

Working within traditional structures to support a collaborative clinical practice

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This paper explores how to meet requirements for formal clinical paperwork in a way that is based on an ethic of collaboration and accountability. Using this approach, traditional clinical paperwork at the stages of ‘assessment’, ‘treatment planning’, and the ‘termination process’, – documents which previously could have been objectifying and further pathologising of people – can instead become collaboratively-produced therapeutic documents. This paper also explores some of the real effects of the current requirements for documentation and measurement, and suggests that practitioners should ‘take care to measure what is valuable rather than simply valuing what is measurable’.

Keywords: assessment, clinical paperwork, collaborative practice, consolidation interviews, termination process, therapeutic documents, treatment plans

Narrative therapy offers an exciting and effective approach to clinical and community work. It has tapped into the hope and passion that brought many workers into the field, and has been increasingly embraced by many practitioners. At the same time, there are numerous challenges to fully implementing these ideas and practices in community settings. Practitioners often face the dilemma of attempting to develop a collaborative clinical practice while responding to documentation requirements; reimbursement structures; and policies and procedures that promote a search for client deficits, obscure client wisdom, and encourage an instrumental 'acting on' approach to clients¹. This article briefly examines this dilemma and highlights several simple shifts that can support practitioners in pursuing a poststructuralist collaborative clinical practice.

The traditional mental health system and the assumptions of the medical model that guide it reflect a modernist or structuralist worldview. Kaethe Weingarten (1998) has concisely summarised the implications of a modernist approach for family therapy:

Within family therapy, a modernist approach entails the observation of persons in order to compare their thoughts, feelings, and behaviors against preexisting, normative criteria. The modernist therapist then uses explanations, advice, or planned interventions as a means to bring persons' responses in line with these criteria. (pp.3-4)

This process of entering a family system, observing how it functions, comparing that to our theories of 'appropriate' behaviour and then developing a series of interventions to tinker with the system so that it functions more 'appropriately' puts us in a particular relational stance with families. It positions us as an outsider acting on the system.

This positioning can be contrasted with postmodernist or poststructuralist approaches in which clinicians position themselves as allies *working with* a family rather than as experts *acting on* a family. Rather than developing a series of interventions designed to bring clients in line with normative standards, the practitioner is, in the

words of Kaethe Weingarten (1998), a 'fellow traveler', listening carefully and participating in conversations that generate many possible ways forward. Anchored in a lateral relationship in which our thinking is made visible to clients, there is an attempt to honour clients' abilities to develop solutions and move forward in their lives, and to draw on their immediate experience (rather than normative models) as the criterion against which we measure our efforts.

The development of collaborative approaches entails a shift in clinical positioning from a more hierarchical relationship to a more lateral relationship. Clinicians seeking to embrace a collaborative approach in traditional settings often find themselves at the centre of differing pulls, generated by differences between a medical model and a more collaborative approach (Madsen, 2004, 2007). One area these differing pulls often play out in is paperwork demands. The questions on particular paperwork forms can profoundly shape the conversations we have with clients. The questions we ask invite the telling of particular stories and shape clients' experience of self in the process. Interactions around the telling and witnessing of these stories influence the development of therapeutic relationships and the way in which work together unfolds. This article highlights counter-practices in responding to the demands of paperwork with a particular focus on what has traditionally been called assessment, treatment planning, and termination processes.

RE-THINKING THE ASSESSMENT PROCESS

In most agencies, clinicians are required to write up assessments. Traditionally, assessment forms are organised in a close approximation of the following sequence:

- Problem and precipitant
- History
- Current functioning
- Medical condition
- Risk factors
- Mental status
- Formulation
- Diagnosis

In a traditional approach, we begin by identifying the problem and its precipitants. We then go back and examine the history that led up to the problem. After examining current functioning and relevant medical information, we assess risk factors and mental status. Finally, we develop a formulation that leads to and justifies a particular diagnosis. Although this approach has a long history and is encouraged by licensing and reimbursement regulations, there are a number of concerns that can be raised about it. Briefly, the initial focus on the problem, precipitant, and history entrenches us in a problem focus. It promotes selective attention to dysfunction and selective inattention to competence. It organises us around a search for causality and locates problems primarily in individuals. This framework encourages us to think in ways that run counter to epistemological assumptions underlying narrative approaches. Developing formulations that justify a diagnosis runs the risk of simplifying and trivialising clients' lives. Potentially thick descriptions of clients' lives are reduced to thin conclusions. For example, describing a woman as having a 'borderline personality disorder' obscures the richness of her life. (A description of her as 'wonderfully resourceful' is also a thin conclusion.) While we are pushed toward thin conclusions by many forces, our assessments can also be vehicles for rich description.

