// INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor MI 48106-1346 USA
313/761-4700 800/521-0600

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

POSTMODERNISM AND CLINICAL SOCIAL WORK

By

ANNE ROSEN NORAN

A dissertation submitted to the Graduate Faculty of Social Welfare in partial fulfillment of

the requirements for the degree of Doctor of Social Welfare,

The City University of New York

1998

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

UMI Number: 9830760

Copyright 1998 by
Rosen Noran, Anne

All rights reserved.

UMI Microform 9830760
Copyright 1998, by UMI Company. All rights reserved.

This microform edition is protected against unauthorized
copying under Title 17, United States Code.

UMI
300 North Zeeb Road
Ann Arbor, MI 48103

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Copyright

1998

Anne Rosen Noran

All Rights Reserved

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

This manuscript has been read and accepted by the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare

4/20/98 — Michael Fabricant

Date — **Chair of Examining Committee**

Professor Michael Fabricant

4/20/98 — Harold Weissman

Date — **Executive Officer**

Professor Harold Weissman

Mildred D. Mailick

Professor Mildred Mailick

Florence Vigilante

Professor Florence Vigilante

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

ABSTRACT

POSTMODERNISM AND CLINICAL SOCIAL WORK

By

Anne Rosen Noran

Advisor: Professor Michael Fabricant

There has been some speculation in the literature about how the postmodern philosophical movement fits in with the goals of clinical social work. The purpose of this study has been to determine what the impact of postmodernism has been on the work of social work clinicians who have embraced it as a frame-of-reference for practice. Via a qualitative study of clinical practice as it was engaged in by twenty-eight postmodernists, this study attempted to create a thematic profile of the parameters and textures of such work.

There was an exploration of what led the clinicians interviewed to consider postmodern ideas, how these ideas had influenced their view of truth and context, the way that they used or rejected theory, their transformed use of language, and how they saw themselves and others.

There was, also, a discussion of how these clinicians translated the foregoing ideas into their clinical work, how they envisioned diagnosis and assessment and how they viewed mental health and the goal of treatment. There was an examination of the role of the therapist from a postmodern perspective and how the traditional ideas of transference

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

and countertransference have been influenced by postmodern approaches. There was a discussion of the logistics of time, fees, and names and a discussion of ethical considerations.

Some of the conclusions were that these practitioners used a both/and perspective in addressing the contradictions of the traditional vs. postmodern approach to thinking and engaging in practice. Most had undergone a perceptual shift in looking at the clinical situation as a product of their own influence on the relationship, the diagnosis, and the outcome. It seemed that these new ideas may have represented a welcome antidote to the exigencies of managed-care on current practice--although there was a danger that some of the new forms of therapy based on postmodernism could become co-opted by managed-care initiatives. Despite postmodernism's emphasis on an egalitarian relationship between clinician and service user, several of the respondents charged high fees and continued to use the medicalizing language of pathology. Some of these results may have reflected the way in which postmodernism has been filtered through a first-order lens and has not been fully integrated into practice. This study attempted to contribute to the emerging postmodern clinical social work narrative.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Acknowledgments

This has been a personal Odyssey for me that has transformed my sense of self and my sense of the world. I am deeply greatful to my advisor, Dr. Michael Fabricant, who has provided the perfect combination of support, encouragement, understanding, clarity of thought, challenge, and respect for my work. This has contributed the ideal blend of difficulty and ease, which has created the optimum learning experience for me. Plus, his artistic but grounded vision of qualitative research has inspired me continuously throughout this project. I would, also, like to thank Dr. Harold Weissman, Executive Director of the Doctoral program, who has guided me with the wisdom of a Zen master from my first days in the program. His advice to take my time and enjoy myself has been invaluable, as well as his appreciation of my tendency to express unpopular opinions. I could not have chosen a better doctoral program. Professor Florence Vigilante's work in the area of constructivism and support for me, as well as my ideas, preceded this project, in which she has been a committee member, and have sustained me throughout.. Her enthusiasm for these ideas has helped me feel less alone with them. Professor Mildred Mailick, also a committee member, contributed many helpful suggestions about how to find respondents. I am greatful to her for the way in which she taught me to think about treatment approaches--with respectful appreciation of intellectual and philosophical precedents. This project began as a paper for her class in practice. I, also, want to thank Professor Irwin Epstein for suggesting that I choose this topic, because he knew how interested I was in it.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

If it weren't for Dr. Lawrence Josephs, I would not have begun this journey. He let me know that it was possible to achieve my intellectual aspirations without being ashamed of them. Steven Dye shared so many wonderful books and ideas with me. A special thanks goes to Roxanna Sarmiento for her arduous efforts to help me find articles and books. Dr. John Seely, Maria-Helena Reis, Annette Kortright, and Tom Beck have, also, provided a great deal of necessary help and support at different points in the process.

I want to thank Dr. Carolyn Saari for having spoken with me before I began this project. Also, Dr. Ruth Grossman Dean contributed the idea of using master practitioners. A special thanks goes to my respondents, who allowed me to enter into a conversation with them about such an important development in the field of social work. I am greatful to all of them.

Finally, I would like to thank my husband Charles for his emotional support and technical assistance.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

TABLE OF CONTENTS

Section	Page
Abstract	iv
Acknowledgments	vi
List of Tables	xi
List of Figures	xi
Introduction	1
I. Background of the Problem	5
Shift from Modernism	6
Postmodernism and Power	9
Postmodernism, Feminism, and Postmodern Feminism	18
Postmodernism and the Narrative	21
The Problem	23
Research Questions	25
Definition of Terms	26
II. Literature Review	28
Theoretical Contrasts	28
The Relationship	32
The Self	35
Postmodern Interventions	37

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Theories in Practice and Theories in Use 43

Questions for Further Study 44

III. Methodology 46

Overview 46

Design 47

Sampling Strategy 53

The Final Sample 58

Guide Creation 61

Data Collection 62

Limitations and Problems 65

Data Analysis 68

IV. Interpretations of Postmodernism 72

Influences 72

Truth, Reality, and Context 84

How Postmodern Clinicians Use or Reject Theory 91

The Language of Helping 96

The Self and Identity 105

Summary 111

V. The Practice of Postmodern Clinical Social Work 114

Diagnosis as a Political Act 114

Therapeutic Goals and Change 127

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Postmodern Influences on Technique 130

Postmodern Clinical Techniques 138

Postmodernism and Clinical Logistics 149

Ethics 155

Summary 157

VI. Conclusions, Implications, and Recommendations 160

Summary of the Findings 161

Discussion 168

Theoretical Implications 183

Limitations 186

Recommendations for Further Research 189

Implications for Clinical Social Work 191

Appendix 197

Bibliography 204

Autobiographical Statement

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

LIST OF TABLES AND FIGURES

Tables **Page**

I. Initial Criteria for Participation 54

II. Description of Participants 60

Figures

I. Initial Statement to Enlist Participation 197

II. Letter to Potential Respondents 198

III. Oral Consent to Begin Interview 199

IV. Interview Guide 200

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

INTRODUCTION

Some have characterized the postmodern condition as a time of disintegrating values, beliefs, institutions, and support systems (Englehardt, 1994; Gergen, 1991; Kegan, 1992; Lifton, 1993). It is the madness of our time that there is an ever-shifting relationship between reality and art, symbols and substance, myth, and meaning. Our society has lost a belief in shared values that make sense out of the images that surround us and the images that inhabit our inner worlds (Gergen, 1991; Hunter, 1989). The line between art and artifice, reality and illusion grows thinner every day. Ruins and upheavals are the metaphors used to describe the assault to the known culture of the modern world that we have experienced in our time (Englehardt, 1994). Required to adapt ourselves to proliferating technologies and new belief systems, we strive to keep up as our adaptations multiply.

In this new world of fractured identities and fragmented realities, it may be possible to come up with an idea of clinical social work practice that mirrors and at the same time heals this dilemma. Via the conceptual shift of postmodernism, the clinical practitioner can mirror and reflect back the multiplicities that are experienced by people-in-treatment in a way that includes an empathic understanding of such diverse realities. Through communion, communication, and the dialogue of relationship, a path of intersubjective understandings can lead the way to interventions that build on strengths rather than pathology. There may even be a way to transform the inevitable power inequities of treatment into a more facilitating and empowering context.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

As a clinician for the past twenty years, I have struggled with the "traditional" approach to social work practice and often felt let down by it. By "let down," I mean, frustrated, disappointed, and constrained in ways that I have not always deemed helpful to the people with whom I work in therapy. In more practical terms, this "traditional" approach is really interchangeable with a "modern" one—in that it implies rationality, logic, bureaucracy, and technology (Keys, 1988). Modernism in its attempt to reject tradition and medieval superstition and in its belief in the laws of the universe has set up a dichotomy that has elevated reason above emotion (Gorman, 1993). The modern social work client, for example, has often been viewed either as a mass of seething tendencies and drives that can be tamed only with strictly planned and timely interventions or as an autonomous being that can be programmed with operational techniques that follow a linear path (Payne, 1991). Even when the environment is considered as integral to treatment (Germain & Gitterman, 1986), there is a sense that it is up to the clinician to interpret its effects.

On one level, all of these modern approaches involve power distributions with the clinician holding most of the advantages. It is up to the clinician to make decisions about treatment, about the nature of the problem, about the boundaries of the interaction, and about how help will take place. Although most of the literature about modern practice emphasizes the importance of the subject's participation (Payne, 1991; Turner, 1986), it is always assumed that the social worker will make the final decision.

If the social worker is to make the final decision about length of treatment, approach, etc., it is incumbent upon social workers to explore their own biases and values

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

as well as make them explicit. Even this level of self-disclosure has been virtually forbidden until recently. In what some have considered to be a bold suggestion (Sanville, 1995), Goldstein (1994) proposed that it might have been clinically indicated in one particular case for a therapist to admit to being a lesbian. Several of the doctoral research questionnaires I have received in the mail have opened up the question of self-disclosure, albeit in a tentative fashion, as though it were a potentially dangerous time bomb that could lead to disintegration of the therapeutic relationship and inevitable regression.

It is via these proscriptions and prescriptions about clinical practice that I have come to believe that power and politics are intrinsic to the therapeutic interaction. Although research has indicated that self-disclosure, true mutuality, or a conversational approach are helpful (Bergin & Garfield, 1994), these have been closely held, little challenged taboos in the realm of most clinical settings. Only recently has the literature about such changes in practice proliferated. In the minds and belief-systems of some master social work practitioners (e.g., Dean, 1993; Goldstein, 1993; Hoffman, 1990; Saari, 1994; Saleeby, 1993), there has been a marked paradigmatic shift toward looking at the political and philosophical underpinnings of therapeutic work, as well as questioning assumptions about practice. It is this paradigmatic shift that I call postmodernism.

Such concepts as constructivism, social constructionism, narrative therapy and analysis, feminist theory, reflexiveness, and deconstructionism—although diverse in their analyses—are all a part of postmodern practice. Although Gergen (1991) warns that the term is becoming so faddish that soon the "lounge lizards will move in," it is sufficiently comprehensive and compelling to warrant further exploration. Postmodernism does not

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

necessarily provide answers to the dilemmas of modern life, its impact is even more profound—it dismantles ideas about the concept of self and of certainty about the world in which we live.

In dismantling these assurances, postmodernism does not reject modernism or premodernism, such as paganism or romanticism. Nor does it exclude technology or positivism, but sees them as among the ways in which reality can be translated or created. In contrast to eclecticism, which involves incorporating what is known and accepted from a standpoint of clinical decision-making about what is feasible (Payne, 1991), it proceeds from a state of not knowing and not valuing certainty. Postmodernism values emotion, narrative, intuition, and interpretation—qualities often undervalued in professional life. Gorman (1993) calls these the natural resources of social work.

Postmodernism in clinical social work comprises a number of facets, including a breakdown in the concept of the authority of the practitioner, sometimes called "deprofessionalization," an increased sensitivity to the social construction of reality, a growing disregard for rational coherence, the emergence of self-reflection on how one knows as well as what one knows, an awareness of the political underpinnings of clinical thought, an emphasis on intersubjectivity, an emphasis on cultural diversity, and a respect for multiple realities. At the level of social interaction, it means the inclusion of previously marginalized and suppressed voices. For clinical practice, it means viewing the concept of self as a process rather than a fixed entity, thinking of diagnostic categories as socially constructed, increased acceptance of spiritual and indigenous beliefs, and an emphasis on narrative rather than on developmental trends.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Chapter I

Background of the Problem

In exploring the influence and development of postmodernism on clinical social work, it is important to look at what historical trends have contributed to it's impact and popularity. The history of postmodernism in social work is directly linked to scientific and philosophical developments outside the realm of social work as well as to the influence of important theorists within the field. Not simply abandoning a "scientific world view, but world views generally" (Smith, 1989, p. xii), postmodernists dispute the notion of rigid disciplinary boundaries among the social sciences, humanities, and natural sciences (Gorman,1993; Peile, 1993). Among the notable theorists and theories that have contributed to postmodernism are: Einstein's *Relativity Theory*; Heisenberg's *Uncertainty Principle* (Gorman, 1993); Maturana & Varela's (1987) *Autopoiesis*; Derrida's (1976, 1978) *Deconstructionism;* Foucault's (1980, 1982) *Discourse Analysis*; Bohm's *Quantum Physics* (Peile, 1993), Wittgenstein's *Language Games* (1958, 1965); poststructural feminism, Bruner's (1986) ideas about the *Narrative Construction of the Possible*; appreciation of *The Narrative*; White & Epston's (1990) *Narrative Therapy*, and Schon's(1987) *Reflective Practitioner*.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The Shift from Modernism

Gorman (1993) suggests that the origins of modernism go back to the seventeenth century with the work of Galileo in astronomy and of Descartes in philosophy. With the enlightenment's emphasis on rational thought came a desire to translate sensory experience into mathematical logic. Paglia (1990, 1992) stresses that Rousseau was responsible for the idea that human beings were infinitely perfectible and, therefore, not ultimately subjected to biological drives. Subsequently what became the social sciences moved in a positivist direction (Heineman, 1981; Peile, 1993; Rich, 1976; Smith, 1989; Toulmin, 1990). Modernism elevated reason above emotion, which was seen as "irrational" and "base" as well as a potential threat to the social order (Gorman, 1993). In the eyes of the modern world, dichotomies were set up in which, for one example, reason was associated with men and irrationality with women. Another dichotomous belief was that the poor were irrational and the middle-class reasonable, as in such works as *The Crowd* (LeBon, 1899), in which street rebellions by the lower social orders were characterized by their social superiors as "bestial."

As a result of discoveries in physics, such as Heisenberg's uncertainty principle and Einstein's theory of relativity in the early twentieth century, there began to be a shift in the modernist belief that reality was empirically knowable and that there were immutable laws of the universe (Capra, 1982; Prigogine & Stenger, 1984). In challenging the idea that there was absolute space and time, relativity theory demanded that context must be included in the definition of an event (Glace; 1987). Quantum theory, with its uncovering

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

of the subatomic world, challenged Newton's view that nature could be measured in a controlled way. Physicists realized that, as a result of the Uncertainty Principle—which suggested that the act of observing altered the behavior of what was being observed—the observer's influence on what was being observed was seen as integral to an experiment (Pozatek, 1994).

The Chilean biologist Humberto Maturana and his colleague, cognitive scientist, Francisco Varela (Maturana & Varela, 1987), further developed ideas about relativity with their concept of *autopoeisis*. Via their experiments with and observations of plants and animals, they discovered that organisms were self-enclosed systems that sought to replicate themselves and couldn't perceive outside of the boundaries of their own capacities. Contending that organisms sought to reproduce themselves in the world, they proposed that organisms changed as a result of their own natures and not only as a result of the impact of the environment. They, also, suggested that organisms were self-referential and had three principal features: autonomy, self-reference, and circularity. This notion contradicted Darwin's theory of evolution, because it offered a different explanation of how evolution occurred. Rather than seeing an organism as adapting to the environment or that the environment had selected a configuration of traits in an organism, it led to the idea that organisms could determine their own changes in a process that is much like thought(Morgan, 1986).

Furthermore, in their demonstration of color awareness in frogs, Maturana & Varela(1987) showed that the brain did not process vision the way a camera did but rather in the way that music was transferred to or from a compact disc. One could not know

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

what the music was like before it was translated by the brain (Hoffman, 1990). As a result of these discoveries, Maturana and Varela (1987) encouraged "permanent vigilance against the temptation of certainty" (p. 245) because the world we see is a world that "we bring forth with others" (p.245). Despite the fact that they had reservations about the application of their ideas to the social world, they suggested that social reality was a product of social interaction and necessarily shared and interpersonal. They implied that not only does "reality" not exist external to the individual, but it exists in the individual only as a result of social relations.

These new theories lead to significant developments in the field of social work—the most important being the idea that the social worker and the person in treatment could not be seen as completely separate from one another in terms of influence and objectivity (Peile, 1993). Diagnosis became more precarious in that what was being seen was influenced by the observer's perceptions (Kirk & Kutchins, 1994). Other repercussions included the formulation of a cybernetic view of human nature and families (Bateson, 1979; Hoffman, 1985; Levine, 1994), viewing clients through a constructivist lens (Pozatek, 1994), and seeing clients' lives as more complicated, multiplicitous, and individual then previously thought (Gorman, 1993).

In the field of philosophy, existentialist and phenomenological philosophers, such as Kant, influenced a postmodern shift away from an objective metaphysics—whose aim was to uncover the true nature of reality—toward a more limited, personal, and fragmented view of reality (Gorman, 1993). In theology, there was a shift away from the rational proof of the existence of God to a sense of faith's fragility (Smith, 1989). In the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

social sciences, there began to be a turning away from established "truths" toward a more relativistic stance that emphasized exploration and expression of multiple voices, as well as "realities" marginalized by the modernist belief in "grand theory" (Rosenau, 1992).

Speculation, personal experience, metaphysics, musings, magic, myth, and mysticism—all previously devalued by modernism—took on increased importance (Gorman, 1993). Rosenau(1992) suggested that postmodernism should be characterized by a turning away from trying to "improve and perfect" theory in favor of explicating underlying assumptions. This change from the search for the general to the search for the specific—in the form of legend, heuristics, folk wisdom, myth, and the unique—has had an effect on bringing the values of social work in concert with the practice of social work (Weick, 1987). Positivist assumptions, for example, have often been in conflict with social work's emphasis on the "transformational nature of relationships" (Gorman, 1993, p. 251) and the personal construction of meaning (Goldstein, 1990).

