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THE CORNER: AN INNOVATION IN RESEARCH IN MINNESOTA

DAVID EPSTON

This issue intends to highlight a pilot project for further research that will satisfy the requirements of the Shine a Light Narrative Therapy Research Fund and more generally "evidence-based research." John and Chris detail their thinking and response to such requirements. I hope this is the harbinger of further such studies.

SPEAKING TWO LANGUAGES: A CONVERSATION BETWEEN NARRATIVE THERAPY AND SCIENTIFIC PRACTICES

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When David Epston asked us to write this piece, he described it as a chance to share emerging ideas that may not be fully formed but that fill us with enthusiasm and excitement. He described it as ideas that make you want to run down the hallway shouting, to share with colleagues who are eager to discuss them with you (Epston, 2010). In this tradition, we are very excited to announce, as we metaphorically run

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down the hallway, that we are part of a team of people who have been able to carry out a pilot research study on narrative that fulfills the requirements of evidence-based research, and at the same time sustains its integrity. This is a bold statement, and we are aware that there are many ways to weigh into what we have said, but from our vantage point, we think we have an innovation that is in its early stages but that we are eager to share. Before we talk about how we have gone about studying narrative therapy, however, there is a very important question that we think needs to be addressed. Why would we want to do research regarding narrative therapy in the first place? The answers to this question are personal ones, situated, as most things are, in our own individual experiences and context, so we'll share a bit about that first.

John's Interest in Narrative Research

For John as a "practitioner," he became interested in this project after his own experience of being told he could not practice narrative because it was not considered an "empirically validated treatment." As part of John's practice, he provides consultation at an agency that interviews children after a sexual abuse report has been made. At a five-year site review, outside evaluators asked him questions about his role as a clinical consultant and the way that he worked. He described how his work was informed by narrative ideas, both in practice and as a consultant. While the evaluators seemed interested, they told John that since narrative was not an empirically validated treatment, he would need to be doing something else when they returned in five years.

John was stunned by this statement and could have responded in several different ways. He could have directly challenged them or addressed his concerns at a higher level. If this were an isolated incident, John would have chosen to go in this direction. His experience, however, was shared by many other practitioners who have

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John Stillman and Christopher Erbes are part of a team that received a grant from the Shine a Light Narrative Therapy Research Fund in 2009 along with Sarah Chance and Michael Mertz (Seneca Centre, California). Their topic was: Narrative Therapy in Group Residential Care. John and Chris have been working together for the past two years as part of an evolving research program. This research outlines an open trial of a "Narrative Principle" manual developed in order to provide narrative therapy with trauma survivors based on the work of Michael White. The trial is taking place at the Minneapolis VA Medical Center.

The Shine a Light Narrative Therapy Research Fund is an independently established not-for-profit organization. (i) The Shine a Light Narrative Therapy Research Fund is committed to encouraging and facilitating rigorous research to contribute to the body of knowledge about narrative approaches (as developed by Michael White) to individual, family, and community psychosocial practice. (ii) It hopes to spark, foster, and support such exploration and enquiry for the enhancement of narrative approaches through the funding of rigorous and creative research methodologies. (iii) The Fund is committed to facilitating new developments in narrative practices that are informed by and predicated on rigorous research and (iv) it is equally committed to the distribution of such knowledge to inform and enhance narrative practices in their role in the prevention, preparedness, and response to the distressing predicaments in which people find themselves, from individuals to communities. For further information, go to http://shinealightntresearchfund.org/FundingRecipientsfor2009.aspx.

been told how they should work based on the research recommendations. He had heard many people say that the agency they work at requires them to practice in a certain way because that is the source of the agency's funding or that the agency only wants to use therapies that are supported by research. Also, many universities use "evidenced-based" criteria when deciding which therapies to teach. As a result, this label can ultimately limit learning narrative therapy, providing it, and as a result, eventually even receiving it. Based on these conversations, John chose to examine how he might go about researching narrative.

