Contextualising a Problematic Relationship between Narrative Therapy and Evidence-Based Psychotherapy Evaluation in Psychology

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Robert Stephen Busch

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Abstract

This thesis problematises a conflict between two discourses: narrative therapy and evidence-based psychotherapy evaluation in psychology. To answer the research question of how narrative therapy can be evaluated, I contextualise both discourses by historically situating them in and through a genealogical examination. Narrative therapy is a postmodern therapy that draws from a diverse history of knowledge involving a range of intepretativist theoretical influences that are resistances to positivist social science. In contrast, evidence-based practice in psychology, the latest model of evidence-based psychotherapy evaluation, is modelled from evidence-based medicine. Evidence-based practice is understood as an improved evaluation model from the empirically-supported treatment movement, and operates within a positivist philosophy that privileges objective methodology over interpretative research approaches. A genealogy enables a power relationship between narrative therapy and evidence-based psychotherapy evaluation to be made visible that indicates an incommensurable conflict (a differend) due to their divergent philosophies on the formation and practice of human knowledge (epistemology). However, a genealogy also enables a fragmentation of the meaning of evaluation and narrative therapy and in doing so pluralises the meaning of evaluation, narrative therapy, and narrative therapy evaluation. I conclude by tentatively considering possibilities for the evaluation of narrative therapy while problematising them within (and reflecting on) the differend between narrative therapy and evidence-based psychotherapy evaluation in psychology.

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Introduction

This research contextualises a problematic relationship between narrative therapy and evidence-based psychotherapy evaluation in psychology. In my thesis, I provide a critical historical perspective for the reader to understand this problematic relationship: that narrative therapy[1] and evidence-based psychotherapy evaluation are philosophically at odds with each other. Narrative therapy, aligned to postmodernist philosophy (Freedman & Combs, 1996; McKenzie & Monk, 1997; White & Epston, 1990) emerged as a therapeutic approach that could challenge modernist assumptions that there can be the discovery and application of universal, authoritative and certain truth claims of human behaviour to client experience. Postmodernism is critical of grand narratives that offer a unitary perspective of the world (Lyotard, 1984). Narrative therapy takes up this philosophical stance by assuming that dominant stories, framed through dominant cultural discourse[2] (e.g., Western psychopathological categorisation), constitute lived experience and that a critical positioning can be made possible in collaborative conversations between therapist and client to render these stories problematic (White, 1993; White & Epston, 1990). Narrative therapy assumes the storied production of local, contextual meaning is more meaningful for the client: "it is through the narratives or the stories that persons have about their own lives and the lives of others that they make sense of their experience" (White, 1993, p. 26). Evidence-based psychotherapy evaluation, on the other hand, frames client experience through medicalised, universal diagnostic categorisation and symptomology and assumes that disorders can be 'treated' through applying standardised, manualised therapy (Bohart, O'Hara, & Leitner, 1998).

Psychotherapy evaluation underwent a revolutionary change throughout the 1990s producing a stringent scientific and modernistic research methodology, aimed at progressing and promoting the empirical knowledge of psychology to establish empirically supported therapies for universal application firmly. A Task Force on Promotion and Dissemination of Psychological Procedures (1995) was established by the Clinical Division of the American Psychological Association (APA) to "consider methods for educating clinical psychologists, third party payers, and the public about

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1 Although there is a range of narrative therapies, I restrict my conceptualisation to White and Epston's (1990) notion of narrative therapy throughout this thesis.

2 Here I'm referring to discourse as a general domain, group, or regulated social practice of a range of statements that can systematically structure human relations (Foucault, 1972).

effective psychotherapies" (p. 1). Established in 1992, the Task Force responded to fears that the courts and legislation would define non-empirically what kinds of psychotherapy could be practiced, and funded in a managed health care environment (Beutler, 1998). As a result, stringent empirical criteria (e.g., manualised therapy, adequate statistical power, experimental design and a clearly defined clinical disorder) for psychotherapy evaluation were introduced (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). The products of such empirical criteria were termed empirically validated treatments (EVTs), later known as empirically supported treatments (ESTs). The aim of the Task Force was to build a repository of authoritative knowledge on which therapies were truly efficacious (as ESTs) so that they could gain funding and status (Beutler, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). The criteria of ESTs were exclusively determined through experimental design[3], until broader criteria emerged in evidence-based practice in psychology (EBPP; APA Task Force on Evidence-Based Practice in Psychology, 2006). Evidence-based practice in psychology continues to produce experimental design as the gold standard (including ESTs) as well as "empirically supported principles" (pp. 271, 273, 280, 284), "the scientific method" (pp. 277, 280), and "psychological disorders" (pp. 275) for psychotherapy evaluation. Narrative therapy, in contrast, involves a critical stance to therapy in that it challenges normalising evaluations and fixed diagnostic labels (White & Epston, 1990).

While I am rendering a problematic, conflictual relationship between narrative therapy and a governing, authoritative evidence-based psychotherapy evaluation discourse in psychology, I am aware that this problematic rift is a source of concern to psychologists and helping professionals. There has been concern about the appropriation of 'EST-speak' into the codes of ethics of psychological associations where, as an ethical requirement of practice, psychotherapeutic interventions must be empirically supported (Bryceland & Stam, 2005). There are also concerns over funding for therapy/therapists. ESTs, particularly prevalent in the United States, are funded by insurance companies and so "the dictum to the therapist is sometimes 'No EST – no payment'" (Hemmings, 2008, p. 43). Particular forms of therapy (e.g., narrative therapy) may not be funded and consequently could be considered unethical if they are

3 Such criteria produced empirically validated treatments (EVTs; Task Force on Promotion and Dissemination of Psychological Procedures, 1995), later rebranded as empirically supported treatments (ESTs; Chambless et al., 1998; Chambless & Hollon, 1998; Chambless & Ollendick, 2001).

not established through and suited to empirically supported, evidence-based criteria. If this scenario occurs, training programmes may have to drop 'unsupported' therapies from their postgraduate curricula, and internships that involve the application of such therapies. This could then marginalise some therapies since EST criteria are "inappropriate for therapies whose primary focus is not to 'cure disorder'" (Bohart, O'Hara, & Leitner, 1998, p. 141) and subsequently could narrow the availability and choice of psychotherapy. So, my thesis is produced in a political context of practitioner concern with the potential effects of the authoritative discourse of evidence-based psychotherapy evaluation on therapies such as narrative therapy.

(Re)Locating the Issue of Narrative Therapy and Evaluation

Admittedly, when I started out my thesis I was also interested in applying authoritative, modernistic research methods of ESTs to evaluate psychotherapy. "How can narrative therapy be evaluated when there appears to be a philosophical conflict between narrative therapy and psychotherapy evaluation?" was not the first question that came to mind when I began exploring topic options for my doctoral thesis. Rather, it was more like, "I would like to conduct some outcome studies of narrative therapy because there is very little literature on its empirical support." I had very little awareness of the importance of the postmodernist philosophy that constituted narrative therapy as a form of resistance to the modernistic aims of the Clinical Division of the APA to build a list of well-established ESTs (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). I was oblivious to a history where EVTs and ESTs were of concern to therapists such as Bohart, O'Hara, and Lietner (1998) who argued that their humanistic therapies did not fit with the EVT philosophy because the "the [Clinical Division] task force's criteria have already made legitimate humanistic research disappear" (p. 143). Before my doctoral study I had been studying clinical psychology papers that had a common mantra stating that psychotherapy had to be "empirically supported" first and foremost for practice. One of the courses had a textbook that included narrative therapy (Gladding, 2002) and I became increasingly fascinated with its postmodernist philosophy. Even so, as a scientifically oriented clinical psychologist aspirant at the time, I assumed that I would use some empirical criteria to evaluate narrative therapy. Ignorant of violating narrative therapy's philosophical constitution, I thought that I could ideally find a therapist, employ a range

of *N*=1 baseline-treatment-follow-up quasi-experimental designs and/or conduct a few quantitative surveys mixed with a qualitative case study to evaluate narrative therapy.

I began to have conversations with potential supervisors and reviewed the empirical literature on narrative therapy, which disrupted my (predominantly) empiricist goals and assumptions. In attempting a meta-analysis of narrative therapy earlier on, I realised that there were few 'outcome' studies, most of them were descriptive case studies (e.g., Clare & Grant, 1994; Kropf & Tandy, 1998; Nylund, 2002; Wetchler, 1999), and only one study had used quasi-experimental criteria (Besa, 1994). One potential supervisor was not interested in research on narrative therapy due to its "lack of empirical support." I had reached a dilemma: having to stick with something 'safe' that I was not interested in but gaining guaranteed supervision (evaluating an EST) or the less safe option of choosing to study a non-EST that I was interested in (narrative therapy) and the worry about not finding a potential supervisor who would say 'yes'. I recognised the power relation between a discourse of narrative therapy and a discourse of evidence-based psychotherapy evaluation. I could ignore the problem of narrative therapy evaluation and study an accepted EST for my doctoral research and yet the power relation that held ESTs in place and marginalised narrative therapy offered a particular tension in the field that warranted research attention. Rather than just accept that EST criteria should be applied to evaluate therapy, I began to question how narrative therapy was (un)suited to such criteria. Having recognised this tension I found two new supervisors and began a thesis journey that shifted to a theoretical interest in examining the power relation between narrative therapy and evidence-based psychotherapy evaluation, enabled through an engagement with Foucault's (1977, 1980, 1986) genealogical works and Lyotard's (1988) notion of the differend.

Reading Foucault (1977), I came to realise that much of what I had thought about evaluating psychotherapy was in an ahistorical, empirical framing that also appeared to be symptomatic of the evaluative research methodology constituted in and through psychology. My focus had been on the methodological assumptions that could empirically progress narrative therapy and it shifted to the question of how the culture and history of psychological methods and evaluative criteria matter to the process of legitimating therapies. Indeed, the APA Clinical Division's Task Force on Promotion and Dissemination of Psychological Procedures (1995) did not cover a history of psychotherapy evaluation and ignored the range of previous research on meta-analytic, process, and descriptive case studies. I came to reflect on how psychology seemed to be

ahistorical, and seemingly unitary as a discipline. I came across a range of psychologists who seemed to echo with my reflection. Sarason (1981) argued that psychology trivialised historical context generally: "for all practical purposes psychology is ahistorical. It has its subject matter: The individual, and all else is commentary— interesting, but commentary" (p. 176, original italics). Likewise, Danziger (1994b) understands psychology as a generally ahistorical discipline that also produces ahistorical subjects through its methodology: "traditionally, psychology has constructed its ahistorical subject-matter by means of ahistorical investigative and conceptual practices" (p.480). Similarly, Hook (2005, p. 28) argued that psychology tended towards "'ahistorical', universalizing, internal and depoliticizing trends of explanation." My interest then shifted to historicise, critically, evidence-based psychotherapy evaluation and to render narrative therapy visible and bring the relationship into an intelligible form. I felt that doing this was important not only for the reader but for its value to psychology, because, as Danziger (1994b, p. 480) argues, "we can hardly hope to understand the character of our own intelligibilities without the relevant historical knowledge."

The purpose of this thesis then is to historicise, critically, a contemporary, problematic conflict between the discourses of narrative therapy and evidence-based psychotherapy evaluation. I accomplish this through a process of tracing fragments of the constitution of both narrative therapy and evaluation through a critical historical methodology called genealogy. This tracing of each discourse can bring to light awareness and understandings of such a conflict as a problematic relationship – a power relation (Foucault, 1980) – for academics and practitioners in psychology and beyond to consider. I trace both discourses to problematise and address the question of how narrative therapy can be evaluated.

Overview

In order to address the evaluation of narrative therapy, in Chapter 1 I render visible a problematic, contemporary and conflictual power relationship (a differend[4]; Lyotard, 1988) between evidence-based psychotherapy evaluation in psychology and

[4] One can understand a differend as an incommensurable conflict between discourses (e.g., narrative therapy and evidence-based psychotherapy evaluation). It is also where one discourse subverts an-other, causing an injustice (Lyotard, 1988, p. 9): "A case of differend between two parties takes place when the 'regulation' of the conflict that opposes them is done in the idiom of one of the parties while the wrong suffered by the other is not signified in that idiom." I will elaborate on this in Chapter 1.

narrative therapy. A differend, is produced here, as an incommensurable conflict between discourses (e.g., narrative therapy and evidence-based psychotherapy evaluation) but is also where one discourse subverts an-other, causing an injustice (Lyotard, 1988). I also draw on Foucault's notions of authority, discourse, truth and social power to provide a 'starting point' for a genealogical examination of psychology's evaluation practices.

Next, in Chapter 2, I introduce genealogy as a methodology and a reading practice for my thesis. I argue that genealogy can be a suitable methodology to contextualise, in the form of historical critique, both narrative therapy and evidence-based psychotherapy evaluation in order to address their contemporary relationship. I explicate the concepts of genealogy to examine methodologically the contingency and constitution of the constituents of the differend in question. I also argue that genealogy can be a transformative research approach to historically fragment (and dissociate) and thus pluralise the meaning of a concept or practice. Fragmenting and pluralising the meaning of both narrative therapy and evaluation enables an examination of the problematics and possibilities of evaluating narrative therapy. I then draw on Lather's (1993) work to bring about questions of reflexivity to the methodological reading practice.

In Chapter 3, I trace the theoretical descent and emergence of narrative therapy and uncover a history of diverse post-positivist and interpretivist influences from the social sciences that constitute the therapy. In this historical fragmentation of narrative therapy, I uncover symbolic interactionist, cybernetic, constructivist and Foucaultian influences, as resistances to positivist science. In locating the disjunction between unified epistemological foundations and narrative therapy's commitment to more fragmented and multiple local narratives, these emerging resistances form a particular temporal relationship with power and resistance. Although produced through discontinuous moments of textual history that enabled the emergence of narrative practices, I use Foucault's conceptualisations of disciplinary power to reopen the thesis question to a question of resistance to evaluation theory located in positivist epistemology.

Following the theoretical influences from the social sciences on narrative therapy, in Chapter 4 I examine the theoretical descent and emergence of evaluation in the social sciences. In doing so, I reconceptualise evaluation through uncovering a history of post-positivist, interpretivist influences that constitute evaluation theory and

are resistant to the contemporary conceptualisation of evaluation in EBPP of a positivist, empirical scientific method. I produce an account of the discontinuity of evaluation and disrupt the view of evaluative practice and process contained by positivist and empirical science. I argue that evaluation can be conceptualised pluralistically through tracing its theoretical descent in the social sciences so that new forms of evaluation that are theoretically congruent with narrative therapy are made possible.

In Chapter 5, I move from theoretically tracing evaluation in the social sciences to tracing the evaluative criteria of psychotherapy in psychology: I examine the contemporary historical context of evidence-based psychotherapy evaluation in psychology by examining its contemporary descent and emergence. I argue that evidence-based psychotherapy evaluation underwent contested conceptualisations through different movements in its contemporary history. I first contextualise evidence-based psychotherapy evaluation by tracing the EVT/EST movement and its emergent governmentality.[5] I then trace the shift from EVTs/ESTs to evidence-based practice in psychology by examining the emergence of resistances to EVTs/ESTs in the Counseling, Psychotherapy and Humanistic Divisions of the APA. Following these resistances, I focus on the emergence and establishment of evidence-based practice in psychology.

After rendering visible the context of evidence-based psychotherapy evaluation in psychology, in Chapter 6 I return to the problematic relationship, the differend, between evidence-based psychotherapy evaluation in psychology and narrative therapy. I then review narrative therapy case studies in contrasted to evidence-based psychotherapy evaluation discourse. Through reflecting on the historical contexts of narrative therapy and evaluation discourse, I return to the notion of the differend; how it produces an elision at the very point where co-construction of meaning and attention to social power relations could be valuable to the evaluation of narrative therapy.

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5 Governmentality can be understood as a rationality of conduct whereby an authoritative system that can be taken for granted can become (re)produced and reinforced as an 'ethical' practice through our own responsible autonomy (Rabinow & Rose, 2003).

Chapter 1
Problematisation

In this chapter, I formulate my research question by problematising the relationship between evidence-based psychotherapy evaluation in psychology and White and Epston's (1990) narrative therapy. Locating myself within the institutional and disciplinary engagement with clinical psychology, I examine the epistemological assumptions in the discourses of evidence-based psychotherapy evaluation (e.g., American Psychological Association [APA] Task Force on Evidence-Based Practice in Psychology, 2006; Chambless & Hollon, 1998) and narrative therapy (White & Epston, 1990). It is here that I witness an apparent problematic conflict (a differend; Lyotard, 1988) between the two discourses. I realised that narrative therapy and evidence-based practice had divergent philosophical assumptions. In contrast to the interpretivist practice of narrative therapy (White & Epston, 1990), evidence-based practice in psychology has emerged from a series of paradigm shifts as an established, authoritative paradigm of best evaluative practice, based on scientific method and favouring experimental methodology as the gold standard (APA Task Force on Evidence-Based Practice in Psychology, 2006). I render visible this contemporary conflict between narrative therapy and evidence-based practice (Arribas-Ayllon & Walkerdine, 2008; Rabinow & Rose, 2003) and trace, contextualise, and further problematise this conflict through genealogical critique.

Competing Paradigms of the 'Truth' of Psychotherapy Evaluation

The emergence of psychotherapy evaluation throughout the 20th Century has manifested as a concept through a series of paradigm shifts and movements. Sometimes a new paradigmatic movement contradicted the previously accepted paradigm. By the latter period of the 20th Century, two broadly accepted paradigmatic movements of psychotherapy evaluation had emerged from changes in the nature of empirical evaluation: meta-analysis and then empirically supported treatments (ESTs). Meta-analysis emerged as a fundamental technique to measure outcomes across quantitative studies of psychotherapy (Smith & Glass, 1977; Smith, Glass, & Miller, 1980) through the historical conditions that formed an empirical resistance to the dominance of the qualitative and theoretical focus of psychoanalysis. Indeed, the key mode of evaluation for psychoanalysis in the earlier half of the 20th Century was through drawing

inferences from descriptive case studies using psychoanalytic theory (e.g., Alexander, 1939; Bergler, 1935; Kempf, 1919).

However, inference from psychoanalytic description was no longer the accepted paradigm of evaluation as time went on. When Rogerian theory became influential from the 1940s, there seemed to be a shift to a systematic approach to psychotherapy evaluation research that contradicted the descriptive focus of the psychoanalytic case study approach. There appeared to be a shift from contextualising patients in psychoanalytic theory to Rogerian process research that involved a more empirical focus with "analyses of discrete decontextualised transactions between therapists and patients" (Drozd & Goldfried, 1996, p. 175). The Rogerian, client-centred paradigm of psychotherapy research at the University of Chicago from the mid-1940s enabled psychologists to establish specific empirical methods, such as the structured Q-sort method (Bergin & Garfield, 1994; Strupp & Howard, 1992) and factor analysis, as acceptable, standard measurement techniques (Bergin & Garfield, 1994). The formation of Rogerian and behaviourist emphases evidenced a drive towards systematised empirical studies of psychotherapy research that undermined the theoretical, descriptive psychoanalytic approach to evaluation (Bergin & Garfield, 1994). One researcher, for example, argued that the sudden rise of psychotherapy research in the 1950s called for a careful defining of variables, further applications of the experimental method, and less of the "unscientific attitude of several psychoanalytic studies" (Mosak, 1952, p. 20). Eysenck's (1952) controversial quantitative review of 19 studies that found 75% of participants recovered from their neuroses whether or not they were in therapy. Psychologists reacted against Eysenck's findings by producing quantitative reviews across studies to measure psychotherapy effectiveness (Garfield, 1981).

The emergence and production of across-study reviews, following Eysenck (1952), created the possible conditions to produce techniques of statistical analysis that were more sophisticated, and evaluators of psychological therapies became more concerned with finding empirical evidence for the effectiveness of therapy. Smith and Glass' (1977) meta-analysis emerged as an advanced quantitative review involving a calculation of effect sizes across studies. In reaction to Eysenck's (1952) analysis of therapy, Smith and Glass (1977, p. 752) argued that Eysenck's conclusions were "tendentious diatribes" and a "myth." Meta-analysis became a key psychotherapy evaluation tool in psychology because it enabled the summarisation of information by

aggregating measured/dependent variables across large numbers of psychotherapy studies (Bergin & Garfield, 1986, 1994; Lambert, 2004). Meta-analysis and its meteoric rise "carved a significant role in the methodological approaches to evaluation in general" (Bergin & Garfield, 1994, p. 33) and thus became a dominant paradigm of psychotherapy evaluation. By the mid-1990s, this paradigm shifted to ESTs where the EST movement considered meta-analysis was as less rigorous than the experimental method for causatively establishing efficacious outcomes (Chambless & Hollon, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

The change from meta-analysis to ESTs produced different movements in psychotherapy that are partially contingent on the particular historical conditions involving an emergence and a subsequent prevailing dominance of experimentalism in psychotherapy research. Following Wolpe's (1958) publication of *Psychotherapy by Reciprocal Inhibition*, there was a gradual rise of interest in behavioural therapies that seemed contra to the therapeutic modalities of long-term-focused, psychoanalytic approaches: "The therapist was active, the focus was on overt behavior, therapy was brief, and [empirical] research evaluation was emphasized" (Garfield, 1981, p. 178). Strupp and Howard (1992, p. 315) asserted that the search for the 'basic ingredients' of psychotherapy in the interchanges between participants "formed part of an emerging trend in the social sciences, particularly in the United States, founded in positivism and behaviourism." The increased dominance of the experimental approach through the emergence of behaviourism began to replace the traditional psychoanalytic focus on case studies. Indicative of this dominance were surveys of practitioners that showed a decrease in clinical psychologists identifying their theoretical orientation in psychoanalysis from 41% in 1960 (Kelly, 1961) to 19% in a comparable survey in the mid-1970s (Garfield & Kurtz, 1976). Behavioural researchers dominated psychotherapy outcome research during the mid-to-late 1960s, into the 1970s (Drozd & Goldfried, 1996).

The domination of behaviourism and its experimental-empirical approach produced the conditions for EST research where behaviourists emphasised systematic criteria for evidence such as the defining of specific clinical problems while employing manualised interventions through randomised controlled trials. Specific questions in this field of evaluation research were "Which specific procedures were more effective in dealing with specific clinical problems?" (Drozd & Goldfried, 1996, p. 172). Methods were cultivated to evaluate therapy in a regimented manner such as "the selection of

patients with some specific 'target problem' (usually phobias or behavioral deficits), the use of specific treatment procedures based on written guidelines, and the random assignment of subjects to different experimental conditions" (Drozd & Goldfried, 1996, p. 172). Such methods appear remarkably similar to EST design criteria (see Chambless & Hollon, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995) and thus EST criteria point to a possible contingency leading to the rise of behaviourist empiricism. In the mid-1990s, through the rise of the empirically supported treatment (EST) movement, randomised and standardised experimental designs were touted as the best way to evaluate psychotherapy outcomes above every other evaluative approach, including meta-analysis (Chambless et al., 1998; Chambless & Hollon, 1998; Chambless & Ollendick, 2001; Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

Such paradigms of apparent consensus among psychologists could be thought of as philosophical frameworks that dominate how evaluation can be languaged and therefore thought about and practised. This domination then becomes a question of what regimes of truth are operating (Foucault, 1980). From a Foucaultian perspective, societies and their institutions create systems of authority that enable the production and perpetuation of 'truth' as a universally assumed way of knowing and/or doing that is actively uttered into practice. Truth therefore, rather than absolute, is understood as an ever-created way of knowing and doing that can have global effects on how people behave. A leading paradigm/model of evaluation requires a discourse of consensus to be (re)produced among followers for it to operate so that it can be practiced and circulated as an, ostensibly, 'tried and true' scientific methodology. In a scientific narrative, truth-value determines acceptability (Lyotard, 1984). It may seem that psychotherapy evaluation history has produced a smooth progression leading to the best, tried-and-truest method of research. However, evaluative truth regimes in psychotherapy have appeared to discontinue due to the emergence of new paradigms throughout history. The shifts from qualitative, interpretative research in psychoanalysis to quantitative, objective methods in behaviour therapy – and from the correlational research of meta-analysis to the anti-correlative, experimental focus of ESTs – are cases in point. Viewed this way, evaluation is less of a progressive, modernist[6]

[6] For Crotty (1998), modernism places emphasis on scientific reasoning and method as the best way to progressively obtain a universal and absolute knowledge of reality and so it grounds itself on

development/project, building on itself, resulting in the most up-to-date, state-of-the-art methodology, and more as a struggle over truth and truth-value. By conceptualising evaluation as a truth regime located in/through historical events (Foucault, 1980c, 1980d), it appears as a largely taken-for-granted practice in psychotherapy – that is, it has been, at times, discontinuously transformed through shifts and reversals but also through an assumed model of consensus, a paradigm, of how evaluation should be practiced.

The Present State of Affairs of Psychotherapy Evaluation in Psychology

Evidence-based practice in psychology (EBPP) is the newest paradigm of apparent consensus in evaluation. The main tenet of EBPP is to integrate the "best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 280). Based on the assumption that best scientific research will guide best practice, EBPP presumes that "systematic and broad empirical inquiry—in the laboratory and in the clinic—will point the way toward best practice in integrating best evidence" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 280). Psychologists obtain evidential research truth to guide practice through the integration of empirical research into their clinical settings. The Task Force Report on Evidence-Based Practice claimed that it "achieved consensus" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273) among its members and argued, "there is sufficient consensus to move forward with the principles of EBPP" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 274).

Although EBPP purports to be broad in empirical enquiry as a research-informing-practice approach, its apparent positivist epistemological[7] stance constricts the meaning of 'broad'. The type of positivism that I am referring to is a general epistemological stance that assumes it is impossible to know beyond a world of

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"generalisable, indubitable truths about the way things really are ... espousing clarity, certitude, wholeness, and continuity" (p. 185).

[7] Epistemology is a branch of philosophy concerned with the "origins, nature, method, and limits of human knowledge" (Reber, 1995, p. 256). Including Reber's conceptualisation, unless otherwise stated in this thesis, I refer to epistemology as a theory of knowledge or how we know what we know. For Crotty (1998), epistemology becomes embedded in our theoretical perspectives and methodological practices. Therefore, different epistemologies, or philosophies of the formation and practice of knowledge, can influence how we practice evaluation methodology.

objectivity that provides for observation (Crotty, 1998; Reber, 1995). [8] This scientific way of knowing is limited to a singular narrative of denotation, an assumption that true statements depict reality (Lyotard, 1984). Multiple/pluralistic meanings of representation are not possible in a denotative narrative of scientificity. In positivism, "all knowledge is contained within the boundaries of science and only those questions answerable from the application of the scientific method can be approached" (Reber, 1995, p. 582). EBPP makes a truth assumption that the *scientific method*, as a way of operationalising psychological practice, is the best tool to find out what works for whom (APA Presidential Task Force on Evidence-Based Practice, 2006). EBPP evidence criteria are contingent on an evidence guideline document that espouses scientific objectivity (American Psychological Association, 2002). This contingency on objectivity limits any claim that positivism can be a broad, inclusive approach as it places less importance on subjectivist-based methodologies or potentially frames them within an objectivist research framework through its positivist stance. The positivist evaluator assumes that facts need to speak for themselves, untainted by interpretative influence as much as possible; objectivity is the paragon of evaluation. Positivism contains assumptions that social phenomena are stable, lasting and replicable, that hypotheses can be formed and tested through objective observation (logical positivism), and that science is value-free and thus detached from prevailing social and cultural discourses (Mirza & Corless, 2009).

Hollway (2001, p. 12) has raised concerns about such an assumption in the development of positivism in/through EBP, arguing, "positivism has developed in such a way that facts are treated as independent of theory and capable on their own of leading eventually to knowledge." This, Hollway (2001) asserts, leads to a dangerous pragmatism, a point echoed by Tucker and Reed's (2008, p. 284) concern that "atheoretical RCTs[9] may indicate that an intervention has an effect but do not reveal how or why." Hollway's (2001) example of EBP also highlights a concern that the positivist approach to EBP seems to take for granted the process of establishing evidence in that it nullifies interpretivist positionings of theory and context from the established 'facts':

[8] There are different forms of positivism today that are content with probability rather than certainty, and where truth is estimated, but the underlying principle and aspiration to objectivity still holds strong (Crotty, 1998).

[9] RCTs are randomised controlled trials.

> Try two different interventions (in controlled conditions and randomising treatments), measure which is more efficacious according to operationalisable criteria and neither the researcher nor the practitioner need inquire how or why it works. Without this knowledge, there is nothing to inform a judgement about the circumstances in which the intervention does work. (Hollway, 2001, p. 12)

Consistent with its positivist approach, the hierarchical research criteria of EBPP rates objective experimental methodology as the gold standard and interpretative clinical expertise is rated lowest (American Psychological Association, 2006). This hierarchy is similar to evidence-based practice in the health sciences and evidence-based medicine where randomised controlled trials are the gold standard of evaluative practice (Kitson, 2002; Rycroft-Malone, Seers, Titchen, Harvey, Kitson, McCormack, 2003). Thus, the institutions of the APA, health and medical sciences authoritatively employ the experimental method in EBPP and evidence-based practice (EBP) as the *best* empirical method. The dominance of the authority of the experimental method as best empiricism overshadows the wider concept of empiricism as an epistemological position that assumes that all knowledge is derived from experience (Reber, 1995), that evidence is "observable by the senses, rather than resting solely on *a priori* reasoning or intuition" (Mirza & Corless, 2009, p. 209, italics added). This limited view of what is empirically best enables a condition to exist where interpretative methodological frameworks that involve making sense of experience in a qualitative sense (e.g., the phenomenological body or the hermeneutic interpretation and understanding of events in a cultural context) are marked as less empirically authoritative.

Psychologists have evidenced the authoritativeness of EBPP through various publications. Since the publication of the APA policy on EBPP (APA Presidential Task Force on Evidence-Based Practice, 2006), EBP has seemed to have proliferated as the framework for evaluation in/through psychotherapy and mental health literature. There have been numerous studies, for instance, espousing the principles of evidence-based practice. Such studies include group therapy (Chen, Kakkad, & Balzano, 2008; Leszcz & Kobos, 2008), organisational change (Korsen & Pietruszewski, 2009), the implementation of evidence-based practice in community and mental health services (Aarons, Fettes, Flores, & Sommerfeld, 2009; Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009) and commentary on the importance of accurate assessment tools for diagnosis and treatment in EBPP (Hunsley, 2009). Indeed, even the term *evidence-*

based is articulated as a concept to determine the status of therapy in/through an experimental empiricism in psychotherapy research. There are studies of evidence-based treatments (EBTs) for specific mental disorders, which are associated with EBPP, but EBTs appear to be supported through randomised controlled trials (e.g., Chorpita & Daleiden, 2009; Ruzek & Rosen, 2009; Sturmey, 2009). Such trials represent the type of design exclusively prescribed by the EST movement to determine the status of specific treatments for particular disorders (Chambless & Hollon, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). This conceptual blurring of EBTs with ESTs is not surprising given that the evidence hierarchy in EBPP privileges experimental methodology as the most stringent (American Psychological Association, 2006). A survey of clinical psychology graduate students found that students often confused EBPP with ESTs (Luebee et al., 2007). However, Luebee et al. reported that such students rated EBPP favourably when the difference between the two was well defined. Without clear boundaries, EST-type research continues under the (dis)guise of the concept of EBT through randomised controlled trials (e.g., Ledley et al., 2009; McHugh, Murray, & Barlow, 2009; Mitchell, Nelson-Gray, & Anastopoulos, 2008; Nathan & Gorman, 2002, 2007; O'Donohue & Fisher, 2008) reproducing the authority and dominance of experimental empiricism.

Generally, it seems that many clinical psychologists have reinforced EBPP as a truth regime in that they assume that it is the leading paradigm of evaluation, to deal with a gap between academia and clinical practice. Proponents of EBPP have endorsed and encouraged the practice of EBPP since it came out as policy in the APA Presidential Task Force Report in 2005 (Bauer, 2007; Kazdin, 2008; Luebbe, Radcliffe, Callands, Green, & Thorn, 2007; Newnham & Page, 2010; Silverman, 2005; Spring, 2007; Thorn, 2007; Walker & London, 2007). Clinical psychologists have promoted EBP and EBPP as a way of bridging a perceived gap between (positivist) science and (clinical) practice in psychology (Chen, Kakkad, & Balzano, 2008; Fago, 2009; Kazdin, 2008; Newnham & Page, 2010; Thorn, 2007). Bauer (2007) argues EBPP is an opportunity to bridge psychology with the medical and health sciences and that clinical psychology is ready for the education and training of postgraduate students in EBPP. Kazdin (2008) argues that EBPP is also an opportunity to refocus research and practice on patient care where qualitative research may also be included as a bridging between research and practice. Luebee et al. (2007) recommended that students needed further clinical education and training in EBPP, a sentiment also echoed by Spring (2007).

Thorn (2007, p. 609) concluded, "EBPP offers a wealth of tools and resources for 'rapprochement' ... of the schism of [positivist] science and [clinical] practice" that exists in psychology. Such views form a consensus that EBPP is the best paradigm for evaluation practice in that it best addresses the gap between research and psychological practice – especially clinical psychotherapeutic practice. The contemporary 'truth' of evaluation in psychotherapy, through consensus, validates EBPP's existence.

As a systematic operation of a dominant truth assumption of scientific consensus, EBPP evaluation also assumes the individual subject is the proper object for research in psychology and in doing so the individual has become naturalised as a discrete identity (Sampson, 1989). Psychologists are beginning to 'naturalise' the use of EBP as a standard decision-making process for evaluation by promoting it as a way forward for the future (e.g., Bauer, 2007; Kazdin, 2008; Silverman, 2005), solidifying its status in psychology. Kazdin (2008) argues that with EBPP "research and practice are united in their commitment to providing the *best* of psychological knowledge and methods to *improve* the quality of patient care" (p. 146, italics added). The APA Presidential Task Force on Evidence-Based Practice (2006) also produced future goals of EBPP, anticipating its longevity, such as articulating the need to forge ahead with the development of "well-normed measures that clinicians can use to quantify their diagnostic judgements" (p. 278). Researching "psychological treatments of established efficacy in combination with – and as an alternative to – pharmacological treatments" (p. 275) and examining the influence of patient characteristics on evaluations are necessary to its evolution.[10] In assuming that EBPP will become a continual, progressive development in psychotherapy evaluation, the purpose of the Task Force was to "set both an agenda and a tone for the next steps in the evolution of EBPP" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 281).

Critics of EBP and EBPP have questioned its truth status arguing that evidence-based practice is not value-free but susceptible to cultural values (Mirza & Corless, 2009). It is also argued that such truth claims have eroded the value of single-case studies (Molloy, Murphy, & King, 2007), and the privileging of randomised controlled trials at the top of the evidence hierarchy favours short-term treatments at the expense of evaluating long-term care of chronic problems (Tucker & Reed, 2008).

[10] There are many other goals listed in the APA Presidential Task Force on Evidence-Based Practice (2006) so I have listed examples for the sake of brevity.

Narrative Therapy: Dissent on the Apparent Consensus of Evaluation

White and Epston's (1990) narrative therapy is one divergent view that appears to resist the consensus or dominant 'truth' of EBPP as best practice in evaluation. Rather than set of formulae or techniques, narrative therapy emerges as part of wider group of therapies that align with postmodernist philosophy (McKenzie & Monk, 1997) located in a post-positivist[11] epistemology, particularly as a confluence of social constructionist and post-structuralist epistemological stances (Combs & Freedman, 2004; Drewery, Winslade, & Monk, 2000; McKenzie & Monk, 1997). Narrative therapy employs a textual analogy in as much as the therapist attends to the narrative of the client; how it shapes and constitutes experience in a broader socio-political context (White & Epston, 1990). Therefore, it is interpretative in contrast to the objectivist angle of medical science that informs the framework of EBP and subsequently EBPP. Rather than taking up positivist values of impartiality, as with EBPP, the therapist and client co-construct meaning (Monk, 1997). This philosophy and approach towards co-constructing meaning focuses on how the conversational relationship between client and therapist enables a languaging of the lived experience of the client and his/her context to be produced into a story. This is in contrast to assuming, as in EBPP, that there is an objective separation between the impartial therapist as the scientist-practitioner and the individual client. The assumption behind this objective separation is that it prevents or reduces biases that could affect clinical or scientific judgement. In EBPP, "clinical expertise involves taking explicit action to limit the effects of these biases" (APA Task Force Report on Evidence-Based Practice, 2006, p 277). Narrative therapy's post-positivist, discursive stance focuses on the meaning and storying of experience produced through conversation, discourse and power relations (Drewery & Winslade, 1997). The Foucaultian discursive emphasis in narrative therapy assumes that the production of meaning is dependent on power relations politically produced through discourse rather than through apolitical, objectivist means:

> Discourses organize and regulate even interpersonal relationships as power relations. Discourses are social practices; they are organized ways of

[11] Here I am not referring to Highlen and Finley's (1996) notion of a post-positivist paradigm. Their paradigm shares similar intentions to positivism: explanation leads to prediction and control. However, the difference, according to Highlen and Finley, appears to be that although objectivity exists researchers can only assume its approximation; although researchers strive for objectivity, they realise that relations between researcher and participant affect the data (a kind of critical realism). In this paradigm, grounded theory seems to have been the most commonly used methodology (Highlen & Finley, 1996).

> behaving. They are frameworks we use to make sense of the world, and they structure our relations with one another. (Drewery & Winslade, 1997, p. 35)

White and Epston (1990), inspired to a large degree by the writings of Michel Foucault, argue that narrative therapy offers a stance that is aware of dominant cultural discourses and narratives that can sometimes take over or 'author' a person's lived experience. For example, although a person may use the authoritative discourse of psychiatric diagnoses to narrate the events that they live through, this may not fully describe or explain their lived experience. An aim of narrative therapy is not to impose categories of symptomology or classifications of diagnosis on clients but to map out how the problem influences the person and explore events when/where the person resisted or overcame the problem (known as unique outcomes) (White & Epston, 1990). The therapist aims to enable the client to actively construct and story their experiences in their 'own words' rather than as a subject who is passively positioned by, and subjected to, discourse (Drewery & Winslade, 1997). Narrative therapy places emphasis on co-constructing narratives in an authority-sharing conversation between client and therapist (Winslade, Crocket, & Monk, 1997). This emphasis on authority-sharing and resisting categorisation is in contrast to EBPP discourse which, when I read such writings (e.g., APA Presidential Task Force on Evidence-Based Practice, 2006; Kazdin, 2008), EBPP appears to be symptomatic of a medical regimen where expert clinicians assess, diagnose, and *treat* people as *patients* who are languaged in/through scientific and clinical discourse. Narrative therapists resist the use of clinical, scientific and technical jargon to evaluate a person, and therefore avoid "the use of words like *diagnosis* and *assessment*, which grant precedence to professional 'regimes of truth' over clients' knowledge about their own lives" (Winslade, Crocket, & Monk, 1997, p. 56, original italics).

Narrative therapy's emphasis on an interpretative, collaborative involvement with the client stems from an engagement with postmodern values that are divergent to EBPP. Contrasting modernist and postmodernist stances of therapy process, Monk (1997, p. 2) pointed out that positivist, modernist assumptions associated with classification, comparing norms, "prediction, certainty, and expert interpretation do not fit well with a narrative style of work." However, EBPP emphasises clinical expertise, uses classificatory language such as "disorder", "clinical problem", and "psychopathology" and views experimental design as most the stringent evaluative

approach (APA Presidential Task Force on Evidence-Based Practice, 2006). In divergence, narrative therapy is critical of treating persons as fixed entities according to normative practices of objectivity (White & Epston, 1990). Narrative therapists represent their work in a post-positivist fashion: "Narrative therapists do not present themselves as distant, objectively neutral experts who diagnose problems and prescribe solutions and treatments, but as curious, interested and partial participants in the person's story" (Besley, 2002, p. 129).

The apparent positivist epistemological basis of EBPP seems antithetical to a post-positivist (i.e., social constructionist and post-structuralist) epistemology of narrative therapy. Instead of valuing objectivity, impartiality and truth, narrative therapy places importance on the construction of experience shaped through narrative, discourse and power relations, questioning the objectivity and impartiality of dominant truth regimes and its effects. Narrative therapists resist the assumed value-free science that is isolated from prevailing social and cultural discourses of EBPP. Informed by Foucault's stance on connecting truth regimes with effects of power, White and Epston (1990, p. 28) write: "we become wary of situating our practices in those "truth" discourses of the professional disciplines, those discourses that propose and assert objective reality accounts of the human condition … we challenge the scientism of the human sciences."

There appeared to be an antithesis between the current evaluative paradigm of EBPP and narrative therapy when I read the writings of narrative therapy by White and Epston (1990) alongside the positivist, medical-languaged assumptions of EBPP (APA Presidential Task Force on Evidence-Based Practice in Psychology, 2006). This antithesis was also evident between the experimental design of ESTs (Chambless & Hollon, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995), and the epistemological assumptions of narrative therapy. However, there seemed to be *more* than just an antithesis because I realised that research on narrative therapy (or the lack of research in contrast to mainstream therapies such as cognitive and behavioural therapies), and any therapy for that matter, was being judged by/through evidence criteria in the EBPP policy of the APA and by EST criteria. This judgement seemed to form part of a problematic power relation (Foucault, 1980), a differend (Lyotard, 1988), an unjust conflict between two discourses resulting from the dominant authority of a discourse judging the legitimacy of a less prominent discourse, as I shall explain further.

A Problematisation of a Differend formed from My Experience

How was this apparent conflict between narrative therapy and evaluation made possible? In this section, I reflexively examine how I first came across this apparent tension between narrative therapy and evaluation before I began my doctoral studies. I began to problematise and establish my research question on the relationship between psychotherapy evaluation and narrative therapy. In doing so, I write about my experiences of witnessing disagreement instead of consensus on the evaluation of narrative therapy. My questioning of a relationship between narrative therapy and evaluation was not possible until I came across the theoretical readings of Michel Foucault and Jean-François Lyotard. In this section of this chapter, I transform my research question(ing) through a Foucaultian problematisation of my witnessing a differend between narrative therapy and psychotherapy evaluation.

A differend represents a particular conflict between discourses (and practices as languaged by discourse). According to Lyotard (1988), a differend can be thought of as a conflict between two (or more) 'parties'[12], specifically a conflict due to two completely different systems/rules/regulations of phrasing, each operating as separate *genres of discourse*.

Discourse can be conceptualised as "any regulated system of statements" (Henriques et al., 1984, p. 105) and as "practices that systematically form the objects of which they speak" (Foucault, 1972, p. 49). As "a set of sanctioned statements which have some institutionalised force…they have a profound influence on the way individuals act and think" (Mills, 1997, p. 62). Discourses are social practices that structure human relations (Drewery & Winslade, 1997). This system of governing what can be phrased along with its genre, characterised as discourse, "determine[s] a set of rules for the formation, linking and validation of the phrases that obey it" (Lyotard, 1988, p. 49). Following Foucault (1972) and Lyotard (1988), I take up the assumption that discourse makes possible that which can be legitmated through the regulation of statements and phrases. This means that different kinds of discourse enable and limit the what, and how, of their articulation. As a practice of social sanctioning, rather than a passive expression, discourse produces relations of power. When people challenge and resist the assumptions and 'truths' of one discourse by counter-arguing in/through

[12] Lyotard (1988) did not confine 'party' to a strict definition nor a singular meaning and neither do I.

another discourse, sites of conflict are generated. The production of sex and sexuality, for instance, appeared in/through multiple forms of discourse whereby such diversity and complexity produced compliances, tensions, and unease throughout history (Foucault, 1978). The bourgeoisie's attempts to limit discourse on sex in the nineteenth century, resulted in an explosion of different discourses and simultaneously saw the consolidation of more peripheral discourses – constituted through resistance. From a Foucaultian perspective, discourse contributes to the production and (re)production of resistance and conflict.

Yet, a differend is not just about a conflict between discourses. It can also be considered as a sign of one discourse subverting an-other, producing an injustice (Lyotard, 1988) at the site where knowledge/discourse of one is privileged over and subjugates another, producing a power relation of domination and subordination (Foucault, 1980c). Foucault (1980c) argued that power relations constitute the social body, and that such relations cannot exist without the production of certain discourses of truth. In a differend, an injustice occurs when one system of phrasing in its genre of discourse is judged in/by the system of rules in another:

> I would like to call a differend [différend] the case where the plaintiff is divested of the means to argue and becomes for that reason a victim ... A case of differend between two parties takes place when the "regulation" of the conflict that opposes them is done in the idiom of one of the parties while the wrong suffered by the other is not signified in that idiom. (Lyotard, 1988, p. 9)
>
> The differend is signaled by this inability to prove. The one who lodges a complaint is heard, but the one who is a victim, and who is perhaps the same one, is reduced to silence. (Lyotard, 1988, p. 10)

In witnessing a differend between narrative therapy and psychotherapy evaluation, I realised that a key component of this conflict involved a privileging of the experimental method in EBPP discourse. Contemporary evaluation in psychotherapy, as a practice governed by a system of rules that make possible a particular discourse that tells us that what should guide practice, is an empiricism aimed towards the use of the experimental method. In psychotherapy evaluation, EBP appears in the privileged position in discourse, with its "gold standard being the randomized controlled trial" (Feltham, 2005, p. 132). It is not surprising that EBPP regards experimental design highly based on the assumption in psychology that "experimental methods provide a

gold standard for identifying useful psychotherapeutic packages" (Westen, Novotny, & Thompson-Brenner, 2004, p. 633). Although the introduction of EBPP has allowed a wider use of evaluative practices, the experimental method remains top-ranked as the *méthode du jour* of psychotherapy research (American Psychological Association, 2005). EBPP (and its former movement, ESTs) form part of a general research movement derived from evidence-based medicine (Strong, Busch, & Couture, 2008), a movement that also privileges the experimental method as the gold standard. Although EBPP is the "integration of research evidence with clinical expertise and patient values" (Levant, 2004, p. 223), clinical practice continues to be strongly guided by the privileging of the randomised experiment in determining best evidence (American Psychological Association, 2005), rather than, say, therapeutic practice informing research.

When I began to examine the contemporary history of psychotherapy evaluation in psychology, I also realised that EBPP discourse was to some extent contingent on EST discourse. Before EBPP, ESTs were developed and contributed to a discourse of empiricism that aimed to shape therapeutic practice. Chambless and Ollendick (2001) claimed that ESTs were formed by the Clinical Division of the APA as part of a wider movement that came about in the United Kingdom, first branded as evidence-based medicine. Since EBP and EBPP are offshoots from evidence-based medicine as well (Busch, Strong, & Couture, 2008), it would make sense that there would be a contingent relationship between EBPP and EST discourse. ESTs depend on empirically validated treatments/therapies (Chambless et al., 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995), empirically supported treatments (ESTs; Chambless & Hollon, 1998), empirically supported psychological interventions (Chambless & Ollendick, 2001), and most recently, EBTs have emerged as randomised controlled trials (e.g., Chorpita & Daleiden, 2009). Some psychotherapy evaluation research still uses EST criteria (e.g., Ledley et al., 2009; McHugh, Murray, & Barlow, 2009). Like EBPP, the authoritative EST criteria stipulate how therapy can be empirically supported, and thus determine 'tried and true' psychotherapies are legitimated through positivist discourse. For instance, an empirically supported and thus 'tried and true' therapy (as either a 'well-established treatment' or a 'probably efficacious treatment') is determined through using a quality experimental design to determine the efficacy of the therapy (Chambless et al., 1998), a commonality shared with the current regime of EBPP today. The operation of positivist discourse

predominantly constructs the experimental method as the key objective in the evaluation of psychotherapy, regulating what is phrased as successful treatments. Through using the principles of "good experimental design" (Chambless & Ollendick, 2001, p. 689) most ESTs are cognitive or behavioural interventions, and none are narrative therapies/practices. Around 60% to 90% of ESTs approved by the Clinical Division of the American Psychological Association are short-term cognitive and/or behavioural interventions (Norcross, Beutler, & Levant, 2006). This inclusion of short-term focused cognitive/behavioural interventions illustrates the exclusion of other therapies that do not fit with EST/EBT discourse; "longer term, more complex approaches (e.g., psychodynamic, systemic, feminist, and narrative) were not well represented" (Levant, 2004, p. 220).

So, when I started to examine the current state of psychotherapy evaluation, I realised that a further examination of its contemporary history was warranted not just because of the apparent contingency between EBPP discourse and EST discourse but also due to their dominance. Even the advocates of ESTs and evidence-based therapy acknowledge the dominance of cognitive/behavioural interventions (e.g., DeRubeis & Crits-Christoph, 1988) as well as concern with the potential for hegemonic misuse of EBP and cognitive/behavioural therapies in mainstream psychology (King, 1998). Nursing academics (see Freshwater & Rolfe, 2004) have also raised concerns about the effects of the dominance of experimental methodology in EBP at the expense of other forms of evidentiary approaches to evaluation:

> The consequent need to establish effectiveness of interventions using comparison groups has led to the ascendancy and eventual hegemony of experimental rather than observational designs in assessing effectiveness. Evidence derived from other sources – expert knowledge, clinical experience, patient perspectives, stakeholder consultation, evaluation of previous policies, non-experimental research and other secondary sources – is devalued and is replaced by something outside of everyday practice. (Kitson, 2002, p. 180)

Counter to the regimen of EBPP, narrative therapy does not aim to use the discipline of hypothesis testing or experimental design to regulate its practice. Instead, narrative therapy belongs to a postmodern movement of therapies (McKenzie & Monk, 1997) and privileges the use of the narrative metaphor and qualitative meaning in its interventions rather than logico-scientific/positivist thought (White & Epston, 1990).

The evaluative rules of narrative are not set by/in a logico-scientific discourse but rather, align toward verisimilitude, lifelikeness, creativity, and believability (Bruner, 1986). Such rules focus on the uniqueness and resourcefulness of the client as storied and enabled through conversation between client and practitioner (White & Epston, 1990; White, 2007) and a creative narrative-making process and outcome that aims to be qualitatively *meaningful* to the client in terms of their lived experiences. Narrative therapy rests on valuing a range of principles of practice that question universality, objectivity and finality of experience. These include providing "options for the telling and re-telling of, for the performance and re-performance of, the preferred stories of people's lives," enabling 'alternative presents' by constructing the unique, contradictory, and historically contingent aspects of lived experience, and exploring alternative knowledges and skills through a (re)engagement between people's past and present (White, 1998, p. 226). Such principles also value, as White explains, using thick description (evoking people's consciousness in explanations of why they do what they do) and rich description (linking stories across time through lives that speak to purposes, values and commitments in common, and structuring contexts for further tellings and re-tellings). The assumptions in narrative therapy seem to be that "lives are multistoried" in that "[n]o single story of life can be free of ambiguity and contradiction," that the "self-narrative structures our experience" and the self-narrative is the "principle frame of intelligibility for our lived experience" (White, 1998, pp. 225–226). The focus in narrative therapy is on the process of meaning making, including its fluidity and contradictions, and some forms of narrative therapy focus on how meaning positions people as subjects, enabled and restricted through discourse (Drewery & Winslade, 1997). Evaluation of narrative therapy would privilege its principles of conveying description, meaning, 'multistoriedness', and experience rather than a set of measurable, calculable or classificatory criteria.

I also came to appreciate that there was a focus on the qualitative, postmodern construction of meaning in narrative therapy appeared contradictory to positivist-based therapy such as cognitive therapy that tests hypotheses and evaluates observable information in relation to particular thoughts, feelings and actions into an expert-discoursed, scientific categorisation of the human subject. A narrative genre of discourse is distinct from a cognitive genre that has its "emphasis on logic, nonartistic proofs, and applied technical knowledge" (Smith, 2008, p. 161). In adopting a Foucaultian stance (particularly from *Discipline and Punish*; Foucault, 1977), narrative

therapy views evaluation as an institutional phenomenon that produces a normalising gaze, a kind of social surveillance that privileges expert/authoritative discourse where there is the assumption that bodies can be easily submissive, compliant, and managed through their docility to such discourse (White & Epston, 1990). Evaluation, according to White and Epston, is a practice of social control that employs categorisation, classification, norms, and measurement to assess and correct lived experience – and the evaluative rules of narrative therapy' are critical of such practices. Narrative therapy does not adhere, for example, to normative evaluative criteria of 'well established' or 'probably efficacious' therapies for ESTs to determine what could be normally acceptable as empirically-supported (Chambless et al., 1998). Rather than a standardised treatment, narrative therapy values movements in meaning (e.g., Drewery & Winslade, 1997; Freedman & Combs, 1996; White & Epston, 1990) and the notion of *polysemy,* offers multiple and shifting meanings of human experience (White & Epston, 1990). Cognitive therapy, on the other hand, focuses on truth and *error* in thinking. In Beck, Shaw, Rush, and Emery's (1979) cognitive therapy, for example, experience can be reduced to types of error, which are identified by, and categorised through, the authoritative therapist's use of technical jargon such as *arbitrary inference* and *selective abstraction* – and the specific meanings that are attempted to be univocally tied to those terms. Cognitive therapy uses hypothesis testing to reveal a hidden, underlying *core* error of a person's (ir)rationality. Narrative therapy, in direct contrast, aims to explore and open up alternative meanings of client experience rejecting any attempt to produce singularities in meaning through scientific categorisation:

> Rather than privileging univocal word use, polysemy is embraced. More than one line of interpretation or reading at any one time is encouraged, and through increasing our linguistic resources, the range of possible realities is broadened. The unique arrangement of ordinary and poetic or picturesque descriptions is encouraged over technical descriptions, and conversation is less purpose-driven and more exploratory. (White & Epston, 1990, p. 82)

The incongruency between contemporary psychotherapy evaluation and narrative therapy evaluation I felt at this stage of the thesis made me wonder about the devaluation of narrative therapy. Drawing on Lyotard's (1988) concept of differend, narrative therapy emerged as a victim of discourse where its voice was not heard through the discourse of contemporary psychotherapy evaluation criteria. I began to

question if proponents of narrative therapy could legitimate their voice within psychotherapy evaluation discourse or question the (non) legitimacy criteria that did not fit with its philosophy. If proponents of narrative therapy cannot prove being wronged (or delegitimated), then, in accordance with Lyotard's (1988) assertion of the differend, they would be reduced to silence. My hunch was that narrative therapy was more exterior to contemporary psychotherapy evaluation (i.e., EBPP and EST) discourse, than it was congruent with it, and because of this it has trouble becoming an 'empirically accepted' therapy within psychology.

Thus, here lies the research problem of this thesis: from my initial readings of White and Epston (1990) and EBPP with some historical contingency with the EST movement, narrative therapy and evaluation in psychotherapy in psychology seem to be at odds with each other. They operate in/as two very distinct and divergent genres of discourse. Narrative therapy adopts a post-positivist epistemological stance to client experience, largely ignored, not heard or, perhaps, even silenced, in and through EBPP's positivist, medical-oriented discourse. The production of evidenced therapies is made possible through established rules of an evaluative process where the evaluation criteria is defined by an objective to strive for experimental designs as the most stringent approach to evaluation (e.g., APA Task Force Report on Evidence-Based Practice, 2006; Chambless et al., 1998).

If a differend is operating, how would I explore and express it? A differend is not only a conflict between two discourses. It is also where one party to a genre of discourse is silenced in the idiom of the other discourse. It signals the "inability to prove" (Lyotard, 1988, p. 10). I am writing this thesis in the discipline of psychology but if I was writing a traditional empirical psychology thesis using the same epistemological assumptions that produce the discourse of EBPP, I could not witness this potential differend between narrative therapy and evaluation in psychology and the silencing of narrative therapy. If I could not express a differend I could not have researched (questioned) it and made it visible. Thus, this is not a traditional empirical thesis in psychology because I needed to find and/or (re)create words outside of 'mainstream' psychology to express the differend and then find ways to address it. Lyotard (1988, p. 13) asserts that a differend is the

> unstable state and instant of language wherein something which must be able to be put into phrases cannot yet be … This state is signalled by what one ordinarily calls a feeling: "One cannot find the words," etc.

I formed my contextualisation of a possible differend between psychotherapy evaluation and narrative therapy through reflecting on potential doctoral project talks with a potential supervisor. I came across narrative therapy in a postgraduate family therapy paper that I studied at Massey University. Interested, I approached my potential supervisor, a clinical psychologist, to ask if I could do outcome studies on narrative therapy for a PhD thesis with him. He replied, "I'm only interested in empirically supported therapies." I said nothing to his reply. My afterthought, however, was more complicated. On one hand, my memory of thinking and arguing in qualitative terms (through studies in human geography at honours and masterate level) had been reinforced with my exposure to narrative therapy. On the other hand, I had also studied postgraduate and undergraduate psychology through a curriculum where positivist epistemology dominated, and that discourse was predominant in my thinking. My postgraduate study consisted mainly of clinical psychology papers where paper co-ordinators emphasised that rigorous empirical studies (i.e., the scientist-practitioner model) must inform clinical practice. I wanted to know the context of the lack of empirical support for the practice of narrative therapy in clinical psychology but I was still judging its effectiveness through a positivist epistemology.

In retrospect, I was experiencing a differend between psychotherapy evaluation and narrative therapy firsthand in the context of my own background. My contemporary understanding of evaluation and narrative therapy was historically located through my own bodily/subjective experience of events. I write bodily experience here, not merely in an individual sense, but also in a social sense. Foucault (1984a), in his genealogical studies, viewed the body as a parchment that can be ascribed through its history. The body may be thought of as docile (Foucault, 1977), as something that is subjected to being a part of a social body where power relations produce knowledge and discourse through it (Foucault, 1980c) and subjects where individual identity is formed by/through power relations (Foucault, 1982). According to Foucault's (1972) archaeological stance on knowledge, discourse is produced from events in history and creates a range of positions that enable the (docile) subject to speak. Experience, in a Foucaultian sense, is a governing process/production that is formed through a complex interconnection between power relations, knowledge, discourse, and the individual and social body. So, my subjective experience of a differend was a consequence of reflecting on my academic history, an awareness of being positioned through a learned

social body (clinical psychology) and its discourse that assumed that 'empirical' was to be articulated within a positivist epistemology. I positioned (i.e., judged) narrative therapy as empirically inferior through such a discourse, shaped by an authority of positivist discourse in clinical psychology where my assumption was that rigorous empirical testing must establish the usefulness of a therapy first and foremost. I assumed that narrative therapy was devalued as it was unable to be empirically tested

My acquisition of positivist discourse in/through clinical psychology made my judgement of narrative therapy problematic in that, earlier on, I did not pay enough attention to the philosophical assumptions of narrative therapy.

The void created through the discourse of empirical support also produced my silence. I felt that I could not form a rebuttal to my potential supervisor's assertion. Silence is not only a phrase/phrasing (a way of speaking) but it is also a symptomatic production of a restricted ability to speak in a particular discourse (Lyotard, 1988). The ability to speak or keep quiet, Lyotard (1988, p. 11) says can be "threatened with destruction" through a regime(n) of a discourse. In my case, my silence was an 'emptiness' of expression because I had few words to describe a differend let alone consider from a narrative therapy stance, as at the time I was still using and thus was reproducing logico-scientific discourse in clinical psychology. I wanted/proposed to *make* narrative therapy empirically supportable *through* positivist discourse in clinical psychology that privileged the experimental method in evaluation.

My proposal, using positivist discourse, to evaluate narrative therapy was a form of silence/silencing; I was ignoring the discourse that produced the philosophy of narrative therapy. A differend, a conflict between two idioms or genres of discourses, may rest on what can (or cannot) be languaged (Lyotard, 1988). Very similar to Foucault's (1972, p .80) notion of discourse, especially as a "regulated practice that accounts for a certain number of statements", Lyotard (1988, p. 49) regards genres of discourse as strategies that (re)produce and link regimens of phrases and together. Genres of discourse "determine a set of rules for the formation, linking and validation of the phrases that obey it." As Lyotard argued, phrases are linked in particular ways according to the genre of discourse in which they are located. According to both Lyotard (1988) and Foucault (1972), how something can be articulated is constituted in accordance with a set of rules, a regime(n), by/through/within a particular kind of discourse. On reflection, I was taking up and rephrasing the existing positivist discourse that I had been exposed to and positioned by as a student of clinical

psychology ‘theory’ in order to solve the legitimacy issue of narrative therapy as an effective therapy without reflexively knowing what consequence that would have. I was phrasing a silence and was being silenced by the same discourse that I was using but I was not aware of it because I did not have the discursive resources to reflect on my own discourse and ‘see’ a differend at that point in time in the very early stages of my doctoral research.

My inability to express a differend at the time seemed to be indicative of a power relation between evidence-based psychotherapy evaluation and narrative therapy. According to Lyotard (1988), a differend occurs when something “asks” to be put into phrases yet cannot. I now realise that my emptiness of expression, or silence, and my frustration that accompanied it, was that particular ‘thing’ which remained to be phrased through the differend - that which exceeded what I could phrase at the time. Perhaps I was using a different set of rules to articulate one idiom/discourse (evaluation in clinical psychology) which subsequently negated that of another idiom/discourse: narrative therapy. The inability to articulate and express the differend produced silence. According to Lyotard (1988) an (in)articulation of silence can be symptomatic of a negation – a denial of the existence of a phenomena, an inexpressibility of it, or an implied worthlessness of it. In this sense of negation, silence can be conceptualised as being produced as part of a power relation between those who adhere to an assumed positivist epistemology of EBPP and those who do not (especially narrative therapists). Foucault (1990, p. 27) conceptualised silence as an “element that functions alongside the things said, with them and in relation to them within over-all strategies” and so it can be conceptualised as “an integral part of the strategies that underlie and permeate discourses.” He proposed to search for what kinds of discourses are authorised and how discourse can impose limits on who can and cannot talk of certain things. So, if silence is formed between two parties uttering two different genres of discourse as Lyotard (1988) would say, this would be indicative of a (con)textual struggle or conflict. Because it was not empirically supported, my potential supervisor was not interested in narrative therapy; narrative therapy appeared irrelevant to his philosophy/discourse of examining only ESTs. I proposed to make narrative therapy relevant by using positivist-empiricist methods but my potential supervisor at the time did not support this as he was adhering to EST discourse that only gave authority to support therapies that fit its evaluative criteria. I then looked up EST criteria and managed to (temporarily) ‘keep in line’ with such discourse to stay on side with him to explore other opportunities

and not bring up the seemingly uncomfortable topic of evaluating narrative therapy again.

However, I stumbled across new discursive resources that enabled me to call on my experience of a differend to make sense of it. My articulation of making problematic the differend between narrative therapy and psychotherapy evaluation was enabled by my accidental finding of Lyotard's (1988) *The Differend: Phrases in Dispute*, as well as my readings of Foucault (1972, 1980, 1984a). Silences have a history (Foucault, 1980). As Lyotard (1988) wrote, "To doubt that one phrases is still to phrase, one's silence makes a phrase" (p. xi) and one can therefore trace doubt/silence. Silence can be a negation of (con)text and so drawing on Foucaultian theory and Lyotard's differend enabled me to contextualise my silence of expression.

