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DOING IT COLLABORATIVELY! ADDRESSING THE DILEMMAS OF DESIGNING QUANTITATIVE EFFECT STUDIES ON NARRATIVE FAMILY THERAPY IN A LOCAL CLINICAL CONTEXT

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This article suggests an approach for addressing the dilemmas narrative therapists face, wanting to make narrative therapy accessible to people seeking help in contexts favoring evidence-based therapy. The approach is inspired by participatory action research and involves clinicians and clients in a local clinical context. The article offers a detailed case description of implementing psychometric effect measurements on narrative family therapy and of creating a shared collaborative stance for researchers using quantitative effect measurements and clinicians using narrative therapy. Our findings suggest that involving narrative clinicians and clients in the development of a research design in the local clinical context might be helpful in overcoming narrative skepticism and criticism towards quantitative effect research. It is our hope that this article will inspire more narrative therapists to participate in the creation of a quantitative evidence base for narrative therapy.

This article is part of a larger story of the Family Therapy Team (FTT), a small unit in the Child and Adolescent Mental Health Services (CAMHS) in the Capital Region of Denmark, practicing narrative family therapy. The mission of the FTT is to make narrative therapy accessible to citizens who seek help in the public-funded psychiatric system offering free services for all citizens in Denmark. Since the CAMHS favors evidence-based practices and narrative therapy is not considered as such, a small research team was developed within the FFT. This team received

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funding (from TrygFonden, a Danish philanthropic foundation) for the purpose of developing a randomized controlled trial (RCT) study of narrative family therapy in the FTT. The goal of the research team was to combine the languages and fulfill the requirements of both the biomedical and the post-structuralist worlds and discourses in the research project (Jørring & Jacobsen, 2014).

This article describes one specific part of the research team's journey towards developing a research project and a clinical culture that will in time hopefully enable us to produce evidence in accordance with the biomedical research paradigm while working in accordance with narrative values and ethics. We involved clinicians directly in the process of choosing and administering questionnaires for an RCT. This was inspired by participatory action research (PAR) in which the practical consequences of the research are continually evaluated and changed accordingly.

BACKGROUND

Narrative Skepticism Towards Research Methods Prioritized by Evidence-Based Practice

Evidence-based practice is a process for clinical decision making based on research results in assessment and treatment contexts (Chambless & Ollendick, 2001; Hjørland, 2010; Kendall, 1998; Ramey & Grubb, 2009, p. 79). Evidence from randomized controlled research designs or metastudies of these is considered the "gold standard" for evidence-based practice (Hougaard, 2007; Zachariae, 2007). Psychometric measures are evaluated by validity, reliability, and standardization (Jørgensen, Nordentoft, & Videbech, 2009). Designing research studies based on these standards is, however, often described as potentially antitherapeutic to narrative therapy (Busch, 2007; Epston, Stillman, & Erbes, 2012) for the following reasons: (1) quantitative medical effect research is thought to support a hierarchical positioning of the therapist/researcher as the expert, analyzing and evaluating the clients' responses (Besa, 1994; Epston et al., 2012; Gaddis, 2004; Speedy, 2004), (2) psychometric measures often represent and support a problem-focused discourse (Besa, 1994; Busch, 2007; Madsen, 2007; Tomm, 1992a, 1992b, 1992c), and (3) quantitative research methods are criticized for making clients "take up the passive subject positions by the 'taylorist' method of ticking boxes. In this way people are reduced into categories" (Tootell, 2004, p. 59). This narrative skepticism often has its origin in general, philosophical, and theoretical arguments (e.g., Busch, 2007; Etchison & Kleist, 2000; Hilker, 2006), personal experiences (e.g., Gaddis, 2004; Speedy, 2004), or lab studies (e.g., Healing & Bavelas, 2011).

