



Refereed Proceedings of

Doing Psychology: Manawatu Doctoral Research Symposium

Edited by Robbie Busch and Ann Rogerson



MASSEY
UNIVERSITY
TE KUNENGA KI PŪREHUROA

UNIVERSITY OF NEW ZEALAND

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NEW ZEALAND



School of Psychology Te Kura Hinengaro Tangata

ISBN 978-0-473-20102-9

Refereed Proceedings of Doing Psychology: Manawatu Doctoral Research Symposium 2011

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Refereeing Statement:

All papers published in these proceedings have been blind peer reviewed by a minimum of two referees.

Doing Psychology: Manawatu Doctoral Research Symposium: 7 December, 2011, School of Psychology, Massey University, Palmerston North, New Zealand.

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Citing Papers from this Online Edited Book of Proceedings:

Here is an example in APA style:

Name, Initial. (Year). Title of paper. In R. Busch & A. Rogerson (Eds.), *Refereed proceedings of Doing Psychology: Manawatu Doctoral Research Symposium 2011* (pp. x–y). Palmerston North, New Zealand: School of Psychology, Massey University. Retrieved from <http://mro.massey.ac.nz/handle/10179/2645>

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Preface

Welcome to the refereed proceedings of the inaugural *Doing Psychology: Manawatu Doctoral Research Symposium 2011*.

The symposium, held in the School of Psychology at Massey University, Manawatu Campus on December 7, showcased the diverse range of doctoral research undertaken at the Manawatu Campus. Papers were submitted by authors who were at various stages of their research. The symposium was a doctoral student initiative in that the proceedings were organised, edited and peer reviewed by doctoral candidates, graduands and recent graduates. We were also fortunate to have international reviewers from Canada and Norway. The symposium was a chance for candidates to disseminate and discuss their research in a supportive environment. It was also an opportunity to both present and publish a concise paper in an online edited book of proceedings. Candidates gained experience in writing and structuring a concise paper to a set format for publication and participating through blind peer review.

The symposium was opened by Associate Professor Mandy Morgan, the Head of School. There were eight paper presentations covering a wide range of topics and methodologies as well as great discussion by staff and students.

We thank everyone who supported the symposium and made it such a memorable and enjoyable event. We look forward to seeing many of you again at the next symposium in 2012.

ROBBIE BUSCH AND ANN ROGERSON
Editors and Symposium Co-ordinators

‘Wade in the Water ...’: Re-thinking Adoptees’ Stories of Reunion

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A b s t r a c t

In 1955, the Aotearoa/New Zealand government legislated the closed stranger adoption period. Approximately 80,000 children were constructed as a legal fiction when deemed *as if born to* a legally married couple. Birth family information was permanently sealed. Yet being raised in a fictional subject position and being denied access to any family of origin has consequences for all involved. After ten years of lobbying, the Adult Adoption Information Act (1985) came into effect. The power of that legislation was to overturn the strategies that suppressed adoptees’ rights to know details of their birth. Adult adoptees over the age of 20 years could access their original birth certificates, which provided a birth mother’s name. With this identifying information, reunions became possible. Birth family reunions involve a diverse range of experiences, reflecting the ways in which adoptees are contextually and historically produced. This paper reconsiders the identity implications of reunion stories using the theoretical concept of hybrid identity. The complexities of reunions are multiple, and adoptees negotiate their identities through being both *born to* and *born as if* and yet neither identity is safe. In the production of this hybrid story, it was possible to see the political and moral trajectories that enable and constrain a sense of self through the complexities of a legal context that produces binary subject positions.

Keywords: Adoption, adoptees, hybridity, identity, birth family, adoptive family, reunion.

Background

In 1955 the Aotearoa/New Zealand government legislated the ‘closed stranger’ adoption period, also known as the ‘complete break climate’. Here illegitimate, unwanted or neglected children could become the child *as if born to* a legally married adoptive couple. Section 16(2)a of the Adoption Act (1955) states “as if the child had been born to that parent in lawful wedlock”. In this way the biological and genetic truth of parenthood is replaced with legal parenthood, yet undeniably both exist (Ludbrook, 1997). This legislated birth created a legal fiction. Fiction in law is a supposition that is a contradiction to fact but accepted because of the practical implications. Legal fictions serve a purpose because they provide solutions to certain problems, in

this case a legitimate identity for those who had none. At the point that the new legitimate identity occurred, birth family information was permanently sealed. Yet, while one apparent problem was resolved, other problems arose such as the disregard for biological identity. ‘Closed stranger’ adoption depended on concealing birth relationships and produced secrecy as necessary to the adoption process. Restricting or stopping contact with the birth parents removed any ‘bad’ influences. This was in the best interests of the child. The ‘complete break’ practice of secrecy based on moral assumptions of ‘good’ and ‘bad’ mothering and enabled through attachment theory represented maternal bonding as vital to producing the ‘good’ mother. Adoption advocates assumed the adoptee would overcome the effects of a birth family ‘break’ in a ‘better’ environment. The adoptive family environment, with its nurturing and care, was alleged to more than compensate for the family of origin (Else, 1991; Rockel & Ryburn, 1988). The adopted child could be shaped and constructed *as if born to* and any difference would never be noticed or could be denied with the birth history permanently sealed. Between 1955 and 1985, approximately 80,000 children were adopted under this system.

Being denied access to a birth history and living the effects of a legal fiction can mean aversive consequences for adopted people, including psychological dysfunction and feelings of homelessness (see for example Griffith (1991), Hoksbergen (1997), Iwanek, (1997), Petta and Steed (2004) and Triseliotis (2000)). Movements protesting the human rights violation of secrecy and denial began to arise. Adoptees themselves began to demand knowledge of their birth histories and saw this as a fundamental human right. After ten years of intense and dedicated lobbying by adoptees and related health professions, the Aotearoa/New Zealand Adult Adoption Information Act (1985) came into effect. Under this legislation adoptees over the age of 20 years could access their original birth certificates (Griffith, 1991). Reunions became possible but opened up new spaces for identity, which could be problematic.

The passing of the Adult Adoption Information Act (1985) enabled adoptees a place to ‘resist’ their birth history secrets. They could challenge the legal fiction

and access information about a birth identity. Given the multiple challenges that adoptees encounter, such as identity diffusion and the sense of not belonging anywhere, it is not surprising that in most cases they search for their family of origin (March, 1995). In my research, I heard stories from adoptees that had initiated a search for their birth origins and those who had been ‘found’ by their birth mothers. They had experienced both the possibility and the impossibility of reunion. Some of their birth mothers were not traceable; some had vetoed access to their information¹, and, even where a reunion was possible, it was not always a solution.

Many of the searching adoptees that took part in this research delayed taking the first step in applying for an original birth certificate, as they were concerned, at times even terrified, that they would encounter a veto that feels like a legalised form of abandonment. They were also acutely aware that a birth family search involved fear of further rejection, abandonment and pain.

Yeah, yeah and there’s also that fear of rejection, of like, you know, being told to fuck off (*Cooley*, 163)

I was scared, I was really scared to umm, to be rejected...I was really scared that if I made contact, I was really scared that - how I would respond emotionally if umm I initiated contact and they said no? (*Barry*, 843, 849)

What if he’d said, buggar off you know?...he could have yeah, so it would have been protecting me as well...from rejection at that level (*Jan*, 421, 423, 425)

Beyond the first step, there are also multiple pathways through the complex processes of creating and maintaining relationships with birth family members. This involves negotiating identities on either side, and in the space between biological fact and the legal fiction of their birth.

A Hybrid Representation

To understand the complex and multiple experiences of reunion and how they matter to adoptees’ identities, I am taking up the metaphor of hybridity. This metaphor produces an understanding of the adopted identity and the positions that are enable or constrained by it. Yet, to realise how this notion can represent the adopted reunion it is important to trace its history and

the way in which it is used. According to Smith (2008), the genesis of hybridity is located in both the hard sciences (for example botany) and the social sciences. In plant biology, hybridity represents the grafting of one plant onto a different root stock (Young, 1999). When considering adoption, this biological metaphor could represent the child grafted onto a different family tree. Once legitimated and constructed *as if born to* a legally married couple the child then grows from another family tree.

Within the social sciences, hybridity is conceptualised as a process of separation from racial, ethnic and/or cultural practices through colonisation. When this separation occurs new practices for ‘being’ in the world are reformed. In this context, new hybrid identities and cultures are constituted when there is a merging of elements of cultures. Here, the notion of hybridity enables new space for producing knowledge of identity and subjectivity in our culturally globalised world (Smith, 2008). In relation to race, ethnicity and culture, hybrid positions enable newly imagined differences after colonisation.

The production of hybrid identities necessarily implicates institutions and power relations, as the grafting of one culture onto another is not a symmetrical process. Historically, hegemonic governance meant that white, western, colonising cultural practices were valued, and these dominant discourses inscribed the bodies of ‘others’ (indigenous, illegitimate, women, girls). Discourse, in a Foucaultian sense, function as the body of statements through which organisations and societies produce rules to direct knowledge, power and truth claims. They construct objects and produce subject positions (Parker, 2002; Ramazanoglu, 1993), so discourse actively governs subject positions and relationships among subjects and objects. At the same time, legislation legitimates particular moral trajectories, excludes others and delimits acceptable practices of citizenship. Through discourse, and law, some subjects are positioned through hegemonic, scientific knowledge, as flawed and in need of fixing when they do not fit the desired norms (Parker, 2005), as occurred with the illegitimate subject. As Smith (2008) posits, these relations of social power disperse and scatter groups of people throughout the world. Such processes of colonisation produce alienation and fragmentation from notions of essential or authentic identity. To take up a hybrid identity means a complex positioning of self within the larger social discourses of class, gender, race and cultural diversity (Luke & Luke, 1999). Hybridity in cultural narratives represents the stories of racial, ethnic and/or

¹ Despite attempts to allow access to previously secreted information after the passing of the Adult Adoption Information Act (1985), it was still legally possible, through a veto, to maintain the secret. Both birth parents and adoptees could place a veto on their records to prevent the release of any identifying information. A veto lasts for 10 years.

cultural identities produced through postcolonial power relations (Smith, 2008).

In postcolonial and cultural studies, the notion of hybridity has shifted from racial discourse of an essentialised notion of a natural category to representing a social constructionist epistemology that rejects essentialist views of identity existing in nature. The social constructionist position, according to Bell (2004), represents self as shaped by context and social interaction. Again, hybridity is a mixing or blending of cultures that occur through experience within the particular cultures. Here hybridity is constructive and represents the ways in which identities are shaped and form over time. Cultural blending is necessary in our global world. Bell argues that it encapsulates the process of regeneration and dynamic change and that any claims of hybridity must be contextualised because ontological hybridity, the identities that 'arise from the *mixture* of two or more cultural origins' (p.125), do not represent a complete break from essentialism. There is still a sense of the natural or the essential embedded in the metaphor, evoked by the idea of 'root stock' onto which another culture is 'grafted'.

Even within a global postcolonial context, producing hybrid identities is problematic. While discussing the movements towards cultural hybridity in Aotearoa/New Zealand, Webber (2008) argues that since one in every ten citizens belongs to more than one ethnic group we need to reconceptualise our national identity to embrace diversity. However, in this process a dilemma occurs for those who are unable to locate self in an ethnic identity category. Not to 'fit' into an ethnic, or a racial category, opens a gap, where a hybrid subject resides, in-between - a "no-man's land" - within continuously negotiated borders.

According to Smith (2008) the possibility of negotiating borders and boundaries, including bodies, language, culture and race can produce advantages. In our global world occupying hybrid space enables both local and global knowledge. When transcending two cultures, knowledge of both enables diversity, multiplicity and fluidity. Hybridity can mean a life constantly punctuated by negotiations. Repeated re-negotiation removes the sense of dislocation or alienation and enables new relationships within specific cultural practices that merge to construct a new hybrid culture.

Theories of hybrid identities are not without critique. Webber (2008) and Bell (2004) describe resistance to hybrid identities in Aotearoa/New Zealand. Internationally, hybridity is realised by non-white minorities who want to gain status in predominantly white societies. However in Aotearoa/New Zealand, resistance

is not about enabling space for the colonised peoples inside dominant Pākehā culture; it involves taking up a unique Māori identity. With the revitalisation of te reo and tikanga Māori, embracing hybridity risks the loss of unique identity. It also appears as if there are two equal though distinct cultures available for hybrid identity formation. However, it has been argued that hybridity perpetuates colonisation through insidious practices of assimilation to Pākehā/Western culture. Bell posits that Pākehā value hybridity because it facilitates Māori to integrate and take up Pākehā customs. Historically, hybridity was viewed as a one way process because racist thought and practices meant that any Māori influences 'tainted' European superiority. Hybridity negates and rejects a distinct Māori identity (Webber, 2008).

While there are arguments against hybridity because some do not easily 'fit' into a particular category which locates them in an in-between space and arguments that caution against its use because of the way in which it reduces one culture to the dominant other, I am still taking up the metaphor of hybridity. Reunion processes are complex and hybridity enables a telling of the reunion story that values the position of *born to* and *born as if*.

Reunion

Research (Griffith, 1991; March, 1995; Trinder, Feast, & Howe, 2004) indicates that particular relational settings can have implications for the reunion process, these include the way in which the birth mother/father respond, the way in which mirroring or difference occurs between adoptees and birth mother/father, the feeling of connection and bonding within a reunion, levels of secrecy and empathy in the relationships, previous expectations, sense of self and boundaries, the adoptive parents reactions and practical factors, such as time and location. There is no contesting that the multitude of events that constitute the reunion experience are important, however here we explore the way in which the legal constitution of an adopted identity means there is always already no distinct adopted identity. And with this an adoptee must try to 'fit' into the binary subject positions of either *born to* and *born as if*.

'Not fitting' or not having a biological family connection opens a gap for the adopted subject: A lack that is realised though the constructed identity of *as if born to* an adoptive family. The imposed legislative identity produces an adopted subject who has to walk in a world that values personal identities which originate with blood ties and a connection to kinship. In this position the relational link that is not blood emerges.

How can you be not blood related but still have that link? (*Toni*, 332)

With no reunion or birth family history, this socially valued biologically connected identity is not possible – there is a gap. For some, after a reunion, connection through genealogy enables new knowledge of self, yet here the adopted identity and the biological identity can remain fragmented. For example, in Barry’s experience, his birth family positions him as belonging to his “own” (adoptive) family and excludes his need to be connected.

They just can’t deal with it, they’ve, they’ve, they, they kind of all believe like I have my own family and you know I have my own life and yeah it’s nice to have, umm, it’s nice that I’m in their lives, arrh particularly for my birth mother, and so I think there’s a lot of respect there for her and their relationship with her...so they’re by proxy with me, but I really get that umm, it’s not with me (*Barry*, 673, 678, 680)

Necessarily, the adopted subject can experience not belonging in either the born to or *born as if* families and here the adopted hybrid subject resides in a no-man’s land. The adopted subject experiences no-man’s land at a very early age and during their lifetime they can return there. Mary, for example, recognises that at some time she had been socially positioned as illegitimate, living in a between space, “no-man’s land”, and Barry experienced himself as “blanked out”.

As I got older, I did think about the illegitimate side of it, you know when you suddenly become aware that children are born out of wedlock. I remember kind of thinking – oh I wonder how that works because I remember thinking that there had to be a time, like when you are born and when you are adopted when you are in no-man’s land (*Mary* 272)

[I was] given away and they just, they probably want to blank that out so you know I’m blanked out so... (*Barry*, 995, 998)

The metaphor of “no-man’s land” signifies the space between two armies, a place where no one is safe. However, by taking up the metaphor of hybridity it enables space for new possibilities beyond that of the *born to* and *born as if*. That space can allow negotiation between and through the borders and boundaries of the two identities, allowing and valuing a diverse, multiple and fluid adopted identity. Here identity occurs through valuing context, social interactions and bodies.

Homi Bhabha (1990) talks about hybridity enabling the possibility of a ‘third space’. In this account, the third space does not arise from being able to trace the two original moments; hybridity *is* the third space. The third space shifts the histories that construct it, and enables new structures and political positions to emerge from the cultural relationships of the past. For Bhabha, hybridity can be understood through a psychoanalytic lens whereby it is not an identity but a process of identification involving the ‘other’/object with which the subject identifies with. Within this theoretical framework, the subject is ambivalent because of their relationship with otherness. Here, hybridity carries the traces of emotions and practices that inform it, always connecting to the other meanings and discourses through which it is constituted. What this understanding enables is a possibility of making sense of the traces of the other/object and how they inform the reunion relation for adoptees, in particular the identification with and through (m)other/s. The embodied adoptee carries the traces of the birth (m)other/object and reunion enables identification with and through her to be realised.

