5

Practicing Psychiatry Through a Narrative Lens

Working With Children, Youth, and Families

Normand Carrey[1]

Narrative therapy has been helpful to me in my work as a child psychiatrist with children, youth, and families. I have been trained in psychophar-macology, psychiatric diagnosis of the *Diagnostic Statistical Manual of Psychiatric Disorders (DSM)* (American Psychiatric Association, 1980), as well as family therapy and, specifically, narrative approaches. I have, how-ever, found combining the two worlds of psychiatry and narrative therapy challenging. Psychiatrists often speak the language of "the biopsychosocial model" (Engel, 1977) but are more individually oriented, while many of my narrative colleagues speak the language of social construction, "multiple perspectives," and "inclusiveness" but often diminish the importance of med-ical, developmental, and biological factors. Often the polarizing differences of the two fields are emphasized at the expense of looking at how they might complement each other in a manner that is helpful to clients.

Through adopting a postmodern philosophy, I realize the epistemological tensions that narrative-thinking psychiatrists face. The meaning of the stories generated through therapeutic conversations can be at cross-purposes with the dominant (medical) discourse expectations of both therapist and client.

I have struggled with the fact that, despite my narrative sensibility, psychiatrists are expected to adopt a traditional expert authority, diagnose people, and prescribe medication as expected by parents, the medical system, and the culture at large. If narrative psychiatrists do not conform to professional expectations, they may be ostracized from colleagues and parents. On the other hand, they may be shunned by narrative therapists because of the perception that all psychiatrists practice within the dominant biomedical discourse.

Sociology and ethnography have identified psychiatry among the medical specialties as peculiarly culture bound (Launer, 1999), occupying an uncomfortable "no man's land" between conventional medical science and the search for meaning, which may extend into political and religious domains. However, narrative medical clinicians stand at the intersection of the world of stories and the world of scientific categorization. Practitioners with a narrative orientation aim at working collaboratively with people to coconstruct or cocreate empowering stories about healing and cope with physical and mental illness. In this view, the doctor works with people to coconstruct a story that is helpful, while acknowledging that truth and knowledge are not absolute, but biographical and interpretive, rather than prescriptive and paradigmatic (Launer, 1999).

Social constructionism states that knowledges, including professional or expert knowledge, are stories that are negotiated among people, often as a means of exerting power (Foucault, 1980; Launer, 1999). To relieve people's suffering, in keeping with social constructionism, I invite them to deconstruct taken-for-granted assumptions about the problems they face (e.g., the idea that most problems can be fixed simply with medication or that a more accurate diagnosis will solve all problems). However, offering a family relief from suffering only through deconstruction is often not enough. Many families also benefit from re-authoring preferred stories as well as being prescribed medication. Psychiatric stories can be used as starting points and then built upon, into alternative, more empowering stories.

Medical narrative therapy draws on a blended epistemology—modernism and postmodernism—that accepts that physical and severe psychological problems (e.g., schizophrenia, mood disorders, severe anxiety, severe aggression, learning disabilities) are often both material or biological and embedded in a culturally based system of meaning (Greenhalgh & Hurwitz, 1999; Kirmayer, 2005). Material or biological brain "disorders" are interpreted, made sense of, and labeled with a cultural context. As such, there cannot be an understanding of "mental illness" outside of culture.

From this view, narrative therapists can draw on the knowledge claims of genetics, molecular biology, neuroimaging, psychopharmacology, and evidence-based medicine, while recognizing that these fields of science are not outside discourse. In this sense, the narrative psychiatrist must be "bilingual": versed

in "brain disorders" as well as the art of translating this knowledge into a story that resonates with clients' own stories. Moreover, the narrative psychiatrist adopts a collaborative stance with those seeking help or relief from suffering.

By recognizing and using the power invested in medical practitioners by society and culture, a psychiatrist can help coauthor preferred narratives that provide meaning, context, and perspective for the child's, youth's, and family's predicaments. The psychiatrist may invite curiosity about the family and the social and historical origins of a problem, while also unpacking conventional biomedical stories.

Within the collaborative approach of narrative psychiatry, I constantly struggle to consolidate and re-create my professional identity as I navigate my relationship with parents, the medical system, and the cultural expectations of me as a medical authority—at the same time as I am trying to integrate narrative ideas and practices into my work. Navigating this territory has resulted in creative tensions as I integrate both narrative practices and traditional medical-oriented practices, such as "interviewing," "diagnosing," and "treating." These three stages of the traditional psychiatric interview involve "interviewing" families about the problem to determine a "diagnosis," which can then be responded to with "treatment."

Narrative ideas can enrich collaborative work with people and generate alternative meanings that can contradict and also complement traditional psychiatric practice. The collaborative approach recognizes the knowledge that children, youth, parents, and therapists have, thereby moving away from the more traditional conflicts that can emerge when a psychiatrist or parents compete to be the "expert" or clients uncritically accept expert knowledge. The story in this chapter is the distilled experience of my interactions working as a team with my family therapy colleagues over the course of 16 years.

This chapter is divided into three sections, in accordance with the three stages of the traditional psychiatric interview mentioned above, "interviewing," "diagnosing," and "treating." In the "Interviewing" section, I review the ways narrative ideas and practices can be used to create a collaborative approach to working with families that recognizes the values of both the psychiatrist's and the family's knowledges. Furthermore, I illustrate the importance of using people's own language, using genograms and reflecting teams to enhance this therapeutic collaboration.

In the next section of the chapter, "Diagnosing," I explore how diagnosing can be used with a postmodern sensibility that acknowledges the fluidity of identity while, at the same time, helping to mobilize people and community resources to assist those whose problems include a biological, material basis. Furthermore, I offer strategies for using diagnosis while at the same time recognizing a child's agency and empowering parents to deal with the problem.

Finally, the section on "Treatment" focuses on prescribing medication within a narrative framework. When I prescribe medication, I take into account the often significant meanings a family attaches to this form of treatment. I am also attentive to the influences, for example, of parents, schools, and pharmaceutical companies in determining which medications should be prescribed for children. I also illustrate the processes of collaboratively prescribing medication using therapeutic letters and documenting families' stories in a manner that does not objectify them.

I begin this chapter with a brief overview of the history of child psychiatry and demonstrate how it overlaps with the ideas and practices of the narrative therapy movement.

Historical Context

Historically, psychiatry has been invested in both deconstructing people's problems through unpacking "meaning" and engaging in the modernist practices of diagnosis and treatment (mostly through individual psychotherapy and prescribing medications). Some of this tradition of psychiatry overlaps with narrative ideas and practices. More recently, with the advent of the *DSM,* a descriptive classification model of mental disorders, psychopharmacology and evidence-based medicine psychiatry have become dominated by a primarily modernist, biologically focused approach to people's problems. These developments in the field have regretfully distanced the field of child psychiatry from its own past and, in turn, from narrative therapist colleagues. I will highlight these historical developments and their implications for bridging postmodernism and modernism through narrative practices.

