Manual for

Collaborative Family Therapy With Psychiatric Multi-stressed Families

February 2013

The Psychotherapy Clinic

Child and Adolescent Mental Health Centre, Glostrup, Denmark

List of Contents

Process Overview

Referral phase:

The secretary receives and registers the referral.

Preadmission assessment: selection of therapists and the person responsible for the case

Phone call by the person responsible for the case, briefing on reason for referral and asking about their hopes for the treatment. Information about the Psychotherapy Clinic (PTK), our treatment methodology, our measuring tools and our project.

Mailing of *appointment letter with the questionnaire "familiens mål" (the family's goals)*.

The *PAM* and *BYI* questionnaires are filled in during the first ½ hour before the actual first conversation. A staff member welcomes the family, gets them started, and receives the filled-in questionnaires.

Clarification phase:

The phase lasts for one to three conversations Subjects: the family's expectations, definition of the problem and vision.

After the first conversation: Clinical team meeting and *re-assessed treatment plan (or the first assessment and treatment plan)* is dictated.

At the second or third conversation: *Treatment plan* is handed out, and feedback/explanation on the questionnaires is provided.

This phase ends when a common understanding of the problems and the therapy goal has been obtained and there is agreement on a structure and a plan for the conversations. If required, the *treatment plan* handed out after the second conversation can be revised.

Work phase:

Work sessions based on a problem or a vision.

Taking stock at every fifth conversation with focus on effect, progress and evaluation.

A *revised treatment plan* can be agreed on and written after the stock-taking, especially if problems or goals should be adjusted.

Summary and revised treatment plan not later than when a process has taken a year at the Centre.

Revised treatment plan is dictated when there are major changes in the treatment.

Clinical team meeting before or right after the stock-taking.

Supervision as required.

Conclusive phase

Approximately three conclusive conversations, depending on the family's needs.

Questionnaires are handed out: *"familiens mål" (the family's goals)*, *PAM* and *BYI* before the last conversation. The family takes them home, fills them in at home and brings them to the last conversation.

Ask the family if we may revert to them for research purposes. In that case, the therapist documents

the verbal consent in the patient record and provides contact information to the researcher.

Is wound up with *written documentation* to the family (can be the discharge letter).

Discharge letter to the referrer and the GP, copy to the family.

Chapter 1: About this Manual

Introduction:

This manual has been written by and for the therapists at The Psychotherapy Clinic (PTK in this manual) at the Child and Adolescent Mental Health Centre, Glostrup, Denmark (CAMHS Centre Glostrup – BUC-Glostrup in Danish).

The manual has been developed over a year or so (2011) and is mainly based on theories from narrative therapy. It is based on the practise developed by the therapist group by using a variety of different psychotherapeutic theories and techniques, and on their work to incorporate this practise in the field of child and adolescent mental health. Also the experience with psychotherapy in a general hospital setting, including accreditation standards and regulations, contributes to the manual. The therapist group has used its knowledge and experience from working with a manual in the treatment of patients with anorexia. Other important sources of inspiration are William Madsen and his book "Collaborative Therapy with Multi-stressed Families", Collaborative Helping Maps, a model integrating a multitude of therapeutic theories, and shared decision making theories (patient-therapist partnership).

The manual was revised after it had been in use for around one year, at the end of 2012, in addition to regular revision whenever it becomes clear that something is inconvenient and calls for a revision.

The manual has a number of purposes:

1. The manual will serve as a description of the commonly defined foundation, on which the therapists base their work; the theories they base their work on, the language they speak and the intentions they have with their work.
2. The manual will represent a snapshot of the knowledge and experience of the therapists, which they use in their work.
3. The manual will serve as a source of inspiration, when you need ideas on what *can* be done in a therapeutic conversation.
4. The manual will serve as a check list/a recipe when you need to remember what you *must* do to meet hospital standards (however, please bear in mind that not all the 'ingredients' are described in this 'recipe', only those that were found to be relevant for the therapeutic work).
5. The manual will serve as a work tool for quality assurance and development of family therapy at The Psychotherapy Clinic at the Child and Adolescent Mental Health Centre, Glostrup (Børne- og Ungdomspsykiatrisk Center Glostrup).
6. The manual will serve as the practical foundation for a research project to examine the effect of collaborative family therapy.

The manual is therefore going to be both a concrete work tool, be developed continuously and form the basis of a research project. It has therefore been compiled digitally to gain, file and evaluate

knowledge and experience on an ongoing basis, with concrete changes being added simultaneously if and when required.

To many people, the title 'manual' conveys specific expectations about purpose and content. If the title elicits expectations of a negative nature in the individual reader, we, the authors, hope that these expectations will not be met. The title has been chosen because it is our wish to provide the therapists at The Psychotherapy Clinic with the framework, guidelines and support that manuals should provide.

The structure of the manual and how to read it:

One of the main principles in collaborative family therapy is that the therapists learn continuously by acquiring knowledge from the families and through their work with them; this means that the knowledge must be added to the manual regularly. We will therefore make use of the possibilities inherent in having a digital manual.

The manual contains several types of paragraphs:

1. Paragraphs describing the underlying theories, ideas and intentions of the actions mentioned below that in our opinion constitute important parts of collaborative family therapy. These paragraphs are included in the 'what and why' paragraphs.
2. Paragraphs describing: Actions to be taken by the therapists at CAMHS Centre Glostrup to meet the common guidelines of the Centre; actions where we want to examine the effect in our research project, which means they must be included in all therapies; and the common requirements defined by us to ensure the work can be termed 'collaborative family therapy'. These details are included in the 'must' paragraphs.
3. Paragraphs describing the actions that the therapist can choose to take based on their therapeutic relevance. These details are included in the 'can' paragraphs. These actions can also become the object of research on their effect.

These paragraphs can be read as in a classic book, and they will be revised from time to time.