Postmodernism and Power

In addition to the philosophical and scientific precursors of postmodernism, there was the highly important element of a shift toward looking at the political and social underpinnings of language, behavior, notions of reality, and relationships. This had a profound impact on clinical social work practice in that it challenged ideas about pathology, the locus of change, diagnosis, and the structure of the person-in-treatment situation. Two of the most influential contributors to this change in the field of social work have been Michel Foucault and Jacques Derrida. Each in their own way has contributed

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

to what could be called a revolution (Hoffman, 1990) in how postmodern clinical social workers perceive "truth" in the clinical relationship. They illuminated the political and cultural context of practice (Fish, 1993).

Foucault. In writing about how power relationships arise, Foucault (1980, 1982) asserted that individuals and groups utilized power in specific ways (Fish, 1993). He believed that power developed from the ground up. This meant that everyone on the power/domination continuum, however unequal and hierarchical, did not have control over the power they either had or did not have. To Foucault, power was intrinsic and inseparable from knowledge. He believed that we were subject to power through the normalizing "truths" that shaped people's lives and relationships. These normalizing truths were revealed through what he called "discourses."

According to Hare-Mustin(1994), discourse refers to a series of practices, statements, and structures that share common values. It is the medium that underlies language concepts, beliefs, and assumptions, and the cultural practices that arise out of these beliefs. Discourses do not describe the world; "they categorize it"(p.21). It is within the discourse that assumptions and beliefs are hidden from view. There are dominant and subjugated discourses, according to Foucault(1980), and what is left out(subjugated) is as important in shaping our beliefs as what is emphasized. Some examples of dominant discourses that shape clinical work are: the assumption that problems have their roots in early childhood, the idea that we can control the behavior of others with the proper techniques, the belief that mature adulthood requires separation

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

from parents or the family of origin, and the notion that the objectivity of the therapist will encourage the person-in-treatment to speak more freely. Unless unmasked and unpacked, the dominant discourses in the therapeutic community may obscure deeper understanding and lead to social control rather than therapeutic change. According to Foucault:

> There can be no possible exercise of power without a certain economy of discourses of truth that operate through and on the basis of this association. People are subjected to the production of truth through power and cannot exercise power except through the production of truth (Foucault, 1980, p .93).

Archeology refers to Foucault's exploration of discourse as a system in itself. *Genealogy* was his attempt to trace the manner in which certain discourses evolved in the context of particular circumstances and institutions while others have been extinguished or subjugated (Fish, 1993).

Foucault's idea about the inseparability of knowledge--such as what medical doctors are presumed to know about how to "cure" illness-- and power--such as how some ideas about how to cure mental illness are used to control others-- is reflected in his assertion that some knowledge is ascendant and some knowledge is subjugated or overlooked. He traced the history of certain knowledges and demonstrated how they achieved status. Among some of the "knowledges" that he considered subjugated were certain indigenous belief systems, such as Voodoo or nature worship, as well as erudite

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

knowledges, such as those written by monks, that had been written out of history because they were politically unacceptable. He believed that through the recovery of the details of some of these subjugated knowledges, we could understand the history of how some minority groups had struggled and lost their power. The wisdom of some Celtic tribes, for example, has been lost forever, because of the dominant culture that replaced it in Europe. It was only recently, for example, that certain herbs used during the time the Celts lived have been rediscovered and used again for healing purposes. Although he did not propose an alternative ideology, Foucault believed that an effective criticism of dominant knowledge could be created that was not dependent on the approval of "the established regimes of thought" (Foucault, 1980, p. 82).

In relating his ideas to individual identity, Foucault believed that when an identity is imposed on someone and then recognized by others, it forces that person into a position of subjugation. Gergen (1991) suggested that authority about the knowledge of the self is often granted only to psychiatrists, scientists, and medical doctors, who are allowed to decide on matters of importance to the individual. These "truth tellers" about the nature of the self have engineered a system that keeps power in the hands of certain practitioners—say, for example, medical psychoanalysts or managed care evaluators—and overemphasizes the power of all practitioners (Gergen & McNamee, 1992; Kegan, 1982).

The issue of the overemphasis of power by practitioners is a critical one for clinical social workers. Often trained to be restrained, neutral, unforthcoming, and adept at fending off attempts to be known in personal ways, clinical social workers have inadvertently stepped into the domain of power-wielding politics. Although Freudian in its

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

origins, this approach has far exceeded Freud's recommendations for practice. Freud was known to walk in the woods with his patients and even bought them presents. The extreme to which clinical practitioners have gone to remain neutral is a prime example of how intrinsic power relations are to practice. The effect on people in treatment is the clue that explains the dynamic: Such withholding attempts underscore the status of the service providers and emphasizes their ability to give or take away. Once presented as the inalienable model of practice, the person-in-treatment has no choice but to internalize or react to such power inequities by feeling subordinated.

Although Foucault was remiss in his treatment of women's issues since he rarely mentioned them, feminists embraced his ideas as an explanation of the relationship among language, power, and knowledge (Sands & Nucio, 1992). In addition to feminists, some social workers (White & Epston, 1990) have based their clinical work on his theories.

Derrida. Utilizing a theoretical tradition arising from the work of Husserl, Hëidegger, and Wittgenstein (Lax, 1993), Jacques Derrida (1976,1978) proposed a theory of language in which it was seen as a system of signs that did not have any positive or negative values. The value given to these signs was a result of the meanings ascribed to them. The meaning of a word, for example, was based on all the distinctions of itself as well as its relationship to other words that may not have been present. Multiple understandings, therefore, were available through the interpretation of what was present in the text in relation to words and ideas that were not present. These different views of a word or words were not waiting to be discovered but were available to each reader based

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

on the perspective of the reader and the framework from which he or she viewed the text (Lax, 1993). Derrida described the difference between what was said and not said as *differance*. It is important to note that this does not mean the opposite of what is said but rather the alternative to what is said.

Derrida's ideas about language have been incorporated into a theoretical analysis called *deconstructionism*. Deconstruction involves taking apart the assumption of meaning one gets from a text and interpreting it in a manner that reveals the underlying assumptions on which the text is based. As these assumptions are revealed, the text is open for alternative understanding (Anderson & Goolishian, 1989; DeShazer, 1991). Words gain their meaning through reference to other words; literary writings gain significance from the way in which they are related to other writings. Thus, language derives its character from other language.

Derrida (1984/1992) was not as concerned with hermeneutics as he was with revealing contradictions and the "politico-institutional structures that constitute and regulate our practice. . ." (pp. 22-23). In other words, his main concern was to demonstrate the importance of social context and power not simply to better understand the meaning of a text. Nevertheless, according to Fish (1993), family therapists, among others, have misconstrued Derrida's theories to mean that all narratives have equal weight and that all clinical material or language represent an equal view of reality.

The dissolution of power. Basing his ideas on Bohm's(1980) and other theoretical physicists' (Prigogine & Stengers, 1984) reflection on the nature of reality—that it may be

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

chaotic, for example—Peile (1993) contended that the notion of power *in-and-of itself* is dangerous. The very belief in the capacity to control has encouraged people to act on their environment and other people in self-assured ways. The assumption is that their superior predictive knowledge gives them either the responsibility and ability to determine what is best for others, or, more destructively, the capacity to control and exploit others for their own self-interest. Bateson(1972) wisely argued that it is not power that corrupts, but simply the idea of power.

Peile (1993) suggested, therefore, that social workers should consider revising their ideas about causality and see their own and their clients' actions as creative instead of causal or random. This kind of an approach bypasses the notion that clinicians can control the outcome of treatment or the behavior or others and makes treatment more interactive with a view toward creating solutions rather than enforcing change.

Paglia. A vehement critic of Foucault, Paglia(1992) contends that Foucault should have given Durkheim (1893, 1903) as well as Max Weber the primary credit for his work. She asserts that "the intricate complexities of analysis of organizations and power groups in Max Weber make Foucault look like a tyro" (Paglia, 1992, p. 225). She criticizes American academics for having been naive about his analysis by thinking that his ideas represent original thought. Her main criticism, however, involves Foucault's ignorance of the biological realities that determine "pecking orders" and "hierarchies"(p. 226). This is an interesting objection, because of recent developments in the field of biogenetic psychology, which posit that power arrangements may be completely intrinsic and out of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

awareness of the conscious mind. Ironically, this supports the constructivist view of inherent biological constructs.

In her criticism of Derrida and Foucault, Paglia (1992) asserted that to see science as "absolutist, dogmatic methodology" (p. 227) is to misconstrue the true essence of science: "We saw, following Aristotle and his seventeenth-century admirers, that science is a system of provisional hypotheses, open to constant revision and disproof" (p. 227).

Bruner. Bruner (1986) suggested a way in which to resolve the dilemma of scientific or paradigmatic thinking vs. a mode of thinking that involved meaning construction, such as deconstruction, which he saw as a kind of backward mapping. He argued that both forms of thought are legitimate but quite diverse forms of analysis. Without throwing out the validity of generalizable rules that involved probability or causal propositions, he believed that it was, also, possible to construct meaning that informed understanding of a single example. Generalizable rules, such as those governing diagnosis, could be formulated—but the individual diagnosis or cause could be discovered only through a backward analysis that started with individual symptoms and could be understood only through the narrative of the person-in-treatment(Saari, 1994).

Finkielkraut. Another philosopher struggling with the effects of postmodernism, the French writer, Alain Finkielkraut (1995), suggested that multiculturalism is paradoxical: It is in many ways similar to the principles of the *Volkgeist* or spirit of the people that the Nazis and other groups throughout history have espoused. When culture

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

supersedes the rights of an individual to participate in the social contract, then the individual is constrained and subordinated by his origins rather than uplifted by them. In his diatribe against popular culture, which he refers to as "barbarism," he stated: "In only two decades, discordant beliefs have become the norm, autonomy has become hegemony, and adolescent culture the lifestyle of everyone in society" (p. 129).

Finkielkraut (1995) summarized his opinion of postmodernism:

> And so as we come to the end, barbarism replaces culture. In the shadow of the great word, intolerance and infantile behavior increase. When it is not cultural identity restricting the choices an individual can make, using threats of high treason to silence expressions of doubt, irony, and reason—opinions that might separate him from the collectivity—it is the entertainment industry, the creation of the technological age, that reduces great works of art to drivel. The life of the mind has quietly moved out of the way, making room for the terrible and pathetic encounter of the fanatic and the zombie (p. 135).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Postmodernism, Feminism, and Postmodern Feminism

Both Derrida's and Foucault's analysis of power arrangements had an impact on the development of postmodern feminism. It would be impossible to discuss the history of postmodernism in social work without looking at developments in poststructural feminism and feminism, in general. Although a detailed exploration of the conflicts among feminist thinkers is beyond the scope of this endeavor, an attempt will be made to convey the significance of different theories.

Before there was postmodern and poststructural feminism, there was liberal, radical, and socialist feminism (Sands & Nuccio, 1992). *Liberal feminism* consisted of an emphasis on the attainment of equality within the existing system . *Socialist feminism* ascribed blame for women's oppression on the class, race and gender divisions produced by capitalism. *Radical feminism* focused on the importance of dismantling patriarchy (Sand & Nuccio, 1992). Nes and Iadicola (1989) observed that most social workers have been closely allied with liberal feminism. A central theme within these feminist theories has been a celebration of differences (Gilligan, 1982; Kaplan & Surrey, 1984) and an appreciation of how certain "female" qualities, such as compassion and an emphasis on relationships or connectedness, are central to social work values (Berzoff, 1989; Sands & Nuccio, 1992).

There has been an inherent controversy between postmodernism, with its rejection of categories, and feminism, with its emphasis on definition and difference. Even the term "postmodern feminism" contradicts the idea that everything has multiple meanings (Sands

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

& Nuccio, 1992). Postmodern feminism, however, both disputes the necessity of categories and at the same time emphasizes the importance of differences. Rooted in French feminist theory (which was heavily influenced by Lacan, a structuralist), postmodern ideas, and poststructuralism, American postmodern feminist theory both embraces and criticizes some of these discourses (Sands & Nuccio, 1992). Structuralists—such as Freud, Marx, Piaget, and Lacan (deGeorge & deGeorge, 1972)—believe that there are deep structures that underlay the organization of the relations among cultures, personalities, or events (Sands & Nuccio, 1992). Poststructuralists—such as Foucault, Derrida, and the French feminist, psychoanalyst, Kristeva (1982)—include and transform structuralism. Moving away from universal truths, they emphasize subjectivity, context, interpretation, and diversity.

In deconstructing the word "woman," for example, postmodern feminists recognize that feminists of the past who were, for the most part, white, heterosexual, and middle-class, have often excluded women of color, lesbians, and Third-World women—when they thought they were speaking for all women. Discussing individual women, such as Latina professional women or homeless African-American women, postmodern feminists can address the issues of a specific rather than a universal "woman" (Sands & Nuccio, 1992).

Unlike French feminists, who have emphasized the analysis of the patriarchal (phallic) discourse (Kristeva,1987), American postmodern feminist social workers encourage political action. Nevertheless, postmodern feminists struggle with the notion of a political agenda that represents all women. Some social work writers who have wrestled

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

with this problem have proposed that postmodern feminists take a position of "both-and" (Nicholson, 1990; Sands & Nuccio, 1992). In other words, there is no need to choose between postmodernism's emphasis on diversity and feminism's emphasis on feminist politics. Multiplicity can be celebrated on some occasions and political action for a group on others. (Sands & Nuccio, 1992).

In relating these ideas to clinical practice, Gergen and McNamee (1993) suggest that postmodern feminist scholars have demonstrated how current mental health practices can be oppressive to women in general. They cite such notions as placing the blame for a mental patient's problems on his or her mother, blaming women for their dysfunctions rather than placing the blame on the unsatisfying conditions of a patriarchal society, and the inherent contradictions in the clinical situation that can pathologize a woman in her position as a patient. Postmodern feminists have also resoundingly criticized family therapy systems theory in its reliance on the patriarchal family model that does not take into account the larger contexts in which families are embedded (Bograd, 1990; Levine, 1994). Challenging the notion that all members of a system have equal power, postmodern feminists want to deconstruct the notion of what constitutes a family at the same time as looking at political and historical precedents to embedded patterns.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Postmodernism And The Narrative

In addition to influencing feminist thinking about clinical practice, Derrida and Foucault have made an impact on family systems theory and individual psychotherapeutic work via their emphasis on the text and the narrative. Unlike the paradigmatic or modern way of thinking that seeks to explain without context, the narrative view attempts to interweave context and story (Widdershoven, 1993). Narrative represents the unique case, the beauty of the specific, as well as the way in which people make sense of their lives[1]. From a postmodern view, a narrative is conceptualized as a "series of moments, rather than a planned progression of events" (Smith, 1989, p. 15). Such narratives represent a vision of reality that their creators acknowledge to be interpretive and fragmentary (Gorman,1993). Widdershoven(1993) suggests that narrative and psychotherapy are interchangeable in that narrative like psychotherapy leads to communication, reconstruction, enactment, and "edifying dialogue" (p. 17).

White and Epston (1990) have translated the theoretical foundations of deconstructionism and discourse analysis into a form of treatment called *narrative therapy*. Based on the belief that power and knowledge are inseparable, narrative therapy attempts to externalize the perceived problem in a way that no longer subjugates the person in treatment to one way of being. Grounded in Foucault's (1980, 1982) theories about the nature of "truth," and Derrida's (1976, 1978) belief in deconstructing

---

[1]It is important to note that there are some societies that do not use narrative as a form of communication(Ong, 1982).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

dysfunctional messages, narrative therapy aims to separate the person from previous self concepts and socially-instilled identifications.

The ideas of White and Epston have lead to a proliferation of writing by social workers (Dean, 1993; Goldstein, 1993; Greene, Jensen, & Jones, 1996; Hoffman, 1993; Horner, 1995; Laird, 1993) about how to deconstruct the traditional therapy model and how to co-construct meaning with people in treatment. White and Epston's model of practice has been criticized, however, by poststructuralists and feminists, such as Fish (1993), who have contended that deconstructionism should shift practitioners' focus to the path that power relations take from the local level, such as in families, to institutions and cultural practices. To split off the world of power in the individual or the family from its institutional or cultural context is to deny that some power arrangements are "bad," leading to subjugation. In the case of a violent father, for example, a narrative therapy that did not involve some amount of injunction would be absurd.

Finally, no history of postmodernism's influence on clinical social work would be complete without reference to Donald Schon's (1982) concept of the reflective practitioner. Schon believes in a system of "knowing-and reflecting-in-action." Although one cannot know and reflect at the same time, one can knit these concepts together in an interactive-feedback loop that becomes a reflection on and then a doing of practice. He claimed that it is possible to criticize technical rationality while at the same time respecting the practitioner as having some knowledge of practice that may also be intuitive. His ideas, which embody postmodernism at its best, have influenced master social work practitioners (e.g., Dean, 1993; Goldstein, 1993; Gorman, 1992; Millstein, 1993), because

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

of his contention that a professional can be clinical and artistic, subjective and objective.

The Problem

According to Argyris(1974): "Clinicians have microtheories of action, which they use to design and carry out their actions, but they are not aware that the theories they espouse are not the theories they use" (p.639). If clinical social workers espoused postmodern ideas, it was important to explore how or if these ideas were translated into actions, or if ideas that disagreed with their prior therapeutic framework actually modified or changed their clinical work. Postmodern theories challenge the assumption of truth based on professional knowledge, which is a concept integral to most social work theory. If such ideas are taken seriously, clear rules and guidelines for therapy may become blurred. Rules that dictate how therapy should be done, how change should take place, how such changes might be achieved, and the nature of the role of the therapist would be compromised.

What is unique about postmodernism, however, is that it focuses on inclusion and reflection—the practitioner reflects on him or herself in action as well as on the other in an interactive feedback-loop (Schon, 1983). Based on this principle of reflection-in-action and the intersubjectivity of meaning, practice interventions can be chosen from a wide range of options that do not include only specifically contrived postmodern therapies.

Nevertheless, the philosophical differences that underlie different aspects of postmodernism present an intriguing question about how postmodernist clinicians have or have not integrated diverse modalities and theories into their clinical work. Many of the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

writers on the subject either disagree with one another or use distinctly different concepts interchangeably—such as constructivism and social constructionism. There are arguments about constructivism vs. social constructionism, traditionalism vs. postmodernism, affirmative vs. skeptical postmodernism (Gorman, 1993) and feminist vs. constructivist values (Fish, 1993), among others.

Since postmodernism does not demand an adherence to one specific school of thought and proposes that context determines use, it was important to explore how postmodern clinicians identified their theoretical preferences and integrated them into their work, if they integrated them at all. The tradeoffs inherent in the adoption of one framework or the other are many: If one were to take a strictly constructivist stance, for example, the advantages would be a much closer alignment with the ideas of the person-in-treatment. There is no doubt that the co-construction of meaning would be enhanced and a deeper bond created (Saari, 1994). What is useful about the constructivist model is that it undermines the assumption that the clinician is some kind of expert about the other person. The downside of this model is that it can present a view of the person as isolated in biological captivity.