In a differend "[a] lot of searching must be done to find new rules for forming and linking phrases that are able to express the differend disclosed by the feeling [of 'one cannot find the words']" (Lyotard, 1988, p. 13). After finding supervisors who were interested in narrative therapy, I became more exposed to post-positivist discourse. I gradually changed my positivist stance to a blend between social constructionism and post-structuralism to presently (dis)locating, predominantly, from post-structuralist perspectives.[13] I searched for, found different theoretical and methodological approaches, and realised that in order to express the differend I needed to take up an *openly political* approach to research in psychology - a partial, ethical stance that candidly acknowledges the oppressive politics of power relations in psychology and seeks to address such practices. Lyotard (1988) hinted at the propinquity of politics and the differend: "What is at stake in a literature, in a philosophy, in *a politics* perhaps, is to bear witness to differends by finding idioms for them" (p. 13, italics added). Both politic and differend enable each other as "politics is the possibility of the differend" (Lyotard, 1988, p. 139). So, I decided that in addition to a different take, an openly political research approach would be useful for finding new idioms to express and make sense of the differend. How could I express the problem of narrative therapy and evaluation without (re)producing the kind of objectified knowledge produced by positivist evaluation research in psychology? How would it be possible to evaluate narrative therapy without subjecting it to a positivist hierarchy containing the

[13] I really do not like putting labels on what I do because it then constricts how I read what I do. But, then this is an academic research exercise and I acknowledge the necessity to make clear philosophical and theoretical standpoints in order to frame, argue, and justify my research.

experimental gold standard in EBP and EBPP? These are nagging political questions that cannot smoothe out easily by the canons of 'mainstream' positivist psychological science or by narrative therapy. I had to produce a different genre of discourse, a different system of phrasing, and find new idioms to contextualise the differend between psychotherapy evaluation and narrative therapy.

Problematisation as a Strategy for Critical Historical Research

Problematisation (Foucault, 1977, 1986, 1988c, 2000b, 2003a; Rabinow & Rose, 2003) is proposed here as a 'new' idiom to address the differend because it facilitates the questioning of a regime of truth, a governing discourse (e.g., EBPP) of assumptions/'givens', that is used to make judgements of others and their discourses (e.g., narrative therapists and therapy). A problematisation involves transforming a situation that is taken for granted to a situation that is questioned, but questioned in a critical historical context; it enables and involves a historical critique of a 'given' that is located in specific regimes of discourse. For instance, it is a 'given' in evidence-based practice in psychology that the experimental method is the ultimate method to strive for if one is to evaluate psychotherapy. The APA Presidential Task Force on Evidence-Based Practice (2006) have also assumed, through their criteria, that the evidence for therapy should ideally be determined by an experimental, cause-and-effect research design where its evidence-based validity (i.e., efficacy) is at its strongest. In order to form a problematisation something prior "must have happened to have made it [a truth] uncertain, to have made it lose its familiarity, or to have provoked a certain number of difficulties around it" (Foucault, 2000b, p. 117). The discourse of narrative therapy has already problematised 'mainstream' evaluation in psychotherapy because its philosophical stance does not fit with White and Epston's (1990) postmodern principles of questioning and challenging unitary and global discourse in narrative therapy. My uptake of 'post-structuralist' readings and discourse as a critical psychology positionality enabled me to be aware of this problem by reflecting on the influence of a will to truth, a determination and desire to find and practice truth, enabled by/through evidence-based practice assumptions in clinical psychology discourse.

Such assumptions/ 'givens' are in the EBPP model produced by the APA Presidential Task Force on Evidence-Based Practice (2006, p. 271, italics added) which states that EBPP promotes "*effective* psychological practice". The desire to make such a model universal is legitimated through reasoning that it "describes psychology's

fundamental commitment to sophisticated EBPP and takes into account the full range of evidence psychologists and policymakers *must consider*." The APA Presidential Task Force on Evidence-Based Practice (2006, p. 274, italics added) boasts the distinctiveness of psychology to combine "*scientific commitment*" with "an emphasis on human relationships and individual differences." The languaging of such statements "fundamental commitment" and "must consider" create an assumption-laden wording that EBPP is necessary, important, and effective, and thus produces a 'given' of psychotherapy evaluation, as an authoritative discourse.

Problematisation changes this 'given' of psychotherapy evaluation into a questioning of its givenness through an awareness of what Foucault (1981) calls the will to truth. The APA Presidential Task Force on Evidence-Based Practice (2006) assumes that the experimental method is the gold standard, the most stringent method, for obtaining the 'truth' on the efficaciousness of, for want of a less medicalising term, treatment. The 'truth' of this claim resonates throughout EBP discourse (e.g., Kitson, 2002; Rycroft-Malone, Seers, Titchen, Harvey, Kitson, McCormack, 2003; Tanenbaum, 2003). Foucault (1981, p. 54) wrote, in the *Order of Discourse* that "we speak of the will to truth no doubt least of all." He described the will to truth as a societal system that operates a discourse of truth that is self-justifying in itself and authorising of what can be true, to the point of exclusion. Taking a Foucaultian interpretation, the 'given' 'truth statement' on the stringency and supremacy of the experimental method can be seen as being bound up in EBP discourse, located within an institutional system focused on the will to truth. So, the fundamental desire to pursue truth, through the randomised experiment as the ultimate method, becomes EBPs *raison d'être.* The truth-assumption of the experimental method, as most stringent for uncovering the evidential truth, is a bit like the saying, 'truth begets truth'. The political consequences of this will to truth in EBP(P) through ignoring and marginalising other possible accounts, is not immediately obvious and therefore cannot be straightforwardly problematised in such a discourse of EBP(P). As Foucault (1981, p. 56) argued: "'True' discourse, freed from desire and power by the necessity of its form, cannot recognise the will to truth which pervades it." As the ostensibly post-positivist politics of narrative therapy (White & Epston, 1990) make it unsuitable to experimental methodology, then applying EBP and EBPP discourse to narrative therapy would mean that it would have a weaker evidence base in contrast to therapies that would be suitable to evaluation through the experimental method.

Problematisation, as a general framework for analysis, enables an examination of power relations by putting the will to truth into question and thereby making its taken-for-grantedness problematic and making visible that which it excludes. Through problematisation "[w]e problematize the accepted, the obvious, the supposedly fundamental; we also pursue what has been obscured or suppressed..." (Prado, 1995, p. 160). Thus, problematisation can enable the challenging of positivist notions of truth in EBPP, while asking how to take into account the postmodern, post-positivist movement of narrative therapy. A problematisation, therefore, allows for the examination and expression of the differend between narrative therapy and evaluation in psychotherapy in psychology because it enables the questioning of the 'given' silence over narrative therapy in 'mainstream' evaluation in psychotherapy. It involves the questioning of two regimes of thought in a historical light; a problematisation allows 'givens' to be questioned as an historically-situated element: a present-day differend.

Like Foucault's (1981) political approach to making problematic the will to truth through historically examining and questioning its discourse, Lyotard (1988) also regarded history as important for conceptualising differends. Lyotard (1988) argued that history and language are interconnected where what is phrased forms and becomes part of history. So, differends in this sense are historically situated. Taking this argument, history can never be an objective discipline because it is simulacra of judgements that are constantly (re)phrased. Eventually, then, through the course of history, a 'given' can become (re)phrased into a question. A judgement of what becomes valued as evaluative, for example, becomes judged and interrogated and so on. Assuming that conflicts are inevitable, there is no final, teleological judgement to the differend and therefore differends are situated through simulacra of indeterminate historical interpretations:

> Phrases form a physical universe as if they are grasped as moving objects which form an infinite series. The phrase referring to this universe is therefore by hypothesis part of that universe: it will become part of it in the following instant. If we call history the series of phrases considered in this way (physically), then the historian's phrase "will become part" of the universe to which it refers ... The history of the world cannot pass a last judgement. It is made out of judged judgements. (Lyotard, 1988, pp. 7–8)

Problematisation, as an historical research strategy, is an approach to examining the history of thought, in critical, reflexive ways where thought and the will to truth, as a discourse and a practice, turns on itself. Foucault (2000b) made it quite clear that his notion of thought is not some underlying behavioural attribute, a structuralist representation of meaning, or a part of a cognitive schema, but rather it is a taken-for-granted re/action that is transformed through an element of problems resulting from "social, economic, and political processes" (p. 117). Problematisation is an attempt to transform the way a situation is captured "from seeing it as "a given" which generates problems that must be resolved, to seeing it as "a question" whose formation and obviousness must itself be subject to analysis" (Rabinow & Rose, 2003, p. xix). This process, I believe, should involve a questioning, a problematisation of my 'own' (re)/actions as 'givens' where I do not become too comfortable or restful in my assumptions while writing this thesis. However, reflexivity is not merely a 'standing back' and acknowledging the inseparability between my personal values and my academic work; it is an awareness of the *disciplinary location* of my assumptions with the theoretical assumptions of others. If this location is something that is reflected on long enough, it *influences* the research process (including the producer of the research and the product itself, the thesis). Much of Western society, Foucault (1981) argued, is bound historically by the will to truth – the prolific desire and the assumption that universal truths *have* to be found because they seemingly exist and so forth.[14] In this thesis, I attempt to make problematic the will to truth in psychotherapy evaluation discourse and its relation to narrative therapy, in/from my own disciplinary location: psychology. Foucault (2000b, p. 117) asserted a potentially reflexive approach where thought becomes the scrutiny of itself:

> Thought is not what inhabits a certain conduct and gives it meaning; rather it is what allows one to step back from this way of acting or reacting, to present it to oneself as an object of thought and to question it as to its meaning, its conditions, and its goals. Thought is freedom in relation to what one does, the motion by which one detaches oneself from it, establishes it as an object, and reflects on it as a problem.

[14] Foucault (1981, p. 56) asserted that the will to truth is something that we are unaware of, yet it appears to be so universally and insidiously pervasive that a critical historical analysis may uncover its effects: "'True' discourse, freed from desire and power by the necessity of its form, cannot recognise the truth the will to truth which pervades it; and the will to truth, having imposed itself on us for a very long time, is such that the truth it wants cannot fail to mask it."

The concept of problematisation emerged from Foucault's genealogical studies (Foucault, 1977, 1986). Foucault (2003a) wished to conduct the genealogy of problems, of problématiques (of problematics and the problematical). Problematisation examines how something, a concept, is constituted as an object of thought. However, this constitutional examination is historical in focus: "Foucault brought in the term "problematization' in order to show his works as genealogies of particular problems" (Nilson, 1998, p. 103). In this thesis, I will examine how mainstream psychotherapy evaluation in psychology and narrative therapy have been constituted and question the solutions to the problem of evaluating therapies. The various 'solutions' posed are quite different (e.g., the establishment of criteria through ESTs in clinical psychology evaluation discourse versus the creation of new meaning and of detailed, non-pathological narratives of lived experience in narrative therapy). Then there are the 'solutions' that I brought to this project (e.g., from earlier on wanting to make narrative therapy efficacious through 'mainstream' evaluative discourse in psychology to advocating for a discursive evaluation of narrative therapy – see Busch, 2007). The task of the analyst is to "rediscover at the root of these diverse solutions the general form of problematization that made them possible ... what made possible the transformations of the difficulties and obstacles into a general problem for which one proposes diverse practical solutions" (Foucault, 2000b, p. 118, italics added). Through the idioms that I use for the theoretical framework of this thesis, and as I am writing this thesis, I am aware that I am making possible various tellings of 'problems' and their implied 'solutions' in their discourse through the idioms that I use.

A problematisation, therefore, can be conceptualised as a "problematization of a present" through a reflexive function of "the questioning by the philosopher [and arguably, in the (con)text of this thesis, me, the critical psychology student] of this present to which he [sic] belongs and in relation to which he [sic] has to situate himself [sic]" (Foucault, 1988c, p. 88). I am situated in the present expressing this potential differend between evaluation in psychotherapy in psychology and narrative therapy; the differend and its discourses appear to be a present-day problematic. When Foucault (1986, p. 11) reflected on his work he argued that what mattered was analysing "the *problematizations* through which being offers itself to be, necessarily, thought—and the *practices* on the basis of which these problematizations are formed". The constitution of how the differend came to be in its present day form, along with its conflict of

practices thus needs to be (dis)located through a critical historical research process as a particular research approach of problematisation. The specific approach that I propose is a reflexive genealogy. The genealogical dimension to Foucault's (1986) work enables me to analyse the formation of the concretisations out of the practices and modifications undergone by problematisation. As an historical ontology[15] of the present, it is a research strategy that (dis)locates present-day taken-for-granted assumptions of what 'exists' as practice by historically examining the multiple events that those practices are contingent on:

> Problematizations are examples where discursive objects and practices ... are made visible and knowable. They often form at the intersection of different discourses and expose knowledge/power relations. Problematizations serve an epistemological and methodological purpose: they allow the analyst to take up a critical position in relation to research; and they allow the analyst to trace how discursive objects are constituted and governed. (Arribas-Ayllon & Walkerdine, 2008, p. 99)

Reflecting on Formulating the (or an Emergence of) Research Question(ings)

In order to problematise the relation between narrative therapy and evaluation, and since this problematisation has been formed from my experience, my "critical position in relation to research" (Arribas-Ayllon & Walkerdine, 2008, p. 99) needs to be disclosed. Up to this point, I have written about the differend between discourses of evaluation in evidence-based psychotherapy and narrative therapy and reflected on how problematisation enabled me to question my experiences of silence, and troubling the relationship. However, when I reflect on what I have written so far, it does not really tell the reader much about 'me' and how I came to the differend between evaluation in psychotherapy in psychology and narrative, therapy. I now turn 'my' research gaze upon myself in how I came to what I wrote in this thesis, disclosing how my values and the discourses that I may have taken up could have affected the process of my research in leading towards my problematisation.

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[15] Ontology is the theory of being and existence, but Foucault was not much into Theory and his 'historical ontology' (as put by Owen, 1994) was perhaps more aligned to historicising (or perhaps historically (dis)locating) the formations of being and existence in terms of analysing how things 'came to be' by analysing how they were made to be what they are but by knowing that those things 'came to be' only through a present-based conceptualisation (the genealogist cannot travel back in time and truly discover how things were).

I am writing from a poststructuralist angle (or at least, a shift towards one) where I understand poststructuralism as a broad movement that rejects the principles and methods of structuralism (Sim, 2001). The method of structuralism assumes that there are underlying systems of conventions that determine meaning (Young, 1981). Structuralism assumes that these systems, in cultural practices, have particular rules and regulations that can be analytically turned into a model of signifying meaning as it if it has some kind of neatly predetermined, underlying structure. Rather than looking for fixed models that structure meaning from a pre-determined essence, a poststructuralist calls into question such an aim and questions her/his critical approach:

> As a self-reflexive discourse, which constantly divides itself against itself and transgresses its own systems, post-structuralist criticism avoids becoming fixed, avoids becoming an established method. It is this self-critical, self-transforming aspect that is often found so irritating and so confusing in post-structuralist thinkers. Looking (mistakenly) for a completed system, the reader finds it impossible to pin down and systematise a series of texts … The breakthrough occurs when he [sic/the reader] realises that his [sic] unease and uncertainty are not the product of a failure to understand, but an anticipated critique of his [sic] own will to knowledge. (Young, 1981, p. 7)

My background and influence on this thesis can thus be conceptualised as a contestable one in my shift towards poststructuralism. 'The Death of the Author' (Barthes, 1977) and 'What is an Author?' (Foucault, 1984c) which can be located as poststructuralist[16] texts, have influenced how I locate myself and my theoretical positioning in relation to this thesis in terms of (non-)originality. Barthes (1977) asserted that the Author(ity)[17] is never more than the instance of writing and that language only knows a 'subject' not a 'person'. For Barthes, the expression of 'I' is no more than the occurrence of writing or saying 'I'. The origin of the Author(ity) is questioned through language; the origin of the Author(ity) (presumably 'I') can be made problematic through a poststructuralist perspective. Language is what Barthes (1977) called a field without origin because it allows a questioning of all origins. This

[16] Note that the concept of 'poststructuralism' was one that has historically been imposed on theorists who did not call themselves such (e.g., see Foucault, 1980).
[17] I use 'Author' to denote a 'structuralist' conception of authorship as authority where one's writings and are structured upon a final, True, and essential source: the Author. I also mean a similar denotation for 'Origin', a True, singular, and final source as a fixed point in history.

poststructuralist take on language, calling into question the unified subject, enables a problematisation of universal truths and of an historian of psychology pretending to travel back in time and come as objectively close to the truth of history as possible. Beside Foucault (1977, 1978, 1984a) illustrating this point through the analytical approach of genealogy and archaeology (Foucault, 1972), Barthes' (1977) assertion of the non-Origin of the Author(ity) was further illustrated through Foucault's (1984c) problematisation of the Author and Authorship. He used the example of the death of the theorist Nietzsche by questioning to what extent he can claim Authorship given the myriad of possible traces of his work.

So, in taking up a poststructuralist stance, I began to question the Authority of evidence-based evaluation. Foucault (1984c) questioned, what if one found notes in a draft paper, a reference, a newspaper clipping, a list on the back of an envelope, or a sketching (and so on)? Such items, Foucault asserted, could be possible origins of work, but there appears to be no grand Origin. Instead, there are multiplicities of possible readings that emerge through the reader's engagement with the text (Barthes, 1977). Reading the evaluative criteria in the APA Presidential Task Force on Evidence-Based Practice (2006) from a poststructuralist perspective shifted my interpretation of its legitimacy to questioning its author(ity). I began to question whether there were hidden or 'less visible' accounts of evaluation that the document glossed over or did not take into account, rather than just accepting the document as a model for evaluation and as progressive step in a continual improvement of psychotherapy evaluation. The reader, Barthes (1977) argues, is a place and a destination where a text's unity lies - the destination gives writing its future rather than origin. This is at the cost of Author(ity), which gives way to the birth of the reader. As I shifted my readership in taking up more poststructuralist discourse, I began to question the Author(ity) that "psychology can help to develop, broaden, and improve the research base for evidence-based practice" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 274), by asking 'improve for whom and at what cost?'

A Location / Disclosure of My Values and a Reflection on My Experiences of Evaluation in Psychology

However, my turn towards poststructuralism and critical psychology to enable this problematisation came as no surprise as I had already ascribed to values that aligned with such perspectives. My values of social justice were shaped by my own sense of

social injustice: experiencing prejudice and stereotyping due to 'coming out' in my late adolescence, being fascinated by political affairs, and being part of those small communities whose public services were taken away during deregulation in New Zealand in the late 1980s. I was concerned about those communities and individuals who were disadvantaged from neo-liberalist reforms of Labour and National governments during the late 1980s and early 1990s. I came across Marxist, postcolonialist, and postmodernist writings during my postgraduate years in human geography, which enabled me to question how cultures are colonised, exploited, marginalised, and universalised (i.e., stereotyped) through mainstream discourse at the time: the boundarylessness of global capitalism, neo-liberalism, and Western science. I started to value diversity and difference more and started to favour positivistic generalisations about cultures and human systems, less. Such values seemed to suit a critical, poststructuralist stance, one that questions attempts to find universal structures and rules to account for human practices.

Critical psychology was another influence on my view of the relation between evaluation and narrative therapy. Prilleltensky and Fox's (1997) view on challenging the status quo of ruling practices in psychology helped me reflect on the discipline of psychology in relation to evaluation and narrative therapy. This reflection enabled me to situate my work/authorship, as part of movement called critical psychology. Drawing on Prilleltensky and Fox (1997), what I mean by 'critical' is the assumption that research is not value-free. The very practices of psychology that enable the status quo of othering to be maintained, prevent it from addressing its oppressive practices and mainstream psychology's highly individualistic focus "neglects the causal role of the larger social institutions in which ... [social] interactions are embedded" (p. 9). My reading of Prilleltensky and Fox (1997) allowed me to reflect on the status quo of the privileged position of cognitive/behavioural therapies through the evaluative practices of predominantly clinical psychology discourse (i.e., ESTs) which created the possibility that perhaps other psychotherapies that were not suited to experimental method and criteria (e.g., narrative therapy) were devalued.

I also borrow from Ang (1996, p. 36) to inform what I mean by 'critical' as an approach: "an intellectual-political *orientation* towards academic practice". Following Ang's (1996) argument, this orientation involves the adoption of a reflexive perspective, one that is "conscious of the social and discursive nature of any research practice," (p. 36) and one that seriously takes up the Foucaultian assertion that the (re)production of

knowledge is entangled in and inseparable from a network of power relations (Foucault, 1980). My reading of power in Foucault (1980) allowed me to see the discourse of evaluation in mainstream psychology as enabling the (re)production of certain knowledges that constitute 'good' therapy, formed through psychology's adoption of the scientific method privileging the bounded, rational individual through psychology as an individualising technology (Rose, 1996). Although narrative therapy predominantly tends to operate as an individual therapy, it has as its focus the historical and socio-cultural contextualisation of the individual and the decontextualised practices of professional clinical discourse in psychology (Drewery & Winslade, 1997). The resultant effect of an individualised approach, espoused by/in psychology, is a "reduced effort to alter the status quo, a state of affairs that benefits the privileged" (Fox & Prilleltensky, 1997, p. 12).[18]

Whether I had been influenced by earlier critical influences or from the discourse of poststructuralism, or both, I started to think about what may be chosen and excluded (narrative therapy?) in the authoritative criteria of evidence-based evaluation discourse. Foucault (1984c) argued that there are limits imposed on an author because his/her function can be conceptualised as a (re)production of discourses that are embedded in particular cultural practices. According to Foucault (1984c, p. 119), the author is not an indefinite source of meaning and representation but rather he/she is "a certain functional principle by which, in our culture, one limits, excludes, and chooses." For Foucault, the function of an author is characteristic of the circulation of particular discourses and their modes of existence and functioning. Realising this function, I started to think of the possibility that perhaps, not just I, but psychologists may be constrained by the authoritative discourse of evidence-based evaluation and its judgement criteria in judging the legitimacy of narrative therapy. The author function is "linked to the juridical and institutional system that encompasses, determines, and articulates the universe of discourses" (Foucault, 1984c, p. 113). Like Rose (1996, 1999) I thought of the possibility that psychologists and their relation to psychology as a

[18] Admittedly, although I found a way of speaking from a critical psychology stance, I cannot escape psychology's privileged 'authority' position. I became most aware of this when I was presenting a paper on evaluation and therapy at the New Zealand Association of Psychotherapists Conference in 2006. I was aware of psychotherapists' disdain of psychology when my seminar had only six people registered to turn up in comparison to 30–40 members registered in three other seminars at the same time. When I talked with members at my seminar I found out that most of them were a minority in psychotherapy but, to my horror and intrigue, they were a working party that was looking at ways to systematically and empirically evaluate psychotherapy and were relying on a 'psychologist/psychology' to inform them.

discipline was possibly self-governed and limited by a discourse of evaluation, and, if this was so, how could it affect my own and other psychologists' judgements of narrative therapy.

My judgement of narrative therapy is embedded in personal experience, my historically located personal identity: as an individual, a researcher, a critical psychology student (turned from clinical psychology, and before that an undergraduate education in mainstream psychology, and before that, postgraduate human geography and undergraduate geography) – a 'personal reflexivity' (Wilkinson, 1988). Wilkinson (1988) argues that a person's research is often an articulation of personal interests and values and so the topic that I choose to study, for example, is likely to come from personal concerns, which it did. When I was in a clinical psychology programme of study, I had no desire to be an orthodox clinical trainee psychologist and follow the status quo of cognitive/behavioural therapies; I found qualitatively oriented psychodynamic therapies and narrative therapy more appealing. Coming from a background of studying human geography, I had a taken with me a prior partiality towards valuing inter-relationships and human interaction with socio-cultural and physical environments, and human influence and ideology, rather than valuing the self-sufficient, autonomous, and bounded individual. I wondered about the limits of clinical practice if I pursued therapies that were not empirically supported, and at the same time questioned the position of narrative therapy in such practice. I had presumed that my clinical psychology training would involve a predominant focus on the therapeutic relationship. My personal values were aligned with therapeutic stances that focused on the therapeutic relationship (i.e., psychodynamic therapies), the therapeutic alliance (e.g., process-existential therapies), and meaning making through the stories that clients told (e.g., narrative therapy). As I negotiated the terrain, I recognised the desire to research psychology, critically. My research intentions were (and still are) political. I wanted to 'validate' narrative therapy somehow but still within the discourse of clinical psychology in order to legitimate it.

Recognising Foucault's (1984c) assertion that the function of the author is connected to particular discourses and their appropriation, the functioning of my research orientation (along with the values and positions that I take up) could thus also be a characteristic functioning of particular discourses (e.g., of positivism). I was also still looking for the truth (the positivist part of me), the 'real' meaning, and wanted to evaluate less valued therapies in clinical psychology through traditional experimental

research designs (the empiricist part of me). The clinical gaze (the detached, objective positivist-empiricist view as well as the essentialist, classificatory gaze that Foucault (1973a) describes) remained embedded in my research process as I compiled existing literature on narrative therapy in preparation for a meta-analysis of narrative therapy case studies. Through clinical psychology discourse, I almost felt compelled to search for a common element that made narrative therapy 'tick'.[19]

As any 'good' psychological scientist would be, I was sceptical of what I thought were unscientific claims yet did not question my own modernist assumptions because I assumed them to be correct judgements. I examined each case study of narrative therapy and was disappointed in how they omitted any reference to (empiricist) evaluative method; I was still judging them within a positivist-empiricist discourse. Consequently, I wanted to conduct my own case studies of narrative therapy and make them more 'scientifically rigorous', that is, have some element of behaviour quantified over time to see evidence of change, and evidence of therapeutic progress. I thought that a partly behaviourist approach, with its assumed 'atheoretical' stance, could still work. I was still trying to evaluate narrative therapy in a modernist framework and was assuming that 'empirical neutrality' was a way to evaluate narrative therapy, an intervention based on postmodern assumptions. I also knew that a behavioural single subject design was not 'atheoretical' or 'empirically neutral'. However, after a selective reading of Lyotard's (1984) conceptualisation of meta-narratives my values changed. I questioned the modernist assumptions that informed my urgency to evaluate narrative therapy in an empiricist framework as a form/function of 'improvement' and 'progress'.

Fortunately, I had found a new supervisor who questioned my meta-analysis proposal, and at the same time, I came across Lyotard's (1984) *The Postmodern Condition: A Report on Knowledge* where I discovered that 'meta' is a totalising concept in that it does not account for difference and heterogeneity. I recognised that I was trying to do something different, to make a difference to narrative therapy, and yet, ironically, I felt trapped in the same denotative discourse that silenced it by accepting that reality is objectively and therefore singularly depicted though a truth statement (a narrative of denotation; Lyotard, 1984). So, as the clinical gaze of the researcher began to turn on itself, I began to transform my position to a postmodern incredulity:

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[19] This is a 'functional' aspect of reflexivity, tied in with the 'personal', in terms of how my research shapes my own values (Wilkinson, 1988). A 'functional' part of reflexivity examines how the form of our research is shaped by our life circumstances, roles, and what we value and believe (Unger, 1983).

"Simplifying to the extreme, I define *postmodern* as incredulity toward metanarratives. This incredulity is undoubtedly a product of progress in the sciences: but that progress in turn presupposes it" (Lyotard, 1984, p. xxiv).

Therefore, the form/function of my research changed to a questioning of the 'given' of empirical improvement in evaluation and the critical relation between evidence-based evaluation and narrative therapy, and to find out whether or not any research had been conducted on this possible problematic relation.

Has the Relation between Evaluation and Narrative Therapy been addressed in Psychology?

Has existing literature in psychology attempted to contextualise and critique the apparent conflict between evaluation and narrative therapy? Short histories of psychotherapy research have been produced but such histories neither appear to give any critical attention to the effects of evaluation discourse on psychotherapy nor do they locate the contribution of narrative therapy in the field (e.g., Garfield & Bergin, 1994; Lambert, 2004; Spring, 2007; Strupp & Howard, 1992).

There also appears to be a paucity of literature that draws attention to historicising psychotherapy evaluation discourse in relation to therapies/therapists that may resist such discourse. It seems that we, as psychologists, perhaps need to focus more critical attention on how psychotherapies may have become marginalised or subjugated for the sake of others in our histories of psychotherapy evaluation. Lambert (2004) and Garfield and Bergin (1994) have briefly overviewed historical developments of psychotherapy, such as the trend toward brief-term therapies in the late 20th Century, the increasing influence of managed care on psychotherapy, and the possibility of using more qualitative approaches in evaluation research. However, they did not problematise how certain concepts of evaluation became used and knowable or historically trace the constitution and governance of such concepts. Likewise, Garfield and Bergin (1994) and Strupp and Howard (1992) produced a brief history of psychotherapy research. They pointed out key moments in history that shaped the effectiveness of psychotherapy, from psychoanalytic studies adopting empirical criteria in the 1930s, through Eysenck's (1952) argument that all forms of training should be abandoned because he 'found' that improvement in therapy did not exceed spontaneous recovery that resulted in the rise of meta-analytic studies. However, there was no critical analysis

that examined struggles between the different historical movements in psychotherapy evaluation and their effects.

Nonetheless, mainstream psychotherapy evaluation had already been made problematic through its own positivist interpretation. For example, Wampold (2001) problematised the dominant medical approach to psychotherapy evaluation through an empirical argument. He conceptualised two models of psychotherapy: the medical model and the contextual model. He argued the medical model was dominant in psychotherapy research, especially in the EST movement with its emphasis on the manualisation of therapy to enable research. In contrast, he argued the contextual model of psychotherapy was less scientific because of its apparent holistic emphasis and focus on common factors in psychology, although it has a scattered history in psychotherapy due to the dominance of the medical model of evaluation. However, across the diverse histories of psychotherapy, there is an underlying commonality - "all of the many specific types of psychotherapeutic treatment achieve virtually equal – or insignificantly different – benefits from a common core of curative processes" (Glass, 2001, p. ix). This is in direct contrast to the specific ingredients approach to ESTs and the medical model of psychotherapy evaluation where the belief appears to be that controlling for (i.e., manualising) specific treatment techniques for a specific disorder and demographic will enlighten psychological practice by revealing what specific techniques produce beneficial outcomes. Although Wampold (2001) argued for a contextual and common factors model of evaluation, he also aligned them within a positivist stance and heavily endorsed meta-analysis.

In an examination of the emergence of EBP Spring (2007) argues that the development of EBP in the United States was in response to the American Medical Association's requirement for a standardised curriculum founded on science and rigour in clinical training. At the same time, at McMaster University in Canada there was a call for 'evidence-based' medicine where a group was formed to produce a standard technique of evidence-based medicine to overcome biases in decision-making, from the formulation of a question, to obtaining evidence, evaluating it, applying it, and assessing its outcome. In the United Kingdom, Archibald Cochrane is attributed with the emergence of increased spending on randomised controlled trials in the British Health System, promoting them as more reliable and less prone to bias than other evaluation methods. Incidentally, the Cochrane Collaboration is now a major

international organisation that influences policymakers and practitioners by promoting randomised controlled trials for evidence-based evaluations (Denzin & Giardina, 2008).

Such historical examinations seem to have lacked a critical analytical focus, as they have not acknowledged a conflict between the positivist psychotherapy evaluation and the post-positivist stance of narrative therapy. Most of these historical investigations (i.e., Garfield & Bergin, 1994; Lambert, 2004; Strupp & Howard, 1992) were also brief overviews rather than in-depth or comprehensive historical examinations of psychotherapy evaluation.

There also seems to be very little literature that critically and theoretically contextualises the theoretical background of narrative therapy in any depth or substantiality, with perhaps some exceptions (Besley, 2001, 2002; Drewery & Winslade, 1997; Freedman & Combs, 1996). Although such exceptions examined some of the key influences on narrative therapy, they did not historicise or problematise the epistemological breadth and diversity of theoretical influences on White and Epston's (1990) narrative therapy and did not consider the effects these influences may have for the evaluation of it.

Some studies have attempted to evaluate narrative therapy but have not theoretically addressed the epistemological conflict between narrative therapy and evaluation. Most of these studies present case studies and descriptive case reports (Besa, 1994; Clare & Grant, 1994; Gardner & Poole, 2009; Huntly & Owens, 2006; Keeling & Bermudez, 2006; Keeling & Neilson, 2005; Kogan & Gale, 1997; Kropf & Tandy, 1998; Leahy & Harrigan, 2006; Merscham, 2000; Muntigl, 2004; Nylund, 2002; O'Connor, Meakes, Pickering, & Schuman, 1997; Rothschild, Brownlee, & Gallant, 2000; Wetchler, 1999) to represent the process of therapy and its outcomes. In a discursive analysis of six published case studies, five suggested that narrative therapy demonstrated positive outcomes for clients (Busch, 2007). This body of research (with the exception of Besa, 1994) appeared to be qualitative in nature and so seemed suited to narrative therapy's qualitative emphasis on applying a textual analogy to problems (White & Epston, 1990). However, across the studies there were no substantial discussions of narrative therapy's postmodernist philosophy. While they examined narrative therapy from a qualitative perspective there was little mention of a possible schism between the philosophy of narrative therapy and that of evidence-based psychotherapy evaluation. In their review of narrative therapy research, Etchison and Kleist (2000) argued that the paucity of reported studies was likely because the

"constructivist" approach was inconsistent with empiricism and the likely lack of research training in qualitative methodology.

It appeared that there had been no critical attempt to contextualise both evaluation and narrative therapy *and* examine the relationship between them – as a problematisation. Therefore, my aim was to perform such an accomplishment.

The Research Question(ing)

The use of the reflexive Foucaultian interpretative framing of problematisation has enabled me to begin to explore a problematic differend between narrative therapy and evaluation in psychotherapy in psychology. My exploration of readings/writings in critical psychology (e.g., Fox & Prilleltensky, 1997), Foucaultian analytics, and *The Differend* (Lyotard, 1988) led me to a particular differend and its problematisation, a research stance located in/through Foucault's genealogical works (Foucault, 1977, 1986). Through tracing a field without origin other than language itself (Barthes, 1977; Foucault, 1984a), and remaining "within the dimension of discourse" (Foucault, 1972, p. 76), I have argued that my reflexive problematisation has created a differend. As a reflexive journey, it has enabled me to be increasingly aware of my research values and of the emergence of the conflict between the two practices of evidence-based psychotherapy evaluation and narrative therapy. Both the practice of narrative therapy and evaluation in psychotherapy appear regulated by a system of rules located within their particular genres of discourse. These practices, constituted through conflicting discourse produce a relationship of domination and subordination, where one practice silences the other. It appears that narrative therapy cannot argue in the authoritative discourse of psychotherapy evaluation in psychology because its interpretivist, multiple-meaning-focused idiom does not match the objective measurement-focused EST and EBPP framing, based on a singular, denotative narrative of scientificity. The problem is how to address this differend through its problematisation.

Therefore, my aim in this thesis is to problematise the differend between evidence-based psychotherapy evaluation and narrative therapy in order to analyse this problematisation (through a genealogical problematisation/methodology that follows on from my research question(ing)). I aim to problematise the differend in order to open up possibilities for new practices of evaluation and evaluating narrative therapies.

From encountering a differend at the early stages of my thesis research, and from being initially aware of an apparent epistemological conflict between evaluation in

psychology and narrative therapy, my thesis research centres on a research question(ing): How can narrative therapy be evaluated? However, in order to answer such a question, I realised that the context of the assumptions of evaluation in psychology and of narrative therapy needed to be unpacked *first* in order to address (i.e., contextualise) their relationship. Therefore, I will examine the contingency and constitution of both kinds of practices/discourses first: specifically, White and Epston's (1990) narrative therapy and evidence-based psychotherapy evaluation. In the next chapter, the methodological section, I justify a genealogical methodology as a way to address my research question(ing).

Chapter 2

Genealogy as a Methodology and a Reading Practice: Transverting the Evidentiary

The purpose of this thesis is to offer a problematisation of psychotherapy evaluation in relation to narrative therapy. Instead of proposing an ahistorical, empirical examination of narrative therapy within an evidence-based evaluative framework (as I had originally intended), I take an alternative research path. Rather than searching for '*the* truth', genealogy is a methodology concerned with the strategic use of historical knowledge to generate critique (Hook, 2005). In this chapter, I present genealogy as a methodology for addressing the issue of evaluation in relation to narrative therapy. Taking genealogy as a method enabling an historical fracturing of a present day practice – a history of the present (Gordon, 1980) – this chapter argues that a critique of the scientific narrative of denotation (Lyotard, 1984) that constitutes evidence based evaluation makes visible the differend between the discursive practices of psychotherapy evaluation and narrative therapy. I argue that genealogy is a suitable methodology to question modernist, progressive views of scientific practice and provides an alternative research approach to such views. I argue that genealogy is an appropriate methodology to dissociate (as in pluralise the meaning of) the identity of a contemporary concept (evaluation) and its practice, produced by current truth regimes. Examining multiple beginnings and emergences of a concept/practice through history as critique, can subvert and change (transvert) taken for granted assumptions of the constitution of 'evidentiary'. Further, I argue that genealogy is a suitable methodology to contextualise, in the form of historical critique, both evidence-based evaluation and narrative therapy in order to address their present conflictual relation to each other to consider how might narrative therapy be evaluated.

The concept of genealogy originated from Frederick Nietzsche's body of work. Nietzsche's *On the Genealogy of Morals* aimed to subvert established moral truths through a critical historical approach. Nietzsche (1967) was critical of 'truths' about morality, and through his critique he demonstrated that morality was an 'ideology' defined by the aristocracy: the noble were more moral and thus the less noble were less moral. He linked the notion of "good" back to "*the same evolution of the same idea* – that everywhere 'aristocrat,' 'noble' ... is the root idea" (Nietzsche, 1967, p. 12, original

italics). 'Good' was understood as "with aristocratic soul" and 'noble' was understood as "with a soul of high calibre," "with a privileged soul" and ran parallel to the ideas of "vulgar," "plebeian," and "low" which were made to evolve into the meaning of "bad". Nietzsche's (1967) 'genealogy' focused on destabilising these truth notions of morality.

Following Nietzsche, Foucault took up the concept of 'genealogy' to critique linear, evolutionary, and progressive notions of history.[20] Foucault illustrated Nietzschean influences in his essay, 'Nietzsche, Genealogy, History' (Foucault, 1984a). Foucault criticised one of Nietzsche's close colleagues, Paul Rée, who examined the history of morality in a linear developmental framing. Foucault critiqued Rée's assumption that history is a singular, linear development where "words had kept their meaning, that desires still pointed in a single direction, and that ideas retained their logic" (Foucault, 1984a, p. 76). Such an assumption resonates with a modernist narrative of science and the scientific method as necessary to discover truths that are generalisable, undisputable and constant, and the structuralist narrative that meaning is never-changing and always in the present (Crotty, 1998). Foucault's (1980, 1984a) genealogical approach critiques and disrupts established truths and finality of meaning by piecing together instances in history.

Genealogy is useful for politicising modernistic research practices in psychology. In advocating a Foucaultian genealogical approach, Hook (2005) argued that psychology is one of the human science disciplines where genealogy is *most needed* given psychology is typically ahistorical in focus and there is a propensity towards establishing universal explanations of individualised and internalised human conduct. Instead of smoothing out history with universal(-ising) narratives, a genealogical approach regards history as laden with discontinuities. Thus, it aims to make discontinuities visible in order to dissociate and pluralise the identification and conceptualisation of something established (e.g., evaluation) (Foucault, 1984a). Dissociation and pluralisation is made possible so that, as Arribas-Ayllon and Walkerdine (2008, p. 98) argue, an "alternative relationship to our contemporary regimes of psychological truth" can be established rather than simply taking such truth regimes for granted.

[20] This is not surprising as Nietzsche's implicit critique of an assumed linear biological progressive narrative of history fits well with Foucault's (1972) work in his readings of Bachelard and Canguilhem's emphases on discontinuity in the natural sciences. Foucault (1972) published his introductory chapter around the time of his essay, 'Nietzsche, Genealogy, History' (Foucault, 1984a).

Genealogy from Archaeology

Discontinuities in History

In order to understand genealogy as a methodology, one must first understand a brief overview of archaeology. This is because a genealogical approach stems from Foucault's (1972, 1973b) archaeological studies. Archaeology is an historical research approach but not in the traditional sense where a particular history places itself as a grand account of phenomena. Foucault (1972) contrasted two types of historical approaches: a *total history* that searches for a governing theory or narrative of a particular period or society and a *'general' history* that moves away from a totalising narrative and instead looks for differences, transformations, dis/continuities, and ruptures. Foucault pursued a 'general' historical approach in his archaeological studies. Influenced by Gaston Bachelard's and Georges Canguilhem's writings with their emphases on discontinuity in the history of the natural sciences (as articulated by Gutting, 1989), Foucault (1972, p. 9) wrote that "the discontinuous was the given and the unthinkable: the raw material of history ... [and] the stigma of temporal dislocation that it was the historian's task to remove from history." Foucault (1972) argued that discontinuity is an unavoidable part of history yet the total historian often attempts to eschew it by rearranging and effacing discontinuities to give the impression of a "face of a period" (p. 10), an unbroken and uninterrupted homogenising theory or account of an historical period. Therefore as a problematisation of what total history does not do, his approach in archaeology, as in genealogy, was to examine discontinuities in history to be able to fracture a history of the present.

Discontinuity is not a theoretical approach but more a research emphasis in relation to genealogical (and archaeological) research. The genealogist considers discontinuity as an inevitable occurrence in aspects of experience (Shiner, 1982). Although Foucault (1980) was labelled as a "philosopher who founds his theory on discontinuity" (p. 111), he was "flabbergasted" by such a statement. A theory of discontinuity could imply that the world that we live in is discontinuous and this would undermine the importance of examining continuity. Such a totalising theory could disallow a critical psychologist, for example, to place research emphasis on how psychology *continues* to perpetuate the experimental method in relation to its individualist conceptualisation of human subjectivity. Foucault (1980) argued, "the great biological image of a progressive maturation of science still underpins a good many historical analyses" (p. 112). However, Foucault (1980, pp. 111–112) also

asserted, “certain empirical forms of knowledge don’t follow the smooth, continuist schemas of development which are normally accepted”. Examples of this are the emergence of different paradigms in psychology’s history: psychoanalysis, behaviourism, humanism, cognitivism, neuroscience, and so on. Therefore what is made scientifically evidential, what is evidentiary, through the lens of a progressivist maturation, can be found to have shifts and ruptures as a “whole new ‘régime’ in discourse ... something that is undeniable, once one has looked at the texts with sufficient attention” (Foucault, 1980, p. 112). A genealogist therefore aims to examine historical moments where there are sudden dramatic shifts in established scientific knowledge and discourse to disturb the legitimacy of the denotative power of a singular narrative, opening spaces for other narratives to emerge:

> My problem was not at all to say “*Voilà*, long live discontinuity” ... but to pose the question, “How is it that at certain moments and in certain orders of knowledge, there are these sudden take-offs, these hastenings of evolution, these transformations which fail to correspond to the calm, continuist image that is normally accredited?” (Foucault, 1980, p. 112)

Rupturing Humanist and Modernist Progressivism

It is through the examination of discontinuity that Foucault also problematises modernist reason and the human(-istic) subject, the “progressive maturation of science” (Foucault, 1980, p. 112). Foucault (1972) stated that modernist reason and the human(-istic) subject are “two sides of the same system of thought” (p. 12). According to Foucault (1984a), modernist reason and the human(-istic) subject cannot be separated from one other. In his critique of modernist discourse, he showed that modernist reason is not as rational as one may portray it, as there is discontinuity of reason and knowledge. Archaeology reveals “that we are difference, that our reason is the difference of discourses...” (Foucault, 1972, p. 147). Foucault (1972) argued that the history of science, ideas, and thought in an attempt to introduce specific strata of discrete periods, has broken up the “progress of consciousness ... the evolution of human thought ... the teleology of reason ... [and] has doubted the possibility of creating totalities” (p. 9). In history, instances of ‘unreason’ emerge from reason; modernist reason, in relation to the human(-istic) subject, is not progressive in the sense that it becomes more truthful, more rational, better, or more refined but is instead full of rupture, reversal, and transformation.

In effect, Foucault (1972) argued that the total historian's attempt to 'remember' by monumentalising temporal continuities through and within the cataloguing of lengthy periods of history that ignores difference has, paradoxically, continued to create discontinuity within and between periods and series. The increasing documentation of history into smaller periods has occurred so much so that scales of inquiry have become smaller, briefer, and more distinct that they turn out to be "irreducible to a single law ... [and] cannot be reduced to the general model of a consciousness that acquires, progresses, and remembers" (Foucault, 1972, p. 9).

Genealogy also extends the archaeological method of subverting modernist-humanistic progressivism by opposing itself to the search for the ultimate, foundational origins of humankind (Foucault, 1984a) and by historically searching for breaks and contradictions in knowledge (Foucault, 1980, 2003b). Both the archaeologist and the genealogist aim to disrupt a smooth, singular, progressive history of the human sciences. They aim to disrupt a modernist rationality, which assumes throughout history science continuously adopts consistently better (universalising and totalising) paradigms for the benefit of humankind. However, the genealogist looks for descent (*herkunft*) rather than a singular origin (*ursprung*) (Foucault, 1984a). The genealogist, for Foucault (1984a, p. 82), does not pretend to perpetuate an unbroken continuity, but instead follows a multifaceted course of descent: "an unstable assemblage of faults, fissures, and heterogeneous layers", hasty conclusions, accidents, and false appraisals as lost events dispersed throughout history. The search for descent disturbs any continual, fixed meaning of a concept as it "fragments what was thought unified; [and] it shows the heterogeneity of what was imagined consistent with itself" (Foucault, 1984a, p. 82). The genealogist becomes aware of cracks in global, totalising theories from modernist science and through exposing such cracks establishes a more localised kind of criticism, one that is "not dependent on the approval of the established régimes of thought" (Foucault, 1980, p. 81).

So, one can use genealogy to historicise and politicise psychology's typically modernist empirical research approaches. One can apply it to contextualise psychology's regime of knowledge, including its discourse and procedures, critically (Hook, 2005). By strategically assembling an array of historical knowledges, Hook stated that genealogy generates critique rather than discovering 'the truth'. This critical historicisation of psychology is particularly suitable for this thesis because I aim to problematise the relation between psychotherapy evaluation *in psychology* and narrative

therapy. Genealogy will provide what Hook (2005) calls an 'epistemology of critique' where both the practices of evaluation and narrative therapy are questioned through an examination of their descent. In order to examine how I could do this, I now describe the association between knowledge, power and discourse in genealogy.

Conceptualising Relations between Discourse, Knowledge, and Power to Disrupt a Unified Concept/Practice

As the genealogist investigates descent to provide an alternative approach to a modernistic, unified history of a concept, she/he examines different practices of knowledge. The genealogist can identify such practices in what Foucault (1972, 1986) calls statements and discourse. Traditional historical methods can involve a *formalisation* of knowledge in that the modernist researcher transfers historical phrasings to a logical proposition, a model or theory (Deleuze, 1999). The genealogist disrupts this formalisation through an examination of statements (Kendall & Wickham, 1999). According to Deleuze (1999), the focus of archaeology is on the statement, the simple inscription of 'what is said'. However, the statement is different from a word, a phrase, or a sentence and yet, a statement can relate to them. For example, Foucault (1972) argued that a graph is not a sentence. Rather, it is a statement (e.g., a normal curve denotes standardisation). Statements influence how words and phrases are conceptualised, used and regulated: "[statements] precede the phrases or propositions which implicitly presuppose them, and lead to the formation of words and objects" (Deleuze, 1999, p. 12). In a speech act or a writing act, "each act is embodied in a statement and each statement contains one of those acts" (Foucault, 1972, p. 83). Therefore, statements are not purely acts of expression as words, phrases, and/or sentences; they are productions of conduct (Kendall & Wickham, 1999).

So, the genealogist and archaeologist are concerned with the examination of statements in their *function* that enables particular modes of existence. The statement is a function that enables possibilities of what one can say. A statement is part of "the set of rules which at a given period and for a given society define ... limits and forms of the *sayable*. What is it possible to speak of?" (Foucault, 1991a, p. 59, original italics). Kendall and Wickham (1999, p. 42) describe the Foucaultian notion of discourse as "a corpus of 'statements' whose organisation is regular and systematic." A discourse can be a "group of statements" that "belong to the same discursive formation" (Foucault, 1972, p. 117).

> Discourses organize and regulate even interpersonal relationships as power relations. Discourses are social practices; they are organized ways of behaving. They are frameworks we use to make sense of the world, and they structure our relations with one another (Drewery & Winslade, 1997, p. 35).

A discursive formation is an enunciative system that governs statements, discourse, and therefore governs what it is possible to speak of (Foucault, 1972). The archaeologist describes discursive formations as 'snapshots' in history, focusing on the regularity and regulation of statements. The genealogist is interested in power relations and *ruptures* in discursive formations, including the government and functioning of statements (Kendall & Wickham, 1999). In doing so, the genealogist often uncovers the institutional locations of discourse that regulate and produce conditions of authority that legitimate practice:

> Medical statements cannot come from anybody ... [as there are] institutional sites from which the doctor makes his [sic] discourse derives its legitimate source and point of application (its specific objects and instruments of verification) (Foucault, 1972, p. 51).

The genealogist, therefore, searches for discontinuities of the discursive *and* the non-discursive, the said *and* the unsaid, connected to apparatuses that have strategic functions (Dreyfus & Rabinow, 1982; Foucault, 1980). An archaeologist may conceptualise evidence-based practice as a methodological episteme, a particular form of scientific knowledge identified and bounded through its discourse on how one classifies, regulates and make sense of evaluation. A genealogist might uncover, within or in relation to the discourse of evidence-based practice, knowledges and statements that represent practices of power and resistance. These practices may relate to various institutions and their administrative and political processes, where relations of forces and particular forms of knowledge reproduce each other through discourse. Thus, a genealogical approach is useful for troubling the evaluation of narrative therapy because it focuses on discursive *practices* of power. For the genealogist, the discursive and the non-discursive are inseparable (Foucault, 1980). The institution, for instance, is "[e]verything which functions in a society as a system of constraint and which isn't an utterance ... [and is] all the field of the non-discursive social ... [but yet] is itself

discursive" (Foucault, 1980, pp. 197–198). [21] The genealogist assumes "there is no power relation without the correlative constitution of the field of knowledge, or any knowledge that does not presuppose and constitute at the same time power relations" (Foucault, 1977, p. 27).

The relation between knowledge and power is an important analytical consideration in genealogical research. The genealogist can examine the possible complex interplay of relations that involve the discursive and non-discursive, which form a backdrop to "various studies of the power of normalization and the formation of knowledge in modern society" (Foucault, 1977, p. 308). Foucault conceptualised power as a social relation rather than something acquired and accumulated individually. Together, power and knowledge enable *and* constrain discursive practices in the sense that power is productive rather than simply repressive (Foucault, 1980, 2003b). Foucault (1980, p. 119) argued that power "forms knowledge, produces discourse ... [and] needs to be considered as a productive network which runs through the whole social body." Power is a net-like organisation that circulates as it exercises through and between bodies, simultaneously. Where there is power, there is resistance; resistance cannot exist outside of power relations (Foucault, 1990). As a research methodology, genealogy examines power-knowledge[22] practices, including the productive and repressive aspects of power in relation to resistance. For Foucault (1980, 2003b), genealogy necessitates an historical analysis of power, its exercise, its effects on the social body, and its resistance. The analysis of power involves an examination of its relational production through the examination of knowledge and discourse (Foucault, 1980; 1990). Genealogy can also involve an examination of governmentality (Hannah, 2009; Larner & Walters, 2002; McCuaig & Tinning, 2010; D. Monk, 1998; Nichols, Walton, & Price, 2009; Rabinow & Rose, 2003; Rose, 1996; Villadsen, 2007).[23] Governmentality is a particular investigation of power based on the assumption that

[21] In Foucault's (1977, p. 307) description of the carceral city and society, for example, he describes an apparatus/dispositif, a system of discursive and non-discursive elements: "there is ... a multiple network of diverse elements – walls, space, institution, rules, discourse ... a strategic distribution of elements of different natures and levels." Here there is an acknowledgement of the interrelations between discourse and power: "the effect and instrument of complex power relations, bodies and forces subjected by multiple mechanisms of 'incarceration', objects of discourses that are in themselves elements for this strategy" (Foucault, 1977, p. 308).

[22] Here the hyphen between power and knowledge symbolises a relationship rather than a single element of sameness (i.e., knowledge is not power but, according to Foucault (1980), they are related intricately to each other).

[23] Villadsen (2007), for example, argues that "for genealogy, the analysis of discourse is not reducible to an analysis of language (or sign system), but one that involves a complex network of relations between statements, institutions, *governmental technologies* and social practices" (p. 311, italics added).

discourses can have a material effect on the rationality and governance of conduct in how individuals survey and regulate their conduct in relation to each other and of themselves (Gordon, 1991).[24] Power is also dependent on discourse:

> [I]n any society there are manifold relations of power which permeate, characterise and constitute the social body, and these relations of power cannot themselves be established, consolidated nor implemented without the production, accumulation, circulation and functioning of a discourse. (Foucault, 1980, p. 93)

Therefore, the aim of the genealogist is *to document knowledges and discourse* in order to examine relations of power (and discourse) because "it is in discourse that power *and* knowledge are joined together" (Foucault, 1990, p. 100, emphasis added). Power and knowledge enable the production of each other (Foucault, 1980). They are all part of an apparatus/dispositif, a strategic network of diverse elements, practices, and relations that involve the contingencies of power, knowledge, and discourse. The genealogist should be aware that, as part of an apparatus, power, knowledge and discourse regulate and reproduce truth:

> There can be no possible exercise of power without a certain economy of discourses of truth... [but] we are subjected to the production of truth through power... [yet] we cannot exercise power except through the production of truth. (Foucault, 1980, p. 93)

So, an important facet of genealogical inquiry is the examination of truth where discourse of truth is understood as a "system of ordered procedures for the production, regulation, distribution, circulation and operation of statements" (Foucault, 1980, p. 133). Truth can be a regime that circulates in the very power relations that "produce and sustain" it (Foucault, 1980, p. 133). A genealogist can produce a history of the present of an evaluative truth regime in psychology to problematise and disrupt its knowledge and power. One can examine the present truth of evaluation by examining its descent, dispersed in history as an unstable, discontinous assemblage of multiple events and meanings. For the genealogist, what matters is "detaching the power of truth

[24] Governmentality can also be understood as a regular "interdependence between the 'government of men [sic]' and ... the 'manifestation of truth'...[namely] 'government in the name of the truth'" (Gordon, 1991, p. 8).

from the forms of hegemony, social, economic, and cultural, within which it operates at the present time" (Foucault, 1980, p. 133).

Disrupting Truth Regimes

A genealogical methodology also requires a 'Foucaultian optimism', one that challenges the status quo in psychology where the processes of knowing 'what evidence is', and how to get it through evaluative criteria, become contestable. Genealogy, as a critical historical examination, troubles often taken-for-granted assumptions and productions of truth and evidence:

> There's an optimism that consists in saying that things couldn't be better. My optimism would consist in saying that so many things can be changed, fragile as they are, bound up more with circumstances than necessities, more arbitrary than self-evident, more a matter of complex, but temporary, historical circumstances than of inevitable anthropological constants. (Foucault, 1988b, p. 156)

My interpretation of the above argument by Foucault (1988b) is that what seems to be determinable, what *is* (made) evidentiary, may, when historicised, appear to be more of a temporary arrangement that is contingent on the conditions that made it possible. Genealogy enables an historical examination of events and statements that a contemporary concept or practice may have been contingent on (Epstein, 2010).

I take 'Foucaultian optimism'[25] to be 'my' academic optimism inspired through a reading of Foucault's genealogical works; by exposing contingent events as happenstance rather than as part of a smooth progressive continuity, and by exposing marginalised knowledges, alternative histories can be written. Genealogy examines power struggles (Foucault, 1980, 2003b). It traces the present history of a concept or practice. Genealogy does this by locating events of dominance, subjugation and struggle throughout history. In exposing such events, one builds a political narrative of science, which is different to a traditional positivist scientific narrative. This means that oppressive hegemonic practices can be both opposed (subverted) and possibly changed (transverted).

[25] Some may view such a phrase, 'Foucaultian optimism', as oxymoronic, and think of Foucault and Foucaultian theory as bleak and pessimistic. Critics of Foucault read his book *Discipline and Punish*, for example, as society that is bleakly totalised through a system of domination because they (con)fuse power and domination to mean the same thing (Falzon, 1998).

As a 'history of the present' (Foucault, 1977; Gordon, 1980), genealogy historically problematises taken for granted practices in present-day society. The genealogist provides an optimistic subversion of the status quo by problematising it (Foucault, 1988b). One nagging question that a genealogist might ask would be "what practices and conditions enable, at present, best evaluative practice of psychotherapy in psychology and who has benefited/suffered from them?" Such a question needs history and psychology to answer the present status of things – or, as Hook (2007) suggested, a genealogical engagement with psychology to perform a genealogy of various psychologies. Genealogy enables one to see that the many scientific paradigm shifts in psychology, where one paradigm is 'naturally' thought of as *better* than all others, depended on *political* movements within the discipline. Positivist science involves a constant refutation of old truth claims to accepting a new truths, and thus an historical-theoretical shift from an old paradigm to a new, improved paradigm (Foucault, 1980) – a 'modernist progressivism'. A single, evolving, correct narrative constitutes these paradigmatic shifts as moments of crisis in science where, through an accumulation of new findings and theories, scientists increasingly question a 'normal science' that aims to keep the status quo (Kuhn, 1970). Eventually, a scientific revolution occurs (e.g., the cognitive revolution, a shift from behaviourism within psychology to the focus on the importance of examining mental processes and states for understanding behaviour). For Kuhn, the influence of scientific revolutions and paradigm shifts have less to do with objective research and more to do with human interests, values, and faults. Truth, then, can be conceptualised as a constantly shifting, *arbitrary* and *political* production. The genealogist can disrupt a governing truth regime of the status quo through examining its multiple descents as arbitrarily formed practices and conditions. Within psychology, the conflict between the 'truth status quo' discourse of evidence-based practice in psychology and the discourse of narrative therapy can be rendered into existence and problematised by examining the descent of their multiple, arbitrary, and political constitutions.

Genealogy as Dissociative Transversion of the Evidentiary

A Dissociative Research Approach

Foucault (1984a) argued that one could practice genealogy as a systematic dissociation of identity. The research methodology that I adopt for this genealogical reading practice is a dissociative one that aims to subvert the contemporary hegemonic

discourse of evaluation as 'empirical evidence' to enable new spaces for practicing the evaluation of narrative therapy. A genealogical research approach problematises the research question(ing) by critically asking, "how is evaluation practiced in psychotherapy in relation to narrative therapy and, how can narrative therapy be evaluated?" Dissociative transversion enables a reading practice that is necessarily critical of the status quo of evidence-based practice in psychology as the best method for evaluating narrative therapy. As a critical methodology, genealogy enables a modality of scepticism towards, and aims to eschew, the authority of absolute truth (Owen, 1994). In doing so, the genealogist "record[s] the singularity of events outside of any monotonous finality" (Foucault, 1984a, p. 76). This means that a genealogical research approach is critical of any truth claim that seems final such as the claim that evidence-based practice and the experimental method is best practice for psychotherapy evaluation. Singularities of events are particular events that do not fit with a totalising truth, such as the 'truth' that psychology is traditionally an experimental science, a truth "hardened into an unalterable form in the long baking process of history" (Foucault, 1984a, p. 79). Truth is something that Foucault (1984a) calls a "history of error" because the genealogist finds multiple events throughout time, as discontinuous singularities and marginalised or subjugated knowledges, to problematise contemporary truth regimes. The claim that evidence-based practice is the best evaluative practice we have (Freshwater & Rolfe, 2004), for example, can be troubled by examining its discourse and tracing events that contributed to its establishment. The genealogist examines the discursive production of events in their singularity, which undermines present-day taken-for-granted truth regimes that produce evaluative practices as necessary for the establishment of certainty and finality of truth. Events enable possible conditions for shifts in discourse (Foucault, 1991a). It is the genealogist's objective to find such shifts in discourse and practices, and link these to "connections, encounters, supports, blockages, plays of forces, strategies and so on" (Foucault, 1991b, p. 76) because they enable "a multiplication or pluralization of causes" that dissociate something as "self-evident, universal and necessary" – something as a truth, as evidentiary in itself. In doing so, not only does the genealogist subvert truth as "self-evident, universal and necessary" but also creates conditions of possibility to transvert what is evidentiary – to transform it, to enable its meaning as changeable and plural rather than fixed and singular, through a dissociative methodology.

Why would one want to do this – to transvert the present-day evidentiary through a dissociative historical approach? From a critical psychological perspective, the question is vital (as in full of vitality[26]): Where evidence-based practice occupies the dominant position in scientific hierarchy, it obscures the narrative competencies necessary to make sense of the complexities of meaning in narrative therapy "beneath the level of cognition or scientificity" (Foucault, 1980, p. 82). This dominance positions local narratives as "unqualified… [and] disqualified" (Foucault, 1980, p. 82). Genealogy, as a dissociative transversion, has the potential to render visible the lowly knowledges by attending to the local and the discontinuous, against the truth claims of a hierarchical, unitary scientific narrative.

In attending to marginalisation and dominance, a dissociative genealogical research approach addresses hierarchical injustice where the ruling experimentalist genre of discourse in evidence-based psychotherapy evaluation is in direct conflict with 'othered' practices in psychology. One can view narrative therapy 'othered' because its discursive genre is not suited to the experimentalist genre and yet many psychologists judge narrative therapy within an experimentalist genre because it is an authoritative, privileged and dominant discourse of evaluation in psychology. Genealogical approaches have the potential to address the hierarchical power relation by problematising the evidentiary, that which subjugates other discourses and practices. Such an approach "gives rise to questions concerning our ... laws that govern us" (Foucault, 1984a, p. 95), to questions of the orders/governance/regularities of discourse, and so it aims to "reveal heterogeneous systems which, masked by the self, inhibit the formation of any form of identity" (Foucault, 1984a, p. 95).

Contingency and Conditions of Possibility

The work of the genealogist is to produce a history of the present: "to demonstrate the negotiations, tensions and accidents that have contributed to the fashioning of various aspects of our present" (Barry, Osborne, & Rose, 1996, p. 4). To do this, the genealogist looks for *contingency,* a multiplicity of possible conditions, rather than a singular and totalising linear cause and effect explanation to account for the present state of affairs of things. The genealogist examines discourse as always

[26] What I mean by 'vitality' is in reference to Foucaultian notion of a breath of life: where subjectivity as resistance introduces itself into history and revolts against essentialising modernistic practices (Gutting, 1989).

already contingent on events in history. Genealogy makes present-day truth claims tenuous, such as evidence-based practice is best practice (Freshwater & Rolfe, 2004), through uncovering multiple events and conditions that produce other evaluative meanings that have contingency with the present-day 'truth'. Ransom (1997) argued that the genealogist should consider two aspects of contingency. Firstly, it is necessary to disrupt the notion of truth where things "which present themselves as natural end products of a comprehensible and progressive history are revealed as a cobbled patchwork of heterogeneous elements" (Ransom 1997, p. 88). Secondly, these things "respond to haphazard conflicts" (Foucault 1984a, p. 88) rather than through some regulated fashion; they are dependent on other elements for their meaning. Thus, contingency is about how things emerge from a disorganised, diverse and fragmentary history:

> The things which seem most evident to us are always formed in the confluence of encounters and chances, during the course of a precarious and fragile history. What reason perceives as its necessity, or rather, what different forms of rationality offer as their necessary being, can perfectly well be shown to have a history; and the network of contingencies from which it emerges can be traced. (Foucault, 1988a, p. 37)

In this project, I examine the contingencies of evaluation and narrative therapy as related to events formed through the interconnection of relations and events (e.g., Michael White encountering Edward Bruner's work by chance, which possibly influenced his work on narrative) (G. Monk, 1998). Reading relations of contingency to examine the conditions of possibility that enable and constrain them, makes visible the complexity of historical relationships (e.g., relations with other encounters) that are free from predetermined necessity, and the multiple and fragmentary occurrences are made meaningful through their relationship.