The traditional assessment process also places therapists and clients in a particular power relationship. In that relationship, client experience is often organised into professional categories. This process runs the risk of obscuring and marginalising client expertise and knowledge, and can have inadvertent disempowering effects on clients. In this relationship, professionals are in a position to 'know' and clients are in a position to receive that knowledge. Often clients who don't 'appropriately' receive that knowledge are labelled 'resistant'. Although the power difference between therapists and clients cannot be erased, there are many ways in which we can make therapeutic interactions more egalitarian.

There are several inherent risks when one party assesses another. Clients, as the object of assessment, may feel objectified and disempowered. The process of assessment may

also encourage distance and disconnection in the relationship between the assessor (clinician) and the assessed (client). One way to use the assessment process constructively is for therapists to shift from a role in which they as experts assess clients, to a role in which they and clients together draw on mutual expertise to collaboratively assess the problems that have come into the clients' lives. This shift draws on externalising assumptions. If we think about people as being in a relationship with a problem rather than having or being a problem, we can conceptualise the assessment process as one in which therapists and clients jointly conduct an assessment of externalised problems. In this way, the concerns raised about the assessment process can be used to mutual advantage. As therapists and clients jointly become the assessors of problems, they increase the possibility that problems (rather than clients) become objectified and disempowered. An assessment of externalised problems may also encourage a distancing in the relationship between families (the assessors) and problems (the assessed), rather than between clinicians (the assessors) and clients (the assessed). The following outline offers a series of questions that can be asked of families to engage them in this type of assessment process. The particular questions outlined here represent questions therapists might hold in their heads and clearly need to be adapted to the language of any particular client or family.

QUESTIONS TO ASSESS PROBLEMS RATHER THAN FAMILIES

Description of the family

- Who are the important people in your life?
- Can you tell me about your life together outside of the immediate problems that bring you here?
- As I get to know you better, what do you think I might particularly appreciate about you?
- Where would you like your lives to be headed?

Presenting concern

- What is the referral source's biggest concern?
- What is your reaction to that?

- What concerns do you have?
(in rank order)
- How will your life look different when these concerns are no longer problems?

Context of presenting concern

- In what situations is the problem most/least likely to occur?
- What is the effect of the problem on you and your relationships?
- How does this problem interfere with your preferred life?
- How do you explain the problem?
- How have you attempted to cope with the problem?
- What broader cultural support does the problem receive?

Family's experience with helpers

- What helpers are currently involved with you?
- What has been your past experience with helpers (good and bad)?
- What impact does that have on your view of helpers?
- How might that affect our work together?

Relevant history

- What is the history of the relationship between the problem and you?
- When has the problem been stronger/weaker in the history of that relationship?
- When have you been stronger/weaker throughout the history of that relationship?
- What has supported the problem's influence on you (family level, family-helper level, broader socio-cultural level)?
- What has supported your influence on the problem (family level, family-helper level, broader socio-cultural level)?

Medical information and risk factors

- What effects has the problem had on your physical health? Has it exacerbated existing medical concerns for you or others?

- What, if any, interactions has the problem had with suicidal ideation, violence, substance misuse, sexual abuse, or neglect in your lives?

Formulation

- Where would you like to be headed in your life?
- What constraints stand in the way of you getting there?
- What abilities, skills, and wisdom can we elicit and elaborate to help you develop a different relationship to those constraints?

When I have used this framework, I have often begun with a contextualising introduction that goes something like this:

As you probably know, one of the things I'm required to do is write up an assessment of your situation. However, because this assessment is a story about your life, I would like to propose that we do it together. What I would like to do is ask you a series of questions to get some information and write down much of what you say so I can make this assessment as close to your words as possible. When we finish, I will write it up and we can go over it and see what you think. We can see what fits for you, what doesn't fit for you, and what you think we should add. How does that sound to you?