Drawing from Bolatagici (2004), hybridity also realises the contradictions and struggles that are involved in living in-between cultural or social groups. Hybridity signifies a co-existence and enables the representation and interplay between two different subject positions, or locations within a family (Bolatagici, 2004; Carrillo, 1999). Hybridity within the context of this adoption research provides a metaphor to represent the ways in which the adopted subject lives in the world negotiating two identities – the *born to* and the *born as if*. The hybridisation of an adopted identity values the constant interaction that occurs between their families, including inevitable tensions. However it is important to also note that within cultural studies Carrillo (1999) asserts that both identities can exist without contradiction in some cases, which is also possible for an adopted subject. Here it may take effort, strategies of management and valuing the complexity of this existence in-between, but it is possible. Carrillo argues that hybridity enables the acceptance of a dual identity.

Even when both of those identities have not been realised through the process of reunion, the embodied knowing of a birth history shapes and splits the adopted subject. Moreover, if a reunion has been possible, adoptees straddle the two different worlds. They can be simultaneously members of a family and not members.

I see how my two brothers from my birth mother right, I see how they interact together...but they treat me like a brother and they love me, but the three of us sitting in a room, they’ve got something

that I haven't got with them...yeah and they love me (birth father siblings) and they're so open to me and they give me everything, but I haven't got what they've got together (*Brendon*, 612, 615, 620)

They all got, they made this real big deal about the grandkids all being around to take a photo and [my birth brother] was the oldest, and you know. I was excluded from it (*Alice*, 737)

Despite Brendon feeling love, living the binary between connection and disconnection locates him outside; there is no access to the 'thing', the sense of belonging. And Alice is able to interact with her birth family and yet is simultaneously excluded. After a reunion, a new identity may emerge for adoptees which can blend the *born to* and *born as if*. A hybrid identity, as Smith (2008) asserts, can emerge in response to the problematics of having two identities.

When one plant tissue is grafted onto another, the original plant still exists, in as much as it has been grafted onto the other plant (Young, 1999). Similarly, the adopted subject produced as a legal fiction still embodies the 'original self', their birth history. Continuing the hybridity metaphor, when neither plant is pruned the hybrid plant returns to its original stock (Young, 1999). For the adopted person with or without a birth family reunion, returning to the 'original' is not always possible but the longing to return is always already there.

I sort of felt, I wanted, I always wanted to know where I came, who, who I looked like (*Margaret*, 112)

So in this embodied space, the time in which the adoptee is neither *born to* nor *born as if*, a literal and metaphoric birth at the hyphen occurs and without significant care, the adoptee can be returned to the place of no-man's land, here they are not returned to their origin, but to a space in-between.

According to Fine and Sirin (2007), the hyphen can be understood as the a "dynamic social-psychological space where political arrangements and individual subjectivities meet...the psychological texture of the hyphen is substantially informed by history, media, surveillance, politics, nation of origin, gender, biography, longings, imagination and, and loss" (p. 21). How we come to negotiate the hyphen is dependent on the contexts, such as work, family environment or talking with a friend. Fine and Sirin argue that you can be born at the hyphen, in the political faults (fissures) that produce social identities. For some the hyphen is a 'traumatic check point' or a 'space of shame' that may involve

feelings of anxiety. For the adopted person the hyphen can be the conduit to stand in the place of no-man's land.

Hybridity can also be located at the hyphen, however according to Bolatagici (2004), again discussing race, the hyphen obscures the complexity of a mixed race identity. When located at the hyphen it reduces a person to the sum of their parts with the hyphen representing a juncture, a land fault that is unfixable. Bolatagici highlights how this fissure leaves a perception of mixed race people having an innate disunion. For some adoptees, the 'life time in-between' cannot be fixed and when adoptees try to talk about the juncture that cannot be fixed, it is difficult in a world that values blood tie kinship and the adopted subject is acutely aware of the lack and loss.

We were at a, a sort of bit of a gathering and there were some other people there and this woman said – "oh yeah, I suppose she is my daughter". You know and it's kind of like - oh okay, I guess I am, but you know, I guess I came along 20 years later. Was there as a baby, came back 20 years later and there's a life time in-between (*Maxine*, 472)

Unless you've been separate from it and then reconnected to it you aren't going to know that...I mean like if you are not adopted then you've always had that connection...if you haven't been adopted and haven't been reconnected then you don't know you've lost it... 'cause you never, do you know what I mean...like you have to have an awareness of having it then losing it, to know that it wasn't there (*Barry*, 563, 566, 568, 570, 572)

To 'have an awareness of having it then losing it' signifies the adopted disruption. Young (1999) uses the language of "disruption" and "forcing" to represent the notion of hybridity - "making difference into sameness [and] sameness into difference" (p. 26). Here similar becomes dissimilar and different is more than merely different. Young discusses Derrida's logic of 'brisure', the simultaneous breaking and joining, the hinge that produces binary operations to signify the way in which hybridity forces the limitation of one by the other.

Hybridity enables a way to represent adoption reunions and a blending of the *born to* and *born as if* identity for adoptees. It enables the possibility of a third space, which can negotiate the borders and boundaries of the two identities and values the fluidity of the adopted identity. Hybridity also represents the hyphen. However, here it also signifies a gap. The metaphor of hybridity does not adequately represent the in-between space, the no-man's land that adoptees encounter. It does not

represent, when fusion is not defined, where adoptees are unable to meld identities or hinge them together. Future inquiry needs to explore that swing between brokenness and joining and how this enables and constrains an adopted subject.

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The Bewildered Brain: Asymmetric Brain Activity as a Source of Cognitive Impairment in Depression

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Abstract

Individuals with depression commonly complain about cognitive deficits such as memory loss and poor decision making ability (Lahr, Beblo, & Hartje, 2007). However, despite considerable research, no single profile of cognitive deficits in depression has emerged (Ravnkilde et al., 2002). This may be a result of heterogeneity within the diagnostic category of depression. While typically diagnosed as a single disorder, the symptoms of depression may stem from different neurobiological causes leading to different profiles of cognitive deficits. Shenal, Harrison, and Demaree (2003) theorised that subtypes of depression could arise from dysfunctional brain activity in each of the quadrants of the brain (right frontal, left frontal, right posterior, and left posterior). For example, reduced left frontal activity in depression may be associated with impairments in tasks reliant on left frontal regions. Little research has directly investigated the possible link between variability in cognitive deficits and different patterns of dysfunctional brain activity in depression. The current paper reviews evidence for this link by describing depressed individuals' performance on lateralised cognitive tasks, and discusses possibilities for future research.

Keywords: Alpha Power, Brain Asymmetry, Cognitive Impairment, Cognitive Deficits, Depression, Depression Subtypes, Lateralisation, Neuropsychology

Introduction

Depression is a common disorder that affects approximately 25% of New Zealanders during their lifetime (Browne, Wells, Scott, & McGee, 2006). Although depression is usually characterised by negative affect, there is considerable evidence to suggest that individuals with depression may also suffer from cognitive impairment (Hammar & Ardal, 2009; Ravnkilde et al., 2002; Rose, Simonotto, & Ebmeier, 2006). Both the affective and cognitive symptoms of depression seem to be highly heterogeneous suggesting that depression is not a unitary construct and may consist of subtypes (Abramson et al., 1997; Merikangas, Wicki, & Angst,

1994). Different subtypes of depression may be associated with different neurobiological bases which may also result in different patterns of cognitive impairment (Shenal, Harrison, & Demaree 2003). Unfortunately, research into this possibility is sparse. An improved understanding regarding the heterogeneity of depression will help to improve diagnosis and treatment of individuals with depression.

Subtypes of Depression

The heterogeneity observed in the symptoms of depression suggests that depression may not be a unitary construct and may consist of subtypes (Abramson et al., 1997; Merikangas et al., 1994). This observation has led to the development of a multitude of classification systems.

One of the earliest methods used to classify depression described two symptom-based subtypes of depression: exogenous or neurotic and endogenous depression (Kiloh & Garside, 1963). Endogenous depression was said to stem from an internal source and could be diagnosed by somatic symptoms such as psychomotor retardation, weight disturbance and a lowered pulse rate (Pollitt, 1965). In contrast, exogenous depression was characterised by emotional reactivity with hysteria, irritability and could often be linked to a psychological stressor (Pollitt, 1965). These terms were later replaced with the terms 'melancholic depression' to describe endogenous depression and 'non-melancholic depression' to describe exogenous depression (Parker, 2000). Melancholic depression is currently listed as a specifier of depression type in the DSM-IV-TR (American Psychiatric Association, 2000) and is now characterised by loss of pleasure (anhedonia) as well as the somatic symptoms described by the endogenous subtype (Parker, 2000). The term non-melancholic depression has been replaced by atypical depression in the DSM-IV-TR, which is distinguished from typical/melancholic depression by mood-reactivity (Singh & Rais, 2007). Each subtype appears to respond to different treatment

providing evidence for distinct syndromes (e.g., Kiloh & Garside, 1963). Despite such evidence, ‘binary’ classification systems have been criticised as representing differences in severity as opposed to being qualitatively different (Cole et al., 2008; Parker, 2000).

Although symptom based approaches to classifying depression seem appealing due to their relative ease of use, symptoms may appear superficially similar but may result from different neurobiological causes. Classifying depression using neurobiological markers could lead to less diagnostic heterogeneity and may be more useful in developing treatment plans (Gruenberg, Goldstein, & Pincus, 2005). For example, Shenal et al. (2003) theorised that depression could be separated into four subtypes based on abnormal brain activity. Shenal et al. (2003) proposed dividing the brain into four quadrants: left frontal, right frontal, left posterior and right posterior. Dysfunction in each of these regions was theorised to lead to a different subtype of depression. Left frontal regions have been associated with the experience and processing of positive/approach emotions while right frontal regions have been associated with the experience of negative/withdrawal emotions. Therefore, individuals suffering from a relative reduction of activity in the left frontal region they may experience diminished positive emotion and approach motivation accompanied by increased negative/withdrawal motivated emotions leading to depression. In contrast, relatively reduced right frontal activity could lead to depression due to a lack of avoidance of negatives situations leading to depression characterised by learned helplessness. Furthermore, right posterior regions have been linked to arousal and responsiveness. Therefore, an individual with reduced right posterior brain activity may be diagnosed with depression due to reduced arousal and responsiveness. The gap in this model is that little research examined the role of left posterior regions in depression (Shenal et al., 2003). These examples show how different presentations of depression could result from different patterns of brain activity and may reflect different subtypes of depression. As discussed later in this article, there is limited evidence to support this hypothesis (e.g., Bruder et al., 1995; Bruder et al., 2002). Further research into different underlying patterns of brain activity in depression may help to explain the substantial variability observed in the symptoms of depression. One domain in which this could be particularly useful is in understanding cognitive deficits in depression.

Cognitive Deficits in Depression

Individuals suffering from depression commonly report difficulties such as poor decision making abilities,

reduced memory capacity and impaired concentration (Gualtieri, Johnson, & Benedict, 2006; Lahr, Beblo, & Hartje, 2007). However, depressed individuals tend to negatively evaluate their own performance making self-reports of their performance deficits unreliable (Lahr et al., 2007). As a result, research using objective measures has been conducted to determine the true nature and extent of cognitive deficits in depression (e.g. McClintock, Husain, Greer, & Cullum, 2010; Porter, Bourke, & Gallagher, 2007). Deficits have been observed in a wide variety of cognitive domains including short-term memory (e.g., Porter, Gallagher, Thompson, & Young, 2003), decision making (e.g., Taylor-Tavares et al., 2007), attention (e.g., Ravnkilde et al., 2002), and working memory (e.g., Rose et al., 2006). However, the findings have been inconsistent and no single profile of cognitive impairment in depression has been compiled (Hammar & Ardal, 2009). Some research has found evidence of global impairments with deficits in a wide variety of cognitive domains (e.g., Harvey et al., 2004; Ravnkilde et al., 2002) while other research only revealed impairment in a narrow set of cognitive functions (e.g., Sweeney, Kmiec, & Kupfer, 2000). Furthermore, several studies found no evidence of impairment (e.g., Fossati, Amar, Raoux, Ergis, & Allilaire, 1999; Wang et al., 2006).

Inconsistent findings are typically attributed to methodological and sampling differences (Hammar & Ardal, 2009; Porter et al., 2007; Rose et al., 2006). Alternatively, such inconsistencies may not be an artefact of study design but may instead reflect heterogeneity within the construct of depression. Although most diagnoses of depression appear superficially similar, there are subtle differences in symptoms and illness course that suggest clinical depression may consist of subtypes (Merikangas et al., 1994). Unfortunately, subtypes have been given little consideration when investigating cognitive deficits in depression. Different subtypes of depression are likely to have different underlying causes and are likely to show different patterns of cognitive impairment. In order to study the link between cognitive deficits and subtypes of depression, the source of cognitive deficits in depression needs to be considered.

Cognitive impairment in depression has typically been attributed to downstream effects of the acute affective symptoms of depression such as reduced motivation or a bias towards processing information in a negatively-valenced manner (Schmand et al., 1994). However, cognitive impairment has been found to remain following remission and may represent a trait marker for vulnerability to depression instead of a state marker that results from being depressed (Hammar & Ardal, 2009;

Rogers et al., 2004; Sweeney et al., 2000). Further evidence that cognitive impairment is distinct from acute affective symptoms is in research showing severity of cognitive impairment to be unrelated to symptom severity (e.g., Harvey et al., 2004). These observations suggest that cognitive deficits in depression may have an enduring cause that persists beyond the affective component of depression. One possible cause for cognitive deficits in depression, that may also represent one of the underlying causes of depression, is abnormal underlying brain activity. If different subtypes of depression have different patterns of underlying brain activity, then inconsistent findings regarding cognitive deficits in depression could result from a failure to account for subtypes (Shenal et al., 2003).

Brain Activity in Depression

One of the least invasive and easily employed ways to measure brain activity in depression is using electroencephalograms (EEG). Brain asymmetry is calculated by comparing brain activity across the left and right hemispheres, known as the difference metric (Gotlib, Ranganath, & Rosenfeld, 1998). This methodology can only elucidate relative functioning of the hemispheres and cannot categorically show which hemisphere is dysfunctional or if the asymmetry itself is problematic (Davidson, 1988). EEG research commonly finds a bilateral reduction in frontal brain activity with a pattern of relatively greater right than left frontal activity in depressed individuals (Heller & Nitschke, 1998; Thibodeau, Jorgensen, & Kim, 2006). A meta-analysis of EEG studies conducted by Thibodeau et al. (2006) found this to be a moderate effect ($d=.54$).

The cognitive/behavioural correlates of this pattern of brain activity can be understood by reviewing models of emotional processing. Evidence suggests that the right hemisphere is specialised for processing negatively-valenced emotion such as sadness (Demaree, Everhart, Youngstrom, & Harrison, 2005). For example, sad faces appear to be processed faster when presented to the left-visual field (right hemisphere) (Natale, Gur, & Gur, 1983; Reuter-Lorenz, Givis, & Moscovitch, 1983). In contrast, the left hemisphere is specialised for the experience and processing of positive emotions, such as happiness (Demaree et al., 2005). This has been termed the valence model of emotion. A similar model of emotion suggests that the right hemisphere is specialised for withdrawal-motivated emotions such as fear while the left hemisphere is responsible for approach-motivated emotions (Davidson, 1992; Demaree et al., 2005). This is commonly called the approach-withdrawal model of emotion (Davidson, 1992; Demaree et al., 2005). While

the two models appear similar, they classify several emotions differently. For example, anger is a negatively-valenced emotion but is associated with approach motivation. EEG asymmetry has been found to predict the extent of negative reaction to a negatively-valenced film (Tomarken, Davidson, & Henriques, 1990). Using these models, one would expect that an individual with greater right than left frontal activity, as in depression, may experience more negative/withdrawal emotions and may also be predisposed to processing stimuli and events in a negative manner (Gotlib et al., 1998). Therefore, an individual born with greater right than left frontal activity may be vulnerable to developing depression (Gotlib et al., 1998).

Alternatively, it is possible that individuals with depression may display a relative increase in right frontal activity as a result of suffering from predominantly negative affect during depression. However, similar to cognitive deficits in depression, asymmetric frontal activity also appears to remain following remission from the affective component of depression indicating that asymmetric brain activity is unrelated to mood state (Gotlib et al., 1998; Henriques & Davidson, 1997). Furthermore, this pattern of asymmetry activity has been observed in those deemed to be at a high risk for developing depression such as infants of depressed mothers (Davidson, 1995; Tomarken, Dichter, Garber, & Simien, 2004). These observations suggest that asymmetrical brain activity may represent a trait marker for depression vulnerability rather than a state marker resulting from depressed mood.

