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Making Sense of Epistemological Conflict in the Evaluation of Narrative Therapy and Evidence-Based Psychotherapy

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Abstract

This paper outlines the epistemological and theoretical formation of narrative therapy and implications for its evaluation. Two authoritative paradigms of psychotherapy evaluation have emerged in psychology since the mid-1990s. The Clinical Division of the American Psychological Association established the empirically supported treatment (EST) movement. A more inclusive but medically emulative model of evidence based practice in psychology (EBPP) then emerged. Some therapies such as narrative therapy do not share the theoretical commitments of these paradigms. Narrative therapy is an approach that values a non-expert based, collaborative, political and contextual stance to practice that is critical of normalising practices of medical objectification and reductionism. Post-positivist theoretical influences constitute narrative therapy as a practice that values the social production and multiplicity of meaning. This paper problematises a conflictual relationship (a differend) between the evaluation of narrative therapy and evidence based psychotherapy. Firstly, it briefly outlines the EST and EBPP paradigms and their epistemology. This paper then provides an overview of some of the key epistemological and theoretical underpinnings of narrative therapy and concludes with some cautionary notes on its evaluation.

Keywords: evidence-based psychotherapy evaluation, narrative therapy, post-positivism, empirically supported treatments, evidence-based practice, differend, epistemology, symbolic interactionism

When I (Robbie) began my thesis research, I realised that few psychologists had evaluated narrative therapy. Part of a postmodern therapy movement, some have called narrative therapy social constructionist (Freedman & Combs, 1996) others post-structuralist (Besley, 2002; Speedy, 2005). Fascinated by the postmodernist approach of narrative therapy, I wanted to evaluate the therapy, particularly when there were very few evaluations of it. I approached a therapy researcher to ask if he would be interested in evaluating narrative therapy. He responded, saying that he was only interested in evaluating empirically supported treatments (ESTs). Evaluated through controlled experimental designs, ESTs are treatments for specific clinical disorders (Chambless & Hollon, 1998). Narrative therapy is not an EST. This made me wonder why so few psychologists published evaluations of narrative therapy. The EST assumptions that therapy could be standardised through manualisation emerged from cognitive-behavioural therapy research (see Task Force on Promotion and Dissemination of Psychological Procedures, 1995). The EST movement applied these assumptions to all therapies, regardless of their epistemological (how we know what we know) and theoretical commitments. I came to appreciate that narrative therapy consisted of a range of assumptions that were incongruent with those that informed EST evaluation criteria. In examining the evaluation of narrative therapy, it became clear that there was a problematic relationship between narrative therapy and the evidence-based psychotherapies, and this needed further examination.

To address the question 'how could one evaluate narrative therapy?' I conducted genealogical analyses of both narrative therapy and the so-called evidence-based psychotherapies in relation to evaluation. Genealogy enables a history of how a contemporary concept or identity is constituted in social practice (Epstein, 2010). A genealogical analysis enabled me to examine the assumptions and epistemologies that constitute narrative therapy and evidence-based psychotherapy evaluation. It also enabled me to examine historical discontinuities of knowledge production: 1) within evaluation practice and 2) between the epistemologies informing evaluation and narrative therapy. I uncovered an epistemological conflict. What we present in this paper is a telling of how I came across this conflict, theorised as a differend (a power relation representing two incongruent dis-

courses where judgements made in one discourse marginalise the possibility of speaking and understanding the other discourse) (Lyotard, 1988). Through this telling, I argue that researchers need to evaluate narrative therapy through the epistemological stances that theoretically constitute it. To make this point, we primarily focus on tracing the epistemology of narrative therapy theory to highlight how I came to realise this conflict. I reflect on my genealogical approach to give a very brief outline of the contemporary history of evidence-based psychotherapy evaluation and then overview some of the post-positivist theoretical descent (the diverse theoretical contributions) of White and Epston's (1990) narrative therapy.

