talk that heals

Collaborative Psychiatry

• Every interaction a therapeutic interaction

In institutionally based mental health work we have required activities such as taking a history, screening for diagnoses, developing and engaging people in care and safety plans, and offering psycho-education. We often think of these activities as different from therapeutic intervention. But we have found that Johnella Bird’s therapeutic strategies can be used in any mental health conversation. When we take up opportunities to engage people we are working with using a collaborative discovery orientation and use therapeutic strategies bring forward the agency, knowledge, resources, intentions and values people hold, any conversation can be experienced as therapeutic. Every interaction can be a therapeutic interaction.

This ‘Collaborative Psychiatry’ section of the website builds on the strategies outlined in the Therapeutic Strategies section and there are links in the text to relevant descriptions of the strategies.

Getting Started

You can begin with the getting started section on this website on Johnella's therapeutic strategies.

Change nothing initially but notice possibilities for change after a conversation and verbally rehearse other possibilities

• Listen for, hear and make note of what you are not expecting

We are used to active listening where we are attending closely and supporting the person to put their thoughts and experiences into language. We are often looking for what we understand and what we know how to respond to. In doing this we risk missing something that is new, different and specific to this person. Careful listening with openness to what we don't expect is required for us to hear something we don't expect. We may need to take a specific verbatim note or we won't remember it. We may not be able to come up with a way of responding immediately and may need to slow down the conversation.

> "Can you pause for a moment. What you are saying sounds important and I want to be sure I am getting it. Just then you said …. Can you tell me a bit more about that?"

Asking about a time when the person negotiated similar challenges and what helped previously can bring out useful knowledge.

• Notice ourselves telling

We often have information which can be very helpful to people but telling involves taking up of the expert position which can get in the way of collaboration. Where possible, frame what we want to say as a question. This puts into practice respect for their judgment. and offers the opportunity for them to be active in taking up, or not, the ideas we are offering. If we miss the mark and our ideas are unhelpful, a question is less likely to cause a problem than telling which misses the mark. A question may provide an opportunity for the person to come forward with something else.

> "Do you think the antidepressants are going to be able to have a useful effect if you are only taking them some of the time?"
> "Is telling your brother that he should brush his teeth and stop smoking marijuana working? Is he more or less likely to do these things after you tell him?"
> "Some people tell me, and research supports it, that they find exercise and engaging in activity is helpful for them. Do you think it would be likely to be helpful to you?"

Telling is an important part of our work. We don't want people to miss out on information they might find helpful. We can ask people if they would like us to provide information.

> "Are you interested in hearing about some of the things other people have found helpful?"
> "Would you like me to tell you about what I have seen in my work and read about in the literature for other people having similar experiences?"

We can invite participation by asking,

> "What are you noticing in your thoughts and feelings as I am talking?"

This has a much greater chance of engaging a person in a collaborative discovery process than the commonly used, "Does that make sense?"

- ### Slow down the conversation

Slowing down the conversation can save time if talk is more focused.

> "I want to slow you down. What you are saying is important and I want to be sure I am understanding."
> "I want to slow the conversation down. There is so much to talk about. Let's decide what to focus on in this conversation."

- ### Attend closely to and make explicit what is happening in the room

Working in the present moment by noticing any apparent emotion, physical body change and making it explicit may seem like deviating from the required agenda. But it may bring in to the conversation key issues or concerns which would be otherwise missed.

> "I am noticing you shifting in your chair and looking out the window. Are you noticing that too?" "Is this because you are experiencing some discomfort in this conversation?" "Could you tell me about this?"
> "Tears are starting to come. Can you put words to the tears?"

- ### Check your own understanding

Ask yourself and listen to your own answer:

> "How well do I understand what this experience is like for this person?"

We may not, in this conversation, have the opportunity to address the gaps in our understanding. All anyone can ever do is our best with what we have available. We can acknowledge the gaps rather than identify a lack of meaning or cover them over with general explanations. It may be helpful to the person to acknowledge the limitations of what we are able to do.

> "There is so much more about several of the things you are telling me, but I have certain things I need to cover. Would you mind if we focus on those things first?"
> "What you are talking about sounds really important. Right now, I am going to have to pause you as there are certain things I need to cover. I will make a note that there are issues including x, y and z that we have not had time to cover and need to be returned to."

But it is always worth thinking about what is possible. The person may be able to help prioritise how we use our time.

We can ask ourselves:

> "What would help to increase the understanding I have?"

We can ask them:

> "Thank you for taking the trouble to explain what is going on. It is very helpful, and I know it is only a beginning. We have a few/5/10/15 minutes left. Is there anything you can think of that you could tell me about in that time which might help me be more useful in working with you to find a way through this?"

Attitude of profound respectfulness

- ### It takes positive action for people to experience the respect we have for them

People consulting us may well be experiencing stigma, from themselves as well as people around them. We are operating in a wider social frame which values the knowledge and experience we hold more strongly than those of the people we are here to serve. We do not need to do any active pathologising, undermining or spirit breaking for people to have that experience. For us to feel unconditional positive regard is not enough. If we are to avoid being experienced as pathologising and spirit breaking we need constant attention to, and skills for, interrupting the flow. We need strategies we practise.

It is particularly challenging to put into practice an attitude profound respectfulness when someone is presenting with challenging behaviours to themselves or others around them, or in any sort of an extreme state. Examples include acute psychosis with disorganisation and impaired reality testing or dysfunction involving extreme emotional instability and impulsiveness.

- ### Profound respectfulness needs to be felt as an attitude in every conversation

We can have a range of attitudes when we ask a question. Consider the difference in attitude between:

> "what are the vulnerabilities, deficits and pathologies which have led to this dysfunction?"

and:

> "what can I learn here about the knowledge, values and resources this person has which will enable movement?"

Although eliciting strengths is often mentioned, professional training tends to focus on skills needed to elicit vulnerabilities, deficits and

pathologies. Many therapeutic models and approaches centralise identification of deficits, vulnerabilities and pathologies to be targeted in treatment plans. A focus on bringing forward knowledge, values and resources people have is deeply counter cultural. This difference needs to be put into practice so that it is felt by the person and their family/whanau and is the cornerstone to collaborative practice.

An example could be when we find someone has stopped taking prescribed medication. We commonly think of non-compliance, lack of insight or poor organisation and look for an opportunity to intervene. If we attempt to understand what happened we may hear something we don't expect.