Chris's Interest in Narrative Research

For Chris as a "scientist-practitioner," his enthusiasm for this project came not just from his love of narrative practice, but also from his training in scientific methods. Chris went to graduate school in clinical psychology with the firm goal of becoming a therapist, but along the way, he found that he really loved and valued the research practices he was being taught. As someone trained in the practices of science, he values trying to understand the way that people work, in a general sense, through systematic collection and analysis of observations. In other words, he was trained to study how what happens with an individual informs us, not just about that individual, but also about all people. Defining "science" is not an easy job, but for our purposes here, we can say that using scientific methods allows a person to seek some form or version of "the truth" that is closer to reality, or at least more consistent with what we can observe, than the previous version. From this perspective, if we have found a set of therapeutic practices to be helpful with one client, or many clients, we are drawn to study them so that we can determine if those practices can be used with other clients, seen in other circumstances, by other practitioners, to provide similar benefits. After all, science is, to some extent, about extrapolating from individual events or sets of events to more general theories that explain those events and can be applied outside of the individual events. So this perspective leads to questions like this: Did one client's success (say "Bob") working with a therapist (like Chris) using narrative therapy mean that "George," or "Sally," or their child, or "Alejandro," or anyone else would also have such similar success, at least in part? Would they enjoy that success if the therapist were someone other than Chris? In other words, are the techniques that are used important regardless of the people (clients and therapists) engaging in them?

So, when Chris heard about narrative therapy and started using it and hearing from those he was working with about how helpful it could be, he wanted to "check it out," to study it and see if it would hold up in a more general sense, if it was studied with scientific methods. Given his training, and the way he thinks about things, this was almost a knee jerk reaction. But Chris, like John, also had a more practical purpose in mind. He wanted to make sure that narrative therapy could have a chance at garnering the attention, respect, and most of all, the amount of use that other therapy approaches have had. Not because those other practices are "bad," but because narrative therapy seems to have so much to add.

A Voice at the Table

We both became concerned, as we know others have, that if we couldn't answer these questions and that without the practices and results of scientific investigation, narrative therapy would rightly or (as we believe) wrongly be relegated to a bit part in the stage of psychotherapy.

And our concern about this was simple: We believe that narrative therapy offers practices, opportunities, and conversations that can respectfully and effectively promote change and that it can do so in ways beyond those that are so often put forth as "state of the art" and empirically supported. To have it relegated to this fringe role troubled us and still does. We very much wanted narrative therapy to have "a voice at the table." So the question we started with was this: How could we help to provide some empirical support for narrative therapy so that its voice could be heard in conversations that do value science and systematically collected data?

Distinction Between Science and Narrative

Typically the answer to a question like that is simple to lay out, if hard to execute (Foa & Meadows, 1997). To help provide empirical support, researchers work with a team of others to design a study that can convincingly demonstrate the efficacy of the therapy. First, they make the therapy concrete by writing a specific manual of techniques that can be applied systematically by other practitioners. Second, they make the outcomes concrete by selecting a target problem (usually a psychiatric diagnosis) that they wanted to help with and using measures of that diagnosis that had been found to be, from a scientific standpoint, reliable and valid. Third, they make the data interpretable by carefully selecting who could and could not be in the study, so they knew what diagnoses or problems they were treating and how effective they were. Fourth, they use a system of observation to ensure that the therapists using the manual did, in fact, do the therapy that they had laid out in the manual. And, finally, they randomly assign people into at least two groups: one who received the therapy in our manual, and the other who did not. Then they would compare the outcomes (using the concrete measures) of those who received the therapy to those who did not.

Given that narrative ideas do not easily fit with this scientific approach, care and concern had to be taken to honor the ideas while taking steps to conduct research. Narrative therapy, based as it is on post-modern thought and values, is an entirely different kind of conversation. Its differences make it powerful, exciting, useful, but also potentially very difficult to study. Narrative therapy is about privileging the voice of those who consult with us, about working with their truth and their version of reality, instead of imposing an outside truth, even if that truth does come from "empirical studies." Put another way, science is about generalizing broad truths that apply to everyone, while narrative is about elucidating local truths that apply to those who construct them and live them.