Broader Consequences of Narrative Skepticism

Discussions based on these narrative arguments often lead to conclusions of incompatibility: What seems to be an ethical imperative from the perspective of evidence-based practice can, from a narrative perspective, be seen as unethical and potentially anti-therapeutic. In relation to this, it is striking that very few studies have investigated the effect of narrative therapy by means of valid and reliable psychometric measures and quantitative research methods (Epston et al., 2012; Etchison & Kleist, 2000; Hilker, 2006; Willott, Hatton, & Oyebode, 2012). No existing studies have used an RCT design to study the effect of narrative therapy (Willott et al., 2012). Narrative researchers favor qualitative research and case studies (e.g., Beaudoin, Moersch, & Evare, 2016; Busch, 2007; Epston, 2008; Gaddis, 2004; Redstone, 2004; Speedy, 2004; Tootell, 2004). This lack of quantitative evidence for narrative therapy diminishes the options for using narrative therapy in health care settings with demands for evidence-based practice (Epston et al., 2012; Hilker, 2006; Vromans, 2008). Since the Danish Psychiatric Association, the Danish medical ministry, and the World Health Organization (WHO) stress that treatment should be evidence based (Danish Ministry of Health, 2013; Region Hovedstadens Psykiatri, 2010; WHO, 2013), narrative therapy falls behind in the choice of treatment (Epston et al., 2012; Madsen, 2007; Vromans, 2008). Because of this, some narrative researchers and therapists describe a need for creating an evidence base for narrative therapy by means of research strategies in accordance with the standards of evidence-based practice (e.g., Epston et al., 2012; Hilker, 2006; Madsen, 2007; Vromans, 2008). They argue that a quantitative evidence base for narrative therapy could contribute to the legitimization of narrative therapy in a wider clinical, political, and societal context (Amundson, 2001; Carr, 2000; Cottrell & Boston, 2002; Hilker, 2006; Laitila, Aaltonen, Wahlström, & Angus, 2005; Madsen, 2007; Vromans, 2008; Vromans & Schweitzer, 2011).

Local Consequences in FTT of Narrative Skepticism

As the research team applied for funding, we informed clinicians about our goal to legitimize narrative therapy in the CAMHS by creating an evidence base. We explained the necessity of conducting quantitative effect research to achieve this. We also explained that we intended to develop a research design that did not compromise the narrative ethics. Our plan was to conduct a review and select quantitative measures based on both biomedical (standardized, reliable, and valid measures) and narrative criteria (see Table 1) of all existing psychometric measures for use in both Danish child and adolescent mental health care settings. The narrative criteria were chosen based on the narrative skepticism described above.

The clinicians, however, were concerned about the ethical and possible anti-therapeutic effects of such a study. They expressed great concern about the effects of the questionnaires, specifically on the clients' thoughts about themselves, the treatment, and the therapeutic alliance, and some downright refused to hand out or receive the questionnaires. From a leadership perspective, this was unacceptable,

TABLE 1. Narrative Criteria for Selecting Psychometric Measures

Narrative Criteria	Rationale
Measures focusing solely on “uncovering” deficit are excluded	To avoid supporting a focus on the perceived problem
Self-report measures are included	To avoid supporting the therapist as a “knowing” expert and to communicate interest in the client’s knowledge
Measures for both child and parents are included	To avoid signaling that the problem is lying within the child and to support focus on the role of the active involvement of parents
Measures focusing on the family’s goals	To support a focus on the hopes and dreams of the family

as it would put not only the project in danger but also the survival of the unit. The effects were long and intense discussions that also put the collaboration between clinicians, researchers, and the leader in danger.

PURPOSE OF THE ARTICLE

Research on narrative therapy thus represents a dilemma. Researchers can ignore narrative skepticism and base research on standards of biomedical research. This might help narrative therapy be accepted as an evidence-based therapy, but it might also make narrative therapists refuse to participate in the research, because they would find it morally unacceptable “being assimilated by the presently dominant discourse of evidence and ‘scientific-ness’” (Haugaard, 2016). Or researchers can refuse to perform biomedical-based research and exclude narrative therapy from gaining the desired recognition, thereby accepting that narrative therapy will not be available to people seeking help in contexts favoring evidence-based practices, such as public mental health institutions for people without private funds/insurance. We will name this The Dilemma in this article. The specific purpose of this article is to suggest that PAR might offer an alternative response to problems such as The Dilemma. Involving the local community directly and actively in all phases of the research process may enable us address The Dilemma and find new ways to develop research designs and clinical cultures in accordance with both biomedical and narrative standards. We believe this is an important step in bringing us closer to our general purpose of making narrative therapy accessible to people seeking help in the public-funded psychiatric system, demanding evidence-based practices.