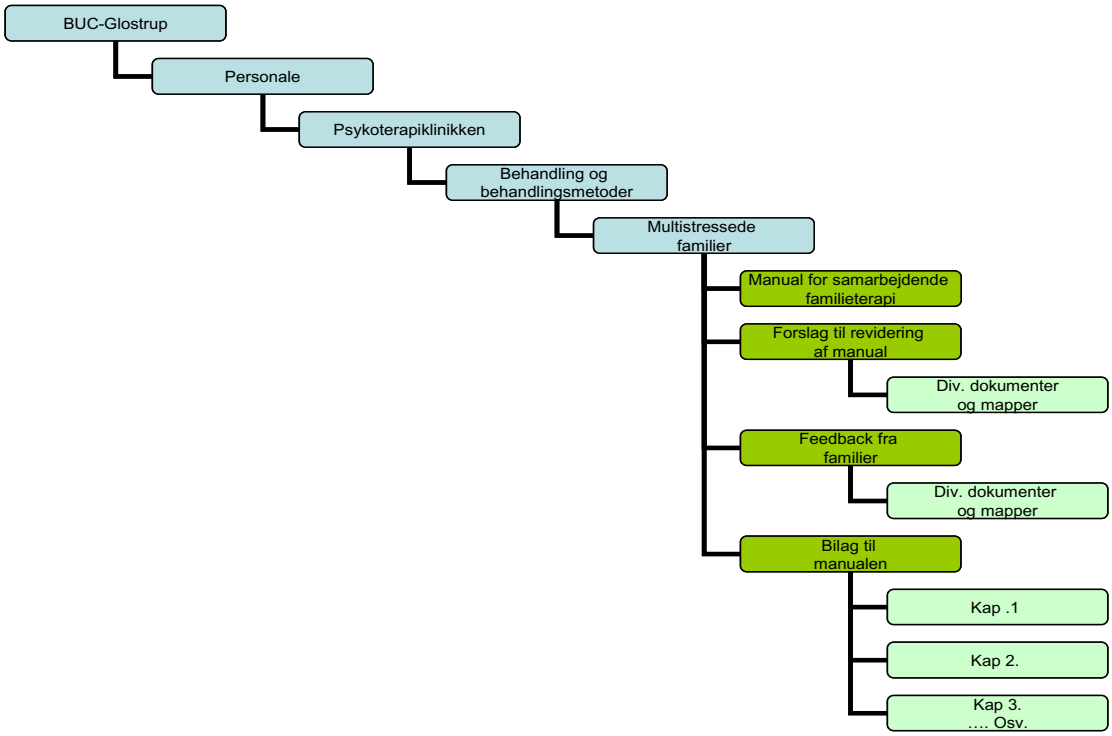
The manual also includes a number of digital documents that are available from the digital folder that The Psychotherapy Clinic has on the P-drive of CAMHS Centre Glostrup (BUC-Glostrup). Here you will find e.g. letter head and treatment plan templates of the Capital Region of Denmark. There will also be folders with concrete suggestions and details of therapeutic techniques. Here you will also find further details on the underlying theoretic considerations. One folder will contain advice and criticism from families who have completed their therapy. That part of the manual will be developed continuously to allow everybody to add new data in the relevant folders.

This is still far from being established, but it will be an important development project.

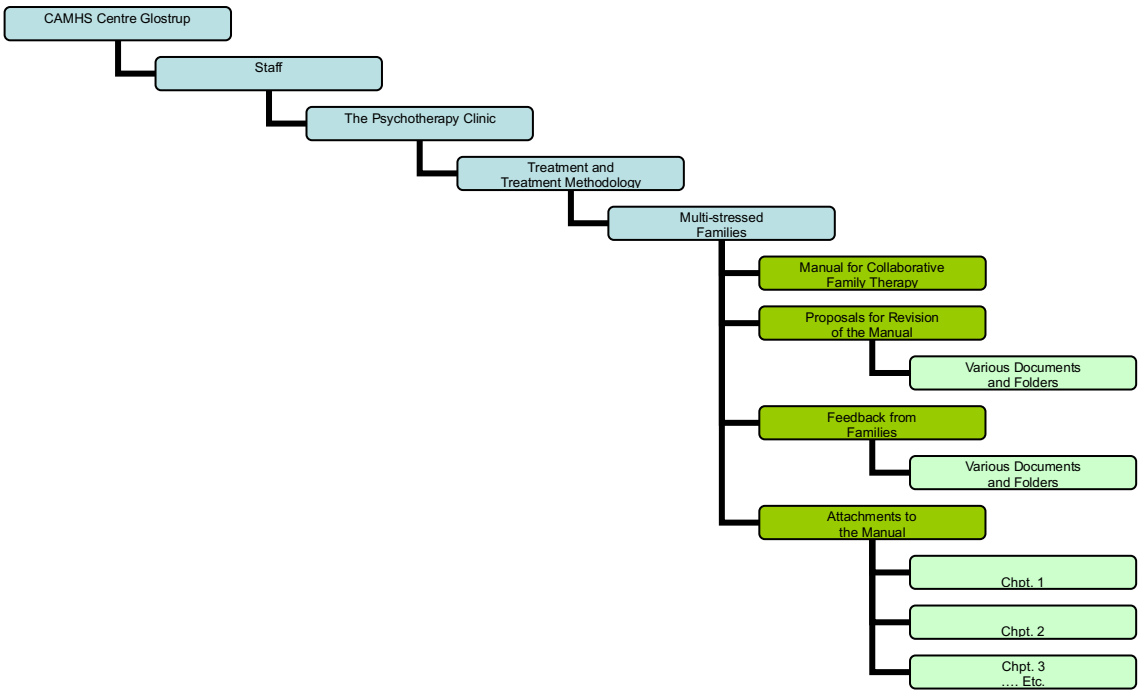
Throughout the 'classic manual', you will find links to various folders in the digital PTK folder.

Digital structure:

At the CAMHS Centre Glostrup (BUC-Glostrup) drive, you will find all the files constituting the manual:



Structure in English:



Everything on the research part and drafts for the research protocol are available at:

BUC-Glostrup → Personale → Psykoterapiklinikken → Forskning.

Chapter 2: About Collaborative Family Therapy with Multi-stressed Families

Introduction:

The expression 'collaborative family therapy with multi-stressed families' is from William Madsen's book with almost the same title "Collaborative therapy with multi-stressed families" (link).

At our clinic, multi-stressed means comorbidity in a child, and that the family is either more burdened than normally because of the psychiatric disorder or that one of the parents is also suffering from a mental disorder. In addition, there will often be indications that the local authority is not up to providing adequate support to the family.