Conversely, social constructionism suggests an evolving set of meanings that result from the interactions among people (Hoffman, 1990). These meanings do not take place within what is thought of as "the individual mind," and thus are part of "a general flow of constantly changing narratives" (p. 3). Bypassing the fixity of a biologically-based view of reality, social constructionism allows the therapist to think of people's problems as stories that they tell (Hoffman, 1992). "The move is from an experiential to a social

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

epistemology" (Gergen, 1985, p. 168).

In addition, if one were to take a strictly social constructionist view, then the result would be an emphasis on empowering the person-in-treatment. Utilizing Habermas's (1971) ideas about the domains of human activity, Kondrat(1995) suggests that all forms of inquiry may exist in the service of specific interest groups. Via critical reflection and inquiry, the clinician can expose these biases and free the person from self-imposed notions that reflect other agendas, such as the suppression of sexuality (Foucault, 1990).

Research Questions

Because of these controversies, it was important to analyze, define, and explore such an important development in social work consciousness. While Simon (1992) presented one view of the way in which different theoretical concepts and approaches could be integrated—into a "both-and" philosophy—it was the purpose of this study to compare and contrast the ways in which other postmodern practitioners have formulated their work—with the goal of discovering what constituted postmodern practice in its actual implementation in the clinical setting. It was interesting to study, for example, how postmodern clinicians utilized diagnostic categories when forced to interact with or operate in such dominant systems as managed care and agency-based practice—where utilization reviews required diagnosis. Some other interesting questions were: How have these therapists integrated the diverse views of constructivism and social constustionism into their existing practice? Do they understand the differences between them? How have they reconciled the theoretical contradictions of traditional vs. postmodern practice?

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

How has postmodernism influenced their ideas about relationship, the nature of the self, the formulation of what constitutes change, and views of health and mental illness? What do they see as the role of the clinical social worker? What do they see as the goal of therapy? What kinds of interventions do they use to achieve these goals? The answer to these questions would provide a sense of how the field of clinical social work has been affected by this paradigmatic shift: how the process has taken place and where postmodern clinicians stand at this moment in time with regard to its theoretical foundations. The fundamental question remains: Is this a departure from the clinical social work tradition, and, if so, to what extent.

Definition of Terms

Postmodernism refers to a general intellectual movement that has influenced art, literature, religion, the social sciences—and now social work. It suggests that many truths may exist at one time. Ideas that are regarded as real are real only because they are based on our experiences and because we believe them to be real.

Constructivism is an aspect of postmodernism. Constructivism involves the notion that reality is created rather than discovered and that we, as individuals, base our understanding of reality on our own perceptions, cognitions, and cognitive structures. It emphasizes the inherent nature of perception and understanding and the idea that people want to recreate their world views in their interactions with others.

Social Constructionism is an important aspect of postmodern thinking. Social constructionist theory suggests that our beliefs, our identities, and our world views are all

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

created by society and history. According to Gergen(1985), social constructionist theory attempts to describe the process by which people explain and attribute meaning to themselves, the events in their lives, and their world. It emphasizes the notion that meaning is socially defined and that people actively participate in the creation of that meaning.

Intersubjectivity refers to the social aspect of human consciousness. Intersubjectivity presupposes that human consciousness is socially constructed and shared through interpersonal communication.

Postmodern clinician refers to a social work practitioner who is both self-identified and socially known to practice therapy from a postmodernist perspective.

Narrative is a unique and specific story told by persons about their life or about an event or events. "Stories are interpretations of life in which the meaning of life is spelled out" (Widdershoven, 1993, p. 8). These stories may have themes, plots, protagonists, and villains, as well as represent values, longings, conflicts, and beliefs.

The narrative construction of the possible refers to the idea present in several different models of postmodern therapy that reality can be co-constructed by the clinician and the person-in-treatment. It implies that there are many possibilities for change and options for self-definition.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Chapter II

LITERATURE REVIEW

Many of the previously mentioned ideas have appeared in the social work literature and, to some extent, have influenced clinical social work practice. Following is a literature review in which I will contrast different theoretical orientations found in the literature that relate to postmodernism, present some ways in which these controversies have been synthesized, describe different therapeutic approaches, and determine what needs to be addressed further.

Theoretical Contrasts

Traditionalism vs. Postmodernism

Several authors have attempted to compare and contrast postmodern ideas with traditional clinical work (Anderson, Goolishian, & Winderman, 1986; Cecchin, Lane, & Ray, 1993; Goolishian & Anderson, 1992; Hoffman, 1988). They suggested that prior guidelines for practice have involved normative standards and an attempt to return people-in-treatment to normal functioning (Levine, 1994). Postmodern clinical workers dispute the validity of the concept of normality. Furthermore, they question the observing system and the notion that reality is only discovered and not created. To a postmodernist, this is a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

false distinction: They believe that reality is fluid; it can be discovered, and it can be created. If the therapist's own reality is questioned, the therapist cannot make unilateral decisions about what is best for a person-in-treatment.

A model of postmodern practice that would synthesize diverse views and controversies into a coherent framework would, perhaps, have a "both-and" quality. Simon (1992), for example, suggested that the philosophical positions underlying traditional and postmodern approaches can be integrated into a "both-and" frame in which a clinician can, for example, have a postmodern mind while doing traditional or modern clinical work. He stresses that it is more the postmodern attitude toward treatment that is significant rather than the techniques themselves.

Bruner (1986) believes that science and postmodernism can co-exist via a kind of backward mapping that he calls "the narrative construction of the possible." This refers to the idea that a person's self-definition can be co-constructed in the treatment situation and that this redefinition can lead to different possibilities. If a person comes in with one diagnosis, for example, they can leave with another more positive one by re-defining how they see themselves. Postmodernism, unlike modernism, does not need to exclude other views. It can be inclusive of science as well as of intuition.

In clinical social work, the relationship between diagnosis and treatment—what could be called the difference between meaning and causation—has been fraught with controversy (Saari, 1994). Clinicians utilizing behavioral approaches to treatment have been able to constrict their analysis to fit into narrow diagnostic confines but have sacrificed a view of the whole person-in-treatment. Other clinicians have abandoned more

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

holistic social work diagnoses in favor of the *DSM IV* (American Psychiatric Association, 1994), despite the fact that research into earlier versions, such as the *DSM IIIR*, (American Psychiatric Association, 1993) have failed to produce a full correspondence between its categories and specified treatment approaches (Saari, 1994). If meaning and causation are separated from one another, but not excluded, then treatment can take place in a milieu that encourages the co-construction of meaning without sacrificing "scientific" validity.

Affirmative vs. Skeptical Postmodernism

Gorman (1993) and Rosenau (1992) have pointed out that there is a distinction between the two ends of the continuum of postmodernism. On one end of the spectrum is "skeptical" postmodernism in which the deconstruction of a text, for example, leads to nihilism and a sense that nothing is worth a commitment. Such an analysis could lead to the tearing apart of a text to criticize its generalizations or deficits without the offering of an alternative viewpoint. This approach implies that the critic has sole possession of the truth (Gorman, 1993; Rosenau, 1992) and that all readings of a text are flawed (Gorman, 1993; Hoy, 1985). It also refers to the disputation of all diagnosis and related categories.

On the other hand, "affirmative" postmodernists accept the value of a shared understanding of human experience and, therefore, try to avoid the extreme relativism unique to skeptical postmodernists. Positive or affirmative postmodernists embrace values, such as social change or ecology, and affirm the importance of collective stories that place people's lives in the context of larger social forces (Gorman, 1992; Richardson,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

1988). They do not exclude diagnosis, but treat it lightly—as another version of how to create meaning. In this arena, it would be important to see how postmodern clinicians place themselves on this continuum.

Constructivism vs. Social Constructionism

Constructivism involves the idea that reality is invented rather than discovered. It suggests that human beings participate in the creation of reality based on their own unique perceptions, cognitive structures, and experiences (Levine, 1994). According to several theorists (Maturana & Varela, 1987; Varela, 1984; Watzlawick, 1984), what is perceived as reality is not a true representation of what is outside of ourselves and does not exist separately from ourselves. "There is no world except that experienced through those processes given to us" (Varela, 1984, p. 320). Questioning objective reality, therapies based on this concept emphasize the creation of ideas about the self and the other. Kegan (1982) calls the creation of meaning-making an act that balances and rebalances the subject and the object. As interactions change, meanings change, based on internal references. Hoffman (1990) likens the process of constructivism to the "attempt to set up a dialogue between different species" (p. 3).

For Hoffman(1990), it is important to draw a distinction between constructivism as defined by Watzlawick (1984) and others (Dell, 1982, 1985; Efran & Lukens, 1985; Elkaim, 1990, Golann, 1988; Kegan, 1982) and social constructionist theory (Anderson & Goolishian, 1987,1988; Gergen, 1985; Real, 1990). She asserts that the two terms are often used interchangeably. Social constructionism posits the notion that our beliefs about

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

reality are social inventions (Levine, 1994). Unlike constructivists, who believe that what we perceive is "filtered through our nervous system" (Maturana, 1978, 1980, 1988), social constructionists believe that what we perceive is explained by the political and social realities of the world in which we live (Hoffman, 1990). In suggesting that reality is socially defined, social constructionists always consider the larger social sphere of influence—and the "vicissitudes of social processes, e.g. communications, negotiation, conflict, rhetoric" (Gergen, 1985, p.168).

The literature abounds with articles by social constructionists (e.g., Gergen, 1993; Hoffman, 1993; McNamee, 1993), constructivists (e.g., Dean, 1992, 1993; Holland, Gallant, & Colosetti, 1994; Watzlawick, 1984), and those who integrate the two or use them somewhat interchangeably (e.g., Pozatek, 1994; Saleeby, 1994). Common to all of these theories, however, is the idea that "truth" or "reality" is a construction—not an independently verifiable fact.

The Relationship

Postmodernist theories raise the question of how the relationship between the postmodern psychotherapist and the person-in-treatment is constructed and conceptualized. Stern(1989) has suggested that the definition of an interaction is an externally viewed, interpersonal event. In contrast, he defines a relationship as the interaction along with its intersubjective interpretation. Thus, an interaction can be discussed in the framework of causality and science at the level of behavior, but a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

relationship takes place in the sphere of meaning (Saari, 1991).

In the postmodern trend away from linearity and positivism (Atherton, 1993), relationship centrality implies more than closeness and mutual regard. It reflects the tradition of respect that women and healers throughout history have had for culture and narrative (Wetzel, 1986; Estes, 1992). Freire (1982) believed that unity and communion create synthesis and lead to liberation. Self-psychologists, who represent an aspect of postmodern practice in their emphasis on intersubjectivity, refer to the relationship as a part of the self-object transference (Ornstein & Ornstein, 1983). Garfield and Bergin (1986), who are experimentalists, found that in looking at over 1,000 process-outcome studies, there were high rates of positive association between good outcome and a strong therapeutic bond—although the definition of what constituted this "bond" varied from clinician to clinician and from theorist to theorist.

Schon(1983) contends that there is a new way to structure such therapeutic relationships: "My concern is to show how the professional-client contract may be transformed, within a framework of accountability, when the professional is able to function as a reflective practitioner" (p.295). To Schon, this means an interactive context in which the practitioner shares his or her own discoveries with the person and is always attentive to changes in the interaction. This intersects with the postmodern aim of deprofessionalization in which the person running the treatment attempts to demystify the power arrangements inherent in the therapy situation.

A postmodern approach to clinical work could help heal the dilemma of the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

fragmented sense of self and the shifting of moral identities. One of the ways to approach this experience of fragmentation is with self-psychological interpretations of an empathic nature that refer back to the relationship with the person-in-treatment. The Ornsteins (1983) suggest that the way in which a person in treatment communicates reveals his or her efforts to establish an emotional connection or relationship with the therapist. This is in service of maintaining the cohesiveness of the self and eventually in service of development and growth. Although constructivists and social constructionists would argue that the concepts of self-development and growth may be oppressive examples of Western individualism and self-determination, "tyrannical measures of human worth in our society" (Wylie, 1994, p. 46), attempts to form a cohesive sense of self-speak to the postmodern problem of fractured identity. It may, therefore, be important, in some cases, for a clinician to help the person in therapy achieve a sense of wholeness. One of the ways in which to achieve this is with empathic attunement that mirrors the sense of fragmentation and reflects an understanding of the pain associated with it.

Mirroring, attunement, interpretations aimed at demonstrating empathy have a place in almost all aspects of clinical work. Such statements have been called "experience near" as opposed to "experience distant" by Kohut (1979), who was a neo-Freudian structuralist, but also by poststructuralists (Saari, 1991, White & Epston, 1990) who value the relationship as a way to redefine or deconstruct the sense of self into a more positive construction.

Nevertheless, how to negotiate or formulate the idea of relationship in postmodern clinical practice raises many issues: Many postmodern therapists (DeShazer, 1991; Saari,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

1991; White & Epston, 1990) contend that it is the goal of treatment to revision the sense of self in such a way as to challenge and redefine a negative self-evaluation. This goes beyond the notion of empathy and enters a whole new sphere of activity. Saari(1991) suggested that it is up to the therapist to negotiate with the "client" in order to achieve a better, more complex organization of the self. Many feel that it is up to the therapist to help the persons-in-treatment see themselves as they can become in the future and relate to the person as more than they are. Saari(1991) credits Kierkegaard with the idea that "we live forward, but we understand backwards" (p. 162).

The Self

The contradictions inherent in all of these ideas lie in how the construction of the self is conceptualized. If it is constantly shifting, then how can it become better organized? If it is seen as ephemeral, than why address it at all? If thinking of self development is tyrannical, than why help someone change?

Although it may not be possible to reconcile all the contradictions presented by postmodern philosophers about the nature of the self, it may be necessary to, at the least, examine some ideas about the self that are central to postmodern theory. Gergen (1991), for example, contends that we are in the dawn of a new consciousness about the self, which he calls postmodernism. He believes that we have gone beyond the romantic conception of the self—as mysterious and passionate—and the modern sense of the self—as possessing reason, intentionality, and personality traits. To Gergen, all such ideas

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

are socially and historically created. Postmodern consciousness involves the demise of personal identity, sincerity, and depth. Instead, he postulates that people can erase and rewrite their identities as the ever-expanding network of interrelationships permits.

DeShazer (1991) has suggested that what most people consider random acts in their lives are based on the belief that there is an integrity to their identities. In other words, if a person with an elevator phobia is able to take an elevator on one particular day, it is seen as aberrant—not representing the true self. Postmodern therapists believe in challenging this construction of the self in order to make random acts the norm and "pathology" or "the problem" as random. The person-in-treatment becomes able, with this formulation, to gain mastery over his or her "problems" by deconstructing a self-fulfilling prophecy.

Lifton (1993) synthesizes all of these ideas about the multiplicity of the self by characterizing the self as "the symbolizing self" (p.29). In his construction, the self is biologically grounded via the capacity of the brain to symbolize—but he sees these symbolizations as capable of being both rational and irrational, individual and communal. This symbolizing self is sensitive to developmental influences but not entirely determined by them. It functions as an open system that is capable of being both observer and observed as well as both at the same time.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Postmodern Interventions

Keeping the relationship at the epicenter of clinical work and retaining an open, self-evolving concept of the self, it may be possible to utilize a number of different approaches to treatment. The postmodern perspective, with its deconstruction and subsequent reconstruction of the concept of self, suggests that a person is constantly changing and that with these changes, different solutions can emerge. Following is an attempt to describe some new treatment modalities that represent these beliefs.

Narrative Therapies

Based on the belief that power and knowledge are inseparable, narrative therapies attempt to externalize the perceived "problem" in a way that no longer subjugates the person in treatment to one way of being. The emergence of narrative therapies like those of DeShazer(1991), White and Epston (1990), Hoffman (1991), and Saari (1991) are reflective of this postmodern trend. Such therapies attempt to separate the person from previous self-concepts and socially-instilled identifications.

These narrative therapies do not involve only the storytelling of clients but include the telling of stories by therapists themselves. As people tell their stories to therapists, therapists can tell stories in return that open new avenues and ideas for people to consider (Holland & Kilpatrick, 1993). In theory, narrative therapies are similar to the strengths-based perspective that Saleebey(1992) recommends in that they seek to avoid pathologizing the person-in-treatment. In practice, they vary in several ways.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

White and Epston's(1990) approach is based on Foucault's text analogy, which proposes that meaning is derived through the stories that people tell about their lives and the meaning that they attribute to their experiences. The treatment involves giving the person a written statement that expresses what has come out of the therapist-participant interaction. The statement is in the form of a letter that may include the therapist's reservations about certain possibilities but stresses the capacities of the person with the problem to change. It reframes the problem in a new light that emphasizes a positive metaphor around which the problem can redefine itself. White and Epston believe in the idea of "unique outcome," a time during which each person in treatment is not oppressed by the problem or moments during which the problem has been protested or has disappeared.

Attempting to integrate her theory with causal explanations and scientific empiricism, Saari (1991) argues for a therapy based on the narrative construction of the possible. In her work, she proposes that the narrative accounts that people give contribute to the co-construction of meaning in the treatment relationship. Substituting a co-constructed personal meaning system for ideas about adaptation (which she believes has provided an inadequate basis for clinical social work theory), she emphasizes the use of stories in individual clinical work. Many of her recommendations involve ideas about the attitude of the clinician. Stressing the acceptance of people's realities, she argues against criticism of people-in-treatment—since it further undermines someone's confidence, if their construction of their world is challenged. Unfortunately, this model is not supported with enough clinical material to replicate it in practice.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The goal of the reflecting team model of treatment, which was developed by Anderson (1987, 1991) and further developed by Hoffman (1991) is to create a form of therapy that is consistent with the postmodern idea that the therapist can create a context for change to occur without determining how this change will take place (Levine, 1994). Mostly used with families, the interviewer and the people-or-person-in-treatment are observed from behind a one-way mirror by the reflecting team. At different points during the interview, the audio-visual equipment is reversed, and the family or person and the interviewer can observe the comments of the reflecting team. This places the team in a collaborative position and capitalizes on the ability of people to find their own solutions.

In questioning the validity of research about what is helpful to people, Hoffman (1991) proposed that the reflecting team is a way for people to gain access to different ideas about what might be useful and challenges the notion that there are developmental standards that should be met by people-in-treatment. She also questioned the validity of the concept of "emotions," which she believes are the result of interaction and communication among individuals and not discrete states that exist within individuals.

Anyone who has observed a reflecting team or been part of a group that has discussed clinical matters can testify to the constraints and norms present in the room. Unless one has been schooled in the same manner as the participants, there is a sense of some contributions as being acceptable and some being unacceptable. Nevertheless, this model provides an interesting way of reversing the therapist-as-expert position.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Solution-Focussed and Brief Therapies.