Aries (1962) was one of the first historians to look at the social construction of childhood and the family, noting that the recognition of childhood as a special stage of life did not appear until the late 18th and early 19th century. With industrialization and subsequent urbanization, the social construction of the category of the child emerged. Institutional responses to the changing status of the child (Jones, 1999) and social concerns about exploitive child labor practices resulted in child labor laws, compulsory schooling, the juvenile court, and child guidance clinics. This period cemented the view of childhood as a special stage of life as the child became the object of public concern and social policy (Skolnick, 1976).

By the end of the 19th century, child psychiatry emerged under the shadow of adult psychiatry, influenced by psychoanalysis, the predominant theory of the time (Freud, 1934). Among other things, Freud focused on the meaning and stories of people's lives by emphasizing dreams and childhood

experiences in his work (Gomez, 1996). Freud's ideas were consonant with and helped shape Western cultural ideas of individuality and the growing preoccupation with introspection and mental life.[2] Freud understood that human mental life reflected the specific nature of the human brain and the social context of human psychological development. Together, brain function and cultural meaning-making processes produced mental life. Neither the brain nor culture by itself is sufficient for human mental life.

In the 1950s, psychiatry's engagement with the meanings of people's stories through psychoanalysis underwent a paradigm shift toward a biological basis for mental distress through the discovery of powerful drugs. The drugs chlorpromazine, an antipsychotic; imipramine, an antidepressant; and lithium, a mood stabilizer, offered the first substantive breakthrough to relieve symptoms of psychosis and mood disorders, ushering in the psychopharmacology movement. Psychiatrists became more interested in carving out symptoms, disorders, and syndromes for which the psychoanalytic model was totally unsuitable. Treatments seeking to explore the meaning of people's problems were considered time consuming, protracted, and ineffective for serious mood problems and psychosis. Consequently, the *DSM,* claiming to be atheoretical, scientific, and objective, was more in line with organic medicine and the neuropsychiatry tradition, which became the dominant psychiatric paradigm.[3] In its successive refinements, the *DSM* has been criticized by psychiatrists and nonpsychiatrists alike for decontextualizing people's lives and overemphasizing an individual (biological and reductionistic) approach (Jensen & Hoagwood, 1997; Kutchins & Kirk, 1997; Tomm, 1990). Both the psychoanalytic and biologic descriptive schemes have been criticized for their failure to distinguish between serious psychopathology (psychosis, bipolar mood disorders) and the everyday distress of life as society shifted toward both drugs and psychological therapy as cultural responses to mental and emotional distress.

In response to the individual trend in psychiatry, other practitioners (some of them psychoanalysts) began to develop alternative ways of working with children, adolescents, and parents through family therapy (Ackerman, 1980; Bowen, 1982; Minuchin, 1974). Family therapists critiqued the individualistic focus of psychoanalysis and biological psychiatry and began to think of the family as the unit that needed to be changed to address problems effectively (Haley, 1976). Family therapy was initially influenced by systems theory and cybernetics, with a shift from linear cause and effect to circular causality (Bateson, 1971). Family therapists emphasized relationships in people's lives, but the assumption shifted from the pathological individual to the pathological family, and interventions still relied on the traditional expert status of the therapist.

Later on, through solution-focused (de Shazer, 1985, 1988; O'Hanlon & Weiner-Davis, 1989) and narrative therapies (White & Epston, 1990), the field began to define problems and solutions in terms of a social construction-ist philosophy, emphasizing strengths in families rather than deficiencies or problems and challenging the traditional professional stance of the therapist as the "expert" in possession of objective truth. In contrast, narrative therapy val-ues the knowledge of clients as experts on themselves and "reality" as cocre-ated in conversations between therapist and client (Parry & Doan, 1994).

Several developments within the field of family therapy began to resonate with postmodern ideas. Specifically, narrative and solution-focused thera-pists were looking for metaphors that would be more helpful than those of organic disease. When applied to people's lives, the disease metaphor inad-vertently reinforces helplessness and hopelessness. Furthermore, these more recent approaches try to be more transparent about the politics of the ther-apy process.

White and Epston (1990), the founders of the narrative approach, were influenced by French philosopher Michel Foucault's (1980) theory of knowl-edge and power, and they translated his ideas to the clinical arena. They con-trasted the scientific analogy of positivistic sciences characterizing psychiatry and medicine to the text analogy of narrative therapy, in which clients are invited to re-author their lives according to a preferred richly storied life. Most psychiatrists and psychologists are trained in reductionistic models that decontextualize people's lives. However, current scientific metaphors about complex biological systems can have liberating possibilities.

In addition to the text analogy, there have been other therapeutic contri-butions from postmodern therapies. Gergen (1990a, 1990b) questions the use of "pathologizing language" in medicine and psychiatry, as it creates a lan-guage of deficiency, reinforces power imbalance in the therapy relationship, and perpetuates a sense of blame and failure in the client. Reflecting teams have been created as a therapeutic tool that embodies the philosophy of the collaborative healing dialogue between therapist and family (Andersen 1991, 1995). Anderson, Goolishian, and Winderman (Winderman, 1986; Anderson & Goolishian, 1988) suggest that therapists adopt a collaborative stance in which the client and therapist have mutually respectful roles in defining prob-lems and solutions. Tomm (1987a, 1987b, 1988) focuses on reflexive ques-tioning. Eventually, family therapists have extended their focus to include the larger cultural context of the family and, in particular, acknowledge the sig-nificance of gender and race within families (Caplan, 1995; Chesler, 1997).

The turn toward narrative therapy in family therapy resonates with those who have held on to the early (child) psychiatry tradition of focusing on stories and meaning through psychoanalysis. In a convergence of schools

of thought, many psychoanalytically trained therapists have adopted and contributed to narrative ideas through a focus on language as the mediator of subjective experience. According to Gomez (1996), "The concept that language is a social phenomenon, and that humans exist in language and become human via conversations—sometimes becoming their conversations and sometimes generating the conversation they become—is not foreign to psychoanalysis" (p. 132).

The dualistic separation of biological and social discourses often negates the complicated relationships in which the embodied mind is at all moments both embodied and inseparable from social meaning-making processes. Rapid developments in genetics, neurosciences, psychopharmacology, and evidence-based medicine have the potential to further polarize the medical model against narrative approaches (although recent gene environment studies point to a complex interplay of reciprocal influences; Rutter, 2005). A heuristic model is needed that incorporates the effects of negative discursive practices within the context of our social discourses but at the same time acknowledges the painful reality of struggling with severe mental symptoms or early traumatic experiences.