The referral to collaborative family therapy comes from the other sections at the Centre and has been preceded by an examination and a diagnosis (link to internal regulation on referral).

An all-embracing feature of the parents of these children is that they are severely distressed by feelings of powerlessness, guilt and perceived incompetence in parenting their child. Our main objective is therefore to empower these parents to be more ready to act, gain more self-confidence and competence as parents and improve their coping skills in relation to the mental disorder.

When you cooperate, you meet the other person with an expectation that they are competent at something, and that person is thereby moved to a position where they are seen, and perceive themselves as competent. This allows them to perceive themselves as competent while contemplating how to deal with the hard stuff, and they are therefore in a better position to find solutions than when they see themselves as powerless, incompetent, etc.

The theoretic foundation of the psychotherapy model is based on narrative therapy, but it is more than that. Through the use of cooperation as the basic approach when addressing people, the conversations will be based on the grammar of the externalising language. Externalising practices are now used in many forms of psychotherapy, including cognitive behavioural therapy, and can thus no longer be claimed only to be a narrative technique. In the same manner, our therapy also applies knowledge from other forms of psychotherapy.

As a therapist in collaborative family therapy with families distressed by a psychiatric disorder, your role is not only that of the facilitator of a process controlled by the client. You also assume responsibility for the process and offer expert knowledge about the mental disorder, a language that can be used to talk about problems so they become manageable, and knowledge of how psychotherapy can be used towards the preferred change.

What and why:

Collaboration is in itself an effective therapeutic technique, and collaboration is the overarching concept in our work. Collaborative practises involve addressing the families with respect, curiosity, hope and belief in the possibility of change, trust and willingness to share your own knowledge. See further details in William Madsen's book "Collaborative Therapy with Multi-stressed Families" (insert link).

One aspect of collaboration is that it means that both parties expect to achieve an outcome of their

joint efforts. At our clinic, the therapists' outcome is the specific new knowledge that the therapist obtains in the work with that particular family. To achieve this, the therapist must constantly be on the lookout for such knowledge and, when it is obtained, it is important to inform the family of this, and what this knowledge consists in, as a part of the therapeutic practice.

Research shows that the most effective factors in psychotherapy are the non-specific factors (the common factors): The clients' own resources, the client-therapist relationship, the client's expectation of the outcome of the therapy, and the therapist's use of specific techniques. (link to Scot Miller's two books, "The Heart and Soul of Change"). Collaboration as an overall principle can in our view ensure that focus is maintained on these particular factors.

The collaborative stance must be pervasive throughout the course of the therapy. The therapeutic component is realised when the clients perceive themselves as competent and being in a powerful position in relation to a subject, when you collaborate mutually on that subject with a person you trust. In the therapeutic situation, the subject will be problems and their effect on the person's life. Through collaboration, the therapist will help the person to move to a more powerful position in relation to the problems and their effect on their lives. All the therapist's actions will therefore attempt to seek out the client's own ideas, knowledge and attitudes in relation to the subject and let the work progress in a direction based on a joint definition, which is founded on the knowledge both parties contribute with. The therapist therefore also has to offer his or her own professional knowledge to turn this knowledge into common ground (link to transparency). It is therefore neither the client, nor the therapist who decides the course of the therapy on their own. The course is determined in collaboration, ideally from the largest possible common knowledge base.

The therapists will try and convey as much knowledge as possible about the actual treatment, their professional knowledge and various psychiatric disorders, etc. to the families. But this knowledge is offered to the families in a way that enables them to embrace it and use it as they choose. The therapists will enact their knowledge about the power that their professional knowledge exerts in a therapeutic framework with an as transparent and non-authoritarian approach as possible to prevent the families from having to submit to it, so they can meet the therapists in a collaboration on an equal basis.

The therapists will aim at showing recognition of the families' perception of their lives in telephone conversations, emails, leaflets, treatment plans and letters, and share their own professional knowledge as well as the knowledge gained from other families.

In this connection, according to collaborative practice the family should receive a written description detailing in their own words the definition of the problem, the aim, hopes and dreams they have for their work at the Clinic. The therapists contribute to this product with their own knowledge and expert background, a broader perspective and an option to prepare and produce the written materials. The family contributes with its expert knowledge about the its own family's perception of the problems, their knowledge about their own competences, and their ideas and attitudes in relation to a good family life.

To the largest extent possible, 'public' note-taking is practised to give the families the opportunity to see what the therapists write about them and thus create joint ownership of this knowledge. The therapists use maps of narrative practices or collaborative helping maps as session templates to optimise the collaborative structure of the conversations. The specific techniques are described in chapter 8 and in the digital attachments.

Must:

The family must throughout the process be met with actions that are collaborative. In the specific

conversations, the therapists must ensure that subjects discussed are seen as relevant by the family, that the work is aiming at a goal chosen by the family, and that it was the family's own choice to come to the therapy. The therapists must ensure that the family all the time sees that the work develops in the direction they prefer. If the work is not progressing satisfactorily for the family, the work must be changed or terminated. The therapists must throughout the process be as transparent as possible, inform about the purpose of the interventions made, so the families understand the underlying intentions and can form an opinion about these.

The family must receive a first phone call, an appointment letter, our leaflet, a treatment plan, written material (as a minimum flip charts from the sessions or photos of these), stock-taking conversations and a final letter (can be a copy of the discharge letter). There are several purposes: transparency, respect, knowledge sharing, supporting the family's memory and their opportunities to ask questions. The aim is to provide the family with sufficient knowledge to be able to choose if they want the therapy or not on an informed basis, and to improve the family's perception and experience of being able to make decisions about their own lives.

When a treatment plan has been prepared, the family must give its consent to it, after having been given the time to read through it. It can be drafted on the basis of a flip chart, where the therapists have used either the map of externalising conversations, the map of re-authoring conversations, or the collaborative helping map. The therapists make a draft that the families take a position on, comment on or concur in.

Overall briefing on the Clinic's project. Together with the appointment letter, the family will be asked to fill in various questionnaires. It can be considered if the family should receive written material in batches, so they don't receive too much at a time. The family must be briefed on which documents we use and the purposes of these, and they must receive information on how the outcome of our evaluation of these is used. In this connection, it is important to emphasize that PAM and BYI are not used in the therapy, but only by the researchers in an anonymised form. So the families can receive the evaluations after having completed the therapy, but only if they want to, and get one of the therapists to explain the evaluations. But this will in that case be an action taking place independent of the therapy.

