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Navigating Postmodernism & Critical Theory in Family Therapy

by

Justine Anne White

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A Dissertation submitted in partial satisfaction of
the requirements for the degree
Doctor of Philosophy in Marital and Family Therapy

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June 2014

Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

_____, Chairperson
Carmen Knudson-Martin, Professor of Counseling and Family Sciences

_____
Douglas Huenergardt, Professor of Counseling and Family Sciences

_____
Winetta Oloo, Assistant Professor of Counseling and Family Sciences

_____
Amy Tuttle, Associate Professor of Psychology, Pepperdine University

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ABSTRACT OF THE DISSERTATION

Navigating Postmodernism & Critical Theory in Family Therapy
by

Justine Anne White

Doctor of Philosophy, Graduate Program in Marital and Family Therapy
Loma Linda University, June 2014
Dr. Carmen Knudson-Martin, Chairperson

Postmodern and critical theories have become important theoretical paradigms encouraging therapists to honor diversity and combat oppressive social structures and practices. However, at times, these two paradigms have been thought to position therapists in contradictory ways, with critical models advocating for activism and postmodern models encouraging pluralism. In many ways, these two therapeutic positions have come to characterize two distinct ways of conceptualizing therapist roles, with little conversation about how to embrace both stances in clinical practice.

Through a grounded theory analysis, fifteen family therapists known for working within postmodern and critical paradigms shared with us how they navigate between positions of activism and pluralism in clinical practice. We found that therapists described their work in similar ways, engaging in a set of shared constructionist practices: therapist transparency, Inquiry as intervention, and staying experience near, and also employed therapeutic activism in different ways, with counter activism and collaborative activism representing two distinct stances.

Keywords: postmodernism, critical theory, collaborative activism, social justice

CHAPTER ONE

INTRODUCTION

This study seeks to locate therapist's understandings and strategies for bridging postmodern and critical theories in clinical practice. We understand postmodernism as a paradigm that is hesitant to embrace universalizing and absolute truth claims, seeking instead to create space where all claims to truth are equally considered (Carchesio & Green, 2011; Gehart, 2010). The critical paradigm offers social critique as a means to incite activism that liberates people from subjugating social structures and processes (McDowell & Jeris, 2004). Currently, in the field of family therapy there appears to be an absence of theoretical support or foundation for working from both a postmodern and critical paradigm. However, it seems that some therapists are attempting to navigate the space between, and often experience theoretical tensions in the process (Miller & Weiling, 2002). In response, the purpose of this study is to explore how therapists who identify with working from both critical and postmodern perspectives would describe the "space between" and negotiate their commitments to postmodern practices while also valuing the pursuit of social justice through taking an activist stance.

At present, it seems professional literature and dominant discourses in our field position these two theoretical frames in one of two ways, either as opposing and contradictory or as congruent and compatible paradigms (Grant, 2006; Dickerson, 2011). In our current research, it is our perspective that these positions are an oversimplification of the connections and disconnections between the postmodern and the critical, failing to take into full account the complexity of the relationship between them (Miller & Weiling, 2002). We see this as having resulted in somewhat of a stalemate debate, placing the

critique of postmodernism from a critical perspective, pluralism, and the postmodern critique of the critical, activism, at odds with each other, making it seem difficult to explore possibilities beyond the divide between the critical and postmodern (Gergen, 1998; Pilgrim, 2000; Ramey & Grubb, 2009). In some respects, we understand the potential tensions between critical and postmodern paradigms to parallel those existing between modern and postmodern paradigms. More specifically, we see critical theory as articulating a "truth" stance in terms of the call for activism around social issues and injustice, which we view to be tied to the "modernist" tradition. Thus, it is our intention to explore possibilities for moving beyond the critical and postmodern, and to identify ways therapists are attempting to do this in their own work. We also hope to construct a map of practice that may prove useful for other therapists who find themselves negotiating a similar terrain between the critical and postmodern.

Background

Critique is often defined as a methodical practice of doubt (Gasche, 2007), and might even be considered a foundational component on which the family therapy profession was built. In fact, Hoffman (2002) suggests that the inception of the entire field was the result of a group of "pioneering psychotherapists who insisted on working against our most persistent illusion, the stand-alone self" (p.1). This early critique and resistance to individual psychological explanations of human behavior created openings to explore systemic ways of conceptualizing and understanding problems. It seems to also have set in motion an ongoing tradition of skepticism and investigation into dominant practices that continues today.

Origins of Critique in Family Therapy

It is important to note that Family therapy's relationship to critique has been instrumentally shaped and influenced by the work of two French philosophers and social scientists, Jacques Derrida and Michel Foucault. Within family therapy, Derrida is most well known for his contribution of deconstruction processes (Wood, 1992), a complex philosophical idea that has influenced many of the critical and post structural threads in our field (Hepburn, 1999). Hepburn (1999) describes deconstruction as a radical force that urges us to heighten sensitivity towards the methods by which meaning and truth are constructed, critiquing dominant conceptions of philosophical thinking and resisting the pull towards binary logic (Hepburn, 2000). Cooper (1989) suggests the object in deconstruction is to reveal the contradictions, ambivalences and double binds that lie latent in any text, emphasizing that, contrary to popular belief, structure is not what organizes process, but process that ultimately governs structure. Therefore, deconstruction serves as a critical tool to reverse this predilection (Cooper, 1989).

Like Derrida, much of Michel Foucault's work focused on resisting, contesting and disrupting dominant social structures and systems of thought (Foucault, 1980), with primary interest on how people come to be categorized as either "normal" or "abnormal" within culture and society (Freedman & Combs, 1996), by focusing on exercises of power and knowledge (Madigan, 2011). In fact, Foucault considered power and knowledge as so intimately intertwined that rather than treating them as separate and related, he preferred to understand and frame them as a single concept, power/knowledge (White & Epston, 1990). Foucault also brought to light the importance of text, language and meaning. Like issues of power, the importance of language and meaning were

largely unexplored topics in counseling literature prior to White & Epston's (1990) initial articulation of narrative ideas (Besley, 2002). For Foucault, language acts as an instrument of power, with the level of power people experience directly linked to their ability to participate in broader social discourses that work to shape context, experience and society (Freedman & Combs, 1996). Overall, attention to power processes, the nature of language and meaning, and the inherently interpretive nature of many discursive practices (Madigan, 2011), represent some of Foucault's most influential ideas to the field of family therapy.

The Emergence of Feminist and Critical Critiques

As the work of Derrida and Foucault gained momentum in the family therapy field, their influence became evident and visible through the emergence of the feminist critique. Within family therapy, many would likely credit the feminist movement as the first major critique of traditional family therapy ideas and theories, simultaneously spurring on both controversy and transformation. One of the most notable figures to bring feminist ideas to the fore is Rachel Hare-Mustin, who wrote "A feminist approach to family therapy" in 1978. The nature of these critiques focused on the underlying theoretical orientation of family therapy at the time, systems theory, and later spread to include specific models of therapy (Leslie & Southard, 2009). The critiques feminism offered to the underlying theoretical assumptions of systems theory directly challenged notions of therapist neutrality and presumed equality between men and women, emphasizing gender as a social construct and organizing variable, and highlighting the

professions inattentiveness to diversity and lack of awareness about issues of power that produce inequities (Leslie & Southard, 2009).

Once these initial critiques became established, focus moved beyond concerns of white women and sexism to other forms of marginalization and oppression (Baber, 2009). This opened doors for critiques from critical race and queer theories, focusing on the impact of structural and systemic racism and homophobia. It was during this time, in 1988, that Peggy McIntosh wrote her pivotal essay "White privilege and male privilege: A personal account of coming to see correspondences through work in women's studies" which contained the now famous excerpt, "unpacking the knapsack of white privilege." Much like feminism originally did with gender, these critical race critiques exposed the effects of race as an organizing factor and social construct. Queer theory (Lev, 2010) did the same in regards to LGBTQ issues and concerns. These critical threads continue to influence the field and have become integral parts of therapy models such as the cultural context model (Almeida, Vecchio, & Parker, 2008).

The Emergence of Postmodernism

Also shaped by the work of Derrida and Foucault, postmodernism's influence on family therapy entered the scene about a decade after the initial feminists critiques. Like the earlier critiques, it too challenged the foundations of modern systems theory, such as absolute truth, objectivism, and neutrality (Gergen, 1998), proposing that human systems existed only in "language and communicative action" (Anderson & Goolishian, 1988). With this postmodern shift came the influence of social constructionism, which has informed an entire thread of therapeutic approaches, such as narrative, solution-focused,

and collaborative and relational practices. Under postmodernism and social construction

attention is drawn to intersectionality (Winslade, 2009) and the multiplicity of meanings

(Gergen, 2009). Another important piece focuses on how meanings are constructed

through language and relationships (Anderson, 1997).

While postmodernism and social construction are concerned with issues of power

and marginalization, they do not hold to activism or social liberation as their primary

pursuit. Instead, they provide a framework for alternative ways of positioning oneself as

a therapist that works to equalize hierarchical structures and capitalize on client

knowledges and expertise.

Present Day

Due to this professional progression over time, family therapy has arrived at a

place where critical and postmodern efforts frequently seem to run contrary to each other

(Grant & Humphries, 2006). On the one hand, therapeutic approaches informed by

critical theories emphasize social issues as the "True" origin of individual and family

problems, and must be addressed as such within therapy. On the other side, postmodern

therapeutic practices view social issues as one possible cause of human problems and do

not insist that they be attended to explicitly. These contrasting positions often seem to

leave little room for exploring alternatives. More often than not, it appears that focus is

placed on ascertaining whether the critical approach is correct, or the postmodern one.

Like others (Gergen, 1998; Miller & Weiling, 2002), our research seeks to examine how

it may be possible to work within a larger dimension in which both frameworks coexist

and therapists feel more freedom to operate within the space between critical and postmodern paradigms.

Objectives

Our overall objective in this study is to explore how family therapists negotiate being informed by both postmodern and critical theories. More specifically, we seek to understand how family therapists adhere to the theoretical implications of each theory simultaneously in their clinical work. For instance, we understand critical approaches to position therapists as non-neutral activists who are often thought of as experts on how sociocultural and sociopolitical contexts shape and impact clients lives (Almeida, Del Vecchio, & Parker, 2008). Most often, it appears this knowledge leads therapists' to focus on increasing client awareness about the impact of larger contexts (Waldegrave & Tamasese, 1994), often accomplished through what we perceive to be practices of telling or teaching. From this stance, it is believed that once clients are informed about these social processes they can become empowered and liberated (Almeida et al., 2008). This contrasts with how we understand a postmodern therapeutic approach which positions therapists as tentative facilitators, hesitant to privilege any one idea or explanation over another (Anderson, 2012). Because of this, postmodern therapists' work to elicit client perspectives and preferences (White & Epston, 1990), careful not to value their knowing over the client's knowing (Anderson, 2013).

In reflecting on the differences between these two approaches, we see the potential for tensions to arise in attempting to embrace both therapeutic stances, especially considering that one seems to privilege therapist knowledge, understanding and meaning, while the other works to privilege client knowledge, understanding, and

meaning. However, our study operates under the assumption that while working clinically from both paradigms may potentially create challenges, it is not impossible. For instance, we believe family therapists may understand and practice activism and pluralism in a variety of ways. Thus, in order to understand this more intimately, our research is guided by the following sub-questions:

Sub Question 1: How do family therapists understand, and potentially work between, positions of activism and pluralism?

Sub Question 2: Given what seem to be differing ideas about therapist role and position, how do family therapists justify working clinically from both postmodern and critical paradigms?

Sub Question 3: How do family therapists attend to critical social issues without sacrificing a postmodern position that refrains from adhering to singular explanations of problems or difficulties?

Sub Question 4: How do therapists remain attentive to issues of social justice without privileging their own interests or agenda?

Sub Question 5: How do therapists remain committed to embracing a position of pluralism without overlooking the serious impact of social issues?

In asking these questions we hope to construct a grounded theory for how family therapists negotiate what can seem to be theoretical tensions between critical and postmodern paradigms in clinical practice. We hope that developing grounded theory that explains how this is done will enable us to also construct a map for practice that can be utilized as a guide for other family therapists who share similar commitments to

critical and postmodern paradigms but that might struggle to honor both traditions in their work.

Rationale

At present, a postmodern and a critical social justice approach to therapy tend to be viewed by some as reflecting theoretical tension (Grant, 2007). For example, although postmodernism is concerned with constructions of power and privilege that impact client's lives, there generally does not seem to be much theoretical provision for addressing these issues explicitly in postmodern therapy. Critical approaches appear to take a much different stance in relation to sociocultural contextual issues, demanding therapists to actively attend to the various systemic and social injustices that clients face (Almeida et al., 2008; McDowell, 2005; Carlson & McGeorge, 2011). In fact, a number of social justice models suggest that therapists who do not explicitly attend to these issues overtly, either by naming them and/or deconstructing them with the client, are colluding with the systems of social control that have been constructed to maintain the interests of members of dominant groups (McDowell, 2005)

What we seem to be left with is a postmodern, social constructionist approach that can potentially appear to overlook the gravity of issues of injustice in client's lives (Sanders, 1998). As a result, therapists may work with clients without appearing to give adequate attention to these realities or attempt to rectify the wrongs that marginalized groups have been burdened with for much of our history. On the other hand however, social justice approaches to therapy could possibly alienate clients who do not feel their difficulties are rooted in issues of systemic oppression. In addition, positioning ourselves as activists within the therapeutic context might potentially lead therapists away from the

essence of client experience, making us susceptible to reducing the personhood of our clients to the critical issues themselves. For instance, it is possible that approaching social justice issues in this manner can lead to the danger of single story identity politics (Madigan, 2011), totalizing everything to social causes. This means that therapists potentially risk losing sight that social explanations may be just one variable among many others that can help us to understand and explain difficulties.

   We hope our study will expand knowledge about these issues in three beneficial ways. The first is that we will be able to identify how therapists working from both a postmodern and critical approach navigate the differing influences from each paradigm. Second, this study will give us the opportunity to build grounded theory about specific clinical practices that many skilled clinicians are likely to already be engaging in, but for which there may be no existing theoretical explanation or guide within family therapy. Ultimately, we hope to provide a map for practice for others seeking to do this complex work. Lastly, it is our hope that our research will allow us to explore new possibilities for alternative ways we might conceptualize, teach about and practice positions of activism and pluralism. We wonder about broader theoretical frames that might extend their reach beyond the current boundaries of critical and postmodern paradigms, and would be pleased if our research was able to contribute to the beginnings of new conversations about practice and theory in this area (Gergen, 2007; Latour, 1993).

CHAPTER TWO

CONCEPTUAL FRAMEWORK

Family therapists have taken many theoretical ideas from other disciplines and applied them to our work, allowing us to transform and reflect on current family therapy practices. Two of the most influential and ongoing critiques in the field come from postmodern and critical theoretical paradigms. We use the term paradigm to convey a set of common understandings in relation to epistemology, ontology, and axiology (Freshwater & Cahill, 2013), and for our study, we utilize postmodern and critical paradigms to discuss what have seemed to become two disparate positions in family therapy, pluralism and activism. Pluralism and activism uniquely shape varying aspects of clinical work, with the following three reflecting our specific interest in this study, 1. therapist positioning, 2. conceptualization of problems, and 3. theories of change. From our perspective, it is the differences in how pluralism and activism shape these aspects of therapy that have given rise to concerns about potential incompatibilities of these two paradigms.

In the following chapter, the basic tenets of critical theory will be outlined along with the influence it has had on shaping social justice approaches to therapy that promote an activist stance. Postmodern theory will also be discussed in relation to the way it has influenced relational practices that challenge ideas of expertise and truth, and for the way it has been critiqued for fueling a sense of pluralism in the field. However, because this study seeks to discover ways therapists negotiate the spaces between the postmodern and critical, or the potential tensions between activism and pluralism, a third and newly

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emerging theoretical framework, Amodernism, will also be utilized to help frame and explore the research question.

Critical Social Theory and Activism

Critical social theory is largely responsible for many of the movements within family therapy that have demanded attention be given to persistent inequalities that occur as a result of systemic oppression. Critical social theory is a grand theory that originated from German philosophers and sociologists during the late 1920's and early 1930's, with Habermas being one of the most well known to our field (Mohammed, 2006). The essence of critical social theory examines power relationships and structures within society that fuel inequalities (Grams & Christ, 1992) and specifically seeks to provoke critiques that excite activism (MacKinnon, 2009). Ultimately, critical social theory can be understood as an action-oriented theoretical paradigm that is infused with an emancipatory interest in addressing the fundamental causes of oppressive social structures within society (Mohammed, 2006).

Critical Race & Critical Feminism

It is from this broader theoretical frame that critical race theory and critical feminism have evolved, both of which have been directly applied to the field of family therapy. In family therapy, Critical race theory is utilized as a framework for addressing race, racism, and power (Delgado & Stefanic, 2001; Abrams & Moio, 2009), with a stated goal of examining, deconstructing and ultimately transforming the very power relationships that have created and sustain the marginalization of specific racial groups

(Freeman, 2011). Critical feminism operates in much the same way but has historically placed greater emphasis on understanding how gender binaries work to construct fixed identities and differences (Gringeri & Roche, 2010). In response to this, critical feminist scholars characterize the main work of critical feminism as being that of destabilization (Angelique, 2012). This means that critical feminism is politically committed (Miller, 2000) to blurring the lines of binary thinking about gender, so that language of difference isn't further reinforced, but is instead deconstructed (Gringeri & Roche, 2010). It is also important to note that in a similar fashion to critical race theory, critical feminism has increasingly extended its focus to issues beyond gender, viewing human rights issues, Queer and LGBTQ concerns, along with practices of antiracism as all intricately interweaved with issues of gender (Gillis & Munford, 2004).

Activism

In the same tradition as critical social theory, critical race theory and critical feminism are action-oriented (Ortiz & Jani, 2010; Miller, 2000), calling those of us within the realm of helping professions to empower marginalized groups and eradicate structures of oppression within society (Ross, 2009). In order to rise to this challenge, McDowell (2005) stresses the importance of finding ways to bring social action into our clinical work as therapists, highlighting the urgent need to move from awareness of diversity and issues of social justice to "positions of action". This emphasis on activism has led to a variety of therapeutic approaches that are broadly defined as "social justice" therapies. These approaches, one of which is the cultural context model developed by Almeida et al. (2008), demand that therapists take an activist stance in their clinical work

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and warn that not doing so is to actively collude with oppressive systemic conditions that impede the wellbeing of marginalized clients. Just Therapy (Waldegrave & Tamasese, 1994), another social justice oriented approach, falls in line with the former in that this model also maintains an imperative to relate therapeutic work directly to political, economic, social and cultural systems that actively inhibit individuals and families from experiencing life and relationships in affirming ways.