Solution-focussed and brief therapies have developed out of the idea that often the way the problem is described may lead to an understanding of how it can be fixed. One of the most influential ideas in brief therapy has been the idea advanced by the Mental Research Institute in Palo Alto, California, that under certain circumstances, problems are maintained by the way they are tackled and that this can exacerbate the problem situation. A problem becomes entrenched as more of the same solutions are applied to it(Cade & O'Hanlon, 1993). Some brief therapists refer to this a "the problem having a life of its own." Social workers who have worked with children, for example, have often been struck by how readily parents intensify their attention to a youngster's problems rather than on his strengths. This can lead to a proliferation of problem symptoms in the face of so much negative reinforcement. Clinicians, as well, can often become committed to a particular diagnosis and treatment approach, particularly when they have made an emotional investment in how they view the situation. Some of the ways that clinicians have addressed this attachment to a clinical idea has been to berate clients or to lecture them. Solution-oriented therapies and brief therapies seek to disrupt this familiar pattern both on the part of the client and the therapist by finding new and different solutions to problems--with solutions often baring little similarity to the problem or cause. Consider, for example, a case in which a person's drinking is upsetting his family. Lots of solutions have been proposed, such as Alcoholics Anonymous and individual psychotherapy. None of these has worked. As a result the person's wife has begun to avoid all social situations in which she would be in a gathering with her husband, because of embarrassment about

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

his drinking. This isolation led to an exacerbation of his drinking. A solution-focussed approach might be to get her to start going to parties with him again(Cade & O'Hanlon, 1993). When this treatment plan was implemented, the husband's drinking lessened as he became more aware of his socially unpleasant behavior..

Demonstrating his approach to solution-focussed therapy with a great deal of clinical material, DeShazer (1991) reconceptualized the therapy experience as a conversation between two people. For him, psychotherapy becomes an interaction in which the therapist and the person-in-treatment work together—through language—to construct solutions. In this kind of treatment, Aristotelian ideas about causality as well as ideas about circular causality are rejected as useless. He is mostly concerned with finding areas of difference with the person-in-treatment's concept of self as fixed and negative.

The Mental Research Institute(MRI). Brief therapies and solution-focussed therapies were pioneered at The Mental Research Institute, known as MRI, in Palo Alto, California. In the 1970's many noted clinicians in the field of psychology, psychiatry, family therapy, and social work gathered there to discuss ideas about how to approach psychotherapy--particularly family therapy--from a new angle, based on ideas that had come out of physics and anthropology, among others. Some of the founders included Gregory Bateson, John Weakland, and Paul Watzlawick, Epston(1993), for example, credits MRI for helping him begin to think differently about his therapeutic work. Some of the therapeutic techniques and strategies developed at MRI have included: Framing interventions, such as altering how the problem is viewed; pattern interventions, such as

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

changing how the person-in-treatment "does" the problem; using analogies, such as anecdotes, parables, and stories; paradoxical interventions, such as prescribing the symptom; circular questioning, which involves asking questions about how the problem affects others as well as the patient; and scaling questions, which involve describing aspects of the problem in numerical terms that can be easily understood by both therapist and client. Some of these techniques represent "first-order" treatment, which looks at the system as the focus of change, and; some of these represent "second-order" treatment, which looks at the therapist and client as part of an interactive, intersubjective whole that cannot be separated into discrete entities.

A hypothetical example of a case in which several of these techniques were used would look like the following: A couple is having marital problems. They fight furiously and frequently. First each one is asked to describe the problem and to rate its severity on a scale of one to ten(a scaling question). Because the woman is an equestrienne, the therapist may ask her to think of her husband as a horse that needs to be trained, not a recalcitrant marital partner. This would demonstrate the use of analogy. It may be suggested that they fight every Wednesday at around nine o'clock p.m., which involves the paradox of prescribing the symptom and, thus, gaining control of it. Circular questioning would involve each one's being asked what he or she believes their partner thinks about the situation.

There are numerous other examples of brief, narrative, and solution-focussed interventions in the literature. It would be beyond the scope of this project to describe all of them or to elaborate on them further. Nevertheless, it is important to note that these

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

therapies have developed out of some postmodern ideas about circularity, uncertainty, variable truth, the importance of context, the co-creation of reality, and nonessentialism--the dismantling of the idea that our inner natures are fixed.

Theories in Practice And Theories in Use

After considering many of the approaches to clinical practice described earlier and many of the influences that had lead to their development, it was important to look at whether any of these approaches had led to clinical research or research into the effects on practitioners or service users. In this aspect of the literature search, there were only three studies that investigated the effects of constructivism and social constructionism on actual practice (Holland, Gallant, & Colosetti, 1994; Levine, 1994; Stone Fish & Peircy, 1987). They found that, for the most part, a paradigmatic change took place in the realm of thinking about practice, but there was less significant change in the realm of actual practice. They, also, found that therapists had become more "meaning oriented" (Levine, 1994) and less focused on the interviewing process. In other words, the therapists studied were not interested only in behavioral change or explanations, but wanted to know what people-in-treatment thought about their behavior: how they understood it and their relationships with others. Some adopted a "both-and" position with regard to theoretical contradictions. An example of a theoretical contradiction might include seeing families from an objectivist, first-order perspective at the same time as being interested in the family as a linguistic system or language-based construction(Anderson & Goolishian,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

1988). The studies also highlighted the lack of clarity about the concepts of social construction and constructivism and some confusion about their meaning.

These findings may be explained in one sense by ideas about professional practice developed by Argyris and Schon (Argyris, 1974; Argyris & Schon, 1974; Schon, 1987). They have contended that theories often consist of fragments rather than comprehensive models. Combined with the clinician's professional and personal experiences, these fragments form a gestalt that becomes the backdrop of a practitioner's work (Dean,1994). Argyris and Schon believe that a difference exists between the theories that we espouse and the theories that we use in actual practice. In this study, I would hope to unearth the actual practices that self-identified, postmodern clinicians use as opposed to the theories that they espouse.

Questions for Further Study

Several writers, most notably DeShazer(1991) and White and Epston (1990), have written about aspects of postmodernism such as social constructionism and deconstructionism, while at the same time including clinical material in which it is possible to see the therapist's contributions. Their treatment, however, seems to focus only on the social constructionist aspects of postmodernism and not on its total vision, which includes a constructivist stance about health and illness. If their work were totally postmodern, it would, also, include a broader philosophical base that does not exclude all of the theories that have gone before, such as psychoanalysis and ego psychology. Nevertheless, their

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

ideas are useful in drawing a picture of the postmodern practitioner *in vivo.*

Although there were several articles about the concept of postmodernism (Gorman, 1993; Hartman, 1991; Pozatek, 1994), few translated this concept into a model of practice. It would be important, therefore, to study postmodernism as an overall concept applied to clinical practice. This raises the following questions, among many others: How is the necessity for determining diagnosis integrated into the treatment? How are different theories incorporated into existing practice? What happens when a therapist's values are directly challenged, such as in the case of treating a child molester? How are the goals of therapy envisioned? Is there still a role for behavioral change? Who runs the therapy session? What is the role of the "professional?"

In the next chapters, I will elaborate on some of these questions more fully, explain the methodology of the study, describe as coherently as possible the ways in which clinicians have interpreted postmodernism, and the ways in which they actually practice. The last chapter will synthesize and summarize the results as well as make recommendations for further research and propose implications for clinical social work.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Chapter III

METHODOLOGY

Overview

This chapter presents the methodology of the study. First, the question being considered is described. Then I will describe how the study was designed. Next I will explore the reasons for using qualitative methods and for initially selecting master practitioners. There will be a description of my sampling procedures after which I will discuss my interview guide and my rationale for integrating it with an open-ended, conversational interview. Following will be my process of data collection: how I established contact with my interviewees, how I got their names, where the interviews took place, etc; how I handled the issue of confidentiality; and their access to the findings. There will be a section on problems and limitations of the of the study and then there will be a discussion of data analysis.

GOAL

The goal of this project was to determine whether or not postmodernism

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

represented a departure from clinical social work practice as it has evolved over the years and to assess the impact that it has had on master social work practitioners who have adopted some or all of its ideas or tenets, such as constructivism, social constructionism, deconstruction, acceptance of "irrationality," etc. In my literature search, I evaluated the few studies and investigations that pertained to postmodernism and its clinical implementation. What I found in the literature search was a surprising lack of specificity about what constituted postmodern practice in the clinical setting. Furthermore, many practitioners were unclear about what different concepts, such as constructivism, meant and how to incorporate them into their actual work(Levine, 1994).

DESIGN

Because there has been insufficient critical reflection in the literature on the nature of postmodern clinical practice, but a great deal written about its philosophical tenets, it was important to study how such practice was experienced by postmodern clinicians. This was important, because of the direction that clinical social work has taken toward embracing some of these postmodern concepts, such as social constructionism and intersubjectivity. The purpose of the study, therefore, was to look at the practice of postmodern clinical social work in order to see what the effects of postmodernism have been on clinical practice. It was my intention to enter the world of self-identified postmodern practitioners via a study that looked beyond the surface(Light, Jr., 1983) at the deep structure of clinical practice as it was engaged in by postmodernists in order to

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

explore its textures and essences. Selecting the appropriate methodology to study the essences of such practice raised the following questions: What kind of research design seemed best suited to this endeavor, and how would this design be carried out?

An effective way of studying essences involves a phenomenological approach, because phenomenologists are interested in how people experience the world. It looks at how a phenomenon is experienced from an individual's perspective(Patton, 1990). Phenomenology implies that there is a subjective aspect to understanding experience, because there is no objective way of understanding the world. This is similar to postmodernism's emphasis on the inability to separate self and object, inner reality and outer reality. Essences, according to Patton(1990) are "the core meanings mutually understood through a phenomenon commonly experienced"(p.70). This assumed commonality of experience by postmodern clinicians would generate a picture of how postmodernists experienced their work. Thus, one aspect of the study would be phenomenological in nature.

In making the decision to pursue a phenomenological study, it became important to question what the essences were that defined postmodern clinical work. Some of these essences appeared to be related more to perception than to action in that postmodernists experienced a shift in awareness of the interactive nature of practice. The literature suggested that postmodern clinicians saw themselves as participant observers rather than objective observers of people-in-treatment(Anderson & Goolishian, 1987; Saari, 1991). Another possible essence of practice appeared to be a more interactive, intersubjective, self-disclosing style in which the therapist took the role of an equal not an

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

expert(DeShazer, 1983; Hoffman, 1993).

Another question asked in designing the study involved what postmodern practitioners actually did in the quotidian, logistical aspects of practice, such as length of sessions, names used to identify self and person-in-treatment, and fees charged. This question seemed to require certain ethnomethodological approaches to research. According to Holstein and Gubrium(1994)ethnomethodology involves looking at how people act in context. Ethnomethodologists ask how people connect patterns of behavior with interpretations of what these patterns mean. Unlike traditional sociologists who are interested in rules and structures, ethnomethadologists are interested in how people justify rules and conduct. In the case of postmodern clinicians, it was interesting to study how they acted with people-in-treatment and how they carried out certain taken-for-granted aspects of practice in order to unmask and understand what the effects of postmodernism were on the level of ordinary professional interactions.

The reason, which will be described further on in more detail, for initially choosing master practitioners was that their experiences would provide more information rich cases, since they had grappled with these new ideas and, perhaps, would have more insight into them. It would, also, have been interesting to test a broad sample of clinical social workers throughout the country or in the Metropolitan area to see whether they had been influenced by postmodern ideas. But this would have been a time-consuming undertaking and would not, based on the resources available for the study, have yielded enough "thick description" (Sherman & Reid, 1994). The resources available included about nine months to devote to interviewing, an interview schedule that would allow the researcher to work

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

full time while pursuing this investigation, and a sample that would provide sufficient information-rich cases.

Since the key question to ask in selecting units of analysis is to decide "what it is you want to be able to say something about at the end of the study"(Patton, 1990), it was important to choose individuals with an understanding of the concepts of postmodernism, as well as sufficient experience with clinical practice to warrant an investigation into its effects. This lead to the initial choice of master practitioners. The study evolved, however, to include people who were not master clinicians. This will be discussed in more detail further on.

Rationale for Using Master Practitioners

My plan was to utilize purposive, criterion sampling to study at least twenty master clinical social workers. The reason for criterion sampling was that it would target information-rich cases that would lead to deeper understanding of the impact of postmodernism. There would be much to learn from master practitioners, who could, in some ways, function as teachers of postmodern practice. Quantitative measures and random sampling would have been more appropriate to investigate whether clinical social workers in general had been affected by these concepts. It was the purpose of this study, however, to look only at those people who had come in contact with such ideas. These practitioners were chosen for their level of experience, degree of identification with social work values(publication in social work journals as an indicator, for example), reputation and self-identification as postmodernists, and extent of present clinical experience.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Although I am aware that the idea of an expert is contrary to aspects of postmodernism that preclude the idea of a superior perspective, it is, paradoxically, experienced, "master" practitioners who have been influenced by and have written about postmodernism. It is important to study the ways in which seasoned clinicians have understood, integrated or utilized postmodernism, because they have the "repertoire"(Schon, 1987, p. 270) from which they can reflect on these new theories and make sense out of them for practice. The work of master clinicians involves a combination of experience and artistry that Schon(1987) contends develops over time. Dean elaborates that because clinical practice evolves over time, it is the experienced clinicians who have had the opportunity to reflect on their own work:

> Therapeutic methods may shift during the clinical process, the client or client group may change over time, and clinicians' thoughts about cases are also in a continuous process of evolution. Clinicians' reflections on clinical work would be different in the middle of a clinical encounter, if we could stop the action, from reflections occurring days, months, and years later, because ideas about practice shift, according to clinicians' interests, studies, readings, experiences, and contexts (p.283).

Furthermore, there are several precedents in the social sciences for studying master practitioners. Among these are anthropological studies on master healers, such as Thai curer-magicians(Golomb, 1986) and Mexican shamans(Fabrega & Silver, 1973).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Qualitative Research

In order to engage in a study from a phenomenological and ethnomethadological perspective, it was important to choose research techniques that would elicit information that was experiential and interpretive, as well as specific. It was, also, important to find a way to inquire about the logistics of postmodern practices, such as length of session and fee schedules.. Previous studies of constructivist and social constructionist practice had not contributed to a better understanding of what postmodern practice entailed and how it had been experienced as different from previous practice. Some of these studies used questionnaires and the Delphi method to determine concurrence of thought among clinicians(Levine, 1994; Holland, Gallant, & Colosetti, 1994). Qualitative methods allowed for delving more deeply into the work of postmodern clinicians, because it involved an emphasis on theory and paradigm formation, as well as embodied a poststructural emphasis on the person being interviewed and the co-construction of meaning(Denzin & Lincoln, 1994). Unlike quantitative methods, which may have been more remote from the actual experience of the interviewee, qualitative methods were better able to capture the subject's perspective in a richer, more meaningful way(Denzin & Lincoln, 1994). This appeared to be a more effective method of determining what comprised the clinician's actual practices and beliefs. Although not heuristic--in that it was not directly (via the text) interwoven with my own experiences and beliefs as a postmodernist--it utilized these experiences and beliefs as a guide, with the aim of generating unexpected and unplanned-for ideas about practice(Patton, 1990). Its purpose was to elicit a grounded picture of the parameters and textures of such work

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Since I was entering the system as a "convert," someone who was familiar with and in agreement with its values(Lofland & Lofland, 1995), I needed to find a distancing mechanism in order to search for and evaluate data without imposing my own thoughts, beliefs, and experiences on those of the participants. On the other hand, it was my direct knowledge of this method of practice that informed and directed my questions. Just as Janesick(1994) explored the idea of dance as a metaphor for qualitative research design, there was a dance to the investigative process itself in that it involved a constant interaction and response between the subject and the researcher. Using myself as an instrument(McCracken, 1988), I employed my experience in "unpredictable" and "various ways"(Miles, 1979, p. 597)and listened to the interviewee with "the whole of my experience and imagination"(McCracken, 1988, p.19). This translated into long, interactive interviews, which I will describe further in my data collection section.

SAMPLING STRATEGY

The following table(See Table One) presents the original proposed criteria for sampling. Participants were required to have at least ten years of postmasters experience, presently see at least five clients per week, and identify with social work as a profession. In regard to the additional criteria, they were to have met at least one of the two: publications on subjects related to postmodernism or reputation as someone interested in the ideas involved.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Table One

Initial Criteria for Participation

Years of Experience (necessary)	Ten years postmasters
Publications(optional)	At least one on some aspect of postmodernism
Self-identification and Reputation(optional)	May consider him or herself to be a constructivist or a social constructionist, as well as or instead of a postmodernist. Indicated by others to be affiliated with these views.
Identification with social work values(necessary)	Indicated by publication in a social work journal or membership in a social-work identified organization.
Present clinical experience(necessary)	Must treat at least five people or work five clinical hours per week

Identification of these participants was to be achieved through contact with professional organizations, such as the National Federation of Clinical Social Work Practitioners, reading publications that pertained to this issue, word-of-mouth or reputation, selecting people slated to speak at a conference on postmodernism, and referrals. Several ideas for finding subjects included: putting an ad in *Currents* or the *NASW News*, calling local schools of social work to see who might be interested in these ideas, getting referrals from professors, colleagues and friends, meeting people at a conference on postmodernism, and calling or writing to people who have published on the subject.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Figure 1(See Appendix) is a model for a statement spoken on the telephone to enlist participation.

The actual sampling varied in the following ways from the original proposal: I interviewed twenty-eight practitioners, eight more than the minimum proposed. In the data collection section, I will describe more about the logistics of these interviews. There were several exceptions to the plan of interviewing people who had ten years experience and a practice that included at least five clinical hours per week. Via snowball sampling, which refers to a process for finding information rich sources by asking for recommendations(Patton, 1990), I asked for suggestions from my original respondents of clinicians who would be knowledgeable about postmodernism. Among these were people who had limited clinical practices or only a few years of postmasters' experience.

I started my sampling by looking through a number of periodicals and books about postmodernism and social work and contacting various published authors within. Among the publications selected were: *The Journal of Teaching in Social Work(1993;* Vol.8, Nos.½),which had a special issue devoted to teaching constructivist practice; *Essays on Postmodernism and Social Work(*Chambon & Irving, *1994),* published by professors at the University of Toronto; *The Creation of Meaning in Clinical Social Work(*Saari, *1991),* a book devoted to the issue of intersubjective practice; and several issues of the *Clinical Social Work Journal* or *Social Work* that had articles germaine to postmodernism. Additionally, a member of my dissertation committee with overlapping interests sent a letter to seventeen people who had published in the journal that she edits(See Figure II, Appendix). I initially contacted about twenty-five more people by

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

letter or telephone. Only one of the people contacted by the member of the dissertation committee responded directly without follow-up calls. This person was an eminent writer on postmodernist subjects. Consequently, I called him immediately to arrange an interview, despite the fact that he was not carrying an active clinical caseload. He told me that he was involved in a community project in which he interviewed several people per week. This only loosely fit in with the criterion of present clinical experience. He was included in the study, however, because of his in-depth knowledge of philosophical ideas affecting clinical social work and because he qualified by reputation as a master practitioner. Next, I called all the people who had received letters inviting their participation in the study. Among the subgroup of potential respondents, about fifteen agreed to be interviewed by telephone or in person. Some wanted to defer the interviews because of poor health or vacations. Several of these people had limited caseloads but were included in the study because of their reputation for clinical expertise. Because many of these respondents lived or worked in far-flung places like Toronto or New Mexico, I arranged telephone interviews. In some cases, when the respondent refused to be interviewed by telephone, I agreed to fly to their location. In other cases, potential interviewees arranged to see me when they came to New York City. This necessitated arrangements for interviews in hotel rooms and restaurants.

