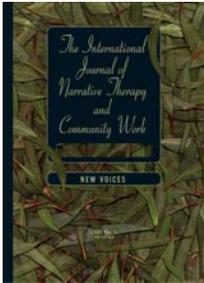


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Narrative therapy and research

compiled by

Dulwich Centre Publications

There are rich connections between narrative therapy and practices of research, and considering these links has been a source of creativity for many practitioners. This short piece seeks to describe how narrative therapy first began to be described as co-research, and describes some of the common research practices that are engaged with by narrative therapists. This piece also considers the powerful challenges that Indigenous researchers are making to the field of research. This paper has been collaboratively created. Marilyn O'Neill, Shona Russell, Makungu Akinyela, Helen Gremillion, David Epston, Vanessa Jackson and Michael White all responded to the questions listed below, and David Denborough then wove their responses into a final form.

Keywords: *co-research, narrative practice, cultural anthropology, policy, decolonisation*

1. What is the history of understanding therapy as co-research?

In the mid 1980s, I remember reading an early version of the article 'Consulting your consultants: The documentation of alternative knowledges' by David Epston and Michael White. This paper had an enormous impact on me. My initial training had emphasised the therapist as the holder of knowledge, as the diagnoser, the advice-giver, the person who was to come up with solutions to the difficulties others were facing. The idea of consulting those who came to therapy offered a very different orientation. It invited me as a therapist to adopt a position of enquiry, to ask questions, to explore the ideas that people have about their own lives. It enabled a position of therapist as researcher – exploring what is important to those who have come to consult us and the knowledges and skills that they have developed over the course of their lives and experiences. Since then, this position of the therapist has become a central part of what is important to me in my work. (Shona Russell)

In the 1970s-1980s a dramatic development took place within the field of cultural anthropology, which in turn led to wide-ranging effects in a number of disciplines including therapy and community work. It was known as the 'Interpretive Turn' and was associated with the cultural anthropologists Clifford Geertz (1983), Renato Rosaldo (1992), Edward Bruner (1986), Victor Turner (1986), Barbara Meyerhoff (1982), and others. Their work questioned what had been widely accepted practices of anthropology. They articulated that it was impossible for anyone to have an objective view in their research and demonstrated the ways in which anthropologists shape their research and influence the communities in which they study. In doing so, they questioned the role of anthropologists interpreting events in a culture other than their own and stressed the importance of acknowledging how anthropologists' own ethnicity, culture, class, gender, etc., influence their research.

What is more, they proposed an alternative form of research, one in which the role of ethno-methodology was to privilege the meanings and interpretations of the people who are being studied. This new form of ethno-methodology involved inviting people of various cultures and communities to interpret and study their own lives and culture. In this way, the people of the community being studied became research partners and the research became

accountable to local people. This was a radical departure from previous traditions of anthropological research and has gone on to influence work in many fields including postcolonial studies, gay/lesbian/ bisexual/transgender studies, cultural studies, social activists, as well as the therapy realm.

David Epston brought his experience as an anthropologist into his practice as a therapist. In doing so, he brought the term co-research into the therapy realm (see page 31). As he describes it (2001): 'I have always thought of myself as doing research, but on problems and the relationships that people have with problems, rather than on the people themselves. The structuring of narrative questions and interviews allow me and others to co-research problems and the alternative knowledges that are developed to address them' (p.178).

In developing what has come to be known as narrative therapy and community work, both David Epston and Michael White (see White & Epston 1990; Epston 1999) were significantly influenced by the 'Interpretive Turn' within cultural anthropology. Since then, many other practitioners have further explored the metaphor of therapeutic co-research (Brigitte, Sue, Mem & Veronika 1998; Grieves 1998; Madigan 1998; Stockell & O'Neill 1999; Nosworthy & Lane 1998; Bird 2000).

Understanding the therapist and client as co-researchers who are investigating the effects of problems and the client's solution knowledges was a significant departure from commonly held beliefs about therapy. It is a metaphor for practice that many have found very helpful.

