POSTMODERN CLINICAL RESEARCH: IN AND OUT OF THE MARGINS

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TC 1 was one of the first events showcasing the postmodern movement in family therapy. While critiques of the limits of research and science (objectivity, grand narratives, normative values, etc.) provided some of the rationale for this movement, any benefits of research also became suspect. Indeed, there was almost no mention of research or science at the conference. A gap between practitioners and researchers, (which preceded TC 1) widened. Our paper invites a re-evaluation of this disdain towards research: noting postmodern research that can be useful to practitioners, and articulating a bridge (centered on the discursive turn) connecting practitioners and researchers. Suggestions on how inquiry (and research) can inform clinical practice are presented, and while no final words on the topic are offered, new and constructive curiosities are encouraged.

In art we are continually judging our work, continually tracking the patterns we create and letting our judgments feed back into the ongoing development . . . That’s how we produce art rather than chaos.

—S. Nachmanovitch (1990, p. 134)

For many readers of the *Journal of Systemic Therapies*, Therapeutic Conversations 1 (TC 1) was like our Woodstock, a spontaneous gathering of innovative thinkers in Tulsa, Oklahoma. It was a collaborative zeitgeist fueled by postmodern and social constructionist ideas, offering new horizons teeming with idealistic possibilities for a better world. We had our therapist stars, too: White, de Shazer, Weiner-Davis, O’Hanlon, Freedman and Combs, Tomm, and Epston, to name a few. TC 1 brought them together in the same venue and helped to consolidate a sense that a new wave of therapies had arrived. However, for a wave of therapies that encouraged and emphasized client curiosity, surprisingly little systematic investigation had been turned

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backward on our own practices and the therapeutic claims associated with these new approaches. In Gilligan and Price’s (1993) edited volume from TC 1, research is not in the subject index, and is seldom noted in the text. The exception is David Epston’s (1993, p. 232) citation of Ken Gergen’s claim that social constructionism opens “new vistas of research . . .” The subject index notes science on three occasions, again with David Epston giving the most attention, referencing Foucault’s critique of science as a hegemonic regimen for determining what is true and real.1

We suspect that the minimal attention to research and science at the conference (and in subsequent years) is, in part, 2 an aspect of the critical gaze created by the emergent postmodern clinical movement. Another aspect of this growing gap between clinical practitioners and clinical researchers was that each group was developing its own genre of professional discourse, with particular cultural mores. While both groups sought to improve the human condition, each did so from very different philosophical premises and values. Adding to this tension, during this era there was a growing political/economic disparity between the practice community and the research community, with evidence-based approaches becoming the preferred societal gold standard. Separate practice and research cultures emerged, making it difficult to find shared dialogue respectful of one another’s position, or incorporate ideas from one to the other. For many postmoderns, research was viewed as irrelevant to front-line practice, and if anything, paralyzing of creativity and dismissive of clients’ perspectives.

This postmodern discourse evoked a shared body of knowledge, meaning, values, and rules (language games), privileging particular ways of knowing, and criticizing other discourses (e.g., positivism, objective reality, scientific methodology, etc.). This perspective led many to place themselves on the margins of the traditional industrial Western societies’ values and norms of therapy and science. This critical posture also challenged the therapist’s role as expert (e.g., Anderson & Goolishian, 1992); cast doubt on researchers’ claims of objectivity in their findings; dismissed grand narratives of absolute Truths (diagnostic categories); invited apprehension about privileging traditional (normative) individual and family developmental stages and structures; questioned cultural and ethnic hegemonic claims; and, mistrusted scientific methods that reduced people’s lived experiences to numbers. From the postmodern margins, there was the call to embrace local knowledge that attended to cultural contexts, social justice, and multiple definitions of reality. Postmodern therapists disdained research that neither spoke to clinicians nor seemed to address the complexity of clients’ experiences. Dismantling cultural and ideological hierarchies, equalizing power through collaboration, and seeking to give voice to disenfranchised groups were central. In this discursive turn, there was a shift to understanding language as constitutive of meaning, rather than reflective of an underlying reality.