When I ran out of potential candidates from the initial list of authors, I ran an ad in *Currents,* the newsletter for the New York City Chapter of NASW. This yielded one response. I, also, tried unsuccessfully to place an ad in *Focus,* the newsletter for the Clinical Social Work Society but missed the deadline. One of the challenges of placing an

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

ad was that the publications required proof that my project had the approval of the school. This took time and, in one case, led to a missed deadline. After attending a conference in Denver on postmodernist psychotherapy, I was able to find three clinical social workers who met all the criteria: One lived in New York City; one lived in Detroit and agreed to be interviewed by telephone but forgot the interview; and one lived in Chicago but withdrew her agreement to be interviewed. I, also, contacted the Ackerman Institute for family therapy in New York City. Known as an innovative agency with an interest in constructivist practice, Ackerman seemed like a logical place to find respondents. When I called, however, they told me that no one knew about constructivism or postmodernism and that I should call a former associate who lived in Massachusetts. She never returned my call. I pursued Ackerman again by looking up the names of clinical social workers on their staff who had written about family therapy from a postmodern perspective. This yielded better results. One of these people agreed to be interviewed and referred me to several others. Most of the people I contacted there, however, were too busy to grant an interview. Surprisingly among the people affiliated with Ackerman who granted me an interview was one of its most published representatives.

After exhausting all of the previously mentioned strategies for finding people to interview, I intensified my quest to get the actual interviewees to refer me to others. One of the problems with this approach was that often those potential respondents did not meet the criterion of ten years postmasters experience. When the same names kept coming up over and over again, as Patton(1990) predicts with snowball sampling, I reluctantly agreed to schedule interviews with them, because the individuals identified had

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

sound reputations as clinicians and were familiar with the theories I was studying. These were among my most informative conversations. Once this criterion(years since graduation) was modified, I found several more candidates in New York City. Among these was a person who had graduated five years ago but had taken a course in postmodernist psychotherapy and someone who had graduated from Social Work school three years ago but had been a practicing psychotherapist for ten years. I was, also, able to identify one clinical social worker who had a doctorate in philosophy and was, therefore, interested in the impact of new concepts on practice. He was very helpful in explaining some of the historical precedents to constructivist thinking.

By the end of my search, I had contacted about fifty people in person, by letter, or telephone. There were fifteen outright refusals or deferrals. Seven people either forgot the scheduled interview, canceled, or changed their minds at the last minute.

THE FINAL SAMPLE

The final sample represented a more diverse picture in terms of the criteria than the original proposed one. The original criteria were violated for the following reasons: There was a dearth of appropriate respondents who met all the criteria, and the researcher noted that interviews with less experienced practitioners provided more detailed and thoughtful information. Two of the respondents had no active caseloads; three had been out of social work school only three years. All of them(28), however, had either written about postmodernist ideas, taken a course related to it, or presented at a conference or seminar

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

on related ideas. Twenty-six were carrying at least one clinical case, and twelve were engaged in some form of clinical practice as a primary activity. All identified themselves as social workers and belonged to at least one professional organization composed only of social workers.

Table II portrays the demographics of the participants. All but one had either had individual psychotherapy training, family therapy training, or both. There was considerable overlap in postmasters training for both individual and family therapy. Many people had both. Several people had certificates, which indicated an advanced level of expertise, from psychoanalytic or family therapy institutes. Many of the people interviewed were chosen because of their publications. Ten of the informants were involved in academic research or were full-time professors. Among these were several, however, who maintained a private practice and had training in either family or individual therapy. There was a disproportionate amount of men(11) compared to the percentage in social work in general. This may have been a coincidence or related to the subject matter, which seemed to attract more interest from male social workers. At several conferences on postmodernism that I attended, there were an equal proportion of men to women. Only one of the respondents was African American; there was one French person; two Canadians; and one Englishman. The rest were Americans from a variety of backgrounds.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Table 2

Description of Participants

Average Years of Postmasters Experience	18
Number of participants with one or more publications(not necessarily in peer-reviewed journals) on a subject related to postmodernism	24
Membership in a professional social work organization	28
Reputation as a postmodernist, postmodern feminist, constructivist, or intersubjective therapist	22
Individual Therapy Training	20
Family Therapy Training	21
Certificate in Psychoanalysis	5
Certificate in Family Therapy	7
Doctorate in Social Work or a related subject	11
Private Practice	7
Agency Practice	8
University Professorship	10
Male	11
Female	17

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

GUIDE CREATION

In the preliminary interview guide (Figure IV, Appendix) , I started with vignettes. This device, I imagined, offered access to the more concrete aspects of clinical practice and provided an opportunity to assess "theory in practice" compared with "theory in use." The vignettes were expected to evoke examples that might raise issues related to postmodernism, such as what to do about diagnosis in the "real world" of managed care and accrediting organizations, what categories of diagnosis could be ignored or considered relevant, and what was the role of the clinician. In going from the more grounded to the more theoretical, I was hoping to find out how concepts were translated into practice and how practice was transformed into theory. Later on, I asked questions about postmodernism, in order to compare theoretical notions with their actual implementation and to see how clinicians defined these concepts.

Although I started out with an interview guide, I quickly integrated it with a more informal-conversational(Patton, 1990) interview style. Despite the more informal approach in which I asked a few spontaneous questions, I made sure during every interview to cover all of the original questions--with the exception of the case vignettes. These quickly emerged as impediments to the free-flow of information from respondents and produced initial interviews that were experienced as tantamount to starting the car with the brakes on. Since the general interview guide can function as a checklist to make sure that all important topics are investigated(Patton, 1990), I varied the pace of the questions according to the context of each interview. Over time, the interview structure

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

evolved into a pattern of beginning with broad, general questions and ending with more specific questions about logistics. People seemed more interested in starting the interview by co-constructing definitions of postmodernism with the interviewer and then moving on to more specifics about practice.

DATA COLLECTION

Following is a description of the general tenor of my interviews and some of the logistics involved. In the previous section on sampling, I described how respondents were identified and selected. Figure 3 (See Appendix) is a statement to obtain oral consent before beginning the interview.

Despite the fact that I agreed to keep all identities confidential, not one person wanted to remain anonymous. One wanted to review the material before being quoted. All others gave permission, which was recorded, to use their names. Nevertheless, I decided to proceed by keeping their identities confidential, except perhaps by including an alphabetical list in the preface of this document. Fifteen of the interviews were in person, and thirteen were on the telephone. Although fifteen of the respondents were from New York City, I interviewed several of them by telephone because of scheduling problems. I traveled to Boston for two in-person interviews, Louisville, Kentucky, for one, and Denver, for two. Several of the people were able to arrange interviews while they were in New York for a conference. This necessitated one meeting in a hotel room and one in a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

restaurant with a loud waterfall. Many of the people in distant locales, such as Ohio, Wisconsin, or Toronto, agreed to telephone interviews. Although I wanted to meet everyone in person and conduct face-to-face interviews,, it just wasn't logistically possible.

Because all of the interviews were tape-recorded, there were several problems with noise control and microphone accessibility. Sometimes the voice on the telephone was too faint to be heard clearly, and sometimes the noise in a restaurant was too loud. Waiters' voices were often picked up on tape and documented by the person who typed the transcripts. It was, however, not difficult to discern who was saying what to whom. I interviewed people in clinics, at their homes, and, in two cases, in a bar-restaurant.

On one occasion, my interview day consisted of taking the shuttle to Boston and the watertaxi to the center of town, meeting my first interviewee in a hotel, going to a restaurant, setting up the equipment for the interview, eating lunch while talking with her, ending the interview and rushing to a subway, getting on the wrong subway, finding the right subway to the train station, jumping on a moving train that was the last one for an hour, thus arriving on time for an interview in the suburbs of Boston. I met the subject in a bar, set up the equipment, and completed the second interview that day. She drove me to the bus, and I made the last flight to New York City. Most of my interviews were less eventful.

The average interview lasted at least an hour-and-a-half (Two sides of a 45-minute tape), and, in two cases, the encounter lasted from two to three hours. After abandoning my original plan of starting with case vignettes, the interviews progressed more smoothly.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The case vignettes were too limiting, and, as I mentioned previously, created an impediment to the free exchange of information. When I first used the vignettes, there would be long pauses but short answers.

Usually I would begin by thanking them for their time. We would discuss where they worked and their amount of clinical practice or experience. Depending on the context of the interview--how easily the person was speaking, how they responded to my initial questions--I would vary my questions, according to the direction the conversation was taking. Often people were interested in where I was getting my degree and whether I knew specific colleagues. They were most interested in discussing influences to their ideas about practice and mentioned books or articles that had affected them. In two cases, I was scolded for not having read my respondents' books and a book that had been written about one person's work. One of these people postponed the interview until I had read her book. Needless to say, I didn't make that mistake again, and tried to read at least one thing written by a respondent, even if I just skimmed it.

As mentioned previously, the interviews evolved over time into a beginning general reflection on postmodern practice and then a discussion of some case material or other aspects of practice. At times, respondents were more interested in discussing the philosophy of postmodernism than in applying these ideas to practice. Towards the end of the interview, people were more ready to discuss logistics, such as time, place, and fees.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Limitations and Problems

There were many problems with this study that became obvious only after it had progressed. Following are some of its most serious limitations:

1. It was difficult to understand exactly what went on in the actual treatment experience. People were unable to convey their method of practice clearly and often referred to the work of another practitioner, such as Michael White, in order to describe what they did with patients. It was hard to pin them down in one interview, and it was hard to get them to trust me enough for them to risk an open evaluation of their work.

In addition, no interview with a practitioner can substitute for the *in-vivo* experience of client and therapist in the treatment setting. Reports of practice must be inherently flawed in that they involve memories and are received through the intervening web of internal signals and associations of both interviewee and interviewer. Nevertheless, viewing actual practice presented another set of problems, involving the impact of the observer and issues of confidentiality and human subject design. For this reason, I did not observe practice sessions.

2. Another problem involved the accessibility of the subjects themselves. Since these were, for the most part, either experienced clinicians or professors, they were very busy and unable, for the most part, to give long interviews. They lived in distant places that were difficult to visit. Several of these reputed postmodernist clinicians lived in Australia and Canada, for example. Although I was able to get around this problem with telephone interviews, which, in many cases, were superior to in-person encounters, it

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

would have been preferable to have met with everyone in person to assess the nuances of their responses and to sense nonverbal communication that would have enhanced my interpretation of the verbal interplay.

3. There was a problem getting people who were affiliated with certain subgroups of the family therapy community to speak with me. This problem may have been the result of *factions* among the groups of people identified as postmodernist. Internal dissent, which is a universal in human settings, may have made it difficult to gain access to certain people(Lofland and Lofland, 1995). In addition, there were tensions between individual and family therapists, as well as systemic vs. nonsystemic therapists. Because I was not affiliated with the in-group of constructivist-oriented family therapists in New York, it took me a while to figure out how to enter the field in a manner that would insure acceptance. I was able to do that after having developed relationships with people who were identified with other subgroups, such as postmodern psychotherapists who were, also, family therapists.

4. Another more obvious limitation of the study was the small, nonrandom sample that made it difficult to generalize from the results. Face-to-face or telephone interviews with a small sample, however, as opposed to more empirically-based questionnaires with a larger sample, may have been able, to provide more in-depth information.

5. A major sampling problem was that many(10) of the interviewees were social work professors. This skewed the sample in expected and unexpected ways. It would be expected that these people were intellectual, aware of the issues, and able to expound on them. In some cases, they expounded too well without being able to ground the data and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

give substance to the ideas that they were expressing. This led to interviews in which most of the conversation centered around the interplay of these new ideas and abstract postulations about their effect on practice rather than actual descriptions of practice. Nevertheless, most of these people were able to explore practice issues, although frequently in general and abstract ways..

6. Because I had only a limited time to carry out this endeavor, I could not improve my interviewing technique rapidly enough to elicit the kinds of responses that would yield the most in-depth information. After the fact, I realize that I did not push people enough to give me clinical material and to explore their own reactions and feelings to these ideas and practices. The results suffered from a lack of complex information about their work. Some people refused to give me clinical examples, because they felt that it would compromise confidentiality even if the interviews would remain confidential. They preferred to speak in generalities about practice.

7. The original intention of the study to investigate only master practitioners was waylaid by a lack of available and appropriate respondents, as well as the observation by the researcher that people with less experience gave more information-rich and thoughtful interviews. The study evolved, therefore, to include respondents with only a few years of postmasters experience or little present clinical experience and a lot of knowledge about postmodernism. This led to some problems in their description of the integration of techniques into practice, because they had just entered practice or had stopped practicing and had little to say about how their practice had changed.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

DATA ANALYSIS

In beginning my analysis of the data, I read through each interview without imposing any categories but thinking about thematic coherence and clusters of ideas. I did this systematically and repeatedly after each interview. The work was done subsequent to the first ten interviews, and then after all the interviews were completed. Next I interrogated the data to determine what categories of meaning were suggested. I wanted to allow the units to cluster themselves, much as paint tends to form shapes when it is dropped on a canvass. As new units were examined, they were compared with data that had already been analyzed. This is the technique of constant comparison(Glaser & Strauss, 1967) that "starts to generate theoretical properties of the data" (p.106). I was looking for themes, issues, and recurring motifs that could be interpreted, supported by data, and isolated.

Next I imposed my own cognitive map on the data by looking for units and aspects enumerated by Lofland and Lofland(1995). Specifically, the areas I was looking at were practices, roles and relationships, which I compared with ideologies, emotional and phenomenological experiences, and hierarchies--since some of my interest was in power relationships. I looked for latent as well as overt meanings as well as co-constructed meaning with the participants. I was interested in seeing how practitioners brought their cognitive and ideological orientations into play in the clinical setting.

After the first read through of all the material, I read through the interviews two times, each time making a note that reflected a category on a separate sheet of paper. It

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

was easy to pick out and designate strips of data, because the typed interviews had each line numbered. After evaluating the emergent categories into which the data clustered as well as interweaving my own units of analysis on the data, there were about fifty codes that appeared to represent ideas about postmodernism in general, approaches to practice, or actual practice.

Next I read through the material a third time without referring to the list of fifty codes. I checked the coding of this reading against the original coding and made some alterations. Three codes were added, and three were condensed. When a category became saturated(Lofland & Lofland, 1995), I did not continue to code it. As categories coalesced and saturated, they began to be integrated. Some were found to be "defining characteristics or properties of other categories" (Rennie, Phillips, and Quartaro, 1988, p. 143). As supporting categories concentrated into a few core categories, or a single core category, there was a foundation from which to make sense of the data(Glaser & Strauss, 1967).Some of the categories fit in with the categories of questions asked, such as responses that were subsumed under Relationship, The Self, etc. When the interviews yielded more depth, there were new categories, such as "closeness and intimacy."

The clinical vignettes were most difficult to code, because they involved a system within a system and because they were reported through the intervening filter of the participants' minds and memories. These were analyzed, however, within the same categorical system enumerated above.

In order to ensure some reliability to the data, I followed the recommendations of Schwandt and Halpern(1988), who recommend asking the following questions: "Are

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

findings grounded in the data? Are inferences logical? Is the category structure appropriate? Can inquiry decisions and methodological shifts be justified?(Were sampling decisions linked to a working hypotheses?) What is the degree of researcher bias(premature closure, unexplored data in field notes, lack of search for negative cases, feelings of empathy? What strategies were used for increasing credibility(second readers, feedback to informants, peer review, adequate time in the field)?(p. 439)

When the categories were finalized, I decided to divide them into two larger categories, which became separate chapters: interpretations and practice. The category of "interpretations," included abstract connections to the clinical work, ontological questions related to influences, and anything related to language and theory. The purpose of this chapter was to describe what respondents thought about practice, not what they actually did. The second category of "practice" included anything that directly related to practice itself on a more concrete level, in other words, what these clinicians actually did. The purpose of this chapter was to explore the translation of theory into practice.

MEMOING

During the entire process of sampling and coding, I kept a log in which I recorded notes about problems and challenges of the interviews as well as thoughts and questions about data analysis. In one memo, for example, I noted that people seemed more

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

interested in expounding on theory formation than on clinical material. I tried to change my interviewing style to encourage more practice-oriented responses--although this remained a problem throughout the interviewing process.

The interweaving of the researcher's theoretical concepts with the data is an unavoidable phenomenon. If the researcher can add some degree of awareness of his or her own biases to the analysis of the data, the use of one's own experience can lead to grounding of the data. I tried to separate out my own beliefs and preferences as much as possible by noting them when they predominated in my journal. At the same time, I tried to use my insider's, "emic"(Sands & McClellend, 1994) perspective to illuminate the material.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Chapter IV

INTERPRETATIONS OF POSTMODERNISM

This chapter looks at what has led the clinicians interviewed to consider postmodern ideas, how these ideas have influenced their view of truth, certainty, and context--central tenets of postmodernism, the way that they use or reject theory, their transformed use of language and conversation, and how they see themselves and others. The discussion reflects the way in which these clinicians think about practice. The following chapter will explore how these interpretations and effects of postmodernism are translated into clinical work--how the clinicians engage in practice.

INFLUENCES

We transform the universe through our creativity and our actions, literally creating our world as we know it.
The artist, Diane Pia

The essence of postmodernism, according to the people studied, is the idea that we create our world and the ideas in it. Every interaction is a mutual creation of meaning in which we as individuals must be aware of our impact on others and of our contribution to the reality that we engender. According to this model, when a clinician makes a diagnosis,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

when a psychotherapist makes an intervention, when a clinical supervisor recommends an action, it is based on this dynamic--that the world is not fixed but illusory and the product of our thoughts and our energy.