Postmodernism & Pluralism

Postmodernism, in perhaps its simplest form, can be understood as both a theoretical and philosophical position contesting objectivity, neutrality, and universal truth claims stemming from modernity (Philp & Geldard, 2011). It stands as a direct challenge to the underlying epistemologies and methodologies of modernism, engendering "reflective skepticism" towards the science-politics dichotomy (Cosgrove, 2004). Postmodernism supports taking a critical stance in relation to knowledge and truth claims (Cosgrove, 2004), encouraging opposition to "metanarratives" (Lyotard, 1984), which are understood as "highly generalized, indeed universalized, theories about everything everywhere" (Shawver, 2006, p.75). From this position, postmodernism does not privilege any one methodology, authority or paradigm (Ramey & Grubbs, 2009), and is instead reflective, reflecting on the multiple and intersecting diversities and shifting realities that are all part of experience (Pilgrim, 2000). Ultimately, postmodernism cautions against allegiance to singular ways of understanding and meaning making, alternatively stressing the importance of considering the relevancy of truth claims within their specified context. This position within postmodernism lays the foundation for what it is uniquely known and critiqued for, pluralism.

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Social Constructionism

It is important to acknowledge that the origins of social constructionism are conceptualized differently by varying writers and theorists (Berger & Luckmann, 1966; Gergen, 2009), and that our research is situated within the frame of social construction that Gergen (2009) considers to be a direct outcome of postmodernism. From this perspective, constructionism is "congenially identified as a constituent of postmodern as opposed to a modern cultural perspective" (Gergen, 1998, p.2), characterized by five underlying assumptions 1.) How we understand the world is not demanded by what exists, 2.) How we come to know, understand and explain the world represent outcomes of relationship, 3.) The way we construct the world becomes important only in light of social utility, 4.) The way we language reality determines reality, and 5.) Well-being is dependant upon reflecting on take for granted realities (Gergen, 2009). These assumptions contrast with traditional explanations that are reality driven and instead, positions truth as a specific construction resulting from relations within a specific group (Gergen, 2006).

Like postmodernism, social constructionism contests absolute truth claims, rejecting the value placed on objectivity and notions of neutrality, arguing that "what seems to be an objective report is a cloak that masks the implicit values" (Gergen, 2009, p. 14). The focus then is not on discovering the truth, but on opening up possibilities for a multiplicity of meanings and understandings to surface. It acknowledges that what may be truth for one group may not be truth for another, and that what may be practically valuable for some may be oppressive to others (Gergen, 2009). Ultimately, the goal of

social constructionism is to "bring forth new and more promising ways of life" (Gergen, 2009, p.14).

Postmodernism and social constructionism have dramatically impacted the family therapy profession, serving as the foundation for approaches to therapy that breaks greatly with traditional ways of viewing and engaging in clinical work. Perhaps one of the more widely known of those therapeutic approaches being narrative therapy, along with relational and collaboratively oriented therapies. In the spirit of postmodernism and social construction, these therapies highlight the relational nature of truth and language, and hold central that all realities are socially constructed and can ultimately be deconstructed in order to find more useful alternatives. This theoretical and philosophical positioning requires therapists to hold their knowledges tentatively, and to understand all things relative to the context in which they were created. This positioning engenders a sense of pluralism, which has been noted by both critics and proponents alike (Gergen, 1998; Harre, 1992).

Pluralism

Pluralism has become a concerning idea in political, moral, and spiritual spheres. Most often, the term carries with it negative undertones leading many to believe the essence of pluralism to be the absence of any guiding values or principles within society or culture, and that essentially, everything and anything goes (Gergen, 1998). Despite the documentation of these concerns in family therapy literature (Harre, 1992; Pilgrim, 2000), there are also alternative ways to understand pluralism within the therapeutic frame, alternatives which offer less nihilistic meanings (Gergen, 2009). The

underpinnings of pluralism in postmodern and social constructionist approaches do not

necessarily support a turn from all that is moral or good. Instead, pluralism, as it is

concerned with these two connected theoretical and philosophical paradigms, supports

understanding that there are multiple and varied morals and goods, and that we ought not

be bound by any particular one (Gergen, 2009). Essentially, this form of pluralism

invites clinicians into the co-creation of meanings and futures, where client and clinician

"speak together, listen to new voices, raise questions, ponder alternatives, and play at the

edges of common sense" (Gergen, 2009, p. 5). It is from this perspective then, that

family therapists are drawn and encouraged into holding client perspectives as just as

integral as the clinicians, and to view pathology as just one way of defining problems

amongst many other definitions. In the present research, we understand a pluralistic

stance as one that is concerned with honoring clients and the perspectives, meanings,

knowledge's and preferences each one brings to the therapeutic context.

Commonalities & Deviations Between Critical & Postmodern Paradigms

Before considering amodernism as a possible frame for bringing activism and

pluralism together, here we briefly summarize and highlight the specific commonalities

that we see critical and postmodern paradigms sharing as well as the various differences

we have observed. We believe this may be helpful in making clear the potential tensions

we have identified and that serve as the foundation of our research.

Commonalities

It can often be difficult to distinguish critical and postmodern approaches to

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therapy as stemming from differing paradigms. The reason for this is that they often

share similar therapeutic interests and reflect corresponding ideologies when it comes to

issues of social justice (Baber, 2009). Both critical and postmodern paradigms seek to

work against hierarchical, patriarchal and oppressive ways of thinking about and working

with families and individuals (Miller & Wieling, 2002), viewing people as dependant

upon context and problems as resulting from experiences that are discrepant with

dominant social discourses and norms (Dickerson, 2010).

Overall, both postmodern and critical paradigms challenge hierarchical

relationships between therapists and clients, seeking to combat oppressive social and

relational processes (Madsen, 2007; Almieda et al., 2008). In light of this, collaborative

efforts are highly regarded and efforts to deconstruct restrictive and pathologizing

dominant discourses are characteristics of both paradigms (Miller & Wieling, 2002).

These related practices create similar therapeutic goals, focusing on engaging with clients

in ways that allow them to locate their own voice, consider new and less confining

perspectives, and reconsider what they have often been told is "true" (McNamee &

Gergen, 1992; Miller & Wieling, 2002).

Deviations

While there are many aspects of critical and postmodern paradigms that appear

compatible (Baber, 2009; Dickerson, 2011), it is our perspective that the way each

paradigm positions and encourages therapists to approach clinical work is perhaps the

greatest difference between the two. As has been discussed, these two differing positions

of activism and pluralism reflect a core aspect of our research in this study, and contribute to incredibly distinct therapeutics environments.

The critical paradigm views problems as rooted in social causes, operating from the belief that because people are often unaware of how political processes and social structures shape their lives, therapists must actively assist clients to become aware of these larger realities. Taking a position of activism within the clinical context, which we believe is rooted in the critical paradigm, generally encourages therapists to actively pursue lines of inquiry that relate to social contexts of gender, race, sexuality, class, religion, and culture (Waldegrave, 2009; McDowell, 2005). The purpose of these actions often seem to be focused on helping clients see the connection between their circumstance and larger contextual issues that may be working to limit, restrict, and oppress them, thereby making problems difficult to overcome (Almeida et al., 2008). When clients do not appear to be readily accepting of these ideas and perspectives, therapists can, at times, appear to engage in practices of telling, teaching, or psycho educating clients so that they have more opportunities to come to understand the "real" nature of things and the "truth" about their problems.

In contrast to this, postmodern paradigms view social origins as one possible explanation for the existence of problems in clients' lives, and trust that clients know the most meaningful way to frame their problems, leaving therapists with the task of assisting clients in locating those perspectives. In light of this, a position of pluralism is encouraged, where therapists embrace varying ideas and different "truth" claims as all equally possible and dependent upon various individual and social contexts (Dickerson, 2011). This is to say that taking a stance of pluralism means that the therapist's way of

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seeing the world and making sense of human problems is one perspective to consider, but not the only perspective, nor the correct way of viewing and understanding people and their experiences (Gergen, 2009). In light of this, therapists aim to consider clients own perspectives with equal weight (Anderson, 2012), seeking to facilitate dialogues that allow individuals and families the space to utilize their inherent agency and to find their own solutions and alternatives (Madsen, 2007).

Amodernism: The Joining of Activism and Pluralism

Recognizing the possible tensions between an activist stance and a pluralist position is not unique to this study, nor is it a new point of inquiry in the field. In fact, there have been a number of clinicians, researchers and educators within the field of family therapy that have attempted to draw attention to these potentially disparate positions by highlighting what they have perceived to be varying theoretical tensions (Sanders, 1998; Pilgrim, 2000). However, within family therapy there doesn't appear to be literature that attempts to bring these potentially disparate positions together within a singular theoretical framework or that appears to adequately make provisions for both positions to coexist and be held with equal importance. As a result, our study turns to the discipline of sociology, where one French philosopher, Bruno Latour (1993), offers amodernism as a broader theoretical space for critical and postmodern paradigms to come together within the family therapy field.

In turning to Latour's work (1980; 2004), it is important to first comment on the nature of critique within the family therapy literature. As we have previously stated, critique has played an instrumental role in the continuing development of the marriage

and family therapy profession. And as we have also demonstrated, postmodernism has received numerous critiques for its perceived lack of attention to issues of injustice and various forms of social domination (Sanders, 1998; Pilgrim, 2000). These critiques have suggested that postmodernism's stance that knowledge and meaning are contextual, perspectival, and rooted in language, disable it from acknowledging and attending to the real effects of power and other forms of social control (Guilfoyle, 2003). In fact, postmodernism is not only critiqued within family therapy, but is also critiqued on broader levels for the sense of pluralism it is perceived as engendering (Eagle, 2003; Firth & Martens, 2008). Therefore, what we feel is unique about the writings of Latour (2004) is that he not only invites us to consider the effects of postmodernism, as much of the existing literature invites us to do, but also calls attention to our tradition of critique itself. In essence, Latour (2004) offers a critique of the critique in a way that does not seem to have been done in family therapy before.

Latour (2004) suggests that perhaps critique has "run out of steam" and that we ought to now "bring the sword of criticism to criticism itself." In the family therapy field, as well as many other arenas, we have used critique to render ourselves experts on the sources of problems in human life, explaining away all things as rooted in "economic infrastructure, fields of discourse, race, class, and gender" (Latour, 2004), indisputable matters of fact. However, in taking this position we potentially expose ourselves to the temptation of indulging in what Latour (2004) describes as the "feel good of the critical mind", which is to say that those assuming the position of the critical stance are always right, and all others are seen as naïve and in need of social education. This means that often, the critical stance might potentially lead therapists to disregard client

understandings of their problems, and see "behavior as entirely determined by action of powerful casualties coming from objective reality they don't see, but that (we), yes (we), the never sleeping critic, alone can see" (Latour, 2004). In respect to family therapy, this seems to reinforce the professional hierarchies and relational power processes that the critical lens was initially brought in to dismantle.

In terms of critical approaches calling for activism and postmodern approaches encouraging pluralism, Amodernism moves away from questioning which is right, and instead asks the question "Is an absolute distinction required between the two movements in order for both to remain effective?" For Latour (1993), rather than reinforcing the distinctions between activism and pluralism, amodernism lays a foundation for how they are able to theoretically coexist in a mutually beneficial relationship. Latour (1993) suggests "so long as we consider these two practices of translation and purification separately, we are truly modern" (p.245) and reveal that "we have never really left the old anthropological matrix (of scientism) behind" (p. 996). Soloweij (2010) contends that it is amodernism that will "add a little color by backing up and out of this false dichotomy" (p.5) of the critical and postmodern, conceptualizing amodernism not as the successor to postmodernism but as an entirely new field where we are able to "direct our attention simultaneously to the work of purification and the work of hybridization" (Latour, 1993, p.290). In other words, amodernism provides the frame in which we can hold to both an activist stance and a position of pluralism that values the multiplicity of things without experiencing epistemological contradiction or theoretical conflict.

For therapists, an amodernist approach justifies abstract thought and concrete action rather than privileging one over the other in the ways that critical and postmodern

theories often seem to do (Soloweij, 2010). Within this frame, therapists are more freely

able to consider the variety of influences and events that create a cultural movement or

idea (Soloweij, 2010), offering therapists a path to a much larger realm in which we are

better suited to refrain from forcing our efforts of action on to clients or proceeding with

too much caution due to a skeptical adherence to truth. Considering that amodernism

deploys both dimensions at once, it is offered as the broadest and most beneficial way in

which to understand the research questions we present: How do therapists negotiate and

navigate the potential tensions between a critical call to activism and a postmodern

position of pluralism? Therapists who are in the throws of bridging what can often feel

like a divide between the two are in what Latour (1993) defines as the "middle

kingdom…as vast as China, and as little known (p. 48).

Conclusion

Although critical and postmodern paradigms share a number of similarities, they

continue to have the potential to shape therapeutic processes in alternative, and

sometimes antagonistic, ways (Miller & Wieling, 2002). While we do not see either of

these philosophical stances of activism or pluralism as being inherently wrong, we do

acknowledge potentiality of problematic consequences when embracing one position in

isolation. For instance, taking an activist stance might privilege therapist knowledge

about social issues, possibly leading to clients feeling as though their own understanding

and perspective on how social concerns impact them are overlooked. Conversely,

embracing a purely pluralistic position may potentially lead to missing or remaining

silent on issues of injustice. So, in this study we build on Latour's (1993) concept of

amodernism, in which we are influenced by the idea that these positions do not have to be

inherently contradictory and embrace the possibility of generating a theoretical model for

how one is able to both attend to serious social concerns as well as honor client

perspectives and preferences.

CHAPTER THREE

REVIEW OF THE LITERATURE

It is clear from a perusal of the literature that the role and position of the therapist in the clinical encounter has been considered from a number of varying perspectives (Monk & Gehart, 2003; Almeida et al., 2008; White & Epston, 1990; Madsen, 2007; Anderson, 2007). As many seasoned, and even newly developing family therapists would attest, negotiating one's role as a clinician is a complex process.

Finding ways to attentively consider the impact of sociocultural and sociopolitical issues on client's lives and therapeutic processes can often be quite difficult. In attempts not to overlook social concerns, a number of practice models instruct therapists to position themselves as activist within the clinical context, explicitly challenging dominant discourses and actively working to dismantle varying systems of oppression (Almeida et al., 2008; McDowell, 2005: Williams, 2011). Other practice orientations emphasize therapists' roles as conversational partners (Anderson, 1997) and narrative editors (White & Epston, 1990), eliciting client's perspectives and honoring their knowledge and experience within clinical dialogues. These differing positions have gained growing attention in recent practice literature, although overall it remains fairly limited, which is why they serve as the focus of our current research. Again, we are interested in exploring how family therapists negotiate what might feel like a dual commitment to both activism and pluralism, which, under the current theoretical paradigms of family therapy, can often seem to be opposing theoretical and therapeutic positions (Miller & Weiling, 2002).

In reviewing professional family therapy journals we were unable to find research literature looking specifically at potential tensions between activism and pluralism. Instead, we discovered that much of the discussion around these positions is situated within theoretical and practice literature. Therefore, our goal in this literature review is to examine current theoretical and practice literature in order to better understand what the varying therapeutic positions look like in practice, identifying the stances and actions each approach advocates, with specific attention to how each model attends to sociocultural issues. We also share a number of questions that we feel this review raises and that we understand to highlight the potential gaps or tensions between critical and postmodern positions.

Critically Influenced Clinical Practice

In exploring family therapy literature on critical approaches to therapy, particularly models informed from critical feminism and critical race perspectives, it seems that motivation situates around dismantling systems of oppression and marginalization that fuel social injustice among particular groups within society. Likewise, these models appear to take seriously their responsibility to conduct therapy in ways that avoid helping clients better cope with these injustices, and instead, seek to empower individuals and families to live narratives of resistance, liberation and transformation. Additionally, in this section we will refer to a few models that situate their approach within social constructionism/postructuralism, and while we understand this to often suggest a more postmodern orientation, we are influenced by the idea that

whenever one promotes or "takes a stance" in the therapy room, it reflects a bent towards

social realism and critically informed therapeutic practice.

Critically Informed Therapeutic Approaches and Clinical Models

While critical approaches to practice take a variety of forms, a few prominent

ones are the Cultural Context Model (Almeida et al., 2008), the Just Family therapy

approach (Waldegrave, 1994) and critical multiculturalism (McDowell, 2005). In

Transformative Family Therapy, Almeida et al. (2008) describe the cultural context

model as an approach to therapy that pursues justice at varying systemic levels,

examining the role of privilege and power in perpetuating oppression and suffering, and

calling therapists to develop a critical consciousness that orients them towards

accountability.

Just therapy (Waldegrave & Tamasese, 1994; Waldegrave, 2005), as well as

critical multiculturalism (McDowell & Fang, 2007; McDowell, Storm, & York, 2007)

also operate from a critical lens, placing attention on sociopolitical realities that work to

maintain inequalities. An important component then of the critical multicultural

approach is "aimed at dismantling structures and discourses that reify dominant cultural

knowledge and further privilege the social positioning of those closest to the center"

(McDowell, 2005, p.1). In a similar fashion, just therapy seeks to relate therapeutic work

directly to political, social, and cultural structures that "depress, deprive and dehumanize

families" (Waldegrave, 1994).

As has been established, a call to activism is central to each of these approaches

on both the clinical (McDowell & Shelton, 2002; Almeida et al., 2008) and social level

(Waldegrave, 2005; Almeida et al., 2008). However, how family therapists actually work to practice this activism clinically and socially varies by approach. The cultural context model (Almeida et al., 2008) "places the connection between family and society at the center of therapeutic thinking and intervention…" (p.2) by "contextualizing the family's presenting crisis within larger crucibles of historical and contemporary public abuse toward marginalized groups" (p.5). From this perspective, problems are believed to be born of social conditions, and helping clients see the link between their problems and the larger context makes them aware of the "network of domination" inhibiting them, which then allows them to imagine a "framework for liberation". In order to help clients make these connections, family therapists are encouraged to "initiate social education respectfully yet matter-of-factly" (Almeida et al., 2008, p.28) to actively raise client consciousness about these social issues. Almeida et al. further articulates that these social justice therapists "intentionally ask questions and sequence events so that clients make a connection between their concerns and the distribution of power and privilege in their relationships" (p.28).

In the Just Therapy approach (Waldegrave & Tamasese, 1994) therapists also actively work to change the meaning of client problems by pointing out the social roots of their struggles. However, this seems to be done more through reflection and reframing than through active educational or consciousness raising efforts. For instance, when a family therapist working from the Just therapy approach gets referred a "multi-problem" family in continual need of housing, a just therapist might say "congratulations for having survived the housing crises; a crises not of your own making…but of the failure of economic and social planners to provide adequately for all their citizens" (Waldegrave &

Tamasese, 1994, p.96) which works to "directly challenge the failure meanings that so many poor families adopt" (Waldegrave, 2005, p.274).

Just therapists also work to make the effects of patriarchy explicit and visible, by "exposing the meanings men give to women, and helping them become self-conscious about their violence and to confront it" (Waldegrave & Tamasese, 1994, p.98). In terms of broader social change and activism, Waldegrave (2009), a founding member of the Just Therapy approach, suggests, "When therapists know that certain social and economic conditions prolong ill health, they should be active in creating public awareness concerning these issues…" (p. 272) by generating social policy recommendations at a federal level, arguing that making these efforts is ethically essential if we are to honor the clients we serve.

Similar to the cultural context model and the Just Therapy approach, other critical multicultural and social justice approaches also place importance on actively linking experiences of struggle and distress to the larger sociopolitical contexts (Beitin & Allen, 2005). However, a therapist's role is also understood as incorporating a broader level of political activism where "therapists must be equal in participation with those they seek to empower" (Beitin & Allen, 2005, p. 13). Similar to many of Waldegrave's (2009) suggestions about "doing the work" in the larger social arena, Beitin & Baber (2005) also call therapists to attend community events, offering their voices and perspectives on community panels and agencies, all of which are seen as ways to "join together to fight for social justice" (p.13).