I often give clients an outline of the categories and offer some explanation for their inclusion. In my experience, clients have found this a valuable and empowering experience. The framework views people as separate from, and more than, the difficulties in their lives and begins with a focus on getting to know families outside those difficulties. This helps to engage clients who might initially be suspicious about the process. If, in the course of a discussion of the draft assessment, differences of opinion emerge, these can be discussed and brought into the final assessment. In this way, the assessment becomes an acknowledgement of multiple perspectives rather than an imposition of a homogeneous single perspective. This process takes more time, but leads to the creation of assessments

that organise and support our work. In this way, paperwork becomes intimately connected to the process of therapy rather than something that is done the night before a paperwork audit.

The framework outlined here includes most of the categories typically required in assessment documents, though the sequence has been altered. I find it more helpful to examine 'history' following an inquiry into the presenting concerns, current context of the problem, and family experience with helpers. This allows us to enquire about 'history' in a way that is theme-driven rather than pursue a vast collection of disconnected data. This framework does not include information on mental status or diagnosis. If we think about mental status as including some of the effects of the problem(s) on individuals, that information could be captured in the section on context of the presenting concern or, if necessary, included as a separate section. While some clients find diagnoses helpful and it is important to respect this, I think they are generally over-used and can have potentially pathologising, objectifying, and harmful effects on many clients. My preference would be to not include a diagnosis in an assessment that I would write with clients. If we are required to include a diagnosis, I would recommend a frank discussion with clients about that requirement and our thoughts about how to handle it. This process can lead to interesting discussions between clients and therapists that make visible the power dynamics in the relationship in ways that may become uncomfortable. However, these power dynamics exist even when they are implicit. Raising them to an explicit level can be a productive experience for everyone involved.

RE-THINKING TREATMENT GOALS AND PLANNING

In most agencies, clinical work is organised by a treatment or service plan. The centrality of therapy goals has become even more intensified in an era of managed care when continued funding for treatment is evaluated against the attainment of concrete, measurable goals. In this context, treatment goals can be seen as a necessary evil that have to be completed to obtain continued funding and maintain employment. However, collaboratively developed goals can provide a focus and organisational framework for shared work. They can

both increase client motivation and ensure that our work is accountable to clients. With some modifications, we can respond to service planning requirements in ways that are grounded in collaborative practice. The language we use in talking about goals and planning is extremely important and both reflects and shapes our assumptions about therapeutic relationships. Common phrases include treatment plans, service plans, and therapy contracts. Each phrase has particular connotations and places clinicians and clients into particular power relationships. In an attempt to utilise language with connotations that fit the values of collaborative practice and yet is not too distant from clinicians' daily experience, I prefer the phrase 'plan for our work together.'²

Traditionally, the process of goal-setting has been grounded in a medical model in which 'experts' diagnose problems, prescribe a recommended treatment, and evaluate results against measurable outcome indicators to ensure accountability to funders. Although this operational structure may work in some settings, it has the potential to encourage a problem-saturated experience and place clients in a disempowered passive stance in the therapeutic relationship. In my own work, I have tried to place the development of therapeutic contracts within a broader organisational framework for collaborative inquiry (Madsen, 2007). Within this framework, we can organise helping efforts around the following steps:

1. Getting to know clients outside of the problem's influence.
2. Helping clients envision preferred directions in life.
3. Helping clients identify elements that may constrain and/or sustain their development of preferred directions in life.
4. Helping clients shift their relationship to constraining elements and/or enhance their relationship with sustaining elements.
5. Helping clients develop communities to support the enactment of preferred lives.

If we view people as being in a relationship with a problem (rather than having or being a problem), we can begin our work by getting to know clients outside of the problem's influence. Getting to know people as three-dimensional human beings – with

multiple aspects of experience that we can respect and appreciate – builds a strong foundation for a therapeutic relationship. The process of getting to know clients outside of the problem's influence often leads naturally into developing a vision of future possibilities or preferred ways of being in the present that can serve as an agreed-upon focus for helping efforts. As clients begin to concretise preferred directions in life, we can ask them why the direction they're describing is important to them (enhancing motivation), enquire about when they see threads of it emerging and steps they are taking to live into that vision (elaborating resourcefulness), and seek to learn about who in their lives might appreciate and stand behind their efforts to develop that life (developing a community).