> "How did you make the decision to stop the medication?" "What were some of the thoughts, feelings or ideas which came up as you were thinking about it?"

Questions like this have the potential to bring forward agency, knowledge and resource. We need an attitude of profound respectfulness in asking and in listening for the answers, with an alertness for hearing what we don't expect.

An example of asking and listening with an attitude of profound respectfulness is when a senior colleague whose work, knowledge and thinking process we greatly respect makes a clinical decision which surprises us. We are likely to be wondering what they picked up about the situation that we missed, if there some knowledge they have that we don't, and if we need to change our practice? We listen carefully to the answers, not wanting to miss the opportunity to learn something, particularly something we did not expect.

Power, experiences of powerlessness and use of power

• We need more than good intentions

The power relation in a clinical encounter is set up by the context as part of the role we take up as clinicians. We did not choose to have it and may wish it wasn't there. But it is. Tempting as it is to put it out of our minds we need to hold it in mind.

When people have experience of the knowledge they hold being discounted in the context of a power relation, they are likely to make sense of this as due to a fault in themselves. We are particularly vulnerable to having this happen when the sense of being discounted is a felt sense rather than an experience we have conscious awareness of and can name. When we have conscious awareness of our ideas being discounted we may experience anger and indignation. These emotional responses can alert us to the need to protect the ideas and values we hold. The skills we, as clinicians, have in building rapport and helping people feel comfortable in engaging with us may make it harder for the other person to have conscious awareness of the knowledge they hold being discounted. Experiencing discomfort or lack of meaning in the clinical relationship, while also feeling grateful for the attentive quality of the listening we are doing can be confusing. Particularly in the context of consulting mental health services it is an easy step to the position; 'What's the matter with me?'

I (Tania) regularly have conversations with people who have sat with the doctor, agreed to take medication, even filled the prescription but have not taken it. On careful inquiry it emerges that they felt the doctor was very knowledgeable and caring and it wasn't until they got home that they realised that they had never really intended to take medication and feel a vague sense of shame about not being a good patient. They are left with a sense of having let the doctor down and reluctance to go back even though they are still wanting help.

• We often won't notice a power dynamic in a relationship

We are often not aware of power dynamics which impact the relationships we participate in. We are particularly unlikely to notice power we hold.

When I (Josephine) was a junior registrar in a forensic rehabilitation unit I was attempting to engage a man in the unit, to understand the experiences he was having. He explicitly challenged me, asking how I could expect him to be open with someone like me who had so much power over him. I was puzzled and taken aback. I was just trying to help. I was very junior in the psychiatric system with little confidence in my clinical skills. Major decisions would be made by the justice system. I did not have a sense of any power in the relationship. Looking back I feel embarrassed about my naivety. From the man's perspective I was a doctor. He was detained, against his will, subject to both the mental health and justice systems. He did me an important service, pointing out the powerlessness he experienced in relationship with me.

In my (Josephine's) current position as a consultant psychiatrist in an inpatient unit I have both the power attached to the role of psychiatrist, and institutional power. I regularly use the Mental Health Act and occasionally I prescribe medication that is to be given against someone's will. I know, in my conscious awareness, that people experience me has having power in these ways. But I do not experience this power in a felt sense. My experience is often of powerlessness. I meet people in desperate situations and have so little to offer which is likely to make a substantial difference to their lives. We have only so many beds and resources which are sometimes not enough. I am faced with disappointing families, community teams and other community agencies who want coercive care or extended inpatient stays which I know are not likely to be helpful

• Experiencing powerlessness may mean we need to attend to constructive use of power

Experiences of powerlessness and perception of the other having power can happen for both people simultaneously in a relationship.

I (Tania) had a conversation with a colleague who had been subject to a decision by his manager of a change in the way he was required to work. He was dismayed by this because it would involve letting down the people he was attempting to serve as well as reducing satisfaction he experienced in the work he was doing. Rather than railing against this decision he attributed it to a failure in himself to assert what he thought should happen. He experienced self blame and a sense of shame. Managers are under pressure in health services to meet requirements for certain identifiable outcomes. It is likely that the powerlessness the manager experienced contributed to their failure to seek consultation with my colleague and consider the wider impact of the decision they made.

Earlier in my career I (Josephine) have used coercion in the belief it would keep people safe and taken up the authority of my role and

generously imparted the knowledge I had such faith in. I have come to realise this is all not so straightforward. The thesis of this whole website is that we are the most useful to people when we are able to work collaboratively, so their knowledge and resources are brought forward alongside the knowledge and resources clinicians bring. I notice now, that when I am experiencing powerlessness, finding myself unable to be useful I am at risk of slipping back into the old ways. Even when I am feeling rushed, tired and pressured I need to take care not to move into exerting the power I hold in coercive strategies and taking up the expert, authoritative positions.

Noticing an experience of powerlessness is a cue to the need to stop, reflect and consider how we can use the power we hold in the clinical relationship for the benefit of the relationship.

We need practical strategies we can use intentionally and skilfully. We also need constant vigilance for opportunities to put these strategies into practice. A collaborative discovery orientation using relational language and the strategies which are introduced in the section on Johnella's therapeutic strategies on this website are a good start.

Working in the present moment

• Noting non-verbal responses

Focusing attention on processes which are happening in the room can feel like a deviation which takes up time. Noting non-verbal responses from people enables us to bring them forward as opportunities for discovery. This can significantly increase the usefulness of the conversation. Wandering attention, a lot of sighing, tears arising, a warm laugh, etc, can indicate a response which may not be available to the person's conscious processing. Noting of the person's apparent response, in a tentative, respectful way is an action which demonstrates valuing of the person's experiential/sensory knowledge. It can be therapeutic in itself and can also bring forward differing ideas of the usefulness of the conversation. Bringing these differences into the open and addressing them explicitly has the potential to increase the focus, effectiveness and efficiency of the conversation. We may hear something which surprises us.

• Noticing judgment in ourselves may be a flag indicating opportunity for discovery

When we are doing our best to work collaboratively and show profound respect, noticing judgment in ourselves is often not welcome. A natural response can be silence in an attempt to prevent expression of the judgment. Spontaneous response in the context of experiencing judgment is high risk. But if we make no response we may be missing an opportunity for discovery. We do need to hold our first response. But the next step is to make an inquiry with an attitude of profound respectfulness holding a readiness to hear the answer. General possibilities include:

> "How well does that work for you?"
> "How did you make the decision to … ?"
> "What were you hoping for when you … ?"
> "I am not sure I am understanding what you are telling me, can you tell me a bit more?"