1Nor does Friedman’s 1993 book, with chapters by many of the same presenters as TC 1 list research in the index.
2We are aware this dichotomy is a simplification and ignores many other aspects as well.
Seen historically, TC 1 was a countercultural event in two ways: (1) for showcasing a new collaborative aesthetic of practice, and (2) for the way this aesthetic contested established practice given the social science of the day. At stake for TC 1 participants was the legitimacy of their collaborative and constructive ways of practice. To be clear, our point is that at the time of TC 1 there was a vibrant postmodern critique of most social science research, especially when such research was applied to clinical practice. In this fervor of critique, research in general was often dismissed outright by therapists. Many therapists based their dismissal of research from particular views of social science that prescribed how good and ethical practice followed from that science. While TC 1 therapists were engaged in contesting modernist therapeutic ideas and practices, in their own silo, many social scientists were similarly engaged in contesting modernist ideas and presenting alternatives to the premises and practices of modern social science (Guba, 1990; Steffe & Gale 1995). While postmodern therapists and social scientists could have benefited from each other’s ideas and practices for addressing shared concerns of culture and the human condition, they largely moved in parallel domains without dialogue.

For many TC 1 therapists, talking about research, and scientifically evaluating (and validating) one’s therapeutic practices, was seen as being complicit with a modernist, hegemonic, patriarchal, and culturally blind status quo. Shortly thereafter, a contentious politics of evidence (e.g., Larner, 2004) followed. In the mainstream research community, there was a growing attention to the audit culture (House, 2008) and an era of accountability increasingly requiring therapists to justify their own work (cf. Johnson, 1995). As funders of therapy sought scientific evidence that therapy worked for DSM-diagnosed conditions and culled clinical approaches down to a select few empirically supported models, postmodern therapists feared such specters of positivism and realism were poised to overtake their dialogues with clients in the name of scientifically supported practice (e.g., Wylie, 1995). These conceptual differences contributed to a widening gap between researchers and postmodern clinicians.

However, as noted, most postmodern therapists were unaware that social science research was undergoing its own postmodern emergence. Narrative research, for example, was developing independent of narrative therapy, permitting researchers to study the emergence of narratives as a narrative therapist might (Davies, 1993; Davies & Harré, 1990; Holstein & Gubrium, 1999; Josselson, 1996; Steier, 1991). Or, one could study the interactive production of a conversational reality achieved in therapy (Avdi & Georgaca, 2007; Gale, 1991; Gale & Newfield, 1992; Kogan & Gale, 1997; Madill & Doherty, 1994; Roy-Chowdhury, 2003; Stancombe & White, 1997). In some cases, the boundaries between therapy and research became—for postmodern researchers—purposefully fuzzy, as approaches to practice based on collaborative inquiries between therapists and clients (e.g., Strong, 2002) gained prominence. However, at TC 1, positivist research was dismissed, and postmodern research was not yet part of the conversation. While postmodern therapists shared these kinds of concerns with postmodern researchers, and shared common philo-
sophical views and texts, for the most part they participated in different professional and discursive communities.

In this article, we will trace developments in research as they relate to the ideas and practices discussed at TC 1. We think the allergy or disdain that some practitioners developed toward research merits reflection and re-evaluation, particularly in light of some developments that have occurred in research, given what research can usefully offer practitioners. Both of us completed PhDs shortly before TC 1, and have been involved in communities of practice (i.e., therapy and research) enamored with the ideas and practices that animated TC 1. We are also both academics for whom research and research supervision is an occupational requirement. As researchers and clinicians, through our work we have sought to engage both clinicians and researchers in critical and generative dialogues we associate with postmodern thought and practice. At times, we (Tom and Jerry) have felt like wandering nomads not quite fitting in either community. We know this all too well for the raised eyebrows and pointed comments we continue to get when we discuss research with practitioners, or advocate for practice centered research and training in institutions that privilege positivist research. It is still widely assumed that research is for academics dealing with matters that concern academics but not practitioners, and that research evidence trumps practitioner evidence, although a recent exception to this perspective was expressed by Barkham, Hardy, and Mellor-Clark (2010).

In what follows, we hope to entice you with what recent developments in research, related to the ideas and practices discussed at TC 1, offer to practitioners of the postmodern therapies. In proposing a bridge between practitioners and researchers, we also hope to offer paths that avoid dualities (modern/postmodern, us/them), erode stereotypes (of research, researchers, or practitioners), and bring forth the voices of the stakeholders (client, practitioner, researcher, and community). One such postmodern bridge has been a shared interest in language, discourse, and narrative, to which we now turn.