While these approaches serve as broader frames from which to address issues of injustice in therapy, the literature also offers a few approaches applicable to specific

clinical issues and clientele. One such example is Socio-Emotional Relational therapy (SERT), a model used for working with couples (Knudson-Martin & Huenergardt, 2010). SERT conceptualizes therapy as a social intervention and frames the therapists' role as "in-session leadership that interrupts socio-cultural-based inequality" with the intention of fostering relational mutuality on varying levels (Knudson-Martin & Huenergardt, 2010, p. 381). The positioning of therapists as active and non neutral in therapy is informed by the underlying assumption that partners in heterosexual relationships begin from differing power positions, requiring therapists to be intentional in highlighting these taken-for-granted realities (Knudson-Martin, 2013). In light of this, a critical role of therapists in the SERT approach is to "recognize unequal relationship patterns and position their responses to interrupt the usual flow of power", encouraging partners who hold more power to initiate relational connection (Knudson-Martin & Huenergardt, 2010, p. 376) by actively "naming the power processes" taking place in relational exchanges (p.380).

Relational justice therapy (RJT) (Williams, 2011) is a direct offshoot of the SERT model and serves as a specific response to infidelity in couple relationships. Similar to the SERT model, RJT works to actively situate infidelity within power inequities resulting from socio-cultural processes that play out in heterosexual relationships, and understands taking a non-neutral stance as an ethical imperative and a necessity for achieving relational repair and healing. An initial goal of this approach is to create an "equitable foundation for healing", in which therapists are encouraged to "avoid colluding with the powerful partner's entitlement to define the problem" and also to "ask questions that create awareness of equality issues" (Williams, 2011, p. 519). The RJT

model (Williams, 2011) also advocates for therapists to actively "reframe the affair within the context of larger social processes" and "make power processes associated with the infidelity explicit" (p.519).

Remaining Questions and Curiosities

The literature above raises a number of questions about practice from a critically informed activist stance. One curiosity is whether some therapists identifying as postmodern in approach might actually be more aligned with positions in social realism, without fully understanding the potential implications of taking this position. Another question is, how do family therapists embracing an activist or critical stance in their work hold on to their client's preferences and hopes for their lives in the face of social explanations? In other words, how do these activist or critical therapists refrain from the many practices they critique, like interpretation, speculation, removing context, in their efforts of liberation?

Critical practice literature also raises a question about the kind of impact the activist stance may have on the therapeutic relationship. For instance, how does actively exposing sociocultural issues shape both therapist and client experiences within the clinical encounter? Esmiol, Knudson-Martin, & Delgado (2012) offer a three-stage process of how family therapy students might develop a contextual consciousness, which enables them to address sociocultural issues in clinical practice, but also highlight that "there is little research that examines the link between addressing larger contextual issues and outcomes" (p.586). A recent qualitative study presented at the 2013 Annual meeting for the American Family Therapy Academy, used Esmiol, Knudson-Martin & Delgado's

(2012) work as a jumping off point to better understand the impact of addressing social issues in therapy. After examining doctoral therapists reflections on in-session actions taken in direct relation to sociocultural issues, preliminary findings suggest that when family therapists take explicit or direct action to address critical and contextual issues in therapy, both therapists and clients sometimes seem to experience feelings of disconnection (White & Patrick, 2013). However, when therapists attune to these issues through interest and curiosity in the client's story, opportunities to dialogue about critical and contextual issues in more organic and fluid ways appear to open up and foster therapeutic connection. Ultimately, this study appears to show that "staying near" clients experiences may be important and raises further questions about whether this is also the experience of other therapists. It also raises questions as to whether or not current critical practices effectively facilitate and support this type of therapeutic *closeness.* In light of this, the literature appears to confirm that looking more closely at how these issues are navigated by family therapists is an important step forward.

Postmodern-Influenced Clinical Practice

Recent clinical literature rooted in postmodern practice paradigms demonstrates an awareness of the broad spectrum of sociocultural and sociopolitical issues impacting client experience (Fraenkel, 2006; Unger, 2010; Cleek, Wofsy, Boyd-Franklin, Mundy, & Howell, 2012). In fact, much of this practice literature conveys deep concern for the intimate nature of how these contexts influence, shape, and in some cases, create the difficulties that bring individuals, couples, and families to therapy (Gehart, 2012; Dickerson, 2013). Winslade (2009) even suggests that the growth of postmodern

practice models are a response to these shifting conditions in peoples lives, and that our work ought to direct focus on the places where we can have the most "critical impact".

In this section we present recent literature focusing specifically on postmodern practice models that express an awareness of larger contextual issue in order to investigate how these concerns are handled in therapy while maintaining congruency with a postmodern stance.

Postmodern-Informed Therapeutic Approaches and Clinical Models

Overall, the majority of postmodern practice approaches emphasize client voice and the need for considering multiple, and often times, non-dominant, perspectives in therapy (McNamee & Gergen, 1998). Likewise, most therapeutic approaches rooted in postmodernism seek to create collaborative relationships with clients in which clinical work takes shape through joint exploration and partnership (Anderson, 2012). Recovery oriented, relational, collaborative, and narrative practices are all examples of approaches situated within this postmodern paradigm, however, one of the ongoing questions about these approaches revolves around how they address sociocultural and sociopolitical issues like power and social justice (Guilfoyle, 2003; Sanders, 1998; Pilgrim, 2000).

Recovery-Oriented Care

Recovery oriented care is often conceptualized as an ecological framework (Onken, 2007) with four common elements: (1) person-centered, (2) exchange-centered, (3) community centered, and (4) re-authoring. Gehart (2012) describes the overall feel of recovery-oriented care as "a non-pathologizing, down-to-earth, and hopeful approach to

working with families with a member diagnosed with a severe mental illness" (p.440). Working from this model requires therapists to "listen to people and respect their choices", "help consumers find their voice and encourage involvement in advocacy activities", "involve people in all aspects of service planning", and "value assertiveness and independence as growth" (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009, p. 61). Practitioners must also "be grounded in an appreciation of the possibility of improvement in the persons condition" and staff need to "envision a future for the person beyond the role of 'mental patient" (Davidson et al., 2009, p.122). Another critical component of therapists work is to help clients map a landscape of recovery (Gehart, 2012). To do this, therapists work to map a person's sense of purpose by asking questions like "If your problems were totally resolved, what would you be doing with your life?" (Gehart, 2012, p. 446). Other areas therapists must help map are clients sense of belonging, intimacy, and hope. To paint a clearer picture of these aspects of clients experience, therapists are encouraged to ask questions such as "To whom do you think you matter most?" "Where do you feel you fit in most?" and "do you believe you can lead a normal life again?" (pp.447-448). Overall, therapists are responsible to "help identify possibilities for removing obstacles to the consumers having a meaningful, fulfilling life (Davidson et al., 2009).

The origins of recovery-oriented approaches are linked to social justice movements and practitioners working from this model are said to *actively* address prejudices experienced in relation to larger contextual factors such as ethnicity, race, religion, sexual orientation, SES, illness and/or disability status (Gehart, 2012). However it is difficult to locate a specific articulation of how this is done therapeutically. It does

seems possible that therapists duties, such as accompanying consumers on shopping trips, medical appointments and helping them navigate local transportation services are ways that social justice is practiced in action (Gehart, 2012), even if it isn't necessarily spoken about explicitly. Other hints about how possible experiences of prejudice, marginalization, and injustice are addressed seem to be connected to efforts to help consumers find their voice in the midst of recovery planning as well as facilitate engagement in advocacy activities (Davidson et al., 2009). Even in considering these efforts, it remains somewhat difficult to understand how the recovery-oriented model specifically attends to these issues or if they are ever talked about directly in the clinical conversation.

Collaborative and Relational Approaches

Postmodern collaborative and relational approaches speak about therapy in ways that communicate *wtihness,* a communal, collective and intimate way of being in relationships alongside clients (Hoffman, 2007). An "appreciative ally" is another way relational oriented therapists view their role, in which family therapists "focus on what is working in clients' lives and seek to support and elaborate on that" while also "continually search[ing] for elements of competence, connection, and hope in [their] work with families" (Madsen, 2007, p. 22). Anderson (2012) further articulates therapy as relational dialogue, an activity characterized by posturing or orienting, eliminating hierarchical divisions between "knower" and "not-knower", facilitating transformation for both client and practitioner. A therapist's role is characterized as a philosophical stance including aspects such as mutual inquiry, not-knowing, and relational expertise.

Family therapists are encouraged to be "hospitable and open to learning" positioning themselves as both a "temporary host and guest in the client's life" (Anderson, 2012, p.15). As a host, family therapists must make an effort to "communicate to the guest their special importance as a unique human being…whose stories are worth telling and hearing", while as a guest, "therapists are careful not to intrude" (Anderson, 2012, p.16). Therapists are also encouraged to offer responses as "a way of participating in the conversation" and should be "informed from inside the conversation and relate to what the client has said…not informed by what [therapists] think a client should talk about or how, nor by some perceived 'truth' about the client" (Anderson, 2012, p.16)

Anderson (2012) also acknowledges the impact of social, cultural, political, and economic conditions on contemporary society, however little is said about how these aspects of experience are attended to or spoken about within these relational dialogues. Nonetheless, Anderson (2012) does clearly emphasize that, as she understands it, therapeutic responsiveness from this relational and collaborative perspective is less about *what you do* and more about *how you are*. So, from within this frame of being, the therapist is a learner, refraining from privileging their knowing over the clients knowing and being careful "Not to maneuver the conversation by promoting or holding onto an idea, opinion, or line of inquiry with which the client does not resonate" (p.19). From a critical perspective, this stance has the potential for issues of justice to be overlooked. It is not clear how one might actively attend to sociopolitical and sociocultural concerns, whether they seem to overtly resonate with the client or not, and still maintain this collaborative and relationally responsive orientation. Are both possible? Or, do therapists have to choose one way of being at the expense of the other? We hope that our

research will be able to offer some idea of how family therapists are navigating this in their work.

Narrative Approaches

Narrative practices represent an aspect of postmodern work that has been more vocal about issues of power, privilege, and particularly patriarchy (White & Epston, 1990; Freedman and Combs, 1996). Dickerson (2013) suggests that patriarchy always serves as "background" for narrative therapists whether or not it is ever explicitly addressed in therapy. Other narratively informed family therapists, such as John Winslade (2009), recognize power's power to subjugate and to silence. He offers "tracing lines of flight" as one possible way therapists can work alongside clients to "investigate the possibilities for the creation of new and more satisfying lives and relationships" (Winslade, 2009, p. 333). When clients are experiencing difficulty or dealing with relational conflicts, therapists utilizing the idea of "lines of flight" work to make it "clear just which lines or power [are] entangling for them…[and] wonder about where the lines of flight [are] in relation to these circumstances" (Winslade, 2009, p. 339). Winslade (2009) suggest that identifying "lines of flight" can be further facilitated by "taking singular identifications and asking questions to introduce the differentiation and multiplicity in relation to these concepts" (p.341). This contrasts the perspective of working to expose lines of power, a practice that Winslade (2009) suggests has potential to dead end. Instead, Winslade (2009) suggests that "lines of flight" are about finding a direction, locating life in the presence of power, helping to "escape the places where lines of power squeeze out the sense of being alive" (p.344), ultimately allowing clients to

become something other that what they have ever been rather than more true to who they are.

Similar to Winslade's (2009) idea of "lines of flight", Dickerson's (2013) narrative/poststructural view of handling patriarchy, power and privilege in practice seeks to pursue the preferred values that already exist in couples' lives. While this practice approach appreciates potentials to replicate oppressive conditions and injustices within the therapeutic context, therapists refrain from directly confronting the ways patriarchy works or from challenging any member in particular (Dickerson, 2013). So, rather than mapping the negative effects of patriarchy, as many narrative practice models have traditionally done, Dickerson (2013) offers an alternative that works to highlight the ways in which couples have maneuvered around the reach of patriarchy. In doing this work therapists are encouraged to be sensitive to the "absent but implicit" by "attending to what is not being expressed but is lurking in the conversation" (Dickerson, 2013, p. 112). According to Dickerson (2013), the ability to attend to what is not being expressed requires therapists to hear the conversation from a position of "radical listening", where they listen for possible alternatives and to "hear the other side of singular descriptions" (p. 112).

A number of questions seem to remain unaddressed in narrative practice. For instance, could Dickerson's (2013) focus on patriarchy potentially blind family therapists to other considerations? And, is it possible that a therapist who makes a decision to view problems through a dominant lens has stepped out of a poststructuralist position and into one of social realism? Also, how does the poststructuralist-minded therapist justify this interpretation of a problem or problems when a central tenet of poststructuralist therapy is

that not just people, but problems can have numerous interpretations (Madigan, 2011)?

These questions highlight possible areas of tension between critical and postmodern

influences, and seem to render the proposed research question of this study as having

significant pertinence to the future development of theory and practice in our field.

Remaining Questions and Curiosities

Despite the fact that these recent practice approaches communicate awareness

about how sociopolitical and sociocultural concerns affect and shape client experience;

there appear to be gaps in the postmodern clinical conversation around the ways in which

they are attended to or the potential consequences of not being more directly attentive to

them. Similarly, there seems to be little discussion about instances in which a more

activist approach could be helpful, or how a therapist who might want to be committed to

both a critical activist and a postmodern clinical orientation might do so, what it might

look like, or whether it is even possible within the existing theoretical frameworks the

field of family therapy currently operates from. Considering these areas where dialogue

appears limited, there is a need to explore how family therapists negotiate potential

tensions between critical and postmodern influences while attempting to maintain

commitments to both paradigms.

Pursuing the Both/And

We explored practice literature for articles directly articulating efforts to work

from critical and postmodern models, but were unable to locate any using these terms.

What we did find, however, was an article discussing the concept of responsive

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persistence (Sutherland, Turner, & Deinhart, 2012). The foundational question underlying the concept of responsive persistence (Sutherland, et al., 2012) is: How can it be possible to be persistently influential while also remaining collaborative in clinical work? Sutherland et al. (2012) argue that this question has become particularly relevant considering that often times, collaboratively oriented therapists are viewed as neglecting to discuss how working collaboratively can be influential without becoming imposing or contributing to the creation of an environment that feels oppositional or unsafe for the client.

Sutherland et al. (2012) define responsiveness as therapists' behaviors that adjust to context and client responses, which "serves to make therapy salient to the client and to relate therapy content to client interests and preferences" (p. 2). Persistence is understood as "therapists flexibly staying a course they have chosen" (p. 3) despite responses along the way that might work to distract or cause therapists to veer off course. Initially, Sutherland et al. (2012) thought of these concepts as two distinct ways to engage in and facilitate therapy, however after reviewing much of the literature, they concluded that it was actually possible to be both responsive and persistent. For instance, they wondered if "being responsive to client's needs and preferences may also involve being persistently influential" (Sutherland et al., 2012, p. 3). Thus, Sutherland et al. (2012) formed the idea of responsive persistence, integrating both ways of being, suggesting to us that an activist stance and a pluralistic position might also have an integrative potential.

Responsive persistence is described as acknowledging "the importance of therapists persisting while making necessary adjustments along the way in light of clients

understandings and preferences, both displayed and communicated" (Sutherland et al., 2012, p. 2). Enacting responsive persistence involves persistently including clients, and being persistent in "eliciting not only their perspectives…but also their preferences for moving forward" (p. 10). Other aspects of enacting responsive persistence in therapy include "showing efforts at codeveloping explanations" and "continuing to offer [your] perspective, adjusting it in light of [client] responses" (p. 11-12). Overall, the authors convey that responsive persistence is not necessarily about "overcoming conversational obstacles but about knowing which conversational 'obstacles' are worth paying attention to as indicators that a shift or more intentional coordination or development of shared meaning may be warranted" (Sutherland et al., 2012, p. 11).

From our own examination, this concept appears to be the closest the literature comes to addressing the experience of tensions between varying therapeutic positions. While it does not speak directly to the potential tension between critical and postmodern practice, it is a potential "therapeutic resource to be utilized by those committed to honoring diversity and equality" (p. 15), helping to inform ways of taking action around serious social issues in therapy while also being mindful to remain open and respectful of clients' perspectives and personal desires for their lives. Additionally, we see responsive persistence to identify an area of needed professional conversation and dialogue. In fact, Sutherland et al. (2012) suggest there ought to be more conversation about these practices with therapists who work from postmodern, collaboratively oriented approaches, which supports the direction of our proposed study.

Conclusion

As the literature demonstrates, there is little guidance for therapists seeking to embody and operate from a shared commitment to both critical and postmodern influences. Aside from the concept of responsive persistence offered by Sutherland et al. (2012), professional and clinical conversations remain somewhat sparse about the integration of critical and postmodern aspects of practice. We imagine this to potentially leave a number of family therapists feeling forced to embrace one position over the other, even when doing so may feel incongruent with how they desire to approach therapy. Thus, we perceive the potential need for a new theoretical framework, utilizing concepts from the writings of Bruno Latour, and leading to a new practice model that would open up space for family therapists interested in working across the spectrum.

CHAPTER FOUR

METHOD

A qualitative research approach will be used to facilitate our exploration of ways in which therapists navigate commitments to both critical and postmodern clinical models. The specific research method we will utilize is grounded theory. Grounded theory strives to produce an explanatory theory of how a particular process takes place (Echevarria-Doan & Tubbs, 2005), and can be thought of as a "systematic way to gather and analyze data for the purposes of generating theory" (Daly, 2007, p. 102).

With the goal of research focusing on theory development, research questions from a grounded theory perspective typically ask "how" things happen. Grounded theory methods have been articulated by a variety of authors and researchers, and subsequently situate the role of the researcher and data in differing ways. Some highlight the task of "discovering theory as emerging from data separate from the scientific observer" (Glaser & Strauss, 1967) while others view theory as constructed through the creative and interpretive process as researchers engage with and relate with the data (Charmaz, 2006). This later perspective (Charmaz, 2006), extending from a symbolic interactionist theoretical perspective, as opposed to the positivist roots of the former, most closely reflects our own perspective of grounded theory research and is the method in which we will aim to employ. By embracing Charmaz's approach we accept that data is arrived at interactively, meaning we understand there is a reciprocal process between researcher and participant that is shaped by temporal, cultural and social contexts (Mills, Bonner, & Francis, 2006). Additionally, employing Charmaz's perspective requires that we remain sensitive to "the tension that exists between developing a conceptual analysis of

participants' stories and still creating a sense of their presence in the final text" (Mills, Bonner, & Francis, 2006, p. 7).

Finally, there is also an aspect of Charmaz's approach that attends to how the researchers themselves are changed by the research process. I imagine that I may be impacted in ways that lead me to view theory more broadly, and to potentially understand tension as an inherent aspect of our work and not necessesarily something that must be eliminated. It is likely that I will come to better understand how I position myself in therapy and to what extent and in what ways I am comfortable embracing activism.