Setting up a collaborative discovery conversation

• Words help in setting up a collaborative discovery orientation but action is needed

People are expecting to engage with us in a power dynamic where we hold power as experts. They may be carrying experiences of stigma and even shame. Some of the people we are attempting to engage are not consenting to the conversation which may even be part of an experience of explicit coercion involving police and handcuffs. We can use telling to make explicit the interest we have in a collaborative discovery conversation.

> "Our job is to figure out how we can support you to live your life in the way you are wanting to. We need to bring together all the knowledge and resources we have. I have learnt and studied about depression/anxiety/psychosis/suicide risk in general but I know very little about you (your child) and your situation. You have a lot of knowledge about yourself (your child), your experiences, what you have tried, what might and might not have felt helpful. We need to bring these together to have the best chance of getting the best life for you."

Words alone cannot shift the weight of community, societal and personal expectations, understanding and experience. The person needs to experience these intentions put into action.

• Show respect to the person as a fellow human being

This can look like meaningless social chit chat and might include comments including shared experience about the weather, noticing a T shirt a young person is wearing, taking trouble to pronounce their name properly, warm smiles or a million other social connecting strategies we might use with any person we engage with.

• Explicitly negotiate engagement

Explicitly negotiating engagement again can seem like using up time without getting to the point, but can also support the effective use of time.

> "Have you ever found a conversation with someone like me helpful?"
> "Are there worries or fears you are bringing to this conversation/admission?"
> "How do you find these conversations?" "Would you be able to let me know if the conversation is starting to feel uncomfortable?"
> "What would I notice?" "If I think I notice something and ask you, would you be able to answer honestly?"

It can be particularly important with someone in an extreme state who is struggling to process the situation.

> "How safe are you feeling here?"
> "I am wondering how easy it is for you to trust that I really am a doctor/nurse/ social worker/psychologist/occupational therapist… and am here to help you."

- ## Find ways to support the person to experience agency

In an inpatient context, where some of the most extreme coercion is found we may be able to offer a choice in timing.

> "I would like to catch up with you, is it best to talk now, or should I come back in half an hour?"

We can offer choice in practical comfort aspects of the conversation.

> "Where would you like to sit?" (This may not be practical if safety concerns mean we need to manage access to the exit door.)
> "Would you like a drink of water (or a cup of tea/coffee/milo if practical)?"
> "Are you feeling warm/cool enough? We could turn on the heater/open the window."

We can make explicit the choice a person has in speaking with us.

> "I want you to know that you have a choice about what questions you answer and how much you tell us. I will do my best to ask questions which feel OK for you to answer. But I don't know you very well and may not be able to find the most useful questions. If I am asking a question that you prefer not to answer it would help us in having a useful conversation if you could tell us that." "Would you be able to tell us?" "It might not be easy to say and if you look away or look down or take your time I might ask you if it is a question you would prefer not to answer."

A decision not to answer a question does not need to be the end of that line of conversation. The person may be prepared to help us understand how they are making the choice, particularly if we are able to manage the conversation so that they are not experiencing this as pressure to answer.

- ## Invite participation in negotiating the agenda

We often come to a conversation with priorities we need to address these but we also need to elicit the priorities people come with.

> "We will cover a lot in this conversation. I want to start by checking, are there specific areas you want to cover, questions you want to ask, particular things you feel we need to know, a place you want to begin?"
> "What hopes do you hold for this conversation/admission?"
> "What ideas do you have about what you would like to be different?"
> "There is so much we could talk about, we need to make some choices. From the referral information the sorts of things I think will probably be helpful to cover include … Which of those sound important to you? Are there some things I haven't mentioned?"

- ## "Are we talking about the right stuff?"

We need to be revisit negotiation of content throughout the conversation. At any time it can be useful to ask:

> "Are we talking about the right stuff?'

Gathering threads can be a good opportunity for this. For instance, having offered a resource based summary of themes in relational language:

> "Which bits do you have most interest in?"
> "Are we moving in the direction you think is most useful or helpful?"

- ## We need to make the priorities we hold explicit

We will need to use the power we hold in the conversation to ensure our priorities are addressed. We can make this explicit to the person and ask permission.

> "this brings up an idea we call 'depression/OCD/psychosis', I'd like to ask some questions around this so we can figure out if it is an idea that will help us. Is that OK?"

In the context of the power relation it would be unusual for someone to refuse permission. At least an explicit request enables the person to have conscious, cognitive awareness of the change we are making in the conversation. A refusal may be an important opportunity for discovery.

> "Thank you for letting me know that a focus on 'depression/OCD/psychosis' is not of interest to you. Can you help me understand how you have come to that conclusion?" "Do you have some experience of using that idea, or similar ideas which has been unhelpful?" "Is there something else which is of more interest to you?"

Of course, we do not know what is going to come forward until we hear what the person says. We are exploring this together. However, it has a good chance of bringing into the open some issues, ideas or experiences which have an important bearing on our being able to make a plan together which will be helpful.

We should offer choice where we can.

> "there are a number of issues which you have brought up. I want to talk more about them, but I also want to be sure we have a chance to clarify whether antidepressant medication has a role here. Shall we come back to that, or talk about it now and then focus on x and y?"

When we offer choice a person may identify an issue to focus on but move to something different. This can feel confusing and frustrating, but, again, it is an opportunity for exploration and discovering meaning together.

> "I notice that you described an interest in talking about x and we have moved to talking about Y. How do you make sense of this shift in this conversation for you today? How do you see X as linked to Y?"

In doing this exploration, there is a commitment to the view:

> "There is something of worth here that I am not getting. What can I do differently to get a clearer understanding?"

As ever, we need to be listening for the answer which might surprise us.

Bringing forward some detail as to how the person is making their choices may lead to useful discoveries.

> "What draws you to this, rather than that?"
> "Is one easier to talk about or is there a worry about judgment or criticism?"
> "If we could find a way to make X easier to talk about do you think that might be helpful?"