**DISCOURSE TURN: RESEARCH ON NARRATIVES AND LANGUAGE**

TC 1 broke new ground by showcasing therapies associated with the postmodern discursive turn. The gist of this discursive turn is that language use, being-in-talk, shapes how people understand and share their experiences. Words, in this sense, are no longer seen as mirrors of nature (Rorty, 1979), and therapists could no longer consider their uses of language innocent (Andersen, 1997; Tomm, 1988). Where earlier therapists conceptualized their work as reframing clients’ understandings, new therapists came to understand that they could be re-storying experiences and talking up new (solution-focused) language games with clients. This led to questioning the idea that therapists and researchers could be experts on what is best for clients (e.g., Anderson & Goolishian, 1992). One aspect of what was post about the postmodern
era was that absolute truths or a singular correct view of reality were abandoned in favor of respect for multiple realities. For Lyotard (1984), postmodernity suggests there is no master story to be told about reality. These ways of thinking had already been taken up by some researchers (e.g., Gergen, 1982) and philosophers (e.g., Foucault, 1972; Gadamer, 1988) before TC 1. Indeed, such ways of thought inspired and informed some of TC 1’s approaches and other postmodern therapies, such as with Foucault’s influence on White and Epston’s (1990) narrative therapy, Gadamer’s influence on the development of reflecting teams (Andersen, 1991) and the collaborative language systems approach (Anderson & Goolishian, 1992), and Wittgenstein’s influence on de Shazer and Berg’s solution focused therapy.

Qualitative research methods regained prominence about the same time as postmodern approaches to therapy, and increasingly incorporated insights from the discursive turn. Narratives of experience, for example, came to be a focus of study in their own right (Polkinghorne, 1988), while local knowledge and how it was understood and enacted, became the focus of increasing numbers of ethnographers (van Maanen, 1988). These discursively oriented researchers shared the aims of postmodern therapists: to develop accounts of experience that fit for the research participants, and that respected and celebrated them (Sampson, 1993/2008). Such research was, in effect, being conducted in reverse of the usual positivist, hypothesis testing done by scientists to predict or explain human behavior. Rather than testing some theory out on people, qualitative researchers took their own not knowing (cf., Anderson & Goolishian, 1992; Gadamer, 1988) approach and learned of participants’ experiences—on participants’ own terms. Patti Lather (1991) suggests the various goals of qualitative and postmodern research involve seeking to understand, emancipate, or deconstruct. This shift towards emancipatory and deconstructionist research blurred the boundary between research and therapeutic practice (Gale, Odell, & Nagireddy, 1995), as these new researchers refused the “stance of disengaged neutrality,” and took up “the responsibility of conceptualizing research as a moral and therapeutic project” (De Haene, 2010, pp. 3–4). Researchers and therapists alike were advised to make transparent their conceptual approaches.

For postmodern therapists and researchers, subjective and inter-subjective meaning was a primary focus. This meant being curious about, and responsive to, the language people used. How people came to understand their experiences has a great deal to do with the cultural languages they were accustomed to using. But, as Gadamer (1988) pointed out, such languages offered horizons of possibility and need not be restrictive in meaning. What mattered therapeutically was what was beyond any problem-saturated horizon or language. One’s experience, language and meaning making of self and others are all intertwined. The use of words like ‘reality’ became highly suspect and surfaced in debates over use of languages with purported reality-prescribing power, like the DSM-IV (Strong, 1993). Whose voice was heard, what language was privileged, and how to give space for everyone’s voice became a concern in postmodern research and therapy (Fine, Wis, Wessen,
The challenge of postmodern-informed inquiry was to deconstruct (so as to not be limited by) how ideas and experiences were named, and the power relations privileged by people’s use of particular names and concepts. And, it wasn’t so much the words themselves that concerned discursively oriented researchers and therapists; it was how people took up particular words, narratives, and discourses, and lived by them, as if they were the only way they could put language to experience. Language was what humans imposed on experience, themselves, and each other to keep life understandable and ostensibly under their control. It took thinkers like Foucault (1972) and Derrida (1976) to point out that our language use came with a cost: it both opened up possibilities, while shutting down possibilities as well.