Two Different Languages: Narrative and Science

We came to view these two sets of ideas—science and narrative therapy—as two different language systems, with different vocabulary, different rules, and at times very different goals. The question that most concerned us, and again probably many others, was this: Can one translate the ideas and practices of narrative therapy into the language of science without losing the essence of narrative therapy? How can we take a snapshot of narrative therapy, which is constantly evolving (informed by many practitioners, but also just as importantly, many consultees), put that into a treatment manual, and say that this manual "was" narrative therapy?

How could we choose a target, such as a given diagnosis or set of problems, imposed by ourselves as researchers, and say that this target was what narrative therapy was "for"? The answers to these questions are, in our mind, not easy or final. Seeking those answers, or at least one possible set of answers, however, seems to us to be both possible and necessary. Now that we are carrying out this study, the idea that we want to run down the hall and yell is simply this: "We're doing it! We're doing it!" We are combining the languages of mainstream scientific practice with narrative therapy without losing the goals of either.

The Opportunity and Challenge

This process started two years ago, when we submitted a grant to the Shine a Light Narrative Therapy Research Fund. Following Michael White's death, Shine a Light decided to provide seed money for research to be done on narrative therapy. The grant that we received required that the research follow all of the criteria of scientific research. This meant that we needed to create a design that would fit standards that are applied in the "mainstream" of scientific studies of psychotherapy. The challenge was that in the process of doing research, we didn't want to compromise the ideas. It was tempting to isolate a few of the practices of narrative and then train therapists to use these practices. If these practices were used, we could then say that narrative therapy was present and measure the results. We could, for example, instruct therapists to externalize the problem in session 1 and use a narrative map in session 2 (White, 2007). If we gained positive results, then we could say that narrative therapy works. We didn't do it this way because we were concerned that if the study were effective, then narrative would be reduced to a set of techniques or tools. We in a sense compromised this very clean way of doing research with the aim of making sure that the research process did not affect the integrity of narrative. We devised another way of going about it that both stayed connected to the ideas and remained flexible to multiple ways of practicing narrative. Most important, the research kept the people being interviewed at the center of the conversations and offered ways to hear their voices and feedback along the way.

What we needed, then, was a "treatment manual" that defined the therapy without constraining it and that, above all, was flexible enough to give therapists and, most

important, those they worked with, room to have conversations that were helpful and that fit for them. We needed a way to assess whether the ideas in the treatment manual were in fact being utilized in a given therapy session. And we needed a way of assessing what happened as a result of the therapy, an assessment strategy, which met standards of "objective evidence" but also gave room and authority to the voices of the participants, both the therapists and those they worked with.

The exact details of how we are doing that are beyond the scope of this essay and we suspect, maybe even beyond the interest of our readers, but we hope that some flavor of how we are trying this may be of interest to you. First and foremost, from our perspective, what we are trying to do is use a team of people who represent both language systems. This was a team process with contributions from many people who were passionate about both narrative ideas and scientific research. We benefited greatly from consultants Jennie Leskela, Elizabeth Wieling, and Walter Bera; therapists Ann Marie Wagner, Amy Bacon, and Kari Fletcher; and research assistants Emily Becher and Hannah Fairman. Next, we tried to find approaches that met the needs of each tradition that we were working with. This will be the focus of the remainder of the paper.