METHODS

Participatory Action Research (PAR) as an Approach to Design Research Studies

PAR is a collaborative process between the researcher and the community. Its aim is to produce knowledge of both general and local interest (Macaulay et al., 1999). PAR has its background in pragmatism, with a focus on producing "knowledge for action" (Cornwall & Jewkes, 1995, p. 1667; Kvale & Brinkmann, 2009), that is, knowledge of practical use to the local community being studied and to society in general (Cornwall & Jewkes, 1995, p. 1667; Khanlou & Peter, 2005, p. 2335; Macaulay et al., 1999, p. 774; Truman & Raine, 2002, p. 138). In addition, PAR has its background in concerns of equity (Cornwall & Jewkes, 1995, p. 1667) and a wish to reduce distrust towards research processes of the people being studied (Macaulay et al., 1999). PAR is associated with a greater local interest and involvement (Lindow & Morris, 1995; Macaulay et al., 1999, Mosavel, Simon, van Stade, & Buchbinder, 2005, p. 2578; Truman & Raine, 2001, p. 226; Truman & Raine, 2002, p. 140), and a greater sense of ownership of a research project (Macaulay et al., 1999, pp. 774–775; Truman & Raine, 2002, p. 138). Further, PAR seems accordant with our collaborative and co-research-based approach (Denborough, 2004, p. 29; Epston, 1999; Jørring & Jacobsen, 2014; Redstone, 2004).

Inspired by the above, we decided to use PAR for implementing the questionnaires. We hoped to address The Dilemma by involving clinicians in the project as important and equal partners. In addition, we hoped that including the knowledge and experience of the clinicians would provide important insight into whether the research design could bridge narrative ethics and biomedical research criteria, as we had intended.

PAR is often carried out as a flexible and responsive process with multiple cycles of planning, acting, observing, and reflecting (Lewin, 1946; McIntyre, 2008, p. 8; McTaggart, 1994, 1997). At the "Plan" stage, the initial steps to change a perceived problem in a local context and to evaluate the effects of these steps are planned (Lewin, 1946, p. 37). At the "Act" stage, the steps from the Plan stage are carried out in the local context (McTaggart, 1994, p. 317). At the "Collect" stage, data are collected to determine whether the desired changes have occurred. At the "Reflect" stage, the data are analyzed and discussed to determine to what extent the "action" has helped solve the perceived problem. This reflection leads to further planning of a new cycle (McTaggart, 1994, p. 317). For an illustration of the process, see Figure 1.

PAR is described as an *orientation* to research (Khanlou & Peter, 2005) rather than a specific research method. The specific research methods used in the different circles are determined by the aim of the project and can include both knowledge from participants and different forms of data, both quantitative and qualitative (McIntyre, 2008, p. 49). Participants are engaged in all aspects of the project (McIntyre, 2008, p. 15), with greater or lesser participation at various stages (Cornwall & Jewkes, 1995, p. 1668).

In PAR projects, success and failure are not evaluated by objective truth as the goal, but rather by "whether people involved are better off because of their experi-

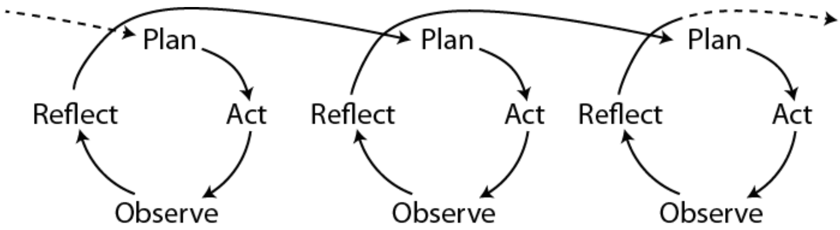


FIGURE 1. Illustration of the Plan-Act-Observe-Reflect Cycles in the PAR Process

ences as participants in the PAR project" (McIntyre, 2008, p. 61). In this case, we also defined success as having created a way to use psychometric measurements without counteracting narrative ethics and therapy.

Setting

FTT was established with the purpose of providing help to families who, despite having received regular treatment from CAMHS, school systems, and social services, still suffer significantly. The unit meets with families in which: (1) a child (0–18 years) and often also other family members have been diagnosed with one or more psychiatric conditions, (2) the primary sector doesn't have sufficient capacity to help the child and family, and (3) there is a need for intensified collaboration between primary and secondary support systems. Families are referred from other sections of the psychiatric system if the primary therapist estimates that "treatment as usual" is not sufficient. The treatment is free and delivered to all Danish citizens, regardless of race, ethnicity, socioeconomic status, sexual affiliation, and religion.

Participants

All employees in FTT (psychologists, child and adolescent psychiatrists, nurses, and secretaries) were involved in the project. Ten families participated in this part of the project. The families were chosen by two criteria: (1) families had given written consent to participate in the research project, and (2) families had started therapy in FTT less than 4 weeks prior.

As the families had been promised anonymity, they are only described on a group level:

Seven out of the 10 children were girls. Five children struggled with anorexia nervosa, four with attention deficit hyperactivity disorder (ADHD), and one with obsessive compulsive disorder (OCD). Six out of ten struggled with multiple problems and were described as having comorbid diagnoses. The average age of participants was 14.6 years (range: 11.0 years to 17.2 years). All were of Danish descent and came from a broad range of economic statuses.