Self of the Researcher

In grounded theory research, especially methods rooted in a constructionist paradigm, it is important for the researcher to contextually locate themselves. This is especially important when considering the integral role researchers play in forming questions, constructing data, and developing theory. It is not possible for the researcher to engage in these methodological processes removed from one's own experiences, assumptions, biases, and intersecting social locations. Therefore, in this section I will attempt to highlight how my own personal experiences and beliefs have drawn me to this research question and make it a personally meaningful pursuit.

I am a white Italian-American female, and believe that positioning ideas, concepts, and identities as opposing or contradictory restricts us from exploring alternatives or envisioning more life giving possibilities. This perspective, greatly shaped through my own personal experiences, has brought me passionately close with our proposed research. Just like many other areas of my life in which I have felt tensions, I

have also felt caught between critical and postmodern paradigms. As a family therapist this has meant that I have struggled with discerning how to attend to sociocultural issues in ways that honor the full weight of injustice that many clients experience, but that does not privilege my knowledge or libratory agenda. And conversely, I have struggled with how to embrace the postmodern stance in a way that is not unresponsive to the serious nature of social issues, but that also remains open to and respectful of multiple truths and varying perspectives. It is from these experiences that I view our research as meaningful and important, and desire to help contribute to conversations within our field that facilitates movement away from what generally feels like a dichotomy between the critical and postmodern and into an exploration of alternatives for how we can adhere to and honor both of these paradigms simultaneously.

Methodology

Glaser & Strauss (1967) developed grounded theory as an inductive method, with the goal of producing an explanatory theory of how particular processes take place (Echevarria-Doan & Tubbs, 2005; Corbin & Strauss, 2008). This method is simultaneously systematic and flexible, seeing data as constructed through observation and interaction, rather than gathered or collected from key sources (Charmaz, 2006). Engaging in the ongoing and constant comparison of constructed data with evolving categories is what enables researchers to construct theories that are grounded in the data themselves (Daly, 2007; Charmaz, 2006). Utilizing this method will allow us to offer a theoretical explanation of how therapists negotiate the clinical tension arising from commitments to both critical and postmodern paradigms.

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Participant Selection

Because grounded theory is specifically designed to generate and construct explanatory theories, it makes sense that theoretical sampling would be a core and guiding principle of this qualitative approach (Glaser, 1998). Theoretical sampling is a process of data collection that is highly concept driven (Glaser & Strauss, 1967), allowing researchers to explore concepts that have direct relevance to the specific research question being pursued (Corbin & Strauss, 2008). In this case, we are particularly interested in how family therapists negotiate the potential tension between clinical positions of activism and pluralism. Corbin & Strauss (2008) contend that theoretical sampling is particularly important when research seeks to venture into new terrain, as this study is attempting to do, as it is well equipped to allow for in depth explorations of emerging concepts and supports the efforts of discovery.

In general, theoretical sampling begins with the identification of participants based on their relevance to the specific topic or concept of inquiry (Daly, 2007). Both the research question and the researchers' a priori assumptions about the nature of the theory being generated determine participant's relevance to the research topic (Glaser & Strauss, 1967). As the research study begins to take shape, the collection of data and its analysis take place concurrently. For example, data collection and analysis is not a stepwise or linear process, rather, researchers analyze the data as it is gathered, allowing subsequent data to continually be informed by the discoveries made in previous analyses (Corbin & Strauss, 2008).

As we step into this new territory, and attempt to articulate a bridge between critical and postmodern approaches to therapy, we will interview family therapists, which

we define as those who identify as systems/relational therapists, who have demonstrated an awareness of the tensions between the two paradigms. The selection process will occur in two distinct phases. In our initial selection phase, inclusion criteria will require that potential family therapist participants' have made contributions to professional and academic literature regarding the tension between critical and postmodern paradigms or work from therapeutic models that attempt to negotiate the tension in clinical practice. We imagine these participants will likely be of a more "expert" level in the field, meaning their work is more widely known and utilized in the field. We will begin sampling through the American Family Therapy Academy, a professional organization committed to advancing family centered theory and practice, influenced by postmodern and social constructionist ideas as well as issues of equality, social responsibility and justice.

During the secondary selection phase we will be reliant upon the "expert" participants to help generate a snowball sample of potential family therapist participants that may not necessarily be regarded as "experts" in the field, but that are identified by our "expert" participants as clinicians who are doing clinical work within the space between critical and postmodern paradigms. We hope that this will increase our ability to obtain participants locally and nationally. Aside from a recommendation from our "expert" participants, additional inclusion criteria for this second phase requires that these participants identify as working from both critical and postmodern ideas, identify as family therapists, and are either a licensed mental health provider or intern level family therapist currently enrolled in a doctoral program for clinical social work, psychology, or marriage and family therapy.

The number of participants needed for a qualitative research approach using grounded theory methodology depends upon theoretical saturation, which occurs when new interviews no longer contribute original ideas or concepts to the development of the grounded theory (Charmaz, 2006). We anticipate it will take from between 12-18 interviews in order for us to reach theoretical saturation.

By interviewing these individuals we believe we will be able to get a sense of how family therapists are actually negotiating the often-conflicting relationship between activism and pluralism in clinical work, and can begin to piece together a theoretical explanation for how this is done. Because of our own commitment and resonance with postmodern practice, we not only place important emphasis on the kinds of questions we will ask, but also how we ask these questions and engage with participants. Conversely, we are not only interested in the content of participants' answers, but how they talk about these issues. This is important because we understand all language and meaning as taking shape within relationships. So, while verbal responses are an important aspect of the interview, how participants engage relationally in the interview is equally valuable because the participant-researcher relationship shapes how responses are constructed.

Potential participants will be contacted via email or telephone, at which time the purpose and procedures of this dissertation research will be made clear to them. During this initial contact with potential participants, the research team will make sure that each one is given the opportunity to ask questions about the research as well as raise any concerns they may have in regards to their participation. Those who feel the research resonates with their own values and interests and express interest in participating in the study will sign an informed consent document that further details the purpose of the

study, what is expected of participants, the risks and benefits, and how confidentiality will be maintained. Because family therapists may be participating in the study from a considerable distance geographically, consent forms will be delivered via email, fax, or standard mail, depending upon what is most convenient to the participant. In cases where researchers and participants reside within similar geographical locations, consents will be reviewed and signed in person at the time of the interview.

The research team, which includes the primary investigator and one doctoral level research assistant, will conduct face-to-face interviews in person or through skype. However, for those unable to participate in face-to-face interviews, telephone interviews will be utilized so as not to disqualify any potential participant on the basis of location or web access. Face-to-face interviews will be held in a location of the participant's choosing, with the primary research interview projected to take anywhere from 60 to 90 minutes, and a follow-up interview of about 10 to 15 minutes in length. For in person face-to-face interviews, it is possible that these could take place in participants' location of work, at their home, or in a public location of their choosing such as a restaurant, coffee shop, or local library. Likewise, face-to-face interviews conducted via skype may also take place in a variety of locations in order to accommodate what is most convenient for each participant. A digital audio recording device will be used to capture data from each interview, which will later be transcribed. In addition to audio data, the research team will also keep interview notes, jotting down information about how participants talk about the issues raised in the interview. For instance, researchers will note the tone with which participants offer an answer, whether responses are generated quickly or take more

time to be formulated. We will also try to attune to whether participants appear hesitant and unsure, clear and confident, or a mixture of both.

In order to maintain the confidentiality of each participant, all digital audio files will be kept in a locked box to which only the primary investigator and one research assistant will have access. In addition, as each audio file is transcribed to a text document, all personal identifiers, including participant name, location of interview and date of interview will be removed from all files. In order to organize and keep track of the interviews, each transcription will be given a number. Participants will also be followed up with in order to check whether there is any information they shared in the interview that could potentially reveal their involvement in the study and that they would like to have omitted from their transcript or kept from inclusion in the analysis.

Data Creation

Questions situated within a grounded theory method are process-oriented, generally beginning more open-ended, broad and flexible, and then becoming increasingly focused and specific as researchers simultaneously engage in analytic processes (Echevarria-Doan & Tubbs, 2005). Furthermore, the research team has constructed and will utilize an open-ended interview guide that will broadly explore how family therapists engage in negotiations between taking an activist stance and one that holds each perspective as equally valuable and worth considering. We will utilize an Amodern lens to frame and shape probes that will explore in greater detail the specific ways in which family therapists relationally situate themselves to attend to the impact of

socio-political issues and concerns while also being careful to not privilege their own meaning or agenda over the clients understandings and preferences.

The full interview guide can be located in (Appendix A). Some examples of the questions that compose the interview guide are: How do you define your stance in the therapeutic process? Probes that will be utilized to expand participant responses include: How do you manage your theoretical stance to avoid selective listening? How do you manage your own biases/critical positions in the therapeutic process? How do you communicate biases/critical positions in the therapeutic process? What position do you take in therapy when problems seem to be of a more serious nature? Other questions in the interview guide will focus on how therapists conceptualize problems: Where do you find the origins of problems people bring to therapy? Probes to open up this specific area include: How do you approach the therapeutic process when problems appear to be attached to discourse? How do you make culture bound problems visible in your therapeutic process? The interview guide also contains questions about therapists' beliefs and ideas about change, for example questions in this section include: How do you believe change happens? Possible probes are: How might you know if your clients are achieving progress? How would you define successful therapy?

We will also conduct follow-up interviews with participants to assess how the interview itself affected them. The follow-up interview guide can be located in (Appendix B). Because our interest in this short 10 to 15 minute interview is to invite therapists to share how they were impacted, we ask the following questions: How did the interview affect your practice and your thinking about your practice? Since our

conversation, have you noticed any changes in your practice or in the way you are thinking about issues related to clinical process?

Data Analysis

The goal of using grounded theory is to inductively develop theory around how family therapists not only navigate the tensions between critical and postmodern therapeutic positions of activism and pluralism, but how they integrate them into a coherent approach that sees the necessary value of both as opposed to conceptualizing them as disparate. In addition, we hope to be able to construct a map for practice that can be utilized by other clinicians who share the similar commitment to critical and postmodern ideas, but that struggle with how to honor both in their clinical practice. The research team will employ the coding method originally developed by Corbin & Strauss (2008), and while our theoretical framework will inform the analytic process, we begin with no predetermined categories. Additionally, like Charmaz (2006), the research team acknowledges and understands that we play an active role in shaping and constructing data and theory, especially considering "we are part of the world and the data we collect" (p.11). Therefore, it is important to express that the analysis of the research team is an interpretive picture of how we understand family therapists to negotiate their dual commitment to critical and postmodern paradigms in clinical practice.

While data analysis commences from the time the initial interview begins, more systematic analyses will take place as each interview is transcribed into a word document. Once all interviews have been transcribed, the research team will begin initial coding with a line-by-line analysis. In grounded theory research, line-by-line coding literally

means going through the transcripts line-by-line and naming concepts and themes. For example, if a participant were to say "When I sense a client's difficulty might be connected to current sociopolitical conditions, I try to offer this idea as one way of understanding it, but I always try to be careful to leave open the possibility for them to express an alternative understanding, and then give that as much consideration as my own" We might code this as "Therapist shows attention to critical issue, but remains sensitive to varying perspectives." Another example might be if a therapist stated, "Generally, I place most of my effort in remaining open to multiple ways of understanding client problems, but when clients bring issues into therapy that reflect serious social injustices, I take a strong stance and actively try to help the client connect their experience with their social context." We might code a response like this as "Therapist alternates between stance of pluralism and activism based on type of clinical issue presented."

Line-by-line coding is a beneficial place to begin because it helps keep the researcher "open to the data and to see nuances in it…and helps to refocus later interviews" (Charmaz, 2006, p. 20). Once the initial line-by-line coding has been done, the research team will transition to focused coding. Focused coding is generally the second phase of coding in grounded theory research and reflects more directed and conceptual codes. In this phase decisions are made about "initial codes that make the most analytic sense to categorize your data incisively and completely" (Charmaz, 2006, p.23). As the coding process becomes increasingly focused, axial coding follows. Axial coding occurs as the researcher relates categories to subcategories, focusing in on the specific properties and dimensions of a category and working to bring the data together

again. Theoretical coding represents the final stages of coding and "moves your analytic story in a theoretical direction" (Charmaz, 2006, p.63). Moving our analysis in a theoretical direction means that we will be attempting to highlight and refine the relationships between categories (Strauss & Corbin, 1998), so that a working theory of how therapists maintain a dual commitment between critical and postmodern paradigms becomes more evident.

While coding and constructing the data, the research team will utilize the constant comparison method that is central to grounded theory research. This means that review of all transcriptions will be cyclical and ongoing, with the research team looking for similarities and differences as they compare codes within and across transcripts, making connections where appropriate. While we are engaged in this process, the research team will be writing memos about how we understand and are beginning to make conceptual sense of the data. Memos are an essential component in the analysis process because it "frees you to explore your ideas about your categories" and "fosters developing and preserving your natural voice" (Charmaz, 2006, p.84). Memos also support the constant comparative process by allowing you to continually make comparisons throughout the data and integrate categories and further distinguish their relationships.

Trustworthiness in Qualitative Inquiry

When conducting research from a qualitative approach, focus is most often shifted away from validity to whether or not a study and its results are trustworthy. Because qualitative research generally understands reality to be a construct of social and relational processes and embraces the "value-laden nature of research" (Denzin & Lincoln, 2008, p.

14), qualitative methods do not claim to be able to achieve validity in a positivist or objectivist sense, but rather, relies on the notion of trustworthiness as evidence of validity.

According to Charmaz's (2008) constructionist approach to grounded theory, the main concepts contributing to trustworthiness include credibility, originality, resonance, and usefulness (p. 182). Credibility refers to whether or not the research demonstrates strong logical links between data and analysis, and "provides enough evidence for your claims to allow the reader to form an independent assessment-and agree with your claims" (Charmaz, 2006, p.182). Originality requires the research to have social and theoretical significance, offering fresh insights and new conceptual renderings of established ideas (Charmaz, 2006). In order for the research to be considered to have achieved resonance, the study should make sense to participants or readers who find themselves in similar tensions between critical and postmodern paradigms, while also adequately portraying the fullness of the studied experience (Charmaz, 2006). Finally, usefulness is determined through whether or not the analysis generates theory that people can utilize and employ in their day-to-day life, and that it has contributed to the advancement of knowledge in the specific area studied (Charmaz, 2006).

One of the ways that we have designed our study to exemplify trustworthiness includes having both the primary researcher and research assistant conduct participant interviews as well as code transcripts. Researchers will also meet with the dissertation chair to discuss emerging codes and theory from alternative perspectives. We see this as contributing to trustworthiness by making sure questions are being asked and shaped from differing perspectives and that coding processes will also not be conducted from a

singular lens or perspective. We will also be actively sharing preliminary analytic categories with participants via email to access their feedback and to assess whether or not the theory we are constructing resonates with their experience.

Another integral aspect of trustworthiness in qualitative research is researcher reflexivity. This is especially important when considering that researchers bring their own "personal biography", values, biases, and interests, to the specified field of study. Because of this it is important to be keenly aware that one constructs and interprets data from unique locations embedded within class, gender, racial, and cultural perspectives. Daly (2007) describes this reflexive practice in research as "examining and monitoring the role that we play in shaping the research outcome" (p.189). The benefit of posturing ourselves in this reflexive way is that we become open to examining our prejudices and political positions, acknowledging the ways in which these values and interests shape the assumptions informing our inquiry. Daly (2007) suggests that engaging in reflexivity is a strategy by which we can enhance objectivity, however, we understand engaging in reflexivity as a way to be increasingly transparent in our analysis rather than achieving objectivity. This means that throughout the data creation process we will be actively looking at our emerging theory, asking ourselves how our perspective and theoretical lens are shaping what we see, notice, and maintain focus on. Questions that will be important to ask ourselves in this process include "What other ways could we understand or look at this?" and "how might our theoretical frame make it difficult for us to see something else than what we do?" An important way we will maintain reflexivity throughout the research process will be through writing analytic memos and engaging in dialogue with the research team. Making these efforts and being transparent and accountable to our

own perspectives will help to reinforce the trustworthiness of our research and our resulting theory.

Results

The hope and goal of this proposed study is that it will ultimately result in a theory that helps explain how family therapists simultaneously remain committed to positions of activism and pluralism. We hope this theory is able to articulate the processes by which these family therapists have arrived at positions that allow them to honor both efforts in their clinical practice. In addition, we are looking forward to this study to result in the generation of new ways of thinking about tensions between the critical and postmodern that free us from being trapped within the dichotomy of the two. Finally, we hope to be able to develop a map of practice that will help guide other family therapists who are interested in honoring both the critical and postmodern in their clinical work but that often feel defeated in doing so by the dominant discourses in the field that position the two paradigms as conflicting and disparate.

Limitations

While this study proposes to examine and articulate an explanatory theory for how family therapists negotiate tensions between taking a critically informed activist stance and maintaining a postmodern posture that honors all perspectives in clinical practice, we are not directly analyzing clinical processes. In other words, our theory will not reflect what we observe happening in the therapeutic exchange; rather, our theory will be grounded in data constructed through participant interviews; what identified therapists

tell us about what they do and why, and raises the question of whether therapists can actually know what it is they are doing in real-time clinical sessions. This means the resulting theory can only go so far and will not directly reflect how family therapists are actually negotiating these tensions in real-time clinical sessions, which we acknowledge as the primary limitation of this study.

An additional limitation we foresee with this study is directly related to the one discussed above. Because our hope is to develop a practice map from the resulting theory we construct, we acknowledge that, unfortunately, this map will not be directly related to actual practice, but to reports from family therapists about their practice. Because of this we realize that there is a potential that the practice map may not accurately reflect the practical aspects of employing this kind of approach in clinical sessions. It may also not adequately solve or remedy the difficulties family therapists experience around their dual commitments to critical and postmodern ideas.

A final limitation that we have considered relates to our methods for participant selection. Because we are going to be heavily reliant on the snowball sampling technique, we are aware that there will potentially be a variety of family therapists that we neglect to interview, not for reasons of intentional exclusion, but simply because those who we interview initially may not be aware of these therapists' work. Along these same lines, it is also possible that those we interview and ask to help identify others we should speak with about this topic, may not understand the relationship between the critical and postmodern in the same way we have conceptualized it, and therefore, may not refer us to family therapists that we might perceive to be great contributors to our research.

Implications

Although there is considerable literature articulating critical approaches to therapy, like the cultural context model (Almeida, et al., 2008), critical multiculturalism (McDowell & Fang, 2007) and just therapy (Waldegrave & Tamasese, 1994), as well as postmodern approaches like narrative (White & Epston, 1990), collaborative and relational (Anderson & Gehart, 2007; Madsen, 2007; McNamee & Gergen, 1998), and solution focused therapies (Trepper, Dolan, McCollum, & Nelson, 2006), there still appears to be limited literature addressing clinical approaches informed by an integrated view of these two paradigms.

The existing literature that does discuss the relationship between the critical and postmodern paradigms often does so in conflicting ways. For instance, some of the literature addresses the two paradigms as though they are theoretically compatible (Dickerson, 2011), while others write about them in a polarizing fashion, describing them as contradictory and disparate (Sanders, 1998; Pilgrim, 2000). Our research operates from the assumption that critical and postmodern paradigms are neither theoretically compatible nor incompatible. We understand that this is clearly a confusing position, but believe this confusion only occurs in response to current theoretical and clinical discourses that characterize our understandings of these two paradigms in contradictory ways. It is this dilemma we seek to attend to by contributing a broader way of understanding and orienting to the relationship between critical and postmodern paradigms by offering Amodernism (Latour, 1980).