2. What are some of the forms of research that are commonly used within narrative practice?

As a therapist, I ask questions of inquiry and this is a form of research. These questions are genuine. I want to find something out that I do not already know about this person's views on their life, their wishes, their position on a problem, and so on. These questions also have a particular purpose. I am not asking them for my own sake. Nor am I asking them to acquire knowledge for others (although the knowledge we discover might be shared). This research is undertaken, these questions are asked, to assist the person concerned to change their relationship with the problem or difficulties for which they are seeking therapy. (Shona Russell)

From empathy to ethnography: the origin of therapeutic co-research

by David Epston

I arrived at the term co-research in 1988-9 when working with families in which one or more family members were affected by a devastating, and thankfully rare, genetic disorder relating to the structure of the skin called dystrophic emolysis bulosa. In working with these families, various expert knowledges had exhausted themselves of their very own expertness or frankly admitted that they could do no more than palliative care. For me to presume to substitute some sort of 'psychological' expert knowledge would have immediately rendered me 'suspicious'. By the same token, my 'suspiciousness' could very well have been experienced as blaming, as had often been the case, despite my best efforts to redress that. I asked myself the following questions:

- How could I request people in peril to stop seeking rescue but rather turn to themselves and to each other?
- How might I proffer something other than a 'miracle cure' to take the place of the forsaken 'medical cure'?
- How could we all take up different relationships with each other and the problem of suffering?

Over sixty families had formed the Dystrophic Emolysis Bulosa Research Association (DEBRA) and, in response to these sorts of questions, together we developed a way of working that came to be known as co-research. This brought together the very respectable notion of research with the rather odd idea of the co-production of knowledge by sufferers and therapist.

When I first started meeting with these families we engaged in fairly thoroughgoing externalising conversations, in which the problem was a problem for everyone – and here I included myself. These conversations led to the co-production of certain knowledges about the problem, and ways of responding to it, that were of pragmatic value to the families. With the agreement of everyone concerned, I made it my practice to document these knowledges in a letter which would be sent to the family after each session and then more widely circulated to every member in the Association. When the annual conference came around I would then interview the family concerned before the assembled members of the Association (grandparents, parents, children, associated professionals, friends), all of whom had been informed of the proceedings through reading the letters. After a half hour or so, my colleagues would then disperse into what we mockingly referred to as 'case conferences' to 'research' the 'insider knowledges' that had been co-constructed so far. An hour or

so later, we would all reconvene and I would interview the spokespeople for each 'case conference', and together we would start cross-referencing the practices informed by such 'insider knowledges' and elaborating them.

The first time I used the word co-research in text was in such a letter to the Worthy family in 1989 who had consulted me with their newborn son, Ashley, seeking my opinion as to what they should do. The following is an excerpt from that circulated letter:

First of all, I think it is important for me to set out my thoughts for your consideration. I am totally unconvinced that the answers you are seeking for Ashley exist within any particular professional knowledge. As far as I can see, medical knowledges don't apply themselves to the day-to-day problems confronted by Ashley, yourselves and your community. Many people seek that day-to-day knowledge from doctors and are sadly disappointed and at times angry. My position is very dissimilar. I propose that the knowledge, so particular to Ashley and yourselves, be developed by yourselves in co-research with me (and your DEBRA community). That is, of course, if you wish my assistance. Co-research implies firstly that the answer is unknown but secondly that it can only be discovered by an experimental attitude on a day-to-day basis. Co-research is also based on the belief that parents and young people can find their own solutions to some of the effects of their medical problems in and on their lives and that of their families. An experimental attitude draws upon something parents already do and that is the close observation of their children and their activities, noting small differences. Such is my proposal for Ashley and yourselves.

Unlike conventional research, the process of co-research does not claim to be objective, nor does it aspire to objectivity. The process itself is inextricably entwined with its purpose, which is to generate knowledge that can influence in preferred ways a person's relationship with the particular issue for which they have sought counselling.

I am aware that the term co-research has cropped up in any number of qualitative and feminist research contexts, but for me this experience with the DEBRA families became prototypical of many other ventures of what I refer to as 'research in action'. In fact, co-researching has become the very methodology of anti-anorexic/bulimic practice (see Borden, A., Epston, D. & Maisel, R. in press: *Biting the Hand That Starves You: Inspiring resistance to anorexia/bulimia*. New York: W.W.Norton).

Many of the practices of narrative therapy can be considered as research practices but there are perhaps two that are most commonly known. The first involves inquiring into solution knowledges and problem-solving skills of people who are consulting therapists. At times, the solution knowledges that are articulated are documented and compiled in archives so that they can be made available to others who are facing similar predicaments, as Rick Maisel, David Epston & Ali Borden describe:

Archival documents can take the form of written documents, such as journal entries, letters, transcripts, or poems, or of visual depictions, such as paintings, drawings or collages. They can also take the form of audiotaped or videotaped conversations. Some archival documents develop a 'portrait' of particular problems, developing rich metaphorical or personified descriptions. Other documents might detail the tactics and strategies of a particular problem and contribute to an exposé of its voice. Some archives document the means by which people come to recognise the tactics of the particular problem and the steps they take to resist it. Some address the ways in which relationship and larger sociocultural messages support the problem or conversely empower and strengthen the person's resistance to it. Archival documents can be read aloud to people during therapy or they can be given to people to take home to peruse at their convenience (in press).