Ethics

Clinicians gave oral consent to participating in meetings and formal group interviews. All families were given oral and written information about the purpose of the project. The families were given full anonymity and gave written consent to participate. Review of data processing is done according to common safety regulations of the Capital Region concerning the processing of personal information under the Privacy Act.

Data collection

Methods and data collection consisted of literature review, in-depth focus group interviews with clinicians, interviews with families, registering issued questionnaires, participant observation, field notes from staff meetings, and interactions with clinicians. A multimethod approach was used, in which specific steps in the plan-act-observe-reflect cycles were continuously determined by the findings from the previous circle and pragmatically chosen based on our purpose of using psychometric effect measurements without compromising narrative ethics. See Table 2 for an overview of the specific methods used in the different phases.

Data analysis

Qualitative interviews were analyzed by meaning condensation (Giorgi, 1985; Giorgi & Giorgi, 2003). The process took place in four steps and had a focus on finding transverse themes in the experience of using the questionnaires (described elsewhere: Ejbye-Ernst, Jacobsen, & Jørring, 2015). Quantitative measures were analyzed by calculating the number of issued questionnaires as a rough proxy for clinicians' willingness to enroll clients in the study. Field notes and participant observation were transcribed.

TABLE 2. Methods Used for Data Collection

Cycle	Methods used for data collection
Cycle 1	Participant observation and field notes
Cycle 2	Quantitative measures of the percentage of families enrolled in the research project
Cycle 3	Focus group interviews of clinicians and secretaries
Cycle 4	Phenomenological interviews of families
Cycle 5	Quantitative measures of the percentage of families enrolled in the research project + Participant observation + Field notes
Cycle 6	Participant observation + Field notes

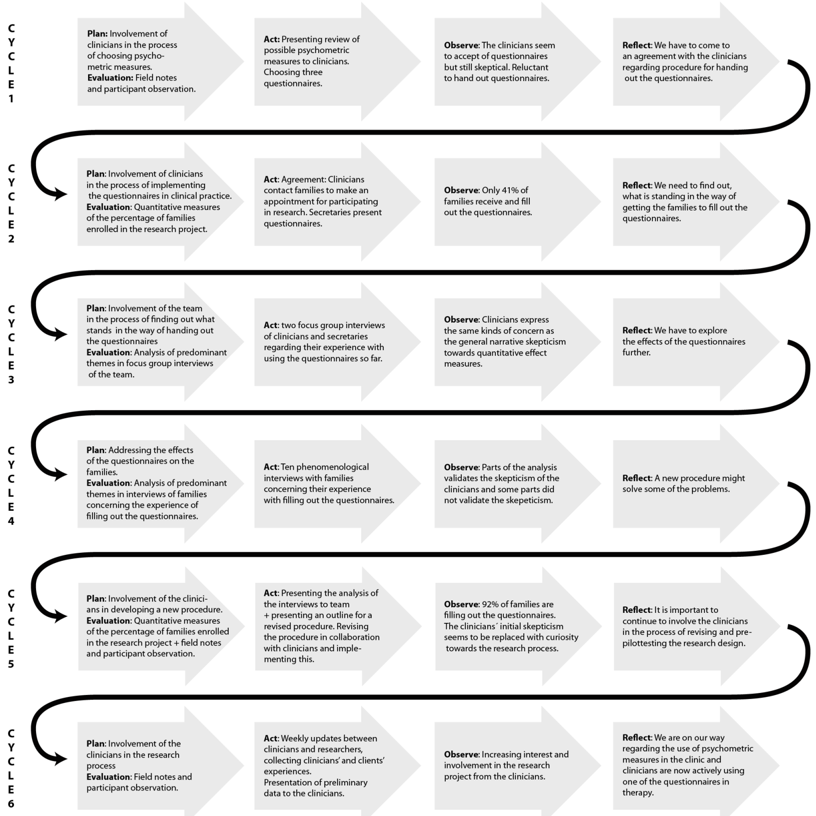
RESULTS

The PAR process and the main findings are illustrated in Figure 2 and described below.

Cycle 1

Plan. To involve clinicians directly in the process of choosing questionnaires for the RCT by holding joint discussions about which effect measures to use. Using field notes and participant observations to evaluate the plan.