Despite the promising use of asymmetry as a marker for vulnerability to depression, inconsistent findings have prevented this model from being widely accepted. For example, some research has found individuals with depressed mood performed poorly on tasks thought to rely on the right hemisphere compared with controls (e.g., Heller, Etienne, & Miller, 1995; Tucker 1981). This finding was interpreted as evidence for reduced right hemisphere dysfunction in depression which seems to contradict EEG findings suggesting a relative left frontal reduction in activity during depression. This conclusion gave little consideration to differences in anterior/posterior brain function and as a result does not provide strong evidence against a relative left frontal reduction in activity in depression. The tasks used in such research may have relied on posterior brain function. Therefore, impaired performance may imply right *posterior* dysfunction but does not conflict with a possible left *frontal* impairment. The other main problem for the hypothesis of brain activity as a marker for depression is that a subset of research has also found non-

significant results, or the opposite pattern of asymmetry (e.g., Kemp et al., 2005; Reid, Duke, & Allen, 1998). Although inconsistent findings are generally explained by methodological differences between studies and small sample sizes (Reid et al., 1998; Thibodeau et al., 2006), they may reflect heterogeneity in the classification of depression (Heller & Nitschke, 1998; Kemp et al., 2005; Shenal et al., 2003).

There is evidence in favour of this possibility in the form of different patterns of brain activity in different subtypes of depression. For example, perceptual asymmetries, indicative of asymmetries in frontal lobe activity, have been found to differ for individuals with melancholic compared with non-melancholic depression (Bruder et al., 1995). Bruder et al. (2002) found that individuals with atypical depression showed an exaggerated right hemisphere advantage for the perception of emotional faces in a chimeric face viewing task. In contrast, individuals with typical depression showed an absence of the normal right hemisphere advantage suggesting right hemisphere dysfunction. Additionally, there is evidence that individuals suffering from depression with low levels of reassurance-seeking behaviour may display the typical pattern of relatively increased right frontal activity, while depressed individuals with high reassurance-seeking scores had the opposite pattern (Minnix et al., 2004). These findings suggest that depression is not a unitary construct and that brain activity in depression may differ according to subtype and symptom characteristics.

The most common finding regarding brain activity in depression is relatively reduced left frontal activity in depression that may indicate that the most prevalent subtype of depression (Thibodeau et al., 2006). Alternatively, it is possible that depression resulting from right hemisphere dysfunction may be under-represented in clinical research (House, Dennis, Warlow, Hawton, & Molyneux., 1990). Right hemisphere dysfunction has been linked to reduced ability to express and understand emotion (Heliman, Bowers, & Valenstein, 1993). Therefore, individuals suffering from depression with right hemispheric dysfunction may be less aware of and less able to communicate their problems resulting in a lower likelihood of diagnosis and participation in research (House et al., 1990).

While the bulk of EEG research has focussed on frontal brain activity in depression, due to the frontal lobes links to emotion, a smaller number of studies have investigated parietal brain activity. Right parietal regions have been associated with arousal (Heller & Nitschke, 1998). As depression is commonly associated with reduced arousal, one would expect a relative reduc-

tion in right parietal activity in depressed patients. This pattern has been observed in a number of studies but has been less consistently detected than the pattern of frontal asymmetry (e.g., Bruder et al., 1997; Kentgen et al., 2000; Stewart, Towers, Coan, & Allen, 2011). Inconsistencies are usually explained by the presence of co-morbid anxiety (Bruder et al., 1997; Kentgen et al., 2000). In contrast to depression, anxiety is associated with increased arousal and increased right parietal activity (Heller et al., 1995). In patients suffering from both depression and anxiety, alterations in parietal brain activity may cancel each other out (Heller & Nitschke, 1998). Unlike frontal EEG asymmetry, there is evidence that parietal asymmetry may be related to the severity of depression symptoms and may represent a marker of the depressed state as opposed to a trait marker for vulnerability to developing depression (Stewart et al., 2011). Reduced brain activity in right parietal regions in depression, leading to reduced arousal, may help to explain the overall decrement in performance observed in depression but is unlikely to explain specific cognitive deficits that remain following remission due to its relationship to mood state.

As discussed previously, different patterns of brain activity may underlie different types of depression. In general, increased brain activity is associated with an increased ability to perform tasks associated with that region (Levin, Heller, Mohanty, Herrington, & Miller, 2007). Therefore, variation in patterns of brain asymmetry could help to explain variation in the pattern of cognitive deficits in depression.

The Missing Link

Evidence suggests that abnormal brain activity and impaired cognition in depression are linked. Two main types of studies have been conducted to investigate this possibility. In the first method researchers have investigated depressed individuals' performance on cognitive tasks thought to draw on certain brain regions. Impaired performance in such tasks was interpreted as evidence for dysfunction in those brain regions. For example, Miller, Fujioka, Chapman, and Chapman (1995) asked individuals to complete a dot localisation task thought to rely on right hemispheric regions and a word-finding task thought to rely on the left hemisphere. Depressed individuals were found to perform worse on the dot localisation tasks than the word-finding task indicating right hemispheric dysfunction. Furthermore, the loss of normal left hemi-spatial bias during chimeric face tasks in depression has been interpreted as evidence of right hemisphere dysfunction (e.g., Bruder et al., 2002; Heller et al., 1995). However,

this method is heavily reliant on assumptions about how different brain regions are involved in performing the tasks in question. Conclusions from such research may give an inaccurate picture of the link between brain activity and cognition deficits in depression.

A second commonly used method involves measuring individuals' brain activity while they perform a cognitive task. For example, Okada, Okamoto, Morinobu, Yamawaki, and Yokota (2003) found that depressed individuals displayed reduced task-related activity in the left dorso-lateral prefrontal cortex during verbal fluency tasks compared with control participants. Such research should be interpreted with caution as depressed individuals may employ alternative strategies during task performance (Fitzgerald et al., 2008). For instance, Fitzgerald et al. (2008) found evidence that patients with depression show intact performance but may achieve this by recruiting more cognitive resources as evidenced by increased brain activity relative to controls in abnormal brain regions. Therefore, abnormal brain activity during the performance of cognitive tasks may not represent the dysfunctional brain region and may instead represent an intact region overcompensating for a dysfunctional region. Given that compensatory brain activity may mask the link between cognitive deficits in depression and brain activity, it is not surprising that a review study conducted by Rogers et al. (2004) cited numerous inconsistent and conflicting results. Such inconsistencies may also result from a failure to account for heterogeneity within the diagnostic category of depression.

Different presentations of depression could result from different patterns of underlying brain activity (Shenal et al., 2003). As a result of dysfunction in one or more regions of the brain, depressed patients are likely to experience impairment of cognitive functions reliant on the affected brain regions. This hypothesis may help to explain the inconsistencies of cognitive deficits in patients diagnosed with depression.

Despite this promising potential explanation for the heterogeneity in the literature regarding cognitive impairment in depression, few experimental studies have directly investigated this possibility and there are problems with the few that have. One of the most direct attempts to investigate this possibility was conducted by Thompson (2010). Tasks thought to be reliant on left and right frontal regions were selected to assess hemispheric dysfunction relative to cognitive impairment. However, these tasks were not matched and the order of the tasks was not counterbalanced. As a result, group differences may have been confounded by task differences. Furthermore, the EEG component of the re-

search was not completed due to time constraints. In other evidence, when depression is divided into subtypes there seems to be clear differences in the pattern of cognitive deficits between different subtypes. For example, Bruder et al. (1989) assessed performance of melancholic and non-melancholic depressed patients on a dichotic listening task. The melancholic patients showed evidence of right hemispheric dysfunction while the non-melancholic patients did not perform differently from non-depressed controls. Furthermore, Austin et al. (1999) also found that melancholic and non-melancholic patients showed distinct patterns of memory impairment suggestive of different patterns of underlying brain activity. However, care should be taken in interpreting these studies as no measurement of brain activity was attempted and the conclusions are largely based on assumptions about how the brain functions when engaged in different cognitive tasks.

Research in this field is plagued by inadequate task design. Several studies did not counterbalance task order (e.g., Miller et al., 1995; Thompson, 2010). As a result, interpretation of task performance is confounded by possible order effects such as reduced concentration. Furthermore, some studies have combined the use of the relative difference metric of brain activity with the performance on single tasks. However, if depressed patients suffer from reduced arousal they are likely to perform more poorly than controls on all tasks. As a result, impaired performance on a single task, relative to controls, cannot be interpreted as evidence of asymmetry. Researchers need to look at relative performance on matched tasks thought to rely more heavily on one hemisphere than the other instead of performance on single tasks. A further problem is using brain activity during task performance to infer dysfunctional brain regions. Compensatory mechanisms may mask patterns of underlying brain dysfunction and make it difficult to assess how abnormal brain activity and cognitive impairment in depression are linked (Fitzgerald et al., 2008). Finally, research involving tasks reliant on parietal regions is problematic. Parietal brain activity is confounded by anxiety and there is evidence that parietal brain activity in depression may represent the depressed state and not an underlying trait (Stewart et al., 2011). Differences in performance on cognitive tasks reliant on parietal regions may reflect severity of depression or be mood related and may not provide evidence of an underlying relationship between cognitive deficits and brain activity in depression.

Proposed Research

To address these problems and to investigate the potential link between variability in cognitive deficits and brain activity in depression more thoroughly, a single aspect of cognitive performance with dissociable components should be investigated. One possible cognitive domain for this research is working memory. Working memory can be divided into spatial and verbal components. Verbal working memory appears to be dependent on left frontal regions while spatial working memory seems to be dependent on right frontal functioning (D'Esposito et al., 1998; Smith, Jonides, & Koeppe, 1996). Therefore, verbal and spatial working memory may be differentially impaired in depression. Such a dissociation will allow detection of how brain asymmetry and cognitive performance in depression are linked. Depressed individuals and control participants will provide a resting EEG and assessment of spatial and verbal working memory function. It will then be possible to assess the link between variability in cognitive performance in depression and variability in brain activity in depression. For example, if an individual diagnosed with depression shows the pattern of relatively reduced left frontal activity then this model would be supported by a disproportionate impairment in verbal working memory compared with relatively spared spatial working memory. On the other hand, another participant diagnosed with clinical depression may show the opposite pattern of frontal asymmetry and display a greater impairment in spatial working memory than verbal working memory.

It is hypothesised that the majority of depressed participants will show relatively reduced left frontal activity as this pattern of frontal activity may be more likely to be diagnosed with depression than patients with depression resulting from reduced right-sided activity (House et al., 1990). It is also hypothesised that individuals suffering from depression with low anxiety may show reduced right parietal activity. Reduced right parietal activity is likely to lead to reduced arousal (Heller & Nitschke, 1998). As a result, it is likely that all individuals suffering from depression and low anxiety will display impaired performance on both working memory tasks. However, due to frontal asymmetry such individuals will show a disproportionate impairment in one of the tasks.

Conclusion

Depression is a highly heterogeneous disorder in which cognitive symptoms vary greatly for reasons that are poorly understood. Cognitive deficits may vary as a function of subtypes of depression. Different subtypes

of depression may be associated with different patterns of underlying brain activity. Reduced regional brain activity could lead to differences in performance on cognitive tasks thought to draw on the impaired regions. Unfortunately, few experimental studies have been conducted to investigate this possibility. A research design is proposed in which brain activity in depressed participants will be measured and compared to their performance in spatial and verbal working memory tasks. The proposed task design should help to elucidate the relationship between variability in brain activity in depression and variability in cognitive deficits thereby overcoming some of the problems seen in earlier studies.

Conducting this research will help to find support for the theory that variation in brain activity in depression, resulting from different subtypes, accounts for the inconsistencies observed in the research regarding cognitive deficits in depression. A deeper understanding of these factors may aid in diagnosing and treating depression.

Acknowledgements

I would like to thank my supervisors Dr Stephen Hill and Associate Professor John Podd for all of their help and support with my research. I would also like to thank Ann Rogerson and Robbie Busch for organising the 2011 Doing Psychology: Manawatu Doctoral Research Symposium.

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Seeking the Voice of Experience: The Complexities of Researching Women's Accounts of Their (Ex-) Partner's Engagement with Living Free from Violence Programmes

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Abstract

Previous research into the effectiveness and impact of domestic violence programmes has often focused on recidivism and re-offence data or self-report measures. Such research is constrained by a reliance on incidences of violence being officially reported and by legal definitions of intimate violence, limiting our understandings of women's lived experiences of safety. Missing voice research is problematic because of the tensions between research processes and the prioritisation of maintaining women's safety. To be able to engage in the process of researching women's experiences of their (ex) partners' engagement with men's Living Free from Violence programmes requires an understanding of the complexities of developing relationships and processes that privilege and protect women's safety throughout the research journey, and necessitates an understanding of the barriers to participation. This involves a collaborative and supportive working partnership to be formed and developed between the researcher and the community, one that at all times maintains the awareness that women's safety must be the focus of research, both in outcome and process. This paper discusses the complexities involved in our attempts to understand how women experience issues of change and safety as a result of their partner's involvement in a local Living Free from Violence programme.

Keywords: Intimate partner violence; community collaboration; safety; living free from violence programmes

Background to Domestic Violence and Stopping Violence Programmes

Despite New Zealand having some of the best policies in place to respond to domestic violence, we are still struggling under the weight of some of the worst reported outcomes (Contesse & Fenrich, 2008). With an estimated 1 in 3 New Zealand women having experienced domestic violence (Contesse & Fenrich, 2008), and 1 in 4 of our children witnessing acts of abuse in the home (Lievore, Mayhew, & Mossman, 2007), this is an area that still demands our urgent attention. Not only are the social and financial costs of great concern (Ministry of Justice, 2007), with economic costs conservatively estimated at 8 billion dollars per year (Contesse &

Fenrich, 2008), but domestic violence is a pressing human rights issue, one in which the state has an obligation to intervene (Contesse & Fenrich, 2008; Dobash, Dobash, Cavanagh, & Lewis, 1999). The effects of domestic violence reach far further than the physical scars, with the psychological costs posing too great a risk to the wellbeing of women and children to ignore. Many women suffer from both physical and mental health problems (such as depression and attempted suicide) related to domestic violence (Cascardi & O'Leary, 1992; Fanslow & Robinson, 2004). For our children, domestic violence has been linked to a range of psychological, emotional, behavioural and social concerns (Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003; Zinzow et al., 2009), with links to youth suicide (Fantuzzo & Mohr, 1999; Lievore et al., 2007) and the risk of repeating the cycle of violence themselves (Ministry of Social Development, 2002).

One approach to address domestic violence in the community is through the provision of stopping violence programmes. Early forms of such programmes (emerging in the 1970s) tended to be individualistic in nature, focussing solely on the male offender and cognitive behavioural interventions, such as anger management (Shepard & Pence, 1999). This individualistic approach has been criticised for ignoring the social, contextual and cultural elements of abuse, and in the 1980s the Duluth Domestic Abuse Intervention Program framework emerged. This incorporated family systems therapy and concepts of gendered power and control, alongside the cognitive-behavioural elements of programme provision (Pence & Paymar, 1993; Shepard & Pence, 1999). A shift from the sole focus on the cessation of violence, this framework attempts to elicit an awareness, education and unravelling of the underlying gendered culture of fear, intimidation and psychological abuse, locating domestic violence as a technology of coercion and control (Shepard & Pence, 1999). Furthermore, this approach allows a broadening of understandings of 'violence' from purely physical acts to processes of psychological abuse and technologies of control (Robertson, 1999).

Because attending a stopping violence programme is a strong factor for women returning to, or remaining with their partner (Contesse & Fenrich, 2008; Dobash et al., 1999; Gondolf, 1997; Walters, 2010), it is imperative to explore whether such interventions actually increase the safety and wellbeing for women and children. Unfortunately, such evaluation research is lacking (Ministry of Social Development, 2002; New Zealand's Parliamentarians' Group on Population and Development, 2005). The research on the effectiveness of stopping violence programmes that *has* been conducted, has produced mixed results, with some programmes reporting positive outcomes, while others finding minimal to no benefits through attendance (Gondolf, 1997; Shepard & Pence, 1999). While programmes that focus only on cognitive-behavioural elements have been criticised as being ineffective at addressing the social, contextual and political elements of domestic violence (Day, Chung, O'Leary, & Carson, 2009; Robertson, 1999), some argue that a focus on the gendered issues of power and control contribute little to programme effectiveness (Dutton & Corvo, 2007). Despite the mixed results, Dobash et al. (1999) report that involvement in stopping violence programmes increases the likelihood of success over the use of state sanctions alone. What is clear is that the benefits of intervention programmes are contentious, and much more research is needed to unpack the underlying debates and issues of if, how and why programmes may or may not enhance women's safety.