Can:

The therapists can in collaboration with the families decide if they want to work on the basis of the family's definition of the problem, or their goal/vision for the work in the family therapy. This will be decisive as to whether the therapists base their conversations with the families on the map of externalising conversations, the map of re-authoring conversations, or the collaborative helping map.

The family will have different expectations about therapy. Many will expect or want us to provide individual therapy to the child. These expectations cannot be met in the form of the only treatment being provided as one of the overall objectives for the therapists is that the parents will see themselves as competent at supporting their children. As a minimum, the parents must therefore participate in a parallel therapeutic process. The therapy will often progress towards giving the parents more time alone than together with the child. Some parents do not want to bring their child. But the therapists need to see the child to be able to use their professional impression of the child in the therapy. This can take place by visiting the family at home, if needed.

The therapy can thus vary greatly in structure, e.g. family conversations with all the children; family conversations with one child; sessions with a varying number of participants, parents, children; divided sessions where one therapist is with a child and the other with the parents.

The therapists can use various therapeutic techniques. See chapter 8 and the digital folders for information on these.

Chapter 3: The Clarification Phase

What and why:

The purpose is to obtain a common understanding of the problem that brought them to the Clinic and the treatment goal they want to pursue.

The family has to gain sufficient knowledge about what PTK can offer, what they will experience at PTK, and what they must do, to be able to decide if they want to participate in a treatment course with family therapy.

The therapists need to obtain sufficient knowledge about the family, their hopes and dreams, their resources, wishes for help, and their problems/barriers to be able to draw up an offer for therapy that is adapted to match this specific family.

In this phase, the therapists should assist the family in finding a preferred position or a scaffold on which they can stand, from where they can look at their problems and their hopes and visions for their lives.

It is our objective that in this phase, the family gains confidence in the therapists and the therapy. It is often important that the therapists for instance are familiar with the process that the family has been through before they came to PTK. It is therefore important, that the therapists have already read the essential parts of the patient record before the first phone conversation. These can be summaries, statements, discharge narrative, etc.

The therapists should in this phase strive to obtain an alliance with the family. In families with small children, this phase will focus particularly on establishing preferred platforms for children and adults as a basis for their participation in the therapeutic work. See further details about joining (link).

Narrative language is used. The key to this is to externalise problems and barriers as well as hopes, dreams, attitudes and visions in order to segregate these from the family members. This enables the family member to move to a different stance in relation to the above instead of perceiving it as an integrated part of themselves. In doing so, the family members can form an opinion, i.e. evaluate the above and their relation to it, and subsequently decide if the relation between the person and the externalised object or feeling should change.

The therapists should contribute with curiosity, respect, kindness, hope and expert knowledge in appropriate amounts to enable the family and the therapists to create a relation, which can form the basis of a constructive collaboration.

The therapists must also apply their therapeutic knowledge and experience to assess and decide how to best meet the family's expectations about the best help in their opinion. These can be wishes to receive individual therapy, counselling, psychoeducation, participation in network meetings, school visits, home visits, etc.

To optimise the family's opportunities to work, they should receive written information or documentation on their own work and the therapist-family collaboration. This is most often done by handing them the flip charts that the therapists write on during the sessions. In doing so, the

therapists show the family members respect and involve them in the process, while at the same time supporting their memory and learning.

Must:

The first step in a new process is a phone call from the therapists. During this call, they introduce themselves, explain briefly about PTK and the content of the referral, and give the family an opportunity to describe the reason for the referral in their own words. The therapists decide during the call together with the parents who will participate in the first conversation. (See description of telephone conversation in the digital attachments)

Overall briefing on the Clinic's project. The appointment letter must contain the PTK leaflet, form about the family's goals, and the hospital's standard consent forms.

The family must arrive ½ hour before the clarification conversation and fill in questionnaires. A therapist will talk about our project, explain why the family must fill in the forms, and how the Clinic uses them.

Accreditation standards: The therapists must use the templates from the Centre for the treatment plans. In the first conversation, the therapists must obtain sufficient information to be able to draw up a treatment plan. If required, for instance if the parents come alone to the first meeting, the drawing up of the treatment plan can be postponed. In that case, a note must be made in the patient record about the reason for this. The therapists write this treatment plan, and the families must indicate their acceptance of the plan verbally and receive it at the second conversation. A note must be made in the patient record about the family's acceptance of the plan.

The therapists must use the IKEA board as ongoing documentation during the sessions to ensure that the family members all the time have the same knowledge in writing as the therapists. Use a special child size version of a flip chart board, so everyone can sit around it and look directly at it, instead of upwards. It is also important that the children can reach it to draw on it. We use the MÅLA easel from IKEA with drawing paper. The flip charts must either be handed out or sent via email to the families as documentation for the work. (link to IKEA board).

Externalising practices for both preferred and difficult subjects are a part of the narrative language that must be pervasive in all therapies. This must be evident from the written documents, both the flip charts, the letters and the plans.

A written document, the treatment plan, marks the conclusion of this phase.

In all templates used, the statements must be phrased in the family's own words. The following items must as a minimum be described:

1. the family's definition of the problem,
2. the family's vision: their hopes, dreams or visions for their lives, and, if relevant, their shared family life.
3. barriers and support to realise the visions
4. agreements: therapy framework and plan, who does what, and a time frame for the course of the therapy.
5. the family's acceptance and their comments, if any, to the plan.

If these items are not adequately described in the therapist treatment plan, which was handed out at the second conversation, an addendum must be written, for instance as a therapeutic letter or as another form of mutual contract.

Can:

The therapists can together with the family explore which use of the IKEA board is the best. The therapists' and the families' different needs for 'external memory' can be included in these considerations. Please see chapter 6 for information about written documentation.

The therapists can decide on their own which template for the conversation they think it is best to use in the individual session. This will often be a choice among the map of externalising conversations, the map of re-authoring conversations, or the collaborative helping map. On the board, more models can be used, for instance classic brain storm, the board square (inspired by Art Fisher) or ongoing note-taking (link).

The therapists can decide on their own, if they will prepare a collaboration plan, or if the therapist treatment plan is considered sufficient as collaboration document.