For a good example of such an archive, see The Archives of Resistance: Anti-Anorexia/Anti-Bulimia (www.narrativeapproaches.com). This archive contains a wide range of information and stories about anti-anorexia/anti-bulimia skills and knowledges.

A second common form of co-research involves an inquiry into what is helpful / not helpful in the therapeutic conversations themselves. Throughout narrative therapy consultations, questions are asked to ensure that the conversation is being experienced as relevant and helpful. Research is also conducted at the completion of therapy to evaluate the effects of particular questions and lines of enquiry (Epston & White 1992; Morgan 2000).

A number of other forms of narrative research have also been developed. One involves co-research in training contexts in which members of a group of trainees take it in turns to view examples of their work with families. The first step involves the trainee therapist (or therapists if they are

working in twos) taking a five to fifteen minute segment of a videotaped consultation and subjecting this to a microanalysis. The therapist examines their own contribution to the counselling session and speculates as to other options and possibilities for therapeutic enquiry that could have occurred. Sometimes this part of the process occurs in the presence of family concerned and, if this is the case, then the family members' responses are also elicited. This process of reflection is videotaped. Part two involves the therapist showing the videotape of the original segment of therapeutic conversation and their reflections on this to the entire training group where a further discussion takes place. This discussion is also videotaped. Part three involves sharing this second videotape with the family concerned and interviewing the family in relation to the real effects of this process of research on their lives and relationships. This three part co-research structure within training contexts has been experienced very favourably by trainees and families (for more information see Murphy in White 1997, pp.172-190).

In another realm, some practitioners, including Marilyn O'Neill and Gaye Stockell, have translated narrative co-research practices into evaluating the effectiveness of services. Reflexive questioning is used to interview those who access health and welfare services and their responses are respectfully gathered, sorted and documented. This documentation is then shared with the people who were first interviewed. They have a chance to review this and are then re-interviewed to gather their interpretations of the data. The views and ideas that emerge from this process are then used to inform future service provision.

This is just a small sample of the different forms of research that are commonly used within narrative practice.

3. What does the concept of therapy as co-research make possible?

An orientation to therapy as co-research assists me to be clear about what it is that I know as a therapist, and what it is that I don't know - what it is that I am seeking to find out in collaboration with the person who has come to therapy. It also evokes a sense of joint exploration. Together we are setting out to explore territory that hasn't been explored before. Together we are trying to seek out unique outcomes and ways of re-authoring these into preferred storylines.
(Shona Russell)

Thinking of therapy as co-research makes a difference to how we understand the relationship between therapist and client. Taking a position of co-researcher invites us as therapists to recognise that our contribution is significant to the outcome of the research/therapy. For co-research to be successful, the therapist will need to utilise various co-researching skills informed by what David Epston (2001) refers to as 'ethnographic imagination'. There are all sorts of skills and understandings that enable a therapist to undertake meaningful co-research/therapy. At the same time, however, when therapy is understood as co-research, the person consulting the therapist is an equal partner in the process of exploration and it is *their* knowledge and skills about their own life and relationships that are the focus of the conversations. Here is an example from Shona Russell of the sorts of explorations that become possible:

I have recently been meeting with a young woman called Meg and together we have been researching the operations of perfectionism in her life. Through extended externalising conversations we keep discovering more and more about how perfectionism, evaluation and judgement have managed to pervade her life in demeaning ways for over ten years. I have learnt so much from these explorations, including how no conversational context is immune from the tactics of perfectionism. Meg and I have agreed to consistently check in during our therapy meetings as to their effects on the influence of perfectionism.

Importantly, during our research we have come to discover a number of practices that are antidotes to perfectionism and that mitigate its effects. These include ways in which Meg can evoke a sense of 'love for herself' or 'respect for herself'. And we have learnt that practices of playfulness and fun can be put to very good use in creating different experiences of life.

Our research together has also involved inquiries into the conditions that made it possible for perfectionism to take such a hold in Meg's life. These have included researching the effects of relations of gender on this young woman's life. And alternatively, we have also inquired into the conditions that have made it possible for Meg at times to experience moments free from perfectionism.