Evidence-Based Psychotherapy Evaluation

One angle of genealogical inquiry involves tracing the emergences of a concept in which knowledge, discourse and power relations throughout history have enabled its production and practice. An emergence is when a concept arises and almost seems to take a life of its own, through those who take up and reproduce its discourse, dominating 'centre stage' and overthrowing other discourses (Foucault, 1984). Analysing the contemporary history of psychotherapy evaluation, I uncovered two emergences within psychology: the EST movement during the mid-1990s and evidence-based practice in psychology (EBPP) movement in the mid-2000s.

Genealogy enabled me to contextualise evidence-based psychotherapy evaluation as a discontinuous history of emergences. Rather than taking evaluation for granted, it became a contestable concept and practice, shifting from one dominant, authoritative model (ESTs) to another (EBPP) amid other, less dominant stances (e.g., Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001).

The Clinical Division (Division 12) of the American Psychological Association (APA) 'hosted' the emergence of the EST movement in an era of managed care in the United States (Beutler, 1998). Clinical psychology had to compete with medicine and psychiatry for funding and status. Consequently, the Task Force on Dissemination and Promotion of Psychological Procedures (1995) and followers (Chambless & Hollon, 1998; Chambless & Ollendick, 2001; Chambless et al., 1998) prescribed strict evaluative criteria based solely on experimental design.

ESTs (originally known as empirically validated treatments) were premised on a positivist epistemological framework that was outcomes focused. The underlying principle of positivism is the aspiration to objectivity (Crotty, 1998), a changeable construct in its meaning and practice throughout the history of science (Daston & Galison, 2007; Strong, 2008). Objectivity shifted from capturing nature in its purest form through photography and classification, to mechanical objectivity (the representation of nature through strict, standard sets of procedures), which was then followed by structural objectivity (using 'impartial' observation and measurement to reveal the structure of phenomena 'as it is') (Daston & Galison, 2007; Strong, 2008). To be as objective as possible, the EST movement stipulated that researchers must use controlled experiments (Chambless & Hollon, 1998; Chambless & Ollendick, 2001). This focus on standardised experimental design relates back to a mechanistic construction of objectivity. Positivist research privileges technical knowledge as objective and assumes that knowledge is "separate from the person who constructs it" (Ryan, 2006, p. 15). 'Treatments' in EST research had to be standardised, manualised and matched for specific clinical (i.e., psychiatric) disorders. The EST movement drew attention away from the importance of the therapeutic process and the relationship between client and therapist (where post-positivists would argue that dialogical interaction constructs valuable therapeutic knowledge), except for the mechanistic controlling of therapist, participant and situational variables that bias and influence outcome (see Chambless & Hollon, 1998). A positivist epistemology assumes that researchers *discover* knowledge through 'objective' methodologies; researchers do not *construct* knowledge (Ryan, 2006). Through manualised experimental design, a range of well established 'treatments for disorders' were 'discovered' through meeting the mechanistically objective requirement of being "superior to pill or psychological placebo or to another treatment" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 21).

Other APA divisions were less than impressed with Division 12's criteria. Division 17 (Counselling Division) argued that the narrow EST criteria and its emphasis on uniform treatments for mental disorders ignored the contextual complexity and diversity of clients (Wampold, Lichtenberg, & Waehler, 2002, 2005). Division 21 (Psychotherapy Division) subtly criticised the EST movement for overlooking the importance of the therapist, his/her responsiveness to clients' non-diagnostic characteristics and the therapeutic relationship as major contributors to therapeutic change (Norcross, 2001). Division 32 (Humanistic Psychology Division) argued that the medicalised, symptom removal

focus of EST evaluation was at odds with their holistic and exploratory approach to therapy (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001). Resisting the EST framework, they produced their own reports and recommendations on psychotherapy evaluation. Some divisions reproduced an objectivist discourse of empirical support (Norcross, 2001; Wampold et al., 2002, 2005) while others completely resisted it (e.g., Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001;).