With an emphasis on contingency, the genealogist examines the conjuncture of events that occur without design. The genealogist looks for contingencies, scattered and random accidents of history as possibilities, instead of trying to draw linear cause and effect relationships between things: "an historical event ... [is] one *possible* result of a whole series of complex relations between other events" (Kendall & Wickham, 1999, p. 5, italics added). The emphasis on contingency produces a disruption of a steady, linear-causative progression of history through an examination of the multiple and

sometimes competing discursive practices as contingent relations between power and knowledge (Foucault, 1984b). These contingent relations constitute the conditions possible for the production of counter-narratives that are resistant to a modernist narrative of cause/origin and effect/finality.

The genealogist refuses the inevitability of origins and finality. Genealogy examines knowledge statements as "an ongoing process" (Kendall & Wickham, 1999, p. 34). Here the metaphor of the rhizome is useful to understand genealogy.[27] A rhizome is a plant that constantly forms roots and shoots from different *nodes*. If a root is cut a new one grows and continues the process of the multiplication of roots and shoots, sometimes connecting back to the original root it was cut from and at other times not. A genealogical metaphor of the rhizome is therefore a multiplicity of '(non-)origins' with no beginning or no end; the rhizome and genealogy are both anti-*teleological*. A genealogical analysis is a "rhizomatic journey that does not have a predetermined point of arrival or departure" (Meadmore, Hatcher, & McWilliam, 2000, p. 470). Neither the rhizome nor genealogist has depth and finality in their journey.

Identifying Contingent Discursive Practices: Subjugated Knowledges, Descent, and Emergence

For Dreyfus and Rabinow (1982, p.107) the "coat of arms" of a genealogical approach might read: "[o]ppose depth, finality, and interiority [i.e., hidden meaning]" and "distrust identities in history" as identities "are only masks, appeals to unity". By focusing on the dissociative work of genealogy, I use such an approach to subvert the mask of unity of evaluation in psychology through an examination of the contingencies of discourse and practices. This is done by historically locating discourse, as a relation of power and knowledge, at and through three important sites of dissociation: subjugated knowledges (knowledges that are 'buried' in the dust of hegemonic practices), descent (numberless '(non)-beginnings'), and emergence (points of power struggle, bifurcations, and 'overthrows' of discourse) (Foucault, 1984a). In my genealogical approach, I historically locate statements and discourse of subjugated knowledges through examining descent and emergence in their contingency, and locate such statements and discourse as resistances to power practices in evaluation

[27] It is important to note here that Deleuze and Guattari (1987) articulated that rhizome is anti-genealogy. However, here they were referring to Chomsky's structuralism and biological metaphors (and possibly Nietzsche's anti-Darwinist use of the term 'genealogy') and not that of Foucault.

psychology. This then enables a dissociation of present-day truth discourse about evaluation to reveal the relation of conflict between evaluation in psychology and narrative therapy where narrative therapy is subjugated/silenced. Through an examination of the knowledge-power relations that dominate evaluation discourse, genealogy unearths subjugated knowledges. These kinds of knowledges can dissociate the positivist standpoint that *one* singular model of evaluative practice can apply to all therapies. The excavation of subjugated knowledges can enable the production of new and multiple possibilities of phrasing and understanding evaluation.

But what specifically are subjugated knowledges, and how are descent and emergence important for a dissociative genealogical analytical reading practice? Foucault (1980, 2003b) conceptualised subjugated knowledges in two ways. On one hand, they are those erudite knowledges that have been "buried and disguised in a functionalist coherence or formal systematisation" (Foucault, 1980, p. 81). On the other hand they are also "unqualified knowledges" that are low-ranking in terms of the hierarchy of scientific knowledge – for example, writings by narrative therapists which may be seen by psychological scientists as 'less than academic' or 'less than scientific'. Genealogy thus pays attention to "local, discontinuous, disqualified, illegitimate knowledges" (Foucault, 1980, p. 83). The focus on subjugated knowledges is useful in recovering excluded and marginalised knowledge (Tamboukou & Ball, 2003). Genealogy is thus the "union of erudite knowledge and local memories" as subjugated knowledges that enable an "historical knowledge of struggles" (Foucault, 1980, p. 83). It is a heterogeneous collection of differends, of discontinuities and conflicts between genres of discourse and discourses of subjugated and hegemonic knowledges. This historical collection of discontinuity enables one to unmask and subvert a contemporary unified concept or practice.

The genealogist examines statements and discourses (practices) of subjugation in and through locations of descent and emergence as tactics to bring local discursivities into play. "Genealogy is gray" (Foucault, 1984a, p. 76) – there is no beginning or end, no finality, no clear identity, truth, or 'black and white' – just rhizomatic plays of contingency. The genealogist locates the descent of statements and discourse to incite dissociation of present-day truth, produced in/through a regime of truth, which then enables a pluralistic enunciative functioning of discourse. Descent is a network of contingencies of heterogeneous elements yet to be revealed. An examination of descent enables the revelation of a myriad of events, countless '(non-)beginnings' of a concept

(Foucault, 1984a). It enables the identification of "reversals ... errors, the false appraisals, and the faulty calculations" (Foucault, 1984a, p. 81) that produce our present-day truths. The examination of descent transverts the evidentiary; it "disturbs what was previously considered immobile; it fragments what was thought unified; it shows the heterogeneity of what was imagined consistent with itself" (Foucault, 1984a, p. 82). Emergence, meaning "moment of arising" (Foucault, 1984a, p. 83), also enables a heterogeneity of statements and discourse to be revealed and collated by the genealogist. An analysis of emergence enables power relations to be uncovered as a re-establishment of the "hazardous play of dominations" in language games, and as a location that is a 'non-place' of confrontation because, as with contingency, the conditions of possibility through descent produce a heterogeneity of possible '(non)beginnings', no *one* is responsible for the conflict (Foucault, 1984a). A genealogical location of emergence makes visible the shifts, bifurcations, and new appearances of discourse as contingently linked to practices of power relations and resistance.

If power is a relational practice that produces things (Foucault, 1980), it must produce resistance: "there are no relations of power without resistances" (Foucault, 1980, p. 142). If one can historically critique the relationships between (and within) evaluation and narrative therapy, and uncover multiple facets of narrative therapy and evaluation that nudge at what appears to be a rigid conflict between the two practices, then a differend may open various spaces to pursue methodological avenues for evaluating narrative therapy. Such a research aim and approach has the potential to engage with this problematic differend and therefore challenge, as an act of resistance, 'best practices' for evaluation in psychology and narrative therapy. This thesis takes up a genealogical research approach through a reading of genealogy as discourse, a methodological examination to produce a reading practice/method for the evaluation of narrative therapy.

Applying Genealogy in the Context of This Thesis

In appropriating a genealogical research approach, I examine the contexts of evidence-based psychotherapy evaluation and narrative therapy. I question what sort of relation there is between these two practices in order to open spaces for considering how to evaluate narrative therapy.

Contemporary psychology and its practices of evidence-based evaluation are dependent on empiricist principles (i.e., gathering data through objective observation and experimentation as proper conduct of scientific method). The bases of evaluation research in clinical psychology have bifurcated into two stable systems of practice: a recent shift in policy to evidence-based practice (APA Presidential Task Force on Evidence-Based Practice, 2006), which is now overshadowing the prior dominant focus on empirically supported treatments. However, both of these systems of practice continue to promote and perpetuate a hierarchical decision-making process of evaluative practices that privilege the experimental method over all other approaches. The evaluation process forming evidence-based practice (or the evaluation of professional practices as defined in and through a specific process of acquiring certain forms of evidence) has been authorised as the best method we have in evaluating psychological interventions (Freshwater & Rolfe, 2004).

Emerging in the late 1980s as a counter narrative to modernist therapies, narrative therapy as a practice understands evidence based evaluation as a "normalizing judgement" (White & Epston, 1990, p. 24). Narrative therapy is a stance that is critical of professional discourses that exclude other ways of understanding experience (Winslade, Crocket, & Monk, 1997). Accordingly, there has been an absence in clinical psychology publications on narrative therapy and to date there has only been one published experimental evaluative study of narrative therapy – but not in psychology: rather, in social work (Besa, 1994). The contest over the constitution of evidence between narrative therapy and evaluation can be conceptualised as a differend (Lyotard, 1988), a conflict between two types of discourse where one discourse can silence or marginalise the other and (re)produce the occurrence of an injustice. This specific injustice is located within psychology where the dominance of, and preference for, experimental-empiricist evaluation practices do not fit with the postmodern theoretical premises of narrative therapy. I problematise and attend to this injustice by examining the practices of evaluation and narrative therapy while attending to the differend.

Collection and Analysis of Documents as Genealogical Method

To transvert the evidentiary, my reading practice engages with the collection and analysis of the documents that form the statements that produce a relation between narrative therapy and evaluation. The genealogist meticulously examines documents, and genealogy is in itself a process of documentation: "[i]t operates on a field of

entangled and confused parchments, on documents that have been scratched over and recopied many times" (Foucault, 1984a, p. 76). Genealogical research has involved the analysis of policy documents (Andersson & Fejes, 2005; Meadmore, Hatcher, & McWilliam, 2000). Lord (2006) has argued that both the museum and its objects are documents for genealogical analysis – a potential documentary practice that would acknowledge both the discursive and non-discursive. Gale (2001) emphasised the importance of semi-structured interviews to produce important data on the practices of power relations for genealogical analysis in education policy in addition to documentary methods used in archaeological and critical historiographical approaches. One could argue that a document is both discursive and non-discursive: it produces statements and discourses but it is also material – an object that forms part of a corpus of discourse. However, Kendall and Wickham (1999) raised an important point about the danger of separating the discursive from the non-discursive. They argued that the body's form "is not independent of discourse, and the articulations of the body ... are always discursive, yet the body itself is non-discursive" (Kendall & Wickham, 1999, p. 40). Hook (2007) also argued that the discursive needs to be viewed through the extra-discursive (history, materiality, and conditions of possibility), and argued that particular forms of discourse analysis (i.e., Potter and Wetherell, 1987; Parker 1992) fail to do so. Foucault (1972) deliberately blurred the discursive and non-discursive with his phrase 'discursive practice' as:

> a body of anonymous, historical rules, always determined in the time and space that have defined a given period, and for a given social, economic, geographical, or linguistic area, the conditions of operation of the enunciative function. (p. 117)

So what does this mean for the *method* of genealogy? According to Foucault (1984a), genealogy materially situates itself through the body and history but the body is also the discursive: the "inscribed surface of events" that is "traced by language and dissolved by ideas" (p. 83). Therefore, both the discursive and the non-discursive are conditions of possibility for genealogical analysis.

The location of the researcher is also an important part of the process of genealogical research. The human body (including my body) is also a document and is involved in a process of documentation; it is inscribed with meaning through history (Foucault, 1984a). The body of research without the body of the researcher (again,

there is inseparability between the discursive and the non-discursive) is unable to be articulated. This means that the 'I' is contingent on a fragmented 'eye'/perspective in and through relations of discourse and power. Thus, genealogy is a reflexive project that is not only a process that involves an analysis of the documentation of discourse; it connects to the experience of practices through a fragmented subjectivity:

> Whenever I have tried to carry out a piece of theoretical work, it has been on the basis of my own experience, always in relation to processes I saw taking place around me. It is because I thought I could recognize in the things I saw, in the institutions with which I dealt, in my relations with others, cracks, silent shocks, malfunctionings ... that I undertook a particular piece of work, a few fragments of autobiography. (Foucault, 1988, p. 156)

Genealogy thus may be a documentary method but the *written* document does not exclusively determine the method. My experience with institutional power relations, and how they constitute evidence-based therapies, informed the genealogical research approach to this thesis. When I look back at my telling in the previous chapter, I see the practices of power and resistance that had complex contingent relations with knowledges and discourses about evaluation and therapy that I had previously encountered. Like Foucault (1988), I recognised processes and cracks in the institution of psychology and so I too conduct this genealogical project with a history of fragments from 'my' experience already greyly embedded in this genealogy as an exteriority of my ascribed body / parchment.

Critiquing and Transforming My Disciplinary Location – Psychology: Genealogy and Reflexivity

I take up genealogy, here, as a mode of critique to question and transform my own discipline and its influences (evidence-based practice and my relation to it in this thesis are located within a broader domain: psychology). Genealogy is not reflexive in the sense of producing a "self-reflective, self-thematizing human subject" (Hook, 2005, p. 28). Rather, for Hook (2005, p. 28), genealogy can be understood as a "critical psychology that addresses the emergence and descent of the discourse and procedures of psychology" which then enables critique of the influence and production of psychological discourse and processes. Foucaultian reflexivity can be understood as a reflexivity of the fragmented subject in terms of a dispensing with the essential and

humanistically constituent subject. The focus of inquiry is on the constitution of discourse and knowledge in a particular historical location (Foucault, 1980). Foucault eschewed deep meanings from phenomenological, structuralist, and hermeneutic approaches; his approach was the examining of the 'surface' of things – being opposed to the idea of essentialist meaning or a deep, hidden meaning (an ultimate truth). If archaeology is about the 'surface' of things, and genealogy is an extension of archaeology, then reflexivity can be conceptualised as a surface-based process in terms of *examining relations*. That is, instead of looking for hidden meaning, the genealogist examines the *relationship* between discourse and reflexivity, and in doing so, the genealogist fragments the phenomenological subject in the process: "I wish to know how the reflexivity of the subject and the discourse of truth are linked – 'How can the subject [and therefore psychology] tell the truth about itself?'" (Foucault, 1988, p. 38). Reflexivity thus becomes a *simulacratic gaze* of genealogical inquiry, of representations/statements of the subject that are inseparable from discourse: "I am working on a history, at a given moment, of the way reflexivity of self upon self is established, and the discourse of truth that is linked to it" (Foucault, 1988, p. 39).[28] There can be no reflexivity without reference and relation to discourse.[29] There can be no 'turning in' on oneself to find deep hidden meaning of core values and beliefs in terms of a structuralist stance nor a detachment from oneself in terms of a Husserlian phenomenological bracketing, but rather a *transformative gaze* on the inseparable relationship between discourse and the subject, which in turn fragments the identity of the self. A genealogy of discourses and processes from within psychology "facilitates a critique of the formation and operation of a regime of knowledge that invents human objects and makes them operationable, practicable within a broader web of social power" (Hook, 2005, p. 28). It is my intention that in critically historicising the relationship between evidence-based evaluation of psychotherapy in psychology and narrative therapy, I exhume fragmentations/discontinuities in the discourse of psychology it*self* to render it as transformative.

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[28] Archaeologically, if we can only know what appears on the surface as a stratum of statements then turning back on our discourses will only reveal different surfaces of strata and their relationships – simulacra of surfaces/strata, representations of representations. Foucaultian reflexivity is "without having to make reference to a subject which is ... transcendental in relation to the field of events" (Foucault, 1980, p. 117).

[29] Foucault (1972) argues that there is inescapability from discourse: that "one remains within the dimension of discourse" (p. 76).

Genealogy transforms how the present can be understood. Genealogy allows for "the dissociation of the self, its recognition and displacement as an empty synthesis, in liberating a profusion of lost events" (Foucault, 1984a, p. 81). The True, Original, and Authorial subject is dispensed with (Barthes, 1977; Foucault, 1984c, 1984d) for a multiplicity of '(non-)origins' (Foucault, 1984a) that transform a subject through a reflexive genealogical gaze. Therefore, interconnected values, subject positionings, and disciplines that can be reflexively accessed (Wilkinson, 1988) are transformed through statements/discourse and events in history, and so reflexivity and the subject can be seen as rhizomatic in nature. Rather than adhering to the scientific method in psychology to evaluate narrative therapy, genealogy enables an historical critique that makes visible *multiple* constitutions of evaluation, central and marginal to psychology, and narrative therapy. Genealogically, reflexivity concerns the relationship between discourse and power and the genealogical journey as rhizomatic – enabling differing positions and standpoints while others are eschewed as more connections and disconnections along the rhizome of genealogy are made. Therefore, the genealogist attends to the transformative power of discourse as enabling new vantage points to articulate a dissociated identity of a subject:

> [A] genealogical method allows the researcher to travel along rhizomatic pathways, searching for new vantage points from which to see the self. New vistas come into view, as some are closed off. What is important is that the journey, as Foucault intended that it should, rejuvenates and in doing so, offers new ways of seeing the present. (Meadmore, Hatcher, & McWilliam, 2000, p. 470)

A Reflection on Genealogy

In this chapter, I have established a genealogical reading practice to transvert the evidentiary, to unmask the unity of evidence-based evaluation as best practice in psychology to open the boundaries of evaluation to make visible in the present, the power relations that marginalise narrative therapy and transform it. This research approach is significant because it allows me to critique hegemonic practices of evaluation in psychology rather than perpetuate them. Genealogy enables the relationship between evaluation and narrative therapy to be studied as a problematisation. A genealogical approach is a methodology that critically examines complex and multiple, contingent possibilities that subvert present-day truths that are

taken for granted and valued. As a critique of unitary science, a genealogical methodology can reflexively examine heterogeneous events of power and knowledge practices, each in their singularity as discourse. Therefore, I have adopted a dissociative, fractured stance rather than 'pretending' to be dispassionately bounded outside such practices and framing them as part of a unified theory or law. Genealogy examines discontinuity in history, contextualises contingent discursive and non-discursive practices as a *history* of the present where quasi/experimental science, mainstream historical methods, and other qualitative methodologies, such as discourse analysis cannot. As a dissociative approach based on the notions of finding discontinuity, critiquing narratives of progressivism and modernism, and attending to complex relations and interplays of discourse, power, and knowledge, genealogy examines subjugated knowledges and uses contingency, descent, and emergence to subvert present practices and regimes of truth that are taken for granted. It is rhizomatic, giving voice to narrative therapy and other(ed) evaluative practices that would be impossible to language and examine through and within mainstream quasi/experimental and other methodologies. Where mainstream methodologies perpetuate the status quo of evaluation in psychology, genealogy as a dissociative endeavour is a practice of criticism that enables the transversion of the status quo:

> Criticism is a matter of flushing out ... thought and trying to change it: to show things are not as self-evident as one believed ... Practicing criticism is a matter of making facile gestures difficult. In these circumstances, criticism (and radical criticism) is absolutely indispensable for any transformation. (Foucault, 1988b, p. 155)

Afterthought: Genealogy and (Transverting) Validity

When I was writing this methodological chapter on genealogy, I thought: "here I am writing about genealogy as a research approach without considering the possibility of what might happen if this thesis was evaluated according to the criteria of my genealogy". Other questions then emerged. How could a thesis on genealogy be assessed when there has been nothing written on what a 'good' genealogical study is? Obviously, there would be some general qualitative evaluative criteria used – but how does/can one 'validate' genealogy as a methodology? What possible criteria could examine whether a genealogical study is doing what it claims to do? Is 'validate' an appropriate word for an antifoundationalist methodology? Would an examination of

criteria be a fitting process or would a set of question(ings) be more suitable? I came across Patti Lather's (1993) notion of validity as an incitement to discourse – validity as an obsession. Lather argued that one could transform validity to mean various things, counter to foundational and modernist notions of the concept. In other words, there is not one meaning of validity but a heterogeneity of possible meanings. Instead of rejecting validity and replacing it with some other term, Lather (1993, p. 674) "retain[s] the term in order to both circulate and break with the signs that code it ... to rupture validity as a regime of truth". Lather's (1993) notion of validity, as breakage and rupture of its foundationalist and modernist roots, fits well with a genealogical stance: to oppose, to cut, and to subvert authoritative and hegemonic practices in the human sciences.

Lather (1993) presents different (re)framings of validity that take into consideration antifoundational discourse theory, three of which appear to have relevance to the project of genealogy: 1) Lyotardian paralogy/neo-pragmatic validity, emphasising discontinuity, 2) rhizomatic validity, stressing an anti-teleological stance and a complexity of contingent relations, and 3) voluptuous validity, emphasising reflexivity and situatedness as necessary excess. A person evaluating this genealogical project, could, for example, ask from a paralogical validity position, is there a "search for instabilities and the undermining of [a] framework within which previous 'normal science' has been conducted" (Lather, 1993, p. 679)? Does this genealogy "foster differences and let contradictions remain in tension" (Lather, 1993, p. 679) rather than produce a history that glosses over breaks in discursive regimes? With regard to rhizomatic validity, does this genealogy enable new ways of seeing the present? The genealogist, in the context of this project, "undermines stability, subverts and unsettles from within" (Lather, 1993, p. 680) the evaluative discursive practices of psychology. Does this genealogy examine the "complexity of problematics where any concept, when pulled, is recognized as connected to a mass of tangled ideas" (Lather, 1993, p. 680) where contingency is important? Does the genealogist aim to examine multiple '(non-) origins' of descent in relation to "their content of possibilities" (Lather, 1993, p. 680)? In relation to voluptuous validity, does this genealogy appear to go at times "too far toward disruptive excess, leaky, runaway, risky practice" (Lather, 1993, p. 686)? Does it transgress the normative assumptions of a traditional experimental or empirical PhD in psychology through an emphasis that "embodies a situated, partial, positioned, explicit tentativeness" that subverts traditional impartial authority for an "authority via

practices of engagement and self-reflexivity[30]" (Lather, 1993, p. 686)? Such notions of validity are transgressive in the sense that they deliberately resist traditional foundationalist notions of validity in psychology where validity is thought to produce stable, fixed, and concrete truths from empirically measuring whether or not the methods used to measure particular phenomena are doing the job with accuracy and without error. However, the use of transgressive validities, as I do here, make possible the transversion of traditional meanings and acts of validity where antifoundationalist methodologies, such as genealogy, can be judged and evaluated in a discourse that is familiar to their own.

Coda

In this chapter, I have focused on genealogy as a methodology for this thesis. Each discourse has a context which can be genealogically traced from the conditions that made it possible to exist in its present form (Hook, 2005). My thesis will trace the movements in evaluation, central and marginal to psychotherapy in psychology, parallel to the theoretical influences on narrative therapy in order to render the differend between narrative therapy and evaluation (highlighted in Chapter 1). This genealogical approach enables me to examine as a problematisation how to evaluate narrative therapy. As a method of dissociation, genealogy can also enable what is evidentiary to be fragmented, and pluralised. By examining discontinuities (as multiple descents, emergences, resistances or subjugated knowledges) in a narrative of evaluation and its limits in relation to narrative therapy, one uncovers new points, contingent on that relationship, to edit that narrative and thus create possible conditions to consider new forms of evaluation. This allows a shift from one way of languaging/narrating evaluation (i.e., a denotative scientific narrative) in relation to narrative therapy, to multiple ways to render and address the problematic differend between evidence-based psychotherapy evaluation and narrative therapy.

[30] Here I do not want to advocate a return to a phenomenological or humanistic self (which I'm sure an antifoundationalist stance on self-reflexivity would not do) but rather see a fragmented self in 'self-reflexivity' where reflexivity is a 'discursive practice'. Through an engagement with discourse, in a Foucaultian sense, the self is always already fractured and dissociated.

Chapter 3

Tracing the Theoretical Descent (and Emergence) of Narrative Therapy

In this chapter, I provide a genealogy of the theoretical descent and emergence of White and Epston's (1990) narrative therapy.[31] To begin to address how narrative therapy can be evaluated, a genealogical fragmentation of its theoretical descent is necessary for understanding how the underlying epistemology of narrative therapy appears as a theoretical practice of resistance to the denotative narrative of scientificity in response to the interpretive crisis in the social sciences. I make the case that the historical body of various works of interpretivist theorists that constitute narrative therapy, overlooked today in evidence-based evaluation[32], are resistances to a singular, unitary narrative of formal scientific inquiry. Positioned as antithetical to the authoritative discourse of evidence-based evaluation in psychology, this discourse subjugates such interpretivist works, to view them as discontinuations and therefore disruptions of an authoritative, denotative narrative of unitary scientific knowledge. Through a critical reading of the theoretical descent of narrative therapy, I argue that post-positivist[33] accounts make possible the emergence of narrative therapy as a resistance to evidence-based practices.

Tracing the Multiple Descents of Epistemology in Narrative Therapy as Emergent Moments of Resistance to Positivist Science

In contemporary psychology and health sciences, the discourse of evidence-based practice (EBP) appears to produce an optimistic stance in that it *is* – self evidently – the way forward for best practice. Not only are randomised controlled experimental trials considered as the gold standard (Kitson, 2002; Rycroft-Malone, 2004), EBP *itself* is constituted as the gold standard or as the valued way of evaluation practice (Freshwater & Rolfe, 2004). It is advanced as a necessary rapprochement of a division between science and practice in psychology (Bauer, 2007; Spring, 2007; Thorn, 2007).

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[31] I wish to note that I am not examining narrative therapy practice from a practitioner perspective. I am not a practitioner of psychotherapy or counselling and therefore I feel that it is not my place to research from such a standpoint.

[32] (The evidence-based practice and empirically supported treatment movements.)

[33] There are contemporary forms of positivism that are content with probability rather than certainty, and the approximation of truth, but the underlying principle and aspiration to objectivity, and the idea that only scientific knowledge is valid, still holds strong (Crotty, 1998). This more modest form of positivism can be called 'post-positivism' but for the purposes of this thesis I refer to 'post-positivism' as a movement that resists the positivist notions of knowledge as completely objective.

The American Psychological Association holds an aspirational goal for EBP in psychology: "We aspire to set the stage for further development and refinement of evidence-based practice for the betterment of psychological aspects of health care as it is delivered around the world" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). Health companies and research organisations have also put considerable effort into developing and promoting what seems to be a growth industry of EBP (Rycroft-Malone, 2004).

There are psychological therapies that fit well with such a positivist epistemological approach to evidence-based evaluation, for example, cognitive therapy (CT). The scientific testing of hypotheses in CT (i.e., reality testing and thought checking) fits well with a positivist theoretical approach in psychology. CT assumes that, over time, through the exploration and observation of negative automatic thoughts one can get to the core of a person's belief system (i.e., a core belief or schema), the primary changeable cause of his/her maladaptive behaviour (Neenan & Dryden, 2004). There is the assumption that the positivist researcher can discover true, real origins through the impartial study of reducing seemingly complex behaviour to its simplest essential form thereby producing a causative factor or mechanism that is measurable. One can then test such a factor or mechanism against behaviours to generalise to universal theories of individual behaviour (e.g., trait theories). A positivist epistemological approach to science and therapy assumes that there *is* a key explanatory element that can be uncovered through due and careful scientific process of reductionistic inquiry (American Psychiatric Association, 1994)[34] and hypothesis testing (e.g., identifying and testing key maladaptive thoughts).

The positivist stance in EBP assumes that "scientific progress supplants older best practices with newer and better ones" (Spring, 2007, p. 618). It also assumes that the psychologist can measure the soundness of research evidence, from clinical observation to randomised experiment trials, privileging the psychologist as the objective expert scientist-practitioner decision-maker *for* the client, where the psychologist languages client context in/through medical and psychopathological terms (APA Presidential Task Force on Evidence-Based Practice, 2006).

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[34] The front end of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994), for example, argues for a reductionistic anachronism of mental disorder because it cannot find a more suitable conceptualisation in and through its positivist, classificatory languaging.

However, narrative therapy does not fit with a positivist, modernistic epistemological approach. Modernist theory assumes a universal, generalisable, absolute, truthful, undisputed and real knowledge and that science and the scientific method produce and reproduce it (Crotty, 1998). The scientific method assumes that empirical causality through objectivity determines truth or the increasingly correct account of things. The textual indeterminacy of narrative in narrative therapy refutes the inevitability of origins and truth claims that are devoid of subjectivity. Instead of searching for the ultimate, true underlying mechanism(s) of maladaptive behaviour, narrative therapists focus on what Geertz (1986) called the indeterminacy of texts (White & Epston, 1990). This approach to textual indeterminacy in a collaborative relationship between client and therapist in narrative therapy enables the production of a multitude of possible narratives to represent lived experience, informed by the language of the client. This textual indeterminacy metaphor also applies to research: the positivist, scientific mode of inquiry is *one* possible narrative of producing forms of knowledge and understanding that through its authority excludes other knowledges.

Narrative therapy emerged in part through a post-positivist movement that questioned the idea of discovering underlying, fundamental and 'objective' facts through scientific knowledge that can account for the current behaviour of a person.[35] Narrative therapy threads together fragments of storied strengths of a client into an ever-changing story that contradicts reductionistic and universal descriptions of clients' lived experiences. More often than not, the expertise of the scientist practitioner produces these reductionistic and universal descriptions.

The positivist desire for objectivity in the growth industry of EBP seems antithetical to a subjectivist, collaborative relationship in narrative therapy. Indeed, narrative therapists *resist* the medico-scientific model of EBP in favour of the multiple and fragmentary events that are meaningful through the therapeutic relationship: "Narrative therapists do not present themselves as distant, objectively neutral experts who diagnose problems and prescribe solutions and treatments, but as curious, interested and partial participants in the person's story" (Besley, 2002, p. 129).

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[35] I wish to emphasise strongly here that it is not my intention to set up a 'better rather than worse therapy' binary between narrative therapy and cognitive therapy. Cognitive therapy may be helpful and effective in aiding the suffering and distress of many clients *and* it fits well with a positivist research approach. My use of narrative therapy in this thesis does not involve delving into the details of therapeutic process in contrasting and competing with cognitive therapy. Instead, I employ narrative therapy's philosophical bases and theoretical premises to open up a multiplicity of ways to begin to conceptualise how it might be evaluated.

This subjectivist, collaborative relationship in narrative therapy emerged through multiple descents of post-positivist epistemologies. Some have called narrative therapy social constructionist (Freedman & Combs, 1996; Kogan & Gale, 1997; Wetchler, 1999), others post-structuralist (Besley, 2002; Speedy, 2005). In social constructionism, the active construction of meaning and understanding is *between* people through language use in contrast to a transmitter-receiver model where language passively reflects what is written or spoken *to* a recipient (Burr, 2003). In narrative therapy, therapists do not speak *to* clients as if they are docile recipients of a set of questions and instructions from an expert who knows best and duly administers treatment. Instead, therapy is a collaborative conversation and a discursive exercise of understanding each other. Together, therapists and clients explore clients' lives in an ethnographical and textual sense (White & Epston, 1990). The therapist uses the client's language to story problems, rather than using psychiatric discourse of enduring diagnostic categories, thus potentially making problems more fluid and therefore more meaningful to the client. Experience is not languaged in clinical pathology. Collaborative conversations and understandings, produced between therapist and client, tailor decisions on the nature of the intervention (Winslade, Crocket, & Monk, 1997). Such conversations take up the client's language, their stories of their cultural and social specificity, which is counter to an approach centred on languaging essentialising, unitary criteria for a specific set of symptoms.

My focus, in this chapter, is on uncovering the underlying epistemologies that theoretically inform narrative therapy. I frame these knowledges as *resistances* to positivist epistemology. Such resistances, emergent as heterogeneity of theoretical nuances, can critically contextualise the theoretical constitution of narrative therapy and provide space for exploring possible ways to consider how to evaluate narrative therapy. I therefore trace narrative therapy's theoretical assumptions, its diverse and fractured history. As Doan (1998, p. 2) argued, "[n]arrative therapy has been linked from its onset to postmodern thought and social constructionism". Through a genealogical analysis of narrative therapy's theoretical descent, and its subsequent emergence as a form of resistance to positivist ideals, I argue that the multiple theoretical nuances throughout its descent are necessary for its evaluation. In the history of the present, narrative therapy is embedded in a sociality of struggles over what constitutes appropriate evaluation.

In applying a genealogical approach, rather than producing a smooth, continuous, and final historical narrative of the theory that constitutes narrative therapy, I produce a fragmented theoretical history of narrative therapy. As a starting place, I bring into view the theoretical descent of narrative therapy through a reading of White and Epston's (1990) approach to narrative therapy and its relationship with a heterogeneity of theoretical origins, including the writings of Michel Foucault, Jerome Bruner, Clifford Geertz, Victor Turner, Gregory Bateson, Edward Bruner, Erving Goffman, and Barbara Myerhoff.[36] These theorists come from diverse disciplinary backgrounds: psychology, history, philosophy, sociology and interpretive/symbolic anthropology. This is by no means a complete, absolute or final history of the theoretical descent of narrative therapy.[37] This genealogy is a result of my engagement with the theoretical readings of narrative therapy; it is constituted from *how* I have read narrative therapy's fragmented theoretical descent so that I can theoretico-historically contextualise these influences in the social sciences as resisting mainstream positivist epistemological practices to address my particular research question, 'how can narrative therapy be evaluated?' How do these descents emerge as resistances?

In unearthing the different epistemological descents of narrative therapy, my readings of each theoretical reference shape the process of this genealogical examination. This process is a partial, incomplete and strategic one that examines the theoretical fragments of narrative therapy to disrupt the denotative narrative of scientificity. It also involves the tactical examination of narrative therapy publications contingently related to *Narrative Means to Therapeutic Ends* (Freedman & Combs, 1996; Winslade & Drewery, 1997) where reference to epistemological standpoints, in their multiplicity, are constitutive of the epistemological influences[38] of the practice of

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[36] Paul Ricoeur, a hermeneutician, a structuralist, a post-structuralist, and a phenomenologist (among many other vertiginous theoretical labels), is also worthy of mentioning albeit briefly (he was very briefly cited in White & Epston, 1990). In his article 'Narrative time', he emphasised the interrelationship between temporality and narrativity, whereby a plot always intersects between events in time and the storying of those events (Ricoeur, 1980). As both Bruner (2004) and Ricoeur (1984) argue, the only way to make sense of *lived time* (cf. clock or calendrical time) is through the (re)figuration of narrative.

[37] Indeed, another genealogical study of narrative therapy may place its foci differently. As Lock, Epston, Maisel and de Faria (2005) have stated, other theorists that have influenced narrative therapy are Bourdieu (1988) and Derrida (1978, 1981), as well as Erickson (1979, 1980) who influenced David Epston's work but not Michael White's. Although I do not delve into these theoretical influences, I want to acknowledge that most of these are, to some degree, resistances to a positivist epistemology.

[38] In using Foucault's reading of Nietzsche (Foucault, 1984c) here, I do not mean ultimate origin in what Nietzsche calls *ursprung.* Rather, I refer to the contingent, immediate, conflictual and contestable descent (*herkunft*) – the multiple descents of epistemology in the theoretical genealogy of narrative therapy including how these descents contribute to the theoretical emergence of narrative therapy as resistances to mainstream positivist epistemological practices in the social sciences.

narrative therapy. I therefore exhume narrative therapy's multiple traces of theoretical descent to articulate a fractured theoretical emergence of narrative therapy in relation to the various epistemological standpoints (e.g., symbolic interactionism, cybernetics, constructivist and Foucaultian perspectives) that contingently constitute narrative therapy.

Symbolic Interactionist Descent: Performance of Meaning

Symbolic interactionism is one epistemological influence that is by-and-large neither acknowledged nor examined in narrative therapy writings. Sociological and anthropological theorists who were heavily influenced by symbolic interactionism informed White and Epston's (1990) formulation of narrative therapy. I argue that symbolic interactionist influences in the descent of narrative therapy enable the conceptualisation of meaning as performed through symbolic and social interaction, and this is resistant to the positivist assumption that objects have predetermined meaning that are independent of human consciousness (Crotty, 1998).

First, it may be useful to get a sense of symbolic interactionism as resistance to positivist epistemology before exploring its theoretical descent in narrative therapy. A modernistic narrative constitutes positivist assumptions where universal meaning (i.e., 'truth') is something to be discovered objectively (Crotty, 1998). Psychology takes up a modernistic narrative to constitute an individually bounded and "transcendent human subject at the core of meaning" (Hook, 2005, p. 27). In contrast, symbolic interactionism is an epistemology that values "meanings as social products, as *creations* that are *formed in and through* the defining *activities* of people as they *interact*" (Blumer, 1969, p. 5, italics added). It resists the positivist epistemological notions that meaning pre-exists in objects independent of subjectivity and that people discover meaning rather than produce it. Symbolic interactionist theorists who have contributed to narrative therapy's theoretical premises are Clifford Geertz, Gregory Bateson[39], Victor Turner, and Erving Goffman (White & Epston, 1990), many of whom have resisted in some way the reductionist, essentialist, and objectivist reasoning of positivist

[39] Although Bateson was better known for cybernetic theory, it was his communication theory that contributed to symbolic interactionist thought.

epistemology by creating alternative theories and methodologies to understand the meanings of lived experience through peoples' social and cultural interactions.[40]

Though sociologists and anthropologists widely used symbolic interactionism as an epistemological framework, while psychologists marginalised it, the social philosopher George Herbert Mead inadvertently contributed to its emergence.[41] Herbert Blumer developed his research from Mead's work and coined the term 'symbolic interaction' (Blumer, 1937, 1969), which other theorists subsequently took up in a variety of ways (Stryker, 1980). Though Mead took a social behavioural approach to meaning making, he differed from mainstream social psychology research in that he created a way of conducting social science research that involved an interpretative framework. For Mead (1927), the self is a socially constructed entity, not an essence that can be located a priori, as the Greeks located the psyche in the heart, head and organs. Instead, the self comes into existence in interaction with other individuals and selves (Mead, 1910, 1927, 1962/1934). This 'post-Cartesian' conceptualisation of human inter-subjectivity has enabled the constitution of diverse readings and writings influenced by symbolic interactionism.[42] For instance, in White and Epston's (1990) discussion of the role of the modern document, Harré's (1983) file-self, the self as reductionistically and 'objectively' constructed through medical files and jargon, is used to conceptualise an 'othering' through 'rituals of exclusion', a concept drawn from symbolic interactionists Goffman (1961) and Garfinkel (1956).[43] A ritual of exclusion is where "in the communicative work *between persons* … the public identity of an actor is *transformed* into something looked upon as lower ..." (Garfinkel, 1956, p. 420, italics added), a process of demoralisation in social standings (Goffman, 1961). Symbolic

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[40] Some of these theorists may not have directly called themselves symbolic interactionists. However, they were influenced by, and loosely located within, symbolic interactionist epistemology.

[41] Social construction is also constituted from symbolic interactionism. Social constructionism has been a key fragmentation and incorporation of symbolic interaction: "The social constructionist approach provides a means by which interactionists address the institutional formulation of social problems … [and]… to the creation of all social life" (Fine, 1993, pp. 75–76).

[42] I put scare quotes around 'post-Cartesianist' because various forms of symbolic interactionism are not post-Cartesianist where it is assumed that individuals operate separately from the social. Blumer, for example, still constructed the individual-social binary where although meaning was derived through interaction, the individual somehow internalised the meaning by which he/she interacts with his-/her-self (as if the self is an individual) (see Blumer, 1969, p. 5). This is an interesting paradox given that, according to Mead, the self is socially constituted.

[43] Garfinkel would be more aptly described as an ethnomethodologist, however it can be argued that ethnomethodology is a methodology formed primarily from the epistemology of symbolic interactionism. I should also mention that in White and Epston's (1990) discussion (on the file-self and the role of the modern document) they draw on Foucault's (1982) notion of dividing practices. However, as I am still on the inside of symbolic interactionism it is too early to introduce Foucault's influence on narrative therapy in the text … but, in a way, I already have.

interactionists used an ethnographic stance to examine the social dynamics of meaning in context (e.g., Goffman, 1961; Myerhoff, 1986). Through this dialogue among theorists, performances of social interaction produce meanings, challenging psychology's determinate stance on human behaviour in favour of indeterminate and fragmentary occurrences made meaningful through their symbolic and social interactions.

Part of the symbolic interactionist epistemological influence comes from symbolic anthropology (often used interchangeably with 'interpretive anthropology'); a movement that resisted the more objectifying practices of anthropology that use the scientific method (Ortner, 1984). As Erickson and Murphy (1998) argue, symbolic and interpretive anthropologists understand culture as a symbolic system of meaning that emerges from human interpretation. However, they also view culture as *lived experience*, a concept used in narrative therapy to explain client experience, embedded within their wider cultural context (White & Epston, 1990). The focus on the symbolic provides an understanding of the representation of meaning in a contingent relation to the system and context of *cultural* life. For symbolic and interpretive anthropologists, "cultural life has meaning, which is best understood as 'lived experience'" (Erickson & Murphy, 1998, p. 159), but cultural life is also "integrated into a coherent public system of symbols that render the world intelligible" (Erickson & Murphy, 1998, p. 157). Following this argument, to make sense of lived experience, it is necessary to *understand* interpretatively/subjectively the cultural context that symbolises and produces lived experience and its meanings, and this is one of the key aims of narrative therapy (Drewery & Winslade, 1997).

A crucial route to a subjective understanding of cultural context that symbolically shapes lived experience necessarily involves a collaborative positioning in narrative therapy (White, 1995). This collaborative positioning is contingent on White and Epston's (1990) relationship with their ethnographic, symbolic interactionist influences. While Turner (1969) questioned his informants to get a sense of the indigenous meaning of symbols in rituals, another symbolic interactionist ethnographer, Myerhoff (1986), actively collaborated as a participant-observer, embedded within her Jewish participant community, to help them produce and publically visibilise their own symbolic cultural events whereby she gained some understanding of their (and her own) lived experience. A similar collaborative performance based on Myerhoff's (1986) work is done in narrative therapy through definitional ceremonies where the therapist

and client collaborate with 'outsiders' (the client's social network) to make visible their experiences so that they make sense of their specific location (Carr, 1998; White & Epston, 1990). This making visible of local lived experience, through a collaborative production of the symbolic that is meaningful to the client, is also a general aim of narrative therapy. The therapist "can look for the special indigenous knowledge of the client" (Monk, 1997, p. 26) through the co-creation of meaning with the client in the therapy relationship. As Monk (1997, p. 24) argues, "the co-creative practices of narrative therapy require ability on the part of the therapist to see the client as a partner with local expertise" through a participatory "process of unearthing dormant competencies, talents, abilities, and resources." Narrative therapists argue, "meaning is constructed socially" (Drewery & Winslade, 1997, p. 34). The therapy relationship and conversation is valued as a meaning-making activity, focused on the "interactions between people rather than on the dynamics of the individual" (Drewery & Winslade, 1997, p. 39). A contingent relation emerges between the production of meaning in the performance of the researcher-participant collaborative ethnographic relationship in symbolic interactionist approaches and the performance of the collaborative relationship between client and therapist in narrative therapy.

I now turn to the multiple descents of statements on symbolic interactionism that constitute White and Epston's discursive practice of narrative therapy. In the theoretical descent of narrative therapy, various influences have contributed to ethnographic understandings of meaning as performed through symbolic and social interaction. I trace Goffman's, Turner's, Myerhoff's, and Geertz's contributions to the performative aspect of meaning making in narrative therapy.

Erving Goffman: Unique Outcomes and Performing Moral Careers

Erving Goffman is one of the key symbolic interactionist influences on the constitution of narrative therapy as a resistance to reductionistic, authoritative professional categorisations of experience. Narrative therapists are resistant to re-enacting the governing, normative Western scientific narrative whereby "we strive for control over our world and hold ourselves responsible for failures to perform according to standards that are often set for us" (Drewery & Winslade, 1997, p. 49). Consequently, they use Goffman's ethnographic framings of experience to produce a narrative that focuses on unique outcomes as experiences and events that a governing narrative cannot predict (Carr, 1998). Goffman (1961), as a physical therapist's

assistant, set out an ethnographic study of mental inpatients that enabled him to understand how customary interactions within the cultural standards of the psychiatric institution shaped conformity and reduced experience in and through the totality of the institution. His approach challenged, implicitly, the morality of the objectifying practices of science, particularly the decontextualising and normative diagnostic judgements of patients imposed on them by a psychiatric culture. Goffman (1961) contextualised patient experiences both inside and outside the influence of the psychiatric institution.

Goffman argued that relationships within the psychiatric institution influenced the moral career or trajectory of a person's experience. In *Asylums*, Goffman (1961) detailed his observations at St Elizabeth's Hospital, a psychiatric hospital in Washington DC. He examined 'The Moral Career of a Mental Patient', from both pre-patient and inpatient contexts, in relation to his experiences at the Hospital. Goffman (1961) defined a career as "any *social strand* of any person's *course* through life" (p. 127, italics added). He suggested that social institutions are highly influential in structuring the self (in this case, he is referring to the mental institution – but not exclusively so). He argued that if the institutional aspect of our lives is so influential in determining how we shape our selves then this undoubtedly leads to a whole range of moral conformities. Goffman was concerned about the moral aspects of a career: "the regular sequence of changes that career entails in the person's self and in his [sic] framework of imagery for judging himself [sic] and others" (Goffman, 1961, p. 128). A career to Goffman has both a private and a public side where the self constantly switches between 'internal' thoughts close to the heart and social/institutional relationships of the self. Instead of a person depending completely on what he/she imagines him-/her- self to be, the production of the self is dependent on judgements from the relationships and performances with others in an institutional context, along with the institution's social sanctions. The 'detainees'/patients and the 'detainers'/staff in a psychiatric institution conform normatively over time to their roles through the particular psychiatric relationships that are expected of them (Goffman, 1961).

In using this notion of career, of a private and public side to one's course of life, Goffman (1961) tried to make sense of how some people were committed to hospital and how others, who equally could have been committed, were not. This is where the notion of unique and alternative outcomes (White & Epston, 1990) emerged as a resistance to psychiatric institutional discourse. Unique outcomes are those unique

characteristics and performances that a person 'glosses over' in his/her career: that which is smoothed over, minimalised, neglected, buried, or ignored by conforming to a particular social category/strand along with the moral transformations that are organisationally required in such a social category/strand. Goffman (1961, p. 127) described unique outcomes in a person's career, to be "any social strand of any person's course through life". Unique outcomes are "neglected in favor of such changes over time as are basic and common to the members of a social category, although occurring independently to each of them." According to Goffman (1961), such 'basic' and 'common' changes over time become mundane and unquestioned. Goffman illustrated the degree of influence social categories, cultures, or strands have on a person's behaviour relative to their 'autonomy'. Careers in an institutional context follow a normative, moral trajectory according to a particular social category or strand where a person conforms to a normative path that is common and basic to members of that category or strand. However, for Goffman, the institution often degraded unique outcomes in the process of a psychiatric patient's moral career.

Goffman (1961) illustrates this normative conformity in his essay of the moral career where fellow patients and staff in the hospital degrade the psychiatric patient over time. Initially after committal, patients try to hang on to their 'unique outcomes' by implicitly constructing optimistic or strengths-based framings of their selves. Such examples from Goffman included a patient describing holding down a job and going to night school, a patient describing himself as managing to get an audition, and another patient, a job as a reporter. However, Goffman found that because they had to conform to the morality of a particular institutional code, there were normative demands constraining their interaction that degraded and therefore decontextualised their unique outcomes. Patients positioned each other as less moral. For example, when interacting with another patient one patient repeatedly said, "If you're so smart, how come you got your ass in here?" (Goffman, 1961, p. 154). After having been degraded and stripped of their liberties, a 'moral loosening' occurs where the patient resigns to life in the institution to take up its mundaneness and customs. So, their lived experience was reduced to, what Goffman (1961) called, the 'totalising institution'. Customary moral disintegration also occured when staff members quashed the assertions of patients' wellness or denial of disorder:

> Each time the staff deflates the patient's claims, his [sic] sense of what a person ought to be and the rules of peer group social intercourse press him [sic] to

> reconstruct his [sic] stories; and each time he [sic] does this, the custodial and psychiatric interests of the staff may lead them to discredit these tales again. (Goffman, 1961, p. 162)[44]

Goffman's ethnographic exposé of the moral careers of psychiatric patients enabled the notion that one could incorporate unique outcomes into a therapeutic narrative. White and Epston (1990) formulated their concept of unique outcomes from Goffman by approximating his notion of 'social stand' and 'social category' to a kind of 'social story' that is both socially and culturally situated and relational. This made possible the notion that a particular 'social strand' can be understood as a 'dominant story', and that 'social category' can be understood as the culture of persons of a specific identity whereby their lives are positioned in and through a governing, dominant story. Dominant social strands (as dominant stories) can degrade unique outcomes and decontextualise the identity of a person. Conversely, unique outcomes, as "exceptions to the routine pattern within some aspect of the problem normally occurs" (Carr, 1998, p. 493), can contextualise lived experience through incorporating local, unique accounts into new narrative trajectories (White & Epston, 1990). Accordingly, unique outcomes can *never be predicted* by a reading of a dominant story. Similarly, Goffman (1961) asserted the degree of *unpredictability* in a patient's moral career while reinforcing the possibility of alternate outcomes in a wider social context: "[u]ntil a person arrives at the hospital there usually seems no way of knowing for sure that he [sic] is destined to do so" (p. 145).

> The kinds of offenses which lead to hospitalization are felt to differ in nature from those which lead to other extrusory consequences – to imprisonment, divorce, loss of job, disownment, regional exile, non-institutional psychiatric treatment, and so forth. But little seems known about these differentiating factors; and when one studies actual commitments, *alternate outcomes frequently appear to have been possible*. It seems true, moreover, that for every offense that leads to an effective complaint, there are many psychiatrically similar ones that never do. (Goffman, 1961, p. 134, italics added)

[44] It is unclear whether Goffman (1961) exclusively interviewed and observed male psychiatric patients. However, St. Elizabeth's Hospital housed both female and male psychiatric patients.

Thus, a unique outcome is an aspect of a person's lived experience that not only often contradicts and undermines a dominant, normative story about how to behave, but is also that which *cannot be predicted* by reading the dominant story (White and Epston, 1990). The exploration of unique outcomes enables the client and therapist to story what is alternatively possible and meaningful to client lived experience rather than what might be otherwise told in a decontextualised fashion. In the case of narrative therapy, it takes an 'outsider', a therapist, to strategically co-construct and co-envisage with a client alternative possibilities.

Consistent with symbolic interactionism's focus on the generation of meaning through interaction, Goffman's metaphors of drama, ritual and game situated his considerations of social life.[45] A key idea of Goffman's thought, alongside the notion of the self as a social product, is that social interaction is contingent on two inseparable aspects of social life: manipulation and morality. In other words, as Branaman (1997) argued, through "the eyes of others" (p. xlvi) we adhere to various moralities (or moral orders) which are not innate but socially constructed through performance. [46] In addition, Branaman argued our access to cultural resources and qualities that are desirable by a dominant culture influences the extent to which we can 'save face' and construct a sense of moral respectability in relation to others.

Goffman's contribution to social interactionism enabled an understanding of how normative institutional expectations, performed through social relations, can decontextualise and degrade the meaning of the self. However, he also enabled, for narrative therapy, an understanding that the meaning performed through storying unique outcomes can build a new story that can contradict dominant, normative stories of relational expectations and conformity. I now trace Goffman's, Turner's, Myerhoff's and Geertz's contributions to the performative aspect of meaning making in narrative therapy.

Victor Turner: Performance of Meaning through Liminality/Subjunctivation

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[45] Ann Branaman eloquently elaborates on the interconnection between Goffman's drama, ritual, and game metaphors: "A performance is simultaneously an expression of deference to the social order as well as a move in a strategic game, according to Goffman. We strategically chart our performances and courses of action and interaction, often with an aim of being a viable member of a morally cohesive social order. On the one side, the performance of morality requires strategy. On the other side, the ritual order constrains our performances and strategic moves" (Branaman, 1997, p. lxxiii).

[46] This reminds me of and is similar to Foucault's notion of the normalising gaze: how, from a normative discourse of how one should behave in 'the eyes of others', a subject self-surveys and becomes an object of his/her 'own' scrutiny, which thus results in a self-subjugation.

Victor Turner, positioned as a symbolic/interpretive anthropologist and ethnographer, also resisted a singular narrative of lived experience by focusing on how meanings are performed culturally and how meanings are transformed through social relations. Turner (1974) was critical of earlier positivist assumptions and metaphors of social science, particularly those that assumed fixity in social life, and of the mechanistic analogies of social and cultural systems. Turner found the split between Comte's 'social statics' (the conditions and pre-conditions of social order), and 'social dynamics' (social progress and evolution) problematic as the split was based on the assumption of both stability and continuity of meaning. Instead, Turner advocated for a transformative metaphor that recognised that society is in constant flux and change, or in his words: "[t]he social world is a world of becoming, not a world of being" (Turner, 1974, p. 24). What Turner (1974) understood by 'being' was a model of the social world that was assumed by many positivist social scientists as fixed, ahistorical, stable and categorisable. He developed 'a world of becoming' metaphor that was used to make meaning of his anthropological experiences, where "meaning is a resultant of … *interaction*" (Turner, 1974, p. 29, original italics). Turner was interested in performances of culture, or rituals and rites of passage as markers of change in relation to an existing social category, and in developing a root metaphor to make meaning and understanding out of such changes, rather than fixing 'timeless' classifications onto cultures.

Turner's (1974) ritual process and rites of passage metaphor constitute narrative therapy's transformative aspect of plotting turning points to change meanings of lived experience. Narrative therapy borrows from Turner's work for situations when clients are encouraged to story unique outcomes through a 'rite of passage' or social performance frame that constructs told events in a series of transitional phases from stability to crisis to stability and so on (White, 1993). Turner's (1974) metaphor, developed from French ethnographer Arnold van Gennep,[47] involves three processes: separation, liminality and reintegration. Van Gennep (1960) argued that in all ritualised processes there is a point in time when a person liberates from a culturally normative way of behaving to a particular social strand/status and adopts new ways of living or experiencing social interactions that are different from the past. The in-between stage, the liminal phase, is a transition period that ends in a new status for an individual in the

[47] van Gennep was originally born in Germany but was a French national.

social (e.g., getting married, or losing one's virginity). In Turner's (1974) rite of passage metaphor, in the separation phase, a person becomes removed from a social status or identity position that is no longer viable, and enters the liminal phase, or a crisis phase, a place between one's former and future social structure. This liminal phase is what Turner calls 'anti-structure' because it is a process of reordering experience, which is unsettling for the person (e.g., the process of breaking up with a lover). Eventually, the individual reintegrates into another social identity, position or status (e.g., a divorcee takes up a new position as single).

Narrative therapy's practice of restorying emerged from Turner's theory on the liminality process. As unique outcomes are about alternative possibilities for events that a person's dominant story cannot predict, liminality is a subjunctive therapeutic process that enables an imagining of these possibilities. As an exploration of possibilities, liminality allows for a reorganisation of experience and thus a transformation to a different, alternative story of the person: "[l]iminality can perhaps be described as a fructile chaos, a storehouse of possibilities … a striving after new forms and structures, a gestation process" (Turner, 1986, p. 42). Ascribing meaning to unique outcomes through using the subjunctive imagination of alternative possibilities, enabled by Turner, is present in the practices of externalising the problem and finding unique outcomes in narrative therapy (White & Epston, 1990). Understanding ritual as a "subjunctive, liminal, reflexive, exploratory heart of social drama … where the structures of group experience … are replicated, dismembered, re-membered, refashioned, and … made meaningful" (Turner, 1986, p. 43), then narrative therapy can be framed as a ritual in itself that involves such processes. The narrative therapist draws from what was Turner's theorising of the liminal ritual process by using an imaginative liminal metaphor in exploring alternative possibilities that contradict the dominant story of persons' experiencing:

> As the therapist gains knowledge of persons' habitual and predictable responses to events surrounding the problem, he or she can *imagine* what sort of response might constitute a unique and unexpected outcome. (White & Epston, 1990, p. 61, italics added)

So, where Goffman's theory enabled White and Epston to produce a 'social story' that is both socially and culturally situated and relational, Turner's theory enabled the social story to be transformed. Through what Turner (1974, p. 24) called a "world

of becoming", the meaning of lived experience is enabled in and through transitional, imaginative (subjunctive) performances of our cultural identity. Rather than assuming a 'thing' that has predetermined meaning through positivist epistemology (Crotty, 1998), meaning of lived experience is understood as ever changing and made possible through ritual performances (Turner, 1974). Enacting a rite of passage in the interaction between client and therapist enables the exploration of alternative possibilities for the production and structuring of identity and experience (White, 1993). Turner argued that it is "by imagining – by playing and performing – that new actualities are bought into existence" (Turner, 2005, p. 121).

Barbara Myerhoff: Symbolic Performances and Reflexivity / Reflexive Consciousness

Another emergence of symbolic interactionist thought that had transformative potential and resisted the objectivist assumptions of positivist research practices in the social sciences was the reflexive and participatory ethnographic work of Barbara Myerhoff (Myerhoff & Ruby, 1982). Her ethnographic reflections on cultural performances fit loosely with a symbolic interactionist epistemology where, like Turner, she examined the performative dimensions of culture, such as rituals, ceremonies, festivals and celebrations for their reflexive potential in meaning making.

Barbara Myerhoff's research on the performative dimension of culture focused on a reflective stance, but more importantly, a reflexive approach to research. It is important to state the difference between reflection and reflexivity as Myerhoff conceptualised them. Reflection involves "showing ourselves to ourselves" (Myerhoff, 1982, p. 105). It is a way of thinking that enables an articulation of selves analogous to holding up a mirror image of oneself and being aware of the reflection of the self, without having to be explicitly conscious of the implications of the act. Reflexivity, on the other hand, does involve an explicit awareness, a process of self-awareness of our own reflective articulations in and through our meaning making systems:

> Cultural performances … are also capable of being reflexive, arousing consciousness of ourselves as we see ourselves. As heroes in our own dramas, we are made self-aware, conscious of our consciousness. At once actor and audience … [we]… watch ourselves and enjoy knowing that we know. (Myerhoff, 1982, p. 105)

> Reflexive, as we use it, describes the capacity of any system of signification to turn back upon itself, to make itself its own object by referring to itself: subject and object fuse. (Myerhoff & Ruby, 1982, p. 2)

Definitional ceremonies are reflective acts but they can also be reflexive. In terms of a reflective process, Myerhoff (1986) argued that people make sense of themselves by showing themselves to themselves through multiple forms. In her conceptualisation of a definitional ceremony, it is a form of cultural mirroring and a way of self-recognition. Such ceremonies are "self-definitions specifically intended to proclaim an interpretation to an audience not otherwise available" (Myerhoff, 1982, p. 105). The reflexive potential of definitional ceremonies introduces the possibility of the transformation of meaning. Myerhoff enabled this transformative possibility through collaboration with an elderly Jewish community[48], one that felt marginalised, stigmatised and rendered invisible by mainstream society. Myerhoff (1986, p. 263) stated, that "through their own ingenuity, imagination, and boldness, aided by outsiders who publicized their activities, they learned to manipulate their own images, flying in the face of external reality, denying their existential circumstances." The community was highly self-conscious in continually interpreting, representing and performing its "self-determined reality" (Myerhoff, 1986, p. 262). For Myerhoff (1986, p. 262), definitional ceremonies involve both "reflecting surfaces" and are reflexive in "demonstrating the creators' consciousness of their own interpretive work." The practice of definitional ceremonies has involved the particular formulation of outsider-witness retellings in the context of therapeutic practice in narrative therapy (White, 1995, 1997, 2000, 2003). Outsider witnesses are listeners and feedback givers to the person(s)' accounts of experiences of therapeutic change. While the reflexive processes of definitional ceremonies also occur in and through the process of co-construction, outsider witness engagement follows the co-authored new account of the client's experiences. The client and therapist invite an 'outsider' to witness the therapeutic change and confirm it. In community practice, the therapeutic team employ outsider witnesses throughout the process of the intervention (White, 2003). The definitional ceremony metaphor in narrative therapy configures rituals that are "acknowledging of and 'regrading' of people's lives" (White, 2003, p. 54).

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[48] This community was the Israel Levin Senior Adult Centre in Venice, California.

Myerhoff (1986, p. 266) engaged the metaphor of definitional ceremony as a process that could change a "crisis of invisibility and disdain by a more powerful outside society." As a strategy, a definitional ceremony creates opportunities for visibility where reflexive performance, involving gathering an audience to witness the performance, positions oneself as noticed. Her philosophy was that a sense of continuity could come from belonging to a revived, reinvented history, and that this "may contribute as much to reflexive consciousness as rupture, pain, and loss" (Myerhoff, 1986, p. 267). The performative aspect of a definitional ceremony is the key component. It is a ritual process that can involve not just mirroring but also involves an enactment, where a marginalised community can produce a corroborative performance among members that has the potential to transform their desires and wishes, restorying a new aspect of their lives. This transformative process enabled White's (1995, 1997, 2000) narrative therapy practice to not only reflect on the degrading rituals that shape people but also to recognise the potential to therapeutically apply 'regrading rituals' as part of the restorying process. White's (2007) notion of re-membering enables the connection between members that does not forget, but is reflexively open to revival. Importantly for Myerhoff (1986), reflexivity is also necessary to resist the detached research practices used in the social sciences. Like the narrative therapist, the researcher values subjective reflections in the practices of negotiating and participating in social relations.

> Why do most anthropologists identify themselves as scientists and their work as scientific yet often fail to describe adequately the [participatory] methods employed in their research and to account for the possible effects of the researcher on the research? (Myerhoff & Ruby, 1982, p. 20)

Myerhoff and Ruby (1982) argued that the ethnographic practices of detachment often involved making decisions to omit the biases and influences of the researcher as an actively embedded and selective participant-observer in the research process. In narrative therapy, there is an active, collaborative relationship between participants that is reflexively constituted through discourse and therapy. Outsider witnesses reflect back the change in the therapeutic process (White & Epston, 1990). Awards, certificates, letters and documents are texts of 'rituals of inclusion' that not only celebrate the success of the client but are also an acknowledgement of the active relationship, and the performance, between therapist, client(s), and community (White

& Epston, 1990). So too in the research process, the researcher as a producer of knowledge and his/her product are inseparable from the process (Myerhoff & Ruby, 1982). Myerhoff's research made her increasingly aware of how her participation as a researcher transformed her research and values; she was an integral part of a cultural performance (Myerhoff, 1982, 1986). The therapist in narrative therapy also engages their cultural values and reflects upon how they can and do shape the therapeutic relationship (Drewery & Winslade, 1997; Winslade, Crocket, & Monk, 1997).

Clifford Geertz: Textual Indeterminacy and Thick Description of Meaning

Clifford Geertz, widely known as a symbolic anthropologist, resisted the position of the unifed rational subject of the social sciences by theoretically configuring the indeterminancy of texts to produce con-textualised rich and diverse human experiences that resist singularity.

Geertz (1983) critiqued aspects of ethnographic, symbolic interactionist research as too generalising of human experience. In examining the drama and ritual dimensions and analogies of the social sciences, Geertz (1983) critiqued Goffman's dramaturgy as a kind of vamped-up social physics, namely "ping-pong in masks" (p. 24), arguing that dramaturgy portrayed individuals as structured and driven by social forces, bleak, and stripped life to "just a bowl of strategies" (p. 25) for every interactional situation. Turner was not immune from Geertz's criticism, either. Geertz (1983) criticised Turner's theory of liminality for being generally applied to diverse social interactions: "[i]t can expose some of the profoundest features of social process, but at the expense of making vividly disparate matters look drably homogeneous" (p. 28). Geertz's resistance to universal metaphors of complex social phenomena bring texts together to view culture, like a literary critic, valuing interpretation rather than empirical observation.