Act. Review results and criteria were presented to the team. Based on the presentation, the research team and clinicians came to terms with the fact that they had to choose "the least evil measurements." Three measures were chosen, some of which



CYCLE 1	**Plan:** Involvement of clinicians in the process of choosing psychometric measures. **Evaluation:** Field notes and participant observation.	**Act:** Presenting review of possible psychometric measures to clinicians. Choosing three questionnaires.	**Observe**: The clinicians seem to accept of questionnaires but still skeptical. Reluctant to hand out questionnaires.	**Reflect**: We have to come to an agreement with the clinicians regarding procedure for handing out the questionnaires.
CYCLE 2	**Plan**: Involvement of clinicians in the process of implementing the questionnaires in clinical practice. **Evaluation**: Quantitative measures of the percentage of families enrolled in the research project.	**Act**: Agreement: Clinicians contact families to make an appointment for participating in research. Secretaries present questionnaires.	**Observe**: Only 41% of families receive and fill out the questionnaires.	**Reflect**: We need to find out, what is standing in the way of getting the families to fill out the questionnaires.
CYCLE 3	**Plan**: Involvement of the team in the process of finding out what stands in the way of handing out the questionnaires **Evaluation**: Analysis of predominant themes in focus group interviews of the team.	**Act**: two focus group interviews of clinicians and secretaries regarding their experience with using the questionnaires so far.	**Observe**: Clinicians express the same kinds of concern as the general narrative skepticism towards quantitative effect measures.	**Reflect**: We have to explore the effects of the questionnaires further.
CYCLE 4	**Plan**: Addressing the effects of the questionnaires on the families. **Evaluation**: Analysis of predominant themes in interviews of families concerning the experience of filling out the questionnaires.	**Act**: Ten phenomenological interviews with families concerning their experience with filling out the questionnaires.	**Observe**: Parts of the analysis validates the skepticism of the clinicians and some parts did not validate the skepeticism.	**Reflect**: A new procedure might solve some of the problems.
CYCLE 5	**Plan**: Involvement of the clinicians in developing a new procedure. **Evaluation**: Quantitative measures of the percentage of families enrolled in the research project + field notes and participant observation.	**Act**: Presenting the analysis of the interviews to team + presenting an outline for a revised procedure. Revising the procedure in collaboration with clinicians and implementing this.	**Observe**: 92% of families are filling out the questionnaires. The clinicians´ initial skepticism seems to be replaced with curiosity towards the research process.	**Reflect**: It is important to continue to involve the clinicians in the process of revising and pre-pilottesting the research design.
CYCLE 6	**Plan**: Involvement of the clinicians in the research process **Evaluation**: Field notes and participant observation.	**Act**: Weekly updates between clinicians and researchers, collecting clinicians' and clients' experiences. Presentation of preliminary data to the clinicians.	**Observe**: Increasing interest and involvement in the research project from the clinicians.	**Reflect**: We are on our way regarding the use of psychometric measures in the clinic and clinicians are now actively using one of the questionnaires in therapy.

FIGURE 2. Illustration of the PAR Study in the Family Therapy Team.

fulfilled the biomedical and others the narrative requirements (for a description, see Ejbye-Ernst, 2012). The three measurements chosen were: Beck Youth Inventories (Bose-Deakins & Floyd, 2004), Parent Activation Measurement (Insignia Health, n.d.; Pennacola et al., 2012), and Family Goals (Law, 2011).

Observe. Clinicians seemed more involved and engaged in the research process and seemed to accept the fact that we had to conduct effect studies in the clinic. Clinicians were still reluctant to hand out questionnaires before the initial meeting with the family:

> I think it is important that it is not at all us [the clinicians] who receive the papers [measures] but the secretaries. Because we don't use them and they are not at all like the things we talk about in therapy.

Reflect. We had concerns that the reluctance of the clinicians in handing out the questionnaires would hinder the implementation of doing an RCT.

Cycle 2

Plan. To involve clinicians in developing a plan for handing out questionnaires in the clinical context. Evaluation by counting the number of issued questionnaires.

Act. The team decided that secretaries would hand out the questionnaires while by phone, clinicians would arrange when to fill out the questionnaires with the families. Both secretaries and clinicians accepted this distribution of roles.

Observe. From December 2011 until May 2013, only 45 out of 111 families beginning therapy filled out the questionnaire. Only 1 out of 12 families who were enrolled in the project and finished therapy during this period filled out questionnaires post treatment.

Reflect. It was evident that something was standing in the way of successful implementation using questionnaires in clinical practice. Was the clinicians' skepticism a factor in the low participation? We decided to investigate the teams' relationship with the questionnaires.

Cycle 3

Plan. To conduct focus group interviews with the clinicians.