These controversies and debates sparked a new emergence of psychotherapy evaluation, EBPP, through the APA Presidential Task Force on Evidence-Based Practice (2006). A sharp break from the experimentalist methodological monism of ESTs, EBPP was methodologically inclusive in its evaluation criteria. It enabled psychologists to use a range of quantitative and qualitative methodologies.

However, a positivist model, emulating that used to develop evidence-based medicine, also constitutes EBPP. This model of evaluation uses medical terminology such 'clinical', 'symptoms', and 'syndromes'. Clients are termed 'patients' and the term 'treatment' is still used to describe therapy. EBPP also privileges objectivism. There is a hierarchy of evidence in that EBPP privileges the experimental method as the most stringent and sophisticated evaluative design over others. Ranked lowest in the hierarchy are clinical opinion and observation.

EBPP also reproduces, through its medical objectivist discourse, the EST notion of 'empirically supported'. EBPP aims to apply "empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). Without conceptualising 'empirical', the APA Presidential Task Force assumed that 'empirical' was a term that needed no justification or epistemological framing, equating empiricism to 'demonstrably effective' (Wendt & Slife, 2007).

Tracing Narrative Therapy Theory

In contrast to the medical, positivist epistemology of the EST and EBPP evaluation movement, narrative therapy is constituted in and through a post-positivist epistemology. Post-positivism is a move away from assumptions of knowledge neutrality. Post-positivist research assumes that people *construct* knowledge in that "knowledge cannot be divorced from ontology (being) and personal experience" (Ryan, 2006, p. 16). A post-positivist stance assumes that people contextually and politically produce knowledge. Researchers of this stance often regard themselves as "people who conduct research *among* other people, learning *with* them, rather than conducting research *on* them" (Ryan, 2006, p. 18, original italics). The more I examined the theoretical descent of White and Epston's (1990) narrative therapy, the more I realised that the epistemology and theory that informed its therapeutic process were at odds with EST evaluation and EBPP evaluation frameworks. As a philosophical approach to therapy, narrative therapy is critical of decontextualised medical discourse and normalising practices of evaluation (White & Epston, 1990). Rather, narrative therapy evaluation focuses on exploring the meaningfulness and successfulness of the narrative shifts of client experience (e.g., from thinly described decontextualised accounts to thicker, context-laden descriptions; from internalised, self-pathologising accounts to stories of control over the problem). Both the therapist and client perform this evaluative exploration through collaborative conversations.

In contrast, medical diagnoses (and the assessment-focused conversations that lead to and follow from them) underpin the evidence-based EST and EBPP models as an essential part of evaluation. This approach assumes that client concerns are objectively ascertainable forms of psychopathology.

However, narrative therapists resist objectivist medico-scientific models of therapy in favour of an involved and largely improvised conservational stance, meaningfully contextualising the clients' telling of events: "Narrative therapists do not present themselves as distant, objectively neutral experts who diagnose problems and prescribe solutions and treatments, but as curious, interested and partial participants in the person's story" (Besley, 2002, p. 129). Narrative therapy's conversational process problematises decontextualising diagnostic categorisations of client concerns as well as troubling most notions that narrative therapy is standardisable (with the exception of White's (2007) *Maps of Narrative Practice*).

The improvised and contextualised conversational meaning making process of narrative therapy is constituted through a range of post-positivist theoretical stances that are resistances to objectifying research practices. For instance, when I engaged with symbolic interactionist theories as a major epistemological influence on narrative therapy, I realised that such stances assumed (inter-)active performances of meaning in everyday life produce knowledge. Symbolic interactionists value meaning as social productions, as "creations that are formed in and through the defining activities of peo-

ple as they interact" (Blumer, 1969, p. 5). Rather than a process that assumes an expert therapist administers manualised treatment, the therapeutic process is a symbolic interaction, a dynamic interactional process of dialogue that enables the generation of meaning. This epistemological assumption that dynamic, social interaction symbolically produces knowledge contrasts significantly with medical positivist stances of knowing through reasoned hypotheses and objective observation.