Interviewing: Inviting Collaboration

I begin to work collaboratively with families by listening to their accounts of their difficulties and sharing with them the information I have received about them from collateral sources. In this initial process, there are often differences between working collaboratively with adults and working collaboratively with children. In work with adults, Simblett (1997) increases his collaborative stance with adults by reading the referral information he receives about the client. This process helps to build a therapeutic alliance in which openness and collaboration are valued. Simblett deconstructs the technical terms used when doctors or therapists communicate professionally. In this manner, people do not have to worry about secret information or being "spoken about" by different therapists or professionals. Previous diagnoses and assumptions behind the diagnoses are explored for their potential to either limit or expand possibilities. During this process, Simblett resists getting distracted by judging previous therapists and interventions and, instead, focuses on whether those encounters were helpful or not.

Working with children and youth versus adults, however, may at times require a different stance. Often the child does not understand the purpose of our work together or, in the worst-case scenario, has not been told about the visit. Sharing the referral information with the parents in the child's presence

may be shaming to the child or have the effect of encouraging the parents to focus on describing all of the child's problems. Instead, I explore what the child knows about the referral. I then introduce the reflecting team or the use of a family genogram and explain who we are, what our philosophy is, what our intention is, what we think is expected from us, how questions will be handled, and how the family can be helped. This establishes the context for a collaborative relationship.

For example, I may say to the family that while I have been trained in using medications and I have been doing therapy for many years, equally important to our conversations is the parents' knowledge about their family and child and the problem. In one instance, a parent, who felt empowered in most areas of her life, kept repeating, "But what do I know? I'm not the professional." I kept reiterating that her knowledge was different than mine and no less important. While families might expect such an approach from family therapists, they are often not familiar with doctors behaving in this manner.

Typically, during the initial clinical interview, a psychiatrist seeks to make an assessment and define the problem people have brought to therapy. The psychiatric interview determines the reason for the referral, the presenting problem, past history, and family-personal history and conducts a mental status examination.[4] The psychiatric interview is traditionally defined as a process in which the expert determines the objective truth of the person's problem. This approach has often emphasized deficiencies and problems rather than solutions and strengths (Gergen, 1990a, 1990b). Narrative psychiatrist Glen Simblett (1997) has started to deconstruct the claims of objectivity in the psychiatric interview through revealing the privileging of dominant discourse over clients' stories—there is an assumption that a psychiatric history taken with sufficient skill will avoid the pitfall of the psychiatrist corrupting the development of objective truth. A postmodernist view of history taking, by contrast, accepts that the process is always subjective, always coconstructed (Simblett, 1997, p. 132).

Simblett (1997) demonstrates that each section of the conventional psychiatric interview (determining the reason for referral, presenting problem, past history, family-personal history, mental status examination) is often conducted in a manner that inadvertently invites people to focus on problems and deficiencies couched in the psychiatrist's language, rather than coconstructing with people alternative, more hopeful possibilities.

Mr. Potato Head

In interviews when I have privileged psychiatric language, meanings, and stories over those of the families I work with, I have inadvertently shut

down possibilities, rather than opening them up. For example, in the first conversation I had with Kevin,[5] who was 8 years old, and his family, he held his hands over his ears for the entire hour to block out his mother's description of his temper problems at home and at school. My focus on Kevin's deficiencies in the first session reinforced a negative shameful story about himself as a failure. Kevin came into the second session expecting a repeat of the first conversation. I scrounged around the playroom to find a way to keep from repeating this unfortunate experience. "Mr. Potato Head" lay at the bottom of a toy drawer. He had helped me in the past collaboratively define problems using the child's own language. Would Kevin be interested in hearing Mr. Potato Head, who had helped me in the past listen to kids talk to adults about their problems? Kevin jumped at the possibility. Everything spoken in that session by the parents, Kevin, or myself had to pass through Mr. Potato Head, who was very knowledgeable but very shy. Mr. Potato Head talked in a nonblaming, nonshaming manner and used Kevin's language to collaboratively define the problem and its solution. For the first time, Kevin began to speak about what triggered his temper.

The conversation of that day was followed up by a letter to Kevin from Mr. Potato Head congratulating Kevin but also reminding him of the teamwork necessary for his family to conquer temper. Kevin's parents joined Mr. Potato Head in encouraging Kevin to look at solutions necessary to conquer temper. Through using Mr. Potato Head, I was able to engage Kevin by using his language and also honor his knowledge about the problem.

The dominant discourse within psychiatric and mental health training privileges the therapist's definition of the problem and solutions over people's own descriptions of their problems and solutions. The language of the dominant discourse can have an oppressive effect on children and adolescents, leading them to feel excluded and marginalized from the conversation, making them tune out the "adult talk." Parents, influenced by larger cultural trends of the biomedical individual model, often mimic or reflect the dominant-language discourse as well. After years of training, I was professionally conditioned to neglect the meaning of the clients' stories because they were perceived as irrelevant to making an expert diagnosis within a deficiency model of pathology. Within the psychiatric discourse, I focused primarily on deficits and problems and was not encouraged to explore clients' stories, strengths, or possibilities for re-authoring identities.

Wrestling Temper

In contrast to traditional psychiatric discursive practices, I find it more helpful to work collaboratively with people to define their problems and

subsequent solutions. One way of working collaboratively involves using the same metaphors and language that families, youth, and children themselves use to describe the problem. Michael White (1995b) refers to this practice as using "experience-near" language. Using people's own language and eliciting and enriching their stories and metaphors often helps mobilize them against the problem. For example, a child named Jodi came in, and I noticed he had the word "Wrestling" emblazed on the back of his jacket. When I inquired about this, he told me he had recently joined the school wrestling team and beamed with pride about this achievement. We were able to use his metaphor to work collaboratively to "wrestle" his hyperactivity and impulsivity to the ground. As well, I wanted Jodi to receive the message loudly and clearly that I was just as (if not more) interested in his accomplishments before we launched into a discussion about the recent difficulties that had brought him to my office.

Using language people are familiar with and metaphors supplied by children to describe their problems often leaves them feeling relieved that someone has listened and understood them and feeling more empowered to solve their problems. Using the traditional mental health approach (i.e., the therapist's solutions are best) reinforces people's dependency on external factors to solve their problems, which may lead them to feel less empowered and less in charge of their potential for change and growth in their lives. Consistent with the narrative approach, the language chosen in the therapeutic conversation not only conveys information but also actually coconstructs the reality between therapist and client. The language used to describe people actually speaks and writes them into the world in a manner that is either helpful or unhelpful to them.