Once we have helped clients envision preferred directions in life and learned a bit about why those directions are important to them, we can work with clients to identify elements that might constrain or sustain the development of desired lives. We can identify constraining or restraining elements at different levels (biological, individual, familial, social network, and socio-cultural). We can also identify elements that sustain, support, or enhance the pursuit of preferred lives. These may include sustaining beliefs, actions and interactions at various levels, as well as the intentions and purposes, values and beliefs, hopes and dreams, and commitments people bring to their lives. We can view these sustaining and constraining elements as externalised entities with which clients are in an ongoing and modifiable relationship. With this map in mind, we can focus our work together on helping clients shift their relationship with constraining or restraining elements, and enhancing their relationship with sustaining elements. The inclusion of both constraining and sustaining elements offers us the opportunity to ask clients whether they would prefer to begin with a focus on challenges or supports, and fit our efforts to their preferences. Importantly, the process of helping clients address their relationship with sustaining or constraining elements is significantly enhanced through the development of a community that can support them in that process. Developing a community to witness and support the performance of emerging stories can therefore be a crucial piece of our work.

These steps can be codified in a 'Plan for our work together' by focusing on the following areas:

- Agreed-upon focus
- Identification of sustaining and constraining elements
- Plan to enhance sustaining elements and address constraining elements
- Ways in which improvement might first be noticed.

Here is one example of such a plan that was used with a particular family.

Description of the family

Lyra is a fiery fifteen-year-old white girl with flaming red hair, multiple piercings, and a passionate approach to life. She lives with her two parents and has had a long history of impulsivity both at school and home. She is tired of adults messing with her life and wants to be left alone. Her late grandmother (whom Lyra worshipped) always kidded her that Lyra would 'leap before she looked'. Lyra acknowledges that maybe her life would be better off if she could follow her grandmother's adage of 'look before you leap'. She has a secret dream to become a fashion designer, but thinks everyone at school sees her as 'trouble' and would laugh at her occupational hopes. While she is currently furious at her parents, they used to have a close relationship and she misses that. Her mother Betty is a quiet, reserved woman who wants a close-knit family and is very worried about her daughter. Lyra's father, Tom, values her outspoken feistiness. However, he becomes furious with how abusive she can be towards others and responds by demanding that she straighten up and respect her elders. Tom and Lyra can easily become locked in escalating power struggles which further upsets Betty as she watches her hopes for a close-knit family dissolve. At those times, Tom becomes even angrier as he sees the effects their arguments have on Betty.

PLAN FOR OUR WORK TOGETHER

Agreed-upon focus

Lyra wants to develop a 'look before you leap' lifestyle characterised by 'planfulness' and caution without losing sight of fun and excitement in life.

This is important to her because a ‘leap before you look’ lifestyle has gotten her in trouble at home and school and prevents others from recognising and acknowledging the hopes and plans she has for her life. While she can often get caught in a Leaping Lifestyle (which can be quite compelling), she has been more able lately to bring ‘planfulness’ and caution into her life, and this ability is increasingly recognised by her parents and two friends.

Constraining and sustaining elements

Lyra can be easily captured by a Leaping Lifestyle and has a number of friends who are into cutting school, partying at night, and ‘not giving a crap in life’. A Leaping Lifestyle gets a lot of support from ‘being cool’. Lyra enjoys the respect she gets from friends for ‘living on the edge and not taking crap from adults’. She wants to be making more decisions in her life and be the ‘boss of herself’. When her parents set limits on her, she can get caught in proving to them that she and not they are the boss of herself by ‘leaping before she looks just for spite’.

At the same time, Lyra has a deep commitment to keeping the trouble that a Leaping Lifestyle has brought into her life ‘in its place’. She is tired of the reputation she has acquired at school and wishes people could also recognise her ‘thoughtfulness and seriousness’. She has two friends who are ‘less cool but also less maintenance to hang out with’ and enjoys the time she spends with them. Her maternal grandmother (who encouraged Lyra to ‘look before you leap’) passed away a year ago, but is still a very important presence in her life and someone who she does not want to disappoint. She misses the closeness she used to have with her parents and wishes she could confide in her mother more.