THE STUDY

One of the first parts of this study was deciding where and how to try out the therapy manual, the therapists, and the observer rating scale. While narrative therapy seems to have utility in many, many areas, the usual research practice is to limit the study to a specific topic or area to ensure defined outcomes. Both of us had a lot of background working with people who had survived horrifying or traumatic events, and Chris works in a veterans' affairs medical center that has resources and facilities for conducting research studies. So, following the advice of a colleague, we decided to focus this particular study on treating veterans who had been through traumatic experiences, including but not necessarily limited to combat experiences. In keeping with the need to have a defined target problem (and thus an outcome), we recruited individuals who met criteria for the diagnostic label of posttraumatic stress disorder. In keeping with narrative practice, however, we did not in any way mandate what the therapy itself would focus on or what the topic of the therapy sessions would be. We thought that the people coming in for treatment would know what they wanted to address and what would be most helpful for them. While the main focus of the research was to demonstrate that the manual could be carried out in research, we also hoped that in the process we would gain some data about the effectiveness of narrative therapy. Since most of our resources went into developing the framework of the study, we knew that we would only have enough resources for a small pilot study. We are still in the process of the research, but it looks as if we will have 12 out of 15 veterans completing the study. This is not enough people to make grand conclusions, but enough to demonstrate that the research was possible

and the manual worked. We will be interested to find out what the data does tell us. The work has been done very deliberately to set the stage for future research. As we had hoped, we are now in a better position for seeking more funding so that we can include more people in the study, have comparison groups, and include other aspects that would increase the significance of the research. Most important, we hope when this next step is funded, we know that the therapy will be done in a way that honors narrative ideas.

One of the most challenging and enjoyable aspects of the entire project has been the challenge to try to speak in these two language systems simultaneously. The process has felt dialectic as we have moved from attending to the organization and rigor of a scientific framework to the person-centered, flexible, and organic nature of narrative practice. At each phase of the study, from writing the treatment manual, to designing the observation system, to designing the assessment procedures, to applying the therapy, all of us involved in the study were constantly moving between these two approaches. In the following sections, we will describe the challenges that have emerged and how we have striven to meet them.

Use of Language

The use of language in this study was intentional. Science has distinct language, which implies a power differential whereby the expert has more authority over the person. This language would not fit well for narrative, wherein the power resides in the person coming for the conversation. In negotiating these terms, it was common in the medical setting of the veteran affairs center for people to use scientific language, but where possible, different terms were used which would be more fitting for narrative philosophy and ideas. For instance, in conversation and papers, a veteran being interviewed was referred to as "the person" rather than "the patient." Exceptions were made when talking specifically to the scientific community. Also, the terms "observation scale" and "observer" were used in place of "rating scale" and "rater." These words better depicted the task of witnessing principles in the interviews and not the measurement of performance. While these were subtle changes, they were important steps that addressed the implication of language.

CREATING THE MANUAL

It was a daunting task to imagine that narrative therapy could be placed in a manual. As noted earlier, in some ways it would have been easier to isolate practices of narrative into a manual and then train therapists to do these practices and measure if they were being done. If they were observable, then we could conclude it was "narrative therapy" and go from there. The problem was that there is no one set of practices that define narrative, and if we chose one, it would of necessity privilege those practices over others.

So the manual had to be open to multiple ways of practicing narrative and it had to stay connected to the ideas that inform it. This became a challenge because research requires a way of identifying and measuring when something is present or absent. There needed to be some way of organizing the ideas so that different people watching videos of a session could agree, based on a certain criteria, that narrative therapy was happening. After a great deal of reflection on Michael White and David Epston's work (e.g., White, 2007; White & Epston, 1990), the result was to take a step back from practice and think of narrative as a set of principles. A focus on principles opened up the possibility that narrative could be practiced in many different ways. It honored different styles, different cultural practices, different settings, etc. A focus on principles also kept attention on the philosophical ideas that inform narrative, allowing narrative to be a continually growing thing rather than something fixed in space and time. For instance, the focus remains on keeping the person at the center and deconstructing cultural and societal ideas. This allows the integrity of narrative to be honored in practice—something to shout from the rooftops! Organizing the manual around principles is one of the innovations that we want to be running down the hall proclaiming.