Programme evaluation is also plagued by the complex nature of domestic violence. Research has noted that psychological and verbal abuse is more frequent than physical abuse (Lievore et al., 2007), yet much of the recidivism data relies on reported acts of physical violence, in particular acts serious enough to attract the attention of police and other professional organisations (Shepard & Pence, 1999). This privileges physical forms of violence and silences the recurrence and experiences of psychological forms of abuse. Lievore et al. (2007) note that little is known about non-physical forms of domestic violence, and without this knowledge it is often unclear how we can best respond to abuse divorced from violent acts (Contesse & Fenrich, 2008). Furthermore, as mentioned previously, relying on incidences of physical violence provides a description of the more serious events (for example, male assaults female) and ignores the patterned and insidious elements of domestic violence and the relational context in which it occurs (Coombes, Morgan, Blake & McGray, 2009; Lievore et al., 2007). This is of concern as research suggests that whilst stopping violence pro-

grammes may be effective in reducing physical acts of violence, other abusive behaviour, such as psychological abuse or control / intimidation, may in fact *increase* as a result of participation (Towsey, 1996).

Evaluation research can also be affected by limitations of design. Domestic violence research is notoriously plagued by low response rates (Gondolf, 1997). This may be a reflection of the complex social arrangements of those affected by domestic violence, with many potential participants having moved away and unable to be located (Ellsberg, Heise, Peña, Agurto, & Winkvist, 2001). Furthermore, due to the sensitive and personal nature of domestic violence, it is not uncommon for those contacted to decline to participate (Coombes et al., 2009; Ellsberg et al., 2001; Morgan et al., 2007). This may introduce sampling bias, with those who are able to be contacted, who pass safety and risk assessments, and who agree to participate representing certain 'types' or groups of offenders and victims. This may over-exaggerate programme effectiveness and under-report recurrence of abuse over time. In addition, studies that utilise men's self-report measures as an indication of recidivism may underestimate the amount and nature of further violence (Gondolf, 1997; Lievore et al., 2007; Robertson, 1999). Furthermore, the inclusion of follow-up periods can skew research data. Often, due to research constraints, follow-up periods are short (Dobash et al., 1999; Gondolf, 1997), and it has been argued that shorter follow-up periods may over-estimate programme effectiveness (Feder & Wilson, 2005). The structure of programmes and referral processes studied is also important, with those who self-refer for programmes and who participate in group-style sessions showing more favourable results than those mandated to attend or involved in a one-to-one session structure (Walters, 2010).

The Need for New Directions in Evaluation Research

Because the effects and benefits of programmes are unclear and subject to debate, many community programme providers may struggle to procure and maintain adequate funding and support from governmental organisations. The danger here is that community responses to domestic violence may become marginalised, returning the provision of services to the 'authorised professional', and ultimately the voice of protest and the call for respect and accountability in the community may be lost (Shepard & Pence, 1999). Such a 'loss' would be in direct conflict with the Te Rito: New Zealand Family Violence Strategy (Ministry of Social Development, 2002), which explicates that communities

have the right and responsibility to prevent domestic violence. Therefore, any endeavour to evaluate or develop stopping violence programmes has an obligation to do so through processes of community collaboration. In order to create a culture of change and non-acceptance of domestic violence, we need to maintain and support community initiatives, evaluating existing programme provision and feeding back to the community what is effective, how it is effective, and what areas for further improvement / development exist (Contesse & Fenrich, 2008; Ministry of Social Development, 2002; New Zealand's Parliamentarians' Group on Population and Development, 2005). In order to meet Te Rito's objectives of avoiding the duplication of services, and the resulting strain and competition of limited resources, a solid knowledge base of existing initiatives and interventions is needed to refine and solidify best practice concerning responses to domestic violence in the community.

In order to contribute to the body of knowledge regarding domestic violence programmes, and also to address some of the limitations noted regarding methodology and design, a 'missing voices' approach to evaluation needs to be taken. Walters (2010) notes that programme compliance does not necessarily equate with engagement and so hearing women's voices may provide a valuable understanding of the processes of change and effectiveness of intervention not accessible through recidivism and self-report measures alone. Although historically uncommon, evaluations need to include women's accounts of violence and safety (Coombes et al., 2009; Dobash et al., 1999; Feder & Wilson, 2005; Morgan, Coombes, Te Hiwi & McGray, 2007). If we are to embrace the Duluth approach with an emphasis on supporting and managing the safety of victims within the programmes offered (Shepard & Pence, 1999), it is imperative that women have the chance to share their experiences with us.

As previously discussed, much of the evidence gathered privileges physical violence, excluding and ignoring psychological abuse and the contextual elements of domestic violence. Qualitative methods that explore victims' experiences of change and safety can take into account context (Lievore et al., 2007; Shepard & Pence, 1999) and the underlying processes of change (Gondolf, 1997), while prioritising women's understandings and definitions of violence and safety (Coombes et al., 2009). Furthermore, qualitative methods, such as semi-structured interviewing, can also address the previously mentioned issue of underreporting abuse through producing multiple points of disclosure, investing time in the interview process to allow women to reflect on and

remember incidents (Ellsberg & Heise, 2002; Lievore et al., 2007) that is not available in tightly structured or survey-style methods of data generation. In addition, the process of relationship building between researcher and participant enabled through this methodology can contribute to more open and detailed accounts of experiences of violence (Lievore et al., 2007).

Missing voice research can place violence within a context of lived experience, looking at the dynamic nature of understandings of safety, change and support. It can explore concepts of protection and resilience (Lievore et al., 2007), and at all times authorises and privileges women's accounts of benefit and safety. As Towsey (1996) notes, women are the real clients of stopping violence programmes, as programmes aim to protect and increase their safety. Indeed, if we are to return to the inception of the highly influential Duluth approach for intervention, programme delivery itself was developed and guided by the experiences of women affected by domestic violence (Shepard & Pence, 1999). Therefore, it is their voices that should strongly guide our understandings as to whether such programmes achieve their goals of reducing and eliminating domestic violence in the community.

The Current Evaluation Research

The current research is an evaluation of the men's Living Free from Violence programme offered by a local community organisation in the Manawatu, Te Manawa Services. Established in 2000, Te Manawa Services emerged in reaction to an identified need for a localised response to domestic violence in the community. Working closely with local services, groups and organisations, the mission of Te Manawa Services was, and is, to create a 'heartful space' that prioritises safety, equality, respect and the cessation of violence for local families and the wider community. They endeavour to provide services that are empowering and adopt a systemic approach, inclusive of, and dedicated to developing, whanau and support systems for clients and families. In this vein, Te Manawa Services do not solely provide a men's stopping violence programme, but also a women's Living Free from Violence programme, Youth and Parenting courses, and Family Support services.

The men's Living Free from Violence programme is a 16 week course with frequent review sessions built in to the curriculum. The group is an open format, with new members of the group being inducted and supported by existing members. The modules incorporate cognitive-behavioural approaches, with the political-educational approach, informed by the Duluth model of

intervention. The sessions are co-gender facilitated, a process that Robertson (1999) argues is important to reduce the risk that male facilitators, located in their masculine social and political position, will collude with the men in the group. The underpinning concepts of all modules are accountability and responsibility, and privilege of the safety and interests of children. Family and whanau presence and support is included in review sessions, as well as the availability for women and children to engage with other services offered by the organisation. This is in keeping with the Duluth approach, where support for victims is integral to responses, allowing for the monitoring of safety and the provision of interventions that are not reliant on the offender being 'rehabilitated' (Shepard & Pence, 1999).

In accordance with honouring the rights and responsibilities of communities in preventing domestic violence, as outlined in the Te Rito strategy (Ministry of Social Development, 2002), the current research is a collaborative effort between Massey University and Te Manawa Services, with Te Manawa Services holding the funding contract for the evaluation project. Informed by the limitations of previous research surrounding intervention programmes, the current study sought to incorporate the 'missing voices' of women in an evaluative project, seeking their experiences and understandings of change and safety associated with the men's Living Free from Violence programme in the form of semi-structured interviews. It was decided that (ex) partners of men who have completed the full 16 week men's Living Free from violence programme were to be asked to participate. Following the recommendations of the Duluth approach (Shepard & Pence, 1999), women and children's safety was prioritised in every facet of the research design and process. In order to ensure no women or children were placed at risk as a result of participation, risk assessments were conducted to identify those women who were 'safe' to participate. This process involved utilising Te Manawa Services staff and their extensive knowledge of safety and risk assessment. Informed by research conducted by Coombes et al. (2009) an advocate system was established whereby an acting staff member adopted an advocate role in the recruitment process. This involved an initial safety check utilising Te Manawa's client file information to identify any previous or current safety concerns. Reasons for cessation of further recruitment processes at this stage were to be if client files revealed that women were still involved with men who posed a significant level of risk. If the files revealed no safety concerns, the advocate then made contact with women in the form of a phone call. During this phone call, any potential cur-

rent safety issues were explored and to date there has been no cessation of progress at the phone call stage of recruitment. However, this process has already highlighted areas for refinement. Whilst information may be gathered concerning the nature of relationship with the client (male completer) of Te Manawa Services, it is also imperative to establish the safety of newly formed relationships. As women may continue to experience domestic violence in subsequent relationships, safety checks must also seek to assess the nature of any new relationship with men unknown to the domestic violence organisation.

Due to previously discussed low-response rates in domestic violence research, these safety procedures severely limit an already limited pool of potential participants. This raises an inherent tension in domestic violence research –should the benefits of the research outweigh the potential safety of participants? By limiting the pool of participants, are we limiting our knowledge of the complexities of domestic violence and thereby potentially increasing the silence and risk for women living in abusive relationships. Ellsberg and Heise (2002) and Shepard and Pence (1999) both discuss that by talking with these women we may be placing them at risk of further abuse, but by not talking to them we are perpetuating the silence surrounding domestic violence and potentially putting them and others at further risk. This tension is very real, and Ellsberg et al. (2001) documented that towards the end of their research, due to time and financial restraints, initially developed safety procedures began to be compromised. Therefore, it is imperative that as researchers we must constantly remind ourselves that women and children's safety are the priority, the reason for this research. No process of the research design or implementation should put their safety at risk. The current research has indeed been affected by low response rates and the need to meet deadlines for funding, however, through negotiating and extending timeframes beyond those initially established we have enabled progression of the research without compromising participant safety. This points to the need for flexibility and the building of responsive relationships between service providers, researchers and funding authorities in order to allow for a negotiation between establishing safety and working within contractual frameworks.

Issues of confidentiality are also extremely vital to ensure safety processes in domestic violence research (Shepard & Pence, 1999). Women may be placed at risk of further harm if their (ex) partners discover they have been discussing issues of relational abuse and violence (Ellsberg & Heise, 2002). Therefore, the current re-

search sought to build mechanisms to ensure, as much as possible, confidentiality and anonymity in the research design and process of recruitment. After initial contact by the staff advocate, the researcher took over the contact process. Therefore, although the Te Manawa Services staff advocate was aware of the initial potential pool of participants they were provided no knowledge of which women accepted or declined to participate. However, there are issues that have emerged due to the local grass-roots nature of this research that must be addressed in order to inform future research practices. Given the small, local nature of the research, it was not possible to guarantee absolute anonymity. Relationships had often been strongly established between potential participants and Te Manawa Services, and so whilst endeavouring to protect the participants' identities, local knowledge and communication meant that some women's decision to participate was known to the organisation. Furthermore, there were tensions and misunderstandings concerning the privileging of confidentiality due to institutional and systemic understandings of the relationship between confidentiality and safety. As conducted through Massey University, and informed by university ethical philosophies, issues of privacy and confidentiality were paramount. However, the guiding principles of intervention in Te Manawa Services are accountability and responsibility. Openly discussing issues of domestic violence are important to meeting the goals of responsibility and accountability, but they are problematic when keeping within the university's requirements for anonymity and confidentiality. This may at times produce tensions in the relationships between stakeholders and researchers, highlighting the complexities of conducting research within organisations with philosophies and approaches outside of university research protocols, emphasising the need for processes of negotiation and communication within stakeholder relationships.

Furthermore, a separate component of the current research involved interviewing male clients of the stopping violence programme. Although no indication was provided to the male participants regarding the women's voice component, many women were still involved in relationships with potential male participants. It was beyond the researchers control to prevent (ex) partners who were still in contact from discussing their participation, however, the complexities of this situation highlight concerns. Firstly, it is known to the researcher that some women participants have discussed their intended participation with men prior to research interviews. Some of those men have either been contacted by the Te Manawa Staff advocate regarding participation or have

completed an interview themselves. This has caused concern that such communication has removed the ability for women to participate anonymously, and it is possible these women may have edited their stories and under-reported abuse, or over-reported the benefits of the programme. To address this, the researcher has emphasised during interviews the confidential nature of participation and that no identifying material will be kept, shared or reported. While the World Health Organisation guidelines for domestic violence research suggest that recruiting male and female participants from the same community should be avoided (Ellsberg & Heise, 2002), this is often not possible when conducting evaluation research of local community responses. This remains an area that needs further attention and development. The researcher believes that in cases such as this, those conducting the interview need to be aware and observant of whether this issue has occurred and if so to address it openly and honestly with the participant. On a related note, researchers should be aware of leaving materials concerning the study at the homes of participants. As is standard in research, information sheets concerning the nature and requirements of participation are given to all participants. There have been instances in the current research where women have consented to participate without their partner's knowledge, therefore researchers must always discuss the potential consequences of partners discovering information sheets and the risks associated. Participants should be informed of potential consequences of participation that they may not be aware of that have the potential to cause harm. As such, it was the researcher's duty in these instances to inform the participants that information sheets may be discovered by their partners and that this may cause distress or conflict.

It has been noted that the interview process itself may produce distress and discomfort for women, and should this happen the researcher must terminate the interview (Ellsberg & Heise, 2002). In the current research, the development of trusting relationships and rapport during the interview process was essential in ensuring that the process of talking about the abuse did not cause women further distress or harm. If the researcher 'sensed' that participants were distressed, the conversation was shifted to less distressing topics. Safety plans and avenues for further support were discussed, such as contacting Te Manawa Services or the researcher directly if needed. In one instance, a participant was contacted the day after the interview to check that a suspected level of distress was reduced and that the participant was in a safe place. While this process is mostly subjective, it is important that those researching in this

field remain observant and engaged personally with those they are interviewing in order to monitor and assess safety and distress levels. Furthermore, in order to maximise the benefits of the current study for the participants, the researcher ensured she invested time discussing why the women's input and experiences were unique, valuable and important. On cessation of the interview, participants were acknowledged and thanked for sharing their expertise and stories. The time invested in this exchange was hoped to provide a self-affirming process for the participants and to communicate that the research would be directly relevant to them (Coombes et al., 2009).

Distress in this field of research is not only of the domain of participants, but the researchers themselves are also at risk of distress (Ellsberg & Heise, 2002). It can be, and indeed the researcher of the current study has found it to be, distressing to hear stories of abuse and violence, and the emotional effects of this can be difficult to process. This can create tensions during the interview process itself, as in this study the researcher felt a personal tension when asking the women to share their stories. Namely, this tension involved whether to 'push' women to tell their stories and possibly re-open and re-live painful memories, or whether to avoid pushing for further detail and risk limiting the data gathered. This was addressed on a case-by-case basis, and again was subjective, but was aided by the development of a strong research relationship. In instances where the distress was indicated by the mannerisms or demeanour of the participant, the researcher often chose to discuss less distressing topics, reasoning that to push for further detail would compromise participants' safety. In such cases, the researcher would concentrate on the processes of the stopping violence programme more than experiences of abuse. For those women who exhibited low to moderate levels of distress, the researcher would follow the participant's lead in conversation and ensure that cessation of the interview occurred at an uplifting or inspirational point. At all times, the researcher made extensive use of debriefing with supervisors and developed personal systems for separating 'work' and 'home' in order to avoid the emotional toll of conducting such research.

Although researching domestic violence on a small and localised scale such as the current study contains tensions and limitations, the value of such work cannot be underestimated. Ellsberg and Heise (2002) note that in order for domestic violence research to contribute to processes of social change, networks and relationships need to be established that can facilitate the dissemination and utilisation of research findings. The aim of the

current study is to produce a final report of the effectiveness of a local community stopping violence programme, and to share the findings with other appropriate stakeholders, groups and organisations invested in reducing domestic violence in New Zealand. Furthermore, it will be an invaluable tool for directing the location and utilisation of funding opportunities for programme provision and development in the future. It will be informed by official records (police recidivism data), men's self-report measures and women's experiences of change and safety, and as such has much to offer in the way of increasing our understandings of where we are now and where we need to go in the future.