As became clear, the postmodern critique involved more than semantic concerns. Language itself wasn’t the culprit; how it was used and what followed from that use was the issue. The title of an early 1990s article in this journal captures some of this: “Change the name and you change the game” (Efran & Heffner, 1991). Postmoderns saw themselves as cultural and therapeutic game changers, consistent with Wittgenstein’s (1953) language games view. It mattered how things were named and who had the power to do that naming. So, for example, Paula Caplan, a therapist and researcher, found herself on the committee to develop the \textit{DSM-IV} classifications of personality disorders. She effectively blew the whistle on that scientific committee’s move toward classifying women’s passivity as self-defeating personality disorder, countering with her own proposed personality disorder for “aggressive men”: delusional dominating personality disorder (Caplan, 1996). For postmodern researchers there wasn’t a world to be neutrally and objectively named—as if the meanings for phenomena and experience belonged to those phenomena and experiences awaiting scientific discovery. Postmodern research was a means to identify, if not disrupt, taken-for-granted meanings, to identify meanings that had been subordinated or marginalized. Where modern research had promised singular correct meanings and understandings, postmodern research countered with efforts to honor and engage local stories and practices left out of the modern science metanarrative (Gergen, 1982; Lyotard, 1984).

**HOW INQUIRY (AND RESEARCH) CAN INFORM PRACTICE**

What counts as adequate research for justifying the use of any intervention or model of therapy has been a consistent source of debate since the mid-1990s (e.g., Norcross, Beutler, & Levant, 2005). Medicine’s gold standard—the randomized clinical trial (RCT)—has been imported (along with many other biomedical assumptions)

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3It is relevant to note how postmodern ideas of community inclusion and community members having voice in the research endeavor has crossed the gap in modernist research design (e.g., Murry & Brody, 2004).
into psychotherapy research as the standard by which therapeutic interventions are to be judged. Where the constructionist therapists of TC 1 favored negotiable and shifting problem descriptions, individuals’ static DSM-IV symptom diagnoses were required for RCTs. Where TC 1 era therapists had spoken of conversational approaches that could be flexibly, even artistically, applied, RCT research seemed to call for a standardized approach to any intervention, so that therapists could practice them in the ways that won the interventions their scientific evidence. Getting discouraged about the insistent privileging of such modern, research-backed, developments guiding the practice of therapy, one of us snidely depicted these developments as conversational hijacking (Strong, 2008a).

There are some signs that the most strident aspects of the evidence-based movement are abating, and that what qualifies as evidence is up for wider discussion (Dumont & Fitzpatrick, 2005; Gale, 2010, personal observation at the 2010 American Association for Marriage and Family Therapy research conference; Nylund & Chang, 2001). In particular, one of the issues that front line therapists have had with most clinical research is that it has been conducted in nonclinical settings that scarcely resemble the actual conversations of therapists. Requiring single diagnoses with no co-morbidities, and manualized treatment, RCTs evaluate something that does not exist in real life. In response, a new movement has arisen: practice-based evidence (PBE; Barkham, et al., 2010; Duncan, Miller, & Sparks, 2004). Using a variety of simple measures and sources of feedback, PBE is intended as a resource for enhancing one’s practice, to learn more about clients’ views of our work with them. Even the language initially associated with the evidence-based movement has shifted, with therapists now seen as making clinical judgments informed by the evidence supporting the use of particular approaches to clients’ presenting concerns.

As academics, we have shared an interest in widening therapy’s evidence base. Much of the focus of clinical research has been on the efficacy of interventions, an approach some qualitative researchers referred to years ago as a drug metaphor approach to research (Stiles & Shapiro, 1989). While outcome research is important to informing our work, it too often provides little to enhance practice. However, this is an area where process-oriented research has much to offer (Barkham et al., 2010). While therapy texts and demonstrations offer a general sense of how to intervene like the “big names” of TC 1 (sometimes at the risk of reductionist mimicry; see Chang et al., 2013), we have both used forms of discourse analysis to examine these practices in more detail, with a view toward improving them, or learning what is actually potent and improvisationally responsive about them. For example, we have examined therapists’ discursive positioning (Kogan & Gale, 1997), solution-focused couples therapy (Gale, 1991), miracle questions (Strong & Pyle, 2009), externalizing questions (Strong, 2008b), and the differences between solution-focused and narrative therapy (Gale, Lawless, & Roulston, 2004). We have also examined clients’ experiences of such conversational practices (Strong & Nielsen, 2008). In this research, we sought to pay closer attention to what therapists can learn from clients, and what they might take for granted in their use of TC 1 approaches to therapy.
Increasingly, therapists are using locally developed wrap-around ways of evaluating and enhancing clinical services involving participant stakeholders in therapeutic services, so that the central participants—clients—receive services shaped by evaluations throughout the process of service delivery (Sparks & Muro, 2009). Agency-based programs in many U.S. states now include former clients and parents on advisory boards. Major federally funded projects are also beginning to involve community stakeholders in defining research protocol and methods.