Eliciting presenting history

• Identifying duration criteria and stressors are different activities from developing understanding

Some of the DSM and ICD diagnoses have duration criteria. We may need to ask how long the symptoms have been present to check if they meet these criteria. But this may not help us, or the person, make sense of the experience they have. Identifying significant stressors has more chance of contributing to making sense of an experience by placing it in a context. But without careful attention it is likely that the role of an event which, in itself, appears unremarkable, can be missed. A failure to say thank you, being overlooked in an interaction or doing something well, but in the person's perception not well enough, can precipitate a cascade of hypervigilant internal judgment processes and function as a major stressor. In a busy mental health context we often will not have the opportunity to explore the person's experience of and responses to events in enough detail to build a unique narrative which makes sense of their experience. We will often need to leave this gap but it is important to identify this as a gap in opportunity to make sense rather than as a lack of the existence of meaning.

• Time and careful inquiry may be needed to identify the meaning of events

A collaborative discovery conversation exploring the relational context can bring out meaning and significance of events. This supports the development of a unique narrative so the person can make sense of their experience.

> "Let's take this slowly to get as clear as we can as to what you have noticed and see if we can make sense of it."
> "You have told me that this experience of wanting to cry which is so painful for you happens for no reason. You have not noticed a connection to any particular events. I am wondering if you would be open to exploring what you notice when it happens in a bit more detail in case anything has been missed?"
> "Where were you when you first noticed this?" "Who else was there?" "Can you described what I would have seen if I had been watching."
> "What has changed in your life, what else have you noticed?"
> "What effect have these voices had on what you do, your relationships, how you are feeling?"

Researching differences can provide an opportunity to clarify contextual issues:

> "Have you noticed any differences in the strength of the worry you are experiencing at different times?"
> "Have you noticed if the voices you have been hearing are more when you are on your own, busy, with others etc?"
> "What is different when you notice these differences in the strength of the voices/worry?" "What would I see if I were there?"

We are seeking to build a unique narrative which places the person as active in negotiating a context. To build the narrative we need to highlight and explore the contextual and relational environment from within which an individual's experiences, feelings, sensations and thoughts emerge.

Eliciting other history

• Eliciting past psychiatric history and traumatic experiences

There is a risk that eliciting past psychiatric and trauma history can be deficit focused, thus contributing to the potentially spirit breaking impact of mental health care. On the other hand it can also be done using relational language and other therapeutic strategies in a way which increases a person's awareness of and access to their agency, knowledge and resources.

> "Have you ever noticed anything like this before?"
> "How did you get through it then?"
> "What kept you going?"
> "Can you tell me about challenges or difficult times you have negotiated in your life?" "I am thinking of a time which might have been frightening or caused other strong emotion." "Some of the experiences people describe include losing someone close to them, a car accident, someone hitting them or giving them a hiding, sexual abuse (inappropriate or yucky touching with clarification as to what this means as appropriate) or seeing something awful happen to someone they care about."
> "When you think of that/those experience(s) now, how strongly are the feelings you notice affecting you; a little, some, a lot?

Looking for difference and researching context can bring forward detail.

"What is different this time from previously?"
"What was happening in your life then which helped you get through?"

Understanding experiences people carry of previous contact with services can help in negotiating engagement.

"Did you have contact with services like ours?" "Did you find anything that was offered by people like us helpful or unhelpful?"

- Asking about family history can bring forward resource

The family may carry knowledge, experience, fears and worries which are important in negotiating current engagement and support.

"Is there anyone in the family who has experience of anything like this?"
"What are the similarities and differences between what you are noticing now and the experience they had?"
"what do you know about who and what was helpful at that time?"
"How does what you know about the experience they had affect you when you are thinking what you (your child) are going through?"
"What knowledge and ideas does the family hold around this?"

- Developmental history can be framed as the story of how an individual has engaged in the life experiences they have had in context

Rather than focusing on deficits, trauma, etc, which might undermine the person's ability to function, a developmental history can focus on personal style in engaging with life, active ways of approaching and managing problems, strategies which have been helpful and opportunities for development.

"Who would you reach out to and how, when you were struggling with something?"
"What are some of the challenges you have negotiated?"
"How did you engage in social relationships/school/work, etc."
"It is clear that you are someone who cares a lot about the people who are important to you. How did you learn about how to do this caring?
"What experiences have you had (or noticed in Johnny's life) that might be helpful in understanding this situation?"
"Was there anything you noticed about Johnny's development which was different from other children?"

Clarifying the context can support people to build their narrative, making sense of the experiences they are having. Context of national and international events, culture and practices and values

Context which contributes to the building of a unique narrative can be at the level of individual life events, values and practices of the person's family, national or ethnic culture and national and international events.

"How did you and your family negotiate the lockdown?"
"Does your family have any traditions, practices, beliefs that you find supportive?
"How did learning at home with your parents working from home affect the relationships between you?"
"What effect do you think your parents having lived through the cultural revolution had on the parenting environment you grew up in?"
"What sort of learning environments were you exposed to when you were growing up?"
"What sort of role models did you have the opportunity to learn from?"
"What effect has the move from India [or any other country] to New Zealand [or any other country] had on the relationships in your family?"

Moving between these different levels provides a change of perspective.

"What was the effect of your father's losing his job on family relationships?" "How did you negotiate this?"

- Bring forward values and intentions supporting AOD use

Making a choice to use substances is a decision like any other and supported by values and intentions which can be brought forward as a resource. Use of alcohol and other drugs is not infrequently cited as a strategy for getting through.

"What sort of role have alcohol and other drugs had in your life?"
"How well have they worked for you?"
"How do you decide when to use and when to stop?"

Mental state examination

- Use therapeutic strategies to bring forward detail, enrich understanding and support agency

Specifically checking out anything we notice, as in working in the present moment can add greatly to richness in what we are able to describe in a mental state examination.

"I notice that as I talk about the idea of illness and medication you look down and away. Is that what you notice?" "Does that indicate that you have limited interest in that discussion?"
"From where I am sitting it looked as if you felt a bit uncomfortable or annoyed when I started to ask you about voices and cameras watching you. Did you notice any feelings like that?"
"I noticed, as I asked you about reading minds, that you looked up and looked animated. Do you have some interest in that?"

Using relational language can increase the person's sense of agency. Relational language places the person as an active agent in relation to the symptom. It also provides a platform for them to have an awareness of being the person experiencing the symptom.

"Are you noticing any unusual experiences?"
"Have you experienced a sense that you can read other people's minds, or that others could read your mind?"