Specifics of the Manual

The principles presented in *Narrative Therapy Trauma Manual: A Principle-Based Approach* (Stillman, 2010), provide a full range of narrative ideas. They include important concepts such as seeing the position of the interviewer as influential yet de-centered. They also focus on externalizing the problem as separate from the person as well as supporting a person's ability to act on their own behalf (personal agency). Other important principles focus on eliciting and identifying preferred stories that have been subordinate to problematic stories in the person's life. These principles allow for rich alternative story development and the opportunity to share these developments in the context of important relationships in the person's life. The focus goes beyond the individuals and their relationships because narrative principles extend to questioning the effects of culture and society (White, 2007; White & Epston, 1990).

Use of Metaphor

The manual uses a hiking metaphor and accompanying illustrations to describe each of the principles. This use of metaphor helps to keep the principles connected to the ideas that inform them.

While this manual could be used to address multiple problems, the focus is on trauma. This allows the manual to discuss some specifics about trauma and then demonstrate how these principles could inform conversations with people who have experienced trauma. Using the hiking metaphor, three possible paths were offered to start a conversation. To climb a mountain, a person can take an easier path, which takes longer but allows the guide to get to know the hiker before a steeper climb would occur. Another

path would be to go straight up the mountain. This may be a preference of the hiker, but more risky, as the guide knows less about the hiker. A third path is the middle path. This is more challenging than the gradual incline, as it deals with some challenges, but not all of them at once and focuses only on certain aspects. The manual prepares the guide (therapist) to be able to conduct a conversation on each of these paths.

TRAINING THE THERAPISTS

The therapist training could not be done in a typical way that outlined the course of treatment that therapists were to follow when conducting therapy. Rather, narrative therapy is individualized around a set of principles, not a set of steps to be followed as in the majority of scientific studies. The training intentionally introduced narrative as a set of principles as described in the manual and followed the order of the manual, starting with a description of each principle and referencing the philosophical ideas that support each principle. The therapist would gain an understanding of the influence of post-structural thought, feminist ideas, cultural anthropology, linguistics, and philosophy. This basic knowledge would allow therapists to fully embrace the meaning of the principles. For instance, since narrative is based on hearing the ideas and direction of the person seeking a conversation, having an idea of this positioning is important before the conversation takes place. Also, recognition of the poststructuralist influence on narrative prevents questions from imposing meaning. Understanding narrative's embrace of feminist philosophy puts a lens on the use of power and how this plays out in conversation. These considerations occurred both before and during the introduction of the practice of narrative. Since narrative questions are not prescriptive and require following the lead of the person speaking, knowledge of the ideas helps the therapist listen with curiosity and think of how the principles would inform the next question.

Along with connecting philosophical ideas to each principle, the manual shows how the principles can be put into practice. The training referenced the sample question sets that were supplied after the introduction of individual principles. The therapists also used the *Narrative Therapy Handbook: Moving Principles into Practice* (Stillman, in press). This book offers a brief description of each principle and supplies practice exercises for the reader. These questions were constructed with direct connection to a given principle and drew from narrative maps and other sources. In the training, participants took one of three different roles while using these exercises. One role was the interviewer, during which the therapist experienced what it was to ask questions that were informed by specific principles. The second role was the interviewee where the therapist experienced what it was to receive a narrative question. The third role was the audience where the participant could observe narrative principles in practice. This third role was especially important as it allowed the therapist to externalize and see narrative from an outside lens. This position and the other two positions allowed the therapist to see how the narrative

would fit into their personal narrative and style of asking questions. This process also allowed the therapist to ask narrative questions in a way that fit their identity as a therapist while still supporting narrative principles in the conversation. Most important, it kept the person they were interviewing at the center of the conversation.

Each of these practice exercises was videotaped, and the therapists were encouraged to watch them and discuss how narrative principles were used in the exercise. This gave therapists an external lens to their work as they could watch it and see themselves asking questions. When they returned to asking questions, they had a new awareness informed by watching the way they asked questions. This awareness allowed the therapists to consider how narrative principles could influence their questions to support the conversation. It was also important to introduce videotaping from the start since it would be used throughout the study. The coding process was also shared with therapists to address the power imbalance of an observer watching a tape and measuring the use of narrative principles.