We see Amodernism as a possible alternative for how we can envision these two paradigms as friends instead of foes. It appears to provide a new model for explaining

knowledge that has the ability to bypass epistemic dualisms and paradoxes that have

shaped the discrepant discourses currently surrounding critical and postmodern

paradigms (Ward, 1996). As critical theories claim "truth" around positions of activism,

and postmodernism claims "truth" around positions of pluralism, we become stuck in a

condition where "Truth is either on or off. We either have it or we don't" (Ward, 1996,

p.111), while amodernism offers a space for both to be "truth". More broadly,

amodernism invites us to explore a new terrain where "at some points we have truth, at

other points we have partial truths, and at other times, we do not have truth at all" (Ward,

1996, p.111).

We hope that the resulting theory constructed from perspectives of family

therapists working under the influence of critical and postmodern paradigms will help to

articulate how family therapists currently negotiate the existing tensions between

positions of activism and pluralism. Additionally, we hope that a practical and tangible

outgrowth of this theory is the development of a variety of maps for practice that can be

utilized by other family therapists desiring to honor both commitments in their work. Our

intention is that these practice maps will offer family therapists a set of guidelines for

how to effectively maintain their clinical commitments to both paradigms, which will

include specific suggestions for how to actively attend to issues of justice in therapy

while remaining close to the clients experience, perspective, and preferences.

Ultimately, we hope to help supervisors and educators better understand the

practical clinical implications of these two perspectives and the various ways they may be

able to navigate within or between them, particularly in relation to issues of social justice.

By better equipping supervisors and educators, we imagine they will be better able to

assist developing therapists to thoughtfully think through the different implications of various clinical stances, and reflectively consider how they desire to positions themselves in their own work.

A larger contribution we hope to make through this research is the development of new avenues of theoretical inquiry leading to dimensions beyond where we have previously been, inviting us to enter "a common search for an originary or universal ethic, one to which all may cling and which will enable us to transcend our animosities" (Gergen, 2007, p. 371) Ultimately, we hope that our theory will facilitate an expansion to the Amodern, opening up perspectives for research, clinical practice, and new theory development within the family therapy field that moves away from "a contentious politics" between the critical and postmodern (Gergen, 1998).

CHAPTER SIX

NAVIGATING CRITICAL THEORY AND POSTMODERNISM

IN FAMILY THERAPY

(Publishable Paper)

Abstract

The field of family therapy continues to encourage commitment to diversity and social justice, despite varying ideas about how to attentively consider these issues in therapy. Critical models have advocated for activism and postmodern models have encouraged pluralism. However, there has been a lack of clarity on how activism and pluralism connect, often engendering the sense that critical and postmodern practices may be disparate. This qualitative analysis drew on interviews with fifteen therapists known for their work from both critical and postmodern perspectives, revealing a connection between paradigms. We found that these therapists generally engage in a set of shared constructionist practices while also demonstrating two distinct forms of activism: counter activism and collaborative activism. Ultimately, decisions made about how to navigate critical and postmodern influences were connected to how therapists viewed ethics, and in what ways they were comfortable using their therapeutic power.

Keywords: Postmodernism, critical theory, collaborative activism, social justice

Navigating varying perspectives concerning the role and position of therapists in the clinical encounter is a complex process, particularly around activism (Monk & Gehart, 2003; Almeida et al., 2008; White & Epston, 1990; Madsen, 2007; Anderson & Gehart, 2007). While both critical theory and postmodernism promote attending to contextual issues, critically informed therapy approaches are typically seen as more social justice oriented, emphasizing activism, while many postmodern approaches are often viewed as lacking attention to larger social factors, and emphasize pluralism (Grant & Humphries, 2006; Miller, 2000). Though some therapists speak about navigating the space between (Miller & Weiling, 2002; Dickerson, 2013), exploring more nuanced understandings of how activism and pluralism intersect has proved difficult (Gergen, 1998; Pilgrim, 2000; Ramey & Grubb, 2009). As a result, there is little theoretical support or guidance for how to work from both a postmodern and critical paradigm. Thus, It is our goal to examine how therapists describe doing so.

Critical and Postmodern Clinical Practice Literature

Finding ways to attentively consider the impact of sociocultural and sociopolitical issues on client's lives and therapeutic processes is a growing concern for family therapists. In attempts to responsibly attend to these concerns, a number of practice models instruct therapists to position themselves as activists within the clinical context, explicitly challenging dominant discourses and dismantling systems of oppression (Almeida et al., 2008; McDowell, 2005: Williams, 2011), while alternative practice orientations emphasize therapists' roles as conversational partners (Anderson, 1997) and narrative editors (White & Epston, 1990), eliciting client's perspectives and honoring

their knowledge and experience within clinical dialogues. How these varying stances blend is unclear, fueling our interest in exploring how family therapists negotiate commitments to both activism and pluralism, which often get positioned as opposing theoretical and therapeutic positions (Miller & Weiling, 2002).

Critically Informed Clinical Practice

Critically informed therapeutic approaches include models such as the Cultural Context Model (Almeida et al., 2008), the Just Family therapy approach (Waldegrave & Tamasese, 1994) and critical multiculturalism (McDowell, 2005). Overall, these approaches describe therapy as pursuing justice at varying systemic levels (McDowell & Shelton, 2002; Almeida et al., 2008), highlighting the social roots of clients' struggles (Waldegrave & Tamasese, 1994; Waldegrave, 2005) by actively linking experiences of struggle and distress to larger sociopolitical contexts (Beitin & Allen, 2005), and "dismantling structures and discourses that reify dominant cultural knowledge and further privilege the social positioning of those closest to the center" (McDowell, 2005, p.1). In general, each of these critically informed practice approaches frame therapy itself as "social intervention" (Knudson-Martin & Huenergardt, 2010; Williams, 2011), relating therapeutic work directly to political, social, and cultural structures that "depress, deprive and dehumanize families" (Waldegrave, 1994), and maintain inequalities (McDowell & Fang, 2007; McDowell, Storm, & York, 2007).

The activist stance prescribed by these approaches leads family therapists to "place the connection between family and society at the center of therapeutic thinking and intervention" (p.2) by "contextualizing families presenting crises within larger

crucibles of historical and contemporary public abuse toward marginalized groups" (p.5). Family therapists are trained to "initiate social education respectfully yet matter-of-factly" (Almeida et al., 2008, p.28), actively raising client consciousness about social issues, and "directly challenge" meanings many clients adopt (Waldegrave, 2005, p.274). Concurrently, this activist stance encourages therapists to focus on "interrupting socio-cultural-based inequality" by "naming implicit power processes" (Knudson-Martin & Huenergardt, 2010; Knudson-Martin, 2013; Williams, 2011) embedded within various aspects of human relationships.

Postmodern-Influenced Clinical Practice

While postmodern practice paradigms demonstrate awareness of sociocultural and sociopolitical issues impacting client experience (Fraenkel, 2006; Unger, 2010; Cleek, Wofsy, Boyd-Franklin, Mundy, & Howell, 2012; Gehart, 2012; Dickerson, 2013), they primarily theorize about emphasizing client voice and the need for considering plural, and often times, non-dominant and conflicting perspectives in therapy (McNamee & Gergen, 1999). Postmodern approaches seeking to create collaborative relationships with clients in which clinical work takes shape through joint exploration and partnership (Anderson, 2012) include recovery oriented, relational, collaborative, and narrative practices. Overall, these approaches embrace similar ideology, framing therapy as a communal, collective and intimate way of being in relationships (Hoffman, 2002) that is "non-pathologizing" (Onken, 2007) and promotes ongoing relational dialogue between client and therapist (Anderson, 2012).

Postmodern practice approaches position therapists to "listen to people and

respect their choices" (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009, p. 61) acting as, what Madsen (2007, p.22) calls, an "appreciative ally." Conversational responses are immediately "informed from inside the conversation and relate to what the client has said…not informed by what [therapists] think a client should talk about or how, nor by some perceived 'truth' about the client" (Anderson, 2012, p.16). Therapists are learners, refraining from privileging their knowing over the clients knowing and being careful "Not to maneuver the conversation by promoting or holding onto an idea, opinion, or line of inquiry with which the client does not resonate" (p.19). Winslade (2009) suggests that another role of the therapist should focus on identifying "lines of flight" by "taking singular identifications and asking questions to introduce the differentiation and multiplicity in relation to these concepts" (p.341). Similarly, therapists working within a postmodern approach are encouraged to be sensitive to the "absent but implicit" by employing "radical listening" in order to "hear the other side of singular descriptions" (Dickerson, 2013, p. 112).

Purpose

In reviewing clinical practice literature, there is clearly little guidance for therapists seeking to embody a shared commitment to both critical and postmodern influences, and an absence of literature directly addressing the intersection of activism and pluralism. Literature informing therapeutic positions confirms that overall, activism is primarily attended to in critically oriented practice literature, and omitted, for the most part, from postmodern oriented practice literature. This seems to suggest that activism occurs in one specific way, when in practice, this may not be the case.

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Additionally, our review raises a number of questions and curiosities. For instance, critical practice literature tends not to discuss the kind of impact the activist stance may have on the therapeutic relationship, or how family therapists embracing an activist stance hold on to their client's preferences and hopes for their lives in the face of social explanations. On the other hand, postmodern practice literature does not directly discuss how serious social issues are attended to, or more importantly, what the potential consequences may be of not being more explicitly attentive to them (Guilfoyle, 2003; Sanders, 1998; Pilgrim, 2000). Thus, the purpose of this study is to develop grounded theory regarding how therapists make decisions to attend to critical issues while also maintaining plural perspectives.

Method

To explore how therapists explained their clinical choices around balancing commitments to both critical and postmodern ideas in clinical practice, we interviewed therapists specifically noted for their work in these areas and employed a qualitative grounded theory research approach (Corbin & Strauss, 2008). Employing grounded theory allowed us to develop a working theory of what influenced therapists' decisions around activism and pluralism (Echevarria-Doan & Tubbs, 2005). Additionally, we aligned with Charmaz's (2006) social constructionist approach to grounded theory, acknowledging that the constructed theory represents our own creative and interpretive process of engaging with the data (Charmaz, 2006).

Participants

Because grounded theory is designed to generate and construct explanatory theories, we utilized theoretical sampling, a process by which participants are directly identified and selected for their specific relevance to or knowledge on the topic, as a core guiding principle for our qualitative approach (Glaser, 1998). We determined theoretical sampling suited this study particularly well, as it supported our need to immediately focus in on therapists who were familiar with postmodern and critical influences and also had the capacity to speak about the various complexities in navigating the two (Corbin & Strauss, 2008; Glaser & Strauss, 1967).

Selection Process

Participants were selected based on their theoretical knowledge of and clinical work around postmodern and critical ideas. Our selection process occurred in two phases, with the first wave identifying therapists whose work was more readily accessible and easily identifiable, and the second wave identified through referral from first wave participants.

First Wave

We began by selecting therapists' we viewed to be "experts" in relation to postmodern and critical ideas. We defined "experts" as family therapists who demonstrated a history of engaging with both postmodern and critical ideas on a theoretical, clinical, and instructional basis. We determined their history of engagement and familiarity by examining the variety of presentations, articles, and educational books

therapists published, participated in, and or contributed to.   Each therapist was invited to participate in an interview in which they would be asked about how they attended to contextual issues while also honoring plurality. Overall, there were 9 therapists who participated in this first wave, which was comprised of 3 Caucasian males, 3 Caucasian females, 1 biracial female, 1 Latina female, and 1 East Indian female. .

Second Wave

During this second wave we relied upon "expert" participants to lead us to other family therapists negotiating critical and postmodern influences in their work, but that were less readily identifiable. However, it proved more difficult to secure the participation of these second wave therapists than originally anticipated, with only 2 second wave participants including 1 Caucasian female, and 1 Asian male.

Data Creation

Data was created through 60-minute interviews in conjunction with a short 15-minute follow-up interview about 2-4 weeks after. The primary researcher conducted eight of the initial interviews, while 3 were co-facilitated by the primary researcher and a research assistant. The primary researcher facilitated all follow-up interviews independently.

In the initial interview therapists were asked open-ended questions about when they first encountered critical and postmodern ideas and what subsequently led to their embracing them in their clinical work. For instance, we asked family therapists "How did critical/postmodern ideas come to be influential in your work?" Over the course of

the interview we became more focused (Echevarria-Doan & Tubbs, 2005), asking specific questions about how therapists managed these two influences in the moment-to moment process with clients, being especially interested in how therapists pursued critical ideas in therapy while still embracing plurality, "How do you pursue critical ideas when it appears the client may not resonate with how you are understanding things?" and conversely, how they embraced plurality without overlooking the very real impact of critical ideas on clients lives, "How do you assess whether following the clients lead means overlooking a context of injustice?"

Follow-up interviews were utilized to help researchers fill in gaps around remaining questions and curiosities. However, in light of our social constructionist approach, the most important aspect of follow up interviews was to investigate the impact the initial conversation had on their own thinking about critical and postmodern influences in their work. This revealed that many therapists had not previously been engaged in explicit conversation around these specific ideas, and welcomed the opportunity to do so.

Data Analysis

Our research team included one MFT doctoral candidate, a second year PhD MFT student, and one faculty advisor. When analyzing transcripts, we employed the coding method originally developed by Corbin & Strauss (2008), and like Charmaz (2006), acknowledged our active role in shaping and creating the data and theory, meaning we understand our findings as portraying just one interpretive picture of how family therapists negotiate both critical and postmodern influences in clinical practice.

Data analysis commenced from the time the first interview began that is, even during the initial conversation, we were already listening for and attempting to identify potential themes. As we facilitated more interviews and transcribed them, we engaged in more systematic coding. The primary researcher and the research assistant individually coded each of the interview transcripts, then met to compare codes and discuss relationships between codes. This process enabled us to begin comparing emerging themes across interviews and develop more cohesive ideas about how therapists were engaging in the navigation process. The primary researcher also regularly met with the faculty advisor to further expand and clarify our emerging theory.

Coding Process

We began the coding process with line-by-line coding, naming concepts and themes. For example, the statement "These ideas shape my work and it's an interesting issue; it's actually a really tricky issue" was coded as "the critical is nuanced." Line-by-line coding helped keep us "open to the data and to nuances in it…and helped to refocus later interviews" (Charmaz, 2006, p. 20).

Over time, we became increasingly focused in our coding, allowing us to create more direct and conceptual codes. For example, as we began to develop preliminary ideas about what our emerging theory was, we focused in on sections of transcripts that seemed to directly relate to these emerging themes, specifically selecting preliminary codes that made "the most analytic sense to categorize data incisively and completely" (Charmaz, 2006, p.23), one of which was the idea of ethical responsibility in relation to critical issues. This then became a focused code for therapists statements like, "Whether

it's patriarchy, power, or who gets to say what…I think it's up to me, as the therapist, to acknowledge those critical pieces and make them visible in some way."

Familiarity with these focused codes allowed us to begin examining the relationship between them, looking more closely at nuances and subcategories embedded within them, a process generally referred to axial coding. As we moved into the final theoretical coding phase, we focused our efforts on highlighting and refining the relationships between the categories (Strauss & Corbin, 1998), constructing an overall theory about what is involved as therapists negotiate commitments to both critical and postmodern influences in therapy.

Results

Exploring how family therapists navigate postmodern and critical influences in their clinical practice revealed notably similar ways in which therapists talked about their work, essentially describing a set of shared constructionist practices. However, there were also considerable divergences regarding how therapists operationalized therapeutic activism and positioned themselves in relation to it. Overall, we observed a spectrum of activism ranging from what we define on one end as counter activism, and collaborative activism on the other. Further, therapists expressed very clear reasons for their respective positions, which we saw as ultimately relating to therapists' understanding of clinical ethics and therapeutic power.

Therapists situated near the counter activism end of the spectrum perceive it to be their ethical role to utilize their therapeutic power to directly challenge sociopolitical and sociocultural contexts they see as negatively impacting client identities and relationship

dynamics. Another group of therapists situated more closely to collaborative activism see their ethical role as refraining from utilizing therapeutic power to define the origins of problems for clients. It is important to note that therapists positioned at either end of the activism spectrum were not fixed in these positions, but did convey an overall preference for one over the other. It is also crucial to note that there were a number of therapists who oscillated between counter activism and collaborative activism, never clearly expressing a concrete preference for one over the other. Therapists located in this middle space engage in activism in ways reflecting sensitivity to the uniqueness of each case, rather than maintaining a clear overarching position of activism. For instance, a Caucasian male poststructuralist therapist in this middle space, shares "I'm not opposed to using what I've learned about people and offering it to clients, but how you do it is critical." He expands on this with "every operation of power is different and complicated. It could go this way or that way, and I can't say for certain how I'll tend to that ahead of time." This reflects openness to embracing counter activism or collaborative activism at any given time, rather than stepping into the clinical space with a predetermined stance.

Shared Constructionist Practices

Because all the therapists we interviewed were sensitized to power and ethics in relation to larger sociopolitical contexts, and value collaboration and co-construction in the therapeutic process, they talk about their clinical work in a number of similar ways, including therapist transparency, staying experience near, and utilizing inquiry as intervention.

Therapist Transparency

In varying ways, every therapist describes being transparent with clients in the clinical process; that is, they make an effort to reveal to clients what informs certain questions or influences specific curiosities about particular contexts in client's lives. For instance, a Caucasian female poststructuralist therapist describes being forthcoming with a client when addressing race, "You know, if at first blush, someone says, 'you know, it's not about race', I'm going to be very transparent about why I even brought it up." This therapist also describes being intentional about situating her interest in race as coming from her own experience. A biracial female collaborative therapist suggests that when offering critical ideas, she too pursues transparency, stating "I want to have some transparency in that, in sharing other perspectives about what they are talking about."

Sharing the lens that shapes clinical practice is how a Caucasian upper-middle class heterosexual integrative therapist employs transparency, "I'll say that I come from a feminist perspective, and will let them know that there are things I will be suggesting and encouraging that will come out of that point of view." A female Latina feminist therapist who situates her work within a social constructionist frame says that sharing where she is coming from conceptually can be helpful, "There has to be some explanation sometimes about why I am saying what I am saying, and about why I am proposing what I am proposing." Overall, the reason for embracing transparency in clinical process occurs as a way for therapists to help orient clients to attending to larger sociopolitical contexts, and to also be responsible stewards of the knowledge they bring to the room and to avoid taking it for granted.

Inquiry as Intervention

Overall, most therapists' preference was to engage in inquiry as intervention rather than education or telling as intervention. This means therapists prefer to engage with clients more from their curiosity about the effects of certain contexts on clients' lives than from their expert knowledge about how those contexts actually do impact clients. A Caucasian male poststructuralist therapist describes his role as "asking really good questions, rather than having really good answers" and states that he always tries to make an effort to pose questions in ways that "provide enough fit for clients" and generally sees that "inquiry has more influence." A Caucasian female poststructuralist therapist suggests that inquiry forces reflection about things in ways that telling may not be able to, stating "Sometimes we can ask people what some of their cherished ideas are, things they don't want to disrupt, things that are really important and that they don't want to let go of. I find this a respectful, and even strategic, way to incite some reflection about those ideas."