We can inquire for agency:

"As I tell you that I am not trying to harm you but am interested in helping you, are you working out in your mind whether to believe me?"
"As you experienced this thought that the man was going to kill you did you find yourself questioning it at all, or accepting the truth of it?"

Researching difference can bring forward detail:

"Are you aware that I don't hold the same level of certainty as you do about this idea that the spies are after you as you do?" "I'd like to invite you to discuss the difference between the view you hold and the view I hold." "As I suggest that do you notice a little bit of interest, no interest, some discomfort, or something else?"
"Your mum is saying that she doesn't hear these voices you are describing. How do you make sense of that?"

As we notice people's presentation and way of engaging we have opportunities to elicit agency, values and intentions, eg asking them about how they make decisions:

"I notice you have a new hair colour, how did you decide on that one?"

Formulations

- Collaborative discovery conversations replace the process of formulating by a clinician

As clinicians we are trained to develop formulations. These are hypothetical understandings of the elements in the person's presentation to explain why this person is presenting in this way now. Using theoretical models to support these formulations is often valued. These are fed back to the person so that the experience that sense can be made of their story can be containing and they can feel confidence in the clinician who is able to understand and make sense of all this.

An alternative approach is using our skills and knowledge to engage the person in a joint discovery conversation building a unique narrative that they can own; a narrative of how they arrived at this place as they negotiated the context of their life. This is supported by the use of the person's own words and theoretical explanations are not valued, except in how they inform inquiry. Active systemic processes such as circular explanations involving vicious cycles are prioritised over linear explanations based on underlying causes. Circular explanations can support optimism as they imply multiple openings for small steps effecting significant change.

Talking about diagnoses

- Diagnoses can be offered as an option for understanding rather than fact or truth

DSM and ICD diagnostic systems have been carefully and explicitly constructed to facilitate communication among professionals in order to clarify the characteristics of research participants and support the development of collective wisdom. Diagnostic labels have multiple roles in mental health services and can have important effects in terms of eligibility for funding and access to services. Despite being constructs developed for a specific purpose not entities in the real world, they have developed a life of their own and attract considerable stigma.

The process of making a diagnosis is that of looking for sameness. This is essential for us as clinicians to be able to access knowledge and experience from other people, situations and research. But in looking for sameness, how this person is similar to others, we risk losing detail. No diagnostic category specifically describes the experience any one person has.

We need to make the knowledge and experience we hold available but it can be helpful to ask the person or family how they understand what is going on before offering our thoughts:

"How are you making sense/meaning of this?"

Offering people a choice as to whether they want to hear our thoughts, ideas or information opens the possibility for an experience of agency. It invites them to consider an option rather than imposing a 'truth'. It sets the stage for the person to process whether and how to take them up or not. Examples include:

"There is another way of understanding this which might be helpful, would you have any interest in hearing about it?"
"The pattern of the experiences you are describing sounds like what we call OCD. Have you heard of this?" "Is it OK if I check out some of the other things which can go with this?" "Then we can talk about what can be helpful."
"Have you heard of Autism Spectrum Disorder?" "I am wondering whether what you are describing might fit with this idea."

ADHD can be conceptualised as a personal style with advantages and disadvantages. Many famous people have ADHD. Medication is an option which can be considered. Depression can be offered as an idea which has generated potentially helpful collective wisdom:

"Everyone feels sad and happy at different times, sometimes the sad, angry, negative feelings get a life of their own and they affect your body, your sleep, your thinking, etc. This can become a self-reinforcing cycle. That's what we call a clinical depression. It's a common experience which means there is a lot of collected knowledge about strategies people have found helpful. They may well be helpful for you. Would you like to hear about them?"

It is also important specifically to elicit responses:

"What are you noticing in your thoughts and emotions as I am talking?"
"I notice your expression changed when I mentioned the idea of 'psychosis'. Do you have some experience of this idea?"

When we need to check out specific symptoms which indicate the potential benefit of an evidence based intervention, we are prioritising a knowledge base where we hold expertise. This is a shift in the conversation from an emphasis on prioritising bringing forward the person's knowledge. We are taking control of the content of the interview. We can make this explicit and ask permission.

"I am wondering if we should be thinking about depression/ADHD. Is it OK if I ask some specific questions which will help clarify that?

When wondering about the possibility of psychosis it can work to say:

"I need to ask my psychiatrist questions. You may have been asked them before, is that OK?"

Recommending interventions

• Our recommendations are a best guess based on knowledge of groups

Clinical recommendations involve making a best guess based on emerging knowledge of the person consulting us and a breadth of knowledge from our experience, training, reading and knowledge of research. Our information is based on probabilities and other people. Thus feedback from the person is very important, to the initial ideas and as treatment progresses as to how it is going. This can be framed in a way which makes the knowledge we hold available but also values the knowledge the person holds:

"I have studied a lot about depression in general and met many other people experiencing depression and can talk about what I have learnt. But am only just getting to know you. You know you. So hearing about what you notice will be very important in sorting out what is likely to work best for you. "
"From my experience, what people have told me and international research, the most likely thing to help someone in a situation like this is X, Y, Z. What do you think of the sound of them? What do you feel most interested in engaging in? It will be important for you to let us know how it is working for you."

• Beware overstating level of certainty we have re effectiveness of medicine

Overstating the level of certainty we have regarding the effectiveness of medication is particularly tempting. Even when positive results are shown on randomised controlled trials effectiveness of a medication in one individual is far from certain.We can explain randomised controlled trials specifying that not everyone in the treatment group got better and that some of the people in the placebo group got better. This supports the person in a risk-benefit analysis around whether or not to engage in a trial to establish whether they are one of the people who will benefit from the intervention.

Conversations about medication can provide possibilities for collaborative discovery conversations. For example; with someone who has lowered mood but stops antidepressants because they do not want to depend on medication:

"Does this indicate a value you place on depending on your own internal resources?"
"What is the history of this value in your life?" "How does this value affect other decisions you make?"

With a young person who says:

"I feel as if I have to take the Ritalin (methyl phenidate) because it helps me concentrate on school work"

This provides an opportunity to bring forward values and agency:

"Is concentrating on school work something you value?" "How did you come to decide this was important?"

• Compulsory care has its own challenges

Compulsory care involves an explicit use of institutional power over a person. This, in itself, is not collaborative. We are making a decision about what we think is in the best interests of the person, overriding their choice and agency. Usually it involves a process of balancing harm and benefit, but it is important we acknowledge the harm. We can embody the decision to coerce, a decision made by a person, not a reflection of the way the world is. We can be clear and specific. We can still be present.