Act. Two focus group interviews were carried out with the clinicians about their relationship with the questionnaires. The clinicians were invited to comment on each questionnaire regarding their experience with and thoughts about the measures (Kvale & Brinkmann, 2009). The descriptions were unfolded by means of open questions inspired by an interview guide (described in Ejbye-Ernst et al., 2015).

Observe. The clinicians described a range of concerns regarding the effects of filling out the questionnaires. First, the clinicians worried that it would direct the families' attention to aspects not relevant to therapy and affect the focus in therapy:

> I think we direct them to something completely different than what the therapy is about. They will go into therapy with a preconception that is not in accordance with what we are going to do.

Second, they feared that filling out the questionnaire would affect clients' thoughts about therapy and themselves:

> I think a lot of the parents are afraid of the consequences of the questionnaires, of whether they will receive a poor treatment [based on their reply] or whether we [the clinicians] will think they are bad parents.

The clinicians worried that this would stand in the way of building a therapeutic relation based on collaboration and trust. Third, they feared it would affect the treatment in directions not in accordance with narrative therapy:

> I actually think what we are doing is good enough. I don't have a wish for us to change our methods to become more solution focused. I am aware that we have to measure as a way to justify our existence, but it is a pity if it affects the good job that we are doing.

Fourth, the clinicians were concerned that it was too big a burden for families, as they are doing really badly at treatment start. Even though the clinicians accepted the necessity of research, the above mentioned made them reluctant to own any of the research project:

> I don't have any ownership in this research project at all. I would like to be able to say [to the families], "This is some stupid research project that is going on in the clinic." Because there is something in relation to the ethics that I just can't vouch for. I can tell them that it is going on, but I can't take part in it.

Further, it made them focus on the fact that participation was voluntary when calling the families to arrange for the first meeting:

> I was saying, "Remember, this is voluntary, you can try, you can leave out some of the questions." I really don't want to force them at all.

Reflect. Even though we had chosen our measures intending to overcome the effects of The Dilemma, the interviews revealed that these were very much alive. It was not evident whether the clinicians' concerns reflected the families' actual experiences. Since the clinicians were much closer to the clients, we could not overhear these concerns.

Cycle 4

Plan. To research the families' actual experiences, we decided to interview them about their experience of filling out the questionnaires.

Act. Ten phenomenological family interviews were carried out. Interviews had a focus on unfolding the spontaneous, detailed descriptions of the families' experiences (Kvale & Brinkmann, 2009; Polkinghorne, 1989). Questionnaires were presented one at a time, and family members commented on their experience with filling out the specific document. Comments were followed by open questions inspired by an interview guide (described in Ejbye-Ernst et al., 2015).

Observe. The families noticed that the questionnaires focused on the entire family, on the role of the parents, and on their hopes and dreams. One of the children said:

> It really made me think . . . It was the entire family who had to set goals and not just me. I thought it would focus mostly on me and my problem and that I would have to set goals. And that I would have to make them myself and that the family would just be like the support behind. But it was the entire family.

The families told us that they really appreciated filling out the questionnaires as it made them think and talk about their situation even before the first consultation. Several families described that they felt "in good hands" being at a treatment facility conducting quality assurance.

However, the families seemed to approach the questionnaires with certain expectations and discourses. Many families expected that their replies would affect their treatment, whether they would receive any treatment at all, or whether they would be deemed "bad parents," with the risk of having their child taken away from them:

> What would they [the therapists] think if I replied this [strongly disagree]? I mean, would you then be completely passé, would it mean compulsory removal (of the child), or what happens then?

The families described how these thoughts affected the way they filled out the questionnaires, in order to avoid being deemed too well functioning or too malfunctioning for therapy in FTT. Eight out of 10 families described that they were filling out the questionnaires with thoughts about "tactics" (mother) and about "what meaning will this have to the treatment afterwards" (father).

Likewise, some of the children felt insecure of how the therapists would use their replies:

> I answered them all completely honest, because I thought I had to. But I also said some things that I did not want my parents to know. And then I thought about whether I had been kind of cheated and whether the therapists would talk to you [the parents] about it.

Reflect. In some ways, the questionnaires' content seemed to affect families the way we intended: They supported a focus on the entire family, on hopes and dreams, and on the active involvement of the parents. However, more than content seems to affect the experience of filling out questionnaires. After a secretary's short presentation, we leave each of the families to their own discourses and expectations concerning the use and consequences of the questionnaires. Fearing, for example, that therapists would forcefully remove a child must be contrary to the goal of building a collaborative, co-researching therapeutic alliance that is essential to narrative therapy (Monk, Winslade, Crockett, & Epston, 1997; Vromans, 2008) and psychotherapy in general (Hubble, Duncan, & Miller, 1999).