Chapter 4: The Work Phase

What and why:

Humans construct their self-image through the stories that he or she tells or others tell about him or her. Questions from the therapists that elicit stories that support the family members' preferred knowledge about themselves and each other are therefore the most important technique in the work phase.

In this phase, the family members should experience that they take action themselves and act during the sessions so their knowledge about their own resources is thickened and enriched.

During the conversations, the family members are supported in envisaging and describing verbally their preferred goals and ways to live their lives.

The objective is that by talking about their preferred perceptions, knowledge and experience, the family members become more attentive to that part of their knowledge and the competences already acquired, or which they will acquire, that will bring them closer to their chosen goals.

Describing concrete episodes in their lives, their mutual relations, their problems and their hopes, their evaluations and assessments of these, is a means for them to achieve greater clarity.

Finally, the work also aims at providing the individual person with greater skills in analysing his or her own intentions when acting, and the effects of these actions, in order to develop more flexibility and ability to change action patterns subsequently, so they become as congruent as possible with the preferred intentions.

Must:

Each session has a basic structure:

1. Welcoming the family (joining / appreciating)
2. Clarifying the agenda, including items on events since the last time, and joint decision on the priorities in today's work
3. Work on today's subjects
4. Conclusion, including handing out written documentation (flip chart)

Use the IKEA board during all sessions.

Summing up and the family members' evaluation of the work must take place continuously during the session.

The therapists are responsible for setting the scope, keeping the structure and the time.

After each session, the work must be documented in the hospital's patient record. This must as a minimum include hospital requirements, and: subject, reference to flip chart/digital photo, and the therapists' considerations for the next session.

In cases where the work takes place in varying groupings, for instance separate therapies for child and parents, some time must be allocated to mutual briefing between 'the two groups'.

Stock-taking must take place. As a minimum, a stock-taking conversation must be held at every fifth or sixth session, and it is noted down in the patient record if there are any changes to the definition of the problem, the goal and the plan made. There must also be considerations about process length and the conclusion.

The therapists brief the family on the stock-taking conversation in the preceding session. They ensure that the conversation is structured to focus on the stock-taking. This can be achieved by showing the plan, a previous flip chart containing the family's vision, or their definition of the problem. It can be rewarding to use time lines on the flip chart and focus on new knowledge or new competences.

A stock-taking conversation must be followed by a presentation of the case at a team meeting. Any changes must be noted down in the patient record. A new collaboration plan must be drawn up when this is considered relevant. In case of considerable changes, a re-assessed treatment plan must also be written.

Can:

Many different techniques can be applied in this phase (link to folder with narrative techniques).

In this phase, the IKEA board is used in every single session, but it can be used in many different ways. The objective is that it is not just a summary, but that it constitutes outsider witness practice

of the preferred stories and a tool to sustain the knowledge the family has or brings forward during the session. Another practice used by the therapists is to apply techniques and drawings, for instance from Acceptance and Commitment Therapy Practice.

In some sessions, it will be relevant to show a previous flip chart, for instance one describing the family's vision. The work on this subject can continue for many sessions, and the technique with the collaborative helping map can for some families be the general theme in the entire process. For other families, externalising practices, managing the problem and the relation to the problem, can be more effective.

As all cases are handled by two therapists, this can be utilized in many ways, for instance for outsider witness practice, verbally or in writing, as poetry, or by using the four categories of outsider witness practice.

One therapist can be the rapporteur, the other can be the interviewer. One can be the observer and focus on special aspects, etc.

Before the session, you can agree what your roles will be and focus on special aspects of the family's problem areas or visions that you wish to support.

If it is deemed relevant, the therapists' notes in the patient record can be forwarded to the family. Please see section on written documentation.

In cases where the therapists work with each their own grouping within the family, it will be even more necessary for the therapists to concur and supervise internally to obtain as much shared knowledge as possible and avoid ambiguities or contradictory communication.

Chapter 5: The Conclusive Phase

What and why:

The conclusion is prepared already in the clarification phase through the description of the goal and the notes on considerations about when and how the process is wound up.

As the mental disorders that the children suffer from often will be chronic, the therapy goal will not be recovery. So the process is not wound up when the child has recovered. The winding up is determined by choosing a date at the outset based on the knowledge that by then the family will be on the right course, and that is the goal. The conclusion can also be determined from when the family will have obtained some competences, a specific change or a new family pattern that they have described as their goal. It is important, that this goal is both concrete and realistic. For some families, a change in their relation to the mental illness or a new or different understanding of it, a relief from a sense of guilt or completion of a grief process will be essential in order to part from the therapy.

Problem and goal may change or develop during the therapy. The therapists are responsible for reminding the families that the conclusion is approaching.

Since the conclusion can often elicit uncertainty, the consolidation of the family's knowledge is important in this phase.

A ceremonial conclusion will thicken and enrich the story of the therapeutic process and the preferred effects.

At the very first clarification conversation it will often be relevant to ask the family members how they will be able to see the benefits from participating in family therapy. You can ask in which concrete ways they will be able to see that they have been through therapy, how they will experience this in the home, and how others will know it. How they will know themselves that they don't need the therapy anymore. Through this type of questions, you build up confidence in the family members' own abilities and competences to cope with their lives and prepare them for the time when they no longer are dependent on the aid from The Psychotherapy Clinic. These questions are therefore repeated often, as a minimum during the stock-taking conversations.

By using techniques such as a time line, you can explore the family members' expectations of the future and when they should stop coming to the Clinic. Drawings of steps or lists of competences or problems tackled can describe the family's progress, thus thickening and enriching their preferred knowledge. This can be essential to empower the family to completely take over and control their lives themselves.

Some families will need further or continued aid for many years to come. For these families, it is important that the therapists ensure that they are 'handed over' to the local social worker dealing with their case, the school or just the physician who will follow up on the medical treatment. This can be done at network meetings or in writing. In this work, there is a risk of sustaining the story about the family members' dependency on expert knowledge and support from others.

The last conversation(s) can be a review of the process, focusing on where the family was when they came, what happened to them, what they have done themselves in the process and where they are now.

To support the overall goal, that the family members experience that their control of their lives is strengthened, it is important during the conclusive phase to focus especially on the knowledge the family members have, which the therapists can use in their work with the next family. Individuals perceiving themselves as being in a counselling position, especially with a person from whom they have received a lot, will have a heightened consciousness of their own worth, competences and knowledge.