The training also focused on the second part of the manual summarizing Michael White's ideas on trauma, since the population served in the study was people who had experienced trauma. This gave therapists a theoretical basis to their learning. Finally, the training included the third part of the manual, focusing on the course of therapy and different directions that narrative therapy can take. This part of the manual was important because it gave the therapist different possible paths that a conversation could take and how narrative principles could support each path. The therapists would be prepared if the person wanted to go directly up the metaphorical mountain and speak about specifics of the problem, or if the person was interested in the benefits of an easier path.

The training was purposefully scheduled for three separate two-day trainings, scheduled one month apart. This allowed time for the therapists to return to their typical practice and use the ideas, as well as experience the philosophical shift brought about by being introduced to these new ideas. Therapists brought excitement, frustration, and informed questions to the remaining workshops. By the end of the training, participants demonstrated both an understanding of narrative ideas, and how these principles could be used in practice. This was an important start, and training sessions twice a month throughout the study were scheduled to support the therapists as they moved into actual conversations. During these meetings, we viewed videotapes of sessions and discussed the principles as they related directly to the therapy sessions. Care was taken during these viewings to respect the person interviewed and keep their positions at the center of the conversation. These videotape consultations were focused on opportunities for the principles to inform the practice. We were deliberate about keeping performance and judgment out of the conversation.

CREATION AND USE OF OBSERVATION SCALE

A main goal of the project was to demonstrate that the manual could be used to carry out research on narrative therapy. As a result of the training they received, if

multiple therapists could demonstrate that their sessions were noticeably informed by a manual, we could then say that narrative therapy was measurable. A manual was important because it would allow us to say that it was the effects of narrative therapy, not an individual therapist, that were being researched. We planned to measure if the ideas from the manual were visible in the therapeutic conversations by watching videotapes of the sessions and coding when narrative principles were witnessed. To meet validity criteria, three different observers had to show initial reliability; that is, they had to be able to make similar independent observation ratings. This process was difficult because, as you'll see, the manual could not be a "cookie cutter" approach that said what to do in each session, and so the observation system had to be as flexible as the manual.

In practice, science called for a scale that the three observers could look at and mark when narrative principles were being identified in the interview. These marks would be compared, and if they were similar between the three observers, then the observation scale would be deemed reliable. Once it was reliable, then observers would be able to watch tapes and, using the observation form, could mark if narrative principles were being used. If they were consistently being observed, it would show that the therapist was influenced by the manual and practicing narrative in the sessions. Consistent results showing that narrative was used in therapy would mean that the results of the therapy measured the effectiveness of narrative principles described in the manual. These results would mean that the manual could be used to train other therapists and the results of that therapy would demonstrate more than the effectiveness of that specific therapist, but would be able to say something about the effectiveness of narrative.

Narrative calls for the therapy to be centered on the person. Rather than the therapist going into a session with a set of criteria and a specific outcome that needs to be met, the content and direction of the session resides with the person at the center. When the conversation begins, the principles of narrative inform the questions that the therapist asks the person. This allows the person to direct the course of the conversation.

Working with principles instead of a set of specific practices allowed for a bridge between these needs of scientific and narrative ideas. An observation scale was created that listed the different principles and added a short description of each as well as their opposite. The observation scale ranged from -3 to 3 so that the observer could view a section of the tape and record the relative amount of questions that were asked by the therapist that were influenced by each principle or their opposite. For instance, if a therapist asked, "What word would you use to describe the ideas you have been discussing?," the observer would have been trained that this question was influenced by the principle of externalization. Depending on how many questions were influenced by externalization over a ten-minute time frame, the observer would record a 1, 2, or 3. The observer would also be observing the therapist's questions for the influence of other principles as well. In the previous example, if the person used "anger" to describe the problem, the therapist's next question could be influenced by any one of the other narrative principles and the