Staying Experience Near

A majority of therapists talk about maintaining interest in staying as experience near as possible when attending to critical issues with clients. For these therapists' this means remaining close to the clients' description and experience of struggles or problems as opposed to what theory might tell them about how problems may be operating on clients. One Caucasian female social constructionist therapist talks about this in terms of emotion, stating "I see emotion as political, and I really want to first understand their emotional experience around the effects of these issues." Making an effort to "know

people outside of the influence of a particular problem in their lives" is another way a Caucasian male poststructuralist therapist describes staying experience near. A Caucasian female poststructuralist therapist acknowledges that her awareness of critical issues is "going to drive the kinds of questions asked" but that she attempts to "make them as experience near as possible," which at times means asking questions like "how did this come about? How did you hold onto this in the face of oppressive contexts? Who supported these ideas? Who supported other ideas?" She asks all these questions in an effort to "get closer to the client's own experiences." A female biracial collaborative therapist describes needing to "just sit together with the client for awhile, getting a sense of their experiences before talking about race or class." A Caucasian male poststructuralist therapist from outside the U.S clearly emphasizes that for him, pursuing critical ideas and questions "Is always about the clients experience and how they make sense of that experience."

Therapeutic Activism

In this study, therapeutic activism is defined as intentionally seeking to attend to and challenge oppressive sociopolitical contexts and processes. Each therapist describes engaging in therapeutic activism as being directly related to their ethical responsibility as clinicians. In fact, one Caucasian female social constructionist therapist refers to therapy itself as a "process of ethics" while another Caucasian female poststructuralist therapist suggests "it's my responsibility to make critical issues visible by bringing them up" and that "it is unethical not to." Another East Indian female collaborative therapist shares "It is my position that if we don't make these stories public, then we continue to make and

institute things like racism, which then continue on." However, there were striking differences between therapists in relation to the kind of therapeutic activism they preferred to embrace. One group of four therapists ultimately felt it to be their ethical responsibility to embrace what we term, counter activism, while another group of four therapists ultimately felt it their ethical responsibility to embrace what we call collaborative activism, and three therapists less certain about their distinct preference.

Counter Activism

Therapists embracing counter activism challenge dominant practices through consciousness raising and social education, foregrounding the sociocontextual lens they operate from. These therapists do not discount the importance of the therapist client relationship, but express a need to ultimately hold themselves accountable to disrupting what they see as oppressive and marginalizing discourses and social processes.

Social Education/Consciousness Raising

Therapists embracing counter activism describe engaging in what we define as consciousness raising practices and social education. These therapists are clear in their stance and hold strong convictions about these practices. A Latina female feminist therapist speaks about practices of social education and consciousness raising as often needing to be active and explicit, suggesting that not doing so may mean "You're making a choice to collude with oppression." Another Caucasian female social constructionist therapist emphasizes "It's important to me how the problem is framed, and well, if the female partner wants to frame it as her problem, I'm not willing to go there completely

with her in that." In light of this, this therapist focuses on "asking consciousness raising questions that begin to help clients see themselves as responding to societal messages, thereby opening up other possible ways of seeing their behavior." A Caucasian female poststructuralist therapist works to pose similar kinds of questions, for example she asks a male client, "what would it be like if you challenged the idea that you had to put work first, and that you could put family first?" We see this as directly making visible a male discourse around work and family, seeking to raise his consciousness about how this discourse came to influence the experience of difficulty in the couple relationship. The Latina female feminist therapist also describes an instance in which she "had to show the couple what was going on; and having to be really clear that what was going on was abusive."

Overall, these therapists place importance on needing to "help raise client's awareness, and help them make the connections" about the critical discourses impacting their lives. Concurrently, these therapists generally take the position that clients are unaware of the larger discourses operating on them, "These are things people have not thought about…they are oblivious, and you have to give them time to sit with it."

Privileging Critical Inquiry

Therapists engaging in counter activism describe privileging critical inquiry in ways that demonstrate an overall ethical responsibility to social context. Specifically, therapists in this group describe maintaining an overarching focus on uncovering and exposing critical issues over the course of therapy. For instance a Caucasian female poststructuralist therapist states, "It's the kind of thing I'm trying to do all the time,

exposing those ideas and challenging them." Maintaining an intentional focus on critical issues is a strategy that a Latina female feminist therapists uses to exert influence in the therapeutic process, "I do exert influence, and continue to ask the questions and gently continue to bring them back again and again, focusing on making those connections throughout the therapy process." These therapists also demonstrate privileging critical inquiry through "staying on track" and holding to a particular line of inquiry.

For instance, therapists were asked about how they handle situations in which clients might not seem to resonate with addressing critical issues in therapy. In response to this, a Caucasian female postructuralist therapist states, "I'm not going to abandon it. It may evolve, and become about something in addition to race, but I don't abandon that direction." The Latina female feminist therapist shares "I don't change my stance. We have to make the connections, and maybe that means bringing up the conversation in different ways, make different points in time, that has to be done, but I don't drop the issues." Further, she acknowledges "I may drop it initially, but I will bring it up again later. It's never gone."

Collaborative Activism

Therapists embracing collaborative activism challenge dominant practices by refraining from social education and consciousness raising, ultimately foregrounding the relational lens they operate from. Although it was their preference to challenge oppressive discourse through the therapeutic relationship itself, they do not view attending to critical issues as unimportant, clearly acknowledging that critical ideas are embedded within the way they see clients and the world. Rather, they embrace a greater

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concern for the immediate therapeutic relationship than needing to explicitly make clients aware of critical issues. Overall, these therapists demonstrate being very careful not to use the power inherent in the therapist role to impose or colonize.

Refrain From Social Education

Therapists privileging collaborative activism are clear in their stance of refraining from practices of social education and express strong opinions about it. A Caucasian male poststructuralist therapist suggests that taking a position of educating clients about critical issues may potentially replicate the same colonizing processes that he feels therapists are called to counter in the therapeutic relationship. "I have spent a lot of time trying to see the effects of critical issues, so I might see them when someone else won't. But to try and convince a client of them is potentially colonizing in a counter cultural sort of fashion." Another Caucasian female poststructuralist therapist expresses feeling that being educational doesn't lead to change, "I don't think change happens by me being educational about oppression with a client." In fact, the practice of "calling out" and "naming" oppressive discourses was described as "taking up a position of knowing better than the client does" which, according to this particular Caucasian male poststructuralist therapist from outside the US, ultimately "leaves the client in a position of having to resist the authority of the therapist rather than resisting the discourse, making it harder for them to actually challenge oppressive forces." Another Caucasian male poststructuralist therapist describes illuminating cultural ideas by "shining a light on them." However, he is very clear that doing so through educating the client or by telling them how they are being oppressed or oppressing another is "substituting one cultural specification for

another, which essentially rigidifies what we are working to destabilize."

Privileging Client Lead

Therapists engaging in collaborative activism embrace privileging client lead in a number of ways, demonstrating an overall ethical responsibility to the client. A biracial female collaborative therapist describes placing clients above critical ideas, emphasizing "people are at different places" in relation to critical issues, "for some it may be honoring to raise those issues, and for others it may be really painful" and that ultimately, "those issues may come up…but they won't be privileged over where the client is at." Similarly, meeting the client where they are is how an East Indian female collaborative therapist describes privileging client lead, "I understand the impact of social conditions. I'm aware of the discourses, but I am trying to meet the client where they are, and focusing on critical threads that I see, may or may not be part of what we do."

Other therapists talk about privileging client lead by engaging tentatively, particularly when bringing critical ideas into the therapeutic conversation. "I introduce those things, but where others are certain of them, I am more tentative," and "I try to raise some questions about it, but am open to the fact that I could be totally wrong." An East Indian female collaborative therapist describes privileging client lead by not necessarily maintaining an intentional overall focus on critical issues, "I realize the conversation may attend to critical ideas as they come up, but I don't do it from a place of intentionality."

Finally, privileging client lead was also means not pursuing a particular critical idea at the detriment of the immediate therapeutic relationship.   Our East Indian female collaborative therapist describes this in terms of what some therapists might perceive as

equality in a heterosexual relationship versus what the clients' preference may be, "I can't just say this is how it should be, that it should all be equal. I mean, do I believe in equality? YES, I do! But I also believe equality can come in lots of shapes and sizes. So I can't tell clients, *this* is how it should be."

Discussion

As we discuss specific implications of our findings, we want to mention a few limitations of our study. First, our results reflect therapists' self-reports about clinical work rather than actual review of their clinical sessions. Therefore, we can only make inferences about what therapists do based on their descriptions and what they identified as influencing those choices in clinical sessions. We also acknowledge that we have both a relatively small sample size and limited diversity. However, despite these limitations, we offer a number of interesting considerations for clinical practice, training and supervision, and directions for future research.

Clinical Practice

Although we were unable to directly examine clinical process, we kept therapy at the forefront of our minds when dialoguing with therapists about their clinical choices and actions. Because of this, our research offers strategies for two distinct aspects of clinical practice. First, we present a set of guidelines to help therapists actively account for their therapeutic power and discuss how to employ a collaborative activist stance.

Accounting for Therapist Power

Generally, postmodern and social constructionist literature offers ideas such as collaboration and respecting client knowledge as ways to account for therapeutic power (Anderson, 1997; Anderson & Gehart, 2007; Carchesio & Green, 2011; White & Epston, 1990). However, there has been less clarity about what exactly those efforts look like, and how to actively employ them (Miller & Wieling, 2002). Being deeply sensitized to issues of therapeutic power, we have often asked ourselves, "So, what do we do differently?", "What actions do we take?" and "What does it look like to be accountable?" We imagine other clinicians may sit with similar questions at times. The results of this study suggest a set of shared constructionist practices, including (a) therapist transparency, (b) inquiry as intervention, and (c) staying experience near, as clear and concrete strategies for actively being accountable to therapeutic power. Although we present these guidelines in relation to clinical practice, they can also be applied as tools to assist supervisors and educators in teaching and training efforts.

Employing therapist transparency in clinical work requires that therapists be willing to, (a) tell clients what informs lines of questioning and curiosity, (b) intentionally situate interests in social issues as originating from their own experience, and (c) be forthcoming with clients about the lens that shapes their distinctive approach. While much of the literature discusses transparency and self-disclosure interchangeably (Roberts, 2005; Jeffrey & Austin, 2007; Partridge, McCarry, & Wilson, 2007), we feel that the strategies we outline above about employing transparency, more closely resemble Anderson's (1997) idea of "suspending" therapist knowledge.

Utilizing inquiry as intervention involves (a) asking about the effects of social issues rather than telling about the effects of social issues, and (b) allowing oneself to be led more by curiosity than by theory. Finally, staying experience near requires (a) understanding the emotional experience of clients in relation to social issues, (b) remaining close to the way clients describe experiencing the impact of social issues rather than what theory tells us about how individuals are impacted, and (c) making an effort to ensure that questions attending to social issues directly relate to client experience.

Employing Collaborative Activism

Our research has expanded traditional ideas of activism to include collaborative activism. The most distinctive characteristics of embracing and employing a collaborative activist stance are privileging client lead and refraining from social education. While there are differing perspectives on what privileging client lead may mean (Anderson, 2012), privileging client lead in our study doesn't mean avoiding social issues altogether. Rather, it includes (a) placing clients above critical ideas, (b) being tentative when bringing social issues into therapeutic conversation, and (c) being willing to move away from critical issues for a time if pursuing them appears to be detrimental to the therapeutic relationship. In many ways, collaborative activism appears similar to Sutherland, Turner & Dienhart's (2012) and Sutherland, Dienhart, & Turner's (2012) concept of responsive persistence. Responsive persistence is described as being persistently influential, for instance, maintaining a particular line of inquiry, while simultaneously being responsive to client's knowledge and preference. Based on this description, responsive persistence and collaborative activism seem to be centered on a

similar question, which is how therapists can be influential while also privileging client process.

Training & Supervision

Overall there is a rich body of literature addressing how to train and supervise students around issues of social justice (Esmiol, Knudson-Martin, & Delgado, 2012; Almeida et al., 2008; McDowell, 2005; McDowell & Shelton, 2002; Ortiz & Jani, 2010). Unfortunately, however, literature addressing training and supervision models that combine social justice efforts and postmodern approaches is lacking. This study targets this current gap, and provides insights for how supervisors and educators can assist students and new therapists to navigate critical and postmodern influences for themselves. Two distinct strategies educators and supervisors can utilize include helping students and new therapists cultivate an ethical stance and determine how they are comfortable using their therapeutic power. We draw further support for this recommendation from what we learned from therapists in the follow-up interviews. Many shared they had not previously had the opportunity to have explicit conversations about the connections of critical and postmodern influences, and felt it was both valuable to articulate their positions and to think critically about the intersections of these two theories in their work. Therefore, cultivating conversations around ethics and power in these ways appears to be an important developmental step for students and new therapists.

Cultivating an Ethical Stance

Educators and Supervisors need to more intentionally consider the ways they can help students situate themselves ethically (Simmonds, 2007), particularly in light of activism. Historically, students and new therapists have often been engaged in ethical conversations around personal biases (Wall, Needham, Browning, & James, 1999), legal issues (Patten, Barnett, & Houlihan, 1991), and delivery of care with unique treatment populations (Bernal & Coolhart, 2012; Grimes & McElwain, 2008). However, there doesn't appear to be a connection in the literature between ethics and activism. Assisting students to identify what feels ethically comfortable entails (a) clearly emphasizing the connection between clinical choices and ones ethical stance, (b) cultivating ongoing conversations about power in the classroom and in supervision, and (c) strongly emphasizing that clinical efforts to account for ones power does not cancel out the effects of power. Clearly linking power to therapeutic decision-making will help demonstrate for students that taking stances with the intent of lessening ones power doesn't eliminate it, supporting the need to determine how to use power in the clinical space.

Determining How to Use Power

Helping students locate their preferred ethical stance is critical, and an integral step in doing so is to help students and new therapists decide how they are willing to use their therapeutic power. While the literature addressing power from varying perspectives is plentiful, such as the need to disrupt power structures and processes within client relationships (Blanton, & Vandergriff-Avery, 2001; Soo-Hoo, 2005; Esmiol, Knudson-Martin & Delgado, 2012) and accounting for therapist power within the clinical

relationship (Enns, 1988; Guilfoyle, 2005; Sutherland, 2007; Anderson, 1997), there is little guidance for how to actually use power clinically. Students need educators and supervisors to help them thoughtfully and reflexively think through the implications of various activist stances and the power connected to them. For instance, supervisors and educators must take the lead in asking students' difficult questions like, "In terms of being responsible to the power you bring as a therapist, are you willing to explicitly confront critical social issues even if it means privileging your knowing over the clients knowing?" Conversely, "Are you more interested in privileging the clients lead, even if it might mean that you possibly miss an opportunity to explicitly attend to a critical issue?" Or, for those students and new therapists finding themselves at the intersections of these two forms of activism, assisting them in identifying their ethical position may require asking questions such as, "Considering your ethical interest in explicitly attending to critical issues and honoring where the client is at, how far are you willing to go to attend to an issue of justice when the client appears to prefer a different direction?"

Future Research

Our findings lead us to consider a number of exciting directions for future clinical research. Our development of a preliminary spectrum of activism, encompassing counter activism and collaborative activism, raises interesting questions about the implications of various forms of activism within therapeutic processes. For instance, what are the impacts of taking a counter activist or collaborative activist stance in therapy? Further, are there different therapeutic effects or outcomes based on the kind of activist stance therapists' employ? Finally, we suggest a need to explore whether various activist

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stances really do benefit our clients in the ways we assume and what leads therapists to consider their positions to be most ethical.

Other interesting future research avenues include looking more closely at therapist transparency, identifying how it is that therapists come to learn to utilize it, and the ways it impacts clinical process. Other constructionist practices identified in our study could possibly serve as components of future outcome research initiatives for constructionist and postmodern approaches (Ramey & Grubb, 2009). For instance, there may be potential to use therapist transparency, inquiry as intervention, and staying experience near as measures for examining the actual practice of constructionist and postmodern approaches. This has historically proved difficult to do with these kinds of therapeutic approaches, but in light of a growing push for the emergence of evidence-based practices (Jacobs, Kissil, Scott, & Davey, 2010), it is needed.

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CHAPTER SEVEN

DISCUSSION

This dissertation research adds to the practice and training literature dealing with diversity and social justice by bringing a new integrative lens of both postmodern and critical ideas. Traditionally, diversity and social justice issues have been attended to within their respective paradigms (Almeida et al., 2008; Monk & Gehart, 2003), leaving a conceptual gap around consideration for how paradigmatic influences can be brought together to form a more expanded approach to contextual issues in therapy (Miller & Wieling, 2002). Our research fits directly into this gap, and helps explain how therapists integrate postmodern and critical ideas in their clinical work, detailing specific strategies therapists employ to account for therapeutic power as well as different ways they embrace and enact varying forms of clinical activism.

Before attending to the specific contributions of our research, we acknowledge that our results reflect therapists' self-reports about clinical work rather than an actual review of their clinical sessions, which means we aren't able to affirmatively say what therapists do in therapy. Instead, we are only able to make inferences about what they do based on how they described the choices they made and what they attributed as influencing those choices in clinical sessions. Additionally, we realize that our sample was quite small and acknowledge that there was limited diversity among our participants. It is important to explicitly address a lack of diversity as a limitation, given that much of postmodernist thought has originated from those in privileged social positions, specifically white males from Western Europe. By interviewing predominantly white individuals, we understand there is the potential to continue a narrow discourse, and may

be missing important perspectives and voices of those in more marginalized social locations. Concurrently, although we did perceive some relationship between ethnicity and where therapists situated themselves on the therapeutic activism spectrum, our limited sample diversity did not allow for us to draw any strong conclusions about this, or to look more specifically at how ethnicity shaped therapists perceptions of their role around issues of power and ethics. In light of this, we believe it would be worth exploring this relationship further to understand how ones intersecting identities influences how activism is embraced in clinical practice.

However, despite these limitations, we see our research as offering a number of interesting considerations for our field. In the following section we outline a number of strategies and guidelines for integrating postmodern and critical ideas in practice that can be utilized by educators, supervisors, and clinicians. These guidelines will assist in training and supervision and also point towards exciting directions for future research (see table 1).

Training & Supervision

The practice of theorizing about activism more directly in therapy models rooted in critical influences (Almeida et al., 2008; McDowell & Fang, 2007), and less directly in postmodern approaches (Anderson, 2012), with the exception of narrative practices (Monk & Gehart, 2003), creates the potential for students and new therapists to feel as though activism is primarily a critical stance, and that honoring client preference is primarily a postmodern position (Miller & Wieling, 2002). Our own development as therapists sensitizes us to the possibility this creates for students and new therapists to

conclude that these are disparate therapeutic positions, making attempts to engage in both feel contradictory. However, our research clearly suggests otherwise.

We began with questions regarding how therapists worked within and between postmodern and critical paradigms and embraced the therapeutic positions encouraged by each. Our findings explain how therapists can embrace both critical and postmodern influences in their work, effectively making clinical choices that support activism and plurality. We see this as having significant implications for training and supervision in 3 specific areas, (a) Making more explicit distinctions between theory and therapy, (b) Focus on developing an ethical position, and (c) Emphasize connections between critical and postmodern ideas, framing them as different, not disparate.