Earlier in the literature section, many of the contributions to postmodern clinical thinking were explored. The clinicians studied, however, showed great interest in discussing the influences that led them to consider such new ideas. In some cases the ideas were transformative or revolutionary in that they created major changes in the ways that the practitioners looked at the world and at their practice of psychotherapy. In other cases, the ideas created evolutionary change in that they led to a gradual transformation of perspective. And some people said that they had thought this way all along and that these new ideas were only a mirror of their own present clinical thinking. Following is a discussion of some of the factors that have led these practitioners to consider postmodern ideas:

The New Epistemologies of Constructivism and Social Constructionism

Although the word *epistemology* has been "used, overused, and abused"(von Foerster, 1985, p.517) in the field of family therapy, among others, the importance of the two emerging epistemologies of constructivism and social constructionism have had a major impact on these postmodernist's clinical thinking. Although often used interchangeably, as discussed in the literature section, the two terms are quite different and come from different scientific and philosophical roots. Constructivism emerged after research in neurobiology that demonstrated that there was no apparent correlation

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

between what the retinal cells receive and the perceived object(Pare, 1995). The epistemological conclusion, according to Maturana(1978) is what he calls "structural determinism," which means that the nature of the perceiving system influences the outcome of any interaction with the outside world. Unlike the modernist view of the objective world as separate and "out there," constructivism makes the observer the reference point of knowledge.

The effect of this idea on the people studied is that they began to see how each person has a unique vision of reality and that this vision may or may not coincide with that of other people. What may be transformative about constructivism in the clinical sphere is that it leads to less ego-centered relatedness and to the opening up of awareness of how one person influences another:

> A big part of the postmodern conversation to me has been exploring the blind spots that we necessarily have. By virtue of our biological constitution. We don't know everything about ourselves and we never can. I don't think we're capable of knowing ourselves without having other people help us out. (R)

> To me, constructivism puts more of the emphasis on the internal workings of the individual in constructing reality. And then constructivism comes in when we're sitting in the room, and I'm doing my circular questioning, and Johnny gets to hear from the others how they're constructing reality, and they get to hear from him how he's constructing reality. This is new information to everyone. It opens up the possibility for them to construct a new reality in sort of an evolutionary way. (W)

In contrast to constructivism, the epistemology of social constructionism has developed more from a critique of modern science than from any theoretical developments

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

within it. In other words, social constructionism emerged from the idea that science represents "a body of cultural stories"(Pare, 1995, p.7), narratives rather than truths about human nature. Springing from this cultural critique of science(Foucault, 1980), social constructionism dismantles outmoded assumptions about intrinsic qualities, predetermined outcomes, and the bitter pill of scientifically determined expectations, such as the inevitable negative therapeutic outcome predicted for people with Borderline Personality Syndrome. "If the modernist is an engineer guided by the laws of science, the postmodernist is a storyteller inspired by the imagination," according to Pare(1995, p.7). The creative possibilities of social constructionism have inspired clinicians to listen to themselves and others with more fluidity, neither expecting themselves or others to behave according to type:

> One of the tools I use in my clinical work is social construction. I think social constructionism makes categories more fluid. Religion, race, class, gender, are all relative positions. So, I think it's paying attention to this sort of relative position. I'm, also, multiple, and in my interactions, the multiple pieces will either come out or go into the background. (V)

> For me diagnosis is often a fleeting thought, just like astrology or body type. I consider what the implications are of such a socially-constructed aspect of treatment. It's only what you bring to it, what you think about it. My expectations are never guided by scientific predictions. (ZA)

Several clinicians were unable to distinguish between social constructionism and constructivism nor were they interested in making the distinction:

> I've been slowly forming the idea that social constructionism is more a practice and constructivism is the larger scene, the philosophy. Whatever it is that you do when you do that, you're creating it as you think it. I mean,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

to my mind if postmodernism means blurring the boundaries, then why divide all this stuff up? Unless you need to. (D)

Negative and Positive Influences of Psychoanalysis

Although some of the influences on these clinicians came from outside of the psychotherapy sphere, such as in the case of developments in epistemology, other influences came from within the field of psychological theories and practices, starting with psychoanalysis. Although many of the clinicians interviewed did not start out as psychoanalysts and have not, therefore, strayed from that model, they have veered away from more mechanistic, behavioral models that were loosely based in psychodynamic theory, such as some of the therapeutic ideas taught in human behavior classes. Several, however, have been trained as psychoanalysts and considered themselves to fall into that category. Nevertheless, the influence of psychoanalytic thinking was strongly felt--in both positive and negative ways--as a springboard for postmodern thought. It is important to note that psychoanalysis does not refer only to Freudian theory. There have been many advances in the field, as well as many theorists who have built on or challenged the early model. Among the analysts who influenced these practitioners were Kohut, Jung, Stolorow, Atwood, Benjamin, Grotstein, Stern, and Hoffman. It is interesting that for them postmodernism does not exclude psychoanalytic thinking but, rather, processes it through a different lens than its scientific precursors:

I've only recently come to understand what postmodernism means. I came back around through the other way. Through Kohut's work, I discovered the work of Stolerow and Atwood. I read a lot about self psychology. And then through the clinical work, I became more and more convinced about

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the relative nature of subjectivity and how we construct something in the clinical moment that may ever have been there before, that had meaning. (N)

For me psychoanalysis is the springboard for everything. It was when I started seeing transference from a more intimate perspective that I became interested in postmodernism. (ZA)

Some of the people interviewed, however, became interested in postmodernism as a result of negative responses to the psychoanalytic model of practice:

I know there are many possible connections between narrative and what's going on in psychoanalytic thought. A major difference for me is that the categorical analysis of stories are so powerful that they push the story forward in powerful ways. I can think of an example that was reported to me in which an analysand told her analyst that she was nauseous. Her analyst, a man, interpreted it sexually. I thought she might have had morning sickness.

The power of this category is to interpret everything in terms of transference and sexuality. Nevertheless, there are a lot of overlaps between psychoanalytic and postmodern ideas. (M)

Surprisingly, some clinicians, who had not been trained as analysts, longed for its deeper, more complicated view of humanity and its tolerance for ambivalence on the part of the person-in-treatment:

You know the kind of slippery surfaces and contrived depthlessness that Jameson talks about. Psychoanalysis has a much deeper sort of way of looking at human beings. Kind of a depth here that has to be probed. Part of the problem with some of the postmodern notions is that they tend to be surface oriented. I'm still a traditionalist in the sense that I think that

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

psychoanalysis is a very valuable way of dealing with the human condition.
(U)

Cognitive Components

The contrast between the more surface view of cognitive-behavioral therapy, with its emphasis on concrete maneuvers, such as counting to ten, and the more in-depth view of psychoanalysis, led clinicians to think twice about the validity of the psychodynamic model--with its grounding in the belief that resistance or negative transference is the reason for poor therapeutic outcome. . Underscoring the link with postmodern thinking, Berlin(1996) says:

> My intent has been to move outward from a cognitive base in order to build a framework for practice that acknowledges multiple sources of human problems and multiple avenues for their remediation...(p.326).

The clinicians studied were affected by the cognitive therapy idea about meaning being more important than preconceived notions of cause, like the Oedipus Complex. Learning about cognitive therapy created a change in the way some people thought about treatment:

> I am very much interested in cognitive therapy, and I think the social construction piece is a cognitive approach to the social aspect of it. I think cognitive theories are becoming extremely central. That's why we have books that look at the combination between psychodynamic and cognitive approaches. (V)

Although there were some clinicians who had started out with a cognitive position

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

rather than a psychodynamic one:

> I was never interested in psychoanalysis--ever! A lot of what strategic therapists do is, also, what you would call cognitive-behavioral. "Count to ten before you hit somebody, Harry," you know, that kind of stuff. (L)

Erickson's Influence

Although the broad ideas of psychoanalysis and cognitive therapy played major roles--in both positive and negative ways-- in the development of many postmodern clinicians, the idiosyncratic and decidedly unorthodox work of the psychiatrist and hypnotist Milton Erickson played another important role. Many practitioners mentioned how deeply affected they were by his work. I use the word "work" instead of "theories" when I speak of Erickson, because no one has ever been able to fully explain the theoretical underpinnings of his thinking and many have tried(DeShazer, 1982, 1985 ; Gilligan, 1987), as well as Erickson himself(Erickson, 1975). This is because Erickson's work was in many ways antitheoretical or, perhaps, "untheoretical" in its approach to the uniqueness of problem solving. Later on, I will expand on how postmodern clinicians look at theory construction. For now, however, it is important to understand how Erickson's approach, which led to baffling "miracles" of symptom cure and patient improvement, influenced the development of postmodern therapeutic strategies.

According to Haley(1967), "when one examines what he actually does with a patient...traditional views do not seem appropriate" (p. 532). Baffled by his inability to grasp the "essence" of Erickson's work, DeShazer(1994) says "No matter what approach

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

to theory construction I tried, I continuously found myself in danger of violating Sherlock Holmes' advice and twisting the data to fit the Theory rather than twisting the Theory to fit the data"(p. 31).

The answer was that in order to understand Erickson, one had to stay on the surface and avoid all attempts at imposing structure. In other words, if one looked too deeply, one would miss the opportunity to create the solution. DeShazer(1994) recommended interpreting Erickson's case histories as "stories" rather than lessons from which to learn how to do therapy. In doing Eriksonian therapy or having been trained by him, many of the therapists interviewed became more aware of the benefits of staying on the surface, a practice similar to the text analysis of Derrida(1976), the possibility of multiple realities, and the imperative to focus on the uniqueness of each case rather than its relationship to prior theories:

> I did not see clients until after I studied with Milton Erickson. So I have no other way of assessing psychotherapy. But I have no way of assessing what my work was, because it was a part of myself, and when I became interested in defining it, I became interested in postmodernism, because it was a way of describing it. (H)

> I didn't get good supervision the first number of years that I was working. And so I reaiiy sought out a lot of training. And the training that I ended up getting involved in was Ericksonian stuff. And actually I read somewhere that Milton Erickson was an early postmodernist. There were many aspects of Erickson's work: His idea of multiple stories, his idea about the importance of the client's reality. (O)

> So I think what Ericksonian hypnosis has allowed me to do is to keep track of many different things that people are communicating at the same time, that there's a multiple level, that we can communicate many things at

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the same time and they're not always aware of each other, you know, the sort of metaphor of parts, that we have a lot of parts that are sort of more or less getting along with each other. (R)

MRI: The Mental Research Institute

Another important influence from the therapy community on these clinicians was the Mental Research Institute in Palo Alto, California. So intrinsic to the postmodern therapy lexicon that people referred to it only by its initials--MRI--it was referred to in reverent terms as one of the most fertile places where postmodern thought was being developed. Briefly, MRI is a center that has brought many of the progenitors of brief therapy and constructivist therapy together to come up with a model of therapy that John H. Weakland(1993) calls "complaint," not pathology, based:

We see the persistence of such problem behaviors as depending primarily--and ironically--on the ways people have been trying to change them, their "attempted solutions"(p.141).

Several of the clinicians in this study cited MRI as the stimulus for their early thinking about postmodernism. In the chapter on practice, there will be more about how clinicians translated these ideas into their work:

And that was the year I got into the MRI stuff, and I started getting more exposure to the people whom I'd say were postmodernists or poststructuralists. And the more I did, the harder it became to think in old ways. (F)

The place is in Palo Alto. Don Jackson was there. Jay Haley. Interestingly Virginia Satir was there at the beginning. Lyn Hoffman was

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

there. John Weakland was there. So you had the initial bunch who were people on the ground floor of family therapy. Well, it was kind of a minimalist approach. You get a definition of the problem. It began to be solution focused. (K)

Michael White

At the same time that MRI was coming up with their ideas for doing therapy from a solution-focussed perspective, Michael White(1983,1985,1987), discussed earlier in the literature section, was inventing, with David Epston(1990), a new form of psychotherapy based on the principles of deconstructionism and Bateson's(1972) idea of negative explanation. Briefly, White believes that problems can be externalized, then fought against successfully--e.g. "How are you dealing with the "Icky Poo" these days?"(1984)in trying to help a child with encopresis. His impact on family therapists and self-identified postmodern therapists in North America has been enormous:

I think Michael White has had the most influence on me. You know, he just took a lot of ideas and made them very clinically applicable.(O)

Well, I was tremendously influenced by Michael White, even before I heard of postmodernism. Of course, at first, I didn't understand a word of what he was trying to do. Now I think it's wonderful and it makes a lot of sense. (Z)

I probably would know who the important people in my client's life were and would ask him to imagine what this one would think about it or that one would think about it. I got that idea from Michael White. In his narrative work, he tried to bring alive important people in a person's life, maybe it was an elementary school teacher or a grandmother--someone who is one person who really knew him as a whole person, who really

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

appreciated him, in the most true way from his point of view. (ZA)

Multiple Streams, Multiple Influences

The influences on these postmodern clinicians do not include only the effects of psychotherapy movements, such as those related to psychoanalysis or cognitive therapy. Nor are these influences related only to specific psychotherapy theorists. Some of the influences on postmodern clinicians have been multiple and varied and come from forces outside the field of social work or psychology. Just as postmodernism cuts across boundaries and categories, these influences have come from a variety of spheres and a variety of interests. One clinician came to his current method of practice after having studied acupuncture for many years. Among the ideas embodied in Acupuncture, which originated in China, is a belief in the "ceaseless transformation of all things and all situations"(Capra, 1977) and what Bohm(1983)would call "wholeness and the implicate order" in his book of the same name. It makes sense that this clinician's interest in postmodernism developed out of this context:

> Well, I started out with an interest in Chinese medicine, acupuncture, and that whole thing, which I think, intuitively had a systemic perspective. Very much aware of the relationships that a person is involved with, you know, and the notion of appropriateness in terms of one's living of one's life in some harmonious or appropriate fashion was a value that they associated with health and sickness. (R)

Several others had a strong interest in social activism and movements for social justice, trends that are reflected in postmodern practice, because of its emphasis on social

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

constructionism and deconstructing the political underpinnings of the clinical situation, as well as removing the "colonial influences of mental health practice" that Hoffman(1993, p. .14) decries. Many of these clinicians became social workers because of its emphasis on social action and the environment. When they became psychotherapists, they continued to be influenced by this ideal. Some of the effects of these political influences on practice will be explored further in the next chapter:

My first personal hero in the social sciences was Ernest Becker and then the Free Speech Movement, because I had just come out of the Air Force. (D)

I actually wasn't planning on becoming a therapist when I went into Social Work. I was interested in social activism. (O)

What interested me in postmodernism was that it combined the social action of social work with a clinical position that reflected it. (ZB)

THERE ARE NO *CLIFF NOTES* OF THE UNIVERSE: Postmodern Clinicians Look at Truth, Reality, and Context

The effect of these influences was to lead to a shift in perspective for the people interviewed. Following are some of the ways that these clinicians have changed their

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

perception of the therapeutic endeavor or ways in which their approach to practice has evolved:

Context

Despite the fact that Social Work has always been known for its emphasis on context(Perlman, 1979), clinical social workers have often focussed more on psychodynamic issues and the internal workings of the person-in-treatment's mind(Saari, 1991). In an ironic shift back to the basics of the psychosocial approach, these practitioners have expanded that model to include beliefs, assumptions, and discourse as part of the contextual frame in which the therapeutic interaction takes place. Based on the notion that we are all part of the unified field(Capra, 1975, 1982, 1988)-- a concept from theoretical physics that, applied to social work, means we are all *one* or part of the whole--the idea of context means that behavior never exists in a vacuum. It is intimately entangled with the environment in which it takes place, and this environment includes both the internal and external relationships that people in treatment have. Behavior, pathology, aberrant acts are all redefined in terms of their interactive components-- the dance of life. It is only an illusion that we act alone in a solipsistic field:

> When you diagnose someone, you identify them as though they did not live in a context or an environment, right? I mean this has been the big problem with Western psychology all along, that there's still this effort to see something as being a property of the person. And the personality is the property of that person. Like, this person is a depression. This person is a schizophrenia. (R)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

As far as I'm concerned any model that does not take into account the environment in which the behavior occurs has sort of isolated the piece of behavior as though it could occur without the context. There is no such thing as behavior without context. For me, postmodernism means that the therapist is part of a system or part of a problem. You're not separate from what's happening in the room and you influence that action, right? But the action influences you as well. (Y)

Well, with an individual, I immediately put the person into context by use of some device, such as a genogram, so what I'm talking about is their grandparents, their parents, their social world, where they live, who they know, what their friends are like, you know... so it is to put people always into a context, so that no problem is just the problem of one person in the system, even in individual therapy. Sometimes in individual therapy, it's harder to do that, of course, because the context, you know, is scattered. But it's internalized. There is no therapy that does not refer back to what your mother did, and what your father did, and where you lived, whether you were rich or poor, or what cultural group you come from. (T)

Reality and Truth

Looking at things contextually implies that there is no one truth or objective vision of reality. The clinicians studied were very interested in discussing their ideas about reality and truth and how they had changed through postmodern influences. These postmodern clinicians believed that there were no easy routes to understanding the individual universes of individuals and families. There were no maps, no certainties, and, most importantly, no assurances that the teachings of psychology or social work were accurate representations of the nature of mind, behavior, or interaction. Although there were some truths--with a small t--that seemed to work in limited ways, these were often seen as effective ways in which to tell a story in a cultural context. Just as a story about unconscious envy might explain one person's plight, a story about restitution, in the form

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

of a spiritual entity, might work for someone else. While the psychoanalytic model, for example, might work in one case situation, a brief therapy intervention might work in another-- not because of eclecticism, which privileges only certain models, but because of a belief in the unique realities of individuals and groups or simply the idea that there may be multiple realities and it is better to be uncertain about them.