observer would make a mark on the observation sheet accordingly. For example, if the therapist asked, "If you don't want anger, what do you want in its place?," the observer would mark that the question was influenced by the absent but implicit. While this would have been covered in training, the observer could refer to the observation sheet as a reference. If the person responded that "peace" was preferred to anger, the therapist could ask, "How does peace fit better with what you value?" The observer would then mark that the therapist's question was influenced by intentionality because it asked the person about their values, hopes, and dreams. If the remaining questions focused on these values, hopes, and dreams, then the observer would move their mark from a 1 to a 3 under the principle of intentionality. As mentioned previously, the observation scale also accounted for questions that were the opposite of narrative principles. For instance, in the earlier example, instead of using externalization to understand the person's experience of "anger," the therapist's question could have focused internally by characterizing the person as "angry." If the therapist asked, "How long have you been an angry person?," the observer would record it as the opposite of externalization. It may be that in the next question, the therapist refers to anger as external so the observer would note this as well. When the observer was done viewing the entire 10-minute section, then these marks would be averaged out. If the observer witnessed externalization taking place in the majority of questions, with this one question being the opposite, they may record a 2 instead of a 3, but in the end, the principle was observed. In this way the observation system attended to both those conversational elements that were consistent and inconsistent with the narrative principles we were studying.

Observer Training

The observers were master's level students with some exposure to narrative but not therapists themselves. Observer training for one of the observers consisted of attending the therapist training and both of the observers met with John and learned key aspects of the principles and what to observe on tapes. Both were exposed to several narrative tapes ranging from students in a certificate program to tapes of Michael White and other well-known narrative therapists. Tapes from other therapeutic approaches were used, and distinctions were drawn between the different ways of asking questions and situating the therapy. The majority of the training took place by doing repetitive observations of tapes and comparing scores. In this first generation of training, many issues were dealt with, deserving a publication of their own, and from it notes were recorded so that a manual can be created to facilitate future observer training. After watching multiple videos, we were very excited that three separate observers could record similar scores on the observation scales to demonstrate that the scale was reliable. This work and subsequent finding means that this scale could be used in our research to observe if therapists' questions were influenced by the manual. If they are, then the results of the therapy can say something about the effectiveness of narrative therapy.

One finding in particular stood out from establishing the observation scale and training the observers. It actually came out of frustration. The two observers and John had difficulty when moving from one therapist's taped interview to a different therapist's taped interview. Listening to one therapist ask questions, the observers could see how the principles influenced the questions, and the scores were similar between the various observers. When a new tape showing another therapist interviewing a different person was shown immediately after the first one, the observers had difficulty and the scores were different among the observers. There was initial concern that this said something about whether the observation scale worked. John recalls making a ridiculous statement to himself at one point. He said, "Why don't all of the therapists ask questions the same way?" After experiencing discouragement for a few days, he realized that this dilemma displayed exactly why this research project was set up around principles instead of specific practices. Therapists don't ask questions the same way, they have different styles, each with separate narratives. While all of the therapists embraced narrative principles, each of them presented these principles in a different way. This finding supported the premise of our research—that we could observe narrative principles influencing questions, and we could also observe when the opposite occurred. And while we were viewing this at a level of principle, it opened up the possibility that there was not just one way of implementing principles in practice and that there is not one set or order of questions. This realization was very exciting, and once we accounted for style, not looking for the same practice from everyone, our scores were once again consistent among us. We had honored the needs of science and narrative as we obtained reliability by scientific standards, while at the same time valuing multiple ways of practicing narrative.