Geertz's (1983, p. 30) textual indeterminacy blurred the boundaries between the science of the social sciences and the humanities: "[a]t a time social scientists are chattering about actors, scenes, plots, performances… and humanists are mumbling about motives, authority, persuasion… the line between the two… seems uncertain indeed." He argued that the textual analogy is the broadest reconstitution of the social sciences but, at the time, the least developed:

> The recourse to the humanities for explanatory analogies in the social sciences is at once evidence of the destablization of genres and the rise of the "interpretive turn," and their most visible outcome is a revised style of

> discourse in social studies. The instruments of reasoning are changing and society is less and less represented as an elaborate machine or quasi-organism and more as a serious game, a sidewalk drama, or a behavioural text. (Geertz, 1983, p. 23)

This notion of a behavioural text has no reference to behavioural theory in psychology (e.g., reinforcement and modelling) but is a conceptualisation of the textual representation of human activity as a blurred genre where textual representations, such as stories (and (re-)storyings of one's life events), are understood as active constructions of human life. People in interaction can be reconceptualised as *readers and writers* in a textual performance. In narrative therapy, the text analogy enables an understanding of lives and relationships as multiple readings and writings of texts where every new reading is a new interpretation and a new writing of a text: "with every [storied] performance [of lived experience], persons are reauthoring their lives" (White & Epston, 1990, p. 13). If every reading is a new interpretation and a new writing then this enables the questioning of a singular, original truth of a text:

> The wrenching question, sour and disabused, that Lionel Trilling somewhere quotes an eighteenth-century aesthetician as asking – "How Comes It that we all start out Originals and end up Copies?" – finds … an answer that is surprisingly reassuring: it is the copying that originates. (Geertz, 1986, p. 380)

This 'copying that originates' textual metaphor leads to the indeterminacy of texts. Thus, the use of re-authoring one's lived experience in narrative therapy as a textual technique can enable multiple possibilities of existence that exposit the impossibility of a unitary fixity of 'this is who one truly is'. This idea of textual indeterminacy in narrative therapy can be seen as a form of struggle against notions of the unified human subject: "psychology, in the form of a model of the psychological individual, have [sic] provided the basis for … attempts at the unification of life conduct around a single model of appropriate subjectivity" (Rose, 1996, p. 28). Just as there are current-day Western economic ideals of economic rationality and rational choice models that are practised and institutionalised through Western[49] selves, so is there of a singular, correct way of constructing subjectivity in psychology, "a single model of the

[49] Perhaps my articulation of 'Western selves' can also be thought of as *Westernised* selves (e.g., non-Western subjects subjected to Western thought).

individual as the ethical ideal across a range of different sites and practices" (Rose, 1996, p. 28). Rose (1996) asserted that the rise of Western thought (the Western modernisation of the self into a bounded, coherent whole) can be seen, partly, as contributing to an 'individualisation' of the self but today the self, as a fixed and unitary individual, has come under question. Geertz (1976, p. 225) also questioned this Western notion of individualisation:

> The Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgement and action, organised into a distinctive whole and set contrastively against other such wholes and against a social and natural background is, however incorrigible it may seem to us, a rather peculiar idea within the context of the world's cultures.

Geertz (1983) resisted the notion that experience is individually bounded and separate, by understanding the human subject as performed and constituted through a blurred textual analogy that allows for the production of a richness and diversity of human experience that resists a singularity of experience. Through a multiplicity of storied possibilities, as the context of behaviour or an event changes, so does the interpretation of it. Geertz (1973) called this idea thick description. Thin description merely describes the behaviour or event. In contrast, thick description attends to the complexity of meaningful interpretation or understanding of the behaviour or event by the situatedness of context (Geertz, 1973).

In narrative therapy, the process of reauthoring and restorying events can invoke a range of possible trajectories or simulacra of re-tellings that resist dominant and totalising stories of lived experience. For White and Epston (1990), a textual analogy situates clients' lived experience as texts within texts (and so on), and every performance in telling or retelling of a story is an encapsulation and expansion upon a previous telling. The potential of opening social relations to indeterminate and multiple trajectories is an alternative to the idea of a dominant, unitary and true story about one's experience. Regarding the research question of evaluating narrative therapy, White and Epston (1990, p. 15) hinted at what is an acceptable outcome:

> When persons seek therapy, an acceptable outcome would be the identification or generation of alternative stories that enable them to perform new meanings … [as] … more helpful, satisfying, and open-ended.

The epistemology of symbolic interactionism informs the theoretical descent of narrative therapy producing meaning in and through the performance of social relationships. From a symbolic interactionist perspective, meaning is constituted as an interpretative, fluid and performative process that is shaped by and shapes human interaction with culture and its symbols. The transformative potential of symbolic interactionism enabled narrative therapists to collaboratively participate with clients in the exploration of specific personal representations of meaning (unique outcomes), and perform restorying through a process of liminality (as a rite of passage). This potential also enabled narrative therapists and clients to collaborate through a process of reflexive and witnessed enactments that destabilise the dominant story and produce visibility to lived experience that is restoried meaningfully (definitional ceremonies). Symbolic interactionism also enabled a collaborative performance of meaning making in narrative therapy through an understanding of locatedness that aims to contextualise lived experience through the narration of thick description, made possible through applying the transformative value of textual indeterminacy. While narrative therapy brings past into the present through a collaborative process of restorying, Bateson (1972) problematised the potential of recursive patterns of interaction in systems of relationships where meaning gets fixed. While Bateson located meaning in human interaction, he was particularly interested in the communicative relations that produced meaning (Denzin, 1992; Hornborg, 2006).

Cybernetic Descent: Meaning through Comparison and Patterns of Interaction

Bateson's (1972) work emerged in resistance to positivist assumptions of objective experience that is measurable. He developed cybernetic theory to resist the concept of a linear relationship between cause and effect. Writing against the Cartesian mind/body dualism, he positioned human phenomena as both holistic and incalculable. Drawing on Korzybski's (1933/1996) statement that 'the map is not the territory', Bateson argued that objects are always constructed through representation:

> We say the map is different from the territory. But what is the territory? Operationally, somebody went out with a retina or a measuring stick and made representations which were then put on paper. What is on the paper map is a representation of what was in the retinal representation of the man [sic] who made the map; and as you push the question back, what you find is an infinite

> regress, an infinite series of maps. The territory never gets in at all … Always, the process of representation will filter it out so that the mental world is only maps of maps, ad infinitum. (Bateson, 1972, pp. 454–455)[50]

Bateson's (1972) process of representation as an infinite regress produces a relation between temporality in mapping and difference; a map, as a representation, has a possibility of being (re)written over time and thus creates a difference in representation, or 'news of difference'. A particular story or interpretation of events may get lost in the relation of difference where dominant discourses construct those events in a particular way.

Gregory Bateson's work provided possible conditions for narrative therapists to enable their clients to learn subtle differences between events in one time and events in another (Monk, 1997). Difference is where, in a communicative sense, the difference between two real or imagined entities produces information called "news of difference" (Bateson, 1979, p. 68), where such information is a "*difference that makes a difference*" (Bateson, 1972, p. 453, original italics). That is, 'news of difference' is a potentiality that can produce a new response and thus enables change. It can be a piece of information produced between a therapist and client, for example, which can potentially enable a therapeutic transformation of meaning through the co-construction of unique outcomes (White & Epston, 1990).

Regarding the news of difference concept, the temporal mapping of events enables an awareness of change: "Human sense organs can receive *only* news of difference, and the differences must be coded into events in *time* (i.e., into *changes*) in order to be perceptible" (Bateson, 1979, p. 70, original italics). Bateson (1972) noted, "language bears to the objects which it denotes a relationship comparable to that which a map bears to a territory" (p. 180). Exploring lived experience through mapping 'news of difference' informs narrative therapy's process of externalisation where a linguistic mapping produces the separation of the person from the problem (White & Epston, 1990). Instead of subjectifying the person as having a problem, the therapist and client

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[50] I can see parallels here running between Gregory Bateson, Clifford Geertz, and Jean Baudrillard. Geertz (1973) refers to "turtles all the way down" a notion that suggests we can never get to the bottom of things, or discover an absolute true nature of the world through our interpretation. Baudrillard (1984) refers to a similar notion, in the age of electronic media, where the map precedes the territory as a precession of simulacra (representations/copies of representations/copies) which produces the territory as 'hyperreal'. In other words, all three theorists question the notion of an ultimate origin of truth and thus an 'objective experience' is oxymoronic.

construct the problem as an object, outside of the person, where the client has a *relationship* with it. In doing so, narrative therapy explores 'news of difference' to produce other fragmented, possible meanings to the problem (Winslade & Cheshire, 1997). Once externalised, the influence of the problem, in its new meaning(s), can be re-mapped (White & Epston, 1990).

Bateson's conceptualisation of difference is one that is non-calculable: "difference, which is usually a ratio between similars, has no dimensions. It is *qualitative*, not *quantitative*" (Bateson, 1979, p. 100, original italics). If Bateson's difference is dimensionless, if therapeutic change in narrative therapy is framed through the examination of 'news of difference', and if difference does not assume a similarity or homogeneity between real or imagined entities, then, by extension, Bateson (1979) makes admissible a non-measurable, qualitative evaluation of therapeutic transformation.

Bateson's (1979) qualitative notion of difference emerges from the epistemology of cybernetics, a theory that focuses on patterns of relationships in living systems to make sense of human behaviour (Bateson, 1972). As a form of systems theory, cybernetics assumes systems or patterns of recursion; it assumes "we face a hierarchy of *orders of recursiveness*" (Bateson, 1979, p. 201, original italics). Bateson rebutted the normative ideas that humans behave in a *predictable sequence* according to some arbitrary aggregation (whether it involves behaving within a certain 'normative' population or class structure). He argued that normative ideas do not adequately address the complexity of relationships, diversity, communication and non-linear causality in living systems (Tognetti, 1999).

Bateson (1972, 1979) was interested in patterns that create order in recursive relationships. In human relations, recursion can involve a group system of individual members who regulate their system in an array of feedback loops, creating particular patterns of communication that construct these loops, reproducing and more or less sustaining the group system. For Bateson, living systems involve a process that involves self-correction known as a move to homeostasis. A system, according to Bateson (1972), is "responsive to difference … and will inevitably be self-corrective either toward homeostatic optima or towards the maximization of certain variables" (p. 315). Cybernetics, nowadays, is synonymous, particularly in popular culture, with computational metaphors where there is a reduction and simplification to variables and

operations.[51] However, Bateson viewed his cybernetics primarily in the communicative complexity of the patterns of human relationships (see Bateson, 1972, particularly his studies on alcoholism and schizophrenia), and that such relationship patterns were non-normative and thus difficult and problematic to quantify. Thus, the conception of cybernetics enabled Bateson to theorise how we know what we know differently, as a resistance to normative scientific epistemology, in a way that knowledge (and thus difference and, accordingly, 'news of difference') is determined, constructed and maintained by the types of patterns of relationships that recur through relational systems.

Undoubtedly, Bateson's cybernetic statements made possible the conditions for the emergence of externalising and mapping the influence of the problem on the client in narrative therapy. Michael White used the recursive knowledge aspect of cybernetics in his conceptualisations of family therapy in the 1980s prior to formulating narrative therapy in its present form (White, 1989). One can find precursors to the process of externalisating and finding unique outcomes in White's use of cybernetic family therapy language. He posited that through the communicative complexity of interaction, families often become stuck in a recursive negative feedback loop where "events take their course because they are restrained in relation to alternative courses" (White, 1989, p. 67). In 'Anorexia Nervosa: A Cybernetic Perspective', White describes a recursive pattern of guilt and blame where family members "just go round and round in terms of the same old premises" (Bateson, 1972, p. 427; White, 1986a, p. 66). Both therapist and client disrupt the problem and its effects by mapping the influence of the problem through examining relationship patterns "between the problem and various persons, and between the problem and various relationships" (White & Epston, 1990, p. 45).

In Michael White's earlier practice of cybernetic therapy, the idea of promoting 'virtuous' (rather than degrading stories) cycles to interrupt the cycles of restraint that

[51] Bateson was particularly concerned about the adoption of cybernetics for the use of computers, particularly the reliance on machines to make decisions. Left unchallenged, they have the potential to form a recursive trap in knowledge making: "… if you follow the computer you are a little *less responsible* than if you made up your own mind … the problem is to *change* the rules, and insofar as we let our cybernetic inventions – the computers – lead us into more and more rigid situations, we shall in fact be maltreating and abusing the first hopeful advance since 1918" (Bateson, 1972, pp. 476–477, original italics). This makes me wonder about the consequences are we using computational and binary logic metaphors in (re)producing 'moral', normative orders of evaluative criteria in psychology.

produce the problem were challenged in the relationship through double-description[52] (Munro, 1987), a process of mapping multiple meanings to the same event. Co-developing double or multiple descriptions of events, is understood to challenge the existing 'vicious' patterns of relationship (that are also resistant to the dominant story) as a normative way of relating. The theoretical emergence of cybernetics produced the processes of externalisation and mapping to disrupt the recursive patterns of relationships where new responses and solutions can unfold. These processes enable the therapist and client to make an existing recursive (and discursive) restraint in a family increasingly redundant: "the receipt of news of difference is essential for the revelation of new ideas, and the triggering of new responses, for the discovery of new solutions" (White, 1989, p. 88). Bateson's concept of 'news of difference' is (re)constituted in narrative therapy to disrupt the "habitual and predictable responses to events surrounding the problem" (White & Epston, 1989, p. 61). Unique outcomes are born out of the therapist and client disrupting patterns of restraint in familial relationships.

Another potential influence on the emergence of narrative therapy was the concept of reframing, developed by Waltzlawick and his colleagues from cybernetic theory as "a contribution to change – not simply a change in attitude, but even a change in the understanding of what an attitude is" (Bateson, 1972, p. 475). Understanding recursive patterns of relationships enables a reframing of patterns of interaction in the family (Watzlawick, Weakland, & Fisch, 1974). Reframing is premised on the idea that as one person acts they do so in reaction to their interpretation of another person's behaviour or situation and therefore the meaning they attach to it (Polkinghorne, 2004). The process of reframing is a co-construction of meaning through which members of the system restory the meaning of events, "reinterpreting or changing the meaning they attach to a situation" (Polkinghorne, 2004, p. 55). For Polkinghorne, the cybernetic practice of reframing enables a meaning-focused approach to narrative therapy.

Bateson's cybernetic influence on narrative therapy enables an appreciation that comparison and patterns of interaction produce multiple meanings. The qualitative mapping between two real or imagined events can produce transformation in narrative therapy whereby 'news of difference' can give rise to new meanings to multiple lived

[52] Double-description was a concept that White (1989) borrowed from Bateson: "The manner of the search is plain to me and might be called the method of double or multiple comparison" (Bateson, 1979, p. 87).

experiences and recursive patterns of interaction in family systems. The theoretical assumptions of cybernetics engaged in narrative therapy enable an understanding of the problematic and recursive relationship patterns in a system. The qualitative examination of difference is possible through mapping multiple differences in relationships and problems to produce new meanings.

Constructivist Descent: Narratives as Constitutive of Lived Experience

Constructivism is another post-positivist epistemological descent that has theoretically informed the emergence of narrative therapy. Constructivism is a loose category of theories that resist claims to an essential reality and share the common assumption that knowledge is constructed and contingent on social relations (Stam, 1998). Through tracing the descent of constructivism in White and Epston's (1990) narrative therapy both the constructivist theories of Jerome Bruner and Edward Bruner emerge as contributing to the assumption that lived experience is narratively constitutive and constituted.

Constructivism

Constructivism is a theory (or more appropriately, theories) of knowledge that argues knowledge is not simply 'about' the self (and others) but is *constitutive* of the self (and others); knowledge and thus learning and meaning are actively constructed (and reconstructed from prior constructions) rather than transmitted passively from one individual to another. Represented through diverse theoretical positions on the nature of knowledge, constructivism consists of standpoints that split into overlapping bifurcations, spanning from Immanuel Kant's (1959) argument that our drawing on prior cognitions shapes experience to *relational constructivism*. The relational constructivist perspective involves the constitution and positioning of subjects (and their narratives of identity) through the relational, dialogical achievement of language. Consequently, individuals construct meanings, languaged from how they position themselves and how others position them (Botella, Herrero, Pacheco, & Corbella, 2004). Constructivism is part of a continuum, between individualist-oriented cognitive constructions of knowledge, to knowledge constructed as a social process between people. The interaction between processes of thinking and acting resist positivist assumptions of the discovery of knowledge (Phillips, 1995). The possible combinations remain caught in a dualistic epistemology where the mind is contingent on the body,

assuming a discrete entity of the self, even when constructivists assume that human interaction is necessary to generate meaning.

Although there are many facets of constructivism, I am interested in the epistemology of the two constructivist theorists, Jerome Bruner and Edward Bruner, whose works influenced the theoretical premises of White and Epston's (1990) narrative therapy – that narratives are constitutive as a mode of thought *and* as an enactment of power. Although both theorists focus on narrative as a key metaphor in their constructivist writings, they come from different epistemological locations. Jerome Bruner (1986) is a psychologist who also contributed to the discipline of education; Edward Bruner (1986) is an anthropologist. Influenced by their disciplinary boundaries, Jerome Bruner, who argued that meaning is a function of thought, placed his work on the cognitive side of the constructivist spectrum and Edward Bruner, who argued that meaning is produced culturally, socially and politically, located his work on the cultural side.

Jerome Bruner's constructivism assumes that the mind is the primary mechanism of constructing reality. His constructivist approach to narrative is "a view that takes as its central premise that 'world making' is a principal function of the mind" (Bruner, 2004, p. 691). Jerome Bruner's position sought to revolutionise cognitive psychology by focusing on meaning making as its central metaphor (Bruner, 1990).

Adding further to the heterogeneous layers of narrative therapy's theoretical emergence is the work produced by Edward Bruner. Although Edward Bruner has been called a constructivist (Turner, 2005) and has called himself a constructivist (Bruner, 1994), his version is more in line with a *cultural constructivism*, the idea that knowledge and reality are produced in and through their historical and cultural contexts that change across time. In this way, the narrative context of lived experiences also shifts over time, and in relation to other meanings. Edward Bruner's view of constructivism purports that reality is constituted through "interdependent co-origination" (Turner, 2005, p. 117) and is a position "that sees all culture as continually invented and reinvented" (Bruner, 1994, p. 397). There is a convergence of conceptions of narrative processes where experience becomes meaningful through its relationship with other experiences: "the meaning of the text is not inherent in the text but emerges from how people read or experience the text" (Bruner, 1994, p. 407). It is this relationship of convergence in constructivism that has contributed to understanding the process of meaning making in White and Epston's (1990, p.12) narrative therapy:

"persons organise and give meaning to experience through their storying of experience…[and consequently]…they express selected aspects of their lived experience" (White & Epston, 1990, p. 12).

Constructing Experience In and Through Narrative Meaning

From his studies of anthropological narratives of non-Western cultures, Edward Bruner asserted that narratives are not necessarily linear and/because narrative structures are culturally specific (Bruner, 1986a). Through a process of reflecting on his Western practice of anthropological narratives he found that Ilongot narratives "may consist of a series of place names or incidents … but they do not necessarily state a problem, develop a plot, or provide a resolution" (Bruner, 1986a, pp. 17–18). The telling of, and what is representative of a 'good story' is *culturally* determined.[53]

Jerome Bruner also argued that narratives are both cognitive and linguistically produced in and through culture. They are interrelated processes that structure meaning through culturally available symbolic systems (Bruner, 1991).

> The heart of my argument is this: eventually the culturally shaped cognitive and linguistic processes that guide the self-telling of life narratives achieve the power to structure perceptual experience, to organize memory, to segment and purpose-build the very "events" of a life. In the end, we *become* the autobiographical narratives by which we "tell about" our lives. And given the cultural shaping to which I referred, we also become variants of the culture's canonical forms. (Bruner, 2004, p. 694, original italics)

Both Jerome Bruner (2004) and Edward Bruner (1986a; 1986b) maintained that there is a productive force of narrative in constructing experience. Narrative therapy uses both narrative theorists in its formulation of narrative as a constructive resource to reauthor lived experiences and is therefore pluralistic in its constructivist epistemologies. Jerome Bruner reasoned that we become the narratives that we tell as we simultaneously structure our 'individual' selves and Edward Bruner argued that the performance of culture constantly produces narratives, and it is this performative process of expression that makes them meaningful.

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[53] Thus, narratives of, and what is, good research is culturally determined – and so psychological research narratives are influenced according to the dominant research culture(s) in psychology, which then (re-)legitimates those narratives and 'others' the narratives from non-Western cultures in psychology.

> It is in the performance of an expression that we experience, re-live, re-create, re-tell, re-construct, and refashion our culture … the performance itself is constitutive … cultural change, cultural continuity, and cultural transmission all occur simultaneously in the expressions and experiences of *social* life. (Bruner, 1986a, pp. 11–12, italics added)

Thus, the constructivist epistemologies of Jerome Bruner and Edward Bruner reveal another node in the narrative descent of narrative therapy. What each theory contributes to narrative therapy is an account of the narrative structures that produce meaning as it shifts and moves, in a dynamic process.

> Narrative structure has an advantage over such related concepts as metaphor or paradigm in that narrative emphasizes order and sequence, in a formal sense, and is more appropriate for the study of change, the life cycle, or any developmental process. Story as a model has a remarkable dual aspect – it is both linear and instantaneous. On the one hand, a story is experienced as a sequence, as it is being told or enacted; on the other hand, it is comprehended all at once – before, during, and after the telling. A story is static and dynamic at the same time. (E. Bruner, 1986b)

Jerome Bruner: Modes of Thought

In Jerome Bruner's (1986) theory, meaning making consists of two modes of thought: the paradigmatic (logico-scientific) and the narrative (narratives of the narrative). They are two different and complementary *ways of constructing* the rich diversity of human thought and are therefore both irreducible to each other (Bruner, 1986). He argued that the paradigmatic mode of thought, the scientific mode that explains meaning as a logical endpoint to an event, is considerably different to the narrative mode of thought that explains meaning through a process of indeterminancy. Without the narrative mode, he argued, one cannot fully capture the diversity of thought and richness of meaning: "Efforts to reduce one mode to the other or to ignore one at the expense of the other inevitably fail to capture the rich diversity of thought" (J. Bruner, 1986, p. 11). The descent of Bruner's theory in the work of White and Epston's (1990) narrative therapy appeared as a resistance to the logico-scientific mode, situating the narrative mode of narrative therapy as an alternative to meaning making in social relations.

Jerome Bruner (1986) asserted that psychologists know very little about narrative but know quite a lot about the logical-scientific, paradigmatic mode of thought. The logico-scientific, paradigmatic mode of thought attempts to accomplish the idea of a logical, formal, mathematical system of description and explanation. Such a mode assumes that "good thought is right reason, and its efficacy is measured against the laws of logic or induction" (Bruner, 2004, p. 2004). The logico-scientific, paradigmatic (or, in other words, positivist) mode of thought operates on principles of employing categorisation, that is "the operations by which categories are established, instantiated, idealized, and related to one another to form a system" (Bruner, 1986, p. 12). It deals in and establishes logical causation, it uses scientific procedures to assure "verifiable reference" and to "test for empirical truth", it orders and governs through "requirements of consistency and noncontradiction", and is defined by "observables" leading to "empirical discovery guided by reasoned hypothesis" (Bruner, 1986, p. 13).

Alternatively, in the narrative mode of thought, truth claims do not configure the basis of a narrative. Rather, believability, lifelikeness and verisimilitude constitute a narrative and its meanings. In narrative, a story may be believable in its imagery and its use of mood and characters, but reducing it down to 'True' or 'False' in the modality of a logical mathematical argument violates the narrative mode of thought because it does not allow for multiple perspectives or a subjunctive aspect. As Jerome Bruner (1986, p. 12) noted, "if x, then y" is a different causative statement than that from a narrative *recit* "The king died, and then the queen died". The "if x, then y" has a logical causative function that leads to searching for universal truth conditions and to a theoretical argument which is either conclusive or inconclusive. According to Bruner (1986, p. 12), the other statement is in the narrative mode, and involves an account, a relating of events, which leads to a search for not the 'Truth' but for likely, conceivable, believable, and plausible connections between the two events, for instance the possibilities of "mortal grief, suicide, or foul play." Reismann (1993) produced a similar argument claiming that narratives can be 'validated' by examining coherence and plausibility through drawing consistency between arguments and examples throughout the narrative.

Moreover, Jerome Bruner (1986), in using his constructivist epistemology, argued that in narrative these possible connections between events (e.g., "The king died, and then the queen died"), and their meanings, are relatively *indeterminate* (Geertz, 1986, also understood this concept of textual indeterminacy). As Bruner (1986, p. 25)

states, the "intention is to initiate and guide a search for meanings among a spectrum of possible meanings". In other words, a narrative concept allows readers to explore a range of possible meanings. Breaking down disciplinary boundaries between narrative and literature, Jerome Bruner's attention to the imaginary produces a relationship between Turner's notion of the subjunctive and his notion of subjunctivation.

Victor Turner, for example, played an important role in conceptualising the imaginative aspects of narrative. The emergence of the imaginative component for producing meaningful narratives in narrative therapy (White & Epston, 1990) involves a contingent relation with Turner's (1986) notion of the subjunctive in his studies of liminality and Bruner's (1986) notion of subjunctivation. The narrative mode enables the formation of what is conceivable, the imaginative dimension – or what Jerome Bruner called the subjunctive mood, or 'subjunctivation' of the narrative structure. The exploration for what is possible, what is likely, or what is conceivable is performed when a reader reads "The king died, and then the queen died" or as Bruner (1986, p. 25) stated, "literary texts initiate 'performances' of meaning rather than actually formulating meaning themselves".[54] That is, the narrative text that is interconnected with the narrative mode of thought[55] allows one to explore meaning out of a range of possibilities; through its subjunctivation, it cannot discover *the* correct, essential and predetermined truth that is fixed and universal as logico-scientific thought aims to achieve. The 'real' reason why "the queen died" will be different to another reader due to his or her subjunctive interpretations.

Wolfgang Iser enabled Jerome Bruner to conceptualise narrative as performances of meaning through language. With regard to narrative, "the reader receives it by *composing* it" (Iser, 1978, p. 21, italics added), an argument that is pivotal to Bruner's (1986) where the narrative mode of thought is inextricable from the narrative meaning produced by the interrelationship between the text and reader. This imaginative composing is an important element in narrative therapy for both the

[54] It is also here that there is an intersection between Jerome Bruner's cognitive constructivist epistemology and the symbolic interactionist epistemology of Victor Turner where the key concept and commonality between the two theorists is the performance of meaning. The nitty-gritty of how performance of meaning is theorised, however, is different between Bruner and Turner due to their differences in how knowledge is constructed.

[55] Where I have written 'narrative mode of thought' I am not referring to this as cognition as part of one's mind as separate from a text. To quote from Bruner (1991, p. 5): "I have great difficulty in distinguishing what may be called the narrative mode of thought from the forms of narrative discourse … each enables and gives form to the other, just as the structure of language and the structure of thought eventually become inextricable".

therapist and the client. The subjunctive performance of narrative composition is "particularly important in the facilitation of conditions for the identification of unique outcomes and for the performance of meaning in relation to them" (White & Epston, 1990, p. 61). Bruner (1986) argued that there is always contestability in how well a reader's interpretation is harmonious with the writer's telling of the story or to what extent it adheres to a particular cultural repertoire. The construction of a 'great' narrative[56] is one that involves a story that is compelling and 'accessible'[57] to the reader and their context but also opens the possibility for imaginative play. Narrative therapy takes up Bruner's notion of imaginative play to construct meaning through imagining conceivable agencies of the client in their rewriting of their lived experience as a function of effective storytelling:

> I have tried to make the case that the function of literature as art is to open us to dilemmas, to the hypothetical, to the range of possible worlds that a text can refer to. I have used the terms "subjunctivize," to render the world less fixed, less banal, more susceptible to recreation. (Bruner, 1986, p. 59)
>
> In a similar vein[58], we would like to rest our case for a therapy that incorporates narrative and written means. We have found these means to be of very great service in the introduction of new perspectives and to a "range of possible worlds" … in enlisting persons in the re-authoring of their lives and relationships. (White & Epston, 1990, p. 217)

Despite the use of the subjunctive as enabling multiple sites of possibility for (re)storying, Jerome Bruner's conceptualisation of narrative is limited by its cognitive constructivist framing because it depends on the assumption of Cartesian dualism: an 'inner' and an 'outer'. In his theory of narrative there is an arbitrary separation between 1) 'outer' narrative and the 'inner' reader of narrative and 2) both 'outer' action and 'inner' reflective cognition of that action that are necessary to enable storying. Assuming that texts such as narratives construct their own objects through an imaginative relationship with the text, readers do not reflect what is 'out there'. The

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[56] This is not in the sense of a grand or universal narrative, but more in the sense of a meaningful and salient narrative.

[57] "…[I]n in any case, the author's act of creating a narrative of a particular kind and in a particular form is not to evoke a standard reaction but to recruit whatever is most appropriate and emotionally lively in the reader's repertory" (Bruner, 1986, p. 35).

[58] White and Epston (1990) refer to and cite the quote directly above by Bruner (1986) of subjunctivisation as allowing a 'range of possible worlds' to be made possible.

indeterminacy of a text enables a narrative to 'communicate' with the reader, according to Iser (1978, p. 61), "in the sense that they induce him [sic] to participate both in the production and the comprehension of this work's intention".

Jerome Bruner also argued that narrative has a two sided-structure, a textual component that guides action, and an affective, subjunctive component that the text prestructures, indeterminately. These two sides are landscapes of action and of consciousness, respectively (Bruner, 1986). This duality of landscape metaphor, which Bruner borrowed from Greimas and Courtes (1976), finds its descent into narrative therapy as a two-stage process that involves action- and cognition-based questions. Narrative therapy takes up the notion of landscapes of action to question a thread of previous acts that have produced an action in resistance to a problem (acting on the actions) and then landscapes of consciousness questions enable the client to reflect on and evaluate their acts (McKenzie & Monk, 1997). White and Epston (1990) use such questionings to enable the client to narrate moments of overcoming the problem (landscapes of action), and to reflect on those moments and make them meaningful (landscapes of consciousness). These questionings enable the threading of unique outcomes into a thicker story of lived experience in that enable clients to draw on their "competency and resourcefulness in the face of adversity" (White & Epston, 1990, p. 45). Hence, the cognitivist epistemological assumptions of Bruner's narrative theory have influenced the practice of narrative therapy. Questions that involve the exploration of landscapes of action (as plotted situational, bodily acts) *and* landscapes of consciousness (as meaningful, cognitive reflection of those acts) enable the transformation of client narrative.

Edward Bruner: Narratives are Politically Constitutive

During the 1980s, Edward Bruner also developed an interest in narrativity and storytelling (Bruner, 1986; E. Bruner, 1986a, 1986b). It was almost by accident that Michael White, in his library research, came across Edward Bruner's ethnographic writings (G. Monk, 1998) on the problematic relationship between experience and narrative representation. Edward Bruner (1986a, 1986b), using Foucault's (1973b) notion of strata, argued that lived experience is always richer than narrative. He also argued that narratives are units of power in that dominant narratives take up space in 'normative' discourse. This dominance forces the articulation of competing stories in more hidden, dissident spaces of discourse. This argument enabled White and Epston

(1990) to argue that many dominant narratives thinly represent lived experience. One of the key strategies of narrative therapy is to examine aspects of lived experience that the dominant story excludes or marginalises. Bruner argued that an historical examination of dominant narratives permits an analysis that destabilises their assumed fixity:

> The importance of dominant narratives is that they become the major interpretive devices to organize and communicate experience, but they remain largely unexamined. Only in a later time period, in a different social place, or in a new phase of history can we adopt the perspective that enables us to see these narratives for what they are – social constructions. (E. Bruner, 1986a, p. 18)

Edward Bruner examined anthropological narratives, written as ethnographies, particularly through the investigation of discontinuities of dominant narratives, to argue that narratives are political. In his examination of the anthropological representations of indigenous cultural narratives over time, Bruner found that dominant accounts that were assumed as 'true' were produced through the assumptions of the research. In the history of the present, dominant academic narratives discredited past principles of assimilation, producing the present as resistance and the future as ethnic resurgence (Bruner, 1986a; 1986b).

He argued that narratives are "not only structures of meaning but structures of power as well" (E. Bruner, 1986b, p. 144). Hence, the dominant stories had constituted different political rationalities. Bruner argued that the future assimilation narrative in anthropological literature during the 1930s was a mask for oppression (i.e., if it is inevitable that they are going to disappear then their land can be sold to whites). Whereas, the present resistance narrative in the 1970s was a rationale for claims of redressing exploitation: "The Indian in the acculturation narrative is romantic, the exotic Other; the resistance Indian is victimised … narrative structures are constitutive as well as interpretive" (E. Bruner, 1986b, p. 144). So, in narrative therapy, through Edward Bruner, the political constitution of a narrative was realised whereby dominant narratives can be challenged at the sites of societal and cultural apparatus of knowledge and power (White & Epston, 1990).

A constructivist descent of narrative therapy has enabled a visibility of the constitutive importance of narrative. Both E. Bruner (1986a, 1986b) and J. Bruner (1986, 2004) argue that narratives are both constitutive of and constituted through lived

experience. As alternatives to logico-scientific thought, narrative structures produce indeterminate meanings through the interpretative, imaginative process of subjunctivation embedded in culturally produced structures of power that can mask or bring into being realities of experience (E. Bruner, 1986a, 1986b; J. Bruner, 1986, 2004; White & Epston, 1990).

Foucaultian Descent: Normalising Practices of Evaluation [59]

Michel Foucault also contributed to the theoretical emergence of narrative therapy in and through a political engagement with theory and practice. Most of the theoretical descent of Foucaultian perspectives in narrative therapy is those of Foucault's genealogical writings. White and Epston (1990) draw on the genealogical work of *Discipline and Punish: The Birth of the Prison* (Foucault, 1977), and specifically from his work on disciplinary power to trouble the effects of normalising judgement of discourse. Positioned as a post-structuralist in the academy, "Foucault is as clear an instance of the critical postmodern model of science as any"[60] (Kusch, 1991, p. 102), he questions the politics of the foundational subject (Sawicki, 1998). Foucault avoided the term 'postmodernism' in reference to his work and was more interested in politically questioning reason and rationality (Foucault, 1984b). He also did not favour structuralism: "structuralism formed the most systematic effort to evacuate the concept of the event … In that sense, I don't see who could be more of an anti-structuralist than myself" (Foucault, 1980, p. 114).

As with all of the theorists mentioned thus far in this genealogy, Foucault also resisted positivist practices in the social sciences (what he named as the 'human sciences'), and he was explicit about his research practice in examining and destabilising established truths. Take his work on madness as an example. Rather than objectively classifying forms of madness, his book *Madness and Civilisation* conceptualised madness as a form of social exclusion and social control where madness eventually became a focus for intervention that often aimed to internalise a pattern of judgement and punishment in the mental patient (Foucault, 2002/1967). Foucault made clear quite early in his works his resistance to practices informed by positivist epistemology:

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[59] White (1997) associates post-structuralism with Foucault. I have deliberative left the term 'post-structuralism' out here because Foucault did not call his work post-structuralist.

[60] I find this statement intriguingly oxymoronic: how can postmodernism be a model or scientific?

> If the medical personage [of the asylum] could isolate madness, it was not because he knew it, but because he mastered it; and what for positivism would be an image of objectivity was only the other side of this domination. (Foucault, 2002/1967, p. 269–272)

Foucaultian resistances to positivist practices in the human and social sciences were evident throughout his works. Foucault's stance on genealogical inquiries, for example, was that they were resistances to mainstream scientific research. They are "not positivistic returns to a more careful or exact form of science. They are precisely anti-sciences" (Foucault, 1980, p. 83). His view of the Enlightenment, and the positive philosophy of science, was that it produced those liberties that it also sought to govern: "The 'Enlightenment', which discovered the liberties, also invented the disciplines … [and] [t]hese sciences … have their technical matrix in the petty, malicious disciplines and their investigations" (Foucault, 1977, pp. 222, 226).

White and Epston (1990) took up the relationship between power and knowledge to trouble normalising narratives of evaluative practices that discipline subjects. Understanding disciplinary power through the metaphor of the Panopticon (Foucault, 1977), White and Epston use the notion of surveillance to make sense of the effects of dominant stories. The Panopticon, Foucault (1977) argued, was not only an architecturally designed institution but also a concept that history has overlooked. The Panopticon was a circular building where prisoners occupied the circumference, watched by an inspector, located in the centre (Bentham, 1995). With the technology of back lighting, the prisoners could not see the inspector but the inspector could see the prisoners. This produced an awareness that one is constantly being watched and judged and consequently, it facilitated the checking, controlling, and thus self-policing of one's own behaviour. Panopticism is an extension of the architectural concept into a theory of disciplinary self-surveillance of human subjects in institutions and society in general: "one also sees the spread of disciplinary procedures, not in the form of enclosed institutions, but as centres of observation disseminated throughout society" (Foucault, 1977, p. 212). This extension of panopticism is where the knowing that one is self-aware of others watching them, in/through institutionalised social norms, is associated with the measures taken to conduct one's behaviour based on this self-awareness. The knowledge of how one should conduct oneself, and thus how one should learn and articulate oneself, is interconnected with an invisible, unverifiable disciplinary power.

This learning of how to conduct oneself is based on Foucault's (1977) notion of docile bodies, a 'political anatomy' and 'mechanics of power' that could be manipulated and changed in various disciplinary contexts (e.g., schools, prisons, army barracks, hospitals, and factories). A body can be "manipulated, shaped, trained, which obeys, responds, becomes skilful and increases its forces… [and]… subjected, used, transformed, and improved" (Foucault, 1977, p. 136). The concept of a docile body is a body that is self-policed but where a human subject uses their body not only as an object but also as a subject, a principle or a rule, of their own disciplinary evaluation:

> He [sic] who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he [sic] makes them play spontaneously upon himself; he [sic] inscribes himself [sic] in the power relation in which he [sic] simultaneously plays both roles; he [sic] becomes the principle of his [sic] own subjugation. (Foucault, 1977, p. 202)

White and Epston (1990) understand their troubling of evaluative practices in/through narrative therapy as being synonymous with Foucault's (1977) articulation of the disciplines, or disciplinary technology, of normalising judgement (White & Epston, 1990). According to White and Epston's (1990) reading of Foucault, the "rise and spectacular success of these disciplines have been entirely facilitated by those practices of evaluation (normalizing judgement) and documentation that enable the subjugation of persons" (p. 190). They referred to psychiatry as an example of discipline (discipline as both a noun and a verb: it is a discipline, a subject and a technology of training and instruction, a branch of education, a system of conduct, and/or a form of correction or ordering, and in being so it disciplines human subjects).[61] The concept of normalising judgement involves a form of *reverse individualisation*. Normalising judgement is a process where power becomes more anonymous with the exercising of surveillance where there is a normative reference to measure oneself against (Foucault, 1977). The individual becomes a technology of power that self-polices according to normative judgements about how one should act, think and feel. Foucault (1977, p. 193) also blames the "sciences, analyses or practices employing the root 'psycho-'…" for "… this historical reversal of the procedures of individualisation." Just as opening corpses in medicine allowed the body to be subjected to a new scientific gaze that could see all of

[61] There are by no means exhaustive concepts of discipline. The point here is to say that discipline has many uses and facets; it does not have a singular meaning.

disease (Foucault, 1973a), the gaze was also conceptualised in disciplinary institutions as a conduct of individuality that was extended into discipline as a practice (Foucault, 1977). He argued that the gaze is a hierarchical, continuous and functional observation where, throughout the eighteenth century, an increasing number of members in institutions were surveying each other until disciplinary power became an "'integrated' system, linked from the inside to the economy and to the aims of the mechanism in which it was practiced" (Foucault, 1977, p. 176). Discipline made possible the "uninterrupted play of calculated gazes" (Foucault, 1977, p. 177) where surveillance became more than a technique. Discipline became a "'physics' of power" where it maintained a "hold over the body" (Foucault, 1977, p. 177). This combination of observation and normalising judgement produced the examination that reverse individualises bodies. The individual "may be described, judged, measured, compared with others, in his [sic] very individuality; and it is also the individual who has to be trained or corrected, classified, normalized, excluded" (Foucault, 1977, p. 191). Foucault saw the individual as a fabricated reality of disciplinary power where the individual becomes his/her own judge of normative behaviour: "when one wishes to individualize the healthy, normal and law-abiding adult, it is always asking him [sic] … what secret madness lies within, what fundamental crime he [sic] has dreamt of committing" (Foucault, 1977, p. 193). The 'psycho-' disciplinary practices that Foucault alluded to takes the individual into the mechanisms of the normative, the measurable and "that of the calculable" (Foucault, 1977, p. 193). Such 'psycho' practices reduce the individual to the associative elements of power and knowledge through the technologies of (self-)evaluation. This surveillance of the self and others in alignment with normative discourses of individual behaviour necessarily produce resistances to such discourses. White and Epston (1990) used Foucaultian theory to conceptualise client problems, lives, and relationships as shaped by normalising discourses and 'truths' that can constrain lived experience through a process of self-surveillance:

> When conditions are established for persons to experience ongoing evaluation according to particular institutionalized "norms", when these conditions cannot be escaped, and when persons can be isolated in their experience of such conditions, they will become the guardians of themselves … we live in a society where evaluation or normalizing judgement has replaced the judiciary

> and torture as a primary mechanism of social control: This is a society of the everpresent "gaze". (White & Epston, 1990, p. 24)

Foucault's theory of disciplinary power and its descent into narrative therapy has produced the conditions to locate normalising discourses (and subjugated or disqualified knowledges of the client) through an examination of power and knowledge relations. However, Foucault's notion of power is not merely repressive; it is also productive (Foucault, 1980). That is, power relations are exercised in and through a net-like organisation between individuals/bodies that (re)produce and constitute knowledges and this production can limit or enable other knowledges. Power is thus constitutive of one's reality:

> We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact, power … produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him [sic] belong to this production. (Foucault, 1977, p. 194)
>
> The individual is an effect of power, and at the same time … is the element of its articulation. The individual which power has constituted is at the same time its vehicle. (Foucault, 1980, p. 98)

In narrative therapy, White and Epston (1990) used resistance as a productive aspect of power. White and Epston (1990, p. 65) argue that externalisation practices in narrative therapy can be understood as "counter-practices" that enable a "deobjectification" process that is linked to a pervasive "fixing and formalizing" of persons in Western societies. Normalising discourses, a pervasive as part of a "*society of normalisation*" (Foucault, 1980, p. 107, original italics), subjugate knowledges of the client. In White and Epston's (1990) narrative therapy, the externalisation process of deobjectifying the client, shifting the gaze back on to the problem rather than on the person, has the potential to uncover subjugated knowledges as unique outcomes. This then enables the construction of an alternative and unique narrative of a person's lived experience in resistance to a deindividualised, dominant and pathological problem narrative. Hence, White and Epston (1990) do not see power as simply repressive, but as socially productive of the knowledge, narrative, and thus lived experience of the

client, and this conceptualisation of resistance is enabled through the Foucaultian epistemological descent of narrative therapy.

Towards a Conclusion

Through tracing and fragmenting the theoretical descent of narrative therapy, I have uncovered a range of interpretative theoretical influences that have produced multiple post-positivist epistemological stances that are resistant to and disrupt a singular, unitary narrative of formal scientific inquiry. The symbolic interactionist stances of Myerhoff, Goffman, Geertz and Turner have placed emphasis on the performance of meaning in and through symbolic and social interaction, and cultural context. Cybernetics has placed importance on how the comparison of events and patterns of interaction generate meaning. The constructivist stances of Jerome and Edward Bruner placed importance on narratives as constituting meaning and lived experience. Foucaultian descent has placed emphasis on the how normalising practices and power relations can enable and constrain the production of knowledge. Such influences are responses to the interpretative crisis in the social science:

> When positivism – the idea that it is possible to have direct knowledge of the world – was successfully challenged, and when social scientists realized that other scientists proceeded by analogy ... they were free to turn elsewhere in their search for metaphors from which to derive and elaborate theories. (White & Epston, 1990, p. 4)

Indeed, the body of work of post-positivist, interpretative theorists that constitute narrative therapy has produced various analogies or interpretive framings to make sense of human experience.[62] Positivist science requires objectivity to denote reality through singular truth (Crotty, 1998). In contrast, through tracing the descent of the post-positivist theoretical influences of narrative therapy, knowledge and meaning can be understood as, what Geertz (1986) might argue, indeterminately produced through a range of interpretive framings or analogies of human experience. For example, Goffman (1961) used the analogy of unique outcomes to frame lived experience differently to the totalising psychiatric institution and Turner (1974) adopted

[62] Admittedly, my views of narrative therapy changed throughout the genealogical process. For instance, I underestimated the symbolic interactionist influences that constitute narrative therapy and I now have a wider theoretical understanding and appreciation of narrative therapy.

the rite of passage metaphor for enactments of transitions and possible productions of new meanings. Further, Bateson's (1972, 1979) news of difference concept enabled narrative therapists to foster the unique outcomes of clients through learning subtle differences between events in time as meaningful moments of client resourcefulness (Monk, 1997).

Such post-positivist interpretive framings make possible the emergence of narrative therapy as a resistance to evidence-based practices. EBP is dependent on a singular, unitary narrative of positivist, modernist science that, as a (r)evolutionary process[63], progresses to increasingly correct accounts of phenomena: scientific progress informs newer and better practices of evidence (Spring, 2007). However, White and Epston (1990) argued that a logico-scientific mode excludes alternative and multiple meanings. Consequently, narrative therapy emerged as an approach that enables a multitude of possible narratives to represent lived experience. These representative narratives are enabled through the assumption of textual indeterminacy (Geertz, 1986), contextualised through thick description (Geertz, 1973), made possible through subjunctivation (Bruner, 1986; Turner, 1986), collaborative relationships and definitional ceremonies (Myerhoff, 1982, 1986), the uncovering of subjugated knowledges (Foucault, 1980), unique outcomes (Goffman, 1961), and the challenging of dominant narratives (E. Bruner, 1986a, 1986b). White and Epston's (1990) narrative therapy resists dominant evidentiary stories and the singular diagnostic categorisations of positivist discourse by enabling collaborative meaning-making conversations between therapist and client that produce multiple enactments and possibilities of meaning, and potentially, multiple narratives of lived experience. If narrative therapy has emerged through a range of post-positivist epistemological and interpretivist understandings, then any 'evaluation' of it would ideally need to engage with those understandings.

[63] I say (r)evolutionary because Kuhn (1970) viewed science as a series of paradigm shifts that revolutionise how we think about the world, but these shifts, he argued, are based more on human interest than objective science.

Chapter 4
Tracing the Theoretical Descent and Emergence of Resistances to Positivist Evaluation in the Social Sciences

In this chapter, I examine multiple descents of evaluation 'theory'[64] in the social sciences to disrupt the authoritative 'truism' of the APA Presidential Task Force Report on Evidence-Based Practice (2006) – that the scientific method in psychology's evidence-based practice results in 'best practice'. As the emergence of the multiple theoretical descents of narrative therapy appeared as a theoretical practice of resistance in the interpretive crisis in the social sciences, resistance to evaluation as a positivist science has also emerged through a multiplicity of theoretical descents. For instance, some understand evaluation as a political process of negotiating constructed meanings between participants (Guba & Lincoln, 1989) and an interpretative process of understanding through dialogue (Schwandt, 1996, 1997). Such understandings have emerged as resistances to the value-free assumptions of positivist science. Just as there are multiplicities of theoretical descents into narrative therapy that heterogeneously constitute its theoretical identity, I argue that evaluation can also be multiply conceptualised and theorised through tracing its theoretical descent in the social sciences. I argue that exhuming multiple descents of evaluation can dissociate its current positivist theoretical identity in psychology. This dissociation can render new forms of evaluation into existence for the examination of their potential theoretical suitability with narrative therapy.

One authoritative descent of evaluation emerged through psychology's appropriation of the scientific method. Psychology's emergence from philosophy solidified into an empirical science through philosophy's positivist epistemological influences. Scientists, driven by a discourse of 'physicalism' in the 1930s, argued that to make sense of psychological phenomena in their research, psychologists should adopt statements based on physical concepts (Smith, 1981). This drive for the physical and therefore tangible measurement meant that objectivity gained authority in psychological research and consequently another practice of psychology, subjective introspection, was

[64] In this chapter, I conceptualise 'theory' not in the sense of theory as produced through empirical inquiry but in the sense of a *prescriptive theory* following Alkin (2004). Rather than empirical theory, it can be understood as an approach or model that prescribes certain conditions for the process of evaluation.

subjugated (Sexton, 1978). Smith (1981) argued that psychologists had a close relationship with positivist philosophers, influenced from the Vienna Circle, also around the same period (the 1930s). Much of psychology at this time separated from moral philosophy (later re-established as the social sciences) to pair up with the natural sciences (Reed, 2005). The emergence of behaviourism in the United States of America was influenced by proponents in the Vienna Circle and it prescribed the view that "scientific psychology must be reductionistic" (Sexton, 1978, p. 13), reducing human behaviour to observable parts. In effect, psychology emerged as a scientific discipline of positivist inquiry (valuing objectivity as the parameter of inquiry) and empirical inquiry (valuing the sensing of matter through observation rather than relying on *a priori* reasoning or intuition) without having to theorise and reflect on how the 'true' nature of objects in psychology (including psychology itself) came into existence or being:

> Psychology thus became a science unlike any other: a science without any ontological commitments, perpetually stuck within the anti-ontological climate of the 1870s. While chemistry and physics went on to mature out of this phase—leading to the great developments of 1900–10 (physical atoms, electrons, photons, the first quantum theory)—psychology maintained a deep aversion to all ontological theorizing. Ultimately, this led to that combination of behaviourism and 'operationalism' which dominated so much thinking about 'the mind' in the twentieth century. (Reed, 2005, p. 286)

At present, the authoritative paradigm of evaluation, evidence-based practice in psychology (EBPP), produces (and is reproduced through) positivist and empirical science. In the APA Presidential Task Force Report on Evidence-Based Practice, (2006) positivist objectivity is implied through "clinical observation" (pp. 274, 275, 277, 284) as valuable for impartial scientific inquiry and evaluation practice. EBPP also values clinical practice as a practice of positivist objectivity: "clinical expertise also comprises a scientific attitude toward clinical work, characterized by openness to data ... without allowing theoretical preconceptions to override clinical or research data" (APA Presidential Task Force Report on Evidence-Based Practice, 2006, p. 277). The traditional grounding in "empirical methods" (APA Presidential Task Force Report on Evidence-Based Practice, 2006, p. 271) and the scientific method in psychology are also regarded as necessary for evaluation by the EBPP Task Force:

> What this document reflects, however, is a reassertion of what psychologists have known for a century: The scientific method is a way of thinking and observing systematically, and it is the best tool we have for learning about what works for whom. (APA Presidential Task Force Report on Evidence-Based Practice, 2006, p. 280)

Dissociating and Pluralising Evidence-Based Evaluation

While a scientific method of evaluation might be useful as a tool to quantify psychological research and practice, we can also understand evaluation as a fragmented discourse, made possible through a multitude of theoretical statements that value different epistemological stances. Such statements may theorise evaluation as a positivist and empirical way of directly appraising observable objects through experiments and quasi-experiments (e.g., Cook & Campbell, 1976, 1979). Other statements may theorise evaluation as a process of appreciating, interpreting and understanding context as post-positivist inquiry (e.g., Lincoln & Guba, 1985; Stake, 1978). Such statements are, what Mabry (2002) argued, actions of an affirmative postmodernism – a movement that reshaped the social sciences through "deprioritizing theory in favor of personal understanding, causality in favor of contextuality, objective reality in favor of constructed realities, [and] generalizability in favor of particularity" (p. 142).

I traced the theoretical descent of evaluation in the social sciences by collecting and examining scholarly publications that placed emphasis on interpretative and contextual approaches to evaluation that produce post-positivist understandings of evaluation (rather than objective and reductionist approaches). I interpreted such publications as *erudite subjugated knowledges* of evaluation. I regarded them as 'subjugated' because they were unacknowledged in the current authoritative positivist and empirical epistemology of EBPP as either they emerged outside of psychology or they placed emphasis on qualitative, interpretative, subjective evaluation, resisting the production of the scientific method in the social sciences.

In this chapter, I use a genealogical research approach to examine the descent of evaluation theory and methodology to disrupt the continuity of evaluation as a positivist and empirical science to its present-day form in EBPP. I expose in psychology's surface of knowledge of evaluation, marginal and multiple elements of evaluation theory in the social sciences – emergent, erudite subjugated knowledges of evaluation as

breaks in understanding evaluation from its present identity. Tracing the descent of post-positivist evaluation enables me to examine (and (re)produce) the emergence of multiple meanings of evaluation. The descent of bifurcations and discontinuities of evaluation as an interconnected process enables a theoretical fragmentation of meaning that includes interpretation situated in context (Geertz, 1973).

Emergent Discontinuities in the Descent of Evaluation Theory

Bifurcations from within Positivist Evaluation

Empirical theorists of evaluation have produced new emergences in the application of the scientific method and this may have helped generate further bifurcations and discontinuities in the meaning (the identity) of evaluation. Donald Campbell and Thomas Cook were key empirical theorists who were influential, for instance, in popularising quasi-experimental designs, enabling a split within experimental evaluation. Social scientists no longer identified evaluation as just a pure experimental activity that imposed control of participants and their environment; it was also realised as a process that needed to adapt its design to research different social contexts (Cook &Campbell, 1976, 1979).

Quasi-experimental designs enabled an understanding that evaluation required a pragmatic approach to testing participants in the 'real world'. Social scientists applied quasi-experimental designs where practical or ethical issues made it difficult to employ the pure experimental method. They developed such designs to deal with the messiness of field research and, consequently, random sampling and assignment, and strict control became unnecessary (Campbell & Stanley, 1966; Cook & Campbell, 1976, 1979).

Although Campbell was a highly influential experimentalist, his understandings of evaluation as necessarily modified for the investigation of 'real world' social environments might have been influential in opening up spaces for interpretive understandings of evaluation (languaged within a positivist epistemology) that were resistant to the strict controls of experimental designs. Indeed, Cook extended on Campbell's ideas by arguing that evaluators need to select methods appropriate to their evaluation and "take into consideration the *context* of each evaluation rather than using the same set of methods and designs for all evaluations – a direct attack on the experimental design" (Alkin & Christie, 2004, p. 23, italics added). Campbell (1975a, 1975b) also resisted the notion that evaluation was a purely quantitative, experimental

endeavour by indicating the potential suitability of descriptive, qualitative methods (e.g., the case study) as complimentary to experimental methods.

Resisting Reductionist Evaluation in the 1960s and 1970s

Daniel Stufflebeam (1967) also conceptualised evaluation as a contextual process that needed to relate to the 'real world'. He understood evaluation as a series of processes that aimed to serve the needs of intended users (Alkin, 2004). Resisting the experimentalist assumption that evaluation should have standardised designs for control and manipulation, Stufflebeam (2004, p. 251) argued that evaluation is an organic process "involving ongoing interactions between evaluator and stakeholders." Stufflebeam (1967) criticised experimental methodology for its fixity in design. He argued that an experimental design impedes changes in the process and direction of the evaluation methodology for the continual improvement of a programme.

Stufflebeam's (1967) contextual approach, 'context, input, process, and product evaluation' (CIPP), understood evaluation as a process of improvement that focused on the needs of those who were being evaluated. The CIPP model identified evaluation as a process rather than a product; it enabled *feedback* and emphasised contextually *improving* rather than scientifically *proving* the evaluation (Stufflebeam, 2004). Resisting the operationalism of experimental evaluation, Stufflebeam (1967, p. 129) understood evaluation process as "continuous, molar, [and] noninterventionist" where "the evaluator does not exercise control over assignment of subjects to treatments, nor does he [sic] insist that the treatments be held constant."

Additional to Stufflebeam's (1967) research, there was an emergent shift to *contextual* and particular, post-positivist conceptualisations of evaluation during the 1970s. There was a sudden epistemological fragmentation from the virtues of applying experimental methodology for evaluating social phenomena to the emergence of new trajectories for (re)conceptualising the meaning of evaluation (e.g., Eisner, 1976; Guba & Lincoln, 1981; House, 1977; Stake, 1976). These reconceptualisations of evaluation enabled social scientists to produce and value new evaluative aims such as appreciating interpretative processes of meaning, understanding local context, and valuing the particular rather than applying universal generalisations.

These new trajectories of evaluation occurred at the time when Geertz's (1973) influential paper *The Interpretation of Cultures* and the criticisms of generalisation that came from within positivist evaluation (e.g. Cronbach, 1975) emerged. Geertz (1973)

argued that there is an interconnection between interpretation and context in that situating a context to an event or behaviour enables *meaningful* interpretations and understandings. This was Geertz's (1973) notion of thick description. His focus on contextualisation was counter to the reductionist assumption in positivist epistemology in the social sciences. The assumption was that 'objects' have a predetermined meaning without consciousness, and, therefore experimental methods could be used to control for the establishment of universal meaning, along with the modernist notion that universals could be applied to understand, predict, and control human behaviour (Crotty, 1998).

Geertz's thick description also influenced positivist evaluators. Cronbach (1975), for example, argued that empirical relations change in every field. He argued that instead of striving constantly for the generation of generalisable theory in/through empirical research, the researcher should look for what occurs in local conditions in observing behaviour in context and for uncontrolled conditions and events. Cronbach realised that there were limitations to forming generalisations in empirical research. He argued that laboratory generalisations might not be good approximations to relationships in the real world. Cronbach's (1975) realisation disrupted and transformed his previous production of evaluation discourse, rooted in the physical sciences and the operationalism of the experiment, to a stance that appreciated social context and changeability in evaluation:

> The positivistic strategy of fixing conditions in order to reach strong generalizations fits with the concept that processes are steady and can be fragmented into nearly independent systems. Psychologists toward the physiological end of our investigative range probably can live with that as their principal strategy. Those of us toward the social end of the range cannot. (p. 123)

Emergences of New Meanings of Evaluation

The interpretative, contextual shift in evaluation in the 1970s also produced post-positivist emergences of new conceptualisations of evaluation that were contingent with Geertz's (1973) contextual notion of thick description. Robert Stake (1976), a strong advocate of thick description (Alkin & Christie, 2004), produced responsive evaluation as a "more naturalistic and perhaps humanistic approach" (Stake, 1976, p. 20) to evaluation in resistance to "a more psychometric and positivistic approach." Influenced by Geertz (1973) and the arts, Elliot Eisner (1976) argued for evaluation as a

process that requires connoisseurship and criticism. Critical of the 'objectivist' standardisation and quantification of education, Eisner (1976) contended that connoisseurship is the art of appreciation, having "an awareness and an understanding of what one has experienced" (p. 140) which provides the foundation for judgement. For Eisner, criticism is the art of disclosure, to render and articulate qualities that cannot be expressed in a quantifiable manner, using metaphor, analogy, suggestion and implication to come to some conclusions about educational practice and its improvement.

Resisting the reductionist operationalism of experimental evaluation, Ernest House (1977) understood evaluation as having an inevitable interpretative, rhetorical process. In *The Logic of Evaluative Argument*, House (1977) argued that evaluation in the social sciences should not mimic the natural sciences because it is bound to context and is interpretative. He argued that all evaluator's claims, whether quantitative or qualitative in design, involve a subjective quality in that they are merely arguments that support particular viewpoints.

Following on from such interpretivist emergences of evaluation, including Stake's (1976) influence, Guba and Lincoln (1981) developed the notion that evaluation should be more responsive to the needs of stakeholders and that evaluation cannot be a value-free, objective endeavour. Out of this movement emerged new qualitative methodologies such as naturalistic inquiry (Lincoln & Guba, 1985) and its successor, fourth generation evaluation (Guba & Lincoln, 1989). I now turn to some of the key emergences of resistances to positivist evaluation in the social sciences.

Responsive Evaluation – Attending to Local Knowledges

In resisting objectivist understandings of evaluation, Stake's (1976) responsive evaluation brought attention to subjective, local understanding between both evaluators' and stakeholders' perspectives in the process of evaluation. Responsive evaluators understand personal experience and subjectivity as necessary interpretative components of evaluation (Stake, 2004). Stake argued that the subjectivity of the *evaluator* is unavoidable in responsive evaluation. According to Stake (2004), the evaluator is *responsive* to the issues of stakeholders by being sensitive to them through revealing back to stakeholders' 'their' perceptions of 'what is going on' and by also making his/her value commitments recognisable rather than trying to pretend to be free of bias. The portrayal of stakeholder concerns through storytelling or verbatim testimonials

enables a tapestry of experience to be reflected back to those evaluated, which can inform decisions on 'where to go next' (Stake, 2004).

Defying the concept of evaluation as a scientific method for empirical generalisation, Stake's (1978, 2004) responsive approach enabled the understanding of human experience through an immersion in and a holistic regard for phenomena that involve localised, contextual forms of 'generalisation'. Stake (1978) introduced the notion of 'naturalistic generalisation' (cf. empirical generalisation), a form of 'generalisation' that recognises "similarities of objects and issues in and out of context and by sensing the natural covariations of happenings" (p. 6). Such recognitions and senses are derived from "tacit knowledges of how things are, why they are, how people feel about them, and how things are likely to be later or in other places with which this person is familiar" (Stake, 1978, p. 6). Naturalistic generalisation is at odds with a positivistic generalisation in psychology that generally premises the creation of empirical inferences from the aggregation of variables through the objective observation of a population sample. Naturalistic generalisation is based on enhancing human understanding through the particulars of human experience and context rather than attempting to progressively build or replace a universal theory (Stake, 1978): "I come out on the other side of theory, petite or local theory" (Abma & Stake, 2001, p. 12).

The theoretical descent of narrative therapy has more in common with the emergence of responsive evaluation theory than the experimental and quasi-experimental 'scientific method' branch of evaluation theory. The emphasis on petite or local theory rather than a universalising, formal theory, and the case study approach of responsive evaluation fits well with the theoretical descent that enables the emergence of narrative therapy. Such theories include a Foucaultian emphasis on unmasking local knowledges (Foucault, 1980) that are unique outcomes (Goffman, 1961) to the client that enable the thick description (Geertz, 1973) of experience to be heard in contrast to what Geertz (1992) calls a intellectual obsession to search for universals: a "thin, implausible, and largely uninstructive comprehensiveness" (p. 129). A localist-focused responsive evaluative approach enables the generation of informative narratives (Abma & Stake, 2001). Clearly, responsive evaluation is a resistance to empirical generalisation in evaluation especially when its establisher, Robert Stake, argued that grand theory is "a force that prevents researchers and others from seeing the uniqueness of a local situation ... and the more we have these powerful theories, the less we are interested in the counterexamples" (Abma & Stake, 2001, p. 12).

Empowerment Evaluation – Fostering Self-determination

Consistent with Stake's (1978) valuing of local experience, empowerment evaluation emerged beyond the 1970s as a political practice to help people help themselves (Fetterman, 1994). Principles of fostering self-determination of recipients, rather than dependency, (in)form the basis of the empowerment evaluation approach so that recipients can conduct their own evaluations (Fetterman, 1994; Fetterman, Kaftarian, & Wandersman, 1996). Fetterman (1994) defined self-determination as "the ability to chart one's own course in life" (p. 2). For Fetterman (1982), the evaluator is like the ethnographer, an outsider who either plays the role of a teacher in teaching participants how to carry out their own evaluations so that they are more self-sufficient, or he/she plays the role of a coach or facilitator in helping others conduct their own evaluations. This process also enables stakeholders to be involved and active evaluators.