What was also interesting was that ethnographic concepts and practices constituted narrative therapy's symbolic interactionist epistemology. Ethnography is a methodology that involves a considerable amount of improvised interaction. This approach does not fit with EST and EBPP assumptions that the objective testing of symptomology against predefined medical diagnostic constructs and measures enables knowledge gains. The ethnographical stances of narrative therapy's symbolic interactionism enable the production of thick description. Rather than simply categorising or abstracting phenomena, thick description attends to the complexity of meaningful interpretation or understanding of phenomena in/through the situatedness of context (Geertz, 1973).[1] For example, Erving Goffman's ethnography, through his experiences as a psychiatric intern, enabled a contextual understanding of institutional conformity and morality in a psychiatric hospital setting. Goffman (1961) found that patients constructed themselves through unique outcomes, which were unreflective, taken-for-granted and unique aspects of lived experience. However, these constructions were quickly degraded by other inmates and staff because the institutional expectation of moral conduct positioned inmates as 'no one special'. White and Epston (1990)'s narrative therapy constructs and explores possible unique outcomes as events that may have been overlooked by the client in relation to the problem. As client context locates unique outcomes, they can be thick descriptions for a conversational plotting of a story that clients regard as meaningful and helpful to them.

Delving further into the theoretical descent of narrative therapy, symbolic interactionist theorists advocated for interactive conversational performances of meaning that produce thick descriptions of client experience. Through what Turner (1974, p. 24) called a "world of becoming," the meaning of lived experience could be understood as enabled in and through transitional, imaginative (subjunctive) performances of our cultural identity. Rather than assuming a 'thing' that has predetermined meaning through positivist epistemology (Crotty, 1998), meanings of lived experience can be understood as ever changing and are made possible through crises and ritual performances (Turner, 1969, 1974). Meaning is indeterminate in that a text is open to multiple interpretations (Geertz, 1986) and through the imaginative, subjunctive process of interaction and narrative in narrative therapy, new forms of identity can emerge.

Newly storied identities of experience can become realised through definitional ceremonies, a collaborative ethnographic strategy that makes visible aspects of a person or group that others, from wider society, may not have known (Myerhoff, 1982, 1986). While Turner (1969) questioned his informants to gain a contextual understanding of the indigenous meaning of symbols in rituals, Myerhoff (1986) actively collaborated as a participant-observer, embedded within her Jewish participant community, to help them produce and publically illuminate their own symbolic cultural events whereby she gained an understanding of their (and her own) lived experience.

White and Epston (1990) incorporated Turner's and Myerhoff's symbolic interactionist approaches into the philosophy of narrative therapy. Both Turner (1974) and Myerhoff (1982, 1986) enabled the notion that lived experience can be meaningfully (re-)shaped through symbolic enactments. White and Epston (1990) use this notion, along with Jerome Bruner's (1986) notion that narratives are constitutive of who we are, to collaboratively examine unique outcomes of clients, involving multiple interpretations to problematise problem stories that clients present as well as play out new plotlines of client lived experience and identity.

Other post-positivist epistemological stances that constitute narrative therapy produce an approach that values meaning making as a relational and constitutive production of lived experience. Bateson's (1972, 1979) cybernetics (the study of communication and control processes in systems) enabled the idea that meaning is (re-)produced through patterns of interaction and comparison in living systems. That is, relational systems, such as families, (re-)produce meaning through recurring relationship patterns. The narrative therapist can explore with clients meaning patterns "between the problem and various relationships" (White & Epston, 1990, p. 45) and examine unique outcomes and/or imagine different meanings that may disrupt habitual responses to events.

Narrative enables not only the exploration of events but it also constructs our realities. The constructivist influences of Jerome Bruner (1986) and Edward Bruner

[1] Clifford Geertz studied at the University of Chicago and was interested in the symbolic. George Herbert Mead's research at the university enabled symbolic *interactionism* to flourish with Herbert Blumer, Victor Turner and Erving Goffman researching there at different times.