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Using a Storybook Method to Understand Young Children's Narratives of Illness

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Abstract

Appreciation of the role that families play in young children's meaning-making about the causes of illness could assist educators and healthcare practitioners to provide more effective support for young children and their families. To date, researchers have largely sought to determine children's understanding at various stages of cognitive development rather than exploring how children might acquire, process, and share their knowledge within particular social contexts. Adopting a socio-constructivist perspective and a narrative methodology, I sought to identify ways in which young children's illness causality concepts are embedded within the familial context. Fieldwork included in-depth interviews with five four-year-old children, their parents/guardians; sibling/s aged five to nine years, and two other family members. Participants from Manukau City, New Zealand, reflected a diversity of cultural communities, spiritual orientations, and family structure. To aid the elicitation of young children's narratives of illness causality, child participants were invited to construct a storybook about 'getting sick' utilizing art materials and photographs of children experiencing illness. A social interactional approach was employed to interpret participants' narratives and suggests that young children's illness causality constructions are significantly influenced by the particular illness experiences, illness prevention messages and behavioural rules within families. Findings indicate that children's existing understandings and associated family practices need to be utilized as the context for children's learning about health and well-being.

Keywords: behaviour, children, families, illness causality, narrative, sociocultural context

Introduction

With the current prioritizing of child health promotion and health literacy programmes (see National Health and Hospitals Reform Commission, 2008; US Department of Health and Human Services, 2000), practitioners in health, education, and family support services are facing the challenge of providing effective health education programmes for young children. Appreciation of the role that families play in young chil-

dren's meaning-making about illness causality has the potential to assist practitioners in this task. To date, researchers have largely focused on children's understanding of illness at various stages of cognitive development rather than exploring how children might acquire, process and share their knowledge within particular social contexts. Traditional maturational models of children's conceptualization emphasize domain-general knowledge and universality of children's concepts (see Bibace & Walsh, 1980), however, current research highlights the existence of domain-specific knowledge and queries normative assumptions. Specific cultural influences have recently been highlighted in investigations of young children's biological reasoning (Legare & Gelman, 2009; Zhu, Liu & Tardif, 2009). Additionally, studies have related familial and cultural practices to biological understandings, although few have specifically focused on illness (Zhu et al., 2009). Consequently, there is currently a need for contextually-based research regarding young children's understandings that can inform both the field of cognitive development and the design of educational programmes (Au et al., 2009; Legare & Gelman, 2009; Zhu et al., 2009).

Over the last two decades the influence of sociocultural contexts on knowledge construction, as highlighted by Vygotsky (1978), has been increasingly recognized within the field of education. Vygotsky's sociocultural perspective focuses on the child-in-context emphasizing the way in which children's social and cultural experiences guide their thinking. This notion of 'culture' embraces the shared understandings and practices developed by communities over time as members work towards achieving shared goals. As knowledge is co-constructed, the child both influences and is influenced by the views of others. Furthermore, access to knowledge is mediated by cultural constraints (Bird & Podmore, 1990). The elements of context (both immediate and socio-historical) and culture are critical in understanding young children's learning and development.

The primary sociocultural context for young children is the family. In the terminology of Wenger (1998), the family is a 'community of practice' in which children are engaged in 'repertoires of cultural practices'. The beliefs and experiences of parents, siblings, extended family members, and family friends have a profound influence on the young child's construction of meaning. Through these people, belief systems and practices are relayed, and children are given the cultural tools to make sense of their world. One of the main cultural tools is narrative. The stories people tell provide insights into specific cultural rules and meanings, and stories about themselves and others are the first tools available to young children for understanding and sharing their experience of the world (Bruner, 1990; Langelier & Peterson, 2004). Seeking to explore children's meaning-making about illness causality in relation to the family context, I decided to use a narrative methodology that acknowledges the social construction of an individual's worldview.

Method

Data Collection

Fieldwork was based at a public kindergarten in Manukau City, New Zealand. I chose this location because of the diversity of families in the kindergarten community in terms of participation in cultural communities, religious affiliation, and family structure. Following ethics approval, I liaised with teaching staff and recruited five four-year-old children along with their parents; sibling/s aged five to nine years, and two other family members, for example, grandparents, aunts and uncles. Most of the data was gathered via in-depth interviews over a period of six weeks. To elicit children's narratives, I invited each child to make his/her own storybook about 'getting sick' using art materials and photographs of children experiencing illness. Using familiar activities and media was an important part of this process especially as 'illness' is a relatively abstract concept for young children. With children's permission, additional data was collected via family members' feedback regarding children's storybooks. Participants' comments during subsequent home visits, particularly when reviewing their transcripts, was also included in the data set.

I interviewed the parents first so that I could ask about each child's experience of illness and become aware of any potentially sensitive issues that might arise during the interview process. I also showed parents the photographic resource so that they were aware of the material that I would be showing to their children. I

interviewed the four-year-olds in the kindergarten in view of the teachers and interviewed the older children at home with their parents on site. I wanted to interview children individually so that I could hear each child's personal thoughts rather than ideas generated during a group interview. I also wanted to avoid children seeing the storybooks that others had written before they had had their turn. To achieve this, I interviewed siblings at a similar time and returned the storybooks to the children after all of the interviews had been completed.

During the storybook interviews, I showed the children a series of topic photographs and explained that they could use these photographs in their book. Photographs portrayed children engaged in a range of actions such as holding their head in their hands, wincing while holding their arms across their body, sneezing, and coughing. To help focus children's attention and leave the scenario open-ended, I specifically chose photographs that depicted one child on their own in a general context. I also chose photographs that featured children of various ethnic backgrounds and reflected the cultural communities in the local area. I invited children to lay the photographic cards out on their workspace and explained that all of the children in the pictures 'weren't feeling very well'. This prompted children to talk about the illnesses that they had experienced. I then encouraged children to select a photograph for each story in their book and asked an opening question such as 'What do you think is happening in this picture?' To draw out more storytelling I reflected children's comments; adopted their phrasing, for example, 'How come he "got the cough"?'; regularly recapped the stories; and frequently checked the content with the children. I was also mindful of attending to children's body language and cultural aspects of communication. Children chose the art materials that they wanted to use and decided whether to write the stories themselves or dictate their accounts for me to write down. Most of the children constructed five or six stories for their book.

Data Analysis

Data analysis was informed by a social interactional approach (see De Fina & Georgakopoulou, 2008) which views narrative as talk-in-interaction and focuses on the way that meaning is co-produced by the storyteller and the listener. This model acknowledges the stop/start nature of talk, non-linear sequencing, inconsistencies, and small stories that are part of the everyday conversations of both adults and children. Focusing on narrative as a form of social practice, the approach highlights layers of meaning at both 'micro- and macro-levels of social action and relationship' (De Fina & Geor-

gakopoulou, 2008), and integrates these meanings with broader sociocultural processes such as the transmission of knowledge and the allocation of roles within communities.

Findings

The four-year-olds in this study were very adept in providing spontaneous explanations for illness and frequently linked their meaning-making to experiences within their own world. During the interview process, children referred to a variety of illnesses and causes of illness. The most frequently cited illnesses or 'states of ill health' were as follows: 'cough', 'bleeding', 'sore eyes', and 'sore/hot head'. Illness references included symptoms, conditions, and both intentional and non-intentional injuries. References to death and dying were also present in young children's narratives, for example, Natalia's comment 'if you smash your car behind you that's when you're dead and then you go in a graveyard', and Joseph's remark 'she's gonna die...they're gonna cut her neck'. Analysis of young children's narrative accounts revealed two major threads regarding children's illness causality constructions: 'behaviour-based explanations for illness', and 'illness prevention messages and behavioural rules'.

Behaviour-Based Explanations for Illness

Children mostly referred to behavioural actions as the cause of illness, often locating responsibility for illness with a particular individual – either themselves or another person. Several stories featured 'eating too much food' (especially lollies and ice-cream) as a cause of illness, for example, 'if you eat too much ice-cream or stuff you get asthma'. Being in the cold and the wind was another causal factor frequently mentioned by children, for example, 'she was playing (outside) then she got cold'. Physical force inflicted by another person also featured strongly in children's stories, for example, 'someone hurt him on the head'.

Illness Prevention Messages and Behavioural Rules

In constructing narrative accounts, children frequently drew on the illness prevention messages and behavioural rules that are regularly communicated within their family and emphasized the importance of this information. Telling a story about a child in a topic photograph, Natalia commented:

Natalia: Her eyes are down low. That means her eyes are sore.

Caroline: Her eyes are sore, ok. And how did she get the sore eyes do you think?

Natalia: When you rub them too much they get so ... they get so blinky and ... You don't rub them when they are sore, you blink them when they are sore...

Caroline: Have you had sore eyes before?

Natalia: Oh yeah. I keep on rubbing them...

Caroline: Do other people in your family have sore eyes sometimes?

Natalia: No. Remember when you cook these bubbles go up on your eyes eh? And they're sore eh? Remember the bubbles hurt you when you cook in the pan and you cook and it hurts eh?

Caroline: Ah, ok. And what's in the pan when the bubbles ... ?

Natalia: We ate some chicken noodles and we had some ham sandwich.

In this extract Natalia explains the link between the character's body language and sore eyes using the phrase 'that means' to provide more information and convey her understanding. In reply to the question about how the character came to have sore eyes, Natalia provides the instruction 'you don't rub them when they are sore, you blink them when they are sore'. Spontaneously repeating the caution, Natalia talks about the importance of the information being shared and stresses the need to 'remember' this information. At the close of this extract Natalia links the narrative to her own world with her comment 'we ate some chicken noodles and we had some ham sandwich'. Following the interview with Natalia, her mother talked about how she has told her children to stay back from the frying pan explaining the height of the pan and how the fat could 'go into their eyes' and hurt them.

Discussion

The behaviour-based understandings and related family practices highlighted in young children's narratives signal the importance of family socialization in children's understandings of illness. Educators and health practitioners need to be aware of the impact of health messages shared within the family, and develop health education and support programmes that recognize prior experiences, exchanges and understandings

within the family context. An acknowledgement of the sociocultural factors impacting upon children's knowledge construction, rather than reliance on maturational models, is required.

Because children engage in health-related practices that are based on the values and priorities of family members (Poutanen, 2006), children may have different rules as a result of the particular 'folklore' (Zhu et al., 2009) in their cultural context. Furthermore, children are likely to be able to understand health information at an earlier age if it is meaningful to them in terms of their family context (Borzekowski, 2009). Thus, it is vital that practitioners engage with families when providing health education and support, fully appreciating family members as both valued interpreters and essential partners in the education of young children. Practitioners also need to recognize that the beliefs of children and their families are inextricably connected to societal beliefs and values including social and political agendas (Ravindran & Myers, 2011). For health education programmes to be effective, children's existing understandings and associated family practices need to be utilized as the context for future learning. More exploratory work focusing on identifying the contribution of sociocultural aspects to young children's understanding of illness causality, especially regarding illness prevention messages and behavioural rules, could greatly aid the development of health education programmes and psychosocial support for young children and their families.

Acknowledgements

I would like to thank my supervisor, Dr Antonia Lyons, for her assistance in the preparation of this paper.

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Stripping the Skin off Humour

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A b s t r a c t

Culturally specific hegemonic processes produce authority over meaning and exclude possibilities for authentic ethical encounters. Contingent on a binary relationship between ‘self’ and ‘other’, humour holds social tensions in particular ways. Where contemporary understandings of humour tend to posit humour as self-evidently desirable (Billig, 2005), there is an absence of psychological attention to the social power relations that constitute the “performativity” of humour – or as Butler (1993, p. 2) suggests, “the reiterative power of discourse to produce the phenomena that it regulates and constrains”. This paper draws on the experience of living the contradictions of hegemonic discourse that produces social positions where laughter is enacted to enable a ‘safe’ encounter. If humour occurs on the boundaries of social convention then what does that mean for the complex relationships at “the hyphen” (Fine & Sirin, 2007; Jones & Jenkins, 2008) between us/them? Is it possible that rather than simply maintaining a particular social order, humour may also enable a re-defining of the contours of social relations? Could humour open spaces at the boundaries through recognition of multiple competing political discourses and make it possible for an ethical response that seeks authentic encounters with the ‘other’?

Keywords: authentic encounters, ethical responses, humour, hegemony, ideological positivism, performativity, hyphenated selves

When I tell people I’m researching humour it often elicits a response akin to laughter. If laughter is read as a response to something humorous, as opposed to serious, then laughter in this instance can be understood as a ‘safe’ reaction to the common-sense idea that humour does not belong in the realm of seriousness.

Discursively produced as independently bounded categories, it appears as if locating humour in the space of seriousness violates boundaries of social convention that constrain how we understand and make sense of humour. Yet in the mundane world of day-to-day living, we regularly encounter violations of apparently fixed boundaries that often pass unnoticed.

Premised on the assumption that humour is a positive phenomenon that carries the potential to enhance well-being, research demonstrates the fluidity of conceptual borders by taking humour as medium for addressing serious issues, as well as a topic of serious investigation itself. Although research regarding the positive potential of humour is inconsistent (see for example Chida & Steptoe, 2008; Erickson & Feldstein, 2007; Kuiper, Martin, & Dance, 1992; Martin, 2002; Martin, Puhlik-Doris, Larsen, Gray, & Weir, 2003), the idea of ‘humour as positive’ persists; and it persists to such an extent that particular forms of humour may soon become protected in law.¹

Putting into question the ‘truth’ of humour as inherently positive, Billig (2005) is critical of contemporary research that privileges humour as self-evidently desirable. Tracing historical shifts in the meanings of humour, he argues that the dominating narrative of ‘humour as positive’ is an effect of what he terms “ideological positivism”, or the ideological tendency to accentuate the positive while repressing the negative. By locating humour in the realm of ideology Billig (2005) makes it possible to re-think humour as a hegemonic discourse that dominates and oppresses.

Reading humour as a hegemonic discourse opens space for investigating the social power relations that constitute the performativity (Butler, 1993) of humour. For Butler (1993) performativity is “the reiterative power of discourse to produce the phenomena that it regulates and constrains” (p. 2), that is, the power of discourse to produce social norms through repetition. Through questions of performativity it becomes possible to ask how humour achieves its status as natural and how some meanings, such as the idea of ‘humour as positive’, are transformed into ‘common-sense’. It also becomes possible to question what this means for our social relations in a hegemonic space.

¹ At present there is a Members Bill before Parliament that seeks to amend the Copyright Act (1994) and to protect the use of satire and parody as a positive form of social criticism (Hughes, 2011).

In the dominating narrative of ‘humour as positive’ questions of the constitution of humour are often taken for granted as self-evident, with those who appear to ‘possess’ or embody ‘a sense of humour’ viewed as experts (Billig, 2005). Dependent upon discourses of individualism, what constitutes humour in this narrative entails a moral dimension that becomes transformed into a matter of authority over meaning, and in the simultaneous split between funny and offensive, humour becomes a space where there exists a violent contest over ‘who decides’. An example of the moral conflict that occurs in the struggle for authority over the meanings of humour was recently witnessed when Jeremy Clarkson ‘joked’ about how he would respond to public servants striking in the United Kingdom - "Frankly, I would have them all shot. I would take them outside and execute them in front of their families" (Top gear host forced to apologise for comments, 2011, para. 9). While Clarkson’s later apology should have resolved the issue if it was simply a case of misunderstood humour, the question of whether or not his comments were funny or offensive persisted. Underpinning the ongoing conflict was an argument that depended upon the idea of a sense of humour and being able to recognise a ‘joke’ when confronted with one.

Asking the question ‘who decides’ presupposes the existence of an authoritative sovereign subject; it also presupposes a subjugated subject. As an account of agency (Butler, 2009) performativity questions the sovereign subject and argues that the subject is constituted in and through a hegemonic process of iterability (Butler, 1993). Butler (1993) argues, “performativity cannot be understood outside of a process of iterability, a regularized and constrained repetition of norms. And this repetition is not performed *by* a subject; this repetition is what enables a subject and constitutes the temporal condition of the subject” (p. 95). That is, the subject emerges as a socially produced agent through the power of discourse to be repeatable.

If the authoritative subject is constituted through hegemonic discourses of humour, then the question of ‘who decides’ becomes dependent upon a circular argument where processes of repeatability lay out the conditions for authority. As such, claims to authority over the meanings of humour can be understood as the production of recognisable subjects – both expert subjects and marginalised non-expert subjects. This means of course that while a claim to authority makes intelligible the temporal condition of the subject it also reproduces the power of humour as a socially accepted form of speech that marginalises and excludes the ‘other’.

In coverage of the controversy surrounding Clarkson’s comment, the media inclusion of particular responses produced figures of authority that included criticism from the Union that represented strikers and members of the UK Parliament, as well as Clarkson stating that his comments were taken out of context. Missing from media coverage were the voices of strikers themselves. Spoken for and about, the effect was an ‘othering’ that produced strikers as a homogenous group of non-expert subjects.