Influences in anthropology, community psychology and self-determination studies constituted the emergence of empowerment evaluation (Fetterman, 1994). Fetterman's evaluation (1994) was influenced by anthropologists who "facilitate[d] the goals and objectives of self-determining groups" (p. 2) but his form of empowerment evaluation was also based on ethnography, due to a disillusionment with quantitative and experimental methodology in the 1970s (Fetterman, 1982). Fetterman's (1982) use of ethnography in evaluation included Geertz's (1973) notion of thick description where contextual interpretations of culture are a necessity.

Ethnographic perspectives have also a played a key role in the theoretical make-up of narrative therapy (e.g., E. Bruner, 1986b, 1994, Geertz, 1973, 1983; Goffman, 1961; Myerhoff, 1982, 1986; Turner, 1969, 1974). Ethnographic perspectives have enabled 'agency' or speaking in one's own voice: "the narrative counsellor looks for alternative stories that are enabling – that enable the client to speak in his [or her] own voice and to work on the problem himself [or herself]" (Drewery & Winslade, 1997, p. 42). This voice can be seen as a form of empowerment or as a consciousness raising activity where the client is the speaker and teller of his/her own story rather than as someone who is the passive recipient of being positioned or subjected (Drewery & Winslade, 1997).

Evaluation as Practical Hermeneutics – Critical, Practical Understanding in and through Dialogue

Practical hermeneutic evaluation also shares with responsive evaluation the notion that evaluation can involve the cultivation of the participant as an active agent in the evaluation process (Fetterman, 1994; Schwandt, 1997).[65] However, practical hermeneutic evaluation places more importance on dialogical understanding as part of the evaluation process. Schwandt (1996; 1997)[66] resisted conventional evaluation in the social sciences and produced the notion that evaluation can be an involved and interpretative dialogical process that involves immersion within the social world.

Schwandt was critical of conventional evaluation for its manifestation as a modernist understanding – as one, universal way of governing the conduct of evaluation. He argued that one conventionally and empirically defines evaluation as "the determination of the merit or worth of some evaluand" (Schwandt, 1997, p. 70). Schwandt (1997) argued that conventional evaluation uses a general, foundational logic: "(1) establish criteria of merit, (2) construct standards, (3) measure performance and compare with standards, and (4) synthesize and integrate data on performance into a judgement of merit or worth" (p. 71). Tied to this logic, he argued, is a modernist paradigm of reason, a universal assumption that there should be a disengaged, solitary researcher, who is free from bias. The researcher and evaluator acts through monologue following correct rules and procedures to gain authoritative knowledge, where the evaluator/knower owns privileged knowledge (Schwandt, 1997).

Schwandt (1997) proposed a practical hermeneutic approach to evaluation, an approach that resisted the general logic of evaluation and its modernist tendencies. His approach aimed to cultivate critique, self-transformation, and practical wisdom in and through dialogical relationships among evaluation participants (including the evaluator). Instead of reproducing the general logic of evaluation, he proposed a process of evaluation that is "reframed as dialogical encounters demanding continuous interpretation" (Schwandt, 1997, p. 77). Rather than assuming evaluation always has to

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[65] Although Schwandt's work on practical hermeneutic evaluation emerged after fourth generation (constructivist) evaluation, its temporal ordering is not as significant as its genealogical descent in relation to fourth generation evaluation. Practical hermeneutic evaluation is contingent with the emergence of the theoretical perspective of practical hermeneutics (Schwandt, 1997), which emerged from the works of Gadamer and Habermas. Fourth generation evaluation is contingent with social constructionism (Guba & Lincoln, 1989). Therefore, as emergent discontinuities of the descent of evaluation theory, the theoretical descent of practical hermeneutic evaluation *preceded* the constructionist descent of fourth generation evaluation.

[66] Schwandt was also partly influenced by Geertz's (1983) and Cronbach's work (Cronbach et al., 1980).

solve a problem, as in conventional evaluation, the evaluator understands through dialogue a "dilemma or mystery that requires interpretation and self-understanding" (Schwandt, 1997, p.77). In practical hermeneutic evaluation, there is no disengaged expert evaluator. There are no pre-determined, standardised criteria to establish and value the worth of something. Rather, the practical hermeneutic evaluator has a continual conversational relationship with stakeholders, understands that issues are contestable, enables stakeholders to cultivate a critical intelligence to debate, and to be critical of controversies and assumptions (including the general logic of evaluation). Rather than assuming that there is an end-goal of setting standards for participants to get from 'here to there', practical hermeneutic evaluation creates conditions for stakeholders to critically question "whether the there is worth getting to" (Schwandt, 1997, p.78). The evaluation process is focused on teaching a critical intelligence that enables a transformative, practical wisdom to occur: it "seeks to improve the rationality of practices in the fields of health care, social welfare, education, and so forth by enabling practitioners in these fields to refine the practices for themselves" (Schwandt, 1997, p.79).

There are also ideas in narrative therapy that appear to have some resonance with Schwandt's (1997) work. The notion of a collaborative, conversational relationship through which meaning is constructed is common to both narrative therapy and practical hermeneutic evaluation. Practical hermeneutics assumes that there is a dialogical understanding of the self developed from within a social context (Schwandt, 1997). Narrative therapy also involves dialogue through conversation to seek ideas and understandings on how "the self is formed and reformed ... [as] an ongoing process" (Drewery & Winslade, 1997, p. 39). In applying understanding on the (discursive, narrative) formations of the self, narrative therapy can also cultivate 'self-transformation', guided by the assumption that such ideas can be used as part of a restorying process to understand and transform the self. For Schwandt (1997, p. 80), practical hermeneutic evaluation involves the evaluator who "works more as a partner – generating supplementary perspectives, enabling conversations ... facilitating examination and critique" and is also "mindful of a postmodern hermeneutics of suspicion that questions the authority of any point of view as definite and certain" (Schwandt, 1997, p. 80). Narrative therapists are also "curious, interested and partial participants" (Besley, 2002, p. 130) in the conversations with their clients and are

challenging of "techniques that subjugate persons to a dominant ideology" (White & Epston, 1990, p. 29).

Fourth-Generation Evaluation – Constructing Understanding through Values and Partnerships

Fourth generation evaluation (Guba & Lincoln, 1989; Lincoln & Guba, 2004; also known as constructivist evaluation) is another emergent interpretivist shift in the conceptualisation of evaluation that enables stakeholders to be active participants in the evaluation process. Such an approach focuses on value-pluralism, an acknowledgement of the multiplicity and differences of values in society. Guba and Lincoln (1989) argued that "values had been implicit in evaluation since its first use; indeed, the very term *evaluation* is linguistically rooted in the term *value*" (p. 34, original italics). They argued that even positivist science is not value-free in that creating something 'objective' involves value judgements, individuals interpret factual results differently and value systems construct and determine facts. In fourth generation evaluation, "every act of evaluation becomes a political act" (Guba & Lincoln, 1989, p. 35). So, the evaluator and stakeholders are active political actors, influenced by their values, who shape the evaluation process.

Due to assuming that evaluation is a political, value-laden process, fourth generation evaluators aim to be conscious and cautious of the ways that different values might shape the collection and analysis of data (Lincoln & Guba, 2004). Fourth generation evaluators acknowledge and respect the process through which "stakeholders speak from their social locations and try to make transparent their own social locations as well as the concerns and issues that bring them to this particular evaluative effort" (Guba & Lincoln, 2004, p. 232). Constructivist evaluators recognise a range of contextual influences that shape the epistemological and value-laden standpoints of stakeholders in the evaluation process, including culture, ethnicity, education, socioeconomic backgrounds and gender (Guba & Lincoln, 2004).

Wary of the political nature of evaluation, Guba and Lincoln (1989) also argued that previous evaluation models' over-commitment to the positivist paradigm lead to a negation of context, moral responsibility of the evaluator, and construction of multiple meaning. They argued that such positivist models of evaluation result in context stripping by assessing the evaluand as if he/she did not exist in a context, ignoring local

factors and conditions. Guba and Lincoln (1989) further argued that such an over-commitment appears to lead to overdependence on quantifiable and calculable measurement and argued that such models do not question the positivist-realist assumption that if evaluators cannot measure a phenomenon objectively, it cannot be real. They also questioned the lack of reflection in the positivist paradigm where questioning the authority and moral responsibility of the evaluator is absent: "one cannot be faulted for telling the truth ... the evaluator (messenger) cannot be held responsible for findings (the message) that simply reflect what exists in nature" (Guba & Lincoln, 1989, p. 38). Guba and Lincoln (1989) argued that the positivist scientific approach shuts out alternative ways to think about the evaluand as when there is scientific evidence "we must accept it at face value ... [but] perfectly reasonable alternatives cannot ... be entertained. There are no negotiations possible about what is true" (p. 38).

So, following on from Stake's (1976) responsive evaluation and their own responsive approach to evaluation (Guba & Lincoln, 1981), Guba and Lincoln (1989) proposed a *responsive constructivist* evaluation that emerged as fourth generation evaluation. Guba and Lincoln's (1989) approach to evaluation is responsive in that it involves a process of negotiation between stakeholders and the evaluator, and seeks different stakeholder views. Guba and Lincoln asserted that fourth generation evaluation is also located within a constructivist, interpretivist, and hermeneutic paradigm. Fourth generation enables a *hermeneutic dialectic* process in that the interpretative sharing and dialogical negotiation of constructions between stakeholders enables movement towards consensus (Guba & Lincoln, 1989). In terms of a constructivist approach, 'truth' is relative rather than fixed, constructions exist in and are shared between the minds of constructors and cannot be split into measurable elements, and 'facts' are theory-laden and are dependent on values (Guba & Lincoln, 1989). The fourth generation evaluators' aim is to embrace the sophistication of social interactions as opportunities to explore shared and multiple meaning, especially in how stakeholders make meaning of their lived experience (Lincoln & Guba, 2004).

Through the emergence of Guba and Lincoln's (1989) fourth generation, with constructivist evaluation as resistance to positivist evaluation, Guba and Lincoln have enabled a transformation of the meaning of evaluation. The conventional view of evaluation is that it is "a form of scientific inquiry and hence has all the attributes of that genre" (Guba & Lincoln, 1989, p. 109). Therefore, as Guba and Lincoln argued,

evaluation, as the scientific method, focuses on the objective, observable, and measurable discovery of root cause and effect with the aim of making 'factual' and 'truthful' generalisations for the ultimate aim of prediction and control. For Guba and Lincoln (1989, p. 107), fourth generation evaluation is a form of constructivist inquiry where its success "can be judged on whether it displays increasing *understanding* of its phenomena" (Guba & Lincoln, 1989, p. 107, italic emphasis). In fourth generation evaluation, evaluation is a value-laden process of understanding the context in which a problem is constructed (Guba &Lincoln, 1989). Instead of searching for the causality of a 'real' and 'true' problem, the fourth generation evaluator examines constructions where evaluators are "subjective partners with stakeholders in the literal creation of evaluation data" (Guba & Lincoln, 1989, p. 110). Evaluation involves a process of aiming to co-ordinate and negotiate consensus on a "better informed and more sophisticated constructions" (Guba & Lincoln, 1989, p. 110). Fourth generation evaluators do not privilege scientific legitimation and authority of an objective evaluator in validating evaluation information. Rather, they understand stakeholder evaluation data as "another construction to be taken into account in the move towards consensus" (Guba & Lincoln, 1989, pp. 110–111). Evaluation information is also produced through the writing of thick description (Geertz, 1973) enabling what Guba and Lincoln (1989) call a vicarious experience for the reader. Guba and Lincoln (1989) argued that fourth generation evaluations need to produce thick description.

Some of the theoretical bases of narrative therapy are also congruent with the epistemological assumptions underlying fourth generation evaluation theory. In addition to thick description (Geertz, 1973), narrative therapy follows similar aims of the constructivist genre of evaluation such as to foster an increasing understanding of lived experience through co-constructing the meaning of problems and experiences in a negotiated, collaborative relationship between therapist and client (White & Epston, 1990). Narrative therapy also has constructivist epistemological influences (e.g. J. Bruner, 1986; E. Bruner, 1986a, 1986b). Edward Bruner (1986a, 1986b), for example, argued that (like evaluation) narratives are politically constitutive of lived experience. Co-constructed understanding is also a commonality in that narrative therapists acknowledge that it is the social, relational domain, the processes and outcomes of social interaction, rather than the individual realm, where persons may be understood (Drewery & Winslade, 1997).

Towards a Conclusion

By examining the emergence of evaluation theories, I have rendered a range of shifts in and fragmentations of values and epistemological assumptions towards interpretive, contextual meanings of understanding phenomena that disrupt the current positivist, empirical epistemology of the denotative scientific method that underpins evidence-based practice in psychology.[67] One can understand these emergences of post-positivist discourses of evaluation theory as subjugated knowledges of positivist, empirical psychology. That is, they are knowledges that have been "buried and disguised in a functionalist coherence or formal systematisation" (Foucault, 1980, p. 81) whereby in the practice of EBPP, the scientific method is purported to be the best tool that prevents "theoretical preconceptions to override clinical or research data" (APA Presidential Task Force Report on Evidence-Based Practice, 2006, p. 277).

There were value shifts towards interpretation and the appreciation of the complexities of the social context in positivist evaluation. These shifts were limited by positivist epistemology at the time, but they enabled conditions that made possible to pluralise the concept and practice of evaluation beyond a pure experimentalist assumption of pure objectivity, control and accuracy. The emergence of quasi-experimental designs through Cook and Campbell (1976, 1979) enabled evaluators to cater for the complexity of the social environment.

Stufflebeam (1967, 2004) also resisted experimental designs by producing an evaluation process that engaged the interactive relationships between the participants and the evaluator forming and improving the evaluation process rather than imposing a design that controlled participants to test hypotheses. Such a resistant emergence of evaluation enabled a focus on the dynamics of the social context, involving a shift in evaluation from prescription to description of social phenomena.

Responsive evaluation, empowerment evaluation, practical hermeneutic evaluation and fourth generation evaluation form an emergent discourse of post-positivist evaluation. Such evaluation theories, though different in epistemological stance, are resistances to the scientific method in psychology. Rather than objective disengagement, or reducing participants to operationalisable variables, these post-positivist theories of evaluation involve an interpretative engagement of the evaluator in

[67] For Foucault (1991b, p. 76), an objective of genealogy is to find shifts in discourse, and link these to "connections, encounters, supports, blockages, plays of forces, strategies and so on" as they enable "a multiplication or pluralization of causes" that dissociate something as "self-evident, universal and necessary."

a relationship with stakeholders in and through the process of evaluation. Such theoretical stances of evaluation do not base their assumptions on measurability, well-normed measures, quantification, reliability and laboratory-based experimentation that are doctrined as goals in evidence-based practice in psychology (APA Presidential Task Force Report on Evidence-Based Practice, 2006). Yet, these post-positivist evaluation theories also are scholarly knowledges that appear to complement the underlying epistemological influences of narrative therapy. These evaluation theories are also situated as contingent with the sudden rupture in the meaning of evaluation in the social sciences in the 1970s that involved Geertz's (1973) contextual writings on thick description as, perhaps accidentally, enabling a wider epistemological view of, and a more pluralistic methodological approach to, evaluation in the social sciences. Furthermore, due to their interpretivist principles, these post-positivist evaluation theories have commonality with some of the theoretical descent of narrative therapy, and this commonality further problematises the relationship between narrative therapy and evidence-based psychotherapy evaluation in psychology.

Chapter 5

Tracing the Contemporary Descent and Emergences of Evidence-Based Psychotherapy Evaluation in Psychology[68]

Evidence-based practice (EBP) has become an omnipresent influence in psychology over recent years as a discourse espousing itself as the best way forward to evaluate psychotherapy. Western health care systems have increasingly accepted EBP as a modern, 21st Century model for evaluation and therapeutic practice (Chwalisz, 2003). The general idea of EBP is that the incorporation of clinical expertise and patient characteristics with established evidence makes for beneficial health decisions for the patient (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996; Sackett & Strauss 1998). The American Psychological Association (APA) Presidential Task Force on Evidence-Based Practice (2006) adopted EBP as an evaluative model for psychology, calling it "the integration of the *best* available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 271, italics added). Clinical psychologists have often touted this political ideal of EBP (Tanenbaum, 2003) as the best way to bridge the gap between scientific research and therapeutic practice (Kazdin 2008; Thorn 2007). The APA Presidential Task Force on Evidence-Based Practice (2006) promoted EBP as an improvement from another forerunner of evidence-based psychotherapy evaluation[69], generally known as the empirically supported treatment (EST) movement.[70]

Documenting and Tracing the Contemporary Descent and Emergence of Evidence-Based Psychotherapy Evaluation and its Resistances

In continuing a genealogical examination of evaluation, this chapter aims to problematise the current taken-for-granted conceptualisation of evidence-based practice as a *'best practice'*, and evidence-based psychotherapy evaluation in general. I will do this by critically historicising psychotherapy evaluation, focusing particularly on the domain and influence of clinical psychology. I argue that evidence-based

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[68] Some elements of this chapter have been published in the peer-reviewed *Journal of Martial and Family Therapy* (Strong, Busch, & Couture, 2008) under the 'Reconceptualising Evidence' and 'Issues, Controversies, and Movements' subsections with other elements also in an in-press peer-reviewed chapter in the book *Discursive Perspectives in Therapeutic Practice* (Busch, in press).

[69] In conceptualising evidence-based psychotherapy evaluation, I include the empirically validated and -supported treatment movements as well as the evidence-based practice in psychology movement.

[70] The EST movement was originally known as the empirically validated treatment (EVT) movement.

psychotherapy evaluation has become a contested practice in its contemporary history with various interest groups promoting and resisting the empirical evidence of psychotherapy. So, to dissociate the identity of 'evidence-based' evaluation, I map different emergences of its contemporary descent. Before the APA adopted evidence-based practice, there was an emergence of empirically validated treatments (EVTs; Task Force on Promotion and Dissemination of Psychological Procedures, 1995), rechristened later as ESTs (Chambless & Hollon, 1998).

Emergences of various resistance movements arose, countering EVTs. There were those who promoted different modes of empiricism such as principles of empirically supported interventions (APA Counselling Division; Wampold, Lichtenberg, &Waehler, 2002, 2005), and empirically supported therapy relationships (APA Psychotherapy Division; Norcross, 2001). The APA's Humanistic Division resisted ESTs by arguing that they were "not paradigmatically congruent with humanistic theory and practice and are therefore not adequate for the evaluation of humanistic psychotherapies" (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001, p. 27).

Examining these various emergences enables a further step towards problematising the relationship between the present 'truth' of psychotherapy evaluation and narrative therapy. By examining the emergence of different discursive practices of evidence-based psychotherapy evaluation as technologies of power, I problematise these evaluation practices as a governing 'rationality', a governmentality (Gordon, 1991) of psychological and evaluative conduct. In the last chapter, I introduced some of the various emergences of evaluation as resistances to the scientific method in the social sciences to fracture the concept of evaluation. I argued that evaluation could be conceptualised and theorised in a variety of ways through its theoretical descent. In this chapter, I trace the movements in contemporary psychotherapy evaluation, dissociating the governing identity of evidence-based evaluation in psychology. I will cover the emergence of empirically supported treatment, and the subsequent emergence of resistant discourses on evaluation that discontinue some of the EST discourse, followed by the ascent to the new paradigm of evidence-based practice in psychology (EBPP).

In this chapter, I continue to use genealogical methodology (Foucault, 1975, 1986; Rose, 1996; Hook, 2007) to conduct a critical historical examination of discursive practices of psychotherapy evaluation. Genealogy aims to disrupt the taken-for-granted present-day 'truth' of a phenomenon (i.e., evaluation) by tracing its multiple,

numberless beginnings (*descents*). Through an examination of descent, I examine counter-knowledges to the present-day 'truth' of *psychotherapy* evaluation. These counter-knowledges materialise as resistances (*emergences*) to the dominant governance of knowledge at the time. Such counter-knowledges can also be knowledges that are 'buried' or silenced, or 'forgotten' by the governing discourse or 'truth' and are termed as *subjugated knowledges* (Foucault, 1980). By examining descent, emergence, and subjugated knowledges, genealogy aims to open up new possible conditions of/for knowing that enable one to know, utter and reproduce other discourses beyond that of a governing and often taken-for-granted 'truth'.

This genealogical examination of psychotherapy evaluation, in looking at its contemporary descent through evaluation texts[71], uncovers a number of emergences and subjugated knowledges of psychotherapy evaluation that perpetuate and disrupt the prevailing positivist and empiricist underpinnings of psychotherapy evaluation in psychology that inform evidence-based practice. In using 'empirically validated treatment' (EVT), 'empirically supported treatment' (EST), 'evidence-based practice' (EBP) keywords through Google Scholar, PsycINFO, and Web of Science databases, I uncovered a range of publications (texts) that produced either a perpetuation of or a resistance to such practices. I came across APA and APA divisional policy documents as task force reports with recommendations for the practice of psychologists regarding the production of EVTs, ESTs, and/or EBP. Such documents, as prototypical texts, are exemplifications of what has become authoritative in psychotherapy evaluation. Such prototypical texts are the Task Force on Promotion and Dissemination of Psychological Procedures (1995) document, enabling the emergence of ESTs (e.g., Chambless et al., 1998; Chambless & Hollon, 1998; Chambless & Ollendick, 2001), and the APA Presidential Task Force Report on Evidence-Based Practice (2006), enabling the emergence of EBP in psychology (e.g., Kazdin, 2008; Thorn, 2007; Spring, 2007). I selected these exemplary texts for examination due to their authority and prominence as leading documents that exemplified a North American (United States), APA-based dominance of prescribed standards for psychotherapy evaluation in psychology. Through examining such policy documents and subsequent publications on ESTs and EBPP, I was able to trace further the contingency and perpetuation of the discourse of

[71] What I mean by a text is a representation of information primarily in the form of authored documents. I am examining documents as specific historical locations of discursive practices (Foucault, 1972) – as multiple descents and emergences of psychotherapy evaluation.

these authoritative movements of psychotherapy evaluation. I also examined scholarly debate and writings on ESTs and EBP, including newsletters from the New Zealand College of Clinical Psychologists and the New Zealand Psychological Society that reproduced some of the governing discourse of evidence-based psychotherapy evaluation.

Further, APA Division documents (e.g., Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001) produced statements that *resisted* and disrupted the authoritative discourse of EVTs and ESTs (e.g., Chambless et al., 1998; Chambless & Hollon, 1998; Chambless & Ollendick, 2001; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). These documents were included for examination as emergent marginalised or subjugated knowledges of psychotherapy evaluation discourse because they dissociated the identity of evidence-based psychotherapy evaluation. These documents typified movements that resisted the practice of EVT and ESTs by putting forward their own recommendations for evaluative practice. They were largely ignored by advocates of ESTs (e.g., Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001[72]) or, paradoxically, were partly subjected to its discourse (e.g., the Counselling and Psychotherapy Divisions of the APA both reproduce the notion of 'empirically supported' to justify their recommendations).

Given the preeminent position the APA plays as a governing body in psychology (e.g., its publication manual governs expected academic language use worldwide), it could be argued that APA policy documents on psychotherapy evaluation enable ideas to be disseminated on how one *can* be a competent psychologist, how one *should* evaluate psychotherapy, and how one *should* practice as a psychologist. The documents are not mere passive observations written down. Rather, they incite discursive practices in that they invite a reader/listener to either agree or disagree, to conform or resist, to express an opinion or remain silent, and to attempt to set up counter-documents to disrupt the arguments or produce documents or other practices that further disseminate counter knowledges.

[72] A substantial part of this document was originally published in 1997 in reaction to EVTs (Task Force of the Development of Guidelines for the Provision of Humanistic Psychosocial Services & Bohart, 1997).

The APA policy documents therefore incite a politicised force of relations. Authorities such as APA officials and Task Force members play crucial roles in producing these documents and they have more authority and hence influence than the average member. For instance, Dianne Chambless, the Chair of the Task Force on Promotion and Dissemination of Psychological Procedures (1995) for EVTs, was also an authority on prescribing evaluative criteria for ESTs (Chambless et al., 1998; Chambless & Hollon, 1998; Chambless & Ollendick, 2001). Others followed and supported her prescriptions (Beutler, 1998; Crits-Christoph, Wilson, & Hollon, 2005; deRubeis & Crits-Christoph, 1998; Kazdin & Weisz, 1998).[73] Such authorities and their documents produce reactions in that they ascribe the body and its conduct with knowledge and therefore enable the emergent production of relationships of power (Foucault, 1977, 1984c). These documents had to be practiced somewhere at some point in space and time by a body (produced by an authoritative body and, when read, statements in them are taken up and reproduced or resisted by another). So, not only are the documents *about* practices (i.e., the practices of evaluation) but they are prescriptive documents that enable the *production* of governing, *politicised* practices of evidence-based psychotherapy evaluation. Such practices involve academics and practitioners choosing to adhere to, endorse, avoid, or challenge governing, prescriptive knowledges on empirically supported treatments and evidence-based practice in therapy, research, professional training, and professional societies.

Governmentality

I will theorise evidence-based psychotherapy evaluation as a governmentality, a particular discursive practice embedded in social power relations, one that enables individual responsibility and professional 'choice' of psychologists to be exercised as part of a disciplinary gaze. What I mean by a disciplinary gaze is the ability to examine/survey conduct that forms part of an institutional expectation of 'normative' behaviour (Foucault, 1977). Foucault's conceptualisation of government is a form of activity that aims to "shape, guide, or affect the conduct of some person or other persons" (Gordon, 1991, p. 2). Foucault's reflections on the mentality of liberal government, along with liberalism and neo-liberalism in the 20th Century, witnessed the emergence of a modus operandi of power that postulated and sought to create certain

[73] Paul Crits-Christoph was also on a Task Force member for the Task Force on Promotion and Dissemination of Psychological Procedures (1995).

forms and spaces of self-government (Rabinow & Rose, 2003). These forms and spaces of governance enabled and produced acts of self-regulation and self-responsibility. The most of obvious examples of these are the disciplinary techniques of normalising judgements and the surveillance of self and others that Foucault (1977) theorised in his historical analysis of institutions (e.g., prisons, military barracks, and schools). Any authoritative system that can be taken for granted can become (re)produced and reinforced as an 'ethical' practice through our own responsible autonomy (Rabinow & Rose, 2003). This is the character of governmentality in that we are free to conduct our affairs which are often shaped by a prevailing, authoritative, and governing 'mentality' (i.e., a discourse), an ethical code that may shape how we think about how we should conduct (i.e., govern) ourselves and how we expect others to conduct themselves.[74] Foucault's conceptualisation of government involves a complex set of power relations that involve resistance or acceptance to a discourse (e.g., an authoritative system of statements) that aims to govern conduct (Gordon, 1991).

The concept of *reverse individualisation* is an example of a process of government that occurs through the exercise of surveillance rather than through explicit means and where there is a normative reference to measure oneself against (Foucault, 1977). The individual "may be described, judged, measured, compared with others, in his [sic] very individuality; and it is also the individual who has to be trained or corrected, classified, normalized, excluded" (Foucault, 1977, p. 191). Government can concern a range of activities: "the relation between self and self, private interpersonal relations involving some form of control or guidance, relations within social institutions and communities and ... relations concerned with the exercise of political sovereignty" (Gordon, 1991, pp. 2–3). It can also be used as an as analysis in its own right. However, in this genealogy, I do not adopt governmentality strictly as a form of analysis (cf. governmentality analysis). Rather, I use it as a concept to draw from in this genealogy, through the critical historical analysis of texts, to help explain the emergence of evidence-based practice and its rules that create conditions of possibility that enable the self-governance of the psychologist within the institution of psychology. According to Gordon (1991), it was the *rationality* of government as a **govern***mentality* that Foucault was principally concerned with (i.e., who can govern, what governing is, and

[74] I should note that government *tries* to shape human freedom but it is not constitutive of freedom: 'The governed are free in that they are actors, i.e. it is possible for them to act and think in a variety of ways, and sometimes in ways not foreseen by authorities' (Rabinow & Rose, 2003, p. 13)

what or who is governed), a rationality that is made "thinkable and practicable both to its practitioners and those upon whom it is practiced" (p. 3).

I aim to make sense of the contemporary rationality of government through the discourse of evidence-based practice in psychology, through my genealogical examination of the two key contemporary evaluation movements, ESTs and EBP. To contextualise the governmentality of ESTs, I briefly trace some key emergences of positivist psychotherapy evaluation before the EST movement arose. I then argue that there has been a shift in the governmentality of psychotherapy evaluation from an EST movement, which perpetuates and *normalises* the application of standardising evaluative criteria to one that in a sense 'liberates' the admissibility of evaluation by broadening the acceptability of methodologies and evidence. Yet, I also argue that this 'liberation' encapsulates governmentality within an emulation of the medical model ever more so. I also trace, intertwined with the practices of ESTs and EBPP, an emergence of movements of resistance involving subjugated knowledges as, to use a governmental notion, "dissenting counter-conducts" (Gordon, 1991, p. 5). Policy texts from the Counselling, Psychotherapy, and Humanistic Divisions of the APA have produced these subjugated knowledges and counter-conducts. I also consider what consequences these governmentalities of psychotherapy evaluation have for the status of narrative therapy.

Events before Empirically Supported Treatments

The rise of positivist, empirical research changed the practice of psychotherapy evaluation in clinical psychology during the 20th Century. There was a drive towards a sophistication of statistical techniques for the empirical measurement of psychotherapy processes and outcomes (Bergin & Garfield, 1994). According to Strupp and Howard (1992), Freud was sceptical of statistics, associated with basic behavioural research in the 1900s. He argued that the information available to the investigator was "so diverse and heterogeneous as to make meaningful comparisons all but impossible" (Strupp & Howard, 1992, p. 310). However, in the 1920s, treatment centres, connected to "psychoanalytic training institutes ... began to collect systematic data on treatment results ... disregarding Freud's strictures" (Strupp & Howard, 1992, p. 311). Some of the data on the outcomes of psychoanalytic therapies in the 1940s was not as impressive as hoped by the psychoanalysts. The emergence of stricter scientific rules of

experimentation through behaviourism in psychology contributed to the subordination of psychoanalytic evidence (Rose, 1999a).

However, the development of more sophisticated statistical measurements did not necessarily equate to consensus on psychotherapy evaluation. Eysenck's (1952) infamous study 'The effects of psychotherapy: An evaluation,' attacked all forms of psychotherapy and concluded that the training of psychotherapists should be abandoned because the qualitative improvement (the size of such an effect) of clients who had psychotherapy does not exceed those who spontaneously recovered from a problem without psychotherapy. Eysenck's (1952) study produced an emergent eruption of publications in psychotherapy outcome research, inciting a range of counter-points from psychotherapy researchers (Garfield, 1981; Strupp & Howard, 1992). Counter-arguing Eysenck's (1952) conclusions, Bergin and Lambert (1978) argued that his original data, if re-coded, could reach a range of conclusions. According to Strupp and Howard (1992, p. 312, original italics) when the data was statistically reanalysed, 67% of "emotionally disturbed people" who did not have therapy "improved in 2 *years*" and 67% of clients who had psychotherapy "improved in about 2 *months*."

Eysenck also played an important role in the emergence of behavioural measurement in clinical psychology. Behaviourism enabled the 'objective' measurement of psychological suffering initially in and through laboratory conditions for application in clinical situations in order to compete with psychiatry and psychoanalysis (Rose, 1999a). Eysenck (1990) instituted behavioural, experimental studies to inform clinical psychology practice at a time when clinical psychologists were subservient test administrators and scorers for psychiatrists. In doing so, he argued that behavioural problems were more to do with learning issues rather than symptomologies of underlying disorders and that psychiatry was unsuitable to treat such problems because behaviourism was outside of its medical scope. This new reasoning created space for the emergence of expertise in behavioural measurement for clinical psychology (Rose, 1999b). This new emergence, according to Rose, involved the assemblage of psychometric techniques together with the goal of changing maladaptive behaviour to socially adaptive behaviour through normalising techniques of behavioural modification. Psychometric testing was used as, what Rose (1996) calls, a mini-laboratory in itself to make behaviour codable, categorisable, scalable, calculable and standardisable.

The establishment of the meta-analysis movement in psychology was another major emergence in the quantification and measurement of psychotherapy evaluation. Gene Glass invented meta-analysis in the mid-1970s as an evaluative technique for measuring psychotherapy outcomes. Meta-analysis involves the statistical analysis of a large collation of analysed results, pooled across several studies so that one can integrate the results (Glass, 1976). Its establishment was born in a conflict with descriptive and interpretative review studies: "It connotes a rigorous alternative to the casual, narrative discussions of research studies which typify our attempts to make sense of the rapidly expanding research literature" (Glass, 1976, p. 3). The most fundamental process of meta-analysis involves establishing a mean effect size across individual studies that contain effect sizes. A definition of an effect size is the "mean difference between the treated and control subjects divided by the standard deviation of the control group" (Smith & Glass, 1977, p. 753). Smith and Glass's (1977) 'Meta-analysis of psychotherapy outcome studies' examined the effect sizes of 375 therapy studies and found an average effect size across all of the studies of .68. This, as maintained by Smith and Glass (1977), meant "the average client receiving therapy was better off than 75% of the untreated controls" (p. 754).

Meta-analytic studies also produced evidence to show little difference in outcome between various psychotherapies, but the APA Clinical Division's Task Force on Promotion and Dissemination of Psychological Procedures (1995) ignored these studies due to their stricter scientific criteria of what should be 'empirically validated'. What was interesting was that Smith and Glass (1977) found there was almost no difference in effectiveness between the behavioural classes and non-behavioural classes of psychotherapies. Smith, Glass and Miller (1980) updated this meta-analysis, examining the effect sizes of 475 psychotherapy studies and found similar results. Others also found little difference in outcome across various psychotherapies (e.g., Luborsky, Singer, & Luborsky, 1975; Shapiro & Shapiro, 1982; Wampold et al., 1997). This became known as the 'Dodo Bird Verdict', an *Alice in Wonderland* metaphor for 'no difference', where the Dodo Bird announced, "Everyone has won and all must have prizes" (Hill & Nakayama, 2000, p. 7; see Wampold et al., 1997). However, the APA's (Clinical) Division 12 Task Force on ESTs argued that practitioner training in psychological therapies should not base their curriculum on the Smith et al. (1980) meta-analysis. The Task Force argued that the Smith et al. (1980) meta-analysis was, 1) based on studies including participants who did not seek therapy, 2) pre-dated the

arrival of the DSM-III (American Psychiatric Association, 1980), which, the Task Force argued, provided a more reliable categorisation of mental disorders, and 3) predated research standardisation of therapy through treatment manuals. Yet, since Glass and Smith's (1977) meta-analysis, the studies of meta-analyses and effect sizes for psychotherapy outcomes has proliferated throughout the psychological research literature such as in the *Handbook of Psychotherapy and Behavior Change*, where numerous updates have been published since the 1970s (Garfield & Bergin, 1978; Bergin & Garfield, 1986, 1994; Lambert, 2004).

Emergence of Empirically Supported Treatments

Evidence-based practice (EBP), the authoritative practice of psychotherapy evaluation, is a relatively new emergence that ascended from evidence-based medicine, empirically validated treatments (EVTs) and empirically supported treatments (ESTs). In 1988, medical clinicians and epidemiologists created evidence-based medicine (EBM), a clinical decision-making model for categorising treatment evidence in different standards for patient care (Donald, 2002). This model facilitated the rise of EBP in mental health (Tanenbaum, 2003). The rationale for EBM was to develop a structured framework for systematic clinical decision-making guided by evidence for best clinical practices (Donald, 2002). Although proponents of evidence-based practice in psychology (EBPP) emulated its framework from EBM, they understand it as a progression from EST evaluation to a more comprehensive evaluation framework (APA Presidential Task Force on Evidence-Based Practice, 2006; Luebbe et al., 2007). However, the use of 'empirically supported' discourse is evident in EBPP:

> The purpose of EBPP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention. (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 280)

The emergence of ESTs was based on a concern for the financial and employment survival of psychologists and the practice of psychological therapies in the United States health care system in the context of managed health care and third party payer funding (Beutler, 1998). During the transformation of the United States managed health care system during the 1990s, APA's Division 12 (the Clinical Psychology

Division) released a task force report on psychotherapy evaluation. A committee created the Task Force on Promotion and Dissemination of Psychological Procedures in 1992 when, according to Beutler (1998), the United States was grappling with the issue of implementing a national health care policy. Managed healthcare, which assessed therapy based on immediate cost and general access, he argued, paid little or no attention to clinical benefit. Beutler, a member of the Task Force from 1995, asserted that psychologists and psychotherapies were in danger of exclusion from national health care policy. In managed health care, "psychotherapy was considered to be a homogeneous treatment and psychotherapists were considered to be interchangeable" (Beutler, 1998, p. 114). Consequently, pharmacologically trained clinicians or lesser-paid practitioners with lower-level training began to replace clinical psychologists (Beutler, 1998). Hence, one of the recommendations of the Task Force report was to educate and convince third party payers about empirically validated treatments, particularly to "convince insurance and managed care companies and governmental agencies whose decisions affect the public" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 12).

Empirically validated treatments emerged when managed health care organisations in the United States were determining the effectiveness of psychotherapeutic interventions beyond established judicial criteria. As Beutler (1998) argued, managed health care organisations in the United States had already adopted non-empirical criteria of effectiveness, determined through legislation and case law. This was due to court recognition that practitioners of psychotherapy do not hold consensual views about successful interventions. In addressing malpractice claims and adjudicating claims against managed health care procedures, the courts adopted two non-empirical criteria for determining whether therapy was effective. These criteria were the principle of the community standard and the doctrine of respectable minority (Beutler, 1998). The principle of the community standard asserts that frequently and commonly practiced interventions in a particular community are valid and true, regardless of research evidence. The doctrine of respectable minority holds that where there are disputes involving theoretical and practice differences, the practitioner has a right for six or more of his/her peers, from the same discipline, to judge his/her practice (Beutler, 1998). Case law considers peer consensus, as a respectable minority, a valid test of the effectiveness of an intervention, regardless of research evidence (Beutler, 1998; Beutler, Bongar, & Shurkin, 1998).

However, the new managerialist ethos of managed health care placed the onus on health care professionals to 'prove' the effectiveness of interventions. According to Beutler (1998), the Clinical Division (12) of the APA elected a group of psychologists for the task of using research data to discover what interventions were of value as to keep in line with the managed health care ethos. This, he argued, was at a time when managed health care programmes started to shift their focus from cost-effectiveness to a criterion whereby health professional were required to be prove, empirically, treatment effectiveness. This requirement, 'new or neo-liberalist managerialism', became a driving cultural ethos of evidence-based evaluation (Davies, 2003), a discourse and a "set of practices that facilitate the governing of individuals from a distance" (Larner, 2000, p. 6). New managerialism is where workers are made to comply with a moral code of work conduct, produced by policymakers, but this coercion is somewhat disguised by the emphasis on individual responsibility (Davies, 2003). The weight on individualised accountability forces the worker to act on their own fears, guilt, and/or sense of responsibility, to 'stay in line' with (and 'naturalise') the moral code no matter how problematic it may be (Davies, 2003; Rose 1999b). The new empirical standard in managed health care created possible conditions for the Clinical Division of the APA to establish strict empirical criteria of EVTs and ESTs while also placing expectations for its members and other psychologists to adhere to (as in Chambless & Hollon, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995; see Busch, in press).

One could argue that the Task Force report on empirically validated treatments is a strategic tool produced to persuade psychotherapy evaluation stakeholders the necessity for empirical research to establish the worthiness of psychotherapies. The Task Force assigned themselves to "consider methods for educating clinical psychologists, third party payors, and the public about effective psychotherapies" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 3). They produced recommendations that data-based treatment approaches be published in the *APA Monitor*, that the APA assist in training curricula for empirically validated treatments, offer training through health management organisations and mental health centres, and that the APA work with the National Institute of Mental Health to cultivate the dissemination of results about the benefits of empirically validated psychotherapy research. The Task Force also recommended media releases, public service announcements and media campaigns to educate the public on empirically supported

treatments. In addition to convincing insurance, managed care, and governmental organisations, the Task Force also recommended that the "APA needs to continue to work to make the empirically-documented benefits of psychotherapy for emotional disorders known to third party payors" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 12).

Such suggestive statements of cultivating practices and knowledges of EVTs induce a prescriptive, (new) managerialist discourse of conduct for psychologists. The Division 12 Task Force recommended training curricula in psychology and educating different society sectors on EVTs, which produces an expectation that individual psychologists will cultivate such recommendations as highly specialised discursive practices. An effective, responsible clinical psychologist, as a scientist-practitioner, has to practice a highly specialised, authoritative knowledge of empirical criteria to establish the efficacy of treatments to inform practice. These practices are what I adapt from Foucault's (1997a) use of the term, technologies. The Greek derivative of 'technology', used by Foucault is *techné,* meaning art, skill, craftship, or a "technique" that is focused on producing a particular aim or goal (Gadamer, 1966). When Foucault (1997a) refers to technologies of power, it is with reference to the domains of knowledges or truths behind the deployment of each technology or practice in that power and knowledge are intertwined (Foucault, 1980). There is an interconnection between the technical practices of power and discursivities of knowledge as 'tech(k)no(w)logies'.

I use the term 'technology' (or tech(k)no(w)logy) to make sense of the governmentality of EVTs and ESTs because it encapsulates a range of considerations. Technology is a technical knowledge or 'know-how' of practice (Foucault, 1997a). It is also a technique or way of knowing, and more specifically an epistemological stance that aims to inform practice in particular ways (Foucault, 1997a). Further, as a technique that involves the interconnection of power and knowledge (Rose, 1996), technology can be thought of as part of an apparatus that could educate but in doing so also disciplines subjects (i.e., the empirically supported treatment movement produces an institutional embodiment of evaluation in psychology). Again, not only the documents I examine on the empirically supported treatment movement are knowledges *about* practices of evaluation, they are prescriptive documents as they *produce* discursive practices of what one *should* practice in psychotherapy evaluation. Rose (1996) extends on Foucault's notion of technology and reconceptualises it as "any

assembly structured by a practical rationality governed by a more or less conscious goal" (p. 26). Technologies of government are what Rose (1996, 1999b) calls 'human technologies', those institutional embodiments that are inspired, permeated, and saturated with "aspirations for the shaping of conduct in the hope of producing certain desired effects and averting certain undesired effects" (p. 52). The individual makes use of a hierarchical observation and normalising judgement, which "compares, differentiates, hierarchizes, homogenizes, [and] excludes" (Foucault, 1977, p. 183) to enable to him/her to govern his or her own conduct. This observation and judgement involves an examinational, disciplinary gaze on the self and others that 'governmentalises' behaviour. Such a gaze, which implies what one *should* know and practice, could be produced when one reads the following statement on ESTs. "Despite the great strides in the development and validation of effective treatments, it is not quite clear that the benefit of our approaches is widely appreciated, even by other clinical psychologists" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 3). Such a statement is indicative of a necessity to promote the value of ESTs and incites judgements towards non-adherent EST practitioners ("other clinical psychologists").

In my examination of the Task Force document on empirically validated treatments and in subsequent debates, I have conceptualised three governmental technologies, as discursive practices of evaluation, and a discourse, that have been constructed through the empirically supported treatment movement. These discursive practices are technologies of standardisation, experimental measurement idolatry, disorder-focused and medicalised prescription and proscription, and a discourse of professional competition.

Technologies of Standardisation

The empirically supported treatments movement (e.g., Chambless & Hollon, 1998; Chambless & Ollendick, 2001; Task Force on Promotion and Dissemination of Psychological Procedures, 1995) produces a technology of power that establishes a relationship between psychologists' practice and the specialised, authoritative knowledge of technical standards for EVTs/ESTs. These standards enable psychologists to verify their (including other psychologists') conduct of psychotherapy research through empirical criteria to judge if their research fits standard criteria for empirical validation/support. The policy on empirically validated/supported treatments

in the Division 12 Task Force document enables a technological examination of one's own practice and the practice of others based on two standard categories: *well-established treatments* and *probably efficacious treatments* (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). In this section, I examine the technical criteria that produce standards of EVTs/ESTs as conditions that enabled the emergence of human technologies of psychotherapy standardisation during the 1990s.

Each category and its criteria produce an authoritative, technical language that makes intelligible the process of evaluation practice as well as producing a clinical and empirical, technical knowledge for scientist-practitioner psychologists to practice. *Well-established treatments* need to demonstrate efficacy according to the following empirical criteria: 1) statistically significant results from experimental group design studies or 2) treatment efficacy as demonstrated in experimental single case design studies (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). In criterion (1), there needs to be a least two experimental group design studies, carried out by two different investigators. According to the Task Force on Promotion and Dissemination of Psychological Procedures (1995, p. 21), the psychologist also has to demonstrate efficacy by making sure that their treatment is "superior to pill or psychological placebo or to another treatment," or alternatively, is "equivalent to an already established treatment in studies with adequate statistical power." Adding further required technical knowledge of the evaluation process, the EST movement later defined "superior" as "statistically significant" (Chambless et al., 1998, p. 4).

Criterion (2) also requires technical knowledge of experimental design and standardisation. As stated by the Task Force on Promotion and Dissemination of Psychological Procedures (1995, p. 21) this criterion must be met through a large series[75] of single case design experiments using "good experimental designs" and the treatment must be compared to pill, psychological placebo, or another treatment. In addition to criteria (1) or (2), psychologists must also make sure that their evaluations of treatments are supported by two other standards: 1) the "studies must be conducted with treatment manuals" and 2) "characteristics of the client samples must be clearly

[75] Later defined arbitrarily as nine or greater (Chambless et al., 1988).

specified" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 21).[76]

These technical criteria, requiring knowledge and standards of objective control and statistical power, were also evident in the second tier of categorisation, *probably efficacious treatments.* One criterion, requiring "two studies showing the treatment is more effective than a waiting-list control group" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 22) had "effective" replaced with "superior (statistically significantly so)" (Chambless et al., 1998, p. 4) and "experiments" replaced the word "studies" in all of the probably efficacious treatment and well-established treatment criteria. A second, alternative criterion required two experiments that otherwise met the well-established treatment criteria of the experimental group design studies, treatment manuals, and clearly specified client samples, except that the same investigator rather than different investigators could perform them. On the other hand, there could be "one good study demonstrating effectiveness" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 22) in the alternative criterion. The EST movement then replaced this second, alternative criterion with a more stringent requirement: to one or more experiments meeting the well-established treatment criteria but without the need to have two different investigators demonstrate the effect (Chambless et al., 1998).

Further EST criteria of the lower-tiered, 'probably efficacious treatments' illustrated implicitly the requirement for a tech(k)no(w)logy of standardisation to produce well-established treatments. Another third, alternative criterion defined a probably efficacious treatment as "at least two good studies demonstrating effectiveness but *flawed by the heterogeneity of the client samples*" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 22, italics added). There was an implicit assumption that homogenous samples produce well-established ESTs. However, the EST movement later omitted this criterion in an update of their criteria (Chambless et al., 1998). A further alternative criterion defined probably efficacious as a "small series of single case design studies otherwise meeting the well-established treatment criteria" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 22) that use good experimental designs and are superior to another

[76] Later, the EST movement added another criterion, aimed at increasing statistical reliability: "effects must have been demonstrated by at least two different investigators or investigating teams" (Chambless et al., 1998, p. 4).

treatment. The EST movement later updated this criterion of "small series," defined arbitrarily as three single case design studies or greater (Chambless et al., 1998).

There was also a third tier of categorisation, *experimental treatments*, which were "treatments not yet tested in trials meeting task force criteria for methodology" (Chambless & Ollendick, 2001, p. 689). This criterion thus covered everything else that was neither a well established nor a probably efficacious treatment.

These constructions of 'established' standard criteria of EVTs and ESTs are symptomatic of a degree of arbitrariness. The Task Force on Promotion and Dissemination of Psychological Procedures (1995) acknowledged that its EVT criteria were arbitrary. The changes in criteria for ESTs from EVTs were made from the judgements of only two psychologists, Chambless and Hollon (1998), taken up in empirical studies of ESTs (e.g., Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Chambless et al., 1998; Chambless & Ollendick, 2001). Further, Bohart, O'Hara and Lietner (1998) argued that the Division 12 Task Force had a political motivation, "a vested interest in making the dodo bird verdict disappear" (p. 152). The Task Force on Promotion and Dissemination of Psychological Procedures (1995) ignored scientific research supporting the Dodo Bird verdict that different therapies work equally well (Luborsky, Singer, & Luborsky, 1975; Shapiro & Shapiro, 1982; Smith, Glass, & Miller, 1980; Wampold et al., 1997). The evidence that therapy works roughly the same across most disorders (Bergin & Garfield, 1994; Seligman, 1995) also contributes to the Dodo Bird verdict. There is an assumption in the EVT/EST movement that standardising the evaluation of different therapies through the movement's criteria is necessary to discover which specific treatments are empirically efficacious for specific disorders. The Dodo Bird verdict of treatment equivalence of effectiveness disrupts the assumption of developing and requiring technical, empirical standards and knowledge to establish differentiations of treatments for disorders.

There was also a degree of arbitrariness in the Task Force on Promotion and Dissemination of Psychological Procedures' (1995) general application of EVT criteria to establish efficacy. The Task Force made generalisations based on a limited review of the psychotherapy literature by "*arbitrarily* excluding in their review studies that were not manualized" (Silverman, 1996, p. 213, original italics). Task Force members based their review of EVTs hastily around their beliefs in the treatments that suited their criteria, revealing the undeniably political and arbitrary nature of establishing EVTs:

> In the interest of time, we did not attempt an exhaustive review of the literature to find every treatment that would meet the above criteria. Rather, task force members *quickly generated* a list of treatments they *believed* to be empirically verified, and we searched for research to document these *impressions*. (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 2, italics added)

Despite their arbitrary formation, criteria of the Division 12 Task Force document appear to be regulated ways of knowing and practicing evaluation as a disciplinary practice of clinical psychology. The onus is on the clinical psychologist to become an expert-driven human technology of standardisation, to conduct their scientific practices in line with the established, authoritative 'normality' of EVT/EST evaluation practice. Standardisation is one of the key cornerstones of psychology and psychological practice (Rose, 1996; 1999a, 1999b). Normative criteria in mental measurements, for example, are established and used to provide appropriate standards of human ability and allow the psychologist to discriminate between deviations of behaviour and norms (Rose, 1979). However, EVT/EST discourse enables psychologists to establish normative criteria for their *own* conduct in research and practice. The discourse serves to repeat statements of standardisation by establishing benchmarks for research process (experimental design) and research outcomes such as being superior "to pill or psychological placebo or to another treatment" (Chambless et al., 1998, p. 4; Chambless & Ollendick, 2001, p. 689; Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 21). The EST movement established and reproduced experimental methods as the normative practice of psychotherapy outcome evaluation. The movement established a practice ethic through the seemingly 'natural', standard practice of using "good experimental designs" (Chambless et al., 1998, p. 4; Chambless & Ollendick, 2001, p. 689; Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 10).

However, what specifically constitutes a "good experimental design" standard was also at variance across EST researchers, indicating the arbitrary production of experimental criteria in and through the EST movement. Publications that have followed the Division 12 Task Force document have evidenced a repeatability and regularity of statements that continue to reify experimental design as *the* technological standard of research practice for ESTs. A special section of the *Journal of Pediatric*

Psychology (Spirito, 1999) produced the same criteria as the original Division 12 Task Force document for well-established and probably efficacious treatments but added another EST category. This additional 'promising interventions' category still privileges the use of experimental design. "Positive support" was required from one of the following: 1) one "well-controlled study", and no less than one other "less-well-controlled study", or 2) a "small number of single case design experiments or 3) no less than "two well controlled studies by the same investigator" (Chambless & Ollendick, 2001, p. 689). Roth and Fonagy (1996) also established 'experiment-supported' criteria similar to the Division 12 Task Force. Their "clearly effective treatments' criteria requires 1) being superior to a control group or another treatment condition through replication, or 2) a high-quality single randomised controlled trial with a patient group and a practitioner-followed method of therapy that could be used as a foundation for training (i.e., a potential for manualisation). Like Spirito (1999), Roth and Fonagy (1996) introduced another standard of 'promising limited-support treatments'. However, for this standard, they introduced more practiced-based criteria in that the treatment had to be innovative and show promise or widely practiced but had limited evidence for its effectiveness. Nathan and Gorman's (1998) *A Guide to Treatments That Work* for empirically supported treatments also produced similar standards to the Division 12 Task Force documents. What they called 'Type 1 studies' had similar criteria to that of well-established treatments, but also included other criteria: blind assessment, up-to-date diagnostic methods, clear criteria for including and excluding participants, and acceptable statistical methods (Nathan & Gorman, 1998). Although most of these EST-based criteria were slightly different in Spirito (1999), Roth and Fonagy (1996), and Nathan and Gorman (1998), they still privileged experimental discourse as the normative standard for evaluation. This privileging is underscored by recurring statements for the need to randomise, control, and compare experimental conditions, to replicate, to have large enough samples and to have adequate statistical power to measure outcomes of 'treatments' (Chambless & Hollon, 1998; Kazdin & Weisz, 1996; Kendall, 1998).

Normative criteria and statistical significance also appeared as a more important evaluative expectation in EST evaluation than context. Kendall (1998, p. 3) contends that the psychotherapy evaluator needs normative measures and comparisons to see whether the extent of client transformation that was beyond chance was enough to

return "deviant clients" to "within nondeviant ranges of scores.".[77] This 'beyond chance' criterion is one standard requirement of ESTs: "statistical significance is needed prior to clinical significance" (Kendall, 1998, p. 3). The apparent governance of privileging statistical knowledge and practice over more contextual knowledges of therapeutic practice is evident in the EST movement. The EST evaluation process quantified clinical standards of change; the magnitude of change is made calculable and thus measurable statistically. Chambless and Hollon (1998, p. 11) state that "if a treatment is to be useful for practitioners, it is not enough for treatment effects to be statistically significant; they also need to be large enough to be clinically meaningful." What is clinically 'meaningful' is not understood contextually in terms of both client and practitioner understandings of change. Rather, empiricist proponents of psychotherapy evaluation determined clinical significance through a need to *measure.* One way to obtain clinical significance is to measure the proportion of clients that meet standard error of measurement criteria between dysfunctional and functional populations (Jacobson & Truax, 1991). Another way is to compare outcomes for individual clients against a normative standard (Kendall & Grove, 1998) or by quantifying an institutional goal met, such as "the number of patients able to live in a group home with minimal supervision" (Chambless & Hollon, 1998, p. 11).

This emphasis on standardisation has enabled an expectation for psychologists to practice their therapy as emulations of laboratory conditions. However, critics identified practical problems with this expectation. Seligman (1995) argued that the artificiality of EVTs did not reflect what occurs in real world practice. Due to the randomised controlled trial focus of EVTs/ESTs, there are methodological problems including imposing artificial laboratory-like conditions, dehumanising diagnostic categorisations, a de-emphasis on therapy process influences, and adherence to therapy treatment manuals (Wampold et al., 2002). These problems, Wampold et al. (2002) argued, limited the applicability of EVTs/ESTs to therapeutic practice. This is because standardised administration diminishes the diversity of client context and the spontaneity of relationships. Due to the artificialness of manualisation, there were also concerns that it constricted the range of therapeutic practices and constrained what one can learn about the process influences of therapeutic change (Westen et al., 2004).

[77] Ironically, proponents of ESTs did not specify a range of non-deviant scores in their empirical investigations.

Treatment manualisation also enables an embodiment of standardisation in the delivery of ESTs. The Division 12 Task Force document prescribed the use and development of manuals as necessary for the development of empirically supported treatments. The document cited the Beck, Rush, Shaw, and Emery (1979) volume, *The Cognitive Therapy of Depression*, marking the "beginning of the availability of a treatment manual for a major treatment approach with a specific patient problem" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 4). The Task Force argued that since Beck et al. (1979), evidence has been accumulating on the use of manuals for effective standardisation of treatment and that "such standardisation ... through treatment manuals … [diminishes] the methodological problems caused by variable therapist outcomes and lead[s] to more specific clinical recommendations" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 4). This statement privileges the authority and dependence on manuals rather than therapist and client expertise. It assumes that without manualised therapy, therapists can be interruptive to good outcomes so they must embody the manual in their practice. According to Chambless and Hollon (1998, p. 11) treatment manuals "should provide a clear and explicit description of the kinds of techniques and strategies that constitute the intervention." This constitution is that which "therapists are to follow" (Chambless & Hollon, 1998, p. 11). However some have resisted this embodiment by arguing that the "therapist is a disciplined improvisational artist, not a manual-driven technician" (Bohart, O'Hara, & Lietner, 1998, p. 145; see Henry, 1998; Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001).

There is also a degree of homogeneity in manualised therapy delivery. EST advocates argued that manualisation requires participants' problems to be homogenous (Chambless & Hollon, 1998). Critics have argued that this assumption of homogeneity is unrealistic in real word practice as clients often present with more than one problem (Henry, 1998; Westen, Novotny, & Thompson-Brenner, 2005).

Some psychologists have also criticised the theoretical homogeneity of manualised therapies in EVT/EST research, namely the cognitive and behavioural therapies. The Task Force admitted that cognitive-behavioural therapies suit manualised delivery because they "more easily lend themselves to session-by-session outlines" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 16). Around 60% to 90% of empirically supported treatments (possibly

depending on which versions of criteria are used) are cognitive-behavioural treatments (Norcross et al., 2006). Tanenbaum (2003, p. 292) argued that EST proponents have an innate bias against psychodynamic and experiential therapies where such therapies are "virtually immeasurable by the task forces' methodology," and where ESTs "are almost exclusively behavioural (41%) and cognitive-behavioural (41%)." The Task Force on Promotion and Dissemination of Psychological Procedures (1995) responded to criticisms that it "reflects the intention of a group of cognitive-behavior therapists to gain advantage over adherents of other approaches" (p. 8). They argued that this intention was not the case. Rather, they argued that they were committed to empiricism. The Task Force's answer to why there was a dominance of cognitive-behaviour therapies listed as EVTs was because "researchers from noncognitive-behavioral perspectives need to get going on outcome studies" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 8). Silverman (1996) criticised this claim, arguing that there was much criticism of the cognitive-behavioural therapies and that advocating empiricism is self-serving because it reflects a bias toward cognitive-behaviour therapies.

To counter criticism that manuals could only be used for cognitive-behavioural treatments, the Division 12 Task Force stated that "at base, a treatment manual is a clear description of a treatment, and this should be possible for adherents of all psychotherapy approaches to apply" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 16). This statement positions psychologists as "adherents of psychotherapy approaches" and implies that they should be able to apply, at the basic level, a manual as a "clear description of treatment." This statement also produces an implicit suggestion that there are more advanced levels of manualisation beyond "base" in terms of a psychologist's competency, elevating manuals as key determiners of effective therapeutic outcome in EVTs/ESTs.

The stipulation of manuals in the EST movement also necessitates manualisation as a specialised technological practice for the treatment of psychopathology. The Task Force on Promotion and Dissemination of Psychological Procedures (1995, p. 9) noted a range of manuals in therapies that are developed for specifically treating particular disorders such as "disorder-specific manuals for psychodynamic treatment." The EST movement also developed Rogerian and experiential therapy manuals for panic disorder and depression. The Task Force restated the need for psychologists to use the "treatment manual for a major treatment approach with a specific patient problem"

(Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 4). Such statements produced the assumption that it is standard practice that manuals *are* developed and used for treatments *together with* specific diagnoses of clients, regardless of the therapy's theoretical approach.

Clinical psychology training standards in EVTs/ESTs were another strategic focus for Task Force advocates. Much of the Division 12 Task Force document focused on concerns and recommendations regarding clinical training programmes in relation to the training of ESTs. Findings from a survey of 167 directors of APA approved clinical psychology programmes found that 22% of the programmes provided "didactic coverage of less than 25% of empirically-validated [now empirically supported] treatments" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 6). This low result was "of particular concern" to the Task Force and so they were motivated to encourage standards for training clinical psychologists in EVTs/ESTs. The Task Force argued that "making students aware" of the literature on empirically supported treatments means that they can look for "clinical training in specific treatments of interest" during their post-doctoral or internship years.

Now that EVTs/ESTs were published, psychologists were encouraged and expected to use these as a technology to monitor the behaviour of themselves and others in relation to the 'correct training' (Foucault, 1977) of students and staff. The Division 12 Task Force on Promotion and Dissemination of Psychological Procedures (1995, p. 7) stated that they "believe students should receive initial training in at least two empirically-documented therapies" and recommended that APA programmes "make stronger efforts to provide supervised clinical experience for such treatments." The Task Force recommended that APA doctoral accreditation officials prioritise EVTs/ESTs training. The Task Force recommended recording the time spent on training in different treatment procedures that "through interviews with supervisors and students," could specifically "investigate the extent to which training to competence" in ESTs "is a part of students' experiences" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 7). In its accreditation guidelines for programmes in doctoral- and internship- training, the APA Committee on Accreditation decided to include some training in empirically supported treatments (American Psychological Association, 1996; Chambless & Ollendick, 2001). Thus, the inclusion

of ESTs has become part of a normative process for the training of budding clinical psychologists in universities, particularly in the United States of America.[78]

The emergence of the EST movement enabled governmental, human technologies (Rose, 1996), directed at the goal of administering standardised therapy (e.g., Chambless et al., 1998; Chambless & Ollendick, 2001; Nathan & Gorman, 1998; Spirito, 1999; Roth & Fonagy, 1996). Although arbitrarily constructed, these 'standardisations' enabled psychologists to position themselves as technical experts who could evaluate and standardise psychotherapy research and practice according to strict empirical criteria. They could examine whether they (or others) were applying EST criteria in their research and/or practice (e.g., manualised therapy), and were adhering to accreditation standards for training in clinical psychology doctoral and internship programmes.

Technologies of Measurement and Experimental Methodolatry

The taken-for-granted use of experimental measurement and methods in evaluating therapy outcomes in psychology overshadowed any case for applying alternative approaches to the logical positivist- and empirical-based scientific method used to evaluate ESTs (Strong, Busch, & Couture, 2008). Empirical measurement-based modes of assessment constitute a key component of the emergence of the empirically (i.e., experimentally) supported treatment movement. While there is favouritism toward the use of experimental methodology in ESTs, such use constrains what is 'evidence' to empirical constructs of *measurement* that define therapy outcomes. For instance, in EST criteria, one needs to demonstrate treatment superiority in a between-groups design through sufficient statistical power (Crits-Christoph, Frank, Chambless, Brody, & Karp, 1995). Large effect sizes between the measured outcomes of treatment and control groups are dependent on adequate statistical power.

Although the idealisation of quantitative measurement and outcome-based experimental design in the EST movement was nothing new, what *was* different was the *exclusive* focus on experimental design and efficacy. This is not surprising given the dominance of experimental measurement in psychology (e.g., Luborsky, Singer, &

[78] However, it is also important to note that the APA chose not to carry on the work by the Division 12 Task Force on listing the efficacy of empirically supported treatments and so the Task Force formed their own standing committee "charged with evaluating the efficacy and effectiveness of psychological interventions" (Chambless & Ollendick, 2001, p. 688).