A further area of overlap we see between therapy and postmodern research relates to the increased use of action research approaches (Reason & Bradbury, 2006) with marginalized and disempowered populations. Narrative therapists, inspired by the important cultural work of Just Therapists (Waldegrave, Tamasese, Tuhaka, & Campbell, 2003), increasingly embrace action research as a form of cultural and community empowerment. The collaborative practices of action research are very consonant with the notion that unpreferred or unjust understandings and social circumstances can be contested and socially reconstructed. Action research, to us, is a clear example of where research participants, like clients, can join researchers in applying their local expertise, curiosities, and preferences to collectively address and re-author personal and social concerns (Denborough, 2008).

As we look ahead, one of our hopes is that the often perceived gap between research and practice narrows (e.g., Dumont & Fitzpatrick, 2005). Mindful of allegiance effects (Botella & Berian, 2010), whereby an enthusiast of approaches like those showcased at TC 1 can co-construct research evidence to support their zeal for their preferred models, we think it is a good thing that therapists seek feedback on their work from clients and others. We also see many theoretical affinities between the TC 1 approaches to therapy and developments in qualitative research (Denzin & Lincoln, 2011). There is now even a Handbook of Constructionist Research (Holstein & Gubrium, 2007), which showcases research approaches that take up the critical and generative themes that were so important to therapists at TC 1. We are also encouraged by recent postmodern responses to excesses from the evidence-based healthcare movement. For example, Gabbay and Le May (2011) in a medical context—advocate a narrative approach to integrating emergent client and circumstance-specific details and general research knowledge, in clinical mindlines. Postmodern thought is very much alive for many researchers; and like the therapists of TC 1, what animates their work are a host of new questions.4

Some of the new questions come from insights associated with the practice (Nicolini, 2013; Schatzki, 2002) or feminist material turn (Barad, 2007; Hekman, 2010). Those taking up these insights take issue with the inadequacy of linguistic focus normally associated with social constructionist thinkers for whom changes to words, discourses, and stories alone could address or transcend the material realities of people’s lives. These practice or material theorists instead suggest we

4A new bridge developing now is that of Buddhist principles as applied to practice, and how both modern and postmodern research is examining meditation, mindfulness and loving kindness practices.
examine more closely how people interact in habitual ways with each other—and with objects—to produce the social and physical realities by which we live. The most vibrant research associated with this turn has come from the growing field of science and technology studies, or actor network theory, where the key figure has been Bruno Latour (2005).

CONCLUDING COMMENTS

Where modern era clinical research sought final or ultimate explanations, postmoderns were wary of any attempt at meta-narratives (Lyotard, 1984), or final words (Bakhtin, 1984). A kind of deflation can occur when the claims of postmodern researchers are contrasted with the claims that seemed possible from modern science (Lock & Strong, 2010). Postmodern research that is clinically relevant seems to point to quite different kinds of knowledge, more humble knowledge that can offer something new to therapists much like the then recently developed therapeutic approaches featured at TC 1 (see for example, de Haene, 2010). While therapists at TC 1 emphasized the importance of curiosity, that curiosity only seemed to apply to dialogues in therapy—evoking new realities for clients through their use of language. We suggest that there is much to stay curious about with respect to the TC 1 therapies and that postmodern and constructionist approaches to research are rich in ideas and practices (e.g., Chang, 2010; Gubrium & Holstein, 2007) that would appeal to postmodern therapists. Postmodern clinical research can very much be within the margins.

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