I often externalize temper by personifying anger as "Mr. Temper." Some parents are reluctant to work metaphorically because they fear the child may escape accountability by blaming Mr. Temper for the misbehavior. Children are reminded that they have to take responsibility for kicking Mr. Temper out of their lives, that it can be difficult, but that they will be helped by their "anti–Mr. Temper team." Often the team is made up of the therapist, the parents, the teacher, coaches, and others. The conversations also explore how others can become part of the team of resisting Mr. Temper, including people who may have previously been defining the child as the problem— people under the influence of the problem.

We continued to use Mr. Potato Head and the team and coach metaphor to tame anger and temper; and despite my own initial reluctance, Kevin and Jodi benefited from taking medication to help them overcome their overwhelming anxiety. Did the helpfulness of the medication mean that externalizing the problem had not worked? At first, I thought so; however,

Kevin's and Jodi's parents reported that they found both approaches helpful, so we continued to work in this manner.

Enhancing Collaboration: Family Genograms

One tool that my colleagues and I have found useful to enhance collaboration is the family genogram (Carrey, Costanzo, Sexton, & Aspin, 2004). Initially used to map intergenerational family influences by structural and strategic family therapists (Bowen, 1982; McGoldrick & Gerson, 1985), genograms were limited by the modernist presumption of an objective truth about the family structure identifiable only through the therapist's expert knowledge. Genograms were often used to trace the family history of "problems" in people's lives. More recently, genograms have been used by solution-focused and narrative therapists (Hardy & Laszloffy, 1995; Kuehl, 1995). The use of genograms helps to enhance collaborative work with families to create opportunities across generations. Genograms can be used to highlight solutions rather than problems and help to discover unique outcomes (exceptions to the problems) and hidden family acts of strength. Genograms also ensure that vital information is not missed. For example, information about a suicide of an extended family member can have implications in terms of a susceptibility to a psychiatric disorder but also simultaneously act as a trauma shaping the family story.

Using family genograms is also a visual way of relating to younger children who may prefer to draw (McGoldrick & Gerson, 1985). The team I work with uses a broad sheet on which the therapist can write down information, and the child can draw with coloring pencils on the sheet at the same time. The whole family is invited to participate in this process. This creates a back-and-forth style of interaction with all family members. Different stories about extended family members overcoming adversity are brought forth, and a virtual community of caring is marshaled to overcome the influence of the problem. We keep the genogram sheet and bring it out at subsequent sessions as a way to document any moves forward in the family.

Enhancing Collaboration: The Reflecting Team

The reflecting team is a relatively new therapeutic tool that illustrates and embodies the technique and philosophy of collaborative healing dialogue between therapist and family (Anderson, 1991, 1995).[6] The reflecting team involves the supervisor, colleagues, and students (e.g., in social work, psychiatry, pediatrics, or psychology) being behind the one-way mirror while a therapist conducts an interview with a family. The team observes the interview

without any dialogue between members so that each team member can offer reflections from his or her perspective, rather than a group consensus or the supervisor's perspective. In the first stage of the reflecting-team process, I have a conversation with the family about their problem and the influence of the problem on the family's life.

In the second stage of the process, the therapist and family then reverse positions with the reflecting team and observe the reflecting team in dialogue about how the family is both burdened by the problem and escapes the influence of the problem. Team members situate and contextualize their comments in their own personal life experiences (White, 1995b). The team is careful to use language that takes into account each family member's developmental level. This "experience-near" level of discussion helps the family reflect on strengths and possibilities to engage in new patterns of change to defeat old patterns. The students are asked to emphasize change and growth metaphors rather than symptom and disease. Therapists are also asked to state their comments from a position of curiosity rather than certainty, offering reflections as possibilities rather than defined truths. In the third stage, the family and the reflecting team are invited into the same room and are asked to reflect on the comments they have just heard about themselves. Finally, in the fourth stage, the family leaves, and the team members deconstruct their own experiences of the interview process, the reflecting team, and any previous (personal) issues that may have stimulated the team's reflections.

This idea of watching and being watched serves to remind therapists and trainees to use language that is more personal and helps therapists to resist the pull to hide behind professional language that distances them from families and asserts unhelpful power relationships (Anderson, 1995). For many families, hearing the reflecting team is the first time they hear others talk about them in such positive, intimate, and familiar terms. Most of our families report that they find reflecting teams are helpful.

While all family members may not be present in the conversations, collaborative family work often benefits from acknowledging all members of the family. After I initially meet the family, I offer children, adolescents, and parents the opportunity to see me on their own, while making it transparent that everyone will be treated equally and no secrets will be withheld from anyone. Often parents speak with me separately because they are afraid what they may say might hurt their child's feelings. As well, parents may want to talk without their child present to talk about tensions between themselves or other family secrets they do not feel the child is ready to hear. Parents' decision to speak with me without the child present is often motivated by their empathy and respect for the child, which strengthens my collaboration with the parents as important agents of change in the child's and their own lives.

Contrary to working collaboratively, psychiatrists are often initially reluctant to abandon the standard interview templates that they have learned during their training, the three-stage psychiatric interview of "interviewing," "diagnosing," and "treating." The standard interview template can reify the institution's and therapist's position in the power hierarchy: The psychiatrist "knows," and families do not. The dominant psychiatric discourse presumes that these templates for interviews are the objectifiable truth passed down from mentors and teachers, who are responsible for maintaining the discipline's tradition. These standard interview formats, which can function as guidelines, are too often mistaken as the truth about people and their lives. Narrative therapy helps therapists acknowledge the therapist's position of power, which, in turn, can be used to create a context in which they can resist automatically privileging their own voices over the parents' and children's voices.

Diagnosing

For the narrative psychiatrist, the exercise of diagnosing and labeling represents challenges and opportunities. Narrative therapists are reluctant to label people because of the potential totalizing judgment (e.g., the person with schizophrenia becomes a schizophrenic) or because of the normative judgments involved, such as expert definitions of "normal" or "abnormal" behavior. As Launer (1999) points out, classifying people can become self-fulfilling prophesies. By compartmentalizing clients' narratives so that a category is divorced from its familial or social context, clinicians run the risk of amplifying the problem they are trying to solve. For example, Launer writes that once someone is labeled as *schizophrenic,* others may stop trying to have normal conversations with that person about his or her life, further contributing to the process of marginalization and isolation. When psychiatrists with a postmodern sensibility diagnose someone, however, they do so realizing the fluid nature of identity and of the psychiatric categories while, at the same time, recognizing the material, biological components of some people's problems.