Luborsky, 1975; Shapiro & Shapiro, 1982; Smith & Glass, 1977; Wampold et al., 1997). Psychological assessments determine outcomes in experimental designs where the psychologist compares baseline measurements before therapy with post-treatment outcomes. Psychological assessments enable the transformation of the individual into something calculable and manageable (Rose, 1996). Psychological assessments "discipline subjectivity, transforming the intangible, changeable, apparently free-willed conduct of people into manipulable, coded, materialized, mathematized, two-dimensional traces, which may become utilized in any procedure of calculation" (Rose, 1996, p. 112). In using psychological assessments in and through experimental methodology, the individual client is dissolved into an accumulated score amongst others where the complexities and contexts of human conduct can be classified, operationalised, shaped, measured, and calculated, to derive and reify a statistical outcome entity called 'efficacy'. The Division 12 Task Force argued, "efficacy is best demonstrated in randomized clinical trials (RCTs) – group designs in which patients are randomly assigned to the treatment of interest or one or more comparison conditions – or carefully controlled single case experiments and their group analogues" (Chambless & Hollon, 1998, p. 7). The evaluator can only obtain treatment efficacy if she/he adheres to experimental design, standardisation by treatment manual, clearly defined and large enough samples, *and* if outcomes demonstrate "superiority" (i.e., a statistically significant difference) over placebo, pill, or another treatment. The emergence of the empirically supported treatment movement has thus enabled a refining of the technology of measurement and experimental idolatry that shifts the discursive practice of efficacy, particularly the "best demonstration" of it, to something that is stricter, more scrupulous and more difficult to obtain than it ever used to be (cf. Smith & Glass, 1977).

Although the technique of the experimental method and statistical measurement are part of an assumed normative standard of practice in EST evaluation, some psychotherapy researchers have critiqued the idolisation of practices. Silverman (1996) employed the concept 'methodolatry' from Greenberg (1991) to resist and disrupt the proliferation of the EST movement. Methodolatry, Silverman (1996, p. 209) argued, is the "emphasis upon technique to the exclusion of other equally important variables" and "emphasis upon technique as the 'be all and end all' of psychotherapeutic change." Silverman asserted that manualisation is an example of methodolatry. Manualised therapy evaluation, he argues, produces misconceptions of therapists as interchangeable

and relatively homogeneous parts with the clients as passive recipients. Examining psychotherapy research, Lambert (1989) argued that the unique influence of the therapist is obvious even for the most carefully standardised techniques. However, experimentalists often viewed such influence as an 'error variance' to outcome (Lambert, 1989). This notion of 'error variance' treats the therapist as not adhering to standards of delivery as if therapist *should* aim to be a relatively homogeneous transmitter of therapeutic delivery in clinical experimental research.

Methodolatry, the idolatry or worship of method, is a discursive practice that has a tautological function. Methodolatry involves the employment of method for the sake of method. It is, what Danziger (1994a) calls a form of methodological fetishism that is a consequence of "preoccupations with a purity of method" (p. 6) in psychology. He recommends we should explore his suggestion that methodolatry is a social activity, governed by mundane conditions, rather than think of it as a realm of pure reason. Otherwise, he argues, we risk exposure to a "naive and self-deluded style of scientific practice" (Danziger, 1994a, p. 6). Methodolatry, Chamberlain (2000, p. 286) argued, is "characteristic of most psychology" because psychology has been preoccupied with methodology since its origins. Chamberlain noted that, throughout the history of psychology, the influences of the dominant behaviourist paradigm and the emphases on objectivity and measurement enabled a dominance of methodolatry to perpetuate to its present-day practice. As methodolatry involves the worship of method, there is an absence of reflection on epistemology and theoretical perspectives (Chamberlain, 2000; Danziger, 1994a) or an absence of a reflexive questioning of the use of method and methodology. The experimental method, Levitt, Neimeyer and Williams (2005) argued, is a tautological process because it cannot discover anything not hypothesised beforehand, making it inapt as an approach to discover complex social processes. Greenberg (1991) was shocked when he entered psychology from doctoral training where methodolatry, the "scientism" of "logico-empiricism" and hypothesis testing, was emphasised over scientific discovery, exploration, and understanding phenomena. He noted that when he started psychotherapy research there were a "set of methodological rules for constructing the individual evaluation study" in contrast to "little concern with strategies of how to proceed from study to study" (Greenberg, 1991, p. 4). Thus, the tight focus and idolisation of experimental control, statistical significance, random sampling, and generalisability, each of which Greenberg (1991, pp. 4–5) terms as "deities" in the "demoralised world of scientism" in psychological research indicates a

reproduction of a methodological myopia. Standards and rules of method, and the establishment of "brute facts" through inferential refutation are valued highly, often without questioning their relevance. Greenberg (1991, pp. 4-5) argued that psychologists strictly adhere to internal validity without examining the 'bigger picture' such as being "guided by theory" or catching "contexts, patterns, and meanings."

Methodolatry involves a repetition of statements on method that legitimates the use of method in and of itself, which could negate the conditions that would enable it to be reflexive of, and question, its own practice in its discourse. The EST movement have reproduced a particular methodolatry, experimental method idolatry, following the Task Force on Promotion and Dissemination of Psychological Procedures (1995) evaluative criteria (Bohart, O'Hara, & Lietner, 1998; Henry 1998). Not only does the Task Force exclusively advocate for experimental methodology, its criteria for well-established treatments include interventions that must be supported by "good experimental designs" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 21). However, the notion of what is "good" is unclear but it suggests that "good experimental designs" produce a research ethic and a moral judgement in that experimental designs are in themselves "good", are part of "good" research practice, or that "good" is some moral criterion. "Good" is neither conceptually nor operationally defined yet it is repeated four times in the criteria tables for well-established and probably efficacious treatments in the Task Force on Promotion and Dissemination of Psychological Procedures (1995, p. 10) document: "good group design", "good experimental designs", "one good study", and "two good studies."

This moral notion/statement, 'good', has been further advanced by advocates of ESTs. As mentioned before, in the follow-up review of empirically supported treatments by Chambless et al. (1998), "experiments" replaced the word "study" or "studies" in all of the probably efficacious treatment and well-established treatment criteria. However, Chambless et al. (1998) restated "good" but it was still undefined. Noone questioned the connotation of "good" as a moral statement, criterion or as part of an assumed but undefined ethic of the practice of evaluation and research. Instead, Chambless and Ollendick (2001), using discourse of "experimental rigor" (p. 688), were concerned that the Task Force "did not draw hard and fast decision rules, leaving room for potential bias on the reviewers' part" (p. 702) and provided "no evidence of the reliability of its decisions" (p. 702). So, to answer their own criticism, Chambless and Ollendick (2001) constructed a review of several working groups' EST criteria, based

on the original Task Force report, and found similar conclusions on treatment efficacy, demonstrating the reliability of their 'good' experimental criteria.

Yet, this answer by Chambless and Ollendick (2001) still does not address the use of the statement, "good", as a moral or ethical practice and thus as part of a power relation in producing or resisting what should be knowledgably "good" in the domain and practice of evaluation. The statement of what is "good" implies that there is "not-so-good" or "bad" conduct of psychotherapy evaluation. Using Chambless and Ollendick's (2001) discourse of "experimental rigor," a "not-so-good" conduct may involve experimental methods that fail to meet criteria of control, comparison, manualisation, statistical power and homogeneity of client samples and "bad" conduct may involve non-experimental methodologies. Statements of "good design" and "good experiment(s)" are also reproduced in other working group criteria of empirically supported treatments in special sections of the *Journal of Consulting and Clinical Psychology*, the *Journal of Pediatric Psychology* (Spirito, 1999), and the *Journal of Child Clinical Psychology* (see Chambless and Ollendick, 2001). These statements are unquestioned as to what "good" is or what it does. Yet, "good" and "experiment" appear as inseparable terms in EST efficacy criteria.

The EST movement's idolisation and use of outcome measurement as technology interconnects with the 'good' experimental focus where psychologists are duty-bound to adhere to its rules for determining efficacy. In their summarising criteria for ESTs, Chambless and Hollon (1998) stipulated that experiments must be conducted with "reliable and valid outcome assessment measures, at minimum tapping the problems targeted for change and ... appropriate data analysis" (p. 18). One reason why outcome assessment measures are used is the need to focus on specific pathologies of behaviour: "typical evidence for efficacy is based on measures of the presenting problem" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 5). Chambless and Hollon (1998) assert that because of this "it follows that outcome assessment tools need to tap the significant dimensions of that problem" (p. 9). Yet, ESTs proponents assume that problems are diagnostic categorisations of symptomology in ESTs and therefore focus on measuring symptomology of a diagnostic construct rather than contextually understanding the person and their relationship with the therapist (Bohart, O'Hara, & Lietner, 1998; Silverman, 1996).

Another reason why outcomes assessment measures are used is more to do with the idolatry of the experimental method where the onus of psychologists is to make sure

that they are controlling for bias, including their own biases – in that such biases may distort *the* truth. According to Kendall (1998), empirical evaluations of psychotherapy are essential to "provide measurements of the outcomes of therapy that are independent of the views of those providing the therapies" (p. 4). Practitioner experience is negated because of "standard biases in inference and decision making", "inaccurate perceptions" and psychologists as therapists might be "misled by taking credit for client improvement in the absence of controls for alternative explanations of the outcomes" (Kendall, 1998, p. 4). The fetish for assessment equates to a desire for correct conduct. Chambless and Hollon (1998, p. 9) argued that it is "desirable that researchers do not rely solely on self-report," as they viewed self-report as a potential source of error that can influence outcome. It is also "desirable ... that multiple methods of assessment be used" (Chambless & Hollon, 1998, p. 9), including a supplement of general measures of functioning that go beyond symptomology (Chambless & Hollon, 1998; Westen et al., 2004). Technologies of measurement-focused psychometric assessment through EST discourse thus enable the control of client experience and practitioner bias.

The assessment fetish in ESTs is a technological embodiment of truth where the measurement of outcomes dominates the practice of therapy evaluation. The government of the individual and the 'manifestation of truth' are interdependent (Gordon, 1991). This governmentality, where the governance of self and others involves the display of truth, can thus manifest the conduct of psychologists who must use psychometric assessment to evaluate therapeutic outcomes as a requirement for empirical support (in the name of the truth). Rose (1996) argued, "truth becomes effective to the extent that it is embodied in technique" where the psychological test is the "paradigmatic technique of the calculable person" (pp. 89 – 90). The psychological test, Rose (1996) asserts, is claimed to "differentiate according to nature and not according to prejudice"[79] and to "answer to the demands only of natural differences and human truths" (p. 90), hence the requirement for the measurements of therapeutic outcome that are "independent of the [practitioner's] views" (Kendall, 1998, p. 4). The government of researcher objectivity is also embodied through outcome assessment technology as "researchers, too, can be subject to bias" (Kendall, 1998, p. 4). Practitioners, who have an allegiance to a particular therapy, are cautioned (Chambless & Hollon; Kendall, 1998). EST advocates argued that psychologists obtain outcome

[79] Although one could conjecture that outcome measurement idolatry (and an idolatry of the experimental method) may cause an intolerance of other ways of knowing and doing evaluation.

measures from research clinics independent of, or in addition to, that of the developer of the therapy (Kendall, 1998). This dominant concentration on (or governance of) outcome assessment pays little attention to any need for the evaluation of process in therapy. There is an assumption that proper adherence to manuals covers process (Chambless & Hollon, 1998). However, the focus on providing outcome measures masks the qualitative process of therapeutic change in how therapy works (Ablon & Marci, 2004).

The empirically supported treatment emergence has enabled technologies of experiment and measurement idolatry to ensue as a governing practice in the conduct of psychotherapy evaluation. ESTs have conditioned the possibilities for a particular type of methodolatry in psychology: a governmental practice that idolises outcome measurement and the prescriptive experimental method. As a researcher, the psychologist is encouraged to desire the employment of psychometric assessment for therapeutic outcomes and practice 'good experimental design', and there is an obligation for both practitioner and researcher to minimise bias through using psychometrics to determine outcomes. These EST technologies are situated within a broader context of the use of therapy in managed care and the medical marketplace (Beutler, 1998). Advocates of ESTs were also closely associated with the broader movement of evidence-based medicine, emulating its rationale that "patient care can be enhanced by acquisition and use of up-to-date empirical knowledge" (Chambless & Ollendick, 2001, p. 686). However, narrative therapists challenge medicalising categorisations by becoming wary of their practices "in those 'truth' discourses of the professional disciplines, those discourses that propose and assert objective reality accounts of the human condition" (White & Epston, 1990, p. 28).

Medicalising Technologies of Disorder-focused Prescription (and Proscription)

As the empirically supported treatment movement with its associated documents (e.g., Chambless & Hollon, 1998; Chambless & Ollendick, 2001; Task Force on Promotion and Dissemination of Psychological Procedures, 1995) enabled prescriptive technologies of methodolatry, one can also postulate that they create conditions that extend a medical and disciplinary gaze on the government of psychological conduct. Whereas medicine created a visibility of disease through the observation of bodies and the spatial arrangement of bodily pathology in clinics (Foucault, 1973a), the empirically

supported treatment movement, associated with evidence-based medicine, extends the medical gaze. This extension manifests reifications of psychological disorder through the doctrine of empirically supported treatments whereby psychotherapies can be scrutinised by the psychologist in order to determine whether they are empirically suitable to treat a particular clinical psychopathology (Chambless & Ollendick, 2001; Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

In the *Birth of the Clinic* the professor of medicine examines the patient, then his/her students, but in doing so his/her conduct is at risk from making a mistake, which may be seen by the gaze of his/her students (Foucault, 1973a). In the EST movement, psychologists are strongly *encouraged* to use efficacious therapies, especially in clinical training programmes (Task Force on Promotion and Dissemination of Psychological Procedures, 1995; Chambless & Hollon, 1998). The movement encourages training programmes to examine clinical psychology students' use of treatments for different problems. The efficacy discourse of empirically supported treatments can provide a possible condition to realise efficacious therapies for alleviating different problems *and* judge the clinical appropriateness of therapeutic technique. Thus it could also be postulated that this condition establishes a disciplinary gaze, one that is normative and corrective: it involves the establishment of "a normalising gaze, a surveillance that makes it possible to qualify, to classify and to punish" while establishing over individual psychologists "a visibility through which one differentiates and judges them" (Foucault, 1977, p. 184).

Society, Foucault (1977) argued, has a carceral texture where the "immense appetite for medicine" is "constantly manifested" (p. 304). We became our own judges of normality, involving a judgement/gaze of ourselves and of others, he argued: "we are in the society of the teacher-judge, the doctor-judge, the educator-judge... it is on them that the universal reign of the normative is based; and each individual ... subjects to it his [or her] body... gestures... behaviour..." (Foucault, 1977, p. 304). Foucault (1977) asserted that the penal apparatus based on the prison dissolves into a new normative power and thus loses specificity through being "medicalised, pathologised, [and] educationalised" (p. 306). In other words, educational, psychological, and medical institutions become apparatuses of a *normative gaze* that performs a disciplinary function for the "formation of knowledge in modern society" (Foucault, 1977, p. 308).

The EST movement created a form of psychological governance that combined a normative, disciplinary gaze, with an "appetite for medicine" (Foucault, 1977, p. 304).

The movement established a new embodiment of clinical normativity through governmental conduct. Psychologists could judge each other in/through treatment-for-disorder criteria: "we do not ask whether a treatment is efficacious; rather, we ask whether it is efficacious for a specific [clinical] problem or population" (Chambless & Hollon, 1998, p. 9) with "some treatments being superior to others, depending on the disorder" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 16). Such a focus on disorder decontextualises the client by focusing on general classifications of symptomology. In experimental research that determines efficacy for empirical support, there is a desirability that samples are described in a diagnostic system such as through the (American Psychiatric Association's (1994) *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; Chambless & Hollon, 1998). This desirability was often the norm in the eight reviews of empirically supported treatments that adhered to the Division 12 Task Force criteria (Chambless & Ollendick, 2001).

This normative, disciplinary gaze, combined with a clinical/medical gaze, then turns to the government of conduct of psychologists in the empirically supported treatment movement. The Division 12 Task Force's stipulation of the use of empirically supported treatment by psychologists and their list of empirically supported treatments to match particular disorders creates conditions that enable the psychologists to check that they and others are adhering to what treatment is 'empirically' acceptable – a normative, 'ethical' subject positioning of professional practice. For instance, the Task Force on Promotion and Dissemination of Psychological Procedures (1995)[80] demanded, "programs *should* increasingly move towards a concentration of effort in training students in those methods which rest on firm empirical support" (p. 3), "every student completing training *should* be competent in at least one intervention with demonstrated efficacy" (p. 4). The Task Force on Promotion and Dissemination of Psychological Procedures (1995) also stipulated, "organizers and presenters *should* be required to state in all promotional materials whether their techniques are empirically validated" (p. 4) in APA-funded continuing education programmes, and "a treatment manual ... *should* be possible for adherents of *all* psychotherapy approaches to provide" (p. 9). Again, the Task Force advocated for treatments to be "established as effective for a *particular problem*" (Task Force on Promotion and Dissemination of

[80] I have added italics to each quote.

Psychological Procedures, 1995, p. 1, italics added). However, a 'particular' problem is a universal diagnostic classification that negates the specific characteristics and context of clients.

Further, this disciplinary, normative gaze is connected with a medicalising gaze where psychologists can not only monitor their conduct in determining, prescribing and administering ESTs to make mental disorders more visible to treat and make sure that they *endure* to apply such treatments to universal diagnostic categorisations. Chambless and Ollendick (2001) identified 22 adult mental disorders, eight child or adolescent mental disorders, and two personality disorders as having ESTs available to treat them. The psychologist must aim to administer empirically well-established treatments for mental disorders just as a medical officer would endeavour to prescribe drugs that have shown efficacy for treating signs and symptoms of physical disease. Indeed, the Task Force adopted EST criteria from the United States' Food and Drug Administration's (FDA) efficacy criteria for approving drugs (Wampold et al., 2005). So, depression may be *prescribed* with Beck's cognitive therapy, interpersonal therapy or behaviour therapy, panic disorder may be *prescribed* with cognitive behavioural therapy, and so forth (Chambless et al. 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

However, as Westen et al. (2004) point out, such productions of 'treatment for disorder' are based on the assumption that clients only have *one* problem and thus can be treated *as if* they do. Yet, "studies consistently find that most Axis I [mental disorder] conditions are comorbid with other Axis I or Axis II [personality] disorders in the range of 50% to 90%" (Westen et al., p. 635). They also questioned the suitability of *DSM* diagnoses for treatments based on empirical criteria: "DSM diagnoses are themselves created by committee consensus on the basis of the available evidence rather than by strictly empirical methods" (p. 634). The Clinical Division Task Force's initial list of 25 ESTs for particular disorders gained momentum and expanded into a considerably more comprehensive list of prescriptions. A review identified 145 empirically supported treatments for mental and physical disorders, which included 108 treatments for adults and 37 for children (Chambless & Ollendick, 2001). This review covered task forces and working groups from the United States and the United Kingdom who reproduced the same or very similar efficacy criteria to the Division 12 Task Force document.

The 'treatment prescribed for disorder' regime of ESTs marginalises therapies that are less disorder and manual focused. The Division 12 Task Force criticised psychodynamic therapies for not having enough manuals because of their "various styles and levels of training" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 5). The Task Force asserted that, "with dynamic therapy in particular, the use of treatment manuals is crucial to accomplish some degree of *treatment specification*"[81] (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 5, italics added). "In the interest of the profession and the public," they argued that "it is critical that *more efficacy evidence* on the outcome of psychodynamic therapies *for specific disorders* be obtained ... if this widely used treatment is to *survive* in today's market" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, pp. 5–6, italics added). The onus is on the psychologist to disseminate and promote further investigations of efficaciousness for therapies that do not 'fit the bill' where the gaze is fixated on adherence to manualisation to match particular medical disorders in the specification of client samples.

One side effect of this prescription for disorder or 'clinical problem' that has appeared to become the norm in the empirically supported treatment movement is that it enables technologies of *proscription* for therapies that do not fit the efficacy criteria. Therapies that do not fit the Division 12 efficacy criteria are, by default, either yet to be empirically supported or non-empirically-supported. This becomes problematic for narrative therapists who view problems as fluid rather than fixed, base their evaluations on shifts in language rather than quantifiable measures, and enable clients to be aware of pathologising/deficit-based discourse and language their problem in/through their own terms (White & Epston, 1990; Drewery & Winslade, 1997). Drewery, Winslade and Monk (2000) contend that due to the decontextualising language of diagnostic categorisation, it is uncommon in therapy to take the effects of power relations into account when examining people's problems: "Certainly the *DSM* reads as if power does not exist in the world" (p. 248).

Narrative therapy enables an examination of the effects of deficit-based discourse in how it enables the positionings of people's accounts of lived experience

[81] In addition, once DSM becomes the official language for describing problems, the therapist can effectively hijack the clinical interview to serve that purpose. This means that, potentially, other ways of formulating problems are subordinated (e.g., psychodynamic formulations) as are the ways of talking about 'the problem'.

(Drewery & Winslade, 1997) but such an approach is antithetical to the EST movement's prescriptive focus on clinical problem categorisation. The *DSM* produces a standard set of symptomological criteria for the eligibility of each disorder to make sense of a person's problem. This decontextualised languaging negates the need to be reflexive about the effects of such fixed descriptions (cf. Drewery, Winslade, & Monk, 2000). As mentioned before, there appears to be a medical gaze produced in/through EST criteria that makes visible 'specific treatments for specific disorders'. There appears to be a disciplinary gaze that aims to regulate desired psychological conduct in/through the EST movement's dissemination and promotion of 'established' criteria and lists of efficacious treatments. Such 'gazes' also diminish reflexive questionings on the effects of promoting, disseminating and reproducing 'treatments for disorders' given that ESTs are assumed to be 'objectively' established through "good" experimental designs and criteria (i.e., experimental methodolatry). For ESTs advocates, counter views do not matter because there is an assumed body of 'established' evidence. For example, to quote Chambless and Ollendick's (2001, p. 710) opinion on an assertion that qualitative research or clinical observation should be sources of evidence:

> No matter how large or consistent the body of evidence found for identified ESTs, findings will be dismissed as irrelevant by those with fundamentally different views, and such views characterize a number of practitioners and theorists in the psychotherapy area.

The political effects of proscription are often harder to 'see' within EST discourse because they are not made as visible through such clinical/medical and disciplinary gazes of reifying experimentally efficacious 'treatments for disorders'. Chambless and Ollendick (2001) associate qualitative research and clinical observation with "those with fundamentally different views" (p. 710) who will dismiss EST findings, calling them "irrelevant". This creates a 'why bother' impression of engaging with EST critics and closes down dialogue for enabling considerations of other forms of evaluation and 'evidence'.[82] The idolatrising experimental 'intelligibility' of ESTs as having "good" experimental designs and criteria, combined with the authority of the

[82] Some who have resisted the DSM and EST movement have produced their own frameworks of evaluation congruent with their philosophical premises and principles that inform therapeutic practice (e.g., humanistic psychotherapists; Bohart, O'Hara, & Leitner, 1998; Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001).

DSM, enables a kind of social exclusion for psychologists who practice therapies that are not evaluated and supported through Division 12 Task Force criteria.

The apparent synergy between the 'treatment' language of the EST movement (i.e., categorising efficaciousness for specific clinical problems) and the diagnostic language of the *DSM* create an authoritative, prescriptive list of 'efficacious treatments for disorders'. Yet, this synergy also produces a proscriptive effect because it marginalises other treatments by making "irrelevant" humanistic, systemic, and discursive therapies (among other therapies) that view problems as fluid and see strict manualisation as redundant. These therapies are "not yet tested in trials meeting task force criteria for methodology" (Chambless & Ollendick, 2001, p. 689). As these therapies are untested, this categorisation produces their inappropriateness for use in health care settings.[83] Put this way, psychologists can use the EST lists and criteria as a technology to govern their use of therapies in a proscriptive manner.[84]

Discourse of Professional Competition

Another justification for the emergence of the empirically supported treatment movement is the particular strategic rationale for the protection and promotion of professional status of psychologists in health care settings. As mentioned earlier, managed health care programmes, during the 1990s in the United States, were moving towards reimbursement criteria where a treatment's efficacy would have to be substantiated empirically (Beutler, 1998; Sperry, Brill, Howard, & Grissom, 1996). The Division 12 Task Force believed that "reimbursement may soon be limited to those interventions with demonstrated efficacy" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 8). The Task Force perceived psychiatry as a threat to psychology:

> We believe that, if the public is to benefit from the availability of effective psychotherapies, and if clinical psychology is to survive in this heyday of biological psychiatry, APA must act to emphasize the strength of what we have to offer – a variety of psychotherapies of proven efficacy. (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 3)

[83] This categorisation also enables a justification to manualise those yet to be empirically supported therapies.

[84] For example, the proscriptive effects of EST discourse prevented me to pursue evaluations of narrative therapy, as it was unsupported as an efficacious treatment.

The establishment of the empirically supported treatment movement was a strategic manoeuvre to compete with psychiatry and medicine. The Division 12 Task Force positioned psychiatry and psychopharmacology as the cousins who were 'better off' in terms of funding and resources. The Task Force asserted that "lacking the enormous promotional budgets and sales staff of pharmaceutical companies, clinical psychologists labor at a disadvantage to disseminate important findings about innovations in psychological procedures" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 3). Chambless and Hollon (1998) compared a Division 12 survey of clinical psychology internship training, which, they argued, lacked training in ESTs. They compared their survey with prior surveys in psychiatry that showed patients were undermedicated or treated with the wrong drug which lead to psychiatry responding "with greater efforts at professional education ... and the promulgation of practice guidelines" (p. 16). Through this comparison, Chambless and Hollon (1998, p. 16) announced their disconcertment that responses from advocates of "the more traditional psychotherapies" often "dismiss the need for controlled clinical trials" which they thought was "short sighted." Such a comparison created an assumption that if psychiatry produced "greater efforts" in promoting and disseminating practice guidelines and professional education then clinical psychology (and hence psychologists) *should* follow the same benchmark.

The Task Force cautioned psychologists not put the discipline at a disadvantage with psychiatry. They argued, "additional research refining our current state of knowledge is vital ... yet to ignore what we do know in the meanwhile is to deprive people of treatments ... and to put psychologists in a disadvantageous position vis à vis psychiatry" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 16). Further, the Task Force assumed that to compete with psychiatry, rigorous treatment evaluation criteria needed to be established by adopting, and being more stringent than, evidence-based medicine's evaluation methods (which is evident when one compares empirically supported criteria with evidence-based medicine criteria; see Centre for Evidence-Based Medicine, 1998):

> We believe establishing efficacy in contrast to a waiting list control group is not sufficient. Relying on such evidence would leave psychologists at a serious disadvantage vis à vis psychiatrists who can point to numerous double-

> blind placebo trials to support the validity of their interventions. (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 5)

In fear of being 'left behind' from the changes in managed care in the United States, there was also a production of statements on the need to pace quickly with the establishment of ESTs. The Division 12 Task Force stated that "this is the time that we must blow our horn and blow it loudly ... many of our recommendations can be implemented without financial cost and in very little time" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 14). There is also a temporal emphasis in the Task Force on Promotion and Dissemination of Psychological Procedures (1995) document on the need to set up competitive psychologists through internship training: "In the future, competent and competitive may be one and the same ... reimbursement may *soon* be limited to those interventions with demonstrated efficacy" (p. 8, italics added). EST proponents also argued the need to establish systematic efficacy criteria to compete against psychiatry and medicine rapidly:

> Time is rapidly approaching when unsystematic clinical impressions will no longer suffice to document a treatment's value, particularly when alternative treatments such as the pharmacotherapies exist that have been subjected to more rigorous empirical scrutiny. (Chambless & Hollon, 1998, p. 16)

As well as time, the EST movement saw cost as another impetus for developing EST documents as competitive technologies for promoting the profession of psychologists. The Task Force on Promotion and Dissemination of Psychological Procedures (1995) argued that psychotherapy could ease the cost-burden of consumers utilising the health care system. In citing statistical and longitudinal studies concluding that health system utilisation decreased after psychotherapy (e.g., Duehrssen & Jorswick, 1965; Holder & Blose, 1992; Mumford, Schlesinger, Glass, Patrick & Cuerdon, 1984), they asserted that "psychological treatment can reduce medical utilization, medical costs, or both" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 14). Judging the cost-effectiveness of treatment was the responsibility of the researcher in that EST proponents argued that it "behooves evaluators of the literature to consider the relative costs and benefits of treatments" (Chambless & Hollon, 1998, p. 16). The suggested focus on cost-effective ESTs was also directed at physical problems: "the evidence reviewed above [for physical

problems] provides an impressive amount of support for the argument that psychological procedures can have an important impact on physical health and are cost-effective as they do so" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 14). The Task Force also recommended that the APA continue to "educate third party payors and the public about the health benefits and cost effectiveness of psychotherapy" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 14). The use of economic terms such as 'cost effectiveness', 'market', and 'consumer' in the Task Force on Promotion and Dissemination of Psychological Procedures (1995) document created a sense of competitiveness where the psychologist is positioned to be prepared to be effective in the provision of empirically supported treatments in the interest of the health funders and the public:

> We believe that clinical psychology has a great deal to offer *consumers* if we can position practitioners to be ready to provide the *effective* psychotherapies that have been developed [i.e., ESTs] and can convince the public and third party payors of what we already know. (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p.14, italics added)
>
> [Health management] organisations need to be approached with the goal of convincing them that it is in their best interest to help their clinicians be *more effective* [in offering professional development training in ESTs]. (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p.11, italics added)

Clinical psychology and competitive discourse in Aotearoa/New Zealand. An examination of the newsletter/journal of the New Zealand College of Clinical Psychologists shows that, during the beginnings of EBP (mid-2000s), a discourse on the professional status of clinical psychology has some contingency with the competitive technologies of the EST movement. College members argued the need to compete with medicine (Galvin & Fernando, 2008) and produced competitive economic discourse:

> If Clinical Psychology is to really emerge as the pre-eminent provider of evidence-based, non-pharmacological treatments for psychological disorders, then we are going to have to demonstrate our unique qualifications and skills to those we wish to employ us. We have to (and let us not be precious about this) sell ourselves and our skills in the market place. The pay rates for Clinical

> Psychologists are, in my opinion, abysmal. True, money isn't everything, but an old saying goes "money is the sincerest form of flattery" – and I might add the most tangible. (Montgomery, 2003, p. 2)

These statements also gave rise to a neoliberal rationality[85] of the self-governing individual (i.e., psychologist) as an integral part of a self-regulating market economy: that as psychologists we have a *responsibility* to sell ourselves in a market place in order to increase our status. The phrases "have to demonstrate our unique qualifications and skills to those who wish to employ us" and *having* to "sell ourselves and our skills in the market place" mirror the comments made by the Task Force on Promotion and Dissemination of Psychological Procedures (1995) that clinical psychology has a lot to offer consumers and third party payers. Such statements enable, as part of neo-liberalist discourse, the production of "indirect techniques for leading and controlling individuals without at the same time being responsible for them" (Lemke, 2001, p. 201). Similar to the discourse on ESTs as a competitive tech(k)no(w)logy, the responsibility is on us as individual psychologists to "sell ourselves and our skills in the market place" (Montgomery, 2003, p. 2). The governing our conduct as 'sellers of our technological capabilities' determines the survival of the status of clinical psychology/psychologists.

There was also competition with psychiatry and medicine from EST advocates in Aotearoa/New Zealand. One College member argued, "Psychiatry has long been the 'Cinderella' of mental health, and its place is secure. The same cannot be said of Clinical Psychology" (Montgomery, 2003, p. 1). There was also an envy of the status of medicine: "Medicine has already forged ahead on the back of certain breakthroughs ... Jim Hegarty's call not to undersell ourselves seems particularly salient as ... hard-won gains still leave us in completely different league from our medical colleagues" (Galvin & Fernando, 2008, p. 2).

The unique placing of clinical psychologists as scientist-practitioners, as possessing and practising exclusive technological capabilities and competencies in empirical science, is articulated in these statements of competition with psychiatry and medicine. Galvin and Fernando (2008) argued that clinical psychologists, "one of the few professional groups who, by virtue of our training as scientists, are in a position to properly consider the difficult unanswered questions that are central to improving

[85] In neo-liberalism, the social sphere becomes part of the economic or the social is governed in an economic sense – and it is 'rationalised' (i.e., reasoned as sensible) as such (Lemke, 2001).

human mental health" (p. 2). This positioning of clinical psychologists who take a unique scientific approach in their practice is also contingent with EST discourse. Cox and Ramsay (2002) argued that clinical psychologists should be on the same salary scale as medical officers rather than allied health professionals, due to their unique training in the scientific method, ESTs, their psychological skills and knowledge. They asserted that clinical psychologists, "as trained scientist-practitioners, have unique skills" (Cox and Ramsay, 2002, p. 16). These skills (technologies), Cox and Ramsay (2002, pp. 16–17), asserted, included using "psychometric tests ... systematic observation and measurement of behaviour" as well as the use of "a range of empirically-validated treatments ... in both mental health and medical settings ... [where] interventions are strongly based on outcomes of treatment-focused research, several of which have proven efficacious in randomised controlled trials."

The articulation of such terms as "empirically-validated", "treatment-focused research", "efficacious" and "randomised controlled trials" also anchor the discourse of the EST movement. Such terms are used in Cox and Ramsay's (2002) argument, "despite being one of the most intensively-trained professionals in health care, Clinical Psychology is under-utilised in the [Aotearoa/New Zealand] health system" (p. 16). This argument is reproduced among other College members (e.g., Galvin & Fernando, 2008; Montgomery, 2003), and echoes a similar stance to the Task Force on Promotion and Dissemination of Psychological Procedures' (1995). Both College members and the Task Force promote the status of clinical psychologists as unique empirical scientists (and practitioners) of psychotherapy in a competitive environment.

Intradisciplinary competition. Within the EST movement 'vanguard', the political statements of having to "blow our horn" and compete against psychiatry, along with subsequent EST publications, exemplify the haste and drive for promoting and disseminating ESTs. However, competitive EST discourse not only cultivates competition between the status and survival of psychology and that of other professions (i.e., psychiatry and medicine) but also *within* psychology. EST advocates warned that psychologists would suffer if they were not educated in such treatments throughout their clinical training programmes. Crits-Christoph, Frank, Chambless, Brody, and Karp (1995, p. 520), for example, gave some concerns about the lack of training in "empirically validated treatments" as equating to a "dearth of coverage" that is "contradictory to the scientist-practitioner orientation espoused by many of these

programs." They asserted that such lack of training "will ultimately restrict their [clinical psychologists'] options" (Crits-Christoph et al., 1995, p. 520). As with the Task Force, Crits-Christoph, Frank, Chambless, Brody, and Karp (1995, p. 520) judged their psychodynamic peers as "less attentive to the research literature [on ESTs]" and concluded they "may not be exposing their students to data-based approaches," which, they argued, "in the current health care climate ... may put students who practice this orientation at a disadvantage." This governmental gaze upon their psychodynamic peers produces an expectation that to be competitive they must join the EST movement and train themselves in EST evaluation criteria. This gaze also extrapolates to other psychologists (e.g., those trained in narrative therapy) who, intentionally or unintentionally, have resisted training in ESTs. Those practitioners are positioned as less able to survive in an economically focused healthcare outcome climate: "We expect that new psychologists who are not competent to deliver treatments of demonstrable efficacy will find it increasingly difficult to make a place for themselves in the emerging outcome-oriented health care market" (Crits-Christoph et al., 1995, p. 520).

Such articulations contrasting psychologists who use EST criteria exemplify "dividing practices" (Foucault, 1982, p. 208). In the EST movement, 'best practice' involves using EST criteria. For EST proponents, "the best source of information to guide treatment selection is arguably the empirical literature" (Kazdin & Weisz, 1998, p. 31). "Efficacy is best demonstrated in randomized clinical trials (RCTs)" (Chambless & Hollon, 1998, p. 7) where "RCT methodology remains the best way to test new short-term, and long-term, treatments as ways to improve upon existing ESTs" (Crits-Christoph, Wilson, & Hollon, 2005, p. 415). This produces a division between those who use RCT methodology and EST criteria for evaluative practice and those do not.

The EST movement has created a division between psychologists, where EST adherents are 'competent', 'competitive' "clinicians... [that are] more effective" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p.11) and, seemingly, those who do not adhere to EST criteria are, arguably, 'incompetent' and 'less effective'. A dividing practice, for Foucault (1982, p. 208), happens when the subject is "divided from others"[86] such as "the mad and the sane, the sick and the

[86] Either this process of the subject 'as divided from others' occurs or subjects are divided within themselves (Foucault, 1982). This 'dividing within' process could be a 'temporal division' such as using EST discourse to judge whether one was a 'good psychologist' today in comparison to past conduct or in

healthy, [and] the criminals and the 'good boys'". Dividing practices have spatial effects (Lock & Strong, 2010) such as geographically constituting and governing where psychologists can practice therapy. For instance, psychotherapists could not practice narrative therapy in hospitals that exclusively require their staff to administer ESTs. In such a scenario the alternative locations of narrative therapy practice thus become, what Hook (2007) called heterotopia: "'other' spaces ... of alternate social ordering" (p. 181) that "critically reflect and subvert a society's commonplace norms and discursive values" (p. 6).[87] Narrative therapists would be those practitioners who, according to Crits-Christoph, Frank, Chambless, Brody, and Karp (1995), find it "increasingly difficult to make a *place* for themselves in the emerging outcome-oriented health care market" (p. 520, italics added). Narrative therapists have aimed to critically reflect on and often subvert commonly held values of the assessment and diagnosis of psychopathology; narrative therapists "have been concerned to work against what we perceive as the damaging effects of many 'scientific' psychological labels" (Drewery & Winslade, 1997, p. 47). In the above health funding scenario, it would be fair to assume that most narrative therapists would have to practice in 'other' settings than those in public health or managed health care. These settings would be spaces that Foucault (2000a) called "heterotopias of deviation: those in which individuals are put whose behaviour is deviant with respect to the mean or required norm" (p. 181) such as individual private practice environments. Following the rules for efficaciousness (Chambless & Hollon, 1998), hospital health systems that would exclusively fund ESTs, rationalised as 'best practice', would effectively proscribe non-ESTs and those who practice them.

Interim Summary

The EST movement has produced a de facto 'best practice' of psychotherapy and evaluation conduct through their statements on psychologists promoting and using EST criteria as necessary to lift the status of psychotherapy in a managed health care environment. The emergence of the EST movement as 'best practice' contradicts the contemporary 'truth' of evidence-based practice as 'best practice'. The EST movement

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anticipation of future conduct (where such judgement may enable psychologists to govern themselves in determining 'normal' conduct [see Rose, 1996]).

[87] Hook's (2007) work includes an extension of Foucault's (1997b) notion of heterotopia. It is important to realise here that the production of evaluation policy discourse in psychology, if taken up by health funders, may have spatial consequences for where particular therapies are allowed to be practiced and by whom.

enabled increased practices of standardisation in/through therapy and research and it intensified methodolatry pertaining to the 'goodness' and use of the experimental method and psychometric measurement. The movement medicalised psychotherapy evaluation through the *prescription* of 'efficacious treatments for specific disorders', while proscribing treatments not meeting efficacious criteria. It also enabled competition with psychiatry and medicine, and within psychology, for health funding and professional status.

Emergence of the EST Resistance Movements

Some psychologists have resisted the technical knowledge and practices of the empirically supported treatment movement. The Psychotherapy, Counselling and Humanistic Psychology Divisions within the APA resisted the EST movement. This enabled a series of emergences, as reactive uprisings, through the publication of their reactions and proposing different criteria as counter-conducts of evaluation. As Gordon (1991, p. 5) asserts, "the history of government as the 'conduct of conduct' is interwoven with the history of dissenting 'counter-conducts'." Such 'counter-conducts' can be thought of as a series of emergences that can be traced and made visible in the historical descent of evidence-based psychotherapy evaluation.

In exhuming the series of such emergences as part of the descent of evidence-based psychotherapy evaluation, I identify them as, what Foucault (1984c, p. 81) calls, "minute deviations" or "complete reversals" of evaluation discourse – as discursive practices/events that enable a pluralisation of the meaning of evaluation.[88] As discursive practices/events, they are involved in relations of power as 'counter-conducts'. This is where various divisions of the APA established different rules for the psychological conduct. Whether they are small deviations or reversals in discourse, they clashed with the technologies of psychological management produced by the EST movement. They are also discursive events that may have been lost or forgotten, and thus form knowledges that, through EST discourses, may have been subjugated or marginalised. The emergence of these 'counter-conducts' in the evaluation of psychotherapy are resistance movements, some of which are not entirely separate from

[88] This also includes the empirically-supported treatment movement being part of a discursive event (i.e. the Division 12 Task Force report), which, in itself was a deviation from a previously general analyses on the efficacy of therapy (Eysenck, 1952; Smith & Glass, 1977) to a more specific, 'treatment to match disorder', manualised, and non-meta-analytic/experimental criteria of efficacy in defining psychotherapy evaluation.

EST discourse. Such movements range from general criticisms of ESTs (most notably, Garfield, 1996; Silverman, 1996) to non-clinical APA divisions and their members forming their own guidelines (and thus forming a plurality of conceptualisations of evaluation). In this section of this chapter, I highlight some of the resistances that have emerged from Divisions 17 (Society of Counseling[89] Psychology), 29 (Psychotherapy Division), and 32 (Humanistic Psychology Division), in relation to the governmental technologies produced by the EST movement. I then synthesise the statements from Divisions 17, 29, and 32 into counter-discourses of evaluation that typify discontinuities of evidence-based psychology evaluation.

Principles of Empirically Supported Interventions (PESI)

After Division 12's Task Force report on ESTs, Division 17 of the APA, the Society of Counseling Psychology, established a group to examine empirically supported interventions corresponding to counselling psychology. According to Wampold et al. (2002) a Special Task Group (STG) was formed in 1996 in response to concerns regarding the clarity of scientific foundations for therapies in counselling psychology, increasing requirements for accountability in practice, 'facts' in advertising[90], and cost-effectiveness. The rationale of the STG was to produce some guidance for evaluating interventions in counselling psychology through three main aims, which were:

> (a) making counseling psychologists and students more aware of the current empirical status of interventions in counseling psychology, (b) increasing predoctoral and postdoctoral training in psychological interventions that have been supported by empirical research, and (c) fostering public understanding and appreciation of empirically supported interventions offered by counseling psychologists. (Wampold et al., 2002, p. 198)

It is interesting to note that such aims, promoted by the STG, were similar to the Division 12 Task Force document where the Task Force aimed to "consider methods for educating clinical psychologists, third party payors, and the public about effective psychotherapies" (Task Force on Promotion and Dissemination of Psychological

[89] Note that I am using the American spelling of counselling here as I'm referring to the Society of Counseling Psychology as a named entity.
[90] Wampold et al. (2002) did not state what these 'facts' or 'truths' were.

Procedures, 1995, p. 3). Minus the emphasis on third party payers, the aims of the STG emulated the aims from Division 12. The Task Force on Promotion and Dissemination of Psychological Procedures (1995) document emphasised the importance of predoctoral and internship training in empirically validated treatments and the lack of training in such treatments. There was also an aim to convince and educate the public of empirically validated treatments in the Division 12 document, which is similar to the STG's aim of "fostering public understanding and appreciation" (Wampold et al., p. 198).

Additionally, there were similar emphases on the importance of the 'scientist-practitioner model' in the Division 17 STG article to the Division 12 Task Force document. Just as the "application of research to clinical practice exemplifies the scientist-practitioner model of clinical psychology" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 6), Wampold et al. (2002) argued,"all [counselling psychologist] practitioners are expected to be 'scientists'" (p. 198) and "training in counseling psychology conform[s] to the scientist-practitioner model" (p. 197).

The Division 17 Special Task Group also adapted the term 'empirically-supported'. In the spirit of the scientist-practitioner approach, the Society of Counseling Psychology joined with Division 12 in advocating for the review of the empirical status of therapies and the dissemination of results to psychologists and the public (Wampold et al., 2002). Like Division 12, Wampold et al. were also concerned with managed care organisations. However, the STG were more concerned with them becoming a *normative* mode and a primary force for driving empirical reasoning with their establishment of diagnostic related groups, emphasis on fixed treatments, standardisation of treatment and cost reduction in the delivery of service.

The STG was also concerned with the EST movement's criteria-based emphasis, a point of divergence between the psychotherapy evaluation aims of Division 12 and that of Division 17. As Wampold et al. (2005, p. 28) argued, the concerns were problematic for the discipline and profession of counselling psychology because of "differences in orientation and values" and because the STG decided that the "criteria for identifying treatments took a narrow view of evidence." Wampold et al. (2005) stated a range of concerns with ESTs. They were concerned about the exclusive focus on treatment, based on FDA criteria, to the exclusion of other possible influences that contribute to outcome. They also argued that the treatment-for-disorder framework did

not account for various other forms of human experience. Another concern was with the small number of studies needed to *only support* a therapy as efficacious and Wampold et al. (2005) contrasted this with the "evidence-based movement [which] has emphasised the accumulation of evidence, often aggregated by meta-analysis, as providing a better means to draw implications from research" (p. 29). The STG were also concerned with the lack of generalisability given that the ESTs movement produced therapies through clinical laboratory trials rather than actual practice. They argued that the clinical trial settings produced a number of issues:

> (a) inclusionary/exclusionary criteria that result in samples unrepresentative of clients seen in practice, (b) significant attrition rates, (c) experimental expectancy, (d) selection of effective therapists, who are given specialized training and supervision, and (e) a greater dose of therapy than is typically provided, at least in a managed care environment. (Wampold et al., 2005, p. 30)

Clearly, there was a difference between the Society of Counseling Psychology's views of what was 'empirically supported' and that of the Division 12 Task Force. Division 17's STG adopted a much broader view of 'empirical' that covered more than just experimental criteria and included 'external validity'[91] or 'effectiveness' research based on 'real-life' counselling psychology practice (i.e., a certain degree of practice-based evidence). Division 17 aimed for a balance between science and practice, "rather than stipulating criteria and ordaining constricted interventions" (Wampold et al., 2002, p. 204). It established broader guiding *principles* for practice and research for 'best practice' in psychotherapy evaluation. It is important to remember here, with the notion of governmentality, that these 'guiding principles' still served as authoritative stipulations from Division 17 on the conduct of psychotherapy evaluation.

Division 17 advocated for the need for specificity in psychotherapy evaluation by stipulating two principles (Wampold et al., 2002). The first principle, "Level of Specificity Should Be Considered When Evaluating Outcomes" (Wampold et al., 2002, p. 205) included broad areas of action, such as guidance counselling, supervision, or psychotherapy, as well as particular approaches in specific areas for definite

[91] 'Validity' is a problematic term that has also been used in 'empirically-validated treatments' because it fell out of favour due to criticisms within clinical psychology around the term producing an absolutist meaning of empirical accuracy (and effectively making other non-empirical therapies 'invalid').

populations. This was counter to the Division 12 Task Force notion that psychologists should narrowly define empirically supported interventions as clinically focused treatments. The second principle, "Level of Specificity Should Not Be Restricted to Diagnosis" (Wampold et al., 2002, p. 205) opposed the prescriptive diagnostic technologies of EST movement criteria and the movement's lists of ESTs. Rather, counselling psychology focused "on health rather than pathology ... recognition of issues related to diversity ... [and] respect for client attitudes and values" (Wampold et al., 2005, p. 32). Specificity, in other words, meant focusing on strengths and matching interventions to the client's needs and context rather than for a particular disorder.

Division 17 also promoted three principles on the need for the appropriate examination of evidence. What underlay the third principle, "Scientific Evidence Needs to Be Examined in Its Entirety and Aggregated Appropriately" (Wampold et al., 2002, p. 205), was a contradiction. On one hand, Division 17 argued that there should be suitable evaluative methods to investigate evidence at its particular level of specificity. Yet, on the other, it advocated for meta-analysis, a method that decontextualises specific client contexts, as the "method of choice" (Wampold et al., 2005, p. 33). The fourth principle, "Evidence for Absolute and Relative Efficacy Needs to Be Presented" stated that psychologists needed to take into account evidence suggesting a) therapy is better than no treatment (absolute efficacy) and b) therapy is better than another therapy (relative efficacy). If there are marginal differences then "factors other than efficacy need to be considered" (Wampold et al., 2002, p. 208) such as client appeal, suggesting a broader notion of 'empirical support' than Division 12. In the fifth principle, "Causal Attributions for Specific Ingredients Should Be Made Only if the Evidence Is Persuasive" (Wampold et al., 2005, p. 34), Division 17 recognised that it is challenging to identify factors that enable a therapy to be successful when there are only outcome-based measures. Such measures, Division 17 argued, do not necessarily indicate that specific 'ingredients' of a therapy are effective. These statements on the appropriateness of evidence suggest that psychologists should take a more comprehensive and meticulous examination of evidence than that of the EST movement when conducting psychotherapy evaluations.

Division 17 also produced two principles on the need for a broader evaluation of outcomes in contrast to the EST movement. The sixth principle, "Outcomes Should Be Assessed Appropriately and Broadly" (Wampold et al., 2002, p. 210) addressed the complexity of assessing outcomes which, according to Division 17, should reflect

multiple methods of assessment and different stakeholder perspectives (e.g., client, therapist, and third-party payer). Division 17's seventh principle, "Outcomes Should Be Assessed Locally and Freedom of Choice Should Be Recognized" (Wampold et al., 2002, p. 210) stipulated that interventions, and their evaluations, should be tailored to and conform to local settings and both psychologists *and* clients should have the liberty to choose what interventions they believe would be most beneficial.

These principles of empirically supported interventions appropriate and broaden the meaning of the word 'empirical' from the emergence of ESTs. Although the Division 17 STG still based their definition of 'empirical' on the scientific method, they conceptualised it beyond a single methodology to include meta-analysis and factors other than efficacy. Division 17 did not base their 'empirical' principles on a treatment-for-disorder framework. Rather, their principles accounted for client context. Although Division 17 STG advocated for meta-analyses, there was less emphasis on standardisation. They argued, "treatment manual adherence ... hinders effectiveness" (Wampold et al., 2002, p. 203). Division 17 also avoided producing a prescriptive list of 'treatments for disorders' in contrast to the EST movement's lists. Instead, the Division produced examples of evaluating principles of empirically supported interventions in counselling psychology. These examples did not focus on clinical disorder but rather on areas of anger management (Deffenbacher, Oetting, & DiGiuseppe, 2002), career counselling (Whiston, 2002), and family-based interventions (Sexton & Alexander, 2002). Rather than producing a fixed list of treatments to strict experimental criteria, the Division 17 STG opted for a more multifaceted approach of developing principles that were more suitable to its values and practices:

> Clearly, the approach taken by counseling psychology differs from that taken by Division 12 ... We believe that the inherent ambiguity created by not establishing a list of treatments is neither a detriment to practitioners or to their clients, but rather a fact of life in professional practice and an honest reflection of the evidence regarding our contemporary clinical practices. (Wampold et al., 2005, p. 37)

Empirically Supported Relationships

Counselling psychologists were not the only group within the APA who reacted against the empirically supported treatment movement. Another emergence of psychotherapy evaluation appeared from Division 29, the Division of Psychotherapy.

In 1999, John Norcross commissioned a task force to "identify, operationalize, and disseminate information on empirically supported therapy relationships" (Norcross, 2001, pp. 347–348). Similar to Division 17's concerns with the EST movement, Norcross (2001) argued that there were influences that the EST movement did not address: 1) the contribution and experience of the therapist, 2) the therapy relationship, and 3) the 'patient's' (non-diagnostic) characteristics.[92] The Division of Psychotherapy Task Force argued that psychotherapy evaluators should address these influences (Norcross, 2001; Steering Committee, 2001). This emphasis on addressing dynamic contextual and relationship factors in psychotherapy evaluation was in conflict with the EST movement's aim to control for variables through experimental design. Norcross (2001) argued that the therapist is a "central agent of change" (p. 346) as they are "inextricably intertwined" (p. 346) with the outcome of therapy, despite efforts of experimental studies to disguise this, particularly when "large therapist effects ... greatly exceed treatment effects" (Wampold, 2001, p. 200). Resisting the EST movement's 'treatment for disorder' focus, the Division 29 Task Force argued that client characteristics are also important to know in psychotherapy evaluation and, at times, these qualities do not fit with *DSM*-based categorisations (Norcross, 2001).

The Division 29 Task Force also criticised the EST movement's neglect of the therapy relationship. Norcross (2001) argued that manuals often state that the relationship is important but few indicate what qualities of the therapist or therapy session (inter)actions bring about healing relationships. The Division 29 Task Force argued that there is a danger with manualisation in psychotherapy evaluation in that it neglects the contributions of the therapist, patient, and their relationship (Norcross, 2001). In note of these deficits/absences of evaluation knowledge, and in resistance to the strict experimental criteria of the EST movement, the Division 29 Task Force produced a broader view of psychotherapy evaluation to include research designs beyond RCTs such as naturalistic, process-outcome, and correlational studies.

The Division 29 Psychotherapy Task Force both adapted and resisted EST discourse. The Division aimed to "identify elements of effective therapy relationships ... [and] determine efficacious methods of customising or tailoring therapy to the individual patient on the basis of his or her (non-diagnostic) characteristics" (Norcross,

[92] Note the irony of emphasising an approach to examining the non-diagnostic aspects of a client while simultaneously calling the client a 'patient'.

2001, p. 348).[93] Emulating some of the EST criteria-focused discourse, the Task Force (Steering Committee, 2001) established a list of therapy relationship elements, based on empirical evidence. These included general elements of the therapy relationship that are provided primarily by the psychotherapist, and relationship elements that involve customising the therapy relationship to individual clients, based on client behaviours and qualities. The general elements were separated into *demonstrably effective* (e.g., therapeutic alliance, cohesion in group therapy, and empathy) and *promising and probably effective* (e.g., positive regard, congruence/genuineness, and repair of ruptures in the therapeutic alliance). The therapy relationship elements included a *demonstrably effective* list (e.g., resistance, coping style, and expectations) and a *promising and probably effective* list (e.g., attachment style, gender, ethnicity, and preferences).[94] The Division 29 Task Force made most of these elements of human qualities and relationships calculable variables. Psychologists could shape these variables into a technological knowledge for the government of evaluation and therapy (Rose, 1999, 2004). However, Division 29 Task Force members argued that many of these elements complexly interconnect in/through therapeutic relationships and that psychotherapists should aim to evaluate them beyond experimentally controlled conditions (Norcross, 2001; Steering Committee, 2001). This stance, that relationship variables "cannot be readily controlled or manipulated" (Norcross, 2001, p. 349)[95], clashes with the EST movement's experimental methodolatry and its attempts to standardise therapy delivery through treatment manualisation.

Humanistic Psychology Resistances

Another emergence of a resistance movement, and one that the EST and evidence-based practice movements possibly overlooked, was the Division of Humanistic Psychology's (Division 32) Task Force. The Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services (2001) produced a document 'Recommended Principles and

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[93] One can view such aims as form of 'mission creep' where EST movement discourse influenced other evaluation movements and others reproduced/tech(k)no(w)logised elements of 'EST-speak'.

[94] As well as the *demonstrably effective* and *promising and probably effective* criteria, there was also a third criteria, *insufficient research to judge* (Norcross, 2001).

[95] However, there were also tensions *within* the Task Force between qualitative and quantitative members as some members wanted "true experimental evidence or persuasive, unconfounded lagged correlational evidence that elements of the therapy relationship contribute to treatment outcome" (Norcross, 2001, p. 349).

Practices for the Provision of Humanistic Psychosocial Services: Alternative to Mandated Practice and Treatment Guidelines' after receiving feedback from its members who were concerned about ESTs.

As with the Society for Counseling Psychology and the Division of Psychotherapy, the Division of Humanistic Psychology Task Force criticised the EST movement for its narrow definition of psychotherapy evaluation. However, the Humanistic Psychology Task Force appeared to be the most resistant movement against ESTs in the discontinuities of evidence-based psychotherapy evaluation discourse. There was a greater epistemological incongruity between the Humanistic Psychology Division and the other Divisions (12, 17, and 29). The Clinical Division's (12) formulations of ESTs are based on positivism (i.e., the theory that only observable phenomena and non-metaphysical facts exist)[96], and experimental criteria. Principles of empirically supported interventions for the Society for Counseling Psychology in Wampold et al. (2002, p. 207) also note the "scientific method" and empirical concepts such as "design, sample, measures" and particular favour towards "meta-analysis", which was mentioned seven times. The Division of Psychotherapy still recommended "experimental rigor" (Norcross, 2001, p. 351) as well as correlative research (Steering Committee, 2001), while recognising the importance of both quantitative *and* qualitative research (Norcross, 2001; Steering Committee, 2001). All three Divisions (12, 17, and 29) promoted a discourse of positivism and empiricism (i.e., the theory that all knowledge is derived from sense-experience – especially that which is directly and objectively observable). The Humanistic Psychology Division Task Force, in contrast, had a dissimilar epistemological stance, shared by most of its members:

> The humanistic world is not a mechanistic one, but rather relies on a nonlinear metaphysics and postmodern constructivist epistemology. We hold that realities people live in are always constructed to some extent, out of their cultural experiences, and out of their personal histories, values, and perspectives. As such there are many viable ways of living life. Humanists value diversity in perspectives on reality, and therefore believe the ultimate goal of therapy is to help each individual, within the context of his or her relationships and culture, find the most satisfying personal and relational life

[96] This is not withstanding the idea that hypotheses can be supported by the falsification and verification of observable data to build general theories and laws (logical positivism).

> paths. (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001, p. 7)

Practising evaluation in a postmodern, constructivist epistemology is antithetical to positivist and empiricist theories of knowledge that enable experimentalist assumptions and practices. Humanistic psychology places emphasis on exploring the goals of the client, a more fluid/changeable phenomenon, rather than assuming that psychologists can universally delivery therapy through manualisation (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001). The Humanistic Psychology Task Force argued that humanist[97] psychologists place value on human difference, culture, context, and thus different constructions of subjective experience. It is no wonder, then, that the rise in popularity of ESTs would subjugate therapies that contain similar postmodern and constructivist stances. The Humanistic Psychology Task Force argued that the proliferation of the EST movement and its positivist assumptions has excluded such therapies "including many psychodynamic, feminist, constructivist, narrative, and family systems approaches, as well as humanistic therapies" (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services (2001, p. 29).

The Humanistic Division criticised the EST movement for its positivist stance that emulated a medical model of psychotherapy evaluation. The Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services (2001, p. 4) critiqued the 'treatment for disorder' approach because it reproduced medicalised approaches that "focused on symptom removal," are "technological in nature" and argued that such approaches, are unsuitable to humanistic interventions that are "discovery-oriented, holistic, and relational." The Humanistic Division Task Force argued that the EST movement marginalised research methods that focussed on "the particular individual, subjective and multiple realities, and contextuality and relationship" (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001, p. 4). The Humanistic Division Task Force argued that disordering decontextualises

[97] Although humanism enables an appreciation of the diverse constructions of human subjectivity, it also does not address social, collaborative constructions of meaning and experience – the kinds of processes that family systems and community minded therapists address.

individual experience in that humans cannot be divorced from their relationships because they are a fundamental part of what it is to be human. The Task Force also asserted that humans are meaning makers and there are multiple constructions of reality. They were concerned that DSM diagnoses, and applying treatments for disorders, masks subjectivity and multiple perspectives of reality. 'Mini-outcomes' that occur throughout the therapeutic process (Strong, Busch, & Couture, 2008) that are found in humanistic therapies (Greenberg, 1991) do not count under the regime of the EST movement "because they are not alleviations of DSM (or similarly defined) disorders" (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001, p. 22).

If the theoretical stances of the Humanistic Psychology Division were so divergent from the EST movement, what did they suggest for psychotherapy evaluation? It is important to note that the Division of Humanistic Psychology does not adopt an 'anti-science' approach. Due to their postmodern, constructivist epistemological stance, and their humanistic values, they assume a holist and pluralist approach to research (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001). Their argument was that positivist- and empiricist-based research methods were of value, but to obtain fuller (holistic) perspectives of human experience, psychologists need to include rather than marginalise post-positivist research approaches for psychotherapy evaluations:

> [The] development of valid and reliable scientific knowledge has to include perspectives in addition to traditional experimental, survey, statistical, and other positivistic research designs. These additional approaches include phenomenological, narrative, qualitative, interpretive, human science methodologies, case studies, and other post-positivistic methods and designs. (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001, p. 29)

Discourses of Counter-Conducts of Evaluation

So far, I have examined a range of discursive practices, tech(k)no(w)logies and counter-conducts of ESTs, enabled in/through different evidence-based psychotherapy evaluation movements throughout its contemporary descent and emergence. These practices of evaluation share the term 'empirically-supported' but I have revealed that there are discontinuities of the term as a *notion* between each movement. Each Division

of the APA has their own set of values and thus language of evaluation 'best practice' that produces knowledge practices (i.e., documentations of psychotherapy evaluation). However, these practices as descents of evaluation were strongest and most prolific in the EST movement. Although one could argue that such practices, as governing standards, "achieve no egress beyond their own idioms" (Prado, 1995, p. 43), there were elements of EST movement discourse, producing hybrids of empirically supported evaluations, particularly in Divisions 17 and 29. The EST movement and the counter-practices that adapted and resisted it are strategic manoeuvres woven through discourse, which "provides the context in which these manoeuvres congeal into learned dialects and procedures" (Prado, 1995, p. 44). In this section, I identify discourses of evaluation counter-conducts as resistant knowledges that are in a conflictual ('non'-)relationship with the technological discourse of the EST movement. In examining statements of the counter-practice documents of Divisions 17, 29 and 32, I theorise three key discourses operating: liberalism, humanism, and contextualism.

Liberalist Discourse.[98] Resistant to the EST movement, Divisions 17, 29 and 32 criticised its constrictive psychotherapy evaluation criteria. Efficacy criteria, according to Chambless and Hollon (1998, p. 18), was based on experimental design which needed treatment manuals, a sample from a specific "population, treated for specified problems, for whom inclusion criteria have been delineated in a reliable, valid manner" as well as "reliable and valid outcome assessment measures ... tapping the problems targeted for change" and so forth. The empirically supported relationships movement, in contrast, argued that this approach was "seriously incomplete and potentially misleading, both on clinical and empirical grounds" (Norcross, 2001, p. 346), that "one-size-fits-all therapy relationships are out" and "tailoring the therapy to the unique patient is in" (Norcross, 2001, p. 353). Resistant to the experimental criteria of evaluation, Division 29 adopted "broader decision rules as to what qualifies as evidence."

A liberalist discourse of being more broad-minded, less interventionist and more 'free thinking' appeared to permeate through Divisions 17, 29, and 32. In the Division of Psychotherapy, outcomes were more "broadly and inclusively defined" (Norcross, 2001, p. 349) and a "broad, integrative model" (Norcross, 2001, p. 353). The Society for Counseling Psychology also took a liberal stance to psychotherapy evaluation. It

[98] I use liberalism here in the sense of 'freer choice' and being broad-minded.

recognised a "broader social-economic-professional context" (Wampold et al., 2005, p. 199), where "outcomes should be assessed ... broadly" (Wampold et al., 2005, p. 209), and its "principles ... were developed to be free of diagnostic restraints" (Wampold et al., 2005, p. 213). The Society also emphasised individual freedom in the decision making process of evaluation. It also reproduced a discourse of liberalism through its statements that "clients should have the freedom to choose among validated interventions" (Wampold et al., 2005, p. 204) but also "that clients *and* psychologists should have the freedom to choose the intervention that they believe is most likely to be beneficial" (Wampold et al., 2005, p. 211, italics added). The freedom to choose among efficacious treatments or programmes was one of Division 17's core values.