Premodern and modern philosophers believed that there was a unique reality that existed outside of or beyond the realm of subjective distortion. Ironically, adherence to a belief in God underlies most philosophers' ideas, including those of Descartes, who is often seen as the father of rationality. If one believes in God or destiny, then there is an objective truth--with a capital T--out there, and this truth is the tuning fork against which ideas about reality are tested. It is not that postmodernists deny the existence of God, it is, rather, that they honor the specific belief systems of individuals and do not privilege one belief system over another, other than to deconstruct the underpinnings of power imbedded within:

There is a postmodernist idea that I think there is a the notion that there is no such thing as actual truth. So in other words, when you're dealing with clients you're not looking for the truth. If you hunt for the truth clinically, you ask questions forever but you never come to a conclusion. There is no such thing. So you work on the assumption that what people do is in response to what they think, which is clinically useful. (T)

And Maturana talked about criteria. You know, each of us brings our own criteria. So that when we ask a question, what constitutes a satisfactory answer is determined by the person who asks the question. And that has nothing to do with truth, right? I mean people accept the most absurd answers sometimes -- by my criteria.. (R)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> Well, I think that the whole educational process is actually built on what Truths are: "Postmodernism is . . ., " and you write three sentences and they would be correct. Everybody would agree on it. If everybody reads Moby Dick, it's like the *Cliff Notes* society, everything has one particular meaning and if you can find *Cliff Notes* that are for everything that happens in life, then it's the same thing for everybody. And postmodernism is just the opposite of that, that there are no *Cliff Note*s in the universe, that there are no single underlying structures, that in the postmodern, poststructuralist world, meanings are different depending on a person's life experience. (E)

The Problem of Certainty

Because of a belief in multiple realities and multiple truths, many of these clinicians have come to the realization that certainty can be dangerous in clinical situations. They have noticed that the help offered to families and individuals in agencies in which they have worked or in private practice settings has not always been as therapeutic as they would like to have believed it would be. According to Pozatek(1994), there is a need for clinical social workers to take a therapeutic position of uncertainty so that work with clients can be more respectful of the complexities of their lives. For some of the practitioners interviewed, there was a sense of having labored in the wilderness of ineffective techniques, until they realized that in a position of uncertainty, there was more of a hope for positive outcome. Taking a more collaborative, uncertain view would help release both clinician and client from imbedded and outdated notions that led to entrenched situations and symptoms:

> The scales were falling from my eyes, and I realized that there were

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> different models, different schools of therapy. And you can step away from them and look at their relative value, their pragmatic value in terms of helping people. This place I work is very psychological. It's very hard for me. It was a big struggle, because I found that in clinical contexts, the cases would be presented in psychoanalytic terms. I found myself getting into so many arguments on a regular basis. Because at a certain point, I just couldn't to listen to people being described with such certainty, in such terms. The more I moved away from seeing people as fixed in these ideas, the more hopeful I became about the people I worked with. (F)

> Having confidence in uncertainty means that you can let the client open up and lead you. But it, also, means that you can share your own views. I'm not telling them something. I'm offering a perspective. I feel that's consistent with a position of uncertainty, because I'm not elaborating truth. (I)

Chaos and the Problem of Not Knowing

When you remove the concepts of truth, certainty, and a fixed reality, you come up with a random, unpredictable notion of everyday human life--a sense of "not knowing." This shift in consciousness, which is influenced in some part by Chaos theory(Glace, 1987) leads to the following question that Pozatek(1994) suggests: "Can linear treatment interventions be used with nonlinear human systems?" She goes on to say that:

> Chaos theory suggests that in simple, orderly human lives there are moments of wild disorder-- and that in disorderly, seemingly chaotic human lives there are moments of precise order(p.398).

Many of the clinicians interviewed were committed to leaving themselves open to the possibility of chaos and to not imposing premature closure on moments of understanding or misunderstanding. This created some problems for them, because it is

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

difficult to suspend structured thinking and understanding. To the Japanese, this idea of suspending closure is not something new but has become a national art form(Tanner & Athos, 1981). Referring to the concept of *Ma*, which means pause, Tanner and Athos suggest that Japanese culture prevents its members from plunging straight ahead and encourages moving gracefully through time. This is a challenging process for most Western-educated clinicians:

I think this is big sort of mission, a personal mission that I'm on. So how do I acknowledge that I hardly know anything and get comfortable with that? With a lot of the people I work with, there's so much chaos,. and letting the chaos sort itself out without their having to go nuts trying to figure things out. The challenge is to be able to accommodate so much and not have to be overwhelmed. (R)

I think assessment has been more harmful than helpful. I think as much as it helps us, it blinds us and cuts off possibility, and so I think this gives us a way if we can figure out how to do it well, how to be humble about our own knowing and values and so forth.
(M)

There isn't a single truth, there isn't a single good way of knowing what is good social work or what is the knowledge base that we all need to know to be able to do good work. That knowledge base is chaotic, it's going to be shifting and changing, based on whom we're working with and who we are, as well. (V)

It's important to me to keep what therapy is about in the background. Sometimes this is the biggest challenge . (Q)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

HOW POSTMODERN CLINICIANS USE OR REJECT THEORY

Social workers are actively engaged in a competitive quest for models and maps that provide practice guidelines and solutions, periodically replaced by new users' manuals. Adrienne Chambon(1994, p. 66).

I become one with the great Pervader. This I call sitting and forgetting all things.
Chang Tzu(1971, p. 16)

In considering the fluid and altered ways that postmodern clinicians view reality, truth, science, and beliefs, one must question how they utilize theoretical constructions in their work. If there are no road maps, no signs, no structures to guide and inform, how does one enter the therapeutic conversation? Is it simply a matter of emptying oneself of all knowledge in a kind of *kenosis*[2] that one interviewee suggested, or are there landmarks or signs to guide one in the darkness of the clinical setting? If we are co-creating reality, how do we know when to intervene? If we emphasize discourse over text, as Hoffman(1993) suggests, and there is no observer and no observed, and, therefore, no need for "the final word" or the "final truth" in the clinical moment, when does the conversation end?

While keeping in mind the idea of discourse, if we look at the clinical interview as a text that is a narrative and poetical construction, one approach to entering, examining or thinking of the text could be a process of crystallization in the mind of the therapist, where

[2]*Kenosis* is the Greek term for emptying oneself. In this case, referring to prior knowledge.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

one entertains multiple realities or possibilities at the same time. Using the metaphor of crystallization in writing about qualitative research, Richardson(1994) describes crystals as:

> ...prisms that reflect externalities and refract within themselves, creating different colors, patterns, arrays, casting off in different directions. What we see depends upon our angle of repose...Paradoxically, we know more and doubt what we know(p. 522).

Several of the practitioners interviewed seemed to reflect this multiple, crystallized view of how to enter the clinical frame:

> If you bring it back to the everyday world of people who are suffering out there, we need to take into account lots of positions at the same time. (U)

> We're living in a postmodern world, so why not be interested in everything. And we're really forced in the way we live in this world where everything is so information oriented, we are forced to be interdisciplinary. (ZA)

> In any event, the point is that there is a clash of theoretical frameworks of how one approaches the patient within a clinical setting and how did that clash of frameworks have to do with whether one sees the structure of the unconscious as it impacts on conscious behavior as being predetermined and, therefore, somehow accessible or whether the unconscious is something like a different linguistic construct put together in a way to conveniently explain why it is. ©

> We work with the theory of no theory. It's both anti-theoretical and untheoretical. I would say we, also, work systemically, strategically, and our work evolved out of curiosity and doubt about different schools of therapy. (H)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Intersubjectivity

Although there may be no particular theory that underscores all of their clinical interventions, several postmodern clinicians mentioned intersubjectivity as a guiding principle. Social workers have always been enjoined to "start where the client is," which often means dispensing with one's own agenda and one's own structural system of practice. But, for the most part, clinical work has been based on a model where the therapist is the observer and not the participant, and meaning is not generated but discovered. In her book on intersubjectivity, Carolyn Saari(1991) stresses the interpersonal creation of meaning in the clinical setting and the reciprocal nature of understanding and communication. Among the people interviewed who were psychoanalysts, this was a compelling frame of reference, which included the notion of a two-person model of treatment, as contrasted with the earlier one-person model. Atwood and Stolorow(1984), Benjamin(1988), and Hoffman(1983) were among several analysts who have influenced their work. The next chapter will describe more about how this theory is adapted into the clinical frame:

I think that theory is in the background. It's sort of like the marinade. I guess the theory that I work from is intersubjective or what I call subjectivity. All I know is that I'm always open to what I might be contributing to the situation, how the patient might be perceiving me.. (N)

I think of treatment as being a two-person model versus a one-person model, but there is the mutuality, that we are mutually influencing each other. That's at the heart for me of intersubjectivity. Really I wouldn't say I'm theoretical in any particular way, except the ways I've mentioned. (A)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Standpoint Theory

In addition to intersubjective theory, another theory that attracted these therapists was standpoint theory. Some believed that it was best to follow a position of cultural inclusivity, which has begun to be called, "standpoint theory." Taking a stand rather than no stand characterizes this view and lends postmodernism one aspect of a theoretical framework. According to Sands and Nuccio(1992):

> Emerging postmodernist feminist theory challenges accepted ideas about race, gender, and class, as well as political rights, equality, and differences, which are basic to the values of both the women's movement and the social work profession(p. 489).

For the therapists interviewed, this was one of the frames of reference from which they approached their clinical work. How it is manifest in the clinical encounter will be discussed in the next chapter::

> My theory is that it's important to privilege the beliefs and the experiences of people who have been marginalized. I really believe that's part of the postmodern theory. (P)
>
> Standpoint theory not only says that oppressed people not only bring something to the table that's comparable, but they also bring something better. And that is that they have an understanding of the dominant views of their culture. Which means that the oppressed people are in a better position to know. See, the whole issue is: Who gets the stuff? Who knows? How do they know, and who gets to decide what gets to be done on the basis of that knowledge?
>
> Standpoint theory says women have had to be attuned to what men think in a way that men haven't been able to be attuned to what women say. So, therefore, women know more. So if you're going to trust somebody's judgement, you're going to trust somebody who has access to both the minority and the majority's viewpoints, not someone who has access to one

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

viewpoint. Any oppressed group may, the argument goes, have access to additional information.

For eons, you know, we've(people of color) been taking care of your kids, sat in your kitchen. We've been in your bathroom cleaning up. We listen to your conversation in a way that you have never been privileged to. We know your children. (S)

I think part of postmodernism, the cultural pieces and the knowledge pieces for me, which connect to feminism and feminist thought, is this immense attention paid to reflexivity. To standpoint. To who is it that we are as practitioners when we're dealing with clients who are different or the same as we are. Some people say that it's class, and race and gender. And that's the standpoint.. It's an intersection of these three. I think postmodernism makes those categories more fluid. I'm, also, multiple and in my interactions the multiple pieces will either come out or go into the background. (V)

Both-And: A Postmodern Compromise Formation

If standpoint theory privileges the views of the minority and the oppressed, and postmodernism, for the most part, avoids privileging one view over another, how can we reconcile these contradictions--and do we need to? Since it is a tenet of postmodernism(Gorman,1993) that we do not have to be "rational" and "consistent," it makes sense that postmodern clinicians do not have to choose between one position and the other. According to Sands and Nuccio(1992), for example, one can recognize diversity but visualize or act on behalf of people in groups when there is evidence of oppression. Because of a belief in multiplicitous views or, more simply, faith in the nonrational nature of the universe, it is entirely possible for clinicians to take a "both-and" position in their theoretical views:

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

I think this is a departure as well as a return to maybe things that we traditionally did a bit of, and, also, a departure at the same time from what we've been doing. (U)

One of the things I was trying to get across is that it is "both-and," that you have to be yourself, but it's not a fixed self. It's always an evolving self, and it's multiple, and it has multiple manifestations. It's just not reified in time or space. It's always something else. (G)

You have to take the position that some of these diagnoses have a gender subtext and that they are misleading. But I take a "both-and" position in that sometimes I use them and sometimes I laugh at them. (E)

What is this postmodernism? To me, postmodernism is inclusive. That why I call it postmodern. To me, it means it's inclusive of both, maybe, essentialist and nonessentialist, or structuralist and nonstructuralist, antitheoretical and theoretical beliefs. It's not exactly eclectic, but it allows for "both-and." You can have empiricism and positivism and intuition and creativity. (B)

The Language of Helping: Consciousness Raising Through Conversation

If one looks at the "both-and" position, it implies not taking one point of view or the other seriously, but taking the validity of both(or all) of them very seriously. This is based on the notion of decentered truth, where there are no hidden jewels of deeper meaning that will suddenly reveal the one and only answer. In this chaotic state where there are no sure guideposts or touchstones of truth, language takes on the central role. It becomes the most reliable means of interpreting meaning, because, in a sense, it is the coin

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

of the realm. It is one of the most important ways in which people communicate. Furthermore, it is believed to play an interactive role in creating reality. Language is considered to be constricting and oppressive, as well as transformative and healing.

At the heart of postmodernism is the idea that language determines reality and relationships. Meaning is located within language itself, not, more deeply, within the person generating speech(Goolishian & Anderson, 1992). Moreover, it is the intersecting point where one person's language meets another person's language that understanding occurs. This is what makes postmodernism different from other clinical movements, such as the paradoxical school of early MRI(Watzlawick, 1978) or the cognitive therapy emphasis on "all-or-nothing" verbalizations(Beck, et.al., 1979), in which language takes a leading role in determining outcome. In these other cases, it is the language of the therapist that is emphasized, not the nature of language itself.

Postmodern clinicians focus on text and text-analysis(DeShazer, 1994), believing that reality is "languaged," a game that we play with words that determine how we think(Wittgenstein, 1958, 1965):

> And then within that, there are people who say in human affairs that the text is everything. Whether it's a numerical system, a methodology, a conversation, a game, a ritual, it's all ultimately about language, text, metaphor. (D)

> I think what's therapeutic is that there is a potential to go beyond one's own thought processes through language. Because when one is stuck or one is in some sort of difficulty, whatever reason they come into therapy, they're kind of locked in with a certain kind of thinking, believing or feeling, and the other person can open up some kind of space for them to think maybe a little differently about it, or in a new way or maybe even give

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

then the opportunity to hear themselves a little bit better. And there is a potential for thinking a little more broadly with the help of another person. (I)

There is a lot of social structure buried in language. (G)

Consciousness Raising

The idea that social structure is imbedded in language is fundamental to postmodern clinical thinking. In commenting on the nature of deconstructionism, Jane Flax(1990) says that all postmodern discourses:

seek to distance us from and make us skeptical about beliefs concerning truth, knowledge, power, the self, and language that are often taken for granted and serve as legitimation for contemporary Western culture(p.41).

Rooted in the philosophical traditions of Kant and Heidegger, among others, deconstructionists, whose ideas are reflected by postmodern clinicians, want to know what role language plays in our vision of the world(Lax, 1993). Postmodern clinicians want to know what role language plays in the subjugation of the client. According to Hoffman(1993),

A new kind of consciousness raising is beginning to take place that does not exempt Marxist therapists, because they are champions of the poor, or feminist therapists, because they are defenders of women, or spiritual therapists, because they follow an other-worldly ideal. These therapeutic discourses can contain the same colonial assumptions as medical

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

approaches. They can all embody oppressive assumptions about personality deficits. They can all offer the client a savior to help them. Spiritualist views about therapy are apt to use the word healing, harking back to shamanistic traditions, while medical views use the word curing, but they both place the client in a submissive place (P.15).

Following are some of the ways these clinicians view language in the clinical setting. The next chapter explains how this view of language is used as a therapeutic tool:

I think this has kind of sharpened some ideas that probably have always been floating around from other places. But it's kind of made me more aware of the political issues around language and how language is used or misused. (G)

I'm much more aware of how the language I use affects the people I treat. If I'm not careful, I could be sending a message that is not the message I want to send. I realize that I can't be neutral, but I don't want to impose my story on the patient's story. (Z)

I try never to use the words "get better" or "mental illness," unless my back is against the wall. (Q)

On a more concrete level, clinicians want to make sure that they are "speaking the client's language," and not privileging or superimposing their lexicon on the ways in which clients express themselves. It is through this "local understanding"(Anderson & Goolishian, 1993:33) that therapeutic change can occur. *Local* (Geertz, 1983) means that language is generated by the people in the community or in the dialogue and not determined or constrained by the larger culture :

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

I hate the old social work model, I mean it's cliched! Awful! So I never wanted to talk like that. If they use certain words, I use them. If they say "fuck," I say "fuck." I attune myself to their person in that way... I will try to mirror it in a certain way. (A)

If someone says they have a problem with voices, I'm not going to come on strong and ask a lot of questions about pathology, reality testing, etc. I want to know through speaking with them what the voices are doing, what kind of relationship are they having with the voices, not are they real. I want to join in the conversation about voices and learn what the words mean. (ZB)

Categories And Dichotomies

Another pitfall of the therapist's traditional language base is the tendency to portray things in polarities or dichotomies. The next chapter will address how these therapists' ideas about diagnosis and pathology have been impacted by a new understanding of categories in language. According to Derrida(1976, 1978), language is a system of neutral signs whose value is determined by the meanings we give them. A word is understood by comparison to its opposites, as well as to words that are not present. Several of these clinicians claimed that their understanding of clients is limited by the constraints of language, as well as the injunction that people should fall into neat categories:

There is the idea about binaries, that our society, our culture tends to put things into binary categories. It's like woman/power, black/white, strong/weak, gay/straight. I guess that 's a lot what Lacan talks about, too, that we're really prisoners of the ways we use language. We can never express ourselves beyond the language that we have. It limits our thinking. Then it starts to conform our thinking and to conform how we function, to fit inside of that language. (A)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

It's my belief that categories have to be fluid. This is a big dilemma of postmodernism. How can there be any kind of political strength? Political correctness, for example, is multi sided--you might be politically correct on race, religion, gender, but not about sexual orientation and mental illness. (E)

What I'm trying to grapple with is what Foucault calls "dividing practices," how we construct the other as others, so he's normal or deviant, sane or insane, healthy, not healthy, schizophrenic, borderline or not borderline. And all of that. By doing that we create categories and classifications of people. And we create their identities , and it's very hard to see a real person in there. In a sense it constructs the dividing lines between the client and the worker. (V)

Conversation As Treatment

When there are no underlying categories that determine action--when certainty is removed from the therapeutic dialogue-- what emerges is a therapeutic conversation. Meaning results from the relationship between the therapist and the person-in-treatment, and "liberation," according to these practitioners, results from letting go of the false split between therapist and patient. This does not mean that all boundaries are summarily dissolved, but rather that a co-evolutionary relationship emerges out of discussion and conversation.

Postmodern clinicians are interested in the meanings that are generated by conversation, in "letting the phenomena lead"(Anderson & Goolishian, 1993: 33) Not knowing, uncertainty, an anti-theoretical approach, lead to the development of what Bruner(1984) calls a "narrative posture" as opposed to a "paradigmatic posture." The paradigmatic stance calls for a "knowing position" in which the therapist draws on all of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

his or her therapeutic understanding, "categories and rules." The "narrative position" calls for a "not knowing" stance that emphasizes the skill of process rather than the skill of diagnosing or categorizing. According to Anderson & Goolishian(1993), the therapist should be both a "participant-observer and a participant-facilitator of the therapeutic conversation"(p. 27). The expertise of the postmodern clinician is in understanding how to ask conversational questions that are based on curiosity, not the validation of hypotheses. According to these clinicians, people-in-treatment will be freed to reauthor their lives and release themselves from predetermined ways of thinking about themselves and others:

> One of the things that helps me about postmodernism is the idea that everything is a conversation. Certain professionals use diagnosis, and that's just a particular kind of conversation. Another part of the conversation is that we explore different metaphors, how they will have an impact on the work that we do. We definitely need to have conversations in order to use other people as a sounding board and to be a sounding board for other people in this sort of ongoing conversation. Another word for postmodernism to me is cooperative narcissism. (R)
>
> If the conversation has real meaning for a client she will stay with you and reflect. It's not your judgment, it's deconstructing her ideas. And not only her ideas, but how do all those, you know, larger social theories enter that room? (M)
>
> The way we work is in terms of a long conversation. (H)
>
> So, I start asking things that are subtle, that often yield important information, that take the client to an important place that I might have missed before. (Z)

Narrative Transformations: The "Not-Yet-Said" Story

Therapeutic conversations are intended to facilitate the development of new

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

narratives, and it is these transformed narratives that are the focal point of the postmodern therapeutic ideal. Telling a story is "constructing history in the present," according to Anderson and Goolishian(1993: 37). They suggest that it is during the process of the conversation that narratives undergo interpretive change and become the starting point for "the new and 'not-yet-said'"(p.37). It is important to emphasize the idea of "starting point" and not goal, because conversation is seen as part of the process of a developing life, and not an "end point" in itself. All of the clinicians interviewed were interested in the fluidity and variability of people's stories:

> It's really hard for a story to remain stable, because every time a story is told, it's told to a different person . It's a different story because the story is co-evolved, because of the person's responses to that story. (F)

> It seems to me that a story is a cultural statement. What a story is in terms of white, Anglo-Saxon Americans may be different to what a story is in terms of Afro-American people, or other groups, there could be a difference. Or different kinds of stories or definitions of a story. (G)

In struggling to define the meaning of the word *narrative*, Joan Laird(1989) contends that no one meaning will suffice, other than to say that it is intrinsic to most forms of human life.[3] She goes on to say that:

> Coherence among events, not the events themselves, generates or reduces dramatic tension in life. (p.430).