Plan

- We will work to help Lyra clarify why she prefers a Looking Lifestyle over a Leaping Lifestyle, and concretise what a Looking Lifestyle might look like in the future.
- We will examine the cultural ideas of ‘being cool, not taking crap, and living on the edge’, where they come from, and the degree to which they suit or don’t suit Lyra (without trying to prematurely talk her out of them).

- We will help Lyra and her parents talk about the fights that they can become caught in, the effects those fights have on their relationships, and different ways in which they can talk about Lyra growing up and making more decisions for herself.
- We will help Lyra and her parents find ways to get back some of the connection they used to have and miss, as well as helping Lyra find ways to keep her grandmother’s spirit more alive in her life.
- We will look for ways that Lyra’s two friends might become important allies in her life in helping others see her seriousness and thoughtfulness without becoming ‘boring’.

Ways in which improvement might first be noticed

- Lyra might be able to better describe what a Looking Lifestyle looks like and better explain why that appeals to her.
- Lyra might notice when the ‘voice of being cool’ is speaking to her and take some time to think before she responds to it.
- Lyra and her parents might notice times when they were almost sucked into a fight and did something different.
- Lyra and her parents might be talking more and fighting less, and Lyra may organise the pictures from her grandmother’s wedding that she has in a box.
- Lyra might talk with her two friends about being in therapy and also tell them how they have been helpful to her.

Comments on this plan

This kind of plan has a number of benefits to offer a collaborative approach. First, developing a proactive agreed-upon focus (for example, ‘where do you want to be headed in your life?’ rather than ‘what problems do you need to work on?’) sets a shared direction for the work and has the potential to become an irresistible magnet pulling people into their preferred ways of being in life. Second, using clients’ language, and developing metaphorical images supplemented by concrete indicators, supports the development of goals that are both concrete and inspiring. Third, identifying constraining and sustaining elements helps to map

the terrain of a family's life and identify supports and challenges on *their* road to preferred lives. Identifying both these constraining and sustaining elements also helps us to hold a comprehensive understanding of clients' lives and elicit both tragic and heroic aspects of their journey in life. Fourth, developing a plan sets out an initial roadmap for collaborative work and supports work that is accountable to clients. At the same time, it is important to consider this a working document that is constantly 'under construction'.

Finally, questions about ways in which improvement might first be noticed orients clients and practitioners to change, encourages a focus on the direction of change rather than the magnitude of change, and reinforces a positive focus and sense of movement. Framing this as ways that improvement *might* first be noticed alleviates discouragement that could arise in the event that changes are not noticed, and opens space for an investigation of other ways in which improvement might first be noticed. Some licensing requirements require indications that goals have been achieved. While I would prefer a focus on ways in which progress might first be noticed than finally achieved, we could frame outcome measures in the context of a commitment to accountability to clients and actively involve them in determining what would indicate that our efforts have been helpful. In the development of outcome measures for collaborative evaluation, it is important to ensure that we are taking care to measure what is valuable rather than simply valuing what is measurable.

RE-THINKING TERMINATION DOCUMENTS

In many community agencies, clinicians are required to complete quarterly reviews and, at the end of services, a termination summary. The review process that accompanies these documents can be an important time of reflection and consolidation. Traditionally, the process of termination has been organised around a metaphor of loss in which the ending of therapy is a painful process that evokes other unresolved losses. This metaphor promotes attention to how the client is grieving the loss of the relationship, and encourages the therapist to view a client's handling of this loss in the context of other unresolved losses. While it is important to

appreciate the significance of therapeutic relationships for many clients and acknowledge the sense of loss that can be evoked in endings, the sole reliance on this metaphor runs the risk of making therapeutic relationships more important than other relationships in clients' lives and contributing to a narrow view of helping efforts. In the process, we can lose sight of the healing potential in clients' natural communities.