The Humanistic Psychology Division also produced liberalist discourse. They argued that its Task Force was necessary due to the context of managed health care and the dictatorial character of the EST movement (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001). The Humanistic Psychology Division argued that such a context "threatened to restrict consumers' freedom of choice" (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services (2001, p. 2). The importance of 'consumer choice' was similar to the Society of Counseling Psychology's STG assertion (Wampold et al., 2005): rather than have treatments imposed on them, "clients should have the freedom to choose modalities of therapy which best fit their personal needs" (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services (2001, p. 12).[99] Liberalist discourse is generated from the values of freedom of the Humanistic Psychology Division where one of the characteristic qualities of being human is that humans are "capable of choice or freedom" (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services (2001, p. 7). Accordingly, humanistic psychologists valued the goals for developing a "greater sense of personal freedom and choice while respecting rights and needs of others" (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services (2001, p. 7).

[99] As an interesting aside, Bohart, O'Hara, & Leitner (1998) made an assertion that it "may not be long before ... consumers begin to demand freedom of choice in the psychotherapeutic services they are offered" (p. 154) where health care plans may enable consumers to seek out other therapies to traditional ones rather than having to adhere to restrictive EST criteria.

This liberalist notion of 'freedom of choice', in its discourse of how psychologists and clients *should* conduct themselves as free agents, has implications for the practice of evaluation. The Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services (2001) argued that imposing one way of conceptualising human psychological living (i.e., through an experimental, manualised and 'treatment-for-disorder' approach) would "result both in stifling free enquiry and in limiting the choice of services available to the public" (p. 6). Liberalist discourse articulates a desire for a freedom to choose different methodologies among a broader base other than experimental approaches, as well as different therapies, for psychotherapy evaluation,[100] and therefore potentially pluralises the meaning and practice of evaluation.

Humanist Discourse. Closely related to liberalist discourse[101], Divisions 17, 29 and 32 also reproduced a humanist discourse of conduct. The *DSM*-focused EST movement presumes that specific clinical problems, as identifiable disorders, can exist in people and that there must be ESTs established to allievate them. For the Humanistic Division, "humanists hold issues of human value as fundamental" (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services (2001, p. 2). The Division argued that focusing on the value of client's subjectivity, judgment and interpretation is important. The Society of Counseling Psychologists argued that the criteria used for identifying ESTs "assume diagnostic specificity, which is both erroneous and dehumanizing to clients" (Wampold et al., 2002, p. 205). This is because the emphasis is on treating a specific diagnostic

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[100] This is to the extent that the 'liberality' of the liberalist discourse of Divisions 17, 29, and 32 are defined by their own idioms of evaluation (e.g., Division 17 appears to be less methodologically 'pluralist' than Division 32). Nonetheless, all three Divisions advocate for a non-monistic methodological approach to evaluation.

[101] Both liberalist and humanist discourse share an assumption of human agency. Some have suggested that the humanist notion of an agentic person-centred approach fits with the underlying principles of narrative therapy. Payne (2000) for example, first thought this in his initial reading of narrative therapy due to his previous humanistic training but concluded, "similarities... can be deceptive... [as] narrative therapy is formed by a *post-structuralist* perspective" (p. 157, original italics). His new interpretation was that in narrative therapy "'human nature' and the 'self' are socially constructed whereas person-centred therapists assume a permanent, essential self, and an objective, real entity called human nature" (Payne, 2000, p. 159). Some may also confuse 'agency', a concept in narrative therapy, as a real entity of individual freedom (e.g., in Drewery & Winslade, 1997) whereas it is more of a 'social agency' where different culturally-produced subject positions that construct an individual's experience can be changed through a critical awareness of discourse 'calling on' certain positions to be reproduced (Drewery & Winslade, 1997). There is an emphasis on the unique individual in narrative therapy but this is qualified through, among other epistemologies, social constructionist and post-structuralist perspectives. Nevertheless, a liberalist and humanist discourse may enable possible spaces for the languaging the evaluation of narrative therapy with a liberalist valuing of methodological choice and pluralism, and a humanistic valuing of client judgement and interpretation.

categorisation from a pathological (*DSM*) model rather than a holistic examination that includes the experience of the client. The Society, in its critique of the EST movement, and in its assertion that "clients do not present with unitary and well-defined problems," suggested that the "full range of human experience" (Wampold et al., 2005, p. 29) must be examined to fully encompass the variety and scope of interventions practiced by psychologists. The Psychotherapy Division Task Force also acknowledged a humanist element to practice by arguing that human characteristics play an important part of the therapy relationship: "adapting or tailoring the therapy relationship to specific patient needs and characteristics (in addition to diagnosis) enhances the effectiveness of treatment" (Steering Committee, 2001, p. 495).

APA Divisions 17, 29 and 32 also shared humanistic aims for psychotherapy evaluation. The Steering Committee (2001, p. 495) of the Psychotherapy Division task force used humanistic notions such as "empathy", "goal consensus and collaboration", "positive regard", "congruence/genuineness" as empirically supported elements of the therapeutic relationship. The Humanistic Psychology Division Task Force also expressed similar humanistic notions. They stated that "effective humanistic therapists are collaborative rather than highly directive, [and are] warm, empathic, congruent and genuine ... help clients organize and articulate their experience, and help them clarify and resolve problems" (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001, p. 24). Wampold, Lichtenberg and Waehler (2005) state that "outcome measures should reflect attainment of [client] goals as well as (or in many instances, instead of) measures of psychopathology" (p. 204). Division 29 shared this sentiment, arguing, "goal consensus ... correlates highly with parts of the therapeutic alliance" (Norcross, 2001, p. 351). The Humanistic Psychology Division also valued goal consensus. They valued the "clarification and development of values and life goals" (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001, p. 2). The Division also valued collaboration between the therapist and client to "work towards individualized goals that are framed in the clients' world view and understandings of their own aspirations rather than on normative diagnostic categories" (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001, pp. 1–2). Divisions 17, 29 and 32, focus on the human characteristics interconnected with the therapeutic process and produce humanist discourse, counteracting the diagnostic technological

discourse of the EST movement. The humanist statements from these Divisions suggest that psychotherapy evaluators should be focusing on therapeutic process as well as (and as important to) outcome and, rather than primarily focus on clinical disorder, they should be focusing on the unique human qualities, values, and individual goals that play a part in the therapy process.

The EST movement place less importance on individual human qualities in the psychotherapy evaluation process. Chambless and Hollon (1998, p. 15) asserted, "participants in research trials do tend to be selected to be homogeneous with respect to the presence of a particular target problem." Diagnostic categories trump human subjectivity. Westen et al. (2004, p. 632) explained, "treatments are typically designed for a single Axis I disorder[102], and patients are screened to maximize homogeneity of diagnosis." Chambless (1996), operating within a prescriptive diagnostic technological discourse, questioned, "if it is really true that each person is so unique that we can draw no meaningful generalizations from one case to another, how can we possibly train our students?" (Chambless, 1996, p. 233).[103] Humanists, on the other hand, argued that such evaluative stances on generalisation, based on assumed sample homogeneity, remove context and human relevance in evaluation (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001). The Psychotherapy Division also recommended that psychologists consider the diversity of human influences and characteristics in the therapeutic relationship, rather than simply evaluate through diagnoses (Norcross, 2001).

Contextualist Discourse. Contextualism (a stance that context *should* be taken into account when psychologists conduct psychotherapy evaluation) was another discourse common to Divisions 17, 29 and 32. The Society of Counseling Psychology STG criticised the proponents of the EST movement (i.e., Kendall & Chambless, 1998) for their decontextualised diagnostic focus. They argued, "not one mention of ethnicity or culture was made, thus assuming that treatments are uniformly effective across various ethnic and cultural populations" (Wampold, Lichtenberg, &Waehler, 2002, p. 206). Rather than assuming the need to establish diagnostic homogeneity of clients in

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[102] The *DSM* classifies an Axis I disorder as a mental disorder.

[103] To answer this question, the Humanistic Psychology Division Task Force argued for the importance of qualitative methods for examining the diverse contexts of clients. "While quantitative methodologies may be drawn upon as an adjunct, humanistic therapy training emphasizes such qualitative methodologies as case studies, grounded theory, ethnomethodology, relational studies, and hermeneutics to vivify the contexts within which clients dwell" (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001, p. 28, original emphasis).

psychotherapy evaluation, Division 17 valued client diversity. Wampold et al. (2002, p. 204) argued that the Society recognised the "complexity of client diversity (gender, race, ethnicity, lifestyle, etc.)" in psychotherapy evaluation. The Society promoted "a recognition of values related to diversity ... a respect for client attitudes and values" (Wampold et al., 2002, p. 206) and developed its principles to include "interventions that focus on systems or environments" (Wampold et al., 2002, p. 213). The Humanistic Psychology Task Force was also critical of the decontextualising character of the 'treatment for disorder' tech(k)no(w)logy produced by the EST movement:

> Humans are whole persons in context and therapeutic solutions must fundamentally be grounded in their life contexts. This means they must perforce be individualized, developed to meet the individual's particular life context, and cannot be chosen as treatments for decontextualized disorders. (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001, p. 7)

Division 17, 29 and 32 also placed emphasis on the context of therapeutic settings and relationships. The Society for Counseling Psychology, for example, was aware of the limiting effects of the EST movement by arguing that strict efficacy criteria hindered the evaluations of psychological interventions (e.g., guidance counselling) that focused on less well-defined problems (Wampold et al., 2002). The diversity of settings and services in context was important in addition to the diversity of client needs. The Society's principles of empirically supported interventions aimed to "reflect the diversity of settings in which interventions are delivered and the diversity of the counseling psychology services" (Wampold et al., 2002, p. 199).

On the contextuality of relationships, Divisions 17, 29 and 32 valued the interpersonal context of therapy in evaluation. The Psychotherapy Division argued that context is "inextricably interwoven into the emergent therapy relationship" (Norcross, 2001, p. 348). Division 17 argued that therapies are "complex amalgams of ingredients delivered in an interpersonal context" (Wampold et al., 2002, p. 209). The Psychotherapy Division also valued the complexity of interpersonal influences, asserting that therapeutic decisions are the consequence of "multiple, interacting, and recursive considerations on the part of the patient, the therapist, and the context" (Norcross, 2001, p. 354). The Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services (2001) also

argued that people live in "relational contexts" (p. 3) and the relationship is "more powerful than any specific 'technique'" (p. 15). In proposing their recommendations for psychotherapy evaluation, Divisions 17, 29 and 32 valued the contextuality of diverse client and practitioner influences that interconnect in the interpersonal relationship of psychotherapy, thus producing counter-conducts to the EST movement's decontextualising practices.

In the EST resistance movements, the discourses of liberalism, humanism, and contextualism can pluralise the meaning of psychotherapy evaluation as an approach that may acknowledge broader and more inclusive methodologies. These discourses produce meanings of evaluation methodology that include the importance of engaging with and understanding client context in and through the therapeutic relationship. They also produce psychotherapy evaluation as a practice that values human experience, appreciates the fluidity of client goals rather than assumes to fix a pre-defined uniform disorder, and recognises the importance of client contribution, the practitioner, and the context of their relationship.

A discourse can "be both an instrument and an effect of power" (Foucault, 1978, p. 101). The production of liberalist discourse in the three Divisions (17, 29, and 32) could instrumentally serve to 'free up' different ways of conceptualising and conducting evaluation as a resistance to EST discourse.[104]

Evaluation at Present: Emergence of Evidence-Based Practice in Psychology (EBPP)

After the emergence of ESTs and their resistances, there was a shift to evidence-based practice in psychology, enabled through the influence of medicine. Evidence-based medicine (EBM), a term coined in 1988 by medical clinicians and epidemiologists (Donald, 2002), facilitated the rise of evidence-based practice in mental health (Tanenbaum, 2003). The rationale for EBM was to develop a structured framework for systematic clinical decision-making guided by evidence for best clinical practices. EBM then proliferated into evidence-based practice (EBP) throughout the medical and health sciences. The rise of EBP has led to the establishment of academic journals that have specifically focussed on evidence-based practice (Harper, Mulvey, &

[104] Indeed *some* of the concerns from the resistances to ESTs in Division 17 and 29 seemed to have appeared in the APA Presidential Task Force on Evidence-Based Practice (2006) who briefly acknowledged the importance of meta-analytic studies (Wampold, Lichtenberg, &Waehler, 2002, 2005) as well as the therapeutic relationship (Norcross, 2001) but within an evidence-based practice framing.

Robinson, 2003). The APA developed its own model and discourse of evidence-based practice (APA Presidential Task Force on Evidence-Based Practice, 2006), reproduced in/through its various advocates (Bauer, 2007; Luebbe et al., 2007; Kazdin, 2008; Newnham & Page, 2010; Silverman, 2005; Spring, 2007; Thorn, 2007; Walker & London, 2007).

The gist of evidence-based practice is the idea that the incorporation of clinical expertise and patient characteristics with established evidence enables beneficial health decisions, particularly for the patient – within a medical model (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996; Sackett & Strauss, 1998). The EBP movement has produced a hierarchical structure of evidence. For example, the United Kingdom's Department of Health's (DoH) National Service Framework for Mental Health created an evidence hierarchy listing five grades of evidence from at least one good systematic review and at least one randomized-controlled trial (highest grade) to expert opinion (lowest grade) (Department of Health, 1999). A similar hierarchy exists for health-based EBP in Aotearoa/New Zealand (Disbury, 2003). EBP has become influential in both health systems and policies in the United Kingdom and North America (Feltham, 2005; Tanenbaum, 2003). It has also become influential in Aotearoa/New Zealand (Disbury, 2003) with the establishment of the New Zealand Guidelines Group, charged with the dissemination of guidelines for clinicians in the medical and health sciences (McKinlay, McLeod, Dowell, & Marshall, 2004). Evidence-based practice has also become a major determinant in the decision-making processes of rehabilitation funding and delivery in the New Zealand public health insurance system, the Accident Compensation Corporation (ACC) with the establishment of the ACC Evidence Based Healthcare Advisory Group. EBP is becoming, what Tanenbaum (2003) argued as, a *public idea(l)* in mental health care, an assumption "that more [positivist] science will bring about better mental health practice" (p. 287).

The emergence of evidence-based practice has not been without controversy and debate. Its assumption that there is a preference for randomised trials, as well as its focus on meta-analyses and epidemiological studies, have been described as too reductionist and ignorant of the complexity of human nature (Petros, 2003). The framing of evidence in EBP has also been criticised for producing experimental design as the gold standard to determine a treatment's efficaciousness or effectiveness (Kitson, 2002; Tanenbaum, 2003).

After considerable debate and controversy over the narrow framing of ESTs, the APA produced two documents on the evaluation of guidelines for treatment and professional practice in 2002 (American Psychological Association, 2002; Reed, McLaughlin, & Newman, 2002). Hinting at the experimental methodolatry of the EST movement, the APA stated that "guidelines based exclusively on the theoretical and methodological perspectives of narrow efficacy studies are unlikely to be relevant to practitioners in real-world practice and are unlikely to be used" (Reed, McLaughlin, & Newman, 2002, p. 1046). This statement implied a partiality to a much broader approach to psychotherapy evaluation than the EST movement. Indeed, a broader approach was recommended when the APA released its 'Criteria for Evaluating Treatment Guidelines'. The American Psychological Association (2002, p. 1053) proposed two dimensions to evaluate treatment guidelines: 1) treatment efficacy, "the systematic and scientific evaluation of whether a treatment works" and 2) clinical utility, "the applicability, feasibility, and usefulness of the intervention in the local or specific setting where it is to be offered" and this included the context of the client. The APA acknowledged the usefulness of both quantitative and qualitative research for compiling and evaluating "adequate studies" but also asserted that "stringent tests of internal validity ... are more persuasive arguments for efficacy" (American Psychological Association, 2002, p. 1054). The APA proposed three levels of evidence to guide evaluation (in ascending order of internal validity from Criterion 2.1 to 2.3, below):

> Criterion 2.1 Guidelines consider clinical opinion, observation, and consensus among recognized experts representing the range of views in the field...
> Criterion 2.2 Systematized clinical observation is weighted more heavily than unsystematized observation in evaluating treatment efficacy...
> Criterion 2.3 The evaluation of treatment efficacy places greatest emphasis on evidence derived from sophisticated empirical methodologies, including quasi experiments and randomized controlled experiments or their logical equivalents. (American Psychological Association, 2002, p. 1054)

Thus, the APA established a hierarchy of evidence from lower level clinical opinion, observation, and consensus to upper level quasi-experiments and randomised controlled experiments as 'sophisticated'. Systematised clinical observation was favoured for evaluating the practice of therapy within a naturalistic location where the

"evaluation typically includes examination of qualitative data" (American Psychological Association, 2002, p. 1054). However, randomised controlled experiments, at the top of the criteria list, were viewed to "represent a more stringent way to evaluate treatment efficacy because they are the most effective way to rule out threats to internal validity in a single experiment" (American Psychological Association, 2002, p. 1054). This evaluative hierarchy, with a broader inclusion of methodologies than earlier efforts in the EST movement, became part of evidence-based practice in psychology (EBPP) policy (APA Presidential Task Force on Evidence-Based Practice in Psychology, 2006). The (re)production of these evidence criteria through EBPP enable a form of hierarchical observation (Foucault, 1977). In using EBPP evidence criteria, psychologists can examine their evaluation conduct to see if their evaluations employ more 'stringent', 'effective', and 'sophisticated' designs (i.e., experimental criteria) than others less so. Randomised controlled experiments have become the highest benchmark of judgement to aim for in the application of evaluation methodology in evidence-based practice across medicine and health care, generally (Kitson, 2002; Rycroft-Malone, Seers, Titchen, Harvey, Kitson, McCormack, 2003; Tanenbaum, 2003).

The APA published a presidential task force report on EBPP, producing a clear separation from the exclusively experimentalist values of the EST movement. Although it may be possible to confuse or blur EST and evidence-based practice evaluation (e.g., see King, 1998), they are two entirely different concepts due to their criteria of what is 'best practice'. Evidence-based practice in psychology involves a broad approach that includes patient values, clinician expertise and the best available research to inform treatment decision-making (APA Presidential Task Force on Evidence-Based Practice, 2006). In contrast to the exclusively experimental focus in the EST movement, the EBPP Task Force favoured the experimental approach but was inclusive of other methodologies. The purpose of EBPP is to advocate for the effective practice of psychologists and improve public health by applying "empirically supported *principles* of psychological assessment, case formulation, therapeutic relationship, and intervention" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273, italics added). These principles are involved in informing "a decision making process for integrating multiple streams of research evidence, including but not limited to RCTs, into the intervention process" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). The concept, 'principles' of empirical support were used by other psychologists who argued for a broader approach to evaluation than the EST

movement (e.g., Levitt, Neimeyer, & Williams, 2005; Mahrer, 2005; Wampold et al., 2002, 2005). The inclusion of the therapeutic relationship in psychotherapy evaluation and practitioner decision-making processes in EBPP was also contingent with the Psychotherapy Division's resistance to the EST movement (Wyatt, 2007).

As with the emergence of other counter-movements, the 'rationality' of the EST was criticised by the Presidential Task Force on Evidence-Based Practice. There was concern over the EST movement's limited focus on brief, manualised treatments (APA Presidential Task Force on Evidence-Based Practice, 2006). The former President of the APA, Ronald Levant, argued, "people had problems with that [EST] approach because those treatments were really validated on a narrow band of the clinical population" (Wyatt, 2007, para. 82). Levant argued that the EST criteria formed more or less an artificial population, excluded coloured persons, and failed to take into account co-morbidity that occurs in many clients (Wyatt, 2007). He also asserted that the most narrow view of manualisation, "reduces the role of clinician to that of *technician* and allows very little deviation ... The manuals that were personified in the Division 12 lists were really rigid manuals" (Wyatt, 2007, para. 83, italics added). Instead of determining whether a treatment is efficacious for a particular disorder, "EBPP starts with the patient and asks what research evidence ... will assist the psychologist to achieve the best outcome" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273).

Despite the emergence of the evidence-based practice in psychology movement, empirically supported treatment discourse has not disappeared (e.g., Ledley et al., 2009; McHugh, Murray, & Barlow, 2009; Mitchell, Nelson-Gray, & Anastopoulos, 2008; Nathan & Gorman, 2002, 2007; O'Donohue & Fisher, 2008). Perhaps part of the continuation of the production of EST discourse is due to the continuation of favouritism towards the randomised controlled experimental design as the gold standard in EBPP and in evidence-based practice, generally. This continuation may also be occurring because the Division 12 Task Force report "increased recognition of demonstrably effective psychological treatments among the public, policymakers, and training programs" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 272). The promotion and use of ESTs continued for almost a decade before evidence-based practice became official APA policy.

The zealous drive of the EST movement remains evident in contemporary psychotherapy publications. Nathan and Gorman's (2007) *A Guide to Treatments That*

Work produced detailed reviews of ESTs for mental disorders. There have been discussions on balancing treatment fidelity with flexibility in ESTs (McHugh *et al.* 2009), making them more accessible (Smits, Powers, Berry, & Otto, 2007), as well as on how they can be further incorporated into the training of clinicians (Rutgers, 2008). There are also websites informing the public and practitioners on ESTs such as the Society of Clinical Psychology, Division 12 website (psychologytreatments.org) and others like Therapy Advisor (www.therapyadvisor.com) (Riley et al. 2007).[105] Evidence-based evaluation in psychotherapy is a growing phenomenon with the emergence of discourse on EBP, EBPP, *and* a continuation of ESTs.

According to Ronald Levant, the APA Presidential Task Force on Evidence-Based Practice based EBPP on consensus, and on a middle ground between extreme views of psychotherapy evaluation. In an interview with Wyatt (2007), Levant argued that his Task Force "tried to get people from all sides of the spectrum ... to essentially debate and dialogue" (para. 100), those with "extreme views" (para. 104) had to "address the middle ground in between them." The Task Force report, "sketches out the middle" to "populate the middle ground" (para. 108) and take "emphasis away from extreme positions" (para. 108). The Task Force argued that there appeared to be "broad consensus that psychological practice needs to be based on evidence and that research needs to balance internal and external validity[106]" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 274) as well as consensus among contributors in general:

> Perhaps the central message of this task force report—and one of the most heartening aspects of the process that led to it—is the consensus achieved among a diverse group of scientists, clinicians, and scientist–clinicians from multiple perspectives that EBPP requires an appreciation of the value of multiple sources of scientific evidence. (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 280)

Regardless of a consensus of various contributions, as evidence-based practice is effectively an emulation of evidence-based medicine, the shift from ESTs to EBP has enabled psychologists to uptake medical discourse to examine their practices of

[105] In addition, researchers have confused empirically supported treatment criteria with EBP criteria even though both are different approaches (Levant and Hasan 2008; e.g., see King and Ollendick 2006).
[106] Note that internal and external validity are positivist concepts that limit the soundness of evaluation.

psychotherapy evaluation. As revealed earlier, the EST movement enabled a discourse of competition in terms of protecting the status of clinical psychology. In the new world of the managed care environment funding health treatments in the United States, EST proponents advocated the need to compete with medical practice/practitioners for health funding and status (Beutler, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). However, EBPP has shifted this rhetoric to the need to adopt EBP as a 'best practice model' that evidence-based medicine established. Effectively, EBPP is an *extension* of medical discourse, enabling a medicalised gaze, *into* the domain and thus the government of psychology/psychologists. Terms in the APA Presidential Task Force on Evidence-Based Practice (2006) policy document such as "medical-cost offset", "clinical utility", "epidemiology", the study of epidemic disease, "treatment utilisation", "prognosis", "symptoms", "syndromes", "treatment response", and "patient" are, arguably, *medical* terms used in evidence-based medicine. The definition of EBPP "closely parallels the definition of evidence-based practice adopted by the Institute of Medicine" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 284) and EBPP "is consistent with the past 20 years of work in evidence-based medicine" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 284). Further, the term "patient", used throughout the policy document, is preferred to be used over "client, consumer, or person" (APA Presidential Task Force on Evidence-Based Practice, 2006, pp. 273, 284). The saturation of medical discourse in EBPP is evident in that "patient" encompasses a range of things that psychology would not normally view as such, including "family, organization, community, or other populations receiving psychological services" (APA Presidential Task Force on Evidence-Based Practice, 2006, pp. 273, 284).

The recent authoritative APA document on EBPP policy (APA Presidential Task Force on Evidence-Based Practice, 2006) enabled a more liberal governance of psychological conduct than that advocated by the EST movement. Psychologists are 'free' to use a variety of different methodological criteria in their evaluations of psychotherapy. The APA supports multiple kinds of evidence. Yet, many of its examples of 'evidence type' implied a preference for the use of quantitative methods. Such examples include "efficacy, effectiveness, cost-effectiveness, cost-benefit, epidemiological, treatment utilization studies" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 274). However, six of the nine possible "research designs" in EBPP may not necessarily involve measurement or other quantitative

evidence. These included "clinical observation (including individual case studies) ... qualitative research ... systematic case studies ... public health and ethnographic research ... process-outcome studies ..[and] studies of interventions as delivered in naturalistic settings" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 274). The other three research design examples, "single case experimental designs ... randomized clinical trials ... [and] meta-analysis," are obviously suited to quantitative-based evaluations. The Task Force report noted that "qualitative research can be used to describe the subjective, lived experiences of people, including participants in psychotherapy" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 274).

Yet, this freer choice also enabled psychologists to practice normalising judgements to compare and differentiate their evaluative practices. Levant represented the goals of EBPP by asserting, "we said that when psychologists practice, they really *should* take into account the research evidence, broadly conceived clinical *judgement*, and work to improve their *own judgement* and expertise" (Wyatt, 2007, para. 94, italics added). Psychologists can now use EBPP as a tech(k)no(w)logy to improve their judgement in the evaluation and administration of therapy. This involves an administrative exercise in judging the validity of evidence as determined by the EBPP evidence hierarchy and therefore enables a judgement of conduct in relation to applying this evidence to clinical decision-making processes:

> The validity of conclusions from research on interventions is based on a *general progression* from clinical observation through systematic reviews of randomized clinical trials[107] ... It is the treating psychologist who makes the *ultimate judgment* regarding a particular intervention or treatment plan. (APA Presidential Task Force on Evidence-Based Practice, 2006, pp. 284–285, italics added)

The shift from ESTs to EBPP has also enabled a new tech(k)no(w)logy of experimental idolatry. Evaluative criteria in the EST movement emergence favoured a methodologically monistic approach to psychotherapy evaluation. While there is a pluralistic approach to psychotherapy evaluation in EBPP, now, the randomised experimental study remains seen as the *best* way of obtaining the most sophisticated and

[107] This happens while also "recognizing gaps and limitations in the existing literature and its applicability to the specific case at hand" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 284).

effective forms of evidence (APA Presidential Task Force on Evidence-Based Practice, 2006). Yet, the extent to which psychologists could apply such an artificial setting design in front-line practice remains limited. Still, the variety of methods and methodologies that are valued in/through APA EBPP could open up possibilities for the evaluation of therapies that EST criteria marginalised.

However, not all is rosy for those therapists/therapies whose philosophical bases do not fit with experimental methodology. There still exists a hierarchy of evaluative methodology that tells psychologists how to conduct themselves and judge the conduct of fellow professionals in the evaluation of psychotherapy. As with EBM and EBP in health-related disciplines, the 'gold standard' of the experimental approach (including manualisation and standardisation of therapy) dominates over all other approaches and renders them as *less important* and *less effective*. This has implications for therapies such as narrative therapy that uses discursive and contextual approaches to make sense of human action. Narrative therapy is critical of normalising judgements of evaluation that hierarchise and divide between normal and other (White & Epston, 1990). As a constitution of post-positivist work, narrative therapy is suited to post-positivist and qualitative methodologies, located lower down the EBPP evidence hierarchy. Narrative therapy evaluation appears to involve a practice-based, qualitative documentation of progress in therapy shared between therapist and client. One of the more salient ways that one practices this is by the practitioner taking notes, recording on audiotape, videotape, and/or writing letters (McKenzie & Monk, 1997). In documenting progress, the therapist and client place more emphasis on contextualising client strengths and unique outcomes than using a classificatory approach that involves pathology and symptomology:

> It is preferable to take careful notes of unique outcomes and unique accounts during the course of the interview, instead of spending the major part of the interview recording the problem story. There is more value in recording the alternative story as it unfolds, because what gets written down tends to be given more value or weight... We think it is more desirable to have a record of competencies than the customary elaborate description of symptoms and problems. (McKenzie & Monk, 1997, p. 113)

The inclusion of qualitative research in EBPP does not necessarily equate to a tendency towards post-positivist research either; qualitative research approaches can

also have a positivist bent to them (e.g., grounded theory and thematic analysis). Indeed, psychology has produced a substantial period of history that has espoused a positivist epistemological stance to science (Chwalisz, 2003) after its separation from philosophy. Wampold (2003) contended:

> the [Western] health care system is based on a medical model that in turn is colored more by positivism than are most aspects of what we do ... I have been to enough meetings with managed health care and health care accrediting agencies ... to know that presentation of qualitative research would be met with derision. (p. 543)

Yet, others are more optimistic about the usefulness of qualitative research in evidence-based practice. Indeed, based on consensus, the APA Presidential Task Force on Evidence-Based Practice (2006) has widened the notion of what should be evidence-based in psychology in contrast to the EST movement. The EBPP report has opened space for additional methodologies for evaluating psychotherapy process and outcome. In addition, one can consider qualitative research as an important complementary approach to quantitative research in evidence-based practice (Disbury, 2003; Tanenbaum, 2003). There are studies that have already used qualitative, discursive methodologies, for instance, in psychotherapy evaluation research that can now be valued more (e.g., Avidi, 2005; Burck, Frosh, Strickland-Clark, & Morgan, 1998; Busch, 2007; Frosh, Burck, Strickland-Clark, & Morgan, 1996; Madill & Barkham, 1997; Strong, Busch, & Couture, 2008). In contrast to the EST movement, evidence-based practice 'liberates' psychologists' choice of acceptable research methodology beyond the experimental method. However, as EBPP is an emulation of evidence-based medicine, positivist medical discourse, and produces an evidence hierarchy, the value and use of qualitative methodologies and practices, particularly post-positivist approaches, are constrained within the regulation of such a discourse.

Towards a Conclusion

I have problematised the current, taken-for-granted conceptualisation of evidence-based practice as a 'best practice' in psychotherapy evaluation. I have done this through a genealogical examination of the contemporary history of psychotherapy evaluation in psychology. In tracing the descent psychotherapy evaluation movements from the 1990s to the present, I identified three emergent movements in history: 1) the

EST movement, 2) the EST resistance movements (APA Divisions 17, 29 and 32), and 3) the emergence of the evidence-based practice movement in psychology. Through using the concept of governmentality, I was able to examine each movement in terms of their discursive practices, and how they enabled and constrained the shaping of psychotherapy evaluation practice. EBPP continues the aspiration towards the gold standard of experimental evaluation in its hierarchical evidence structure. However, the assumption in EBPP that one can integrate the best available research with clinical expertise and patient values is a relatively recent notion that emerged alongside evidence-based medicine. EBPP also emerged partly because of the struggles of various movements that resisted the EST movement's strict criteria of what is evidence and how psychologists *should* evaluate psychology.

The EST movement enabled four tech(k)no(w)logies psychologists were to use in 'self-managing' or 'governing' their practice. Psychologists could consider these as ways of knowing and practising psychotherapy evaluation. According to Rose (1999b), strategic objectives that "produce particular desired effects and avert particular undesired effects" (p. 52) infuse human technologies of management/government. As a technology of standardisation, the EST movement enabled psychologists to check if their psychotherapy evaluations met a standard(ising) set of criteria.

Manualisation, the requirement to use treatment manuals in the evaluation of psychotherapy, also enabled further perpetuations of standardisation in psychological practice. The EST movement enabled a technology of experimental methodolatry, an idolisation of the experimental method to the exclusion of other possible methodologies. The establishment of the movement also produced a prescriptive technology, which made possible a medicalisation of therapeutic practice: the production of 'treatment for disorder' formulations where they must fit a specific diagnostic problem/categorisation for evaluation. This, in turn, excluded therapies (such as narrative therapy) which are wary of diagnostic categorisation and do not use deficit-based/pathologising discourse. Further, the EST movement facilitated the production of a discourse of professional competition for psychologists to compete with their medicine and psychiatry counter-parts so that ESTs could gain status in the health care environment but to the potential exclusion of those therapists/therapies who/that do not comply with EST efficacy criteria.

A variety of resistant counter-conducts emerged from Divisions 17, 29 and 32 of the APA. These Divisions produced their own task force/groups on the evaluation of

psychological interventions. These counter-conducts produced knowledges that the dominant EST movement ignored and thus marginalised or subjugated. The Division 17 Society of Counseling Psychology, Division 29 Psychotherapy and Division 32 Humanistic Psychology all called for a broader, inclusive approach to psychotherapy evaluation. Each advanced their own idea of evaluative 'best practice(s)'. However, the three divisions advocated for the inclusion of the practitioner, client, and the relationship into the evaluation process rather than focusing exclusively on validating treatments for clinical disorders. The three divisions also produced alternative discourses to the ESTs. Liberalist discourse expressed the need for practitioners and clients to choose therapies freely and Divisions 17, 29, and 32 adopted broader approaches to evaluation rather than a one-size-fits-all approach. The three divisions also produced humanist discourse, emphasising that therapists tailor psychotherapy around human characteristics, need and goals. Contextualist discourse also emphasised the needs to take into account in evaluation the diversity contexts of each client, as well as the interpersonal context of therapeutic relationship.

The EBPP movement established, partly, it seemed, in critical response to the EST movement and partly due to the proliferation of evidence-based practice in Western health care systems. EBPP is different from the empirically supported treatment movement as it is broader and inclusive in that it takes into account the integration of client values, practitioner experience, and best available research to guide practice. It is also methodologically pluralistic but only in the sense of reproducing positivist medical discourse. EBPP has some similarity with ESTs, however. Like the EST movement, EBPP enables psychologists to adopt a medical discourse to explain psychological and social phenomena and continue to perpetuate experimental methodolatry.

Evidence-based practice has the potential to both include and marginalise therapies that have theoretical premises that are unsuited to experimental approaches. On one hand, a wider range of methodologies, including qualitative approaches, enable the evaluation of qualitative- and discursive-focused therapies such as narrative therapy. On the other hand, as a technology of hierarchical observation, EBPP, with its evidence hierarchy, marginalises such therapies. This is because the methodologies used to evaluate them are valued as less 'evidentiary' due to the idolisation of the experimental method as 'sophisticated' and most 'stringent'.

Although evidence-based practice now enables the use of qualitative methodologies in psychotherapy evaluation, they are less important in psychotherapy research. Psychologists still judge and regulate them through the (re)production of a positivist discourse of medical science in EBPP. Consequently, the governing use of evidence-based practice produces a conflict, specifically a differend (Lyotard, 1988), with discursive therapies/practices that are critical of a medicalising gaze/discourse (e.g., narrative therapy) (White & Epston, 1990). Due to this conflict, it seems that the current discourse of EBPP needs to be more epistemologically pluralistic and reflexive before it can become what it purports to be: a more inclusive evaluative practice.

Chapter 6
Contextualising a Genealogical Relationship: A Differend[108]

In this chapter I turn my focus back towards a differend (Lyotard, 1988), produced through the genealogical relationship between narrative therapy and the discourses and practices that govern evidence-based psychotherapy evaluation. It is the form the differend takes that has the potential to disrupt the power relations that both privilege evidence based psychotherapy evaluation discourse and marginalise narrative therapy discourses of practice. Returning to my research question that asks how narrative therapy can be evaluated, I argue that it is necessary to reflexively engage with the methodological congruencies that are epistemologically specific to narrative therapy. I exhume some narrative therapy evaluations as methodological congruencies of narrative therapy and contrast these with evidence-based psychotherapy evaluation discourse to visibilise this differend.

I have genealogically investigated both narrative therapy and evaluation to contextualise an apparent conflict between them. I have found, through the theoretical descent of narrative therapy, various post-positivist epistemological influences – including cybernetic (Bateson, 1972, 1979), narrativist/constructivist (E. Bruner, 1986a, 1986b; J. Bruner, 1986), Foucaultian (Foucault, 1973a, 1973b, 1977, 1980, 1982, 1984a, 1984b, 1984c, 2002/1967), and symbolic interactionist epistemologies that place emphasis on the performance of meaning (Geertz, 1973, 1983; Goffman, 1961; Myerhoff, 1982, 1986; Turner, 1969, 1974, 1986). Such theoretical influences are resistances to positivist research. For example, in symbolic interactionism, meaning is played out through social/cultural performances. The performance of meaning is something that is dynamically co-constructed, negotiated and shaped in the interplay of dialogue between the therapist and client in narrative therapy (White & Epston, 1990). This stance is in resistance to a positivist consideration of meaning as predetermined in objects and as independent of any consciousness, ready for the scientist to *discover* (Crotty, 1998).

Next, I uncovered a multiplicity of post-positivist evaluation theories, or methodologies, which emerged from the interpretive turn in the social sciences during

[108] Some small fragments of this chapter have been published in the peer-reviewed journal; *The Australian Journal of Counselling Psychology* and an in-press book chapter (see Busch, in press).

the 1970s, beyond experimental and quasi-experimental studies. These different theoretical conceptualisations broaden the meaning of evaluation beyond simply an expert-centric objective assessment or appraisal that weighs up if something works or not (and therefore determines its value or worth). Among these different conceptualisations are hermeneutic and constructivist evaluation. According to constructivist and the hermeneutic evaluators, evaluation can also be viewed as an involved practice, one where collaboration enables us to find out how we understand each other through an interpretative framing (Guba & Lincoln, 1989; Schwandt, 1997). Constructivist evaluators judge the success of evaluation on "whether it displays ever-increasing understanding of phenomena" (Guba & Lincoln, 1989, p. 107). This is in stark contrast to the traditional scientific approach where evaluation success criteria focus on prediction, control and finding root causes. For hermeneutic evaluators, evaluation can be about generating an understanding of each other through a collaborative process, where the evaluator works as a partner, creates supplementary standpoints and facilitates examination and critique (Schwandt, 1997). One of the aims of evaluation, from a practical hermeneutic sense, is self-transformation through dialogical relations between evaluator and stakeholders (Schwandt, 1997). In this sense, evaluation is not a positivist approach of establishing 'objective' criteria of worth to measure[109] against, constructing standards, and then measuring the performance of evaluands with the evaluator's standards to determine the worthiness of something. In constructivist and hermeneutic evaluation, evaluators are subjective partners with stakeholders rather than detached, objective experts (Guba & Lincoln, 1989; Schwandt, 1997). Rather than the evaluator aiming to discover something as true or false using normative criteria, practical wisdom and understanding are goals in hermeneutic evaluation (Schwandt, 1996; Schwandt, 1997). So, evaluation has emerged through post-positivist epistemologies in the social sciences that are congruent with postmodern collaborative therapies such as narrative therapy.

Yet, when I examined the recent history of *psychology's* psychotherapy evaluation discourse/practices, I found incompatibilities between such discourse/practices and that of narrative therapy. These incompatibilities stem from an epistemological conflict between the positivist science of evidence-based psychotherapy

[109] From a constructivist evaluator's perspective, measurement is merely a constructed technique (or technology) to make sense of something and so it is not a universal requirement for a meaningful evaluation (Guba & Lincoln, 1989).

evaluation and the post-positivist descent of narrative therapy. In conducting a genealogical examination of psychotherapy evaluation in psychology, I found that the empirically supported treatment (EST) and evidence-based practice in psychology (EBPP) movements reproduced experimental methodolatry and/through the privileging of positivist medical discourse. A relatively recent shift to evidence-based practice in psychology has enabled a plurality of methods and methodologies. However, these methods and methodologies are produced within a discourse that emulates medical science and views the experimental trial as the most sophisticated and stringent method of evaluation. A discourse of empirically supported treatments (ESTs) is still prominent in publications (e.g., Ledley et al., 2009; McHugh, Murray, & Barlow, 2009; Mitchell, Nelson-Gray, & Anastopoulos, 2008; Nathan & Gorman, 2002, 2007; O'Donohue & Fisher, 2008) despite the shift toward evidence based practice. The EST movement promoted the experimental method (typically, randomised clinical trials) as the *only* method to evaluate psychotherapy, and stipulated that manualised treatments should be used for specific clinical problems/disorders (Chambless et al., 1998; Chambless & Hollon, 1998; Chambless & Ollendick, 2001; Kazdin & Weisz, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995; Westen et al., 2004). Psychotherapy evaluation, in the circumstances of EST and evidence-based practice policy, reproduces discourse from medicine, a science based on a positivist epistemology that privileges objectivity.

In contrast to the objectivist positivism of ESTs and EBPP, narrative therapists maintain that discourses, power relations and narratives socially produce various subjectivities that constitute our experiences and our (inter)actions (Drewery & Winslade, 1997). Narrative therapy bases its philosophical premises on post-positivist, interpretivist works such as Barbara Myerhoff and Victor Turner who epistemologically privilege and espouse subjectivity. From such influences, subjectivity is not something that exists as a discrete, internal entity of the mind that exists separate from social interaction but, instead, it is socially produced, forming a 'relational being' (Gergen, 2009). Subjectivity can be experienced as a performative endeavour; it can be something that is (en)acted upon socially (Myerhoff, 1982; Turner, 1974).

In understanding, valuing and experiencing subjectivity as symbolic enactments through social interactivity, such acts are also textual representations (Geertz, 1986). Subjectivity, according to Foucault (1972, 1980, 1982), is something that is produced through power and knowledge relations and therefore human subjects can be

objectified, classified and subjected to another by control and dependence, "tied to their own identity by a conscience or self-knowledge" (Foucault, 1982, p. 212), and positioned by others in/through discourse. Narrative therapists advocate for their "clients to speak from subject*ive* positions rather than as subject*ed* persons" (Drewery & Winslade, 1997, p. 43, original italics). Rather than being subjected to professional discourse, the client is an active participant in a collaborative relationship. A collaborative languaging process in narrative therapy invites the client to engage in a political awareness to (re)story and thus question and address who and what has positioned them and how. Narrative therapists necessarily improvise conversations in therapy where the therapist and client's dialogue collaboratively plays out meaning (Madigan, 2011). This approach to therapy cannot prescribe manualised monologues because such a prescriptive stance produces what White and Epston (1990) call a 'normalising judgement', one that is made by the therapist *for* the client. This judgement is a specific form of dominance that subjugates the client through 'professional' monologue rather than enabling collaborative conversations to flourish. The production of 'evidence' in narrative therapy is not only socially and relationally subjective, it is inescapably political.

'Evidence' is a concept contingent on multiple conceptualisations of the *value* of facts. The human subject who articulates 'evidence' is subjected to, and is a subject of, a discourse of evaluation, its genealogy and its possibilities of conditioning social power relations (Dreyfus & Rabinow, 1982). Discourses are "not 'things' but form relations *between* things; they are not objects as such but *rules* and *procedures* that make objects thinkable and governable" (Arribas-Ayllon & Walkerdine, 2008, p. 105). Therefore, what can be made knowable and how it can be known (i.e., epistemology) is framed through discourse and its rules/regimen. 'Evidence' can be negotiated through collaborative relationships between different stakeholders who have differing values about what is meaningful rather than 'purely' based on so-called 'value-free' judgements through objective and normative evaluative criteria (Guba & Lincoln, 1989). According to Guba and Lincoln's constructivist evaluation stance, 'evidence' or 'facts' cannot be separate from the values that may be brought to their meaning. This stance is contradictory to the positivist notion of 'evidence' in evidence-based practice (EBP). As Wendy Hollway (2001, p. 12) argued, evidence in EBP is "limited by the paradigm of man (sic) the scientist, the rational objective information-processing figure who stands outside the phenomenon being studied." Contemporary psychotherapy

evaluation (EST and EBPP) discourse values objectivity, and the rational/logico-scientific professional who uses an empirical method that privileges detached observation through experimental design. According to Rose (1996, 1999), the detached scientist can, through such a discourse, be made classifiable/categorisable, calculable, measurable, standardised, and regulated by such techniques. On the other hand, narrative therapy discourse places value on subjectivity as embedded within socio-political contexts and symbolic interaction. This emphasis not only applies to the social realities of clients but also to their engagements with the therapist and therapeutic institutions. Narrative therapists avoid reproducing authoritative diagnostic/medicalised 'truth regimes' of psychotherapy administration (Winslade, Crocket, & Monk, 1997). In narrative therapy, 'evidence' is less about what must be 'true' and measurable according to an objective, expert clinician and more about what can be meaningful according to a shared understanding between therapist and client.

In Chapter 5, drawing on the notion of governmentality, I traced evidence-based psychotherapy evaluation as a practice constituted in/through a governance of experimental methodolatry, standardisation and medical discourse. Narrative therapy is critical of and challenges standardising practices of diagnostic categorisations and positivist, logico-scientific discourse (White & Epston, 1990). Therefore, there is a conflictual relationship between evidence-based psychotherapy evaluation and narrative therapy. However, there were also resistances to ESTs such as the Counselling, Psychotherapy and Humanistic Divisions of the APA. These resistances produced fragmentations of evaluation that pluralised its meaning. Some of these resistances, for example, value humanistic, client-centred or contextual understandings of experience rather than diagnostic categorisations (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001).

Yet, what does the descent of the narrative therapy evaluation literature say to evaluation *and* does it further problematise the epistemological conflict between narrative therapy and psychotherapy evaluation in psychology (see Chapter 3)? In this chapter, I discuss the relationship between two discursive practices: narrative therapy and evidence-based psychotherapy evaluation in psychology in order to address my research question, 'how can narrative therapy be evaluated?' To do this, I examine the some of the narrative therapy evaluation literature (Besa, 1994; Busch, 2007; Clare & Grant, 1994; Gardner & Poole, 2009; Huntly & Owens, 2006; Keeling & Bermudez, 2006; Keeling & Neilson, 2005; Kogan & Gale, 1997; Kropf & Tandy, 1998;

Merscham, 2000; Muntigl, 2004; Nylund, 2002; O'Connor, Meakes, Pickering, & Schuman, 1997; Rothschild, Brownlee, & Gallant, 2000; Wetchler, 1999). I uncover this literature as subjugated knowledges of psychotherapy evaluation to find out how narrative therapy discourse relates to evidence-based psychotherapy evaluation. In addition, I refer to sources from my previous genealogical examinations from the chapters on the theoretical emergence of narrative therapy, evaluation theory and psychotherapy evaluation. Narrative therapy is constituted from interpretivist theoretical influences as emergent resistances to positivist science. Such interpretivist understandings view meaning and lived experience as produced socially and relationally through performance (Myerhoff, 1986; Turner, 1986), narrative (E. Bruner, 1986a, 1986b; J. Bruner, 1986), comparisons of events, and patterns of interaction (Bateson, 1972, 1979). These contextual, interpretative influences disrupt governmental practices of standardisation and factual diagnostic categorisation in evidence-based psychotherapy evaluation. Through examining some of the evaluation literature on narrative therapy, I reveal how narrative therapy and evidence-based psychotherapy evaluation discourse in psychology contribute to a relationship that is conflictual and incommensurable.

A Problematisation of a Differend between Narrative Therapy 'Evaluation' Discourse and Psychotherapy Evaluation Discourse in Psychology

In this engagement with what can be said, I arrive at, or (re)turn[110] to, a differend (Lyotard, 1988) as a way of philosophising the relationship between narrative therapy and evaluation. I use Lyotard's (1988) *The Differend* as a conceptual tool in this chapter to make sense of my genealogical examinations of the problematic relationship between narrative therapy and its evaluation. In the last chapter, I argued that the EST movement views therapies that do not fit the criteria for ESTs as 'experimental' or 'non-empirical' and therefore of lesser value. Therefore, narrative therapy is devalued. A differend happens when a conflict occurs between two discourses such that an injustice results from the fact that "the rules of the genre of discourse by which one judges are not those of the judged genre or genres of discourse" (Lyotard, 1988, p. 70). It also occurs, according to Lyotard, when there is no universal

[110] The reason for '(re)turn' is that I have already articulated my experience of a differend between narrative therapy and evaluation when formulating my research question as a Foucaultian problematisation in Chapter 1.

rule of judgement to resolve both 'sides' equitably, an impossibility he suggests. Grand narratives seemed to have lost some of their credibility since the advent of post-industrial, postmodern culture (Lyotard, 1984). Post-positive methodologies have enabled a questioning of universal criteria or one-size-fits-all approaches to evaluation (Guba & Lincoln, 1989; Schwandt, 1996, 1997). Modernity, in its quest for certainty, lost some of its momentum in its production of timeless generalisations and universal theories (Toulmin, 1990). No longer can science legitimate itself as a purely objective act. Rather science can be viewed as a political act where technology, capitalism and truth interrelate to reinforce and reproduce its authority (Lyotard, 1984). There are now different and competing political discourses of science with competing strategies and criteria (e.g., the EST movement versus the EBPP movement) which make any universal criteria, judgement and application problematic.

One can think of narrative therapy as a type of discourse subjected to judgement in/through the prescriptive rules of the genre of discourse of EST criteria in psychology. It is also judged in and through an evidence-based practice evaluative model that privileges medical scientific discourse. Narrative therapists are resistant to medical discourse because it reduces client experience to professional terms of diagnosis and treatment (Drewery & Winslade, 1997). In applying Lyotard's (1988) differend, narrative therapy is wronged in/through the rules that form a different type of discourse – a discourse of evidence-based evaluation, informed through the EST and EBPP movements.

In a differend, an injustice occurs because two (or more) different regimes of discourse are at play but they are in direct conflict with each other such that if one regime judges the other, it wrongs the other because of their incommensurability (Lyotard, 1988). A differend occurs when one uses an authoritative regime and genre of discourse with specific criteria to judge a discourse that has a different set of rules and assumptions. However, a differend is not just about difference. It is also symptomatic of a power relation where each discourse gains its legitimacy through language games (or rules/customs of articulation) in that each game (re)produces a relationship of power. The rules of language games govern the properties and functions of utterances where every utterance performs a move in a game (Lyotard, 1984).

So, a differend can be indicative of a power relationship through an examination of the governance and (inter)play of different discourse genres – in which discourse rules over and marginalises the other. According to Lyotard (1988, p. 49), a discourse

"determine[s] a set of rules for the formation, linking and validation of the phrases that obey it." Such a set of rules can form a language game where its rules guide assumptions on how one can phrase, express and thus judge others (Lyotard, 1988). A phrasing determines what can and cannot be said, what is and is not possible according to rules of its own formation (Lyotard, 1998). Therefore, such an act forms a statement of discourse, a system that governs what is possible to speak (Foucault, 1972). Smart (1998) argued Lyotard's version of language games is a shift from the anthropocentrism of Wittgenstein, who suggested that people use 'language like a toolbox', to the notions of 'phrase regimen' and discourse. This 'post-Wittgensteinian' view of language games, or 'phrase regimens', is based on the notion that players are situated in/through the discourse/regimen that those phrases present (Lyotard, 1988). A narrative therapy discourse invites collaborative conversations between client and therapist. These conversations consider how the client is positioned through global discourse and grand narratives and how they can resist such positionings through the co-construction of new narratives (Besley, 2002; Carr, 1998). EST discourse, based on medical knowledge involves denotation, the depiction of reality through a true statement about an object. The therapist is positioned as an expert as he/she administers therapy in a manualised fashion on the client to test the alleviation of a specific clinical problem/disorder (Chambless & Hollon, 1998; Chambless & Ollendick, 2001). In EST discourse, the psychologist reproduces the authority to make a particular move in the game of denotation. Instead of viewing language 'like a toolbox', it is more like a way of *governing* how players reproduce and link phrasings/ statements that are part of language games/'phrase regimens' (i.e., the rules and procedures of the formation of discourse).

Bar a few exceptions, I will show that players from the context of narrative therapy discourse phrase/state 'evaluation' in divergence to players of the hierarchical types of evaluation discourse in psychology, namely empirically supported treatment and EBPP discourse.[111] This divergence will be set in the context of the genealogical

[111] I will interpret such 'players' as authors of narrative therapy literature and authors of empirically-supported and evidence-based practice literature. In line with Barthes (1977) assertion of the death of the author, I acknowledge that my interpretation is a (birth of a) reading (from a genealogical stance, using the Lyotardian concept of the differend) of many possible readings, and it is not a fixed truth of what each 'author'/'player' meant. An 'Author' is never more than the instance of writing, in that language only knows a 'subject' not a 'person' (Barthes, 1977). Following Barthes (1977), the expression of 'player' is no more than the occurrence of writing or saying 'player'. Therefore, 'players', and inevitably, 'I' as an 'author' (Busch, 2007; this thesis) and thus a 'player', are subjects of discourses of a differend and (this) genealogy. 'I' too am bound to this differend.

examinations that I have carried out in the thesis. I will argue that this divergence between these two different discourses produces a differend, symptomatic of uneven power relations between subjugated/marginalised players of narrative therapy discourse and players of evidence-based evaluation discourse in psychology. This exploration of the differend then enables me to address the power relation between narrative therapy and evidence-based psychotherapy evaluation.

Juxtaposing Narrative Therapy Evaluation with Evidence-Based Psychotherapy Evaluation Discourse

Quantitative studies of narrative therapy. Although most narrative therapy evaluations have focused on descriptive or textual-based accounts of therapy, there is one exception. One of the earliest peer-reviewed empirical studies of narrative therapy was an experimental study. Using multiple baseline designs, Besa examined six cases of parent-child conflict. Outcomes were assessed by parents in 'measurable' terms such as "not doing chores, attention seeking instead of doing homework, making too many phone calls, and not doing homework" (Besa, 1994, p. 311). The design consisted of three periods. There was a baseline period where the researcher trained parents to take baseline measurements of behaviour by filling in a 'tracking form' of problem behaviours as they observed their child. An intervention phase followed, where the therapist asked about unique outcomes. Then, a follow-up period occurred where parents measured their child's behaviour at least one month after the termination of therapy. The study concluded that narrative therapy was effective in reducing parent-child conflict.

The rationale for utilising single-system multiple baseline design was that the experimenter assumed that it met criteria of being "respectful, non-judgemental, and collaborative" and could not rely on "classification, diagnostic categories, or be pathologizing" (Besa, 1994, p. 310). Besa (1994) acknowledged that "[i]t would be both hypocritical and illogical to use a form of research based on normal curves and psychopathological classifications to study the effectiveness of NT [narrative therapy]" (Besa, 1994, p. 310).

The study left me wondering whether Besa's method was a 'common practice' of narrative therapy. Arguably, "refusal to do chores" (Besa, 1994, p. 319) and "attention seeking" (Besa, 1994, p. 311) could be viewed as subtle forms of 'pathologisation' – as deviations from normative expectations of 'good/compliant

behaviour/conduct'. These problems were externalised as "rebellion" and "the influence of San Jose" (Besa, 1994, p. 315). However, they were measured and charted as "frequency of attention seeking" (Besa, 1994, p. 318) and "dot = cooperates ... circle = refuses" (Besa, 1994, p. 320) which seemed to be more of an attempt at imposing pre-defined measures than collaboratively understanding the influence of the problem. To have a parent monitoring problem behaviour is a form of, what Foucault (1977) calls, hierarchical observation in that an authority figure produces some form of functional surveillance of the child. There may have been possible conflicts (i.e., power relations / resistances) between the parent and the child, which could have had an effect on the outcome measures. However, the study did not mention if there were any possible conflicts.

Besa's (1994) methodology is at epistemological odds with narrative therapy. The "strong preference for ... textual analogy" (White & Epston, 1990, p. 9) in narrative therapy, along with Geertz's (1976; 1986) questioning of a bounded, fixed, and original individual, seems to contradict the reductionism of experimental design. White and Epston's (1990) emphasis on giving meaning to experience through a textual analogy, incorporating Bruner's (1986) and Geertz's (1986) 'indeterminacy of texts', is in conflict with the positivist notion that objective measurement can be obtained. Even Besa (1994) acknowledged that, due to the subjective perceptions of parents on measuring their child's behaviour, "objective measures were not considered to be especially relevant" (Besa, 1994, p. 324). This apparent constructivist view of parents' "perceptions (not 'objective reality') that influence their narrative of their child's progress" (Besa, 1994, p. 323) is at odds with the positivist view of the experiment as the direct method to establish some scientific 'validity' (Crotty, 1998). Experimental designs establish cause and effect through the controlling of variables so that a certain degree of replication can occur with similar populations and problems (Chambless & Hollon, 1998; Kazdin & Weisz, 1998). Yet, Besa (1994, p. 324) noted that statistical "reliability is not important when measuring narrative change" and he deliberately did not use reliability checks to verify the parents' counts from monitoring their children.

However, Besa's (1994) advocation of experimental research for optimising specific techniques of narrative therapy to address specific problems also undermines the post-reductionist stance of narrative therapy. Besa (1994) suggested that others could modify his single-system experimental design to "discover the relative effectiveness of each technique" (p. 324). He proposed that a "refining" of narrative

therapy could result from this "so that a given problem could receive an optimum balance of interventions" (Besa, 1994, p. 324). However, such phrasings/statements are in line with EST discourse, which produces the assumption that therapy must be standardised and that therapy occurs somewhat separate to the therapeutic relationship. Such statements are also aligned to a medical discourse, where there is "keen interest in moving to more specific conclusions about treatment by identifying concretely those techniques that have support on their behalf for specific clinical problems" (Kazdin & Weisz, 1998, p. 26). Proponents "take seriously the inclusion of a treatment approach as efficacious for a given disorder" (deRubeis and Crits-Christoph, 1998, p. 49). Besa (1994) seemed to assume that problems are inherently stable and do not shift in therapy.

Yet, narrative therapy views problems as "fluid and evolving" (White & Epston, 1990, p. 49) in that they shift through collaborative conversations between the therapist and client, particularly when clients struggle to identify descriptions that suitably represent their experience of the problem (White & Epston, 1990). McKenzie and Monk (1997, p. 100) argued that when a therapist "clings to an early externalized description, it tends to rapidly become redundant. The client has moved on in the account of the problem story."[112] They briefly illustrated an unfolding story of a man who gained his sight. However, his definitions of the problem "changed from 'this problem' to 'normal vision,' 'trouble,' and 'fear,' depending on the direction the conversation was taking" (McKenzie & Monk, 1997, p. 100), thus illustrating textual indeterminacy (Bruner, 1986; Geertz, 1986; White & Epston, 1990).

Besa's (1994) experimental approach focused on explorations of single cases/systems but overlooked the interpretivist premises of narrative therapy. His focus on turning individuals into stable and calculable measures, along with a 'technological reductionism' (i.e., refining narrative therapy techniques as optimal tools for problems as operational definitions that do not change through therapy), ignores the premise of textual indeterminacy in narrative therapy. In doing so, it implicitly discounts such premises and reinforces experimental methodolatry in evidence-based psychotherapy evaluation discourse.

Qualitative studies of narrative therapy. Now I turn to the qualitative and descriptive studies of narrative therapy, which speak to evaluation in situ of a

[112] One downside of time-limited, empirically supported therapy is that the restriction of time and preoccupation with alleviating a clinical disorder may inhibit client-directed and -customised explorations of the problem.

relationship between the context of narrative therapy discourse and the context of psychotherapy evaluation discourse in psychology. Such studies of narrative therapy evaluations include heuristic inquiry (Keeling & Bermudez, 2006; Keeling & Neilson, 2005), ethnography (Gardner & Poole, 2009; O'Connor, Meakes, Pickering, & Schuman, 1997), textual analysis (Kogan & Gale, 1997), linguistic-semiotic analysis (Muntigl, 2004), thematic analysis (Leahy & Harrigan, 2006), and descriptive case reports (Clare & Grant, 1994; Huntly & Owens, 2006; Kropf & Tandy, 1998; Merscham, 2000; Nylund, 2002; Rothschild, Brownlee, & Gallant, 2000; Wetchler, 1999) including a discursive evaluation of some of those case reports (Busch, 2007).

Keeling and Nielson (2005) examined how Asian Indian women experience narrative therapy. Rather than imposing a standardised therapy process through manualised delivery, the study was tailored to suit this distinct non-dominant cultural group to address certain characteristics such as shyness and fear of stigmatisation. To do this, Keeling and Nielson (2005) used journaling and art, two narrative-focused assessments and interventions that would be difficult to manualise. Six Indian Asian women, recruited through snowball sampling with an age range from 22 to 30, participated as co-researchers. EST and EBPP movements do not acknowledge this collaborative, interpretivist approach because a (re)production of expert medical discourse positions clients as passive adherents to treatment administration. Keeling and Nielson (2005) found that the use of writing and art filled the clients' needs to explore their problems and empowered them to tackle problems by using their own talents.

Keeling and Nielson (2005) used heuristic inquiry (HI) whereby the process of such evaluations is interpretatively relational and collaborative, resisting the traditional objectivist approach to psychotherapy evaluation. The researchers used HI because their research was exploratory and it reflected the "researchers' desire to preserve and identify participants' experiences and voices while acknowledging the influence of the researcher's values, perspective, and experience" (Keeling & Nielson, 2005, p. 439). Heuristic inquiry is a qualitative research approach. It examines meaning through an initial immersion of an exploration of the subjectivity of the self that then enables a move to an examination of others' experiences (Douglass & Moustakas, 1985).

Heuristic inquiry may seem congruent with some of the philosophical premises of narrative therapy, especially its collaborative practices. Co-authorship involves a shaping of a conversation between the therapist and the client, which can enable shared

meanings to emerge (Winslade, Crocket, & Monk, 1997). Co-authorship involves acknowledging the social context of the therapeutic relationship where power manifests in professional practices, and so there is an attempt to share authority between therapist and client (Winslade, Crocket, & Monk, 1997). As narrative therapy involves a storied production of experience between therapist and client, it "acknowledges that stories are co-produced" (White & Epston, 1990, p. 83). Narrative therapy is also incredulous of the effects of dominant cultural discourses on the therapeutic relationship (White & Epston, 1990).

This collaborative therapeutic approach in both HI and narrative therapy is in striking contrast to evidence-based psychotherapy evaluation discourse in psychology where administration of 'treatment' is valued. Evidence-based practitioners focus on "administering treatment" (Kazdin & Weisz, 1998, p. 20). Therapeutic programmes are "administered" (Kazdin & Weisz, 1998, p. 23) and the therapist is required to have "requisite skills in administering" (Kazdin & Weisz, 1998, p. 27). Therapy administration is performed 'objectively', consistent with expectations of manualisation. There is the assumption in EST policy that clinical psychologists "read the [EST] literature about developments in effective treatments and then to go forth and learn to administer these therapies" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 11). In an EST evaluation of panic disorder, therapists were "trained to administer a standard 15-session protocol" (Chambless & Ollendick, 2001, p. 707). The American Psychological Association Presidential Task Force on Evidence-Based Practice (2006, p. 278) recommended, "identifying technical skills used by expert clinicians in the administration of psychological interventions that have proven to be effective." All of these statements add to a discourse of psychotherapy evaluation in psychology that value the administration of treatment (as if it were a medical dispensation) by the expert and authoritative therapist (Stiles & Shapiro, 1989). This is in contrast to the improvised, collaborative conversational and relationship-focused approach of narrative therapy that is produced in direct resistance to mainstream psychotherapy with its assumptions of bounded individuals with essential structures to treat deficit-based psychopathologisation and the detached practitioner (Besley, 2002). Narrative therapy discourse states that therapy should be collaborative while being mindful of power relations, whereas the other more hierarchical, evaluative genre produces a different language game: that therapy should be a process whereby the expert therapist administers standardised treatment for the good of the client.