"Right now, I hold the belief that you need to be in hospital and take this medication. I could be wrong, but this is the decision I have made."
"I am aware that this must be hard for you, being stuck in hospital when it makes no sense to you." "The fastest way to get out of hospital is to do what we are asking and take the medication." "Is there anything we can do to make the time you spend here easier?"

Having family to support where possible and minimising physical coercion are important. Using force to inject medication cannot always be avoided but needs to be considered very seriously with use of alternatives if possible. However, we can still treat the person with respect. We can be present as a human being with the person as a human being. We can be as available as possible to meeting with the person when that is what they are asking for. We can listen carefully for agency and resource and gather threads. We can empathise and validate. We can talk about the pathway out of hospital and towards building the life they want.

Talking about suicidal feelings

- ### Suicidal feelings are experiences and can be explored by a collaborative discovery conversation

Careful use of therapeutic strategies in each step of the conversation can support movement and experiences of agency and resource. Using relational externalising to ask whether the person is experiencing suicidal thoughts positions them in the conversation as an agent in relation to the experience of the suicidal thoughts or urges. This gives them some separation from the thoughts. It also supports moving out of binary, in contrast to:

> "Are you suicidal?" or "Can you guarantee your safety?"

Relational externalising also supports contextualizing of the suicidal thoughts/urges, opens up the conversation to:

> "the suicidal thoughts you experienced when …".

This can bring forward knowledge as well as the possibility of movement if the suicidal thoughts are not described as a fixed attribute of the person, but in relation to circumstances which may be able to be addressed. Researching difference through time can also support the possibility of movement:

> "You were saying the suicidal thoughts are the strongest when you and your mum are arguing. Do you notice them as soon as the argument starts, or do they take a while to gather strength?"
> "How did you get through?" can move the focus to agency."
> "What kept you going?" or "Has there ever been a time when life felt worth living?" support focus on presence rather than absence .

Working with families

- ### We do not have a mandate for family therapy but can help with family conversations

I (Josephine) had a formative experience with respect to clinicians offering family interventions when my mother needed open heart surgery. My siblings and I were talking together about how to support her and my father. Old interaction patterns of varying degrees of helpfulness were starting to surface. I could see we could benefit from a family therapeutic approach but as the idea flashed through my mind of a clinician offering us family therapy I knew my response would be of irritation. I wanted to address the problem at hand. However, if a clinician had offered to support us with working together to optimise the support we were offering our parents I would have felt interest and appreciation. This is the mandate we have working in mental health services. Families are potentially a vitally important resource and it is our role to optimise this, not to find pathology and fix it.

Psycho-education is an important, evidence based and institutionally supported intervention. We can offer families information about what to expect, what their loved one might be experiencing, available treatments, risks, potential pitfalls and information from research findings about what sort of family responses are helpful. This is information based on other people and groups. It is also important that we are offering this as knowledge to sit beside the knowledge they hold of their family and the family member they know and love.

Profound respectfulness in working with families is vitally important and may require even more positive action on our part than in working with individuals. Family blaming is less prominent in mental health discourse but is alive and well in the community we live in. The family is likely to be experiencing shame and stigma.

We have the potential to be significantly helpful to families. Having a conversation with a non-family person included means the conversation will not be the same as at home. This difference has the potential for discovery and for shift. We can optimise this with simple strategies such as asking each person in turn to speak about how they understand the issues and what ideas they have about what might be helpful.

> "It is great that we have you all/both here to support X. I'd like to hear from each of you as to how you are making sense of what is happening."

We can support explicit conversation such as asking the person what they would find helpful and how they are experiencing support which is being offered.

> "What is working well at the moment for you and the family?"
> "Are there changes, or different things which might be helpful?"
> "You are all working with a new situation, having X being unwell. Would it work for your family to set a regular time to review these questions among yourselves at home?"

- ### Bringing forward intention and positive regard

It is unusual for family members to intend harm to each other but it is not so unusual for unhelpful patterns of behaviour to happen and repeat. Where we have concern that talk might not be helpful we can explicitly ask about intention.

> "Can we stop here for a minute? I am wondering what you are hoping X will take from what you are saying?"
> "Is the strength of the anger/frustration you are feeling an indication of the strength of the love you feel for x?"

Many adolescents I (Josephine) have met who are struggling with suicidal thoughts and urges have a rational, cognitive belief that their parents love them but the young person does not feel this love. It is also common for them to experience a ‘no' as a communication of a lack of love and care.

> "Do you feel the love your parents have for you?"
> "When your mum said you could not go to the party what feelings and thoughts did you notice?" "Is it possible that the ‘no' is because of the love she feels for you, the worry she holds that it won't work out well for you?"

- ### We may need to use the power we hold for the benefit of the conversation

Asking each family member to speak in turn is an example of this. It shifts the usual pattern of conversation and allows a different experience. Slowing the conversation down can be an important intervention.

> "[? Holding up hands, leaning forward, firm voice.] I want to stop you all for a minute. It is great to feel the energy in the room and we need to slow the conversation down so we hear what everyone is saying."

Where one person is talking for some time we may want to do some checking.

> "I am going to stop you for a moment. What you are saying sounds really important, I want to check with X what they are thinking and feeling as you are talking"
> "Can I stop you, I want to do some checking. [to everyone] "X is talking for the family, is this the way you usually do things?" "How well is this working?" "Should we just continue or should we be stopping every now and again and check if other people what to add something?

If family members are lecturing or asking for change from the person they are unlikely to comply with:

> "I'd like to check with you; is this the type of talking you do at home?" "How well is has it been working?" "Would you like to try something different?"

We can use a similar strategy if there is clear conflict or talk we are concerned might be hurtful.

> "[?Hold up hand, assertive body position, firm voice] Let's stop for a moment. Is this the sort of talk which happens a lot at home?" "How well does it work for the family?" "How do you think it is for X?"

- ### Gathering threads in relational language can be a powerful intervention

Often a lot is happening in a family conversation and there is a risk that much can be lost. To gather threads effectively requires good note taking or we will lose. Feeding back a summary in relational language gives an opportunity to slow down the conversation and review direction.