However, drawing on the work of Derrida, Butler’s (1993) use of the term iterability recognises repeatability is simultaneously constrained and undetermined. As a form of speech the repeatability of meanings is contingent upon historical, social and cultural conditions that have contributed to the emergence of humour as familiar and also unfamiliar, open to unimagined and unintended reiterations (Butler, 1993; Morgan & Coombes, 2001). In *Humour and Hatred: the Racist Jokes of the Ku Klux Klan*, Billig (2001) examines the connections between humour and hatred and shows how attempts to rebuke violent racist humour as categorically distinct are destabilised by both the certainty and ambiguity surrounding the multiple meanings of humour. While the dominating narrative enables racist humour to be classified as a form of hate speech (Billig, 2001; Butler, 1997a), it also creates space for hate speech to exist as humour – it *is* just a joke.

In a turn of humorous speech, the effect of ‘it’s just a joke’ is that those who may typically be identified as authoritative voices on racist discourse are silenced and transformed into positions of powerlessness – the non-expert ‘other’. So how do we challenge racist humour when offense indicates lack – lack of a sense of humour?

It may be uncomfortable to realise how the authority of ‘just joking’ can be used to silence voices critical of racism, but the silencing effects of humour have long been known by those voices regularly marginalised and excluded from the power to have authority over the meaning. Lowe (1986) attempted to write against the “darker, better-known side of ethnic [directed] humour” (p. 439) by arguing that the ‘decision’ of ethnic groups “to enter laughing” (p. 439) not only eased the struggle for full citizenship but also opened spaces for a new form of multicultural humour. At about the same time Billy T James had begun to emerge as an icon of Kiwi humour that represented the best of biculturalism. Consistent with Lowe’s (1986) argument the Billy T brand of humour did, in many ways, have the effect of diminishing the line between in-group and out-group, and it had the effect of transforming how we made sense of

our relationships here in Aotearoa New Zealand, but it wasn't without controversy. It was also criticised as racist for drawing on racial stereotypes that re-produced the ethnic 'other' as the butt of humour.

While Lowe (1986) suggests that ethnic-generated humour has the potential to enable participation by undermining the 'darker' side of racially aggressive ethnic-directed humour, what is missed is a consideration of how participation through humour is conditional upon a process of iteration that keeps the relationship between domination and oppression intact. If participation as a legitimate subject is both constrained and enabled by hegemonic discourses of humour that are shaped by specific historical, social and cultural conditions, then is it possible that what Lowe (1986) sees as a 'decision' to "enter laughing" may also be understood as akin to a 'forced choice' where few doors were open and available?

Would Billy T humour have been successful if it didn't draw on existing discourses about our relationships in a colonial society? Was it funny because it was true? Was that how 'Maoris' were? Or was it funny because colonial discourses about Maori had become so familiar as to appear as common sense?

Butler (1993, 1997a) argues that context is important for performativity, and as Billig (2001) demonstrates what constitutes humour or hatred is dependent upon situational factors that shape meaning in particular ways. While it may appear a simple exercise to mark racist humour of the KKK as hate speech in the context of a wider social intolerance toward bigotry, what happens when the contextual conditions of social acceptability enable the re-production and perpetuation of bigotry through the performance of humour? How do we make sense of the status of the racial comparisons in Billy T humour? As a product of its time, do the 'Māori and Englishman' jokes in Billy T humour still make sense in today's society as socially acceptable humour, or racist humour, or even hate speech?

For Butler, hate speech is always retrospective, forms of speech do not become hate speech until articulated as such by an authority (Butler, 1997a, 1997b). Similarly, Billig (2005) argues that humour is also retrospective, and that it is often through a process of taking back authority over meaning that events are transformed into humorous during the re-telling of stories. Again, who decides? Who is without the authority to name hate speech that is performed as if it were humour, and when are they excluded? And how do those without authority name and challenge the hegemonic effects of humour if engagement means repeating processes of oppression?

Understanding humour as an exercise of performativity that delimits authority by holding social power relations in particular ways brings into question the possibility of natural or authentic humour that sits apart from the ways we speak ourselves and others as (il)legitimate subjects. If humour is understood as originating from discourse rather than subjects, then what do we make of intention? Can a joke be just a joke?

What I have tried to do up until this point is to disrupt common-sense notions of humour to enable a re-thinking of humour that questions what humour is *doing*. This entails questioning how humour is positive and for whom it promotes wellbeing. Who has the authority to identify humour and hate speech; to say when a joke is funny? And to consider that if the source of humour is discourse and not subjects, and the performativity of humour, as it is commonly practiced, means the maintenance of a hegemonic relationship, then what does that mean for ethical relationships with the other? Can we continue to repress the negative effects of humour in the knowledge that this re-produces processes of domination where some have authority over meaning? Is it time to rethink humour as both positive *and* negative?

While Billig (2005) isn't explicit about how humour constrains the potential for an ethical response to the 'other' specifically, his work enables a rethinking of humour that makes it possible for dialogue to occur in space where meaning is negotiated on the boundaries of the hyphen – between the 'one' and the 'other' – or between the positive and negative. For Fine and Sirin (2007) the hyphen is a "dynamic social-psychological space where political arrangements and individual subjectivities meet...the psychological texture of the hyphen is substantially informed by history, media, surveillance, politics, nation of origin, gender, biography, longings, imagine, and loss" (p. 21).

Is it possible that rather than simply maintaining a particular social order that conceals the complexities of our relationships at the hyphen, could re-thinking humour enable a re-negotiation of how our relations might look? If space is to be opened in which an ethical response (Spivak, 2004) that enables authentic encounters with the 'other' (Said, 1978) becomes possible, it is necessary to analyse how humour is implicated in the re-production of a hegemonic relationship that constrains authority over meaning. By stripping the skin off humour we create the potential to maintain our desire to enjoy humour, while also opening spaces that recognise multiple competing political discourses, and through this it might become possible to respond to the call of the 'other' ethically and authentically.

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Care as a Contemporary Paradox in a Global Market

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Abstract

The contemporary mother faces difficult choices when deciding whether to be either a 'stay at home' or a 'working mother'. Conflicting discourses of good and bad mothering revolve around a political divide under pressure, one that territorialises the public and private domains. Gilligan (1982) famously highlighted the existence of these domains by challenging Kohlberg's findings that men were endowed with higher moral reasoning powers than women. Disappointed by what she identified as the masculinist bias of Kohlberg's work, Gilligan conducted her own research, finding that men and women reasoned differently but equitably. Gilligan's thesis now theoretically informs a feminist ethics of care that has reputedly transformed political spatial boundaries of the public and private domains, domains traditionally gendered as masculine and feminine. Yet the 'care' that Gilligan has drawn our attention to is seemingly a new phenomenon. Appearing in language around the same time as the birth of Gilligan's feminist ethics and indeed amidst the growing dilemma of the working mother, this care shows no visible sign of its maternal origins. In this paper, I attempt to define and locate care amidst the dismantling of the spatial divide that separates the public and private, a dismantling that coincides with the commodification of care within a global market.

Keywords: care, feminist, ethics, sexual difference, public and private domains, maternal

Within a contemporary global economy, many women are unable to choose whether they stay at home and look after their children or return to the workforce immediately after the birth of their child. Women faced with the predicament of having to return to work and leave their children at childcare facilities during the day have limited and conflicting discursive resources to justify decisions predominantly made for economic reasons. Participation of women in the workforce is now an economic reality, yet the guilt of abandoning the child to professional caring facilities remains.

The Working Mother

Discourses available to working mothers have adapted to highlight the positive aspects that early

mother/child separation and the quality, as opposed to quantity, of mother/child time can have on the development of the child (Barnett, 2005; Bianchi, 2000; Galinski, 2005; Johnson and Swanson, 2007). For the working mother, day care also articulates as providing the child with invaluable socialisation skills and early education. Self-actualisation (Lupton & Schmied, 2002) and self-realisation (Bailey, 2000) where the mother has her own goals outside of motherhood are also available avenues of work-life justification. Working mothers are therefore able to articulate the integration of motherhood and public life as beneficial to both mother and child to appease the guilt associated with hands-off mothering.

The Intensive Mother

The stay at home intensive mother finds the changing attitudes towards a necessity to work troubling, and struggles, like the working mother, with shifting motherhood ideologies of good and bad mothering (Hays, 1996). She insists on staying with her child for at least the first few years of its life and believes that quantity of access is synonymous with quality: early mother-child separation is dangerous for a normative developmental process (de Marneffe, 2004). She articulates her role as a stay at home mother as necessary for the child; that it is better to care for the child at home within a close mother-child relationship than to place the child in a professional caring facility, such as day-care. Self-actualisation equates to selfishness and is no match for the rewarding satisfaction of selfless mothering (Hays, 1996; Kahu & Morgan, 2007).

Once lauded as a template for ideal mothering, the role of the intensive mother is now under fire. To be socially acceptable, she requires the economic stability of a partner with a middle class salary. Indeed, contemporary discourse subjects the solo intensive mother to a political and social flaying that depicts her as an economic leech using the benefit system to prop up a slothful lifestyle. If the intensive mother does bow to financial and social pressure and ventures from the caring/nurturing role into the public world of employment, statistics suggest that the work she obtains is likely to be

casual, part-time, poorly paid and most probably within the service industry. This industry is labour intensive and predominantly employs women and migrants on a part-time casual contract system that offers minimum wages (Fine, 2007).

For the intensive mother who decides to make the transition from the private to the public realms of care, there is a wall to climb. A pioneer of work-life mothering discourse research, Hays (1996), describes the current dilemma of the intensive mother as follows:

The wall between the public and private spheres, always inadequately maintained, now has many cracks. When this is coupled with women's apparent refusal to remain on their assigned side and their decision to instead seek out recognition and remuneration in the public sphere, one would expect this fragile barrier to completely crumble and the ideology of intensive mothering to be crushed under its weight (Hays, 1996, p.153).

This wall, brought to our notice here by Hays (1996) separates the private and public domains amidst the confusion of what makes a caring mother: it holds unexplained dangers for both intensive and working mothers. These dangers sit within the surrounds of an ethical impasse glimpsed by Carol Gilligan (1982) thirty years ago when she maintained that women spoke with a different voice and coined care as inseparable from morality and equitable ethical encounters.

Care as Ethical

Gilligan (1982) extracted care from a masculine world of ethical theory where her mentor Kohlberg had been experimenting with the concept of higher moral reasoning, developing a scale of the same name. The rationale behind his scale was as inspiration gleaned from the ethics of John Rawls (1958/1972), who maintained that those who possess higher moral reasoning would reason outside the law to achieve an ethical solution. Kohlberg subsequently concluded that boys possessed higher reasoning powers because they were willing to look past cultural sanctions to obtain the most ethical outcome. Gilligan, somewhat disconcerted by what she saw as Kohlberg's masculinist attitudes and phallogocentric experimental methods conducted her own research, underpinned by her developmental psychology background and the theorising of Chodorow (1978). Chodorow's work refuted the thesis of Freud (1977) concerning the development of boys and girls by suggesting that although Freud had insisted that girls must reject their mothers in favour of their fathers as a natural progression of development, this was not the case. Girls

remained attached to their mothers and did not undergo an inevitable separation as posited by mainstream developmental psychology.

Within her research, Gilligan (1982) presented a vignette to child participants, Jake and Amy for consideration as to what would be the most ethical outcome. The story presented to Jake and Amy went as follows: Heinz has a sick wife who is in dire need of medication that he is unable to afford. The chemist has refused Heinz credit. The children consider whether Heinz should steal the medicine to help his sick wife. Jake believes that Heinz should steal the medication. He only has one wife: he must save her life. The business owner can recover his costs from other customers. Amy however believes that Heinz cannot steal the medication. For her, the theft causes other problems. What effect will the possible incarceration of Heinz have on the ongoing health of his wife and indeed his family? Who will look after her when he is in jail and how will the family cope with the shame involved? Surely, there are legal ways to obtain the money to pay for the drugs.

Gilligan (1982) suggested that although there was certainly a difference in the moral reasoning of boys and girls, one was in no way inferior to the other. She concluded that boys reasoned with an ethics of justice and girls reasoned with an ethics of care. This equitable difference in moral reasoning identified by Gilligan becomes noticeable within the confusion of work-life balance discourse, where women go to some lengths to justify their decisions on how to care for their children, even though there are no real choices involved for many.

The care that Gilligan (1982) identified was a private care, a care that resides in the realm of the family. This care now underpins the global ethics of care that drives the feminist care movement (Held 2008; Sevenhuijsen, 1998; Tronto, 1993, 2008). An ethics of care seeks to take its uniquely feminine wares to the public market in a bid to sell care as an occupation of some worth.

Interestingly this care only appeared in the public domain in the late 1970s, not long before Gilligan's (1982) groundbreaking research on moral reasoning. Care is a relatively new phenomenon (Forbat, 2005), first officially appearing in literature and formally in dictionaries in the 1980s (Bytheway & Johnson, 1998). Before this, according to Barnes (2006), care was just something that women did within the context of families, kin keeping and mothering.

The Advent of Caregiving

From the early 1980s to the present day, researchers have produced a barrage of mainstream research in an effort to investigate the entity called care and the effects its administration(s) might have on the caregiver. According to Barnes (2006), encouraging the production of this research enhances the feminist move for public recognition of private unpaid and underrated care work. Research covers many popular conceptions of caregiving related variables including burden (Essex & Hong, 2005), strain (Bernard & Guarnaccia, 2003), stresslessness (Pinquart & Sorenson, 2005), aggression (Shaffer, Dooley & Williamson, 2007), distress (Gallagher-Thompson & Coon, 2007), attachment (Cicerelli, 1995), decision making (Cicerelli, 2006), personality traits (Hollis-Sawyer, 2003) and caring skills (Schumacher, Stewart, Archbold, Dodd & Dibble, 2000). According to Bowlby (2011), this deluge of research on those who care, dwarfs the modest output of research on those in need of care or care relationships themselves.

The raft of contemporary research on caregivers highlighting care as a matter of public worth produces definitions in an effort to capture both care and care giving as concrete constructs. For Walker, Pratt and Eddy (1995, p. 402), a common definition of caring requires “one or more family members [to] give aid or assistance to other family members beyond that required of normal everyday life.” Yet according to Walker and Pratt (1991), there is a difficulty in separating acts of friendship and acts of aid. For example, a family friend may shop for a family member in an act of perceived friendship irrespective of the fact that the family member may or may not be able to do his or her own shopping. These acts of friendship are excluded by Schofield et al., (1998, pp. 3-4) who states that caregivers “are people who are under some kind of obligation to care because of their close kinship or emotional bond to the care recipient.” Caregiving here equates to burden and obligation beyond ordinary acts of friendship.

According to Ross (2003) the legally defined caregiver in the United Kingdom, is “an individual who provides or intends to provide a substantive amount of care on a regular basis for another person.” Care is now not only obligatory and a burden, but becomes measurable in quantity and maintainable over time. The intention to provide care is apparently also enough to qualify as a caregiver. This means that inadequate care or no care potentially becomes available as a marketable commodity. In other words, once defined as intending to provide a quantity of care over time, the caregiver can regularly administer no care under the umbrella of such a definition. No care, ‘administered’ in varying

degrees becomes care purely through intent. These forms of care are evident in research undertaken by Brechin, Barton and Stein (2003, p. 165) when they consider “difficulties in care relationships”, “care that might give cause for concern” and “suboptimal care.” Care discourse now portrays care as good, bad, non-existent, neglectful and downright dangerous.

Within contemporary western global society, definitions of caregivers are increasingly appearing in forms that are compatible with statistical analysis under the careful guidance of the OECD. Care is manifesting as user-friendly lists of economic indicators: family relations turn into matters of economic worth (OECD, 2011). The term caregiver can be refined to include a primary caregiver only and one who is an unpaid family member. According to Fine (2007, p. 30) a carer publically defined as such in the private domain is not paid and is not a neighbour, friend or teacher. Carers are not “mothers, fathers, step-parents, foster-parents and custodians of children who are not disabled or suffering a long term health condition...” nor are they “grandparents providing care for grandchildren and people with disabilities caring for their own or other children.” Care now becomes explicitly non-maternal.

Attempts to define the meaning of care as a construct in Fine’s (2007) opinion can only end in frustration and dispute. Fine (2007, p. 31) describes care as a “social phenomenon that is constituted and reconstituted by our actions, so that its meaning cannot be held still to study.” If this is indeed the case, we should be very wary of the statistics and their primary indicators that official definitions of care generate. For example, Stalker (2003) informs us that statistics gathered through our evolving economic care indicators show that the gap between the numbers of men and women carers is closing. According to Stalker (2003), this suggests that care is no longer a woman’s domain or in other words, a predominantly feminine ethical attribute as was once discovered by Gilligan (1982). Considering that the definitions of care are many and varied, as are the indicators employed in global statistical gathering, how can we have faith in such a claim?