The evaluative approach of heuristic inquiry appears antithetical to the EST movement's assumption that psychologists should administer standardised treatment. Keeling and Bermudez's (2006) evaluative approach of heuristic inquiry examined a narrative therapy intervention that specifically focused on externalisation. Eighteen undergraduate communication studies participants used an instrument containing externalisation questions drawn from Freedman and Combs (1996). The instrument involved art work and journaling exercises to embody the problem through a sculpture, 'guided journal questions' to map the influence the problem and identify unique outcomes, plus a reflective journal exercise on summarising their experience, their change in perceptions and the project's helpfulness (Keeling & Bermudez, 2006). The reflective journaling process resists EST proponents Chambless and Hollon's (1998) assumption that self report is a form of bias and that standardised measures should be used to produce reliable outcomes. The study found that relationships were highly important in that they contributed to problems, were affected by problems, and were useful resources in overcoming problems, which was a similar stance made by the APA's Psychotherapy Division (Norcross, 2001) in its resistance to EST criteria. Also, three participants found the intervention to be "unhelpful or minimally helpful" (Keeling & Bermudez, 2006, p. 415) and it was concluded that "there can be no one-size-fits-all solution for the varied problems and contexts people present" (Keeling & Bermudez, 2006, p. 415).

Despite appearing to have some suitability as a qualitative methodology with narrative therapy, doctrines of essentialism and truth guide heuristic inquiry. Such doctrines do not fit with narrative therapy discourse. Heuristic inquiry aims to examine the "essence of the person in experience" (Douglass & Moustakas, 1985, p. 43). Narrative therapists do not view meaning as made from an essential self (Payne, 2000) but rather take the epistemological standpoint that meaning can be contextually dependent in that it arises from common, shared understandings but also differences among people. "Meaning is constructed socially" (Drewery & Winslade, 1997, p. 34). Realities, according to Freedman and Combs (1996, p. 22), are "socially constructed", "constituted through language", "organized and maintained through narrative", and so "there are no essential truths." Furthermore, the creative, imaginative notions of narrative and experience from Jerome Bruner (1986) and Victor Turner (1986), which contribute to narrative therapy (White & Epston, 1990), are in opposition to a unitary, essentialist truth of experience. Subjunctivation, as mentioned in Chapter 3, is a stance

where meaning can be performed through the imaginative aspect of storying (Bruner, 1986), and liminal experience (Turner, 1986). It involves "beholding the world not univocally but ... trafficking in human possibilities" (Bruner, 1986, p. 26), and includes "the mood of maybe, might be, as if, hypothesis, fantasy, conjecture, desire..." (Turner, 1986, p. 43) and not what essentially 'is'.

So, from a narrative therapy perspective, people can collaboratively plot their experience into narratives but this also means that multiple possibilities of experience can be (re)storied (White & Epston, 1990). As I have mentioned in Chapter 3, a narrative mode cannot 'discover' *the* correct, essential, and predetermined truth; it inevitably involves multiple perspectives through the subjunctive mood, which does not fit with the 'fixing' normative clinical gaze of EST and EBPP evaluations. Narrative therapy discourse is contingent on post-essentialist discourse that includes Foucaultian (Besley, 2002), social constructionist (Drewery & Winslade, 1997; Freedman & Combs, 1996), narrativist/constructivist (Bruner, 1986) and symbolic interactionist stances (Turner, 1986).

At first sight, heuristic inquiry (HI) seems suited as an approach to evaluating narrative therapy due to its aims of explore meaning through an examination of the self and other. The focus of HI, according to Douglass and Moustakas (1985, p. 42), is on "meanings, not measurements", "quality, not quantity", and "experience, not behavior." However, HI's assumptions are that its "power ... lies in the potential for disclosing truth" (Douglass & Moustakas, 1985, p. 40). Further, the paradoxical claim that subjective perception is "the most objective assessment" (Douglass & Moustakas, 1985, p. 43) produces an assumption that there are "essential meanings ... of the phenomenon to the researcher and to the participants" (Keeling & Bermudez, 2006). Such assumptions violate the post-essentialist stance of narrative therapy discourse which counters humanist assumptions of therapy that presume 'true' or 'essential' characteristics of individuals (Besley, 2002). In the sense of essentialist epistemology, although heuristic inquiry goes some way to produce a collaborative, interpretive evaluation, it seems unsuitable as an evaluative methodology for narrative therapy.

A more suitable methodology used in narrative therapy 'evaluation' that resists standardising tech(k)no(w)logies of ESTs and EBPP is ethnography. O'Connor, Meakes, Pickering, and Schuman (1997) and Gardener and Poole (2009) both used participant observation and interviews in their ethnographic research to understand client experience of therapy. The ethnographer shapes research problem(s) (which can

change in/through the ethnographic process) around context-specific issues (Fetterman, 1982).

O'Connor, Meakes, Pickering, and Schuman (1997) conducted an ethnographic study involving interviews of families. Eight families, participants in family screenings by the research team (O'Connor et al., 1997) at a university outpatient clinic, were recruited through opportunistic sampling. The families, reported a variety of problems among their children (aged six to 13 years of age), namely, "conduct, family violence, attention deficit/hyperactivity disorder (ADHD), school problems, aggressive behaviours with siblings and others, grief over parental divorce and death, and refusal to obey rules and directions" (O'Connor et al., 1997, p. 483). The families were at various stages of their therapy and the therapy used a narrative team (the research team) who witnessed the family in therapy behind a one-way mirror.

Ethnography and narrative therapy privilege contextual and collaborative explorations of meaning. The researchers reported that narrative therapy provided "an excellent context for the ideas and practice that empower personal agency in family members" (O'Connor et al., 1997, p. 490) in that family members were enabled to take responsibility and credit for their change and successes. The families appreciated the presence of the consulting and reflecting teams that facilitated change as well as the involvement of a larger audience that witnessed change. EST and EBPP discourse underprivileges this contextual, collaborative and client/family-focused approach to therapy and research. Through EST criteria, the manual dictates the research and therapy process, individuals are homogenously sampled in terms of having the 'same' disorder and client context is consequently unacknowledged, decontextualised and thus marginalised. EBPP discourse also (re)produces families as patients through a clinician-as-expert medical model (APA Presidential Task Force on Evidence-Based Practice, 2006). Both ethnography and narrative therapy are approaches that value the improvised production of meaning in/through context and understanding each other. EST and EBPP largely ignore and marginalise this improvisation by producing thin descriptive meaning in/through a regimen of clinical expertise and set medical terms.

One of the main findings was also that all family members experienced a reduction of the presenting problem but therapy was most effective over a year's time because there was a greater benefit with those who were involved in narrative therapy for a longer period. The findings from O'Connor et al. (1997), showing that lengthier involvements with narrative therapy were more effective, are contrary to the time-

limited focus of most ESTs and its associated cost-effectiveness discourse.[113] In wanting to persuade third-party payers the cost-effectiveness of ESTs, the Task Force on Promotion and Dissemination of Psychological Procedures (1995, p. 12) stated, "that many of our effective treatments are short-term should prove attractive to those who foot the bills and this point should be made salient." Westen et al. (2004) argued that most ESTs "typically range from about 6 to 16 sessions" (p. 632). In implicit reference to ESTs, the Task Force on Promotion and Dissemination of Psychological Procedures (1995, p. 14) recommended that the APA educated "third party payors and the public about the ... cost effectiveness of psychotherapy research." EST proponents contributed to a discourse of cost-effectiveness. Chambless and Hollon (1998) argued that psychologists should give greatest weight to cost-effectiveness research on ESTs. DeRubeis and Crits-Christoph (1998, p. 38) were "encouraged by the growing interest in the cost-effectiveness of treatments." A consequence of strengthening the rationale for cost-effectiveness in ESTs is that it excludes process-based evaluations of therapies that may potentially produce better outcomes in the medium- or long-term than the short-term.

However, time-limited therapy formats suit the experimental design focus of ESTs because they easier to control. Westen et al. (2004, p. 633) argued that the preference for brief therapies is a "natural consequence of efforts to standardize treatments to bring them under experimental control." They claimed that lengthy therapies "pose substantial threats to internal validity" (Westen et al., 2004, p. 633) and so "treatments are manualized and [are] of brief and fixed duration to minimize within-group variability ... aimed at maximizing the internal validity" (Westen et al., 2004, p. 632).

This normative expectation of evaluative practice that psychologists should prevent the erosion of "internal validity" by imposing time limitations on therapy is incongruent with narrative therapy practice. Narrative therapy does not stipulate time limits; it is an approach that characteristically focuses on therapeutic conversations, which are variable and diverse (Freedman & Combs, 1996; Monk, Winslade, Crocket, & Epston, 1997; White & Epston, 1990). Unlike in EST evaluations, narrative therapy researchers do not endeavour to (re)produce artificial laboratory settings and processes

[113] It is also interesting to note that Westen, Novonty, and Thompson-Brenner (2004) also point out that naturalistic studies have found that longer therapies (1–2 years and beyond) seem to be more effective than briefer therapies.

over short-term periods to maintain internal validity. The EST movement's goal of preventing the purge of internal validity negates the ethnographic findings on therapy length from O'Connor et al. (1997) because lengthier involvements in therapy form "substantial threats to internal validity" (Westen et al., 2004, p. 633).[114]

O'Connor et al.'s (1997) rationale for choosing ethnographic research was that it enabled a nuanced account of the family's experiences of narrative therapy. The researchers interviewed each family, using four open-ended questions: "1) What has been helpful in the therapy? 2) What has not been helpful in the therapy? 3) What is your overall experience of narrative therapy? 4) What is an image or symbol to describe your experience of therapy?" (O'Connor et al., 1997, p. 483). Such questions were constructed to cultivate a "rich description of clients' perceptions of narrative therapy" (O'Connor et al., 1997, p. 483), consistent with Geertz's (1973) thick description.[115] Such descriptions have considerably less relevance within EST and EBPP movements, which (re)produce experimental methodolatry that describes clients in/through statistical measurement based on medical terms.

Like narrative therapy, ethnography enables the privileging of client voice rather than subjugating it through predefined measurements based on diagnostic terminology. Gardener and Poole (2009) conducted an ethnographic study of narrative therapy with data collected from participant observation, extensive field notes, and in-depth interviewing. They recruited twelve older adults (55 to 75 years of age), seven were men and five were women. Many of them were immigrants from diverse cultural backgrounds who had addiction problems. However, the study avoided using diagnostic terminology to describe participants' problems. Participants appreciated that they could tell their stories through shared experiences within their cohort (Gardener & Poole, 2009). EST criteria enable the omission of such shared experiences because of its focus on the statistical aggregration of variables through experimental design and medical discourse. EBPP discourse would devalue the participants' experiences

[114] Furthermore, during the emergence of ESTs, there were "concerns about the exclusive focus on brief, manualized treatments" (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 272) and evidence-based practice in psychology was subsequently born. Yet, ironically, one goal of EBPP is to also "improve quality and cost-effectiveness" (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 272) but it remains unclear if this sense of cost-effectiveness would continue to favour brief, manualised therapy through experimental design.

[115] Although the study was ethnographic in methodological focus, the analytical coding of the data consisted of content analysis (Berg, 1995) where an inductive grounded theory approach to written interviews (in)formed the codes (Miles & Huberman, 1984).

because it assumes ethnography is far less stringent than experimental design. However, the ethnography found that all participants reported that the therapy was helpful and experience was positive: "eight participants felt narrative therapy had a very beneficial effect on their substance misuse and at the time of the interview four participants indicated they were presently abstaining from use" (Gardener & Poole, 2009, p. 610). Thick descriptions of *how* narrative therapy helped them would be irrelevant and/or lost within EST and EBPP discourses but would be necessary within both narrative therapy and ethnographic discourse.

Both O'Connor et al. (1997) and Gardener and Poole (2009) are proponents in narrative therapy 'evaluation' discourse who resist the standardised focus of evidence-based psychotherapy evaluation discourse. They played a different language game to EST and EBPP discourse. O'Connor et al. (1997, p. 483) argued, "persons interviewed in ethnographic research are not regarded as subjects, but as participants and co-researchers." The study used their participants' input in the research process to guide one of their recommendations. O'Connor et al. (1997, p. 492) noted, "traditionally this is not done." Indeed, as previously argued, in EST research, the expert therapist is the administrator of a treatment. Clients are recipients of manualised treatments for specific clinical disorders (Chambless & Hollon, 1998; Westen et al., 2004). Gardener and Poole (2009) suggested that the foregrounding of narratives for older adults could be a way to "resist disempowering practices in addictions and mental health such as 'traditional' assessment procedures that label and limit individuals" (p. 615). However, standardised, psychometric assessment instruments play an essential(ist) part of measuring EST outcomes in relation to identifying and alleviating mental disorders (Chambless & Ollendick, 2001; Mitchell, Nelson-Gray, & Anastopoulos, 2008; Westen et al., 2004).

O'Connor et al.'s (1997) and Gardener and Poole's (2009) ethnographic discontinuities of psychotherapy evaluation stand against a tide of discourse on standardisation from EST proponents. In the previous chapter, I revealed that the EST movement enabled a governmentality of standardisation as a conventional knowledge/ technique for psychotherapy evaluation. The Task Force on Promotion and Dissemination of Psychological Procedures (1995, p. 4) stated that "standardization and precise definition of treatment through treatment manuals and other procedures reduce the methodological problems caused by variable therapist outcomes and lead to more specific clinical recommendations." Beutler (1998, p. 116) argued against mere clinical

impressions as he stated that the "danger is that such unstandardized observations would be given greater weight than standardized ones and that this could undermine the scientific credibility of the field." Treatment manuals have become an integral component of the governing criteria of EST (Chambless et al., 1998; Chambless & Hollon, 1998; Chambless & Ollendick, 2001; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Adherence to manuals are continually stated/phrased as integral to establishing ESTs (Ledley et al., 2009; McHugh, Murray, & Barlow, 2009; Mitchell, Nelson-Gray, & Anastopoulos, 2008; Nathan & Gorman, 2002, 2007; O'Donohue & Fisher, 2008). Under EST criteria, ethnography becomes invalid as an evaluative methodology. O'Connor et al. (1997) and Gardener and Poole's (2009) ethnographic approach to evaluating narrative therapy is not recognised under EST criteria.

EBPP policy is more inclusive of ethnography but limits and devalues its use. Proponents of EBPP viewed ethnography as "especially useful for tracking the availability, utilization, and acceptance of mental health treatments as well as suggesting ways of altering these treatments to maximize their utility in a given social context" (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 274). Accordingly, there is some acceptance of ethnography in EBPP. However, such a statement on 'usefulness' and 'utilisation' relegates/marginalise ethnography to *clinical utility,* defined as "the applicability, feasibility, and usefulness of the intervention in the local or specific setting where it is to be offered. This dimension also includes determination of the generalizability of an intervention *whose efficacy has been established*" (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 275, italics added). This implies that ethnography is to be used *after* a therapy's efficacy has been established where efficacy is favoured by "randomized controlled experiments [which] represent a more stringent way to evaluate treatment efficacy because they are the most effective way to rule out threats to internal validity" (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 275). EBPP's evidence hierarchy locates ethnography lower than experimental designs and therefore marginalises its value. Ethnography is a 'threat to internal validity.'

As I found in my genealogical investigation of psychotherapy evaluation, EBPP is a model that emulates the principles of evidence-based medicine – namely, medical scientific discourse. The American Psychological Association Presidential Task Force

on Evidence-Based Practice (2006, p. 274) calls EBPP an "integration of science and practice" where "good practice and science call for the timely testing of psychological practices" in a manner that "adequately operationalizes them using appropriate scientific methodology." Moreover, the American Psychological Association Presidential Task Force on Evidence-Based Practice (2006, p. 280) produced the statement that their document was a reassertion that the "scientific method is a way of thinking and observing systematically, and it is the best tool we have for learning about what works for whom." Such phrasings/statements calling to "test" and to "operationalise" as "good science" with the "scientific method" as "the best tool" form a denotative narrative of scientificity that contributes to a moral assumption of what is "good science" in that a positivist epistemological stance is the best way to (per)form research and therapy.

Ethnography does not fit with evidence-based notions of "good science." The EBPP moral assumption of "good science" parallels the research ethic/methodolatry of applying EST criteria of "good experimental designs" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 21). Indeed, the statement that experiments are "sophisticated empirical methodologies" (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 275) ties in well with the statement that the "scientific method" is "the best tool" because it can be "operationalised" in order to "test" hypotheses. Such an assumption also fits with with the standardisation part of experimental design, inherent in the criteria of ESTs, that produces manualised therapy for therapists to practice. Ethnography is an interpretive and exploratory methodology that values thick description (Geertz, 1973, 1983); its methodology is not languaged through hypothesis testing and variable control. The "good science" assumption may privilege the (re)production of ESTs in/through artificial laboratory settings at the expense of researching therapy in 'real life' practice settings.

Although EBPP accepts ethnography, it positions O'Connor et al.'s (1997) and Gardener and Poole's (2009) narrative therapy ethnographies within/through a positivist, medical regimen. Such as regimen suggests that expert-driven objective 'observation' through the scientific method (with experimental design as 'best method'), produces best evidence. Both EST and EBPP discourse reproduce this metanarrative of 'good' (experimental) scientific method, which marginalises ethnographic evaluations of narrative therapy. Metanarratives are continuations of truth

statements that guarantee its legitimacy (Lyotard, 1984). There are, what Lyotard called, 'meta-prescriptives', which are presuppositions of science that legitimate what is admissible *as* science. Ethnographic concepts, such as thick description (Geertz, 1973, 1983), (in)form the post-postivist epistemological descent and process of narrative therapy, which is also critical of the logico-scientific mode of positivism with its search for universals (Madigan, 2011; White & Epston, 1990). EBPP and EST discourses assume that ethnography is a lesser science because they meta-prescribe experimental design, informed in/through positivist principles, as the gold, stringent standard for psychotherapy evaluation. EBPP and EST discourse marginalise or ignore narrative therapy through a devalued ethnography and violate its epistemology through evaluating it with 'more stringent' positivist methodologies.

Nevertheless, ethnography fits well with the theoretical descent of narrative therapy due to a range of ethnographic influences (i.e., E. Bruner, 1986a, 1986b, 1994; Geertz, 1973, 1983; Goffman, 1961; Myerhoff, 1982, 1986; Turner, 1969, 1974; see Chapter 3). This suitability appears to be especially pertinent to Myerhoff's (1982, 1986) contributions as a participant observer in definitional ceremonies that enable corroborative performances, and outsiders who witness the performance, to transform meaning where desires and wishes of participants can become confirmed, visible, and told into existence. Edward Bruner (1986a, 1986b) also asserted that narrative performances of expression construct our lives and can give new meaning to our ethnographic accounts of lived experience. Turner (1986) argued that rituals of change influence experience in/through refashioning it and making it meaningful. Accordingly, ethnography seems a suitable 'evaluative' methodology for narrative therapy.

The ethnographic studies by Gardener and Poole (2009) and O'Connor et al. (1997) conceptualise evaluation differently to the expert-driven discourse of empirically supported treatments and evidence-based practice in psychology. These narrative therapy 'evaluation' studies view understanding experience, particularly the meaning of experience, as a goal of evaluation (similar to Guba & Lincoln, 1989; Schwandt, 1997). O'Connor et al. (1997, p. 493) argued that "clients' experience in evaluating effectiveness of therapy is the core of the research" and ethnography "seeks to understand and explain that experience ... from the families' point-of-view." The purpose of O'Connor et al.'s (1997) research was to "discover clients' perceptions and the meaning that they attribute to their experience of narrative therapy" (p. 482). Similarly, Gardener and Poole (2009) examined client experience as well as their

experiences of therapy. So, a qualitative, ethnographic examination of *understanding* client *experience* is one possible and suitable way to evaluate narrative therapy.

Such ethnographic conceptualisations of evaluation are in complete divergence to EST discourse where the rule/process of practice is not in understanding experience but in measuring changes in symptomology of a clinical disorder, matched to a specific treatment. There must be an identified "population, treated for specified problems" (Chambless & Hollon, 1998). EST proponents have listed their 'well-established treatments' according to strict experimental and standardised design, which includes psychometric instruments to measure therapeutic change. For example, Butler, Fennell, Robson and Gelder's (1991) comparison of behaviour therapy and cognitive behaviour therapy *for* generalised anxiety *disorder* used psychometric scales such as the Beck Anxiety Inventory (BAI), the Beck Depression Inventory (BDI), the State-Trait Anxiety Inventory (STAI) and the Dysfunctional Attitude Scale (DAS). Phrasings in EST discourse such as "depressed patients assigned to the problem-solving treatment experienced greater symptoms reduction" (DeRubeis & Crits-Christoph, 1998, p. 40) typify a reduction of experience to measurement- and statistically-based variables and thin descriptions. Expert professionals administer pre-defined assessment questions to clients. Such professionals are "university researchers, clinicians and/or health service managers with very occasional input from client groups" (Speedy, 2004, p. 44). They administer and evaluate disorder-focused treatments in controlled and manualised laboratory-like research settings (Chambless & Hollon, 1998; Kazdin & Weisz, 1998). This prepackaged therapy delivery system silences does not value giving voice to and contextualising client experience as ethnography and narrative therapy does.

Other discontinuities of psychotherapy evaluation involved textual analyses of narrative therapy. These included analysing language *in situ* in therapeutic contexts (Kogan & Gale, 1997; Muntigl, 2004). These studies were process-focused approaches to evaluation. Evidence-based psychotherapy evaluations have been criticised for overlooking the therapy process in that its proponents often narrowly predefine and frame it in medical terms (Norcross, 2001).

Unlike EST evaluation, textual analysis is not typically a standardised research practice. Similarly, narrative therapists do not assume that there is a standardised process of assessment and treatment. In evaluation, narrative therapists often commit quite strongly towards embedding their approaches "in the histories and archives of their practices and in the knowledges of the people consulting them" (Speedy, 2004, p.

45). Kogan and Gale's (1997) textual analysis of narrative therapy examined three 12-minute segments (beginning, middle, and end) of a transcript of videotaped couples' therapy session with Michael White as the therapist. The white, heterosexual, and married couple were Tom, who was in his forties, and Jane, also in her forties. The couple wanted to maintain changes with their current therapist where Tom's role was to be more active and assertive with Jane, while Jane assisted in enabling Tom to express his views and be more in charge. The turning point in therapy was when "Tom began he could feel he could disagree with Jane, and she began to respect him more since he stood up to her" (Kogan & Gale, 1997, p. 109). However, there were also gender issues that emerged around Tom constructing expectations of Jane through androcentric discourse. A textual analysis made visible these local details and particularities, linked to wider discourses, rather than what Speedy (2004) noted in evidence-based psychotherapy outcome research as a form of textual smoothing in/through a "one-size-fits-all style" (p. 44).

Kogan and Gale's (1997) analysis was drawn from a combination of methods from conversation, discourse, and narrative analysis, from postmodernist premises, consistent with narrative therapy, to provide an account of how context can be created through talk between therapist and clients. The analysis did not adopt the empiricist view of language as a medium to express observably 'true'/'(f)actual' behaviours (i.e., "this is what s/he actually meant"). Instead of the empiricist "voice of god ... all-seeing authority" (Speedy, 1994, p. 44) approach in evidence-based psychotherapy, they focused on "how language and discourse *functioned* to create possibilities for meaning and interaction" (Kogan & Gale, 1997, p. 102, original italics). Their analysis involved a less detailed and less micro-analytic focus than conversation analysis (CA) due to the concern that such a focus on the minutiae of turn-by-turn talk would obscure its embedded sociocultural context (Kogan & Gale, 1997). They argued that issues of "conflict, oppression, and differential power arrangements are lost in the microscopic analysis" (Kogan & Gale, 1997, p. 105). Although they focused on the turn-by-turn construction of meaning, they used concepts from discourse and narrative analysis to conceptualise how a positioning of a person is embedded in a wider social order (see Strong, 2008 for another CA-esque look at narrative therapy). In their analysis, they used theory from Smith (1990) and Foucault (1980) to conceptualise how wider social orders enable representations to be locally produced and to be aware that "meaning, while produced locally, is embedded in 'strategic envelopes' of possibility such that not

every meaning has an equal chance of being produced" (Kogan & Gale, 1997, p. 106). Such a conceptualisation is compatible with the Foucaultian focus in narrative therapy on examining and challenging the production of systems of knowledge, discourse, and power (White & Epston, 1990; Drewery & Winslade, 1997).

In examining and contextualising the turn-by-turn accomplishment of meaning in conversation, Kogan and Gale's (1997) textual analysis visibilised power relations in play between Tom and Jane in relation to androcentric discourse. Both EST and EBPP proponents adopt positivist discourse whereby the 'objective' process of evaluation masks the politics of its (re)production. However, narrative therapists are interested in the politics of therapy (Speedy, 2004), which is what (critical) textual analysis can visibilise. The therapist facilitated a deconstruction of the wider social context of the problem, shared authority, and made the "meaning-making process democratic" (Kogan & Gale, 1997, p. 122). The therapist used a *reversal* practice, a technique that "subverts or reverses a dominant narrative" (Kogan & Gale, 1997, p. 119) to decentre accounts. Tom talked about how Jane had not been 'dressing up' for Tom for a while. The therapist asked Tom if he would do the same for Jane to which he replied, "I may have lost that also, yes I would you bet" (Kogan & Gale, 1997, p. 120). Kogan and Gale's (1997) analysis of this segment is placed within a wider social context by referring to Smith's (1990) discussion on masculine discourse and how the "gaze of masculinity organizes female behaviour in ways that are not reciprocal" (Kogan & Gale, 1997, p. 120). Using Smith's (1990) discussion, Kogan and Gale contextually interpreted that Tom stated a typically prescriptive male-centric stance that neglected the effects of such a stance on an 'other' (i.e., Jane). They interpreted the therapist as reversing this stance by shifting to the perspective of the 'other'/Jane, to which she answered that it was important for Tom to 'dress up' for her. This shift, according to Kogan and Gale (1997, p. 121) enabled Tom to reflect on and deconstruct a male-centric discourse and his positioning of Jane:

> I think sometimes you get so caught up in it ... that I don't quote dress for Jane either ... but that's ok for me because I'm the breadwinner right so the man doesn't have to dress for the woman ... but I can see the importance me maybe dressing for her too from time to time...

In their analysis of narrative therapy, Kogan and Gale's (1997) phrasing/statements of 'evaluation' are produced in/through a post-positivist discourse,

which are at odds with EST and EBPP discourses. They used interpretivist statements such as “decentring”, “text”, “context”, “discourse”, “narrative”, “meaning-making”, “construction”, “deconstruct”, “marginalised”, and “turn exchanges” to make sense of the social context of therapeutic conversation. They valued talk “as an agent that must be evaluated by its consequences” (Kogan & Gale, 1997, p. 123). Their ‘evaluation’ examined the process of clients’ conversational accomplishments, and attempted to make sense of the effects and consequences of such accomplishments in/through a wider social context. In resisting positivist epistemology, they concluded:

> In accord with post-positive research in both qualitative and quantitative efforts, we envision research as the production of knowledge that is always informed by theory, systems of method, and social context. (Kogan & Gale, 1997, p. 123)

In contrast, a genealogy of evidence-based psychotherapy evaluation discourse in psychology showed an authoritative regime that reductionistically decontextualises clients instead of looking for broader social influences. Instead of “constructing” a “narrative” of client “context”, EST proponents privilege clearly defined “samples”, and predefined “measures” of “disorders” and their statistical outcomes (Baucom, Shoham, Mueser, Daiuto, & Strickle, 1998; Chambless & Hollon, 1998; deRubeis & Crits-Christoph, 1998).

Experimental studies that evaluate ESTs for specific disorders negate the social, dialogical context of the client and therapist. Pre-treatment and post-treatment measures from assessment instruments produce aggregated statistics of therapeutic change in EST evaluations (e.g., Barlow, Craske, Cerny & Klosko, 1989; Butler, Fennell, Robson, & Gelder, 1991; Chambless & Gills, 1993; Clark, Salkovskis, Hackmann, Middleton, Anastasiades, & Gelder, 1994; Ledley et al., 2009). Such measures capture client responses to predefined, standardised questions about symptomology and functioning, usually in an aggregated sample bar single case experiments. Yet, they cannot portray *in situ* the relational context of somewhat improvised, moment-by-moment turns of conversational accomplishments between participants and its construction of possible meanings within a wider social context. Textual analysis visibilises this dialogically contextual creation of meaning. Yet, Kogan and Gale’s (1997) study is ignored or undervalued by those who privilege standardised assessment and treatment through the gold standard of the experimental method in the EST and EBPP movements.

Although EBPP discourse encourages an exploration of socio-cultural context and includes qualitative research (APA Presidential Task Force on Evidence-Based Practice, 2006), again, such a framing is constrained by its use of positivist medical discourse. For instance, EBPP policy encourages the examination of cultural influences in psychopathology in contrast to locating and critiquing psychopathology within wider socio-cultural discourse. Furthermore, reducing the "family, organization, community, or other populations receiving psychological services" (APA Presidential Task Force on Evidence-Based Practice, 2006, pp. 273, 284) to a "patient" downplays the importance of relational contexts in such systems (see Strong, 1993). A patient is a value-laden term that is historically embedded within hierarchical relationship practices between the expert clinician, who knows best and administers treatments, and the docile medical patient. Yet, narrative family therapists collaboratively 'map' with families, the influence of relationships as an examination of the effects of power and discourse (Gladding, 2002). Such a collaborative mapping seems less possible in a medical discourse of evidence-based practice that privileges a hierarchical relationship between the expert-knower clinician and the docile patient.

Textual analysis can also map the production of improvised meaning in narrative therapy, which provides a thicker description of the therapy process than often-used pre-test and post-test measurements in evidence-based psychotherapy evaluation. Muntigl (2004) conducted a textual analysis of a couple's (Fred and Wendy's) relationship in narrative therapy using linguistic-semiotic analysis – or systemic functional linguistics (SFL; Halliday, 1978, 1994). SFL assumes that meaning generation involves drawing from our diverse contexts of meaning making (Halliday, 1978). Muntigl analysed language use *in situ* and examined turn-by-turn conversations from transcripts of video- and audio-taped sessions. However, rather than contextualising the conversation like Kogan and Gale (1997), his use of SFL methodology purportedly enabled him to examine how clients construct meaning through their utilisation of textual resources. He found that there were three stages of the therapy process involving different semiotic repertoires (beginning, transitional, and developed), which involved the use of different resources that enabled different genres of talk. The first stage involved a narrative genre of the clients using extreme case formulations (recounts of extreme behaviours) and negative evaluations.

An analysis of textual resources enabled Muntigl (2004) to show a shift in the therapy process. The middle stage involved an expository genre of talk with the

therapist asking questions to map the influence of the problem and to externalise it in order to co-produce a new narrative. Muntigl (2004) used the SFL notion of the semiotic concept of causality to examine conditional-causal meanings produced in narrative therapy. This is different to the experimentalist assumption of causality in EST and EBPP discourse that there is an objectively controlled, observed, measured and mono-directional singular cause and singular effect. SFL uses a semiotic notion of causality that enables the production of multiple meanings of causality (Halliday, 1994). For example, the therapist provided a conditional-causal question to Fred, "what ... impact or effect ... does this lecturing style ... what impact does that have on you" (Muntigl, 2004, p. 120).[116] This enabled Fred to reconstitute the problem as an external object that had different influences on him and thus had various meanings: "it makes me feel... like a child... it makes me feel ... like ... I'm ignorant ... that I can't grasp it quickly" (Muntigl, 2004, p. 120).

In examining the final stage of the conversations, Muntigl (2004) found that clients began using linguistic resources, enabled through the previous externalisation stage of therapy, to efface problems. The clients' construction of a new narrative genre produced shifts where the new narratives "seemed to foster a host of new opportunities for clients, opportunities that provided new directions for relating with others" (Muntigl, 2004, p. 130). This new narrative genre was analysed using Labov and Waletzky's (1967) generic stages of narrative construction: abstract, orientation, complication, evaluation, resolution and coda. The resolution was that Fred storied that he made a decision faster than he used to and did not care about doing things the wrong way. In Muntigl's (2004) analysis, the presenting problem had also *changed* throughout therapy from Fred's lecturing style to him having to make decisions and his fear of doing things the wrong way. EST discourse cannot language such textual indeterminacy, valued in narrative therapy, because EST criteria assume that clients *must* have a singular, fixed clinical disorder that never changes throughout their therapy.

Muntigl's (2004) semiotic-focused analysis resonated with the ideas of multiple textual and narrative constructions of meaning in narrative therapy's theoretical descent. Edward Bruner's (1994) argued that meaning is formed from how we read or experience texts, and Jerome Bruner expressed a similar view in that "literary texts initiate 'performances' of meaning rather than actually formulating meaning

[116] Note that the marks of omission in this quote and the subsequent quote below it are not my or Muntigl's omissions. They indicate the therapist's pauses.

themselves" (Bruner, 1986, p. 25). Accordingly, in narrative therapy, different possible meanings can be produced through how we (con)textually perform and constitute them (White & Epston, 1990). With SFL, "interactants draw from systems of meaning in co-constructing their social worlds" (Muntigl, 2004, p. 110) and Fred drew from linguistic resources in the therapy conversation (the externalisation of a problem in the sense of its influence) to co-produce different, multiple causative meanings of the problem.

Muntigl's (2004) study violates the positivist assumption of causality in EST and EBPP discourse – that the experiment is the best and most stringent method to understand causality. Such an assumption is evident in EST and EBPP discourse: "we believe that randomization (or its logical equivalents) affords a particularly compelling means of testing for causal agency" (Chambless & Hollon, 1998, p. 14), and "single-case experimental designs are particularly useful for establishing causal relationships" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 274). Further, "RCTs and their logical equivalents (efficacy research) are the standard for drawing causal inferences about the effects of interventions" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 274). These phrasings/statements on causality (re)produce experimental methodolatry, viewing experimental design as the norm for establishing causality. Muntigl's analysis viewed causation as a semiotic concept, one that can have multiple representations that could create conditions to enable empowerment and multiple meaning.[117]

Adding further to discontinuities of psychotherapy evaluation, there are studies that did not apply any explicit theoretical or methodological stance to inform their work (save, perhaps narrative therapy). Some studies simply described therapist and client experiences of narrative therapy in the form of a case report (e.g., Clare & Grant, 1994; Huntly & Owens, 2006; Kropf & Tandy, 1998; Merscham, 2000; Nylund, 2002; Rothschild, Brownlee, & Gallant, 2000; Wetchler, 1999). A synopsis of each case study follows. Elizabeth, an 80-year-old woman, stated she was experiencing depression because her vision and mobility had worsened (Kropf & Tandy, 1998). Forty-five-year-old Susan was anxious about travelling, had anxiety attacks, and feared losing control of her life (Wetchler, 1999). Richard, 53, was an AIDS sufferer who had attempted suicide and experienced depression (Rothschild, Brownlee, & Gallant, 2000). Yana, 17, experienced a range of difficulties including problematic peer relationships (Huntley &

[117] That said, such a perspective does not appear to fit with social constructionist views that consider *conversation* as interpretive practice.

Owens, 2006). Nannette, 33, was battling anorexia (Nylund 2002). A 23 year-old woman, Summer, had been suffering from post-traumatic stress disorder (Merscham, 2000). Another case study examined narrative therapy for four intellectually disabled women (ages 16, 22, 27 and 32 years) who were survivors of sexual abuse (Clare & Grant, 1994). While EST criteria do not recognise descriptive case studies, EBPP criteria place them at the bottom of the evidence hierarchy under 'clinical observation' as a way of generating hypotheses for more 'sophisticated' evaluations (APA Presidential Task Force on Evidence-Based Practice, 2006).

Using a narrative approach (Riesmann's (1993) narrative validation criteria of coherence and plausibility), I found that most of these descriptive case studies coherently narrated changes in client experience, and their shifts in meaning, from pathological-based accounts to strength-based accounts (except Clare & Grant, 1994; see Busch, 2007). For example, Richard stood up to work habits controlling him and felt content (Rothschild, Brownlee, & Gallant, 2000), Summer saw her family as a strength and began to feel comfortable around men (Merscham, 2000) and Elizabeth realised her self-worth through her former husband and saw herself as an adapter and survivor (Kropf & Tandy, 1998). Susan recognised herself as a meticulous planner (Wetchler, 1999), Jana found confidence and made new friends (Huntley & Owens, 2006) and Nannette conceived herself as a successful poet (Nylund, 2002).

From these narrative therapy 'evaluations', what is apparent is that they are products of a plurality of methodologies (e.g., experimental research, discourse and narrative analysis, ethnography, heuristic inquiry) and methods (e.g., interviews and case studies). There are potential possibilities for evaluative approaches as well such as definitional ceremony as a form of collaborative research (Speedy, 2004), narrative interviews, life stories through the co-authoring of poetic documents, writing as inquiry and auto-ethnography (Speedy, 2008). There are instances where the epistemological stances of particular methodologies do not seem to suit the epistemology of narrative therapy such as experimental methodology and heuristic inquiry. However, the range of post-positivist methodologies, including the ethnographies, the (con)textual analyses, as well as the descriptive case studies, suit the post-positivist epistemological stance of narrative therapy.

This context of a plurality of 'evaluations' in a genealogical investigation of narrative therapy discourse is in conflict with the discourse of evidence-based psychotherapy evaluation in psychology, which strives towards the gold standard of the

experimental method. The EST movement advocated for the experimental method as the *best* method for evaluating psychotherapy. It was the *only* method proposed in their criteria. The EBPP evidence hierarchy, placing experimental design at the top, also suggests that the experimental method is the best method to evaluate psychotherapy. The experimental methodolatry of both EST and EBPP movements devalues the importance of a plurality of qualitative methodologies that seem suitable to 'evaluate' narrative therapy. There are two divergent genealogical contexts, one involving the descent and discourse of evidence-based psychotherapy evaluation in psychology and the other involving the descent and discourse of narrative therapy. This divergence indicates an uneven power relationship, a differend (Lyotard, 1988), where EST evaluation and EBPP are authoritative and dominant discourses of evidence-based psychotherapy evaluation. Experimental methodolatry enables a valuing of evaluations and therapies conducted through positivist experimental designs but this marginalises post-positivist evaluations of narrative therapy that are congruent with its epistemological descent. There are 145 efficacious treatments identified for specific disorders (see Chambless & Ollendick, 2001). Yet, there is a relative paucity of narrative therapy evaluations (Etchison & Kleist, 2000; Gardner & Poole, 2009). In general, these evaluations are languaged outside of the authoritative EST and EBPP discourses, which is also symptomatic of a differend.

Accordingly, there is a methodological conflict between narrative therapy and evidence-based psychotherapy evaluation discourses. The evaluation genre seems to value standardisation, manualisation, experimental methodolatry, statistical aggregation of client data, medical objectification, diagnosis, administration of therapy by the expert therapist on the adherent client, reductionist accounts of clients through psychometric measures, and 'universal' criteria to judge evaluations. In divergence, the other(ed) narrative therapy discourse genre values the unique case of the client(s), collaborative relationships and conversations, co-authoring, textual indeterminacy such as changes/shifts in the meaning of problems, influences, and experience, as well as valuing the socio-political context of the client, therapist and therapy itself. There is no one-size-fits all model of evaluation. Narrative therapy and its 'evaluation' discourses embrace the heterogeneity of client backgrounds and problems, along with the fluidity of their meaning constructions throughout the therapy sessions. In contrast to narrative therapy practices, evidence-based psychotherapy outcome evaluation is "not uncertain, incomplete, non-commensurate, contingent, tentative or ambiguous" (Speedy, 2004, p.

44). Rather, client voices, cultural backgrounds and local accounts are "'smoothed out' of the text, subsumed into 'grand narratives' about, for example, addiction, abuse or eating disorders" (Speedy, 2004, p.44).

Thus, I come to an apparent impasse, a differend as an historical problematisation of two divergent and discontinuous genealogical contexts that produce two genres of discourse that are at odds with each other. Evidence-based psychotherapy evaluation discourse stipulates the application of universal criteria to evaluate/judge therapy through EST and EBPP evaluations. It involves pre-scriptive and proscriptive language game with the production of policy on evidence criteria and the use of terms such as "should"[118] and "must" (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006; Chambless et al., 1998; Chambless & Hollon, 1998; Chambless & Ollendick, 2001; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). This produces an obligation for psychologists to do evaluations through such evidence-based criteria. The post-positivist, postmodernist aspects of narrative therapy discourse do not fit the universalist criteria of EST and EBPP evaluation. This is an epistemological conflict between a pre-scriptive objectivist discourse and descriptive, interpretivist/constructionist discourse. Narrative therapy discourse does not value prescriptive practices. It does not stipulate universal criteria for its evaluation, as that would violate its postmodernist philosophy. Narrative therapy *describes* therapy and methodology, method, and meaning in its 'evaluation' discourse more than it prescribes it. Due to narrative therapy's postmodernist and post-positivist descent, its proponents cannot use universal criteria in/through EST and EBPP evaluation to argue for or 'prove' their legitimacy for others to hear, acknowledge and value their research. In using universal criteria of an incongruent discourse, a proponent of narrative therapy discourse would be "divested of the means to argue and becomes for that reason a victim" (Lyotard, 1988, p. 10).

The universal criteria produced by the EST and EBPP movements are based on an assumption that there *is* a shared understanding of evidence in that it is produced in/through the scientific (i.e., *positivist*) method (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006; Kendall, 1998). Yet, proponents of *post-postivist* narrative therapy discourse do not share and therefore resist that assumption. Any articulated assumption that is contra to the authoritative

[118] See Chapter 5 for 'should' statements of EST discourse.

dominance of evidence-based psychotherapy evaluation discourse in psychology constitutes a resistance. "There are no relations of power without resistances" (Foucault, 1980a, p. 142). Thus, such 'resistance' by narrative therapists forms an uneven power relationship with the proponents of evidence-based psychotherapy evaluation discourse in psychology.

What if a proponent of narrative therapy discourse resists, whether intentionally or unintentionally, such universal criteria by being critical of it (e.g., Speedy, 2004, 2008) and/or produces alternative methodologies that suit the epistemological descent of narrative therapy (e.g., O'Connor et al., 1997)? According to Foucault's (1980) notion of genealogy, hierarchical scientific discourse of the EST and EBPP movements would subjugate or marginalise such knowledge generated by O'Connor et al. (1997) and Speedy (2004, 2008). Furthermore, according to Lyotard's (1988) differend, when those works of O'Connor et al. (1997) and Speedy (2004, 2008) are judged within the authoritatively dominant evidence-based psychotherapy evaluation discourse and its universal(ising), positivist criteria, their post-postivist works are negated. Thus, in such a situation of a differend, "a complaint is heard, but the one who is a victim, and who is perhaps the same one, is reduced to silence" (Lyotard, 1988, p. 10).

Chapter 7
Addressing the Differend: Towards a Conclusion

How can narrative therapy be evaluated? Perhaps some universal criteria are needed to judge both genres and contexts of psychotherapy evaluation discourse in psychology and narrative therapy discourses? In *The Differend*, however, Lyotard (1988) argued that applying universal criteria to judge is impossible. He argued that discourse is necessarily political in that there are stakes involved in discourse and so universal value-free criteria are not possible.[119] Further, because there are political stakes involved in discourse, conflict and incommensurability are inevitable and, therefore, differends are inevitable (Lyotard, 1988; Rojek & Turner, 1998; Smart, 1998). Inevitability makes it impossible to establish universal criteria for 'everyone' to agree to. For instance, the literature on the 'evaluations' of narrative therapy, excluding Besa (1994), can be conceptualised as resistances to the one-size-fits all universal criteria for evidence in empirically supported treatment and evidence-based practice discourses. There is the possibility that some narrative therapy proponents deliberately chose to resist such evidence criteria/discourses and so put forward their own 'evaluations' (e.g., Speedy, 2004, 2008). There is also the possibility that proponents of ESTs and/or evidence-based practice will judge (or have already judged), in their discourse genre, such narrative therapy 'evaluations' as unconventional. This differend creates a condition of impossibility such that neither proponent of their discourse genre can transcend the differend without violating the other genre of discourse (Lyotard, 1988).

If, as Lyotard (1988, p. xii) argued, there is an "impossibility of avoiding conflicts (the impossibility of indifference)" and "the absence of a universal genre of discourse to regulate them (or, if you prefer, the inevitable partiality of the judge)," how can this differend between narrative therapy and psychotherapy evaluation in psychology be dealt with? My interpretation of Lyotard's view on the problem of the differend is that a differend does not need transcendence. Rather, a differend needs *addressing*. One way to address a differend is "to save the honour of thinking" (Lyotard, 1988, p. xii). Lyotard argued that a differend could be addressed by

[119] The constructivist evaluators, Guba and Lincoln (1989) also assert that evaluation is not value free in that each evaluation action is political due to the values that the evaluator brings and the plurality of values involved in interpreting findings.

philosophising, reflecting and thus being reflexive. The style of the *The Differend* is "philosophic, reflective" (Lyotard, 1988, p. xiv) in discovering the rules of different genres of discourse that bring about a differend. In doing so, the reflecting philosopher attempts to create/find new idioms to express the differend (Lyotard, 1988). Another way to address a differend, Lyotard (1988) hinted, and Smart (1998) argued, is to be politically aware. Lyotard (1988) noted that politics is the threat of the differend as it exposes differends as signs of injustices of silencing/wronging 'others' through the judgement of a discourse that is incongruent with the 'other'. Smith (1998) expanded on Lyotard's political approach of addressing differends. Smith (1998, p. 60) stated that it seemed as if Lyotard left an obligation "hanging in midair," an "obligation to conduct just judgements" and to use the differend as an indeterminacy of justice, which enables us to "keep open the question what is just and unjust."

So, in order to *address* the question of how narrative therapy can be evaluated, a politically reflexive stance needs to be taken. It seems that I have already done this. I have politically examined the relationship between narrative therapy and evaluation in psychology. I have done this through conducting a genealogical examination of different contexts of narrative therapy and evaluation and linking them together using *The Differend*. I have reflexively examined my own experience of the differend (see Chapter 1). This differend between narrative therapy and evidence-based psychotherapy evaluation came from my experience of wanting to conduct a project on homework in narrative therapy to which my potential supervisor replied that he was only interested in ESTs. On reflection, I now realise that his articulation was part of the dominant authoritative psychotherapy discourse that was in direct conflict with the philosophical premises of narrative therapy. At the time, I could not express such difference clearly, because I did not have access to the discourse to language a differend. So, I experienced silence, as Lyotard (1988) would have expected. I then came across the works of Foucault and Lyotard and subsequently found new idioms that enabled me to express (i.e., historicise and politicise) the differend, its possible conditions of power relations, and thus construct it into existence. I have reflexively examined my own discipline's (i.e., psychology's) governmentality of evidence-based psychotherapy evaluation. I have examined the emergence of the standardising, objectifying human tech(k)no(w)logies and discourses on the conduct of evidence-based psychotherapy evaluation, often incongruent with the interpretivist, post-positivist and collaborative philosophy of narrative therapy.

Further, to open up possibilities of evaluation for narrative therapy, I have used dissociation as a key strategy of genealogy (Foucault, 1984a) to pluralise the identity/meaning of evaluation. I have done this by showing that there are other, multiple conceptualisations of evaluation in the social sciences outside of psychology that have some congruency with the post-positivist premises of narrative therapy (e.g., Guba & Lincoln, 1981, 1989; Lincoln & Guba, 1985, 2004; Schwandt, 1997; Stake, 1976; 1978; see Chapter 4). I have also shown that narrative therapy research has involved diverse ways of doing and constructing evaluation. These multiple conceptualisations of evaluation and narrative therapy evaluation disrupt positivist assumptions that evaluation is about objectively appraising or assessing the worth of something according to some standardised criteria. Rather, evaluation can be conceptualised much broader in/through a plurality of stances such as through responsive, hermeneutic and constructivist evaluation theories. Such post-positivist stances add diverse views to the value-free aim of traditional evaluation by adopting messier, complex and involved projects of understanding each other through the construction of meaning (Guba & Lincoln, 1989; Schwandt, 1997). There is no standardised 'true' or 'false' binary to weigh against by an expert evaluator but rather a collaborative process of negotiating differences and commonalities in values and understandings between stakeholders (including the evaluator). These alternative and multiple views of evaluation enable a pluralisation of the meaning of evaluation rather than defining and applying it in/through universalist principles of expert-driven objectivity and experimental methodolatry that are (re)produced in/through the EST and EBPP movements.

So, it seems that I have made some way in addressing the question of how narrative therapy can be evaluated from a political, reflexive stance. This has involved me endeavouring be aware of the influences, effects, and consequences (i.e., power relations) of my own attempts (a personal reflexivity; Wilkinson, 1988) and/with psychology's attempts (a disciplinary reflexivity; Wilkinson, 1988) at addressing the research question. (This has also included an awareness of locating myself within and outside the discipline and discourses of psychology to make sense of the question.) Using the works of Foucault and Lyotard, I have been able to contextualise and question the relationship between narrative therapy and evaluation in psychology to address the research question. A Foucaultian reflexivity enables the 'gaze' of psychology to be turned back on itself so that an historical problematisation of the effects of knowledges,

tech(k)no(w)logies, discourses, and power relations (of evaluation) on ourselves and others as psychologists in/through the discipline of psychology can be made 'visible' (Rose, 1996, 1999a, 1999b). I have reflected on my discipline and its effects by examining psychology's contemporary history of evidence-based psychotherapy evaluation. From this, I have unmasked the production of tech(k)no(w)logies and discourses of evaluation governance that serve to (re)produce standardisation, experimental methodolatry, and medicalisation that are in conflict with the theoretical descent of narrative therapy.

In my contextualising and questioning of the relationship between narrative therapy and evaluation in psychology, it appears that narrative therapy discourse *and* post-positivist evaluation discourse are negated/subjugated/marginalised through the emergence of the EST and evidence-based practice in psychology movements. This is because their production of universal evaluation criteria is languaged in an opposing epistemology – the positivist 'scientific method'. In contrast to the EST movement, which stipulated the experimental method as the *only* empirical methodology for establishing evidence, the emergence of EBPP has enabled an inclusion of range of evaluative methodologies. However, this 'enablement' of new methodologies is languaged through positivist inquiry, of "scientific method ... [as] the best tool we have for learning about what works for whom" (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 280). It is also languaged through medical discourse and experimental methodolatry. Consequently, EST and EBPP evaluation movements have not recognised post-positivist evaluation research and theory in the social sciences and narrative therapy.

I am wary of a possible contra-argument made against my argument of narrative therapy discourse (and its proponents) being marginalised/subjugated by evidence-based psychology evaluation discourse (and the possibility of producing yet another conflict and differend). This contra-argument could be that proponents of narrative therapy discourse may also unjustly judge the professional-speak and hierarchical-speak of evaluation discourse *in their own discourse* and that the methodological stance that I am taking is bound up in Foucaultian discourse that is more in line with narrative therapy discourse than EST or EBPP discourse. In other words, one could argue that narrative therapy (and I) am 'wronging' or doing an injustice to EST and EBPP discourses.

To respond to this possible contra-argument, and to use a political, reflexive stance from Lyotard (1988), it is important to think about which discourse appears to be 'silenced' or 'negated' (to use Lyotard's expressions) or 'subjugated' (to use Foucault's expression) in relative terms. Which discourse dominates over and marginalises the other in psychology – narrative therapy discourse or psychotherapy evaluation in psychology discourse? Where does the weight/dominance of the power relationship seem to lie in relation to its resistance? The most obvious answer is that evidence-based psychotherapy evaluation discourse, constituting ESTs and EBPP discourses, is the most dominant discourse in psychology by far and the criteria of both devalue post-postivist methodologies that are congruent with narrative therapy. Therefore, EST and EBPP discourses (re)produce an injustice through their authoritative criteria that marginalises narrative therapy.

Second, my personal view is to value and advocate for methodological pluralism (giving voice, and opening possibilities, to a multiplicity of methodologies in a postmodern era where (con)quests for universal dominance are constantly questioned). My opinion is that experimental methods have a place in evaluation research, but that they should not be 'exclusive' or 'universal' as the only method (as in ESTs) or the best method (as in EBPP) to evaluate – and neither should there be one dominant epistemology in evaluation. These opinions seem to come from my present and past engagement with postmodernist discourse, which values plurality, but also from my other background in learning and teaching experimental psychology. These views mean that I am at least trying to be politically inclusive, not exclusive, even if I unintentionally reproduce differends.

Thirdly, differends seem to be inevitable relations that occur and so it is important to be reflexive about them (Lyotard, 1988). They are a part of everyday life and seem to be impossible to avoid as with the inescapability of politics (Lyotard, 1988; Rojek & Turner, 1998; Smith, 1998) and power relations (Foucault, 1980). I am addressing this inevitability by, what Lyotard (1998) argued, saving the honour of thinking: to philosophise and reflect on a differend between narrative therapy and evaluation in psychology and to "keep open the question what is just and unjust" (Smart, 1998). This political, reflexive posture involves being reflexive of the influence of my own discipline (psychology) on evaluation and narrative therapy, to show an awareness of such influences and their potential conflicts, to contextualise them through a genealogy and to make such influences and conflicts/power-relations visible. The

visibility of the differend enables one to anticipate and address possible consequences, conflicts, damages, wrongs, subjugations/marginalisations and injustices when embarking on any evaluation as a judgement. Such political-reflexive anticipations also enabled me to include the possibility that I may be 'wronging' or doing an injustice to EST and EBPP discourse, and subsequently creating or perpetuating differends, in the context of this thesis.[120] Nonetheless, in adopting a politically reflexive approach, I hope I have helped open a space for enabling further discussions on the relationship between evaluation and narrative therapy.

A Foucaultian genealogical examination of narrative therapy and evaluation in psychology, using Lyotard's (1988) *The Differend*, enabled me to unearth an historical complexity of two different genres of discourse operating from different contexts. This complexity of different contexts enabled me to visibilise the differend between narrative therapy and evaluation in psychology, to make a seemingly 'hidden'/'silenced'/negated problem and conflict (negated in/through universal criteria) visible, so that I and others can 'see' the differend, reflect on it and politically address it.

To tentatively conclude on the question, 'how can narrative therapy be evaluated,' I have answered this question in at least three ways. Firstly, in this chapter, and through the enablement of my third point (see below), I have provided a review of narrative therapy evaluations, showing apparent suitable examples (e.g., ethnographies, textual analyses and descriptive case reports). I have also shown unsuitable examples (heuristic inquiry and experimental design) due to their epistemological incongruity with the post-positivist descent of narrative therapy. It seems that discursive, narrative, and ethnographic research suits the interpretivist theoretical influences of narrative therapy (e.g., Foucault's contribution to discourse; Jerome and Edward Bruner's contribution to narrative; Goffman, Myerhoff, Geertz, and Turner's contribution to ethnography). I concluded that the variety of research approaches (marginal to evidence-based psychotherapy evaluation) indicates a pluralist approach to the evaluation of narrative therapy. Further, some researchers produced a bricolage of methodologies, an ad hoc borrowing from different methodological genres to suit their evaluative aims. For example, Kogan and Gale's (1997) textual analysis used concepts from conversation, discourse, and narrative analysis to fit what they wanted to do,

[120] I thought about how useful it would be to adopt an agonistic stance to produce conflict-based change or to adopt a rhetorical stance by attempting to persuade proponents of psychotherapy evaluation discourse in psychology 'on side' so the injustice of the differend could be addressed. Given the apparent inevitability of differends, there is probably no final answer on this.

which was make sense of participant conversations in a wider social context. Gardner and Poole (2009) used ethnographic methodology to understand the experiences of older adults with addiction and used constructivist grounded theory to understand further such experiences in a thematic framing. Muntigl (2004) used a combination of linguistic-semiotic, Labovian narrative and conversation analyses to understand semiotic-linguistic change in a narrative therapy session. I used a blend of discourse and narrative analysis to examine shifts in client subject positions in descriptive case studies of narrative therapy (Busch, 2007). Such studies indicate a pluralism of methodological use where researchers use multiple methodologies, including combinations and bricolages, for narrative therapy evaluations.

Secondly, to address the question of the evaluation of narrative therapy, I examine the power relation (the differend) between narrative therapy and evaluation discourse. In this genealogy, I uncovered a range of theoretical constitutions (descents, emergences, resistances, and subjugated knowledges) of narrative therapy and evaluation that are marginal to (or subjugated by) psychology's positivist scientific method of evidence-based psychotherapy evaluation. These marginal constitutions, formed in and through various epistemologies (e.g., symbolic interactionism, constructivism, cybernetics, and Foucaultian stances), could serve as possibilities for the further exploration of narrative therapy evaluation. Addressing the power relation between narrative therapy and evaluation discourse enabled me to consider (and appreciate the importance of) epistemological and theoretical congruency between evaluation and psychotherapy.

Through examining some of the marginal theoretical constitutions of narrative therapy, I have found congruent epistemological and theoretical stances between narrative therapy and evaluation. In trying to minimise the risk (but still taking a risk) of being prescriptive or creating standardised criteria, I re-qualify these marginal constitutions as *constitutive possibilities* for inclusion/consideration in the evaluation of narrative therapy. For instance, evaluation *could* be reconceptualised as a practice that employs thick description (Geertz, 1973), a contextualisation of lived experience. Researchers use thick description as an interpretative, contextual method, especially for descriptive case studies, in fourth generation evaluation (Guba & Lincoln, 1989).

If evaluation is reconceptualised as an involved, collaborative practice that includes the goal of *understanding* how we understand each other (Guba & Lincoln, 1989; Schwandt, 1997), an evaluation of narrative therapy could also value

understandings of how meaning is contextually constructed and is transformed/transformative in and through social interaction. Evaluation could value textual indeterminacy, the assumption that a text produces a multiplicity of possible meanings and representations (Geertz, 1983, 1986; J. Bruner, 1986). The evaluator could look for how subjunctive processes (J. Bruner, 1986; Turner, 1986) and the production of different meanings or a'news of difference' (Bateson, 1972, 1979) can transform meaning and client experience in narrative therapy. The evaluation process could involve reflective, collaborative relationships between researchers and participants whereby their enacted interaction constructs meaning (Myerhoff, 1986; Myerhoff & Ruby, 1982; Speedy, 2004). The process of evaluation could involve an inclusive dialogue, aimed at understanding each other (Schwandt, 1996, 1997). The evaluator could use narrative theory to evaluate transformation of meaning in narratives in/through the examination of likely, conceivable, believable and plausible connections between events rather than searching for causal connections to establish evidential truth (J. Bruner, 1986; Riesmann, 1993). The evaluator could also be wary of the effects of power, knowledge, and discourse relations and the effect of disciplinary power (e.g., normative examinations and hierarchical relations) (Foucault, 1977) in relationships between stakeholders in the evaluation process. The evaluator could examine what effects these power-knowledge relations might have on the co-production of meaning in the therapeutic relationship.

Accommodating such *constitutive possibilities* of narrative therapy evaluation would require an interpretative shift in evidence-based practice in psychology (EBPP). This would require an inclusivity of a range of post-positivist epistemological stances in as well as a reconceptualisation of evaluation to include goals of increasing understanding through interpretative, relational and contextual approaches (e.g., Guba & Lincoln, 1989; Schwandt, 1997; see Chapter 4). However, a shift of this kind would also mean violating EBPP's methodological premises, positivist epistemology and its medical discourse.

Ideally, narrative therapy needs to be evaluated in relation to its own terms and discourse. However, even if narrative therapy is evaluated through its own discourse the problem with the differend remains in terms of the legitimacy of narrative therapy evaluation. EST and EBPP criteria may not recognise or value such evaluations. Then again, an argument for theoretical congruency in narrative therapy evaluation could influence proponents of EBPP and further transvert the meaning and practice of

evaluation in EBPP. However, this possibility raises another problem: EBPP proponents could evaluate narrative therapy on its terms but *without* the post-positivist epistemologies and discourse that informed those terms. Like other therapies, there is a danger that narrative therapy could become assimiliated into a positivist medical evidence-based discourse and hybridised into a manualised treatment.

In the current context of evidence-based evaluation, there are both challenges and opportunities to include post-positivist, interpretive and contextual approaches in the evaluation of narrative therapy. How can we evaluate narrative therapy when researchers are encouraged to ascend/aspire to employing context-thinning experimental designs as the gold standard of evaluative practice or adopt medical discourse to describe their clients? Perhaps another possible way would be to explore the merits of practice-based evidence (PBE) and practice-based research (PBR) approach to narrative therapy evaluation. PBE psychotherapy evaluation values therapist-client collaboration (Miller, Duncan, & Hubble, 2004). Duncan, Miller and Sparks (2007) argued for a client-directed evaluative approach that puts clients in charge of therapy, "using their feedback to guide all decisions"(p. 41). Fox (2003) argued that "'evidence' is contingent and needs to be contextualised" (p. 84) but PBR, leading to PBE, could also be emphasised because PBR assumes that "research is not a process of individual discovery but a collaborative activity" (p. 96). PBR is transgressive in that it constantly challenges existing structures and concepts, and rules out one true way of doing things (Fox, 2003), perhaps suiting the post-positivist stance of narrative therapy. PBR is, according to Fox, action-oriented with weight put on emancipating the client. The collaborative, socially contextual stance of PBE and PBR may suit the collaborative process of narrative therapy and seems to have similarities with Epston's (2001) and Speedy's (2004, 2008) co-research practices. However, critical research needs to compare the suitability of the philosophy and principles of PBE and PBR with those that constitute narrative therapy, as well as the political consequences of aligning narrative therapy to PBE and PBR.

Thirdly, to address the question of how narrative therapy can be evaluated, a political, reflexive stance is needed to be aware of and address differends that may emerge from such a question. As Smart (1998, p. 54) aptly states:

> a philosophical politics seems to be able to mark the incommensurabilities between phrase regimens, illuminate differends, and thereby to challenge the

> authority of discourses claiming to be able to resolve disputes by invoking criteria (in)appropriate for translating difference into 'the same'.[121]

To find out how to evaluate narrative therapy is to therefore philosophise, reflect and be reflexive in a political way that enables an awareness of potential epistemological and methodological conflict in order to address such conflict. This involves a contextualising of the research question. The differend emerged from my own historical location in psychology, from where and when I initially experienced it in a relationship between postgraduate student and potential supervisor. Consequently, I have reflexively questioned psychology's/my/ psychologists' involvement in evaluation in relation to narrative therapy through a genealogical examination. Such a political, reflexive stance has enabled me to examine methodological congruencies of narrative therapy evaluations through genealogically making visible an uneven power relationship/differend between proponents of narrative therapy discourse and proponents of psychotherapy evaluation discourse in psychology. Thus, narrative therapy needs to be evaluated with caution. Already there is a plurality of methodologies in the evaluation of narrative therapy. However, due to a differend between evidence-based psychotherapy evaluation and narrative therapy, any future evaluation needs to take into account carefully the epistemological premises of narrative therapy so that its damage/marginalisation is minimised. A political, reflexive stance enabled me to dissociate the identity of evaluation and show its plurality of meaning through genealogy which thus strategically opens up new spaces of evaluative possibilities to "save the honour of thinking" (Lyotard, 1988, p. xii), to philosophise, reflect, and be reflexive on the doing of narrative therapy evaluation. This politically reflexive thinking on narrative therapy evaluation also requires one to consider and address potential differends. We need to be wary of reproducing and perpetuating differends that serve to subjugate, marginalise, negate and/or silence the post-positivist premises and interpretive principles of narrative therapy.

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[121] Evidence-based practice in psychology (EBPP) is an apt example of this. It claims to have come from a consensus of different views and is methodologically inclusive (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006; Wyatt, 2007). Yet EBPP policy is also written in positivist, medical discourse and produces a hierarchy of evidence – all of which are incongruent with the post-positivist epistemological descent of narrative therapy.

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