Cycle 5

Plan. To return to the clinicians with this new knowledge and develop an outline for a plan to change the negative implications of the research project. Quantitative measures of the number of families enrolled in the project and field notes were used as evaluation.

Act. We presented results of the analysis of the 10 interviews to the clinicians at a focus group session. The clinicians reacted strongly as the results seemed to confirm their beliefs. In collaboration with the clinicians, we developed new strategies for presenting the questionnaires. We introduced an outline for presenting the questionnaires and indicated that the questionnaires would have no effect on the upcoming treatment. Two clinicians volunteered to develop presentation of the questionnaires further, and the practice was introduced at another staff meeting in which all team members agreed to implement this new practice. Further, the clinicians took it upon themselves to present the questionnaires, as this would allow them to know what was said to the families and to ask them at the following therapy session whether it was okay for them to fill out the questionnaires.

Observe. We noticed that the clinicians were more involved in talking about the research project and that they expressed an interest in hearing the preliminary results. The criticism that the research project was taking up too much time at staff meetings seemed to have lessened. We are aware that there is also a time factor involved, in that the clinicians had time to get used to the procedures for conducting research. It is important to note, however, how many families were enrolled in the research project after this point in time. From May 13 to June 15, 88 of 96 families were enrolled in the project, and 26 of the 35 families finishing therapy filled out questionnaires post treatment.

Reflect. We were getting closer to getting the clinicians to accept that we had to conduct quantitative effect research, as the concerns of the clinicians were taken seriously, studied, and implemented in the new clinical practice. We were grateful that the clinicians had made us aware of their observations of the effects of the questionnaires.

Cycle 6

Plan. To continue collaborating with the clinicians to ensure that implementation of the research project would only affect the therapeutic context in ways that were not anti-therapeutic. Participant observation and field notes were used for evaluation.

Act. At the first session, therapists asked the families whether it had been okay to fill out the questionnaires; and at the last therapy session, all families were asked how it had been to participate in research project. At staff meetings, the research project is a permanent topic on the agenda. Both clinicians and researchers are invited to contribute, and feedback is presented from the preliminary results of the research project.

Observe. Clinicians described that most families said participating in the research project was okay. Some families showed a great interest in the results of their questionnaires, and when requested, we sent them their pre and post measures. Families stressed that filling out the questionnaires was a hard job and that it made them think about the therapy and treatment they were going to enter, but none of the families described that filling out the questionnaires made them fear the consequences of their responses.

In addition, observations revealed another kind of interest and involvement from the clinicians in the research project and a more positive attitude towards conducting effect research on narrative therapy. The therapists describe how feedback about the families' experiences provided them with insider knowledge that they could use with the next families, thereby giving them some answers the first families did not get (before they were interviewed).

Reflect. The therapists now feel more part of the research project and could introduce it to the families loyally. The collaboration between researcher and clinicians must continue at some level, as this is beneficial to both clinicians and families.

DISCUSSION

The specific details in the PAR project are not aimed at generalization to other research contexts, as they are most likely context dependent. Some of the findings may, however, be generalizable to similar situations. Based on the previous description of our experiences with using a PAR to develop research projects, there might be some implications of this approach on narrative therapy and psychotherapy research in general.

First, PAR seems to offer an alternative to the philosophical and theoretical arguments described above. The article illustrates how PAR can help us develop a research design that is experienced as suitable across different theories. PAR might make it possible to cope with The Dilemma in ways that are experienced as beneficial to the people involved in the project (McIntyre, 2008, p. 61). PAR helped us create discussions that were experienced as helpful and interesting by all parties. Further, it helped us develop a research culture and design that is now experienced as more suitable to all.

Second, our study stresses the importance of taking into account that research is in itself an intervention as well as treatment is. Filling out the questionnaires affected the families' thoughts about themselves, therapists, and therapy in general. In addition, the article illustrates how research is also an intervention in relation to the clinicians that might have both counterproductive and productive effects on their actions. This underlines the importance of considering which therapeutic understandings of the perceived problem are supported by different assessment methods in relation to psychiatric or psychotherapeutic research in general. In relation to narrative therapy, the study thus stresses the importance of developing quantitative research designs that affect clients and clinicians in accordance with a narrative discourse (as in Epston et al., 2012).