There is a lot to take in

- ### Something is better than nothing

The therapeutic strategies and approach Johnella has developed to engage people in a joint discovery process can inform every interaction in mental health practice. One of the things I (Josephine) noticed, once I started to apply the ideas I was learning from Johnella, was that although my facility with them was limited and I only managed to use some of them some of the time, they seemed to make a difference. We need not think in a binary - collaborative psychiatry vs non-collaborative psychiatry. We can be moving towards an increasingly collaborative clinical practice. There are other approaches and tools which can help.

- ### Tools from The Gift Box can support collaborative discovery conversation

The Bridge of Trust diagram provides a pictorial representation of the task of building trust between two people with some similar and some different ideas, values, experiences etc, supporting explicit negotiation of engagement. Having a laminated illustration for clinician and person to focus on together can also decrease the intensity of the interaction.

Use of the Feel-o-meter offers a practical way for people to identify their experience of wellbeing on a scale of 1 to 100. This puts into action a demonstration of interest in the person's experience and makes it very easy for them to communicate at least something. This might be a first step which the clinician can build on. It also facilitates a focus on the positive - for example, asking "what's putting you at 30 rather than 25? What might help get you to 40, or 50?". By being offered at the beginning and end of the session, it can also help provide vital feedback about the helpfulness or otherwise of the session, without the need to share too much detail. If the feelometer score is less at the end of the interview, it opens the possibility of checking in about what has happened and what might help them to feel better.

The Gift Box also contains sets of cards some of which, When I am at my best and Things that help/ways of getting support, are available to download from this website and can be printed and laminated. Each card describes a thought, feeling, activity or body sensation. They have been developed by a clinicians and other people with and without lived experience. These can be offered to people to choose which apply to the experiences they have. Asking a person to select cards they are drawn to provides a structure for them to make choices about how they want to describe their experiences and ideas. Choosing a card from available options is an easier cognitive task than being asked to generate answers, particularly for someone in an extreme state. This has the potential to reduce anxiety a person might experience in a clinical conversation and enable them to experience competence and agency.

It also allows more reflection and specificity around certain choices – for example 'listening to music' or 'doing my hobby' might prompt exploration of what music/hobby do you enjoy; do you have access to it? When did you last listen/do your specific hobby. What are the barriers? What helps? Etc. We can also ask, "Anything else?" (there are wild cards to prompt this question).

- ### Motivational Interviewing focuses on bringing forward resource

Motivational Interviewing is institutionally supported but profoundly counter-cultural. As with Johnella's work the emphasis is on bringing forward the knowledge of the person, rather than prioritising the clinician's knowledge. The intention of a question is to bring forward the person's knowledge and support a shift in the thinking they are doing. It is an evidence based approach which is widely used with substance abuse and addictions. There are also studies supporting its use in increasing medication adherence. Doing a training will give you a chance to

practise and experience micro-skills to enable the person to speak out experiences and ideas they have which support change. The clinician might guess but does not know what these will be. The skill of the clinician is in structuring a conversation which enables the person to access this knowledge they hold from their experience and bring it forward. Careful listening is integral and the role of telling limited and managed.

• Brief Solution Focussed Therapy eschews ideas of deficit, pathology and problems

An evidence base for Solution Focussed Therapy exists but is slim and institutional support is more limited. But trainings are available and it provides a structure which can relatively easily be learnt and taken up. Engaging in training and learning about solution focussed strategies can help us experiment with shifting some of the practices we commonly use. It uses inquiry to generate a discovery conversation focussed on evidence and effect of forward movement. These conversations focus on presence rather than absence and use imagination as a therapeutic resource.

Underlying contextual issues

• We are set up to be dis-empowering

The risk of imposing meaning within a power relation, present in any therapeutic work, is accentuated in psychiatry. We believe the process of prioritising the knowledge and expertise we have, particularly when it is in line with the dominant cultural ideas, is central to the energy behind the anti-psychiatry movement. The slogan 'Drop the Disorder' makes this explicit. The wider societal understanding of having mental health issues tends to be pathologizing and disempowering. We call this 'stigma'. Often the person can be stigmatising themselves.

Our work in mental health also reaches right out to the margins of extreme states and risk. Setting up a collaborative discovery conversation has special challenges when people are experiencing extreme states. They may present as disorganised and in need of a high level of care which might include compulsory containment and treatment. The process of holding someone against their will and possibly even forcing medication on them is a very small part of the work of psychiatry, but it is part of our work. It is work we (Tania and Josephine) have participated in and learned from.

However, these extreme situations are only the tip of the iceberg in terms of risk of imposing meaning. Negotiating use of medication and other evidence based interventions requires that we prioritise knowledge we hold in order to identify when evidence based interventions are likely to be helpful and make them available. Institutional health services usually operate on an illness model, with a focus on identifying, treating, preventing and alleviating illness. We have institutional requirements such as screening, recording histories as part of an assessment, communicating with colleagues and completing forms which require diagnoses. Writing a prescription or an application for compulsory care under the Mental Health Act involve explicit exercise of institutionally defined power. We need to provide all this but our practice has the potential to be so much more.

• We have a duty to make evidence based knowledge available to people

The process of categorisation in terms of professional knowledge is a necessary activity if we are to bring people the benefits of evidence based knowledge. The DSM and ICD diagnostic systems were designed to support a process for people working in psychiatry in different contexts to share knowledge and experience. This process has been crucial in developing an evidence base of interventions, supports and responses which have been found by careful study to be helpful for people with particular clusters of experiences and behaviours. We have a duty to make the knowledge we have of these available to people for whom they could make a positive difference. In order to do this we need to bring a diagnostic system into our work.

These diagnostic systems are imposed meaning for all of us. They have been developed by systematic processes which are outside any one person or group's meaning making processes. They are also deficit based and often attract stigma. In order to work collaboratively we need strategies to make the knowledge and expertise we hold available to people alongside the knowledge, experience and values they hold; available be taken up by them as it enables them to live their lives by their ideas; on tap, not on top.

Prioritising clinical knowledge and meaning systems carries a risk of losing access to the person's knowledge. These clinical meaning systems invite us to categorise what people say and then act on it as fitting in to that category; "this is what this means". Because of the power relation people are not likely to contradict us. Ordinary questions often do not get asked because we are fitting what we are hearing into a category. We can manage this by using our clinical knowledge constructions to inform a question we ask and ready ourselves for an answer that may shift this professional knowledge category we are considering.

One example was an answer a man with a criminal history and substance addiction gave to being asked how he decided not to maintain contact with his child.