Must:

It is part of the accreditation standards that the first plan contains an estimated conclusion date. If it changes, the new date and its rationale must be noted down in the patient record, in a revised treatment plan.

The winding up must be brought up in each stock-taking conversation.

The winding up must be planned in collaboration with the family. It must therefore be evident from a written document when and how the process is expected to be wound up.

As a part of the conclusive process, the family members must again fill in questionnaires. These are handed out before the last conversation, the family fills them in at home and brings them to the last conversation. The PAM and BYI forms are scored by the researchers and are not used in the therapy. "Familiens mål" (the family's goals) is used by both the researchers and the therapists, the latter use it to talk about either how the goals have changed, or if the family feels they are closer to the goal.

During the conclusive phase, the entire process must be recounted at least once. One recounting

must focus on the family members' experiences and the preferred changes they have made. Another recounting must focus on the advice the family members give the therapists. This is best achieved through a separate recounting, distinct from the other recounting.

They talk quite a lot about how important it was that they learned all the little details – how to behave at the table and that sort of things. I wonder how they learned it. And was there anything in the way they learned it that was important?

As a part of the conclusive phase, the therapists talk about the knowledge they have acquired in their work with this family in particular. It is an advantage if this is something concrete and specific. It can be conveyed through outsider witness practice or/and in a written document.

As a part of the quality assurance and research on outcomes, we conduct qualitative interviews. The therapists must ask the families if they will participate in research interviews after having completed the process. In that case, the therapist documents the verbal consent in the patient record and notes down the contact information for the researchers.

After the last session, the therapists provide a briefing at a clinical team meeting on the new knowledge they have acquired by working with this family, or/and which feedback the family gave on the therapy and its outcome. A discharge letter is written to the referrer. A copy of this must be sent to the family.

Can:

The session can be a celebration of the goals achieved by the family or the child/children, focusing on the steps taken to get that far.

The focus can be on the competences that the family members have now, and which problems they managed to overcome.

The recounting with the advice to the therapists can focus on:

- The techniques used in the therapeutic conversations – and the families' perception of these. What parts had an effect for them
- Was there anything in the way the family learned what they learned that was important?
- Which of their own actions were most efficacious?
- Which of the therapist's actions were most efficacious?
- Which of the contributions from someone not linked to the process were most efficacious?
- What were the essential turning points.

In addition to the discharge letter, a decision can be made to send the family another document.

Diplomas can be used (link to Torben Marner's book).

The therapists can hand out a collection with images of all the flip charts.

Chapter 6: About Written Documents

What and why:

Writing is communication that supports the spoken word. The written word will remain as long as the paper exists, whereas the spoken word disappears up in the air right after it has been said. In that way, written words support the memory. So written and spoken words have different qualities. Speech is accompanied by body language, the mood people are in and the context of the speech. The use of the two media therefore contribute with different options for the therapists.

It is regulated by law that treatment plans must be handed out to the patient. The accreditation standards of the Capital Region of Denmark includes a specific template, and this template must be handed out at the second conversation and revised at least once a year.

In collaborative psychotherapy, where the thinking of social constructionism is one of the underlying theories, the focus is on which discourses and which world you invite the persons to, when you talk with them and write to them. It is therefore important that the documents you prepare to signal collaboration are written in a language indicating respect, curiosity and wish to collaborate.

The hospital's treatment plan templates are written in doctors' Latin and is the proprietary work tool of the therapists and the hospital, which the families have a right to see. This may signal various forms of distance that can be an obstacle for the therapists' wish to signal equal status, respect and collaboration.

It is the therapists' aim that the family understands the shared ownership to the document and that it is a shared work tool. Over a period we therefore worked on writing another plan, for instance a collaboration plan in which the family's own words are used, where it is easier to signal equal status, respect and collaboration.

Originally, The Psychotherapy Clinic aimed at using the treatment plans consistent with the regulations in the actual therapy to support the regulatory goal of user involvement. But it is our hypothesis that the templates requiring the use of diagnoses, doctors' Latin, etc. signal authority, expert knowledge and distance that can be counterproductive to building up a collaborative practice. Examination of this hypothesis can be the object of research.

It was therefore decided, that the therapists should work with two types of written documents: documents that meet the Capital Region accreditation standards and other documents for therapeutic use. However, this is unrealistic for efficiency reasons.

In practice, the therapists have therefore to the widest extent possible used the family's words in their treatment plans to remain loyal to both the regional accreditation standards, the collaborative therapeutic practice and regulatory principles of user involvement. If the therapist finds it too difficult to convey appreciation and/or use a language that meets the family where it is, a therapeutic letter can provide an opportunity to ensure these purposes.

Handing out the flip chart with all the therapist's notes signals transparency. The fact that therapists are taking notes 'in public' reduces the imaginings elicited in the family members' minds about what is written down. If the therapists involve the family members in the decisions on what to write, the preparation of the document will contribute to the collaborative practices and in itself be a therapeutic technique.

The therapists may find themselves in a dilemma when taking notes. Are the notes taken to support the therapist's memory, the family's memory or to focus in particular on the subjects the therapist

finds are important to achieve change? Is the therapist able to make the purpose of the note-taking clear?

Must:

Respect can be part of the practise, as concrete action. To ensure that respect is pervasive in all aspects of the actions taken by the therapists, any written communication between The Psychotherapy Clinic and other parties involved in a family must to the widest extent possible be produced in collaboration with the parents. If the therapist writes the documents herself, the family must see them before they are sent to other parties, and the family will subsequently receive copies of the final documents.

NOTE: For adolescents above 15, the adolescents must give their own consent to delivery of patient record material to the parents.

Hand out the therapist treatment plan after the first conversation.

To be revised at least once a year.

The family must be offered to receive the flip chart or a digital photo of the flip chart after each conversation.

Copies of all written material to the family.

Copy of the discharge letter to the family.

(Link to internal regulation on treatment plans: The first assessment and treatment plan, re-assessed treatment plan, summary and re-assessed treatment plan, discharge letter)

Can:

Letters referring to the conversation that day can be used.

Verbal and written outsider witness practice can be used during the session and handed out after the conversation.