Diagnosing people helps to mobilize people and communities against problems that have material, biological components. In some situations, making the diagnosis can create potential possibilities for children, youth, and their families. In our jurisdiction, children and youth who are diagnosed as autistic are privy to qualify for more therapeutic services. Children diagnosed with learning disabilities may also qualify for more school resources. Caring for children with these diagnoses can impose significant emotional and financial stresses on the family, and any help that they can receive (e.g., financial, social, educational) is often welcomed by the family. In children

with severe developmental and/or psychiatric problems, some parents may need the initial "certainty" associated with diagnosis as a way to name the unknown. Parents want to know "what they are dealing with," while at the same time, I want to resist totalizing a child's identity with a label or diagnosis. Diagnoses of biological components to people's problems can have positive consequences because they can be used to enlist and recruit "antiforces" or teamwork to fight against the influence of the problem.

As psychiatry tries to align itself with the success of the organic model in medicine and the biomedical discourse, it is required to use the same language of "disorder" and "psychopathology," and hence everything that is labeled in the *DSM* (like disruptive behavior) is categorized as a disorder, obscuring potential psychosocial or developmental elements. Some of the behaviors labeled as disorders (shyness, oppositionality) are temperamental traits that have both positive and negative aspects to them. In addition, the "adaptability" of these traits is dependent on how the environment responds to them. Other disorders may prove to have more of an "organic" basis, such as autism and reading disabilities. For the profession and many parents, however, all diagnostic labels seem definitive and certain and imply a final judgment that only the expert can make and, in certain instances, unmake. Other labels are subject to diagnostic fads, as with the recent cultural preoccupation with pediatric bipolar disorder to explain all kinds of oppositional behavior in children and teenagers. As parents often believe in the biomedical labels, before we are able to explore other alternative understandings, I find it is important to reassure the child and parent that we are not missing any serious biological problems.

Diagnosis: Too-Darn-Smart-for-His-Own-Good

I find it helpful to be creative and playful with some diagnoses, especially in the service of liberating a child and a family from a label associated with an oppressive story. For example, I met a youth named Duncan prior to his being admitted to a residential facility after numerous interventions had failed. His foster parents, the social worker doing the preadmission, and myself, his outpatient psychiatrist, were present. In an effort to review the file, the social worker asked Duncan to confirm his previous diagnosis of attention-deficit/hyperactivity disorder (ADHD). Duncan's identity was being storied into the conversation through a narrative about his deficits. Duncan deflated and slid into his chair. I blurted out, "He also has a diagnosis of TDSFHOG, Too-Darn-Smart-for-His-Own-Good." Duncan brightened upon hearing this label that acknowledged he was very intelligent, which I found out had been celebrated before as one of his strengths. His foster

parents appeared relieved. This act of relabeling served to re-story Duncan's identity according to an identity story he preferred.

I have found it useful to unpack the metaphors surrounding psychiatric disorders that imply deficiency. For example, in the case of ADHD, parents usually come in with the understanding that their child's condition is a neurobiological disorder. As a result of the dominant psychiatric discourse, parents often have a limited understanding of how other factors (e.g., social, cultural, or problem-saturated stories of people's identities) can impact the child's behavior. Many parents have had the child assessed by a psychologist or have visited the family doctor. Medical discourse invokes a disease metaphor to understand both physical and mental difficulties. For example, the medical discourse leads psychiatrists to approach fixing ADHD in the same way they would fix a broken arm that needs a cast or defective vision in need of eyeglasses or a diabetic who needs insulin. All of these medical metaphors to describe mental difficulties imply a deficit that needs to be corrected, invariably with medication.

Giving people a diagnosis often stories them according to possible deficits, and the label often precludes celebrating the wonderful talents and energies most children demonstrate as individuals (many of them with great coordination, energy, and superior visual-motor skills). Narrative therapy has allowed me to invoke labels and diagnosis in a tentative manner, while at the same time acknowledging the fluidity of these categories, the multiple factors that create such conditions (biological and otherwise), and the person's preferred identity.

Diagnosis: Consummate Multitasker

In working with parents of a child with ADHD, I usually start by extending the medical metaphor by suggesting, for example, that a person with diabetes also needs a good diet and exercise. By extending this metaphor, I emphasize the importance of the child's agency, contrary to what a simple disease metaphor infers. Then, I often suggest metaphors of excess or abundance rather than deficits: "Your child has a surplus of energy that I would like to bottle and sell"; or "Your child is creative to have so many thoughts"; or "Your child is the consummate multitasker." I then may suggest restraining metaphors to complement the abundance metaphors: "Your child's energy is like a team of wild horses. Do you think we can teach them to run in the same direction?" In addition, along with celebrating their child, I often find it helpful to give parents the opportunity to acknowledge frustrating and difficult moments as a result of the problem in the child's life; otherwise, the parents may feel that the therapist cannot relate to the stresses in their lives.

In working with families, I find it is important to be attentive to empowering parents (Suberri, 2004). While parents may initially define their child or youth as "the problem," I resist defining the parents as "the problem" for doing so. They often do not intend to blame the child; rather, they are often caught in culturally normative way of individualizing problems. I find it helpful to acknowledge the parents' caring for their child, recognizing that they are the ones requesting the service, as children do not typically have the verbal skills or psychological development to understand the impact of their behavior. Parents seeking help may also experience loss and guilt, because after a long search, the psychiatrist may confirm their worst fears. I often discuss all of these factors with the family before I seek to separate the problem from the person and propose an intervention such as externalizing the problem. My eagerness to wrestle the problem from the person and not spend time acknowledging the effects of it on the family often conveys the message to the parents that I am minimizing the seriousness of the problem.

I acknowledge hopefulness about change as well as the challenges children and youth with serious emotional difficulties and their families face with autism, extreme aggression, bipolar disorder, overwhelming anxiety, severe obsessive symptoms, and psychosis (see White, 1995a). Although "talk therapy" can help people contain overwhelming feelings, I am often faced with the limitations of what can be accomplished in these severe cases. At the same time, I am often in situations in which parents want to pursue *only* the "true" or underlying diagnosis. I resist being critical of this pursuit and realize parents are often their child's best advocates and supports. Thus, I find it helpful to see parents as consultants, rather than thinking I need to win them over to my point of view. Some parents, however, will remain diagnosis or medication driven, and I must work to enrich the story within this personal or family paradigm.

A narrative approach does not preclude comprehensive assessments of the child's cognitive and emotional level. In this instance, I find the distinction helpful that Suberri (2004) makes between biological problems within the child (e.g., severe cognitive or emotional limitations, such as autism and severe ADHD) and interpersonal, interactional, or transient developmental or traumatic difficulties. For example, children with mental retardation or with fetal alcohol syndrome may not benefit as much from narrative approaches compared with children with better cognitive function. These distinctions may be important to parents still trying to make sense of how to understand their child's problem and then how to help him or her. Sensitive comprehensive psychological assessments are often compatible with a narrative orientation. These assessments are different, however, from the computer algorithms generated as a result of filling out rating scales or symptom

checklists. The latter often results in a decontextualized understanding of a person's life and circumstances.