Theory vs. Therapy

Sometimes, theory and therapeutic approaches are discussed interchangeably (Flaskas, 2013), which we feel can lead to viewing broader theories to be the same as therapeutic models themselves, and vice versa. This is potentially problematic because it can contribute to students perceiving differences in model approach as differences in theory, when in reality, distinctive models can and do originate from the same theory, and may even draw upon multiple theories (Dickerson, 2010). There is certainly a "balancing act" required in training and supervising around theory and therapy (Flaskas, 2031), and it is important for educators and supervisors to clearly highlight the distinctions between them, emphasizing that therapeutic models are an application of a theoretical orientation and not the theory itself. Making this more explicit in training and supervisory processes will assist students in traversing tensions they may feel between models and specific

therapeutic stances, allowing them to understand tension as emerging from differences in interpretation and application rather than theoretical contradiction.

Ethical Positioning

It was striking to us that the majority of noted therapists did not describe a tension between critical and postmodern influences. It was almost as though the positions they took in relation to therapeutic activism were so intertwined with their ethical positioning that their stance was almost taken for granted. Meaning, they were so ethically clear in their position that any experienced tension was either embraced or dismissed because they were keenly attuned to what they were willing to risk, and not risk, when it came to being accountable to their therapeutic power. In light of this, it seems important to attend to ethics and power in deeper and more nuanced ways.

Thinking about ethics in relation to therapeutic work is not new (Inger & Inger, 1994; Sporakowski, 1982), and has been discussed from a variety of perspectives. Ethical issues have been raised regarding therapists' personal morals around sexual issues (Hill & Herbert, 1992), clinical positions regarding infidelity (Williams & Knudson-Martin, 2013), practices with dependant children and transgendered youth (Simmonds, 2007; Bernal & Coolhart, 2012), identifying who the client is when working with a complex treatment unit (Beamish, Navin, & Davidson, 1994), and the need to embrace a relational perspective in therapeutic work (Wall, Needham, Browning & James, 1999).

An overall review of the literature conducted nearly 23 years ago by Patten, Barnett & Houlihan (1991) identified engaging nonattenders, maintaining confidentiality, and terminating therapy as some of the most common ethical issues for marriage and family therapists. While these same issues continue to be represented in the literature

(Grimes & McElwain, 2008), ethical conversations have not grown as expansive as Hines & Hare-Mustin (1978) suggested they needed to decades ago. Hines & Hare-Mustin (1978) encouraged ethical conversations to grow to include thoughtful consideration of how therapeutic actions impact or may even infringe on the rights of clients, yet there remains little conversation about the intersection of activism and ethics, which seems amiss given growth of activist efforts in family therapy.

Therefore, educators and supervisors need to more intentionally consider the ways they can help students situate themselves ethically in relation to activism. Facilitating this process in students and supervisees involves (a) Clearly emphasizing the connection between clinical choices and ones ethical stance, (b) Cultivating ongoing conversations about power in the classroom and supervision, and (c) Strongly emphasizing that clinical decisions originating from an effort to be accountable to ones power does not cancel out the effects of power (Foucault, 1980). Clearly linking power to therapeutic decision-making will help demonstrate for students that taking stances with the intent of lessening ones power doesn't eliminate it.

Another aspect of developing ones ethical stance involves helping students and new therapists decide how they are willing to use, and not use, their power when it comes to therapeutic activism, inviting them to think through the implications of various activist stances. We see this as a unique training and supervisory strategy given that literature discussing the utilization of therapeutic power is virtually non-existent. Much of the literature that does address power in marital and family therapy practice focuses on disrupting power structures and processes within client relationships (Blanton, & Vandergriff-Avery, 2001; Soo-Hoo, 2005; Esmiol, Knudson-Martin & Delgado, 2012) as

well as how therapists can attend to their power and engage in ways that help equalize inherent power imbalances between therapist and client (Enns, 1988; Guilfoyle, 2005; Sutherland, 2007; Anderson, 1997)

While considering power from these perspectives is critical, it is equally important to reflect on the ways we use power, and how we are most comfortable using it. For instance, educators and supervisors must take the lead in asking students' difficult questions like, "In terms of being responsible to the power you bring as a therapist, are you willing to explicitly confront critical social issues even if it means privileging your knowing over the clients knowing?" Conversely, "Are you more interested in privileging the clients lead, even if it might mean that you possibly miss an opportunity to explicitly attend to a critical issue?" Or, for those students and new therapists finding themselves at the intersections of these two forms of activism, assisting them in identifying their ethical position may require asking questions such as, "Considering your interest in explicitly attending to critical issues and honoring where the client is at, how far are you willing to go to attend to an issue of justice when the client appears to prefer a different direction?"

To further deepen reflection about what feels most ethically congruent for students and new therapists, educators and supervisors can consider asking additional questions, like "If you are employing counter activism, what might alert you to the possibility that transitioning to collaborative activism could be more beneficial to the client?" or "If your initial strategy is collaborative activism, are there certain social issues or issues of justice that you might hear that would lead you to take a more counter activist stance?, If so, what might those be?"

Inviting students and new therapists to thoughtfully think about and consider these questions will benefit them as they consider their respective position from different vantage points. These questions also work to shine a light on taken for granted aspects of stances therapists take as well as how clinical decisions are made, foregrounding the role of power in how each one of us decides to negotiate client preferences in the face of social issues (Besley, 2002).

Different Not Disparate

Exposing students to theory often involves highlighting distinctions and epistemological differences to facilitate students' and new therapists' ability to differentiate between them (Dickerson, 2010; Fraenkel & Pinsoff, 2001). Training about and supervising students around therapeutic models follows a similar process in order to assist students in understanding distinct concepts unique to each (Walsh, 2010; Fraenkel, 2009). While we resonate with the need to engage in these teaching strategies at times, focusing primarily on distinctions can make it difficult to readily identify similarities.

Educators and Supervisors need to more explicitly examine and discuss connections between postmodern and critical ideas, being careful not to (a) further embed ideas that those taking a more counter activist stance are less sensitive to clients perspectives, and (b) that therapists taking a more collaborative activist stance are less sensitive to serious social issues impacting clients. Therapists in this study clearly demonstrate desires to do both, describing their work in ways that show how they do so.

Further, while our findings show that activism can and does take on critical and explicit characteristics like social education and active consciousness raising, there are

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alternative approaches to activism as well, such as collaborative activism, which privileges client process. While there is a large amount of literature supporting a number of the distinct aspects of a counter activist stance (Almeida et al., 2008; McDowell, 2005; McDowell & Fang, 2007), literature addressing the collaborative activist stance is much more limited. In fact, the only literature we were able to identify resembling collaborative activism were two articles discussing the concept of responsive persistence (Sutherland, Turner, & Dienhart, 2012; Sutherland, Dienhart, & Turner, 2012). Responsive persistence is described as the practice of continuing to pursue a particular clinical direction while at the same time making adjustment based on client preference. Essentially, Sutherland, Turner & Dienhart (2012) examine how therapists are both influential, meaning exerting power in ways that direct clinical process towards a particular goal, and responsive, or remaining open to client understandings and preferences. This concept seems to support our identification of collaborative activism and also confirms the need to pursue more integration between critical and postmodern ideas.

Therefore, educators and supervisors need to more explicitly help students and new therapists uncover the connections and similarities between different stances and theoretical ideas, emphasizing that although they may be different ideas about how to be responsible for ones power, or to address social issues in therapy, they both share similar interests and are not inherently disparate. Emphasizing these points will allow students and new therapists to feel more at ease with exploring different ways of employing activism.

In light of this, educators and supervisors can utilize an activism spectrum to present students and new therapists with a conceptual image of varying forms of activisms, which we include in figure 1. Presenting students and new therapists with this will help in developing a broader perspective about how one can embrace an activist stance, and also helps in conceptualizing the distinct attributes of varying forms of activism. For instance, educators and supervisors can help outline that counter activism is interested in social contexts and the therapeutic relationship, but ultimately supports making the effects of social contexts visible through specific practices. On the other hand, collaborative activism can be presented as valuing both the therapeutic relationship and social contexts, but ultimately encourages responsibility to the immediate therapeutic relationship. There are likely a number of other forms of activism that exist on this spectrum as well that educators and supervisors can explore and discuss with their students and supervisees. Pluralizing activism in this way will allow students to exert more therapeutic creativity in how they employ activism, enhancing their ability to know when and how to adapt to clients in relation to it, and will support their efforts to situate themselves in ways that feel congruent, which is an important aspect of ethical development (McLaurin, Ricci, & McWey, 2004).
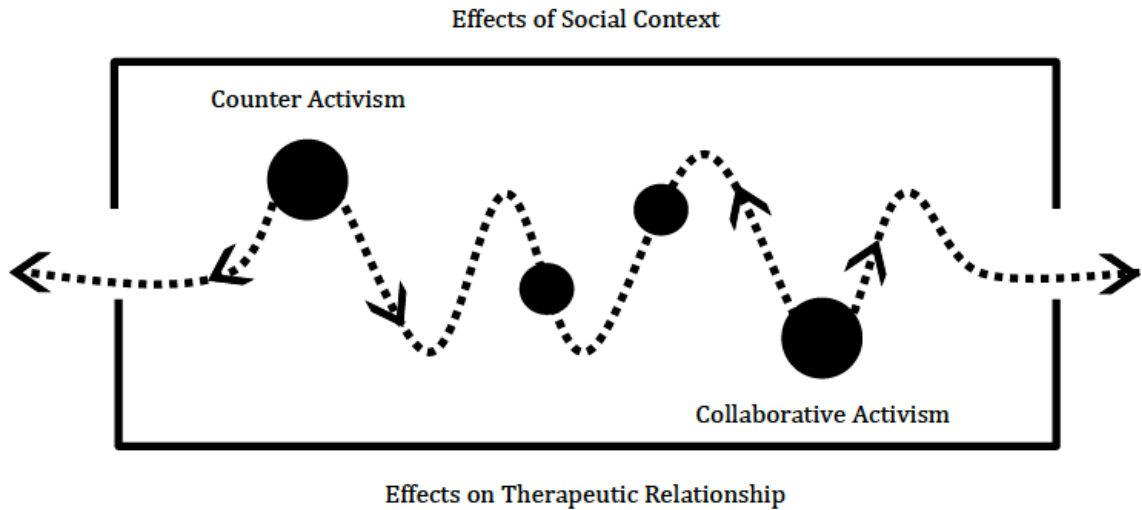
Figure 1. Spectrum of therapeutic activism. The open line and arrows depicts the fluidity of therapeutic activism, highlighting counter activism as more explicitly attentive to the effects of social context and collaborative activism as more explicitly attentive to the effects on the therapeutic relationship, but that therapists tend not to be bound in one position or the other.

Future Research

Our findings lead us to consider a number of exciting directions for future research. To begin, pluralizing activism and developing a preliminary spectrum of activism, encompassing counter activism and collaborative activism, raises interesting questions about the implications of various forms of activism within therapeutic processes. For instance, those embracing varying forms of activism seemed to feel confident about their choice, describing it as the most ethical position for them to take, leaving us wondering about how therapists come to consider their positions as ethical.

Before being certain about ones position, it seems prudent to first understand the effects of varying activist stances in therapy. For instance, no existing literature discusses the impact or effectiveness of taking a counter activist stance and engaging in social education and consciousness raising in clinical practice. It is certainly possible that

taking this stance is beneficial to clients and overall therapeutic processes, however, as long as it remains a taken for granted position, we limit ourselves from actually knowing how it benefits clients, or if it benefits those who seek our help in the ways we assume. This goes for collaborative activism as well. It seems as though therapist make the assumption that a collaborative activist stance is more ethical because of its collaborative intentions, however, without examining the effects of such a position, it is difficult to know what the benefits may be, or if there are even different outcomes than that of a counter activist position.

Additional future research avenues include looking more closely at therapist transparency, identifying whether there is a type of therapist that may be more inclined to engage in it, or if it is a matter of being exposed to the practice. Unfortunately, there is limited literature on the use of transparency in clinical practice, and what does exist, often discusses transparency and self-disclosure interchangeably (Roberts, 2005; Jeffrey & Austin, 2007; Partridge, McCarry, & Wilson, 2007). While it's not our interest to focus on the differences between transparency and self-disclosure, we do support a distinctive definition of transparency in this study from how Garfield (1987) describes self-disclosure as sharing personal feelings and experiences. Instead, we frame transparency similar to the way in which Anderson (1997) discusses 'suspending knowledge.'

Further, we find it important to identify how therapists come to learn to utilize transparency, which would enable educators and supervisors to devise more directed strategies for fostering the development of transparency in students and new therapists. Concurrently, it seems equally critical to examine the ways transparency impacts clinical process and clients' experiences of therapy. For instance, does it work to cultivate a

deeper and more connected therapeutic relationship and allow clients to feel like more equitable partners over the course of therapy?

We also wonder whether the set of shared constructionist practices identified in our study could possibly serve as components of future outcome research initiatives for constructionist and postmodern approaches. For instance, there may be potential to use therapist transparency, inquiry as intervention, and staying experience near as measures for examining the actual practice of constructionist and postmodern approaches, which has historically proved difficult to do with models originating from postmodern paradigms.   Despite these difficulties, however, Ramey & Grubb (2009) continue to argue for the need to invite both evidenced based dialogues and postmodern conversations to the same table, noting that postmodern approaches can play a critical role in bringing issues of "oppression, social justice, and local perspectives" to research. Jacobs, Kissil, Scott, & Davey (2010) go a step further, suggesting that postmodern and community based approaches may play an even more critical role in moving research in a practice-based evidence direction, or in other words, "a bottom-up approach of gathering data that relies on the input from practicing clinicians to inform treatment." Therefore, utilizing and employing these shared constructionist practices we identified to help shape research around postmodern practices would be an incredibly exciting endeavor given the continued push for evidenced based practices at the policy level (Jacobs, Kissil, Scott, & Davey, 2010).

Theory Development

We were interested to find that when asked to locate their work, the overwhelming majority of therapists situated their approach under a more postmodern

domain, ranging from poststructuralism, social construction, to collaborative relational and solution focused practices. We found this to be quite interesting considering therapists were specifically selected due to embracing influences of both critical and postmodern ideas in their work. However, after developing theory around how therapists situate their work and make clinical decisions, it became increasingly apparent that therapeutic approaches couched within a postmodern paradigm are incredibly nuanced. In fact, it is often difficult to understand what being a postmodern, social constructionist, or even poststructuralist therapist means (Cosgrove, 2004). Those less familiar with these approaches might feel these descriptors to be vague and ambiguous, while at the same time, it may even be difficult for those embracing these positions to articulate them fully.

What we find exciting about this research is that it outlines distinct practices among postmodern, social constructionist, and poststructural therapists that help explain specific characteristics of these approaches, and the possible ways in which social issues are attended to. Even though there is a generous amount of literature articulating the nature of postmodern practices (e.g., Anderson, 1997; Gergen, 2009; Miller, 2000; Miller & Wieling, 2002; Monk & Gehart, 2003), our research outlines specific strategies that some therapists employ, such as therapist transparency and staying experience near, in their efforts to attend to social issues, which remains a limited discussion in family therapy literature (Sutherland, Dienhart, & Turner, 2012). Additionally, they have been operationalized in a way that will allow others to employ them in both teaching and supervisory processes.

An additional theoretical consideration we offer deals with bounding our work within a particular theoretical tradition, an issue that has been raised by others as well (Fraenkel, 2009: Fraenkel & Pinsof, 2001). Because therapists in this study described their work in very similar ways, we were left wondering whether bounding our work within one theoretical tradition versus another is necessary or even appropriate, particularly considering all therapists were continually engaged in the ongoing blending of multiple influences. Although some have suggested the appropriateness of locating ourselves in an overarching epistemology (Dickerson, 2013), we question whether this may actually be necessary, and whether there actually may be more bridges between epistemologies than previously embraced (Latour, 1993). We say this because to us, it did not appear that any therapist remained rooted in a singular epistemology, nor did they firmly plant themselves within the boundaries of a singular theoretical frame.

In response to this, we find it pertinent to briefly return to the notion of amodernism within family therapy. Given that therapists claimed no singular epistemology, nor firmly planted themselves within the boundaries of a singular theoretical frame, we believe it may be time to rethink or begin to dismantle our field's attachments to epistemological boundaries. We live in a world that is now producing dynamic hybrids combining technology and society, human and nonhuman, politics and science, and nature and culture in new and exciting ways (Ward, 1996). So in the end, we cannot help but to return to our call for a new approach to theory and practice in the family therapy field, which we have titled amodern. The amodern approach to therapy (Latour, 1993) is not interested in whether truth is "on" (modern) or if it's "off" (postmodern), but analyzes truth, and/or epistemology, by their stages of becoming or

destruction, not by their intrinsic nature or correspondence (Ward, 1996). We think

Bruno Latour (1987) sets the course for an amodern approach to therapy when he writes,

> From now on, the name of the game will be to leave the boundaries open and to close them only when the people we follow close them. Thus, we have to be as undecided as possible on which elements will be tied together, on which they will start to have common faith, on which interest will eventually win over which. In other words, we have to be undecided as the actors we follow.

The amodern approach we speak of here continues our fields move from binary divisions

of all sorts.

Table 1

Guidelines for integrating critical and postmodern ideas in training, supervision, and practice.

Training & Supervision	Explicitly distinguish between theory and therapy
	• "differences in model approach do not mean differences in theory"
	• "therapy models are application and interpretation of theory"
	Help develop a clear ethical position
	• "In terms of being responsible to the power you bring as a therapist, are you willing to explicitly confront critical social issues even if it means privileging your knowing over the clients knowing?"
	• "Are you more interested in privileging the clients lead, even if it might mean that you possibly miss an opportunity to explicitly attend to a critical issue?"
	• "Considering your interest in explicitly attending to critical issues and honoring where the client is at, how far are you willing to go to attend to an issue of justice when the client appears to prefer a different direction?"
	Emphasize connections between critical and postmodern ideas, framing them as different, not disparate
	• Challenge ideas that further embed, such as:
	  o Critical approaches are less sensitive to client preference
	  o Postmodern approaches are less sensitive to social issues
	• Present activism on a spectrum

Clinical Practice	Accounting for Therapeutic Power
	• Therapist transparency
	  o tell clients what informs lines of questioning and curiosity
	  o intentionally situate interests in social issues as originating from their own experience
	  o be forthcoming about the lens that shapes their distinctive approach
	• Staying experience near
	  o understanding the emotional experience of clients in relation to social issues
	  o remaining close to the way clients describe experiencing the impact of social issues rather than what theory tells us about how individuals are impacted
	  o making an effort to ensure that questions attending to social issues directly relate to client experience
	• Inquiry as intervention
	  o asking about the effects of social issues rather than telling about the effects of social issues
	  o allowing oneself to be led more by curiosity than by theory
	Employing collaborative activism
	• place clients above critical ideas
	• be tentative when bringing social issues into therapeutic conversation
	• move away from critical issues for a time if pursuing them appears to be detrimental to the therapeutic relationship

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APPENDIX A

INTERVIEW GUIDE

APPENDIX 6: Interview Guide

This study is interested in understanding how you experience working from both critical and postmodern influences in your work as a family therapist. We approach our research from the perspective that the critical paradigm generally advises therapists to assume an activist stance, while the postmodern paradigm most often encourages a position of relativism. In our own experience as clinicians and students of marriage and family therapy, we have experienced that these two positions can potentially feel incongruent and sometimes create what feel like theoretical tensions in our clinical work. However, we realize this is only one way for potentially understanding the space between critical and postmodern paradigms and hope to learn how you negotiate working clinically from both paradigms. In order for us to do this, we will ask you a series of questions that we hope will invite you to think out loud about how you work in the space between critical and postmodern paradigms and negotiate positions of activism and relativism. We do not believe there are any right or wrong answers to these questions, and encourage you to share from your own unique perspectives.