We could also frame termination within a rite of passage metaphor and view it as a ritual to celebrate and consolidate the development of new identities. Termination then becomes less about an ending with a focus on looking back, and more about a transition with a focus on the future as well as a review of previous work. David Epston and Michael White (1995) have proposed a series of questions that can be posed to a client or family in a special meeting to elicit and document the changes made and the knowledge gained in the process of therapy. I have adapted these questions into a broader format that has been used in a number of different contexts (Madsen, 2007). A 'consolidation interview' consists of a specific interview that reviews the work a client has done. The interview can be seen as an invitation to reflect on a client's journey towards a preferred direction in life and used to solidify the integration of a new identity. An example of a consolidation interview organised around five broad areas of inquiry with sample questions is outlined below.

QUESTIONS FOR A CONSOLIDATION INTERVIEW

Reviewing-the-journey questions

- What were you most concerned about at the beginning of our work together?
- What problems were you struggling with?
- How strong were those problems (on a scale of 1-10)?
- How strong would you say those problems are now (on a scale of 1-10)?
- When you compare the problems' influence at the beginning and now, what do you notice?

Re-authoring questions

- What steps did you take to bring about that change in the problem's influence?

- How did you do that?
- What has it meant for you to take these steps?
- What does it tell you about each other and about your relationships?
- What does it say about what you care about and value in your life together?
- With these new achievements as a foundation, what changes might follow next?

Circulation questions

- Now that you've accomplished these changes, who else should know about it?
- What difference do you think it would make in their attitude toward you if they had this news?
- Would it be better to go along with people's old ideas about you or catch them up on these new developments?
- What would be the impact of those people hearing about these developments?
- What would be the best way of letting them know about these accomplishments?

Problem resurgence questions

- If this problem were to attempt a comeback, how would you first notice that?
- What might give you an indication that this problem was coming back?
- What might be the first sign of that indication?
- What have you learned about managing this problem in the past?
- What of that knowledge could you bring to addressing its attempted comeback?

Sharing-client-wisdom questions

- I periodically meet with other families struggling with the same kind of problem you described. From what you now know, what bits of wisdom would you have to offer them?
- If they were to ask you about what you've learned in dealing with this problem, what would you say to them?

- Much of what I've learned about helping families comes from my work with families. Based on what you've learned in your accomplishments, what suggestions would you have for us mental health folks in trying to help other families struggling with similar issues?

This type of interview can begin with discovering whether a client would be interested in taking some time to review the work they have done in order to better understand and solidify that work. This can be proposed ahead of time and discussed. Usually, clients are very interested in the idea. The interview can start by juxtaposing where clients were at the beginning of therapy and where they are at currently. This sets a foundation for inquiry into their journey and its personal significance – hence the name *reviewing the journey questions*. Once we have elicited the story of their journey (landscape of action), we can use *re-authoring questions* to elicit the significance of those developments and the alternative story that has emerged in the course of joint work (landscape of meaning) (White, 1993, 2005). These questions highlight client agency and many clients have described this reflective process as validating and promoting of self-appreciation. In the following section, *circulation questions* can help identify and recruit an audience that can witness, honour, and help solidify these changes. The questions in the consolidation interview thus far should feel familiar to clients who have experienced narrative inquiry. This process offers a way to revisit and thicken previous conversations.

Problems can often be tenacious and find opportunities for resurgence in people's lives. The fourth area of inquiry, *problem resurgence questions*, can help clients anticipate possible reappearances of problems and develop contingency plans. These questions help further solidify clients' developing abilities, skills, and wisdom. If a problem should reappear, the fact that clients have a previously-developed contingency plan in place helps them to regard those problems as difficulties they have effectively managed in the past. Often, the simple fact of having a contingency plan in place provides an effective buffer against the resurgent effects of problems.

Sharing-client-wisdom questions seek to capture the important lessons clients have learned in their experiences with particular problems and the ways in which that wisdom might be useful for others addressing similar problems, as well as for therapists trying to help others in similar situations. These questions have many beneficial effects. They bring forth wisdom and expertise that can be helpful for other clients and therapists. They also elicit ideas from clients that can be brought back into their own lives. As one family remarked, 'You know, these are great ideas we're coming up with. We should remember them.' In this process, the focus is on eliciting nuanced reflections rather than simply soliciting sound bites of advice. These questions can have empowering effects on clients and set a foundation for a more mutual and emotionally-powerful ending.