Treating

The biomedical psychiatric tradition creates a linear cause-and-effect process in which people are assessed through the "psychiatric interview," "diagnosed," and then treated through the "treatment phase." Everything in the psychiatric assessment leads to a diagnosis, in the belief that once a definitive diagnosis is established, treatment naturally will follow, as in the medical model of pathology. In the "treatment phase," attention is given to medication and psychiatric stories. Focusing on psychiatric beliefs and perceptions about medication and reliance on medical expertise about treatment can crowd out alternative or complimentary possibilities that may enhance alternative solutions and enrich lives.

Although I believe *solely* relying on medications is often problematic, I also find medication can be helpful for many families. I have found prescribing medication with families can be opportunities for growth and rich story development, but, at the same time, there can be numerous minefields. Regretfully, often a prescription for medication signals the end of an interview, prematurely closing down potential helpful meanings that can be made of taking medication, rather than the start of an therapeutic alliance (Blackwell, 1973; Pruett & Martin, 2003).

How I relate with the people who consult with me during all stages of the interview is as important as what I actually offer them in terms of medication options or "treatment." Often the traditional psychiatric approach defines the helpfulness of a session only in terms of determining a correct diagnosis and "treatment." The helpfulness and importance of the psychiatrist's relationship with the family in creating change is often rendered invisible. Poor alliances lead people to terminate the therapeutic relationship, just as good alliances with people, in which they feel understood, lead to better outcomes. Along with Pruett and Martin (2003), I believe the relationship I have with families is more important than the pills prescribed. Sometimes, in children I have followed for a long time, I ask the parents about the child's medication right away rather than asking them about their lives first. My training often leads me to assume that some other therapist is supposed to do that part of the work, or I forget that there is a person behind that prescription.

In a situation where medication is part of the treatment, the stories that psychiatrists and families cocreate are influenced by the effects of the medication, the therapeutic alliance, the person's developmental stage, the

psychological-familial context in which the medication is prescribed, and the larger cultural understanding of drugs. Often medications change children's mood and behavior, which, in turn, leads children or young people to think their choices have no influence over the problem. This is especially so in children and youth forging their self-identities. How does the medication change the evolving story of a person's identity? Does it enhance it or diminish it? Often too much control is credited to the medication by the parents or the youth. Alternatively, how does the therapist balance the person finding medication helpful in relieving suicidal ideation, for example, and the person's perceived false sense of control over the problem? The crucial issues of the various roles that the child, the parent, the therapist, and the medication play in controlling the problem have significant implications for a child's or a young person's developing sense of identity.

The meanings associated with taking medications often change as children and youth develop. Medications can be storied as poisons, magic bullets, mind restraints, brain implants, or contraceptives. I codevelop helpful metaphors for taking medications by listening to and collaboratively working with families. Often dominant psychiatric discourse restrains psychiatrists from taking the time to have such conversations. I work at being a good listener, a decipherer and a translator, and not merely a doctor who needs to be obeyed and knows what is best for the client. Doctors in particular, by habit of training and cultural pressures on them, must resist prematurely reaching for the prescription pad.

Recommending medication without knowing the meaning the family attaches to taking medication can have devastating effects on the child or the family. Sometimes family members conclude that the doctor is giving up on them by giving in to medication. However, in other instances, I find parents are frustrated and have tried many solutions by the time they meet with me and are ready to consider medication. Such parents may feel relief when medication is suggested because of the affirmation of the seriousness and accuracy of their concern for the child's difficulties. They may also feel less judgmental and self-deprecatory about failures to date, seeing medication as a new lease on effective parenting, and be more hopeful about their child.

Alternatively, unexamined feelings of loss and grief over having a child so sick as to warrant a diagnosis and a trial of medication can be problematic if the therapist is not aware of parents' feelings and the meanings they attach to their child taking medication. Parents may perceive the acts of diagnosing and treating by the psychiatrist as the beginning of lifelong journey of what they think may be a chronic illness, and they may begin storying their child

primarily in terms of "deficits," which, in turn, has serious implications for the child's developing story about herself or himself.

Prescription Politics

Apart from the opinion of the psychiatrist, diagnoses are often negotiated in conjunction with parents, schools, and indirectly through pharmaceutical companies. For most children, medication is prescribed to them and administered through the agency of their parents. Often parents operate from the dominant psychiatric discourse, which suggests with certainty that a child's problem is the result of a "chemical imbalance" and hardwired genetic influences. According to child psychopharmacologists Pruett and Martin (2003), the term *chemical imbalance* masks multiple meanings that need to be unpacked or deconstructed to distinguish between parents' legitimate requests for thoughtful diagnostic clarification and attempts to avoid investigation of personal or emotional issues. Parents may also have the impression that the study of genetics in psychiatry is far more advanced than the field actually is. Discussion of heritability questions in the context of a biomedical model of psychiatric diagnosis and treatment has the potential to exacerbate parents' guilt and shame for genetically "giving" their children problems, and it emphasizes deficiencies.

School officials may share in the delusion of precision (Gutheil, 1982), perceiving drugs as specific, concrete, and targeted agents that are uniformly effective. Teachers and administrators feel the urge to control children for reasons other than those related to the children, such as overcrowding, understaffing, and new meritocracies of mandatory testing with their norm-driven academic testing. Some parents work collaboratively with the schools, but others may grasp at solutions such as changing the teacher, classroom, or curriculum to solve their children's problems. I try to appreciate these larger issues within a dominant education discourse and resist resorting to the prescription pad because of these, at times, intense systemic pressures.

The process of diagnosing children is also influenced by the corporate interests of pharmaceutical companies, and, as a result, it has become more culturally acceptable to medicate children and solve their problems through chemical means. These corporations assert influence through academic institutions and by bombarding individual doctors and parents through direct advertising, with the biomedical paradigm of understanding people's problems. They influence the choice of solutions sought (individual and biological rather than social and communal). Direct marketing to consumers often results in requests from

parents for specific medications, in the mistaken belief that a new product will cure their children, and distracts parents from exploring other possibilities that might be contributing to their children's problems (Carrey, 1999).