A therapeutic letter can be drawn up, or a collaboration plan prepared as a joint effort. Here the therapists can use the collaborative helping map (link to article by WM) or letters outlined according to the four outsider witness practice categories or the maps of narrative practices.

(Link to a description of how writing on a flip chart can be tackled. Art Fisher)

(Link to the four categories in outsider witness practice)

(Link to map of externalising conversations and map of re-authoring conversations)

Chapter 7: About Evaluation and Measuring the Outcome

What and why:

Psychotherapy is effective. But the tradition of systematically evaluating the treatment is rooted in recent history. Until now, research on the outcome of psychotherapy has used the same tools to measure the outcome as those used for medical treatment, for instance medicinal products.

Furthermore, the major part of the tradition encompasses measurement of the therapists' evaluation

of the treatment.

Our objective is that the families should evaluate the treatment outcome. To respect their need for treatment, which we want to fulfil, we find it most relevant also to ask them to evaluate the outcome. This objective may conflict with the scientific and medical tradition for measurement of the outcome.

There is a natural link from outcome measurement to the discussion of ending the treatment. It should be the logical conclusion on ineffective treatment that it must end. But it may happen, even if the therapist and the patient see no effect of the psychotherapy, that the therapy goes on and the same kind of techniques are used. When psychotherapy is effective, the logical conclusion is to continue as long as you see a positive effect from the treatment. But for how long?

The outer requirements from the hospital sector for brief interventions and efficiency may conflict with the above. It is therefore important to give words to these dilemmas early in the process and that the therapist team works on solutions for these dilemmas.

I an attempt to meet the requirements of our system to be able to show an outcome of the treatment, professionally developed measuring tools are handed out. These tools can also support the patient's and the family's own evaluation and can be used in support of this purpose.

The measuring in itself affects the clients and as such it has a therapeutic effect, which may be both negative and positive. We use the questionnaire "familiens mål" about the family's goals as the tool where we continue to have a close dialogue with the family, which is connected with our form of psychotherapy.

Checking continuously with the family members during sessions, where the therapists ask if they are talking about the things that are relevant for them, is the most local form of evaluation and effect measurement.

It is a part of the objective of our research project to find tools that measure the effect. We want to cover the multiple purposes set out: efficiency requirements, quality standards, and research to find the specific parts in which therapy is effective.

We use 3 questionnaires:

1. Parent-PAM, measuring parents' competency to act in relation to their child's illness. Competency to act is a goal in the treatment offered, which is why it is an important outcome to measure. Furthermore, PAM is an international tool, which has been validated, allowing us to make comparisons.
2. Beck Youth Inventory, a form measuring the child's or the adolescent's levels of anxiety, depression, anger, disruptive behaviour and self-esteem. Although evidence of the form's sensitivity in measuring change does not exist yet (cf. Thastrum 2008), we have chosen to use the form. The rationale behind the choice is that this form is the best to point out strengths as well as weaknesses, while at the same time emphasising what the child/the adolescent 'feels' and 'perceives' without linking this to traits in the child/the adolescent.
3. The last tool is connected with the progression towards the goal set out for the therapeutic work: the form on how the family meets the goal ("Familiens målopfyldelse"). With this form, we follow up to see if the family through the therapy obtains their own goals for coming here at the Clinic.

In the long term, it may be desirable to use a form measuring the opposition/resilience in children and parents.

The therapists' work must be developed all the time. Video footages are important. And it is our goal that as many sessions as possible are filmed. These can focus on the family with a view to supervision in relation to the family's problem areas. They can also focus on the therapeutic techniques with a view to developing and improving the therapists' competences for the therapeutic work.

The optimum quality assurance of the Clinic's work is obtained by continuously evaluating and supervising the work. So there must be regular supervision on all cases. Therefore the Clinic needs a regular forum for supervision by external supervisors in support of the development of the Clinic's work.

It will be a part of the project objectives to examine how the questionnaires affect the therapeutic work in the families. We have had many considerations about the best use of the evaluation forms in relation to the therapy. It is not a part of narrative therapy practices to use measuring tools that compare the result with a norm. Information from conferences where session rating scales and outcome rating scales are used, indicates that quite a considerable part of the therapy is focused on measuring the effects. This is not what we want. We have therefore decided that the therapists will not be informed about the results of PAM and BYI, and consequently, the families are not informed about the results either. The results will therefore only be used in the research project to examine if there is a visible outcome of the therapy, and if the results and the family's own evaluation of the outcome are coherent. This will meet the classic requirement to avoid that the research project affects the therapists. Likewise, we avoid that the families, because they want to show an outcome, fill in the forms under the influence of what they have been told about the information obtained from the first form. This decision must be communicated to the families as it does not on the face of it appear to be in line with showing respect to retain information about a family. The family must be given the option to receive information about the results, if they are interested.

Must:

The form concerning the family's goals must be forwarded together with the appointment letter.

General briefing on the Clinic project, its purpose as described in a leaflet, must be forwarded with the appointment letter.

The secretaries hand out the questionnaires before the first conversation.

The same questionnaires are handed out before the last conversation.

During the sessions: Ask the family members if we are discussing subjects that are relevant for them, and ask them about the reason.

It is not realistic that all cases are supervised regularly, but it is important that all therapists participate in and receive supervision.

Can:

Summing up and recounting of the family members' or the patient's statement during a session can be a natural introduction to the evaluating questions. Questions about relevance, importance and reason for this relevance or importance. Similarly, this becomes a natural stepping stone for clarifying and pointing out problems, intentions, effects, etc.

Video footages, see above.

Chapter 8: Therapeutic Techniques

What and why:

Collaborative family therapy has been developed with the purpose of supporting families that are especially encumbered with a psychiatric disorder in one of the family's children.

There is evidence that it has an effect when the therapist intentionally uses a technique. Therefore, the therapists must always be aware of which technique they are using and what the purpose is. It is the overall goal of the therapy to build up the family members real and perceived control of their own lives, to build up their coping skills and perceived personal agency. The techniques must therefore focus on supporting and building up the client's own resources, the client's confidence in the therapist and the techniques, the client's hope and the mutual alliance.

The various techniques are not described in detail in this manual, but in the digital attachments.