ASSESSMENT AND EVALUATION

One of the challenges we faced in our conversation between narrative and science was how we would assess the outcome of the therapy. We had found a way to write a manual and measure whether it was being put into use, which met the needs of both science and narrative. Conducting assessments was more difficult because in science the observer (scientist) is often centered, and the people in the study (subjects) are not, while in narrative the person is centered. To be able to meet the scientific research criteria, we needed to use measures that were already established in order to demonstrate that our results were credible. Thus, we used the Clinician Administered PTSD Scale (CAPS; Blake, Weathers, Nagy, Kaloupek, Gusman, Charney, & Keane, 1995) before and after therapy as a primary outcome measure because it is deemed as valid and reliable. We also used other common self-report measures of symptoms and well-being. If we find that the majority of our participants improve on these established measures, it will support the value of narrative therapy for treating PTSD.

Unfortunately, there are no established narrative scales to use to complement these more centered assessments. By using the CAPS, we were not honoring the voice of narrative because the tool and not the person was at the center of the assessment. Further, the CAPS and our other self-report measures focused on targets and symptoms that we, as researchers, had chosen to focus on but did not evaluate what our participants themselves wanted to address in therapy. Since we could not alter these measures, we chose to create some additional evaluation forms that would ask the person to assess their own progress and to assess the therapy itself. This would permit the person to have a voice in the assessment process, allowing the observed to become the observer. The person completed one of these evaluations along with the CAPS at the beginning and the end of treatment. The person also filled out questionnaires after each session assessing their progress and what they found helpful. The forms we used were designed to be similar to narrative therapy itself, starting with some general questions but then asking for elaboration to better understand the meanings the clients were bringing to their answers. We also constructed an exit interview that asked for the client's view and evaluation of the therapy and its usefulness in their lives. We suspected that we would learn as much from their own words as we would learn from the more tightly structured, standardized interviews and forms.

Along with the person having a voice in the assessment process, we also thought it was important for the therapist to have a voice. After each of the sessions, the therapist filled out a questionnaire identifying which narrative principles informed their session and which questions he or she believed were the most helpful. Collecting data from these two viewpoints—traditional research and a narrative framework—should allow us to compare and evaluate the types of information that we receive from each approach. We also suspect that there is much we can learn from our clients that would simply never be heard without this combined approach. We are hoping that with more use and data regarding these narrative questionnaires, they can be evaluated scientifically and become considered legitimate by scientific standards. We are looking forward to comparing and contrasting what these two assessment approaches tell us about the therapy and about those who received it and to sharing what we find in future papers. Thus, we are hoping to foster a conversation between narrative and science regarding assessments that we hope continues.

RELEVANCE TO PRACTITIONERS

Since this column is geared to practitioners, we want to point out that our excitement for being able to carry out research goes beyond the label of empirically validated treatment. Both the manual and the evaluation tools created for the research have relevance for practice, whether or not you are interested in conducting research. First of all, the organization of the principles in the manual is a useful and helpful way of learning narrative ideas and practices. It also provides a useful reference for narrative

practitioners. During or after a session, practitioners can look at the list of principles as a reminder of possible directions that a conversation can take, while being mindful to keep the person at the center of the conversation. Second, the evaluation forms can be helpful in gathering information at intake and at periodic intervals during the therapeutic process. Since they are written from a narrative perspective—starting with the exceptions and then getting to the problem—the questionnaires fit nicely with a narrative conversation. They also meet most of the institutional requirements (insurance and agency) so they can be used in place of standardized forms that don't fit as well with narrative ideas. If you are interested in either the manual or the questionnaires, please visit www.caspersentherapycenter.com.

CONCLUSION

We are thankful for having the opportunity to share the excitement we have about our work in this article. We want to make sure to point out that the way we went about this project is only one possible way of having a conversation between narrative ideas and science. As we've alluded to before (and it is only fitting given that we practice narrative ideas), these are some possible answers to the questions we posed earlier in this article. We do not view them as the right answers or in any way the only answers. Our hope is that by sharing these ideas and these potential answers, new conversations may be born, new ideas may arise, and new sets of answers can emerge either supporting or supplanting the ones we're presenting now. We look forward to taking part in these future conversations!

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