Collaborative Prescription Writing

Routine prescription writing can be enhanced by collaborative work. I find that I need relief from the many times a day I write prescriptions to renew children's medication. In psychiatry, prescriptions are often referred to informally as "scripts." Reenacting this ritual every day has made me want to become a more creative scriptwriter. This new script needs to acknowledge the helpfulness of medication while also honoring the agency and responsibility people take to overcome their problems. While not belittling the serious medical responsibility of prescribing medications, I want to reenvision how the usual routine phone conversation or brief meeting can both acknowledge the effect of medication and facilitate rich story development. I now try to "spice up" my routine phone calls for medication renewals by inquiring as to whether the parent has noticed any moves by the child in the right direction, and who is responsible for this change.

For example, Harry's mother called me for his 3-month renewal of a stimulant for his ADHD. (I had previously been engaged with the child and the family extensively for other issues related to family trauma in the past.) The mother did not volunteer, so I asked how Harry was doing. "Oh, he's been doing just great," she said, with pleasure in her voice. I asked what she attributed this change to. "To the medication," she replied. I then asked her whether she thought all the change was due to the medication or whether part of the change was due to his efforts. She replied, "Oh, of course, a lot of the change is him, he is much more thoughtful and mature now." She went on to tell me how much more responsible Harry was than before, and so forth. I ended the conversation by reinforcing my message for her to be on the lookout for more changes coming from him.

Therapeutic Letters

"Treatment" can also take the form of writing therapeutic letters. I find many families enjoy receiving these letters. They experience themselves as important by receiving a letter from what they perceive to be a "busy doctor." The letters personalize the relationship and diminish professional distance with children, teenagers, and families. David Epston (Epston, Lobovits, & Freeman, 1997; White & Epston, 1990) disciplines himself to write a letter after every session, and the letter becomes part of the official chart record. Letters are written in a conversational, age-appropriate tone

and use the child's and family's own words and metaphors. The letters document change, alternative moves in the right direction, and possible next moves. Letters are not used to reinforce diagnoses or medication instructions. Letter writing creates reflexive loops that reinforce the family's ability to work on problems together without developing an overreliance on the therapist's solutions. Often letters reinforce solutions talked about in the office that may be forgotten once the client leaves.

Documentation

Another unintended consequence of the psychiatric interview and treatment is therapists constructing clients as objects of analysis through their systems of documentation. The documents created (medical notes and files) are archived in the hospital, reinforcing the idea that clients are under official scrutiny and that their lives are under the experts' control. The child sees the medical record and may conclude that the thicker it gets, the bigger failure he or she is. Epston et al. (1997) and Simblett (1997) subvert the medical-legal construction of the medical record. Simblett bypasses this practice of objectifying people by reviewing whatever he writes in the chart with the person's input, and in some instances, he recirculates the official chart document so that it creates a reflexive loop as coconstructed by the client and therapist. The documents thus created are live documents open to possibilities, rather than simply documents acting as constraints and reminders of dominate oppressive ideas. Similarly, my consultation reports are written so that the family, rather than other professionals, is the main intended audience for their reception. The family has a chance to review the report and send it back to me before it becomes part of the "official" hospital record.

Conclusion

Drawing on early child psychiatry and narrative therapy has enriched my work with families. Engaging the tensions and contradictions of invoking both narrative and psychiatric work has led to many possibilities in conversations with families. Specifically, by working collaboratively, I have increased my effectiveness in engaging in the traditional stages of the psychiatric interview: "interviewing," "diagnosing," and "treating." In the past, I have inadvertently limited exploration of people's alternative, more empowering narratives. As the psychiatric interview is designed to determine a diagnosis rather than alternative stories, it is often focused on the precision of delineating symptoms at the expense of collaborating with families by focusing on the meaning behind symptoms, on strengths, and on generating hopefulness.

Parents are anxious about their children not fitting in and not being equipped for the future and feel a great responsibility toward them. Some parents find narratives consistent with the dominant psychiatric discourse limiting, and they support the development of alternative views. Parents whose children have serious adaptation and emotional difficulties often find that narratives of hopefulness can help the family cope with enormous stresses. Working collaboratively in a transparent manner has helped the families and myself find solutions that emphasize their own knowledges and expertise.

As illustrated in this chapter, there are many psychiatric traditions; the field is not homogeneous. Along with narrative therapists, many within mainstream child psychiatry disagree with the current overemphasis on the biomedical model. Many psychiatrists, among them my mentors, work collaboratively and are respectful of clients' strengths. In addition, while based in a modernist framework, many current "talk therapies" (e.g., cognitive behavior therapy, interpersonal therapy) have similarities with narrative therapy approaches. The possibilities for synthesizing narrative therapy with other approaches is perhaps best summarized by narrative psychiatrist Glen Simblett (1997):

> Narrative beliefs and practices allow me to consider different views of problems and their effects on people. Instead of trying to marry dichotomy and difference, I use an alternative metaphor that views experience as an ecological system, with each part dependent on and influenced by the other. The biological and biochemical are neither ignored nor overemphasized. (p. 145)

Narrative ideas have given me permission to return to traditional child psychiatry practices of being creative and getting down on the floor and playing with children. With the diagnostic and psychopharmacological movement, one could argue that much of the fun has been taken out of child psychiatry. When I have been relegated to the role of "med checks," it has resulted in a professional pessimism and stifling of therapeutic creativity. More than anything else, the narrative philosophy has reintroduced *hope* into my vocabulary. A narrative approach has allowed me to become changed by the stories I have been privileged to hear, as the reciprocal shaping of identities happens between myself and families.

Notes

1. I want to thank Anne Sexton, MSW, for review and thoughtful discussion of the text and being a wonderful, supportive colleague throughout all the years.

2. It should be emphasized that there were many competing psychoanalytic ideas. Freud's Oedipal theory of the role of the father in male identity formation was emphasized in contrast to Otto Rank's more inclusive theory of character formation due the mother's, probably more important, pre-Oedipal role.

3. See Berrios (1996) for a history of psychiatry and Micale and Porter (1994) for a critique of the history of psychiatry and antipsychiatry movements.

4. While a formulation using the biopsychosocial approach is made, this information is reduced to a multi-axial system where the psychiatric diagnosis (axis 1), predominantly individualistically based, is given the most importance. For example, children may end up with a plethora of diagnostic acronyms on axis 1 (e.g., ADHD, ODD, and CD, or PDDNOS-) without consideration being given to how a child's difficulties may be created by her or his cultural, family, or institutional context.

5. All case names in this chapter are pseudonyms.

6. I appreciate Michael White's (1995b) development of the definitional ceremony and integrate some of these ideas into work with reflecting teams.

References

Ackerman, N. (1980). The family with adolescents. In E. A. Carter & M. McGoldrick (Eds.), *The family life cycle: A framework for family therapy.* New York: Gardner Press.

American Psychiatric Association. (1980). *Diagnostic and statistical manual.* Washington, DC: American Psychiatric Press.