Slippery Care

Although Fine (2007) laments the loss of care in that it is unable to be captured adequately as a construct, actually it is difficult to lament the loss of something that is relatively new and most definitely present, even though we are not actually sure what it is and where it came from. We can only surmise that it has slipped not so stealthily away from its maternal origins and made its way across the boundary between the public and private

domains in an effort to establish itself within public policy. Yet care's arrival, as a new public phenomenon no longer sits compatibly with the traditional maternal underpinnings that Fine reminds us are no longer connected. For example, O'Conner (2007) has identified disturbing differences in the caring behaviours of daughters caring for their mothers when they have identified themselves as carers and their mothers as patients. These caregiving daughters are more likely to make decisions that defy their mother's wishes than those who do not identify their mothers as patients and regard themselves as daughters. O'Conner is not the first to make this observation. Barnes (2006) acknowledges this subtle shift in signification as a necessary side effect if a feminist ethics of care is to become a universal statute of good and not just a natural responsibility of women, contained within the private domain where once it was something unspoken, just something that women did. In other words, caring duties exist when they become publically recognised and maternal connections nullified.

Care Ethics

According to McIlwraith and Madden (2010, p. 658-659), care "ethics is not simply the study of 'right' conduct" and "is the study of rational processes for determining the course of action in the face of conflicting choices." This might explain the eclectic mix of Western moral philosophy of community good that underpins the administering of public care.

There are two major versions of western moral good, deontological ethics and ontological ethics. Deontological ethics captures Kantian ideals of universal unchangeable laws, such as you do not kill under any circumstances (Cornman & Lehrer, 1974). Ontological ethics or the utilitarianism of Mills and Bentham, seeks the greatest good for the least harm (Cornman & Lehrer, 1974; Williams, 2009). Both of these conflicting ethical stances exist within the moral codes of caring professional practice. A universal law of the medical profession requires that a medical practitioner must not aid in a patient's death no matter what the circumstances. Euthanasia would require a utilitarian ethical approach measuring the consequences of prolonging life against the act of deliberately causing death. These approaches are obviously incompatible, yet deontological ethical values such as honesty and the preservation of life continue to exist in conjunction with ontological ethical considerations required by a contemporary lack of resources. Medical practitioners are increasingly asked to allocate care on a least harm, most help basis as well as to decide who is most entitled to precious health re-

sources (Williams, 2009), especially in regard to the elderly, the poor, smokers and drinkers.

To complicate this contradiction even more, ethical care adds a sprinkling of Aristotelian virtue in the guise of empathy and compassion; a touch of eclectic ethical principles (Staunton & Chiarella, 2008), such as autonomy, beneficence and nonmaleficence (Garrett, Baille & Garrett, 1993); and a collection of non-rational approaches such as following accepted practice and consulting superiors (Williams, 2009). An eclectic conflicting foundation of philosophical ethical theory therefore guides the caring professions and their armies of contractual labour into a global economy and attempts to regulate a 'construct' that is relatively recent and ambiguously defined.

A brief summary of care ethics reminds us that a feminist ethics of care also originates from a hybrid of rationalist thinking inspired by Rawls and subsequently Kohlberg's research on moral reasoning. The ethical ponderings of Rawls (1958/1972) combines universalism with utilitarianism, theorising a hierarchical interaction between the two. Deontological reasoning represents Kohlberg's masculine powers of higher reasoning and utilitarianism the lower registers.

Gilligan's (1982) thesis therefore identifies an equitable morality of justice and care and highlights deontological matters of universal greater good framed as the public concerns of masculinity. It also reveals women as being more likely to practice a utilitarian ethics of risk management within the private domain for the purpose of appeasement and kin keeping, hinting at a struggle to keep a tenuous hold on maternal ethical encounter. This would suggest that women are more likely to practice ethical strategies to negotiate a position designated to them within western society and that a feminist ethics of care is more likely to be based on a feminist ethics of survival.

In other words, we can celebrate the fact that thirty years ago Gilligan (1982) temporarily rescued care from the clutches of utilitarianism by reframing it within maternal connections even if philosophy has snatched it back through the care ethics work of Tronto (1993) and her predecessors. This tug of war between care generated by both philosophy and Freudian developmental psychoanalysis has continued, accentuated by the work of Hollway (2006) and isolated amidst a flood of political global care theory and a feminist ethics of care. Hollway's (2006) work combines mother-daughter psychic encounter, Gilligan's (1982) psychoanalytically based equitable care and Tronto's (1993) public care with parental equality within a contemporary public domain that overshadows the mother-daughter connec-

tion. Yet the mother-daughter encounter forms Hollway's initial basis of care. Therefore, she advocates dispersion of the public private boundary, turning the dilemma of the incompatibility of maternal care and philosophical care into the age-old discussion of gender equality and equity.

Equity and Equality

In the context of this paper, gender equality differs to equity in that it can be aspired to publically within economic discourses of equal pay, equal employment and promotional opportunities and ultimately, equal status. In short, equality means being equal to men and treated accordingly. Within this discourse, men set the benchmark of achievement. Equity, on the other hand, means equality in respect to difference: one does not have to aspire to sameness to be equal. The assimilation of care administrators into caregivers, patients and parents spells equality, a benchmark of public achievement, or in other words, sameness. Care, as a unique feminine difference equitable with justice no longer has currency in the public domain.

Hollway's (2006) work therefore endorses Chanter's (1998) warning that theories of gender equality gloss over the obvious discrepancies between the differences in rights between men and women (Chanter, 1998) and this is by no means a new concern. Feminism has struggled with Marxist theories of an economic gender based division of labour on offer on the public/justice side of Hays' wall and psychoanalytic theories of phallogentric discrimination imposed through the delegation of gender and engrained in western culture on the private/care side. In the early 1980s, Hartmann (1981) initiated discussion advocating a dualist approach in that lack of economic equality and gender discrimination were two separate problems. Young (1981) was adamant that Hartman was mistaken, that the two issues were impossible to separate: phallogentricism was an economic anomaly.

For Gatens (2003) it is philosophy's active pursuit, as demonstrated by Kohlberg, to frame women as less capable of rational decisions, as the catalyst for women developing their own theories of feminine sexual difference. Cixous (Cixous & Clement, 1986; Makward & Cixous, 1976) and Irigaray (1985) incorporate an embodied feminine unavailable through mainstream philosophical theory that at first glance appears simultaneously workable with public matters of economics and class. This ideological debate works towards equitable difference through an articulation of the embodied feminine, an embodied maternal and through an active production of feminine writing.

While the equality-equity debate continues amidst disagreement, there is still such a thing as oppressive phallogentricism within the private domain as well as optimism that a self-determined equality is possible within the public domain. For Soler (2006), feminist aspirations of equality and/or equitable sexual difference sit at opposite poles. Feminism oscillates between these poles in a state of equilibrium that is at this stage erring toward the extreme of equality. Soler (2006, p. 158) suggests that: "Although this movement has not yet accomplished its goals completely, its effects are becoming more general, and its triumphs seem irreversible to me." Indeed Soler (2006) is not the only believer in the impending triumph of equality, given that the nuclear family upon which early maternal psychoanalytic theory of normative development upholds, no longer appears to be the predominant model of care production. There is a movement of opinion voiced also by Hollway (2006) that the gender inequity debate is now redundant. The birth of an androgynous public care that reconstitutes mothers and daughters as caregivers and parents has given rise to talk that work-childcare is no longer solely a woman's issue; it is a family or parental concern (Halpern, 2004, 2005).

This suggests that Soler's observations are indeed correct. The increase in equality sees the demise of equity. Care now detached from the maternal offers an equality that excludes theories of equitable difference. Within discourses of care, both work-life balance and a feminist ethics reveal that not only is the mother disappearing under a barrage of empty commercialised care, but also at the same time, mother/daughter caring connections, accentuated by Chodorow (1978) after being dismissed by Freud, are becoming increasingly difficult to articulate.

While this battle between equality and equitable difference continues, care remains lost, reconstituting itself amidst an eclectic mess of non-meaning. Mothers remain confused as to what constitutes an ethical maternal caring role and continue to articulate their concerns through the available conflicting discourses of intensive mothering and work-life balance. These concerns remain framed within a utilitarian discourse of appeasement.

Although Soler's (2006) observed state of equilibrium makes sense within the bounds of available discourse, a question remains of how that could possibly be the case. How can equality articulate as sameness, set up as an opposite pole to equitable difference? If we accept that an equitable feminine difference allowing for a unique maternal ethical 'caring' connection is not available alongside equality then this crumbling 'wall'

between the public and private stands firm, despite Halpern's (2004, 2005), Hays' (1996), Hollway's (2006) and indeed Soler's (2006) insistence that this boundary is in a state of decay. Both intensive and work-life mothers will continue to exist in a seething mess of discourse that articulates ambiguity, responsibility and conflict mixed with justifications for a mothering role dictated by global economics. Gilligan's glimpse of equitable care as the forerunner to a feminist care ethics becomes lost and plunges headlong into contemporary discourses of assimilation and equality.

The way forward therefore, for theorising an ethical equitably based care becomes an exercise of retracing the underpinnings of Gilligan's (1982) work back towards the pre-oedipal mother in an effort to find the source of her equitable care. Chodorow's (1978) unique mother-daughter connection provides a good starting place to engage with a pre-commodified, pre-spoken care, a pre-signified care that is truly equitable when spoken alongside discourses of economic equality. In other words, it is time to re-write a culturally enforced child-mother split that has resulted in women's participation in a utilitarian morality of rational confusion and burden, inextricably entangled within Freudian based theories of normative development.

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The Problem with Death: Towards a Genealogy of Euthanasia

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Abstract

A hugely contentious issue in society today is whether individuals have the right to choose when and how to die. The ethics, legality and morality of euthanasia have been hotly debated in many countries around the world. However, the phenomenon of euthanasia has not just emerged recently, on the contrary a wide ranging and diverse network of events have all played some part in our present day understanding. This paper presents a genealogical analysis, an overview of a Foucauldian 'history of the present', that addresses the issue of how euthanasia has emerged as a possible solution to terminal illness. It examines the conditions present at particular periods of time and a specific, but disorderly collection of incidents that have allowed our present constructions of euthanasia to come about. This focus recognizes the intrinsic relationship between discourse, knowledge and power as the construction of particular discourses of euthanasia that may prevail in our society today, and are accepted as 'common sense,' provide the potential to act in certain ways, while marginalizing alternative practices. This genealogy challenges both the origins and functions of our present day 'knowledge' regarding euthanasia and the assumptions of self-evidence and inevitability that accompany prevailing discourses.

Keywords: euthanasia, Foucault, bio-power, autonomy, neo-liberalism

Introduction

Genealogy is an unsettling methodological device (Gutting, 1994) that has the potential to challenge the very origins and functions of our present day 'knowledge' regarding euthanasia. Although Foucault frequently used this historical technique he termed it a 'history of the present' because rather than attempting to identify an overall grand narrative of historical progression, he was instead interested in the multitude of ways in which certain events and understandings may have come about. Thus, unlike traditional histories that trace the causal factors that have led to the inevitable present situation, Foucault focused on the incidental nature of history in order to undermine these assumptions of inevitability. His 'history of the present'

demonstrated that institutions and practices and the knowledge upon which they are based have in fact been quite different in the past and it is not particularly obvious or necessary for things to be the way they are today (Gutting, 1994).

Therefore, in order to examine the 'history of the present' of euthanasia we need to address the issue of how euthanasia has emerged as a possible solution to terminal illness. We want to know what conditions present during a particular period have allowed the emergence of certain discourses and specific ways of doing things rather than any alternatives. How have, for example, discourses of personal autonomy and medicalisation attained a 'taken-for-granted' status and been accepted as so self evident that they can be used to endorse the practice of euthanasia? This genealogy will focus on a small but significant collection of incidents that can help support our understanding of how we have arrived at this present point.

Power and Death

It is important at the outset to situate this genealogy of euthanasia within its context by explaining the relationship between death and power. The status of death underwent a significant transformation with the change from a repressive regime of sovereign power that was characterised by the monarch's right over life and death to a new positive form of power that was concerned with the administration of life. The emergence of this 'bio-power' has been attributed to some key developments that took place early in the 17th century that were accompanied by the need to manage people. Central among these was the Industrial Revolution and the rise of capitalism with the corresponding requirement for a constant docile workforce. No longer were human beings dispensable at the whim of the Sovereign as in feudal times; the control of the body and populations became essential for the success of the capitalist economy (Power, 2001). However, the relationship between bio-power and capitalism was, according to Foucault, mutually dependent, as one was neither possible nor necessary without the existence of the other (Rabinow, 1984).

Bio-power, which centred on the fostering and regulation of life, oscillated between the human body as an object for manipulation and control and the collective politics of the population. This called for the coming together of power and knowledge to monitor, regulate and transform human life via procedures termed 'disciplinary technologies'. The concomitant development of the physical sciences provided the necessary tools for the empirical analysis required for the methods of normalization that were an essential component of these procedures (Rabinow, 1984; Rabinow & Rose, 1994). However, of central importance to this genealogy is the point that Foucault (1978) highlights that although bio-power seeks domination over life, it has not in fact turned away from death because death can be viewed as the limit to this power.

Having contextualized this issue of the connection between power and life and death this paper will give a brief outline of what a genealogy might look like by first considering the notion of suicide and its historical link to euthanasia and the development of moral arguments. This will be followed by an examination of the changing roles of the priest and the physician in the dying process and the medicalization of society more generally. The influence of scientific knowledge, changing socio cultural boundaries, and the development of neo-liberal ideologies on the present-day constructions of euthanasia will then be analysed.

Historical Constructions

The taking of one's own life has been part and parcel of human culture since ancient times but there have been widely varied attitudes through the centuries and amongst different societies. The ancient Egyptian view that the living and dead were just different forms of existence led to a neutral or ambivalent approach to the question of self-destruction. The ancient Greeks held diverse views, and laws and practices differed from city to city. For example in Thebes self-killing was condemned and the person was denied funeral rites. Likewise in Athens the law required the hand (responsible for the deed) to be cut off and buried separately from the victim's body (Evans & Farberow, 2003). However, in some Greek communities magistrates presided over special tribunals that would hear arguments from citizens who wished to kill themselves. Permission could be granted and the poison hemlock supplied if sufficient grounds such as profound physical or mental suffering were established (Evans & Farberow, 2003).

The Greek 'father of medicine', Hippocrates (460 – 377 B.C.) formulated the Hippocratic oath that is still used today as a guiding principal for medical ethics and

professional conduct. It is thought that the sentiments expressed in the oath originated from a group of Greek philosophers called Pythagoreans who condemned self-destruction as advocated by many other Greeks of the time. The oath specifically denounces self-killing and also rendering assistance to someone to kill themselves: "I will neither give a deadly drug to anybody if asked for it, nor I will make a suggestion to this effect" (Evans & Farberow, 2003 p.119). The ramifications of this oath still resonate today with physicians involved with end-of-life issues.

However, many Greek philosophers judged the act of self-killing based on the moral or ethical nuances of the circumstances. Socrates viewed life as belonging to the gods and therefore without their permission taking life was wrong. However, if dying became necessary it was permissible by the gods and could be considered as noble. Thus, when Socrates was condemned to death by an Athenian court in 399BC for corrupting the minds of the youth of the city he took his own life by drinking Hemlock. Socrates pupil Plato (428- 348 BC) also disapproved of self-destruction, recommending that anyone who killed himself should be punished because of the lack of manliness of the act by burying the deceased in an unmarked grave on the outskirts of the city. His student Aristotle (384-322 BC) reinforced the illegitimacy of self-killing based on the notion that man belonged not only to the gods but to the state, not to himself (Evans & Farberow, 2003). Thus, his condemnation was widened to incorporate a political rationale that viewed man's allegiance to the state as morally precluding him from taking his own life.¹

The Romans however, although punishing self-destruction under certain conditions, expanded the criteria of the law to justify taking one's own life in circumstances of *taedium vitae* which is a mental state which can variously be described as depression or simply having had enough of life. This criterion however, was not extended to slaves who were considered the property of their owners, soldiers, or those accused of a crime (Szasz, 1999; Lieberman, 2003). Later came the Stoic philosophers, disciples of the Greek philosopher Zeno, who articulated a more pragmatic view on self-killing. Although they advocated careful contemplation before the act of self-destruction, they recognised that death was an option to release them from life's sufferings. Indeed, the Roman Stoic who opted to end his own life could utilise the services of a trained technician to sever his veins. Seneca (4 B.C. – A.D. 65), one of the most famous Stoic philosophers, recommended that as

¹ The gendered language in this section is a reflection of the law of this historical period.

you reached old age you should kill yourself to avoid the inevitable accompanying decay and this should be completed earlier rather than later when you may not be able to complete the act yourself (Szasz, 1999; Evans & Farberow, 2003).