Gradually, session by session, we have created documents that have articulated the small steps that Meg has been able to take to in relation to reclaiming her life from the grip of perfectionism. At first, Meg's position and understandings about perfectionism were not so clear. But overtime, through what has been a gradual process, Meg has

been able to focus more on those aspects of life that are antidotes to perfectionism.

In our most recent meeting, I heard nine different stories of times when Meg experienced moments free from perfectionism. I wrote these down and together we created a document acknowledging these times and the skills and knowledges that made them possible. Neither Meg nor I had any idea that this is where the session would take us. It was only through our joint commitment to enquire, to discover, to question and to research that we learnt of these stories and these skills.

Without this co-research, I could not have possibly known about these operations of perfectionism on Meg's life. They had been unnamed, unexplored and unchallenged for ten years. I also couldn't possibly have known about Meg's hopes for her life, about what matters to her. And I couldn't have imagined that conversations about these sorts of things could at times involve playfulness and laughter.

4. How can research projects contribute to us as therapists/community workers/researchers making a contribution to policy discussion and decision-making?

On a broader scale, the work of the Just Therapy Team of Wellington, New Zealand (Waldegrave et al. 2003), has inspired therapists to explore how forms of research can invite policy makers to respond to the stories and experiences of marginalisation that bring many people to counselling rooms. How can the stories of those who come to therapy be harnessed towards affecting change on broader issues of economic, racial, gender and sexual justice? Recently, some community workers have been exploring how narrative practices can inform their research on social justice concerns. For instance, the Just Tasmania Coalition (Flanagan 2001) conducted research into the stories of those affected by poverty in Tasmania, organised a 'freedom ride' against poverty, and then invited Tasmanian Parliamentarians to act as a reflective team to the stories that had been collected. After the Parliamentarians had heard the stories of the people involved in the research they were asked to respond to the following questions: What moved you about what you have just heard? What has it made you think of, in terms of your own life? What do you think is a priority for action? (Flanagan 2001, p.85-86).

Other practitioners are trying to influence the research practices of policy makers. By encouraging policy makers to move away from research methodologies in which outsiders study and then interpret the 'needs' or 'experiences' of particular communities, they are hoping that over time all research projects will enable communities themselves to derive the meaning and analysis of the data that is produced. In turn it is hoped that this will create far more relevant and influential policy.

Local research projects also have the potential to influence broader policy. For instance, Helen Gremillion's study of gender and power at an anorexia treatment centre (2003) is providing tools of analysis for workers to question the ways in which hospital programs may unwittingly be participating in culturally dominant ideals of gender, individualism, physical fitness and family life.

The work of Vanessa Jackson in excavating oral histories of African American psychiatric survivors is a further example of research as community building, as honouring history and as political action (Jackson 2002). In deliberately sharing with her readers the skills of oral-history research, she also demystifies the practice of research and invites broader exploration (see box below).

Researching history

Vanessa Jackson

It is important for us to ground our political movements in a firm understanding of history because the forces of oppression that have so effectively silenced and separated us benefit from our ignorance regarding our past abuses and successes. The medicalization of mental illness and confidentiality laws have reduced our experiences with madness (as a mental illness and as an expression of outrage) to an individual illness rather than part of a larger social and political response to oppression and invisibility. It is difficult to listen to the history of African-American survivors without feeling intense rage and profound sadness. We can be torn apart or immobilized by these feelings, or we can use them as a force to unite and mobilize us in our search for the truth, a part and present truth of our experiences as African-American psychiatric survivors. (2002, p.27)

5. Like many professional disciplines, the discipline of research has been implicated in cultural domination. What are some of the key issues evolving as Indigenous researchers and researchers from non-dominant groups begin to influence the field?

As part of what I refer to as 'Testimony therapy' with people of African descent in the USA, I am currently working with a group of activist students who visit African men in prison and hold discussion groups with these men about political and cultural issues affecting the wider African community in the USA. These discussion groups are a form of research and through them prisoners write essays and poetry which is then taken to the community and presented. Video recordings of these presentations are then taken back to the prisons so that those imprisoned are able to witness the community members' responses and questions about their work. The prisoners and students then engage in follow-up discussions about the community response to the ideas and writings of those imprisoned. This has allowed a process of 'breaking down the walls' of division between black men who are incarcerated and their community. It has allowed these men to become actively engaged in dialogue with the wider community about issues that are pertinent to people on both sides of the wall such as poverty, reparations, police brutality, education, hip-hop culture, etc. We see this as work to reconcile individuals with their community, as in African traditions a sense of community-connection and wellbeing represents the highest state of mental wellness. (Makungu Akinyela)

Some of the most creative, challenging and invigorating thinking about research is now emerging from Indigenous researchers and researchers from formerly colonised communities who are articulating their own research agendas, developing alternative ways of conducting local research with their own people and for their own purposes, and to do so are drawing upon their own cultural histories, meanings, traditions and processes. Kiwi Tamasese has played a key leadership role in bringing these issues into the therapy realm (Tamasese 2003; Waldegrave, Tamasese, Tuhaka & Campbell 2003; See also Smith 1999; Wingard & Lester 2001; Jackson 2002; Akinyela 2002).