(1986a, 1986b) enabled the notion that narratives are not only interpretative in that there are multiple interpretations of the same narrative, but they also (re)constitute our lived experience. Narrative can be a mode of thought and a discourse (J. Bruner, 1986; Bruner, 1991), which is more subjunctive (an imaginative mood for constructing possibilities) and textually indeterminate than in logico-scientific, paradigmatic thinking (J. Bruner, 1986). Narrative can also be a unit of power enabling a (re-)production of dominant cultural discourses that shape how we understand our experience (E. Bruner, 1986a, 1986b). Edward Bruner argued that dominant narratives are primary interpretative mechanisms for shaping and sharing our experience but they mostly remain unanalysed. Narrative therapy uses narrative as a way of analysing unanalysed stories of experience and as an influential relational process of conversational enactment that can question dominant narratives and their effects on the lives of clients.

Foucauldian theory also plays an important role in narrative therapy's theoretical descent in understanding how people constitute themselves through power, knowledge and discourse. White and Epston (1990) used Foucauldian theory to understand how normalising discourses shape problems, client experiences and relationships. Foucault (1977) theorised that people, as docile subjects of discursive practices, learn to survey and discipline themselves and others through institutionalised social norms of observation and examination. White and Epston (1990) drew from this disciplinary power relation concept of conduct to make sense of how dominant, normative narratives can influence one's construction of themselves, of others and of various interactions between the self and discourse. Foucault (1980) also theorised that there is a relationship between power, knowledge and discourse in that struggles involving resistance and dominance produce knowledge. According to Foucault, dominant, authoritative knowledges gloss over, mask and/or marginalise scholarly and popular knowledges that influence social conduct.

Narrative therapy draws on Foucault's notions to 'deconstruct' dominant, normative narratives that contribute to client's problem stories. As a partial, inquiring and curious participant in the therapeutic conversation, the narrative therapist actively listens to resistances to problem stories and highlights these subjugated knowledges as unique outcomes of client experience (White & Epston, 1990).

To summarise, the theoretical descent of White and Epston's (1990) narrative therapy has revealed a range of interpretivist stances that constitute its post-positivist epistemology. In symbolic interactionism, meaning is performed in and through social interaction rather than something that is predetermined, neutral or fixed in time. Bateson's cybernetic theory assumes that through patterns of interaction, human systems can reproduce certain meanings beyond the individual. From constructivist perspectives, narratives constitute meaning and construct our realities. Foucauldian notions of power, knowledge and discourse enable us to deconstruct normative, dominant narratives and discourses, and help us unearth subjugated knowledges that we may find more meaningful to our lived experiences.

A Differend

These post-positivist stances are at odds with contemporary notions of objectivity, a primary cornerstone of medical positivism, which constitutes the EST and EBPP movements. The discourse of narrative therapy is epistemologically, and, by extension, ontologically incongruent with the governing discourse of contemporary evidence-based psychotherapy evaluation in psychology (ESTs and EBPP). Through an epistemological stance of objectivity, positivists ontologically view our being and existence as *discovering* and reflecting an external world as 'given' and 'as it is'. Evidence-based psychotherapy evaluation assumes that the researcher discovers evidence through objective techniques (standardisation of therapy and diagnostic assessment of clients). In contrast, post-positivists view multiple constructions of being and existence, and view worlds constituted through language use and social interaction. They understand narrative as a subjunctive and textually indeterminate discourse that enables the construction of possible worlds of meaning and being (J. Bruner, 1986). In narrative therapy, the adaptation of symbolic interactionist, constructivist, narrative and Foucauldian stances through collaborative, exploratory and improvised dialogue between therapist and client *produces* meaningful narratives of lived experience.