Humphrey and Clement (1998) suggest that the approach of the Greeks and Romans which allowed for self-killing under certain conditions may have influenced the authors of the Bible. The ancient Hebrews recognised the sacredness of life given by God and therefore prohibited the ending of one's own life except under extreme conditions such as defeat in battle or being forced to betray the Jewish faith. However, the Old Testament does not offer a judgement on the rights or wrongs of self-killing but describes a number of instances of self-destruction that are represented as justifiable. For example the first king of Israel, Saul kills himself to prevent falling into the hands of the Philistines; and Samson, after being betrayed by Delilah, pulls down a Philistine temple upon himself and his enemies. The New Testament also neither specifically condemns nor supports the taking of one's own life and little comment is made on the hanging of Judas Iscariot after betraying Jesus (Evans & Farberow, 2003).

The Christian Church followed the Platonic view that God gave humans life and as such it belonged to him and could only be taken by him. However, early Christians embraced the idea of dying for God to show their absolute love, for example Saint Ignatius (d.c. A.D. 119) the Bishop of Antioch beseeched his congregation to feed him to the wild beasts so that he could become a true disciple of Jesus. Although the early Church viewed this honourable taking of one's life for God as a noble sacrifice in much the same way as the early Romans, the rate at which Christians sought martyrdom eventually resulted in the Church issuing edicts against the practice (Szasz, 1999; Lieberman, 2003).

The Church's position on self-killing was formalised by the works of the great theologian Saint Augustine of Hippo in the 5th century. He denounced self-destruction on the grounds that it was an act of murder against oneself in direct violation of the fifth commandment: Thou shalt not kill. It was in defiance of divine authority and punished by denial of both funeral rites and burial in consecrated grounds. Saint Thomas Aquinas (1225-740) reinforced Augustine's teachings and revived Aristotle's idea that not only did life belong to God but self-killing was also an act against society. This view was used in the Middle Ages to support many barbaric practices and civil penalties against those who had taken their own life, and their surviving families. Thus, in England all properties were confiscated and the body was dragged

through the streets and buried at night at a crossroads often with a stake driven through the heart to prevent the soul wandering (Evans & Farberow, 2003; Lieberman, 2003). Foucault (1978) comments that it was unsurprising that suicide was characterised as a crime when the power of death, which was perceived as the sole right of the sovereign (whether on earth or in heaven), was appropriated by the individual in this act of self-destruction.

This stance on self-destruction still remains in effect today in the Roman Catholic Church, many traditional Protestant churches and in Judaism but it has been ameliorated by the medical view, accepted also by secular law, that self-killing can be excused on the grounds of insanity, thus avoiding religious penalties (Evans & Farberow, 2003). However, there is no doubt that the concepts of suicide and euthanasia and assisted dying are bound together historically and share similar moral arguments. It also seems that euthanasia and assisting dying, have been regarded as more acceptable forms of suicide throughout antiquity. This view continues today with many advocates of the right-to-die attempting to distance the practice of assisted dying from these historic connections to suicide and the corresponding taboos on the grounds of terminal illness (Norwood, 2009).

Medicalisation

Lavi (2005) argues that the modern concept of euthanasia can be traced back to the movement of death and dying from the domain of religion to that of medicine and law. The meaning of the word 'euthanasia' itself has changed radically over the last two hundred years. The term comes from a Greek root meaning 'well-dying' and implies a 'good death' or 'easy death'. In this original sense, the Christian world viewed euthanasia as a death blessed by God. The deathbed at this stage was very much a public event and the province of religion, with behaviour surrounding it governed by a book of rules known as *ars moriendi* or 'the art of dying'.

However, during the nineteenth century the physician began to usurp the role of the minister as dying became a medical event. The physician was now charged with helping the patient achieve this easy death while not hastening it. Thus, by the middle of the nineteenth century the meaning of euthanasia reflected the assistance of the physician in providing a painless death. This medicalisation of death on the other hand was somewhat problematic because the physician could not cure dying patients: therefore, the option of hastening death by, "medical euthanasia emerged as a possible solution to the problem of dying" (Lavi, 2005, p. 6).

The subsequent attempts to legalise medical euthanasia had the effect of taking death and dying into the realm of law and public policy.

The causes of death have also changed, particularly over the last century, with deaths from infectious disease giving way to death from more chronic degenerative conditions such as cancer and heart disease. Thus, the experience of death and dying has been transformed over time by significant advances in medical technologies from a short-term event to one that usually involves a prolonged time of slow decline. Alongside this has been the movement away from dying in the home surrounded by friends and family to dying in a hospital or other medical setting being tended to by health professionals (Lyons & Chamberlain, 2006).

It is important at this point to emphasize the profound effect of medicalisation on society. Health and medicine are integral to the concept of 'normality' that is an essential component of the disciplinary techniques of bio-power that seeks to regulate and transform human life. The medical 'gaze' encompasses all aspects of our lives, constantly monitoring and regulating our bodies in order to achieve social control of the population. At no other point in our existence is this medical regime as strict as when we move into frail old age or become terminally ill (Lupton, 1997). Foucault argued that medicine had formed a unique relationship around death and the modern subject. However, in contrast to the changed relationship between power and death that accompanied the shift from sovereign power to bio-power, the normalizing role of medicine required a different reorientation in its relationship to death. Developments in Western medicine at the turn of the 19th century lead to a change of focus from the promotion of life through the cure of disease to concerns regarding the pathology of death. New light was shed on death by examining the anatomy of the corpse in order to determine the nature of disease and illness. Therefore rather than our common perception that medicine's sole preoccupation is with the maintenance of life, it can in fact be characterized as having a positive relationship with death (Tierney, 2006).

Scientific Knowledge and Autonomy

The interest in euthanasia and assisted suicide continued to grow in the late nineteenth century as a by-product of Darwin's theories of evolution. The so-called social Darwinism was augmented by the principles of eugenics espoused by Galton and expressed in the desire to 'weed out' the weaker, less productive members of society. These beliefs, based as they were on scientific knowledge of the natural world, found international

favour. For example, this initial mandate was channelled into a call for the voluntary legalised mercy killing of terminally ill patients with the founding of the Euthanasia Society of America in 1938. Likewise in Germany, the initial interest in eugenics-as-euthanasia was based on the concept of humanely removing 'lives not worth living' as a service to both the individual and to a burdened society (Szasz, 1999). It was only following World War II and exposure of the Nazi regime's euthanasia practices that there was a widespread public backlash against both the eugenics and euthanasia movement.

However, changes in the socio cultural climate during the 1960s and 1970s that saw increasing secularisation and challenges to traditional authority led to a growing demand for individual rights, and autonomy. This, coupled with the advances in modern medical technology that could prolong the dying process, provided fertile ground for the renewed growth of right-to-die organisations (Gorsuch, 2006). Importantly, this was fuelled by claims to civil rights rather than an ideology of improving social 'stock'.

Indeed, one of the major assertions in the euthanasia argument is that individuals should have the right to self-determination and control over their own dying. However, there is much to suggest that rather than recognising personal autonomy, euthanasia in fact represents an extension of the medicalisation of death. Medicine has expanded its normalising power to include suicide as a 'treatment' for terminal illness. Nevertheless, in the Netherlands where euthanasia has been legalised and 'normalized', studies have indicated that in practice some members of society will inevitably be sidelined due to their inability to appropriately engage with the complex discourses involved (Norwood, 2009). This exclusion has been heavily criticised by Szasz (1999), as he believes that it is an indication of just how little control and autonomy the Dutch actually have on the way they die. He suggests that the illusion of control lies in the way that patients can manage the request to die to their doctor to obtain the necessary legal sanction, but it is always on the doctor's terms. In his provocative book *Fatal Freedom*, Szasz (1999) is most concerned with who exerts control over the taking of one's own life. In charting the historical changes to people's attitudes towards self-destruction he points out, "Suicide began as a sin, became a crime, then became a mental illness, and now some people propose transferring it into the category called 'treatment', provided the 'cure' is under the control of doctors" (p.x).

Neo-liberalism

The significance and importance that we ascribe to this concept of autonomy can be seen as a reflection of 20th-21st century neo-liberalism. In other words, neo-liberalism places value on economic markets, efficiency, consumer choice and personal autonomy in order to shift risk from governmental authority to individuals. It is a form of self-regulation and self-discipline that bears the hallmark of bio-power. However, closely linked to this imperative to be in charge of your own destiny is the individual's responsibility to ensure that they minimize the risk they pose as a possible burden to society. The rationality of government is very much focussed on the commodity of an economically productive life. It demands a fiscally prudent approach to the cost of each individual life to society. At the same time it also needs to economize on its own activities so that it can achieve more but with a lesser show of strength or power (Gordon, 1991).

Coupled with the emergence of this aspect of government has been the changing face of death over the last century that has resulted in both an extended dying process and a rapidly growing aged population. The amalgamation of these two factors creates a situation that will inevitably shape the knowledge and practices surrounding the governing of death. It is no accident that renewed calls for euthanasia are coming at a time when the proportion of the population not in the work force, i.e. unproductive labour units; is increasing at such a rate that a successful capitalist economy cannot be sustained. For example, the increase in the aged population over the next 25 years means that 70 million in OECD countries will retire to be replaced by just 5 million newcomers (Ministry of Health, 2004). Added to this are burgeoning health costs that are disproportionately allocated to the elderly and terminally ill who often require expensive, long-term treatment before death (Humphrey & Clement, 1998). There have even been suggestions (Fung, 1993) that insured patients could be offered a benefit conversion for agreeing to euthanasia, thereby avoiding costly, aggressive treatments, which would assist in bringing health budgets under control and lower insurance premiums. As Battin (1987) succinctly states, "suicide is cheap" (p.169).

Summary

Euthanasia is ostensibly a humane response to the incalculable pain and suffering associated with chronic and terminal illness and the loss of quality of life. It can be viewed as a noble aspiration, laying claim as it does to individual rights, freedom of choice and personal autonomy. However, this genealogy is able to

open up that discursive space surrounding euthanasia to at least a modicum of suspicion.

In tracing the historical development of moral arguments, we are able to gain some insight into Foucault's suggestions about the formation of the self through self-subjection within these ancient ethical frameworks. The ethic of self-killing was firstly identified in order for it to become moulded by moral actions. This required the subjection of the self to a recognised moral order. For example, the ancient Greeks and Romans subjected themselves to the gods or the state and the early Christians to their Creator. As a result this moral obligation became objectified into ethical discourses and rules of behaviour. Turner (1997) argues that these 'discourses of subjectivity' have the effect of producing identities, for example the chronic sufferer and the terminally ill. As this genealogy further unfolded it became apparent that in Turner's words, "it is these identities which then become the object and focus of medicalisation and normalization" (p. xii). Foucault argued that medicine was at the center of the quest for normalization and by its infiltration of the law had created a 'juridico-medical' web that represented a major structure of power (Foucault, 1996).

The increasing demands for the legalization of the right-to-die are unlikely to deliver the promised 'freedom of choice' or control of our own dying. Rather it will result in an escalation of governmental power. Euthanasia can be viewed as emblematic of neo-liberalism that is intrinsically linked to an art of government that develops the ways and means in which to shape and guide the conduct of each and every one of its citizens. It requires the population to be acted upon to ensure its own welfare and for its own economic good through techniques that need to appear reasonable and acceptable to both the practitioners and the people (Foucault, 1991). Hegemonic discourses of medicalisation and personal autonomy that prevail in our society today and are accepted as 'common sense' seek to represent euthanasia as the obvious response of a humane society to terminal illness. They endorse a practice that is widely viewed as the logical extension of a fundamental human right. However, it should be recognised that these discourses also allow for the exercising of power while simultaneously masking that power.

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

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Abstract

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

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

When I (Robbie) began my thesis research, I realised that few psychologists had evaluated narrative therapy. Part of a postmodern therapy movement, some have called narrative therapy social constructionist (Freedman & Combs, 1996) others post-structuralist (Besley, 2002; Speedy, 2005). Fascinated by the post-modernist approach of narrative therapy, I wanted to evaluate the therapy, particularly when there were very

few evaluations of it. I approached a therapy researcher to ask if he would be interested in evaluating narrative therapy. He responded, saying that he was only interested in evaluating empirically supported treatments (ESTs). Evaluated through controlled experimental designs, ESTs are treatments for specific clinical disorders (Chambless & Hollon, 1998). Narrative therapy is not an EST. This made me wonder why so few psychologists published evaluations of narrative therapy. The EST assumptions that therapy could be standardised through manualisation emerged from cognitive-behavioural therapy research (see Task Force on Promotion and Dissemination of Psychological Procedures, 1995). The EST movement applied these assumptions to all therapies, regardless of their epistemological (how we know what we know) and theoretical commitments. I came to appreciate that narrative therapy consisted of a range of assumptions that were incongruent with those that informed EST evaluation criteria. In examining the evaluation of narrative therapy, it became clear that there was a problematic relationship between narrative therapy and the evidence-based psychotherapies, and this needed further examination.

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

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

Evidence-Based Psychotherapy Evaluation

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

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

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

ESTs (originally known as empirically validated treatments) were premised on a positivist epistemologi-

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

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

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

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

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

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

Tracing Narrative Therapy Theory

In contrast to the medical, positivist epistemology of the EST and EBPP evaluation movement, narrative therapy is constituted in and through a post-positivist epistemology. Post-positivism is a move away from assumptions of knowledge neutrality. Post-positivist research assumes that people *construct* knowledge in that “knowledge cannot be divorced from ontology (being) and personal experience” (Ryan, 2006, p. 16). A

post-positivist stance assumes that people contextually and politically produce knowledge. Researchers of this stance often regard themselves as “people who conduct research *among* other people, learning *with* them, rather than conducting research *on* them” (Ryan, 2006, p. 18, original italics). The more I examined the theoretical descent of White and Epston’s (1990) narrative therapy, the more I realised that the epistemology and theory that informed its therapeutic process were at odds with EST evaluation and EBPP evaluation frameworks. As a philosophical approach to therapy, narrative therapy is critical of decontextualised medical discourse and normalising practices of evaluation (White & Epston, 1990). Rather, narrative therapy evaluation focuses on exploring the meaningfulness and successfulness of the narrative shifts of client experience (e.g., from thinly described decontextualised accounts to thicker, context-laden descriptions; from internalised, self-pathologising accounts to stories of control over the problem). Both the therapist and client perform this evaluative exploration through collaborative conversations.

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

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

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

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

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

Delving further into the theoretical descent of narrative therapy, symbolic interactionist theorists advocated for interactive conversational performances of meaning that produce thick descriptions of client experience. Through what Turner (1974, p. 24) called a “world of becoming,” the meaning of lived experience could be understood as enabled in and through transitional, imaginative (subjunctive) performances of our cultural iden-

tity. Rather than assuming a ‘thing’ that has predetermined meaning through positivist epistemology (Crotty, 1998), meanings of lived experience can be understood as ever changing and are made possible through crises and ritual performances (Turner, 1969, 1974). Meaning is indeterminate in that a text is open to multiple interpretations (Geertz, 1986) and through the imaginative, subjunctive process of interaction and narrative in narrative therapy, new forms of identity can emerge.

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

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

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

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

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

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

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

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

To summarise, the theoretical descent of White and Epston's (1990) narrative therapy has revealed a range of interpretivist stances that constitute its post-positivist epistemology. In symbolic interactionism, meaning is

performed in and through social interaction rather than something that is predetermined, neutral or fixed in time. Bateson's cybernetic theory assumes that through patterns of interaction, human systems can reproduce certain meanings beyond the individual. From constructivist perspectives, narratives constitute meaning and construct our realities. Foucauldian notions of power, knowledge and discourse enable us to deconstruct normative, dominant narratives and discourses, and help us unearth subjugated knowledges that we may find more meaningful to our lived experiences.

A Differend

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

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

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

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

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

Perhaps some universal criteria are needed to judge both discourses (of evidence-based psychotherapy evaluation and narrative therapy)? Lyotard (1988) argued that applying universal criteria to judge a differend is impossible. He argued that discourse is necessarily political in that there are stakes involved in discourse and therefore universal value-free criteria are not possible. Further, because there are political stakes involved in discourse, conflict and incommensurability are inevitable and, therefore, differends are inevitable (Lyotard, 1988; Rojek & Turner, 1998; Smart, 1998). Inevitability makes it impossible to establish universal criteria for 'everyone' to agree to. The interpretivist, post-positivist stance of narrative therapy resists universal criteria of evidence in contemporary evidence-based psychotherapy evaluation discourses. Some narrative therapy researchers resisted such evidence criteria/discourse and proposed their 'evaluative' practices through narrative therapy theory (e.g., Speedy, 2004, 2008). There is also the possibility that proponents of ESTs and/or evidence-based practice will judge (or have already judged), in/through their discourse, such narrative therapy 'evaluations' as unconventional. This differend is characteristic of an impossibility such that neither proponent of

their discourse can transcend the differend without violating the epistemological assumptions of the other discourse (Lyotard, 1988).

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

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

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

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

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ISBN 978-0-473-20102-9