Third, the study illustrates that we, the researchers, are simply not in a position to figure out how the research process is experienced by its users, neither by the clinicians nor the clients. Involving clinicians and clients in the process of developing the research design in the clinical context made us aware that the questionnaires were experienced somewhat differently than we had expected. Clients and clinicians helped prevent us from measuring something completely different than we thought. Further, they helped us diminish the risk of developing a research design that would probably have been considered anti-therapeutic to the following treatment. Even though we might initially have saved time and money by just overlooking The Dilemma and continued the implementation of the research design, the study shows that in the long run, PAR might save researchers both time and money (Cornwall & Jewkes, 1995, p. 1667), as the collaboration with clinicians and clients led us to discover and correct the unintended effects of the presentation of the questionnaires. In addition, it helped us towards a clinical culture of interest and collaboration between researchers and clinicians. These experiences suggest that both clinicians and clients have valuable insider knowledge about how research designs are working, and involving them in all phases of effect research is rewarding and could pave the way for developing research designs that are in accordance with, for example, narrative therapy.

Fourth, it is often said that there is a gap between research and clinical practice in psychology. According to the U.S. Department of Health and Human Services (2001), it often takes one or two decades to integrate new research knowledge into the clinic. It is our experience that a pragmatic and PAR–based approach brought our research into the therapeutic context and gave the research project life in the clinic, "realtime," and not just as a project separate from the clinic. By using PAR, we found it possible to integrate research findings as they appeared in the clinical context.

All in all, we believe that the quality and validity of our research improved as we used PAR for developing the research design in clinical practice. However, we also believe that user involvement should be a means to an end, not an end in itself. Although we found user involvement fruitful and mutually rewarding, there are all sorts of obstacles against continuous and sustained user involvement (Truman & Raine, 2001, p. 225).

First, our PAR project had a built-in inequality between clients, clinicians, and researchers since it was not an option for clinicians to choose not to conduct a quantitative effect research study. While the level of participation seemed to vary at different stages, with a greater degree of participation towards the end, the ultimate formal control was with the research group (Cornwall & Jewkes, 1995, p. 1672). We were very aware of this hierarchy of power and tried not to disappoint or provide the clinicians with false hope. During the entire process, we aimed at complete transparency with the possible range of influence of clinicians: While the details in the study were negotiable, there was no choice as to whether or not to go through with the study. Openness about the limitations of this influence made it clear that we were all in the same boat, with a common wish to behave in accordance with narrative ethics and to practice narrative therapy with the CAHMS. This made it possible for us to collaborate on this common goal.

Further, while user involvement seemed to provide us with fruitful insights into the effects of research, it also put an even greater workload demand on both clients and clinicians. The clients we interviewed had just started therapy and had been referred to therapy because they were dealing with complicated psychiatric problems. As a result, not all contacted families had the time or energy to participate in the project. This meant that the interviewed group of families might represent a select group. However, the families often expressed appreciation of participating in the PAR. Many called it meaningful and felt that their experiences would improve and develop the research, thus benefitting future patients. They also felt that the CAHMS was listening to them and that they were taken seriously. This is in accordance with our narrative wish to support the feelings of agency and competence in the families.

In hindsight, it is clear that our evaluation study would have benefited from greater user involvement from the outset. Many of the initial problems we encountered might have been avoided if the clinicians had been able to participate as fully at the beginning of the research as they did at the end. However, involving clinicians in all aspects of the research process—for example, seeking funding and reviewing literature—might also have put too heavy a work load on them. In our case, we found that too much involvement also caused frustration, because the clinicians felt they spent too much of their scarce free time on the research project. In the end, we came up with a framework for involvement in which the research project only took a limited of time at staff meetings, and all other forms of involvement by the clinicians was voluntary.

So, using PAR is far from easy. In contexts like our CAHMS, in which there is no choice not to utilize evidence-based practice, PAR does seem to offer an applicable solution. In relation to this, we believe PAR could be relevant to many psychological theories that are not based on medical discourse. In societies that increasingly prioritize evidence-based practices (Hansen & Rieper, 2004), they might as well have to conduct research in an area of potentially conflicting paradigms (Madsen, 2007).

Concluding Remarks

This article describes how practicing research as a cyclic PAR–inspired process can open up the formation of a clinical culture and a research structure that allows for quantitative effect research of narrative therapy. We hope that the detailed description of our process will inspire others in the same way we were inspired to do this. PAR did not solve The Dilemma, but it helped us cope with it. We believe that we, as a team of researchers and clinicians, are better off now than before we embarked on the PAR project. PAR helped us to not only build bridges for researchers and clinicians to visit the opposite and juxtaposing discourses but to create a collaborative curious stance and build foundations where we can stand together. We believe PAR offers a way where researchers and clinicians can travel together towards the common goal of making narrative therapy accessible to families within services that favor evidence-based practices.

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