If post-positivist epistemological stances constitute narrative therapy as a philosophical approach and therapeutic process, would it not be reasonable to base evaluations of narrative therapy on those epistemological stances and their theoretical assumptions? Would it make sense to evaluate narrative therapy on the interpretivist principles, which forms its practice, and justify the epistemological stance of evaluation that one uses? For example, Speedy (2004) has proposed the use of definitional ceremony not only as a therapeutic practice but also as a reflective methodology of collaborative research between the therapist and client. This is where both members collectively write a reflective narrative on their writing of their therapeutic conversation. It

involves including significant others (outsider witnesses) as contributors to drafts, and it is an approach that fits more in line with post-structuralist and collaborative premises of narrative therapy.

However, not only is there a conflict between narrative therapy discourse and evidence-based psychotherapy discourse, there is also a power relation between them. I theorised this conflictual power relation as a differend (Lyotard, 1988). In a differend, there is an unequal power relationship. That is, authoritative evidence-based (EST and EBPP) criteria marginalise narrative therapy through epistemological incongruity between the two discourses. Narrative therapy resists a medicalising positivist stance to evidence-based psychotherapy evaluation discourse and therefore it becomes marginalised within such a discourse. In a differend, one discourse is more dominant than the other such that the dominant discourse's evaluative rules/grammar (to which make judgements of others) marginalises and silences the other(-ed) discourse:

> A case of a differend between two parties takes place when the "regulation" of the conflict that opposes them is done in the idiom of one of the parties while the wrong suffered by the other is not signified in that idiom… The differend is signaled by this inability to prove. The one who lodges a complaint is heard, but the one who is a victim, and who is perhaps the same one, is reduced to silence. (Lyotard, 1988, p. xii)

Perhaps some universal criteria are needed to judge both discourses (of evidence-based psychotherapy evaluation and narrative therapy)? Lyotard (1988) argued that applying universal criteria to judge a differend is impossible. He argued that discourse is necessarily political in that there are stakes involved in discourse and therefore universal value-free criteria are not possible. Further, because there are political stakes involved in discourse, conflict and incommensurability are inevitable and, therefore, differends are inevitable (Lyotard, 1988; Rojek & Turner, 1998; Smart, 1998). Inevitability makes it impossible to establish universal criteria for 'everyone' to agree to. The interpretivist, post-positivist stance of narrative therapy resists universal criteria of evidence in contemporary evidence-based psychotherapy evaluation discourses. Some narrative therapy researchers resisted such evidence criteria/discourse and proposed their 'evaluative' practices through narrative therapy theory (e.g., Speedy, 2004, 2008). There is also the possibility that proponents of ESTs and/or evidence-based practice will judge (or have already judged), in/through their discourse, such narrative therapy 'evaluations' as unconventional. This differend is characteristic of an impossibility such that neither proponent of their discourse can transcend the differend without violating the epistemological assumptions of the other discourse (Lyotard, 1988).

Assuming that differends are inevitable, a political, reflexive approach can help address the question of how one can evaluate narrative therapy. Lyotard (1988) argued that we could use this approach to address differends. Smith (1998, p. 60) argued that Lyotard implied that there is an obligation to "conduct just judgements" and to address differends to "keep open the question what is just and unjust." This means, for us as psychologists, to be mindful of the consequences of imposing evaluative judgements on therapies that are epistemologically incongruent with those judgements.

Due to its post-positivist epistemology, narrative therapy, as a philosophical approach, is critical of the effects of normalising evaluative judgements, medical objectification and dominant narratives (White & Epston, 1990). This makes it difficult, if not impossible, to use evidence-based psychotherapy evaluation discourse to judge narrative therapy without violating its premises.

Promisingly, there are some terms congruent with narrative therapy's theoretical stance (e.g., 'collaborative' and 'context') in EBPP (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006). Although a medical objectivist stance is the interpretative framework that produces the evaluative meaning of these terms, EBPP is a small step closer to congruency with narrative therapy discourse in contrast to the rigid evaluative criteria produced by the EST movement.

Evaluating narrative therapy in and through its discourse, or somewhere close to it, while being reflexive of its epistemology and aware of producing differends, may do less harm in marginalising what it stands for. Such a political and reflexive approach may produce some interesting, thought-provoking research.

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