2018.

There were a few more presentations/workshops before and after this but the one constant was that I maintained my priority of privileging my personal life over my work one, and so I said no often. This stance seemed perplexing to some, but I have been clear to myself (and others) about my own preferences.

¹ To diverge: For the sake of transparency, I must admit I was once a member of the “narrative police,” encouraging the orthodoxy that I believed in back in the day. But that was then, and this had long become now; I had been opened up to a multi-verse of possibilities. I was also saddened by the real effects of the oppressive practices of narrative orthodoxy that had come to light. Little did I imagine they would eventually be turned on me.



Back to the past?

In early 2019, I was contacted by Cheryl White who wondered if I was interested in being part of a discussion around neurobiology and narrative therapy. She said that they were planning a journal with "...a range of papers coming at this from a few different angles." It was insinuated to me that this was to be part of a larger effort to address the lack of respectful conversations that had been occurring around differences in the field. I was enthusiastic at first, particularly about the latter part, as I had been long concerned about the divisiveness I had been witnessing. A very long story (and a lot of emails) made short, it eventually became clear to me that this was not really going to be a discussion. Indeed, Cheryl was, "...with people wanting to talk about the departure from such ideas." Once I escaped naivety, I respectfully said no thanks. I had heard from students and senior practitioners alike that if you don't do what Cheryl wants, she can walk away from you. To my great loss, I fear I have been added to that list. For me, the decision was an ethical one; I didn't want to legitimize a process that I was (and am) strongly against...the use of the power and authority of a dominant institution to de-legitimize new points of view that are challenges to their orthodoxy.

When I last presented in Adelaide, I was taken to a private dinner with the "Other Ones," those who had split off with Michael before he died, partly to protest the oppression of narrative orthodoxy. I also met up with some others at the conference I had gotten to know on earlier visits, who said that they had previously been made to feel unwelcome, given that the ideas they had that weren't in accord with dominant Dulwich teachings. Many of these wonderful folks were part of the original think tank that I had met on my first visit to Adelaide. As Cheryl said to me, "The beginning of this narrative practice work came from fierce and bold speaking." So, so, so sad to me that in the end the tolerance for this had changed so much.

Is narrative therapy coming to its end? Most forms of psychotherapy evolve in the cultural context in which its ideas and practices make sense. After the culture evolves, usually the not so current anymore forms of therapy retreat into a much smaller niche. In order for that to be different, the therapy must evolve in a way that makes it relevant to current times. Whether narrative therapy meets this fate or not, is dependent on young people's willingness to protest the ways it does not fit for them, and to question all "truths" they are being sold on. For



example, we upended a lot of truths in the Vietnam war protest days and created change; cultural change usually starts with the young people of the day.

Interestingly, before he died, Michael was studying the neurobiology of memory, and we are only left to imagine what new ideas and practices would have emerged in this process. While Michael was not prone to discussing affect directly, I've never seen anyone better at following the affect in a conversation; studies of memory are very tied to affect, as what we remember, as I said earlier, is related to the affect invited out by the situation. I mention this to address the affective turn in today's therapy world, a turn I understand to be related to the way technology has taken over our lives and its real effects on our brain. A therapy in our current context must somehow address how technology has taken us away from the important role affect has in our lives.

Anyway, Michael was no fan of orthodoxy, and before he died, he and David were planning to develop new approaches to narrative work. How I wish we could have spent hours talking about these new ideas, both Michael's and mine...

The end of the story?

D'Ann and I grew tired of the scene in San Francisco, too much entitlement and unfriendliness since the Tech crowd took over the city. So we planned a move to Denver (where our daughter Meg lives), and found a house there in February 2020. Well, you know what happened next... We've been living there since the end of April 2020 and love it, but, like everyone else, we are trying to navigate these difficult times, all the while trying to figure out our lives here, both personal and professional.

So, at this time, I'm not sure what the future will hold for me professionally. I've been (virtually) presenting in VSNT's advanced training, and I so appreciate Stephen Madigan's ongoing support of my work. My presentations have always been fun, full of video, music and pictures...but the virtual thing is so far unsatisfying to me, given my dependence on "feeling" a connection to the audience. Is it time to reinvent the wheel?

I will soon have a reckoning with my eye issues; if they break bad it will be life changing. Stay tuned...thanks for reading...



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Review of “Reclaiming Lives from Sexual Violence: Understanding shame through innovative Narrative Therapy” by Tim Donovan and Dale Johns

Dale Johns

Donovan, T., & Johns, D. (2022). *Reclaiming lives from sexual violence: Understanding shame through innovative narrative therapy*. Routledge.

My name is Dale Johns and recently, together with my counsellor Tim Donovan, we have co-authored our book, which has been 7 years in the making. It's extraordinary how I met Tim. I had just experienced my second court appearance, in a case against Catholic priest Gerald Ridsdale for childhood sexual abuse. I was struggling deeply. After the court appearance, I met a social worker from the Office of Public Prosecutions who made an appointment for me at a sexual assault agency in Bendigo, Victoria, Australia. Incredibly, it happened to be the agency where Tim had just taken up a position.