It is anticipated that the families' feedback will increase the therapists' knowledge on the techniques that are perceived as most effective for the individual families and problems, and therefore the therapists should in the course of time develop greater knowledge on which techniques are most adequate when and for whom.

From the digital folder attached to this chapter, descriptions of various techniques must be available. In addition to this, links to relevant literature must be available.

As narrative therapy is the corner stone in this form of psychotherapy, storytelling will be a key approach in the therapy. You acknowledge and use the fact that people explain their world and their existence through storytelling. A story consists of episodes over a period of time with a plot containing causal explanations and suggesting possible expectations of the future. Each person has many stories about his/her own life, compares it with the lives of others, finds role models and so on in stories about other people's lives, etc. Whereas some stories are forgotten, other stories are remembered, thickened and enriched through recounting. Some stories may have an adverse dominating effect on a person's expectations of his/her own life, actions and interpretations of life. Other stories will have a positive and supportive influence on the person. The creation of these stories forms the basis of the therapeutic change in narrative therapy (link: Michael White and David Epston: Literary means to ….. and Michael White: Maps of Narrative Practice)

The narrative language uses externalising practices as a cornerstone for the grammar. According to social constructionist theories, there is nothing to control us outside of ourselves. There is nothing inherent in nature that gives us our direction or our values. Our values and social structure are created and changed all the time depending on what is in existence and on the differences there are. Externalising practices provide an opportunity to talk about this.

By externalising, you get many options to address the relation you have to your disease or the disease of your relatives. It allows the differentiation between the disease and the person, differentiation between the social discourses (e.g. a sense of guilt) attached to a mental disorder and the person or the disease. More specifically, an object or feeling is externalised through naming and personification where it is given names. You can also externalise positive objects, ideals, norms, attitudes, etc. This enables the person to look at the externalised object or feeling, evaluate it and decide which value it should be given, and which relation he/she wants to have to it (link to Michael White. Perhaps also to Foucault and Deleuse). This makes room for change.

Curiosity: The therapist must be genuinely curious; at the same time the therapist must ask questions that allow change to take place and the family members to gain new knowledge. Taking

an ignorant stance is to recognize that we do not know the answer, even to questions we believe we know the answer to. This paves the way for strategic questions. The therapist must use the questions to move to a peripheral but influential position. By this we mean that it is not the therapist's need for an answer that should be met, but the therapist must ask the questions she believes will affect the therapy and the client's potential development in a positive direction.

Use of psychoeducation varies. This can be in the shape of advice, when parents seek 'tools', stories from other families (insider knowledge, David Epston), and metaphors that convey knowledge on psychology in general (see example folder about ACT).

Various techniques are mentioned below. Each technique will be thoroughly described in the digital folder belonging under chapter 8.

It is a prerequisite for developing the therapists' competences in using the techniques that they learn and receive supervision continuously. That is the reason why the Clinic organises tuition regularly and has both internal and external supervision to support the therapists' work on their own development.

Must:

The following techniques must be part of the therapy at some point:

Curious questions, externalising practices and respect

The flip chart board

Summing up and evaluation must be covered in all sessions

Joining

Map of externalising conversations and map of re-authoring conversations

Collaborative helping map

Talk about the conclusive phase

Set a date for the conclusion, the last conversation

Supervision of the therapists' use of the therapeutic techniques.

Can:

Collaboration plan. This plan can either comprise the items from the map of externalising conversations, the map of re-authoring conversations, the four categories of outsider witness practice or the collaborative helping map. As the therapist treatment plan is mandatory, the accreditation standards do not need to be observed in the collaboration plan. But the items that are important to move the therapy forward must be described.

Magic questions. Example: "If this was the last conversation".

Questions about the future

The post-it method

Psychoeducative metaphors (link to ACT)

Time lines

Offer on insider knowledge

Circular questions

Person description (link)

Outsider witness practice. Family members can be outsider witnesses, a therapist can be an outsider witness. (link)

Home visit

Dividing the family into smaller units

Games, walks and other approaches specifically adapted to the child's mental age.

About supervision: Subjects for supervision can often be the division of roles between the two therapists, internal tasks, choice of techniques, focus points, etc. With a view to learning, you need to remember to focus on the cases with progress and positive effects of the therapy, as this increases the learning value for the therapists.

Chapter 9: Case Work

What and why:

The following covers the 'meeting and procedure structure' at the Clinic, which ensures that all cases are always treated in a timely manner.

As various parts of the procedural structure always will be comprised in the accreditation and/or quality assurance that it is necessary to follow at The Psychotherapy Clinic, and other parts will only be a part of the research project, it will vary when the family should be asked, and when they should not be asked. It is important that this is completely clear for all therapists and other staff at the Clinic.

Must:

Each family is allocated two therapists. The cases are distributed according to the following principles:

1. Those who can find the time.
2. Those who have specific competences or wish to develop a competence.
3. One therapist is responsible for the case. It is not necessarily that person who dictates for the record and for letters, and sends emails. But the person is responsible for ensuring that it is done.

The cases are brought up at a clinical team meeting:

1. after the first clarification conversation. Here the final decision is made as to whether collaborative family therapy will be used with this family.
2. When revision of the plan is needed.
3. For briefing, at least every third month.
4. When the case is to be concluded.

5. Upon conclusion of the case, with a view to sharing learning and development at the Clinic.

The cases are brought up for supervision:

1. When support is needed.
2. When the case progressed outstandingly, with a view to sharing learning and development at the Clinic.

All the families must fill in the forms used for measuring the outcome. They are briefed so they know that this is part of the quality assurance at the Clinic, and that it is an important part of our research project to examine what and which parts of the family therapy that work for the families, and how you can see that there is a positive effect from being in family therapy.

When special projects are going on, for instance qualitative interviews or similar carried out by our researchers, all the families must be briefed and asked to participate.

Can:

The therapists may, if required, always ask if they could speak with others about a case outside the team meetings.

The therapists may ask other therapists to participate to make an examination, for sparring purposes or similar, if required.

Chapter 10: Attached Files and List of References

What and why, must and can:

In various digital folders we will compile more detailed descriptions of techniques, continuously collect knowledge from the various therapies, compile literature in a literature list, etc. This will form part of the knowledge for the revision of the manual. Additionally, it must form part of the background knowledge for the preparation of a research protocol.

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