The following interview guide is a semi-structured guided discussion about your practice, including what you do and how you do it. We will cover a few specific topics, but the flow of the conversation will follow your lead.

Getting Started:
1. How long have you been a family therapist?
    a. Can you briefly describe the kind of clinical work you do?
2. How did you become interested in postmodern and critical ideas/paradigms?
    a. How would you describe the relationship between these two paradigms?
    b. How long have you been navigating these tensions in your clinical work?

Therapist stance/position:
1. How would you define your stance (Critique, Social realism, Postmodern, Poststructuralist, Other, etc.) in the therapeutic process?
    a. Can you give an example of what taking this stance means to you in your clinical practice? (probe for examples of what is particularly distinguishing)
        i. Can you describe what it might look like, or what might stand out about your stance to someone observing you?

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    b.   Given your therapist stance, how do you manage your theoretical stance to avoid the potential of exclusively pursuing an idea or issue that you see as important? (ask and probe here for examples)

        i.   Can you give an example of a time when you were aware or conscious of this possibility? How did you handle it?

    c.   How do you manage your own biases/critical positions in the therapeutic process? (Probe here for specific examples)

    d.   Do you communicate your biases/critical positions to your clients? How do you do so and in what circumstances?

    e.   How do you handle issues of hierarchy?

        i.   What do you do to negotiate expertise and collaboration in regards to hierarchy?

2. What do you believe are the possible implications to the therapeutic process when you take a position of critique? For example, when you choose to actively address issues of gender or racial inequality or to highlight and focus on dominant discourses surrounding privilege, racism, and/or stereotypes?

    a.   How do you maintain this position when clients do not seem to resonate with your concerns? Can you think of a time when this was the case with a client you were working with?

    b.   What is it like for you to take this position considering you also value honoring multiple perspectives?

    c.   What do you think it is like for clients when you take this position? How do you know?

3. What do you believe are the possible implications to the therapeutic process when you take a position of embracing multiple perspectives? For instance, when you attempt to follow and honor the client's perspective even if that means not addressing critical issues.

    a.   How do you maintain this position when client problems seem to reflect blatant injustices? Can you think of a time when this was the case with a client you were working with?

    b.   What is it like for you to take this position considering your attentiveness to critical issues of injustice?

    c.   What do you think it is like for clients when you take this position?

Therapist conceptualization of problems:

4. How do you usually conceptualize the origins of problems people bring to therapy?

    a.   How do you determine whether they are connected to social issues or not?

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      b. If you view some problems as culture bound, what ways do you attempt to make them visible in your therapeutic process?

      c. If you view some problems as relational, what ways do you attempt to make them visible in your therapeutic process?

      d. How do you approach the therapeutic process when problems seem to be attached to discourse?

5. Do you use the DSM 5 in the therapeutic process?

      a. If so, how do you use it?

          i. Can you provide a few examples?

      b. If no, how did you make this decision?

Therapists' ideas about change:

1. What are your beliefs about how change happens? (give example of how you see this and work with this in your cases)

      a. Do you see change as occurring through dialogue and language?

      b. Do you see direct action as necessary for change?

If needed to expand the conversation: Use clinical scenario as probes

1. A minority couple or family that does not express awareness of discrimination

2. A couple where woman states she is struggling with depression and describes many examples of male dominance in her relationship.

APPENDIX B

FOLLOW-UP INTERVIEW GUIDE

APPENDIX 7: Follow-Up Interview Guide

1. How did the interview affect your practice and your thinking about your practice?

2. Since our conversation, have you noticed any changes in your practice or in the way you are thinking about issues related to clinical process?

APPENDIX C

INVITATION TO PARTICIPATE

APPENDIX 3: Invitation to participate

NAVIGATING POSTMODERNISM AND CRITICAL THEORY IN FAMILY THERAPY

Dear [insert name],

We would like to invite you to participate in a research study focusing on therapists' experiences of working from both postmodern and critical paradigms in therapy. Justine White, an intern marriage and family therapist and a fourth year doctoral student at Loma Linda University in the PhD MFT program, and Christopher Hoff, a licensed marriage and family therapist and first year doctoral student at Loma Linda University in the PhD MFT program will conduct this research under the supervision of Carmen Knudson-Martin, PhD. There are no current research studies looking at this aspect of clinical work. By participating, you will help us understand how family therapists work clinically in ways that embrace both postmodern and critical influences in therapy.

If you would like to participate in our study, we will set up a time for you to be interviewed by one of our researchers. The primary interview will last anywhere from 60-90 minutes. Following this interview the researcher will contact you for a brief (15 minute) follow-up interview. The purpose of this follow-up interview is to see how the initial interview has impacted your thinking and practice around postmodern and critical ideas. The follow-up interview will occur 2-4 weeks after the initial interview. The conversations you have with the researcher will be audio recorded and transcribed into a written document. Once the transcriptions are completed, all audio recordings will be deleted, and each transcription will be given a participant identification number. All names and references to places, and people will be removed from the transcripts or given fictitious names and locations in order to increase the likelihood that participants' identity will remain private. The reason for doing this is to ensure that when results from these interviews are published, readers will not be able to identify participants.

If you would like to participate in this study or have questions about the study that we may clarify for you, please contact the lead researcher, Justine White, or research assistant, Chris Hoff.. You may do this by phone or email, both of which are listed for you below. Once we hear from you by phone or email, we will contact you to schedule an interview time that is convenient for you. We would also like to remind you that you have the right to end the interview at any time if you feel led to do so. We will respectfully honor your decision.

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We appreciate your willingness to talk with us about this specific area of theoretical and clinical work, and are looking forward to hearing about and learning from your unique experiences. We realize that the openings this research may create are dependant upon your thoughts, opinions and perspectives, and we are very thankful to you for contributing to the family therapy field in this way.

Again, if you would like to participate in this study, please contact lead researcher, Justine White, or research assistant, Chris Hoff, to inform us of your desire to participate. You may respond to this e-mail or the researcher contact information listed below.

Justine White, M.A, MFTI
juwhite@llu.edu
(562)447-5493

Chris Hoff, M.A, LMFT
choff@llu.edu
(714)767-5861

Faculty Supervisor:
Carmen Knudson-Martin, Ph.D, LMFT
cknudsonmartin@llu.edu
(909) 558-4547 ext. 47002

APPENDIX D

RECRUITMENT SCRIPT: EMAIL & SCREENING CALL

Recruitment Script: Email (Phase 1)

Hello _____(Name of potential participant)_____.
My name is Justine White, and I'm a fourth year doctoral student in the PhD MFT program at Loma Linda University.
I'm contacting you because I have identified you as a leader in the field that would be able to contribute a valuable perspective to my dissertation research, "Navigating postmodernism and critical theory in family therapy".
I'm hoping we can set up a time to talk over the phone so that I can share a bit more about my research, and to see if we both think you might be able to contribute to the study. Please let me know if you are willing to learn more about this study and, if so, please suggest some good times that I may call you.
Thank you for considering participating in this study.
I look forward to hearing from you.
-Justine White

Recruitment Script: Email (Phase 2)

Hello _____(Name of potential participant)_____.
My name is Justine White, and I'm a fourth year doctoral student in the PhD MFT program at Loma Linda University.
I'm contacting you because [name of person] has identified you as someone who would be able to contribute a valuable perspective to my dissertation research, "Navigating postmodernism and critical theory in family therapy".
I'm hoping we can set up a time to talk over the phone so that I can share a bit more about my research, and to see if we both think you might be able to contribute to the study.

Please let me know if you are willing to learn more about this study and suggest some good times that I may call you.
Thank you for considering participating in this study.
I look forward to hearing from you.
-Justine White

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Recruitment Script: Screening-Call

Following an affirmative response to recruitment email

Hello, ____(Name of Potential Participant)____!

Thank you for taking the time to talk with me about my dissertation research, "Navigating postmodernism and critical theory in family therapy." This is an interview-based research study, that will require you to participate in an interview lasting approximately 1 hour, along with a brief (15 minute) follow-up interview that will occur 2-4 weeks after the initial interview. The purpose of this follow up interview is to see how the initial interview has impacted your thinking and practice around postmodern and critical ideas. In the initial interview we will ask you a series of questions about how you work from both a postmodern and critical paradigm in therapy, and in the follow-up interview we will ask you about how your thinking or clinical process has been impacted since the initial interview. Ultimately, we hope to better understand how therapists navigate or negotiate the potentially conflicting ideas and influences unique to postmodern and critical paradigms.

The study goal is to interview only therapists that meet the inclusion criteria so I'm now going to ask you a few brief questions to help us determine this.

First, do you identify systems/relational theories as the organizing frameworks for your clinical practice?

If not, what theoretical orientation would you identify as the foundation for your clinical practice?

If yes, would you also describe yourself as a family therapist?

If not, how would you describe yourself?

If participant is deemed a good fit, follow part 1. If participant is deemed not a good fit, follow part 2.

Part 1:

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"Ok, well based on our brief conversation, it seems that you are in fact a great fit for this study, and think your participation would be a valuable asset. Are you interested in moving forward with your participation?"

If yes: "Great! We look forward to more conversation with you about this topic. Let's set up a time for the interview. What times would be good for you (Agree on a time). What is the best way for me to send you the informed consent document? Ok, I will send you an informed consent form to review, which we will go over together before we begin the scheduled interview."

If no: "No problem. We understand that schedules are busy, and very much appreciate you taking the time to speak with us today. If you should change your mind and decide this might be something you do want to participate in, please contact us. We would be very interested in speaking more with you about this topic. Thanks!"

Part 2:
"Ok, well based on our brief conversation, it seems the foundation of your clinical work may be a bit different than what we are looking to focus on in this study. We appreciate so much that you were willing to take the time to chat with us about our research."

APPENDIX E

INFORMED CONSENT

LOMA LINDA UNIVERSITY

School of Behavioral Health

INFORMED CONSENT

TITLE: NAVIGATING POSTMODERNISM AND CRITICAL THEORY IN FAMILY THERAPY

PRINCIPAL INVESTIGATOR: Carmen Knudson-Martin, PhD
Loma Linda University
Counseling and Family Sciences
(909) 588-4547 ext. 47002

WHY IS THIS STUDY BEING DONE?
The purpose of the study is to learn how family therapists negotiate the space between critical and postmodern paradigms in therapy. We are especially interested in how they navigate potential clinical tensions that may arise between the two. Justine White and Christopher Hoff, doctoral students at Loma Linda University will be conducting this study under the direction of Carmen Knudson-Martin, PhD. We are pursuing this research in hopes of generating a grounded theory that helps to explain how therapists do clinical work in the space between critical and postmodern paradigms.

The rationale for this study is that the field of family therapy could benefit from a more cohesive theory that bridges critical and postmodern practices. So often therapists are forced into oppositional positions of activism versus relativism, which may limit therapeutic encounters. We think a first step in this type of research should begin with learning from therapists how they are currently working across paradigms.

You have been invited to participate in this research study because you have been identified as someone who is knowledgeable about critical and postmodern paradigms and attempts to negotiate the tensions between them in clinical practice.

HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?
Approximately 15-20 persons will participate in this study.

HOW LONG WILL THE STUDY GO ON?
Your participation in this study will be a 1 hour interview and a short follow-up phone call that will last approximately 15 minutes. The study overall will be ongoing until June 2014.

Subject Initials _____
Date _____
Page 1 of 4
Consent Version Date: 10/28/13

Loma Linda University
Adventist Health Sciences Center
Institutional Review Board
Approved _11/4/13_ Void after _10/30/2014_
#_5130324_ Chair _R.L. R..........._

A Seventh-day Adventist Organization
DEPARTMENT OF COUNSELING AND FAMILY SCIENCES
11065 Campus Street, Loma Linda, California 92350 · (909) 558-4547 · *fax* (909) 558-0447 · www.llu.edu

HOW WILL I BE INVOLVED?

You can participate in this study if you are a licensed mental health provider or an intern level family therapist currently enrolled in a doctoral program for marriage and family therapy or a related field. You must identify as a systems/relational therapist and consider both postmodern and critical ideas influential in your clinical work.

Your role will be to participate in an interview lasting approximately 1 hour, either in-person or via Skype or telephone. If you meet the study criteria and are willing to be interviewed, a researcher will contact you to arrange a convenient time and place. During the interview, you will be asked about your clinical experience, clinical conceptualization and how you integrate postmodern and critical therapy models. The research team does not believe there are right or wrong answers to these questions. We encourage you to share from your own unique perspectives and clinical experience.

After the interview the research team will send you a copy of the interview transcript and invite you to verify that you are comfortable with what is included. You will also have the opportunity to request to have parts or all of the interview removed from the study.

You will also participate in a short follow-up interview lasting approximately 15 minutes. The purpose for this interview is to see how the initial interview has since impacted your thinking and practice around postmodern and critical ideas.

You may also be asked to identify others in the field that also navigate postmodern and critical ideas in their clinical work. In doing so, you are also agreeing to allow the research team to identify you as the person who recommended the other potential participant to the research team.

WHAT ARE THE REASONABLY FORESEEABLE RISKS OR DISCOMFORTS I MIGHT HAVE?

There are minimal risks involved in participating in this study. The greatest risk to you is a potential breach of confidentiality and that private information that you may not have wanted to reveal publicly could inadvertently be revealed. Also, there may be some questions that arise for you that you may not have considered previously. You could possibly experience some unsettling feelings as the interviewer asks you to reflect on your theoretical orientation and how you respond clinically. However, if you do not wish to answer a question, you are free to skip it and go to the next question. You may also stop the interview at any time.

WILL THERE BE ANY BENEFIT TO ME OR OTHERS?

Although there is no expected personal benefit to you, we anticipate that participation in this study will allow family therapists to feel that they are contributing to the potential development of new theory and clinical models. We also anticipate that participation in this study will help the field move beyond tensions that arise when family therapists feel pulled in disparate directions by critical and postmodern paradigms. We also imagine participants could benefit from the opportunity to talk about and reflect on the ideas that guide their clinical work.

Subject Initials _____
Date _____
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Institutional Review Board
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5130324 Chair *R. L. Raglyand*

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WHAT ARE MY RIGHTS AS A SUBJECT?

Your participation is completely voluntary. Should you decline to be interviewed, even after you have started to participate in the interview, there are no negative consequences and the researchers will respect and honor your decision.

WHAT HAPPENS IF I WANT TO STOP TAKING PART IN THIS STUDY?

You are free to withdraw from this study at any time. If you decide to withdraw from this study please notify the research team.

HOW WILL INFORMATION ABOUT ME BE KEPT CONFIDENTIAL?

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. No one outside of the research team will know of your involvement and participation in the study. Additionally, all personal information you share during your interview will be held in strict confidence. Identifying material such as names, places, or anything that might allow people to know of your identity will not be used in presentations or publications of study results. All audio recordings, transcriptions and all other materials associated with this study will be stored in a locked box which will remain under the supervision of the research team at all times. If you would like to review a copy of your interview transcript so that you can identify any parts that you do not want included in the study, please provide an address or email address (below). Please use an address that will reach you directly, as the transcript will contain confidential information about your participation in the study.

WHAT COSTS ARE INVOLVED?

There is no cost to you for participating in this study.

WILL I BE PAID TO PARTICIPATE IN THIS STUDY?

You will not be paid to participate in this research study.

WHO DO I CALL IF I HAVE QUESTIONS?

You may call the student researcher, Justine White at (562) 447-5493 or e-mail her at juwhite@llu.edu. You may also contact her co-researcher Chris Hoff at (714) 767-5861 or her faculty supervisor, Carmen Knudson-Martin, PhD at 909-558-4547 x47002.

If you wish to contact an *impartial third party* not associated with this study, call 909-558-4647 or e-mail patientrelations@llu.edu for information and assistance with complaints or concerns about your rights in this study.

Subject Initials _____
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Loma Linda University
Adventist Health Sciences Center
Institutional Review Board
Approved __11/4/13__ Void after __10/30/2014__
#__5130324__ Chair R L Ragpleymd

Navigating Postmodernism and
Critical Theory in Family Therapy

SUBJECT'S STATEMENT OF CONSENT

- I have read the contents of the consent form and have listened to the verbal explanation given by the investigator.
- My questions concerning this study have been answered to my satisfaction.
- Signing this consent document does not waive my rights nor does it release the investigators, institution or sponsors from their responsibilities.
- I may call Carmen Knudson-Martin at (909) 558-4547 ext. 47002, Justine White at (562) 447-5493 or Chris Hoff at (714) 767-5861 if I have additional questions or concerns.
- I hereby give voluntary consent to participate in this study.
- The interviewer(s) will review this consent with you at the time of the interview and will answer any questions you may have about your participation. If, after you sign this consent and discuss the study with Justine White, Carmen Knudson-Martin, PhD., or Christopher Hoff you choose not to participate, you have the right to withdraw from the study at any time.
- I understand I will be given a copy of this consent form after signing it.

_____   _____
Signature of Subject   Printed Name of Subject

_____   _____ AM / PM
Date

Please list a telephone number at which the researchers may call you to arrange a convenient time for your interview. If there is a time of day that you prefer to be called, please indicate this as well.

Phone: _____

Times: _____

Please provide an address where a copy of this consent form can be mailed to you:

_____

_____

_____

I have reviewed the contents of the consent form with the person signing above. I have explained potential risks and benefits of the study.

_____   _____
Signature of Investigator   Printed Name

Date _____   Phone _____

Subject Initials _____
Date _____
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APPENDIX F

TABLE OF PARTICIPANT DEMOGRAPHICS

Selection Phase	Sex	Theoretical Orientation	Ethnicity/Heritage	Geographical Region	Follow-Up Interview	Activism
1	M	Integrative	Caucasian	NY	N	Counter
1	F	Soc.Construction	Caucasian	OR	Y	Counter
1	M	Poststructural	Caucasian	MA	Y	Middle
1	M	Poststructural	Caucasian	S.CA	Y	Middle
1	F	Poststructural	Caucasian	S.CA	Y	Collaborative
1	F	Collaborative	Biracial	S.CA	Y	Collaborative
1	F	Poststructural	Caucasian	N.CA	Y	Counter
1	F	Collaborative	East Indian	NY	Y	Collaborative
1	F	Feminist	Latina	OR	N	Counter
2	M	Solution Focused	Asian	S.CA	N	Collaborative
2	F	Postsructural	Caucasian	MN	N	Middle
2	F	Integrative	Caucasian	S.CA	Y	Counter
2	M	Postructural	Caucasian	S.CA	Y	Collaborative