> "I don't want him to have a father like me."

This provided rich opportunities for bringing forward the care he felt for the child in wanting a certain sort of father, what sort of father he wanted for his child, his knowledge and experience which informed him about the sort of father he wanted for his child and what parts of that he might be able to offer or work towards offering.

The nature of knowledge

• Knowledge in the dark ages was established by royal or religious decree

In the Dark Ages knowledge was established by royal or religious decree. Knowledge was valued according to the power and position of the person who espoused it. This method of evaluating knowledge has been partially, but by no means completely, superseded. The change

which is referred to as the Copernican revolution was the idea that knowledge can be gained by the individual knower. Initially this was with astronomy, by careful observation of the heavens. In a modern context it is hard to conceive that this idea was revolutionary, but that is how it was experienced at the time. The revolution gave rise to Modernism and the scientific method.

• Modernist epistemology is the foundation of modern science, technology and medicine

On a modernist view knowledge is understood as building sequentially towards absolute truth. Scientific method maximises objectivity. Language is understood as a mirror of reality, to use words to describe reality was seen as in the nature of holding up a mirror, so the audience might perceive what was described objectively, as the speaker did. A primary activity is to seek causal explanations in terms of underlying structures. Modernism has been very successful, underpinning almost every aspect of our modern lives, including evidence-based practice.

Experience in quantum physics has shown seeking underneath explanations in terms of causation by underlying structures to be a limited strategy. The further physicists looked 'underneath' for smaller and smaller particles, the more they were led to empty space and the less they were able to engage in objectivity. They could not observe sub-atomic particles without affecting them. In working with people, looking underneath can lead to pathologising formulations. Even trauma based formulations often focus on damage rather than resource and agency.

• Evidence based practice has yielded helpful interventions

Evidence-based practice is grounded in the modernist study of natural phenomena. Deducing and testing hypotheses are valued activities, with the randomized, controlled trial being the gold standard. Developing and applying evidence is dependent on labelling and categorizing. Research in this paradigm has yielded helpful treatment interventions which can be lifesaving and have the potential to improve people's quality of life. It is strongly institutionally supported and explicitly prioritized over personal knowledge. It is a rare intervention that works for everybody.

Working in a modernist epistemology involves an understanding that the clinician has more and better knowledge and uses this knowledge to assess, identify problems and intervene from an expert position. The prioritizing of clinician knowledge, risks undermining the person's sense of the value of the knowledge they hold so that it gets sent underground and we lose access to it.

• In social constructionism we see meaning as constructed

Social constructionism is a post-modern view of knowledge. Rather than being understood as a cumulative progression towards an absolute truth, knowledge is understood to be represented in meaning which is constructed in social interaction through generations and day to day. While starting off with innate reflexes and behaviour patterns a new baby learns to attend preferentially to what is important to its parents. This is in contrast to the idea of knowledge being 'found' by objective study and looking underneath (an approach found unrewarding in subatomic physics). Meaning is embedded in language. To describe oneself as a clinician, or a document as an academic paper is quite a different activity from holding up a mirror. Such descriptions depend on a range of shared cultural and sub-cultural understandings. In a simplistic way we can describe language and shared constructions as lenses through which we perceive the world. Our sense of ourselves and reality is socially constructed.

Knowledge constructions are value laden and can serve power groups. For example, feminists describe the qualities identified as feminine, nurturing, non-confrontative and in need of protection, as supporting male power. Karl Marx, described religion as the opium of the masses. He was referring to religious ideas which focused the attention of the workers on the morality of their individual actions and seeking fulfilment in the afterlife. This protected the capitalists from the possibility of revolutionary action by workers seeking an equitable share of resources in their earthly lives. Diagnostic systems such as DSM and ICD can be seen as serving the interests of mental health professionals. Increasing the number and availability of diagnostic labels which pathologize and disempower those described by them, has the potential to increase the perceived credibility and sphere of influence of psychiatry.

Constructions can be evaluated by usefulness and effect. Evidence- based practice has considerable claim to be valued on this basis. Resonance with people's understandings and values supports the Recovery Approach.

• Social constructionism allows us to value multiple knowledges evaluated by usefulness

A social constructionist epistemology frees us from a modernist epistemology where there is objective truth so some people will be more right than others and knowledge not based on objective science can be dismissed. It opens us up to the possibility of multiple viewpoints, each with validity. It gives us a way of understanding people's knowledge as sitting beside ours, with both as possibilities, rather than having to let go of one to take up the other. Knowledge constructions can be evaluated according to their usefulness in the value system of the people using them.

• Social constructionism allows us to let go of ‘underneath' explanations

'Underneath' explanations have a risk of being experienced as pathologising. Social constructionism opens us to the possibility of explanations which include wider issues such as gender and cultural factors, societal stigma and bias as well as specific relationships and personal experiences. It supports circular explanations such as vicious cycles where blame is not attributed to any specific event, person or factor. Such explanations can be taken up or not as they are experienced as congruent, validating, useful, empowering and supporting movement. We can develop a unique narrative for each person as to how we have negotiated the life situations and contexts we have encountered.

• Social constructionism places diagnoses as potentially usefully ideas, not entities

Social constructionism gives form to the understanding of diagnoses as ideas, constructed to serve a purpose, rather than entities in the real world. The DSM and ICD systems are explicitly developed constructions designed to be useful within the context of evidence-based practice. From a social constructionist view the process of developing diagnostic labels is not understood as a process of discovery of disease entities

in the world and applying the correct label. It is understood as developing constructions which are judged on how useful and effective they are. A diagnostic label is offering one way of understanding an issue, rather than a statement of fact.

- A social constructionist approach gives us possibilities we need to promote actively

Many factors in the social context of our work support blame, pathologizing, prioritising clinician knowledge and underneath explanations. Unless we work actively to prioritise the knowledge and resources of people we serve we risk being experienced as pathologizing and undermining, even if this is not an intention we hold.

A doctor who had visited a psychiatrist in the role of a patient described this experience in a research context.

> "I went because I thought I was having a few problems. And he told me I was depressed and that I needed antidepressants and I was devastated and I remember coming out of that thinking ‘God I didn't realise it was this serious' … it felt like I had my feet taken out from underneath me and it kind of felt a bit like I'd had my power taken away … I guess the thing I didn't do… I didn't argue against it. I didn't argue with him because he knew."

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