Andersen, T. (1991). *The reflecting team: Dialogues and dialogues about the dialogues.* New York: Norton.

Andersen, T. (1995). Reflecting processes: Acts of forming and informing. In S. Friedman (Ed.), *The reflecting team in action.* New York: Guilford Press.

Anderson, H., & Goolishian, H. (1988). Human systems as linguistic systems: Preliminary and evoking ideas about the implications for clinical theory. *Family Process, 27*(1), 371–394.

Anderson H., Goolishian, H., & Winderman, L. (1986). Problem created system: Towards transformation in family therapy. *Journal of Strategic and Family Therapy, 5*(4), 1–11.

Aries, P. (1962). *Centuries of childhood.* London: Jonathan Cape.

Bateson, G. (1971). A systems approach. *International Journal of Psychiatry, 9,* 242–244.

Berrios, G. (1996). *The history of mental symptoms: Descriptive psychopathology since the nineteenth century.* New York: Cambridge University Press.

Blackwell, B. (1973). Drug therapy: patient compliance. *New England Journal of Medicine, 289,* 249–252.

Bowen, M. (1982). *Family therapy in clinical practice* (2nd ed.). New York: Jason Aronson.

100   Writing in the Social

Caplan, P. (1995). *They say you're crazy: How the world's most powerful psychiatrists decide who is normal.* Boston: Addison-Wesley.

Carrey, N. (1999). Making the grade. *Readings: A Journal of Reviews and Commentary in Mental Health, 14*(1), 6–12.

Carrey, N., Costanzo, L., Sexton, A., & Aspin, J. (2004, November). The Dalhousie Family therapy training program: Our six year experience. *Bulletin of the Canadian Academy of Child and Adolescent Psychiatry, 13,* 114–118.

Chesler, P. (1997). *Women and madness.* New York: Four Walls, Eight Windows.

de Shazer, S. (1985). *Keys to solutions in brief therapy.* New York: Norton.

de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy.* New York: Norton.

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science, 196,* 129–136.

Epston, D., Lobovits, D., & Freeman, J. (1997). Annals of the "new Dave." *Gecko: A Journal of Deconstruction and Narrative Ideas in Therapeutic Practice, 3,* 59–85.

Foucault, M. (1980). Truth and power. In *Power/knowledge: Selected interviews and other writings.* London: Harvester Press.

Freud, S. (1934). *A general introduction to psychoanalysis.* New York: Pocket Books.

Gergen, K. (1990a). Therapeutic professions and the diffusion of deficit. *Journal of Mind and Behavior, 11*(4), 107–122.

Gergen, K. (1990b). Therapeutic professions and the diffusion of deficit. *Journal of Mind and Behavior, 11*(4), 353–368.

Gomez, E. (1996). Radical constructivism and narrative. *Journal of American Academy of Psychoanalysis, 24*(1), 1–14.

Greenhalgh, T., & Hurwitz, B. (1999). Why study narrative. *British Medical Journal, 18,* 48–50.

Gutheil, T. (1982). The psychology of psychopharmacology. *Bulletin of the Meninger Clinic, 46,* 321–330.

Haley, J. (1976). *Problem solving therapy.* San Francisco: Jossey-Bass.

Hardy, K., & Laszloffy, T. (1995). The cultural genogram: Key to training culturally competent family therapists. *Journal of Marital and Family Therapy, 21*(3), 227–237.

Jensen, P., & Hoagwood, K. (1997). The book of names: *DSM-IV.* In *Context, Development, and Psychopathology, 9,* 231–249.

Jones, K. (1999). *Taming the troublesome child.* Cambridge, MA: Harvard University Press.

Kirmayer, L. (2005). Culture, context, and experience in psychiatric diagnosis. *Psychopathology, 38*(4), 192–196.

Kuehl, B. (1995). The solution-oriented genogram: A collaborative approach. *Journal of Marital and Family Therapy, 21*(3), 239–250.

Kutchins, H., & Kirk, S. (1997). *Making us crazy: DSM: The psychiatric bible and the creation of mental disorder.* New York: Free Press.

Launer, J. (1999). A narrative approach to mental health in general practice. *British Medical Journal, 318,* 117–119.

McGoldrick, M., & Gerson, R. (1985). *Genograms and the family life cycle: Genograms in family assessment.* New York: Norton.

Micale, M., & Porter, R. (1994). *Discovering the history of psychiatry.* New York: Oxford University Press.

Minuchin, S. (1974). *Families and family therapy.* Cambridge, MA: Harvard University Press.

O'Hanlon, W., & Weiner-Davis, M. (1989). *In search of solutions.* New York: Norton.

Parry, T., & Doan, R. (1994). *Story revisions: Narrative therapy in the postmodern world.* New York: Guilford Press.

Pruett, K., & Martin, A (2003). Thinking about prescribing: The psychology of psychopharmacology. In A. Martin, L. Scahill, D. Charney, & J. Leckman (Eds.), *Pediatric psychopharmacology: Principles and practice* (pp. 417–425). New York: Oxford University Press.

Rutter, M. (2005). Environmentally mediated risks for psychopathology. *Journal of Academy of Child and Adolescent Psychiatry, 44,* 3–18.

Simblett, G. (1997). Leila and the tiger: Narrative approaches to psychiatry. In G. Monk, J. Winslade, K. Crocket, & D. Epston (Eds.), *Narrative therapy in practice: The archeology of hope* (pp. 132–145). San Francisco: Jossey-Bass.

Skolnick, A. (1976). *Re-thinking childhood.* Boston: Little, Brown.

Suberri, K. (2004). Pediatric psychology with a postmodern twist. *Journal of Systemic Therapies, 23*(1), 21–37.

Tomm, K. (1987a). Interventive interviewing: Part 1. Strategizing as a fourth guideline for the therapist. *Family Process, 26,* 3–13.

Tomm, K. (1987b). Interventive interviewing: Part II. Reflexive questioning as a means to enable self-healing. *Family Process, 26,* 167–183.

Tomm, K. (1988). Interventive interviewing: Part III. Intending to ask lineal, circular, strategic or reflexive questions? *Family Process, 27,* 1–15.

Tomm, K. (1990). A critique of the *DSM. Dulwich Center Newsletter, 3,* 5–8.

White, M. (1995a). Psychotic experiences and discourse. In *Re-authoring lives: Interviews and essays* (pp. 112–153). Adelaide, Australia: Dulwich Centre Publications.

White, M. (1995b). *Reflecting teamwork as definitional ceremony.* In *Re-authoring lives: Interviews and essays* (pp. 172–198). Adelaide, Australia: Dulwich Centre Publications.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: Norton.