The day and time for my first appointment with Tim had arrived. What really hit me that day was the view out of the counselling room window; it was quite unnerving having the Bendigo Catholic cathedral, which was such a powerful image, casting a shadow over the counselling room window and over my mind, how ironic. I was anxious going to counselling. My past counselling experiences were excruciatingly painful; I never told any previous counsellor or psychologist about my experiences of childhood sexual abuse because I didn't trust any of them, and their demeanor and counselling rooms were cold and clinical. I didn't know them, and they didn't know me, or even attempt to get to know me... From the very first time I saw a counsellor or psychologist most of them did not care about or believe me, from the onset most of them made some painfully destroying accusations. I needed to trust whoever I was going to divulge my soul to and share my most painful truth. I was crying out for help. So, I took the opportunity I was given to see Tim; I needed to be able to break the silence I had held for 42 years. My other counsellors and psychologists had all been female, this was the first time I was seeing a male counsellor. Apart from my dad and





brothers, I did not trust other males. Ridsdale and other boys and men had been so cruel to me with physical and verbal abuse, which was heartbreaking for me, so I never really trusted other males. In saying that, I have always craved male friendship, but have never found any I really trusted. So, under all the anxiety I was feeling, I was quite excited about meeting Tim. I had been praying continuously before and as I approached the sexual assault agency and, as I put my hand on the door, it seemed to take such force and strength for me to push through what felt like a wall of chaos, a fight between my integrity and shame, guilt and silence, but I pushed my way through. Yes, I made it into the waiting room, I had jittery legs and my heart felt like it was going to pound out of my chest, I found it difficult to sit down. Then this young man popped his head around the corner of the door, “You must be Dale,” we shook hands and he said, “Hey Dale, I’m Tim,” and I followed him down the hallway into that room with the infamous view... It wasn’t long before I realised I had made the right decision giving counselling another chance. Tim made me feel welcome, his demeanor calmed my anxiousness, and I felt the vulnerability from both of us in the room, which was a comforting, new experience in the counselling room. I felt accepted, not even the slightest bit judged, and I felt a real connection with Tim. I remember making a joke about the overpowering view out of the window... We laughed. I had made a decision that if Tim was the right person, I was going to start dealing with my unbearable silent past. But I knew there was so much work to be done to get me to that point... Tim took the time to get to know me; we got to know each other, that was so important for me.

Our therapeutic journey spanned three and a half years, and now, nearly eight years on, we are working together and have just published our book. Tim has supported and walked alongside me through the process of Narrative Therapy. His professionalism, incredible knowledge, and the way he works with such innovation, understanding, care, compassion, vulnerability, and sensitivity is amazing. It was December 2014 when I first started seeing Tim, and it is now 2022. Tim’s dedication and the time he has, and continues to, put into ‘walking alongside’ me has brought me incredible freedoms. Tim created a space for me where I was believed, with no judgement or detrimental comments or assumptions were ever made. With other counsellors and psychologists prior to





and during the court process, I endured horrendous treatment, soul-destroying judgements and comments, and an environment where I wasn't believed.

When Tim and I began working together we had no idea that we would ever be writing a book. However, as a result of the way Tim goes about his work, all our notes and documentation were saved and readily available for future study. For example, Tim shared note taking during each session on a whiteboard. He would then email me a photo of the whiteboard along with a new set of questions for me to think about and have a go at answering before the next appointment. It was incredibly freeing for me and an amazingly gentle way for me to break my silence. And for me to have the most secret, painful information, which had been locked inside of me for forty-two years, things that I had never even been able to whisper to myself, written down outside of me on the whiteboard, in this space of vulnerability, now that is incredible for me, this most private information, my lifelong secrets each week were now out there, outside of me. Tim worked gently, asking the right questions through externalising and scaffolding conversations, leading me in the direction of my truth, which was hidden deeply and controlled by shame and guilt, keeping me in a place of dark defeat, self-hate, self-blame, and silence for forty-two years, that private information was now all written down outside of me, there was such freedom in that for me. Tim also interviewed me as 'Shame,' it was painful, yet extraordinary, and it awakened my integrity. I was then able to reclaim my integrity, which gave me the strength to dig myself out of the deep dark pit covered in shit and blood, the filth of sexual violence, which brought me into the light of wanting to live again, revealing to me that I was innocent and not to blame for the violent sexual abuse. Because of the way Tim worked with me through the process of Narrative Therapy, with absolute consideration and care for me, the client, I now have a deep understanding of the way shame works and can fight through shame's power to break the silence and talk about my story of childhood sexual violence. Breaking my silence with this deeper understanding of shame has brought such freedom to me. Tim could see that my fight for justice was becoming political, I wanted to stop the shame and silence, and stop the abuse. I hated the thought that there are so many men out there that are suffering in the same ways I have been. We absolutely needed to





share our story of reclaiming lives from sexual violence through innovative Narrative Therapy approaches.

Why did you write this book?

This book came out of the knowledge that this subject had not been approached or produced in a book before, so it was paramount that we told our story. Our hope in writing this collaborative book was to: 1) to share the compassionate and innovative way Tim works; 2) to reach out to other professionals working in the mental health sector to treat clients of sexual abuse with careful consideration, compassion, and respect; and 3) to give students studying in this field a case study to read about and consider. And above all else, we wanted to reach out to anyone out there who is living in silent turmoil after being violently sexually abused as a child. It is our wish that this book will give other people like me hope for a future free from silence, shame and guilt and to gain some justice through the opportunity to share their story.

Dale Johns



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

Nina Tejs Jørring, MD¹

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

¹ Specialist and supervisor in family therapy. Child and Adolescent Mental Health Centre, Capital Region of Denmark, Denmark. <http://www.ninatejsjorring.dk/en/welcome-nina-tejs-jorring/>





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 (Borrell-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* (Luhmann, 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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