The questions in this section that solicit lessons for therapists serve a dual purpose. When I have asked clients these questions, I have invariably found their responses interesting, useful, and moving. Their input has enriched my practice and for that I am grateful. However, I am primarily interested in the effects of this process on clients. Clients have felt validated to be asked about their thoughts and have responded eagerly. The process of consulting with them shifts their status from a recipient of services to a more equal participant in the therapeutic relationship. It legitimises and honours their knowledge and expertise, and breaks down the barriers between professionals and clients. It decreases a 'less than' experience of self for clients and invites increased participation in both therapy and their lives.

This interview format can be used in a variety of situations and is easily adapted to quarterly reviews. While many clients and families have remarked on the power of these types of interviews, their significance can be amplified when they are marked through a document or symbol that concretises them. For example, these interviews can be videotaped and clients can be given the videotape. In addition, they can be captured in a symbolic way, or documented in therapeutic letters. Finally, we can also mark interviews such as these through alternative approaches to required paperwork such as termination summaries, which I'll now explore.

USING TERMINATION SUMMARIES TO DOCUMENT ALTERNATIVE STORIES

Clinicians who work in community agencies are routinely required to write termination summaries. Traditionally, licensing agencies require that termination summaries contain the following required information:

- Presenting problem and diagnosis.
- Treatment goal and plan.
- Client condition and level of functioning at termination.
- Reasons for termination.
- Follow-up recommendations.

This format for termination summaries can be modified in ways which both fit with licensing requirements and hold the information that emerges in a consolidation interview. We could co-author termination summaries with clients organised in the following fashion:

Initial concerns

- Client/family's initial concern and level of concern
- Effects of problem(s) on family members

Therapy goals and plan

- Agreed-upon focus of therapy
- Therapy plan (who did what to address that focus)

Course of therapy

- Current level of concern
- Comparison of initial and current level of concern
- Client/family contribution to changes

Status at termination

- Rationale for ending
- Early warning signs of possible problem resurgence
- Client/family plan to solidify progress and address possible problem resurgence

Follow-up recommendations

- Family/therapist recommendations for family
- Family recommendations for other families and therapists working on similar problems.

Many clients have reported that they have found these types of termination summaries helpful as a periodic reminder of 'how far they had come'. There are several options here. One option would be to transpose this summary into a therapeutic letter summarising the work. A letter is more personal and offers possibilities to pose questions that further extend the conversation. In an age of computers, it is easy to write a consolidation summary and then cut and paste a letter that adds such questions. Another option would be to send the report itself which holds certain legitimacy as an official document. Choices can be determined by therapist and family preferences and what seems best suited for a particular situation.

A termination summary written in this fashion also holds certain advantages for clients in its effects on other helpers. The report humanises clients and invites a consideration of them as more than 'just another case'. Follow-up recommendations that reflect their wisdom and knowledge are potentially more applicable and immediately useful to families in the future. Finally, a termination summary written in this fashion represents a significant shift in how and for whom reports are written. Traditionally, termination reports document professional efforts with clients and are written to summarise our work for the benefit of other professionals who might read it at some future date. This alternative format provides a way to document client efforts and is written to summarise their work for their benefit.

CONCLUSION

Therapeutic documents are a powerful adjunct to therapy efforts. Informal studies have suggested that therapeutic letters alone are worth four to five sessions of therapy and clients have attributed 40% to 90% of positive outcome to letters (Freeman, Epston, & Lobovits, 1997; Nylund & Thomas, 1994). Clinicians in community agencies have

paperwork requirements that could have enormous therapeutic potential and could significantly enhance effective clinical work. Unfortunately, that paperwork is often regarded as an unnecessary burden and a distraction from the 'real work'. This article has offered counter-practices that can help community clinicians respond to paperwork demands in ways that support their 'real work' and help them to institutionalise collaborative poststructuralist practice.

NOTES

- ¹ There are many ways in which we could refer to the people who consult us. Throughout this article, I will be using the generally accepted phrase 'clients'. While there are problems with this phrase, it is less problematic than many phrases in our field. It is close to the daily experience of community workers, and I try to be judicious in my use of phrases that feel distant to front-line workers.
- ² This is a phrase I learned from Laura Chasin of the Public Conversations Project in Watertown, Massachusetts, USA.

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