Indigenous researchers are also very successfully turning the gaze back onto the dominant culture. This is a deliberate strategy which is redressing the long history of colonising groups

using research to define, specify and disempower marginalised communities. At the same time this research into the dominant culture is providing greater information about the operations of power that maintain privilege.

Significantly, Indigenous researchers are strongly challenging the neutrality of research (Smith 1999). Far from trying to achieve or maintain neutrality in research, it is becoming more widely accepted that all research involving marginalised communities concerns matters of justice and that it is unethical to conduct this research without some aim of addressing the injustice currently being experienced by that particular community. In this way, the notion of objectivity has been turned on its head. Research is now being understood as a form of action, and when it is being conducted in communities experiencing marginalisation there are ethical responsibilities for the researcher to be contributing to redressing this marginalisation in some way.

Linda Tuhiwai Smith, a Maori researcher and writer, has articulated many of these issues in *Decolonizing Methodologies: Research and Indigenous Peoples* (1999). It seems appropriate to end this piece with a short review of this book.

Decolonizing research The work of Linda Tuhiwai Smith

From the vantage point of the colonized, a position from which I write and choose to privilege, the term 'research' is inextricably linked to European imperialism and colonialism. The word itself, 'research', is probably one of the dirtiest words in the indigenous world's vocabulary. When mentioned in many indigenous contexts, it stirs up silence, it conjures bad memories, it raises a smile that is knowing and distrustful. It is so powerful that indigenous people even write poetry about research. The ways in which scientific research is implicated in the worst excesses of colonialism remains a powerful remembered history for many of the world's colonized peoples. It is a history that still offends the deepest sense of our humanity. Just knowing that someone measured our 'faculties' by filling the skulls of our ancestors with millet seeds and compared the amount of millet seed to the capacity for mental thought offends our sense of who and what we are. It galls us that Western researchers and intellectuals can assume to know all that it is possible to know of us, on the basis of their brief encounters with some of us. It appals us that the West can desire, extract, and claim ownership of our ways of knowing, our imagery, the things we create and produce, and then simultaneously reject the people who created and developed those ideas and seek to deny them

opportunities to be creators of their own culture and own nations. It angers us when practices linked to the last century, and the centuries before that, are still employed to deny the validity of indigenous peoples' claim to existence, to land and territories, to the right of self-determination, to the survival of our languages and forms of cultural knowledge, to our natural resources and systems of living within our environments. (Smith 1999, p.1)

So begins Linda Tuhiwai Smith's book *Decolonizing Methodologies: Research and Indigenous Peoples*. This is a book that not only traces of the history of the ways in which research has been implicated in imperialism and colonialism, but that also sets out an inspiring indigenous research agenda. Explicitly political, this indigenous research agenda is broad in its scope and ambitious in its intent as it involves decolonization, healing, transformation and mobilization (p.117).

Having outlined this research agenda, Linda Tuhiwai Smith outlines twenty-five indigenous projects currently being undertaken by indigenous communities in different parts of the world: Claiming, Testimonies, Story telling, Celebrating Survival, Remembering, Indigenizing, Intervening, Revitalizing, Connecting, Reading, Writing, Representing, Gendering, Envisioning, Reframing, Restoring, Returning, Democratizing, Networking, Naming, Protecting, Creating, Negotiating, Discovering, and Sharing. By naming and describing these in particular ways, the author powerfully acknowledges the current agency of Indigenous communities while also issuing a call for further action.

While this is a book primarily written for Indigenous researchers, we highly recommend it to anyone interested in or conducting research, for there is something within it to challenge and inspire us all:

In talking with people in the community I became interested in the questions which they were asking of health which were not being addressed by research. 'We know we are dying,' someone said, 'but tell me why we are living?' 'Our health will not improve unless we address the fact that we have no sovereignty', 'We're sick of hearing what's wrong with us, tell us something good for a change', or 'Why do they always think by looking at us they will find the answers to our problems, why don't they look at themselves?' (p.198)

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