It is the first-person narrative with which most postmodern clinicians are

---

[3]As noted earlier in the literature section, there are some societies that do not have narratives.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

concerned. This "self-defining" narrative arises out of social interactions and conversations with others as well as oneself. Anderson and Goolishian(1993) make a strong case for the role of narrative in motivating behavior:

> Individuals derive their sense of social agency for action from these dialogically derived narratives. (p.31).

Many of the clinicians studied believed that via therapy or, rather, therapeutic conversation, the narratives of people-in-treatment would be transformed:

> You have to look at where the stories don't mesh, because that's where the struggle will be. (J)

> And this issue of transparency that White writes about is very important, that we somehow keep ourselves acutely aware of our own ideas and where our stories and our intentions are coming from. And by the way, I'm not so sure that relationship is the central issue in therapy. This is what's still being taught, even though in many cases, people may not see a client more than twice. I'm beginning to think that's not what's so central to change. I think that it's the opportunity to tell one's story in an unfettered way.(I)

> I think that with the narrative, you're less prone to be pre-packaging interpretative frames for current meanings. (M)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

THE SELF AND IDENTITY: How Postmodern Clinicians View Themselves and Others

Central to the idea of narrative is that the self develops out of a dialogue or a conversation with significant others(Goolishian & Anderson, 1993). The first-person or self-defining narrative emerges out of this conversation, according to many of the clinicians interviewed. Several of them believe that the self is fluid and changeable, according to who they are with at the moment, as well as who they were with in the past. This is a self that changes and develops out of the stories that we tell about ourselves and that others tell about us:

> Storying is, also, the self talking to the self and listening to the self. So the self is a constant for reflexive creation. As you tell the stories of your life, you keep rethinking them, and you keep repositioning yourself. (M)

> People are quite malleable according to context and relationship and what emerges in a conversation--or what is constructed in a conversation--is new and original. You know, I'm different with you than I am with anybody else. (B)

It is important to emphasize that this storied self is not stable to most postmodernists. It is in flux. It is not the "isolated, machinelike" (Gergen, 1991, 140) self of modernity that has a predictable and authentic core not too deeply embedded within, unlike the deeply mysterious core of the self depicted by the romantic movement. It is a self that is envisioned as multiplicitous. Based on the blurring of categories and the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

multiple perspectives mentioned previously, it is a self that emerges and cannot be contained or held in time:

> Cognitively we have the ability to create a cognitive and emotional state that seems stable to us. But if you saw me from situation to situation over a period of months and years, you might not know that I was the same person, except I look the same. (D)

> If that's the case, I can have a new self by having new relationships and new contexts. (X)

> It's desirable to expand beyond yourself into larger circuits. So that the unit of mind is no longer conceived as in one's body. It approaches interaction. You see yourself as connected to larger contexts. Your self is not just located inside of your skin, but it extends into other contexts that you're in interaction with. The definitions of your boundaries are completely arbitrary from that perspective. (F)

This fluidity of perspective and the mercurial nature of the self-concept poses an interesting question for postmodern clinicians: How do they imagine the selves of the people they treat and what do they think is going on within the "mind" of the client? There seems to be a movement away from seeing the other person as objectively knowable to seeing the person as a being who participates in the creation of his or her identity in different ways at different times. This involves an acceptance of the protean nature of the self(Lifton, 1993):

> We construct versions of ourselves as we go along. We constitute ourselves so that there are things that we say to ourselves, images we see,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

memories we have, comparisons we make. I guess you can call those things inner dynamics. (O)

I think there is an overarching self. But I do not believe that there is only one core self. We can have multiple notions of the self. It's when the paradox can no longer be tolerated, when "I love Mommy but Mommy is hurting me" goes to "Mommy is locking me in a closet and abusing me" that you can't bridge the experience. With one patient, I had to hold on to the paradox of her being one person who walked in and sometimes there being many others in the room. (N)

To one person, this expressed itself as an existential position, a belief in the "*Zeitgeist* of expansiveness"(Yalom, 1980, 19) and a desire to free oneself of the anxiety of nonbeing:

My interest in the self and the development of a self is really from an existential point of view, related to meaning, related to finding meaning in the world. It is kind of a Buddhist idea. We have to develop ego, we have to develop the self, and the goal after a certain point in adulthood is to lose it. Just lose the whole self, lose the ego. (P)

Nevertheless, several other people did not see the self as completely fluid and, therefore, unknowable and without boundaries. They held onto an image of the self as stable and biologically based:

I agree that we act differently with different people, but I think there's still something unifying. We're not totally haphazardly different people. There's still something that beknights all these selves, or integrates them or holds them together somehow. That's an old-fashioned idea these days. (X)

If you take it down to a biological level, there are aspects of the self that

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

are a biological person, that are stable, relatively stable. (F)

Identity

If the self is the way in which we experience our being from the inside out, than our identity is the way in which we portray ourselves to the world or the way in which we believe others see us. In a traditional society, one's sense of identity was unanimously confirmed by the general population. There was a strong agreement about moral behavior. But in this postmodern world where people are thrust into constantly expanding spheres of behavior, interaction, and activity, it is not possible to define oneself in a unified way. There are too many demands and too many conflicting expectations(Gergen, 1991).

Burke(1991), for example, has studied identity processes as a cause of stress. Emphasizing the excessive demands arising from the many roles that people maintain, he suggests that there is an interesting relationship between stress and role identity. Although he does not resolve the implicit contradictions between too few or too many identities, he contends that stress results from the disruption of the identity process, which he sees as a continuous process rather than a trait or a state. According to identity theory, the "identity is a set of meanings applied to the self in a social role ...defining what it means to be who one is" (Burke:837). Identity process is a "continuously operating, self-adjusting feedback loop" (Burke: 840). People continually adjust their behavior to keep their reflected evaluations the same as their identity standards. Strobe, Gergen, and Gergen (1982) note, for example, that death of a spouse may be a stress, because it disrupts the ongoing aspects of life with a partner on whom one has depended for many shared

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

response continuities. Remondet, Rule, and Winfrey (1987) found that widows with advanced preparation for a spouse's death were able to plan for their future and, therefore, felt less disrupted. How one defines oneself, according to the practitioners studied, reflects this postmodern view. It can be problematic or liberating, depending on the choice of criteria or the method of self evaluation:

> I am interested in how people's self definition evolves. Let's take mothers, for example, it's very important for them to see themselves as good mothers, so that's how they'll identify themselves. (J)
>
> If you define your body as your self, which is what most people do, the rest is window dressing. So that whole piece of what people do with their bodies is interesting. In working with AIDS patients, for example, who've been dying, how do you come to terms with the decaying body. They have to come to terms with what is, what was, and what was to be, and what is now, all at the same time. (J)
>
> What we're really talking about is how much space do you claim, how much power to you have. I'm thinking of an example of a woman who learned to cross dress and what it was like. She talks about the difficulties of some of the things she had to learn to do, because it was different. It was undoing the difference, which made it so much fun. Women have often had to define themselves in defiance of others who are taking up space. (J)

How one chooses one's identity is a matter of choosing the criteria on which to focus, according to some clinicians. All agreed that context and vantage point were important elements:

> What is a person is easier than what is a family. How do you define it? What is your family and what is my family. You might say that this is a family, and if you interview each particular person, their idea of the family is very different. So it's a construction. Who's in and who's out. How do we conceive of ourselves and what do we pay attention to. There is a basic assumption in society of what is considered to be held normal. (T)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

We identify people as though they did not live in a society, a context. This is ridiculous and useless. (Z)

Becoming more curious about the criteria that they applied to themselves, these clinicians defined themselves in some of the following ways:

I see myself as different from the Right to Lifers, for example, so that's one way I construct my identity. (N)

I was born in France, but my parents are from Romania and Transylvania. They are part of the ethnic minority, the Hungarian ethnic minority in Romania. And Jewish. My name doesn't tell you that. So I've had sort of this history of migration, which is much more sort of linked to national entities or towards transformation of a national entity. And there is much more fluidity of ethnic identities with migrations of people. People's sense of belonging to one country, to one ethnic identity, is much more blurred. And how until recently we always assumed that countries would have one major ethnic identity. (V)

I try to be aware of how I might be perceived in terms of power differentials when I meet someone. Sometimes I resist those categories and refuse to give defining characteristics, because I want to be seen as multiple and diverse. (ZA)

In the modernist enterprise, therapy has been seen as an endeavor to rectify defects and repair structural damage to the self. If postmodern clinicians see themselves as multiple and others as having transient identities and fluid selves, then they will not be as prone to treat people as though their personalities were fixed in time. This has implications for diagnosis and treatment, which I will discuss in the following chapter.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

SUMMARY

This chapter looked at what led the clinicians interviewed to consider postmodern ideas, how these ideas had influenced their view of truth, certainty, and context--central tenets of postmodernism, the way that they used or rejected theory, their transformed use of language and conversation, and how they saw themselves and others. It is important to note that this chapter reflected what the respondents thought about practice-- not what they actually did.

The practitioners showed great interest in discussing the influences that had led them to postmodernism. Among these were the new epistemologies of constructivism and social constructionism; the negative and positive influences of psychoanalysis; the impact of cognitive theory and therapy; the work of Milton Erickson, Michael White, and the people associated with the Mental Research Institute(MRI); as well as their interest in issues of social justice and eastern philosophy. It was generally agreed upon that the idea of context was an important consideration for practice and that there was no one truth or objective vision of reality. Based on a belief in multiple realities and multiple truths, these clinicians agreed that certainty was often not helpful in the clinical setting and that taking a more collaborative, uncertain view might be more helpful to clients. Many of the people interviewed were committed to leaving themselves open to the possibility of chaos and tried not to impose premature closure on their understanding of the people with whom they worked in treatment.

In discussing their use of theory, the respondents, for the most part, adopted a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

crystallized, multifaceted view of theory that included many theories but eluded identification with one theoretical system. Some people refused to consider any theories, and some leaned toward intersubjectivity or standpoint theory. Based on the belief that one does not have to be rational or consistent, most subscribed to a "both/and" position that allowed for multiple positions that could, at times, be contradictory.

From this chaotic position, where theory took on a diminished role, language took on a more prominent role for them. They believed that reality was " languaged" in that it was determined by how language was used. For them, social structure, meaning, and value was embedded in language. Via consciousness raising, a therapist could become aware of some of the oppressive aspects of clinical language and avoid falling into habitual patterns of using language, such as terms about pathology, without thinking about it first. Another pitfall of language, according to these respondents, was its tendency to divide and separate subject from object, therapist from client, diagnoser from diagnosed. If hierarchical dividing practices were eliminated from the treatment situation, then the tone of a session would take on an informal note. It would become more of a conversation. Many people believed that a co-evolutionary relationship emerged out of discussion and conversation, that an emphasis on narrative in the conversational sphere could lead to interpretive change and become the springboard for positive outcome.

Finally most of these practitioners saw themselves and their clients as having multiple identities and multiple facets to their personalities, which no longer took on a cohesive structure. Several of them described the self as fluid and changeable, according to who they were with at the moment, as well as who they were with in the past. Almost

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

all agreed that identity, which is the way one is portrayed to the outside world, could be equally fluid and changeable. They did not want their own or their clients' identities to be fixed or constrained by the expectation of consistency.

The next chapter will explore how postmodernists translate these ideas into actual practice. It will look at whether postmodernism has had an impact on how postmodern clinical social workers engage in the practice of diagnosis, assessment, intervention, clinical logistics, and ethics .

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Chapter V

THE PRACTICE OF POSTMODERN CLINICAL WORK

In the following chapter, I will evaluate how the clinicians interviewed have translated postmodern ideas into their clinical work. First, I will explore how these clinicians envision diagnosis, pathology, and assessment--all, to a greater or larger degree, contributions from the medical or modernist model of treatment that are often seen as an inevitable part of psychotherapy practice. Next, their concept of mental health and the goals of treatment will be discussed, because it is not possible to understand treatment without having an appreciation of some concept of the outcome. Using these ideas of mental health as a context, there will be an examination of postmodern clinical techniques, including an evaluation of the role of the therapist and how more traditional ideas of transference and countertransference have been influenced by intersubjectivity, constructivism, and social constructionism. Next, the relationships between such concepts and the logistics of practice, such as time and fees, will be investigated, and, finally, the ethical considerations raised by postmodernism will be explored..

Diagnosis as a Political Act: How Postmodern Clinicians Look at Diagnosis and Pathology

After considering the ways in which language and theory are interpreted by postmodern clinicians, it is necessary to look at how these ideas are translated into clinical

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

work. A good place to start is to examine how diagnosis, assessment, and pathology are understood and utilized from a postmodern perspective. Based on the previous discussion, that perspective would suggest a tendency to discard categories or to dismantle them by examining the underpinnings of the language in which those categories are constructed. In one study of the *DSM-III* (American Psychiatric Association, 1980), Cutler (1991) suggests that it's diagnostic nomenclature is based on linguistic dualities, such as "appropriate" vs. "inappropriate," that make the client into an "object"--someone different from the clinician--and the practitioner into a "subject"--someone possibly immune to categorization--as a way of keeping a distance between the two.

Traditionally, diagnosis is seen as a necessary component of clinical work. The concept of mental disorder, however, like many other concepts in medical science and social work, lacks a sound operational definition that can be applied consistently in a variety of situations. According to the *DSM-IV* (American Psychiatric Association.1994) the idea of mental disorder can be defined by a number of different concepts, such as "distress, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, etiology, and statistical deviation" (p. xxi). For the sake of comparison, let us say that, for the most part, modern-day clinicians have been taught to classify the symptoms of their clients, use numerical diagnoses across five axes, and develop a clinical portrait that can be understood by other clinicians (Cutler, 1991). The purpose of such diagnosis is, therefore, to provide a basis for communicating and treating mental disorders.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Postmodern Views of Diagnosis

Most of the clinicians interviewed, however, disagreed that this traditional view of diagnosis and felt that it did not meet the present-day needs of clinical practice when seen from a postmodern perspective that values deeper understanding and a more subjective view of the client:

> In our field, when a diagnostic label is formed, it doesn't really inform. I think our categories are a little more mixed up when it comes to dealing with people. I'm more interested in process. (A)
>
> The problem with diagnosis is the reification. You begin to mistake the diagnosis for the client. (Z)
>
> The positivist, modernist types have labeled people into diagnostic categories and made rules about how people should behave. Maybe it's true for some people, but it certainly isn't what good practice looks like. (L)
>
> And by doing that we create categories of classifications of people. And we create their identities, and it's very hard to see a real person in there. So the intent is a good one. It's to understand the specificity. But we focus so much on that particular categorization of the specificity that we lose the person. So it's dividing practices this way. But then it's also dividing practices in the sense that it constructs the line, the dividing line, between the client and the worker. (V)

Many saw diagnosis as a bad thing meant to relegate clients to the category of "uncooperative." They believed that diagnosis was a way of controlling people:

> It's easy to label clients as manipulative or resistant, and that gets us off the hook. It's a way of subjugating people. (F)
>
> Sometimes we're putting labels on people that don't really apply. Then we

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

say it doesn't really matter. That's terrible. (G)

From a political standpoint, some clinicians believe that diagnosis says more about the rules of society or about the person doing the diagnosing than about the category itself. Some people suggested that the diagnosis a person chooses says a lot about the values or personality of the person who is making the assessment. Take the case, for example, of a clinician who says that a client is "co-dependent," a common label for people who are seen as overly anxious to please. That designation may, in some cases, represent more about the values of the labeler--who may be "counter-dependent," afraid of intimacy-- than about the person being labeled. It is not a value of present-day Anglo-American culture for people to be dependent. But it may be a positive value for other cultures, such as Asian or South American. Several clinicians saw diagnosis clearly as a function of the diagnoser--not the client--and representative of the culture at large and the context in which the patient is seen:

> Well, I presented a case at a conference recently, and the psychiatrist asked me whether the patient looked like he was psychotic or a schizoid type. And I said, well, you know, in certain contexts he looks very psychotic and in others, he doesn't. If I see him in my office with his mother, he will look weird and hostile to me. If I meet him on the street, which I have many times, he can carry on a normal conversation. How do you make sense of that? He's a different person in a different context. (F)

> When I was in graduate school, I got all As except in my class on diagnosis. I tried to show that in all the case studies we had, the diagnosis said more about the person doing the diagnosing than about the client. I demonstrated what these cases represented about the clinician. The teacher tried to fail me. (R)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Other clinicians were interested in the similarities between symptoms and solutions rather than the similarities between diagnoses. If, for example, a client is depressed and has a problem sleeping, that may be more similar to the problems of a client who has sleep problems related to financial worries than to another depressed person who sleeps all the time. It is a tenet of Brief Therapy practitioners (Anderson & Goolishian, 1990; DeShazer,1991; White,1990) that symptoms and solutions take precedence over diagnosis. Thus, several clinicians agreed that they were not concerned about diagnosis but rather about the task that the patient is assigned. In this regard, the use of the word "task" refers to the proposed solution to the problem or symptom that is jointly created by patient and therapist. An example of a task may be to jot down how many times the person awakens during the night and to guess whether this can be predicted by internal or external cues beforehand:

> There are often more similarities between people with different diagnoses, because of factors other than diagnostic factors. You know, the person who has a problem drinking and the person who has a food problem may have the same task. That is quite different from the accepted wisdom of therapy, which is that we treat similar problems in similar ways. (P)

> One time I had a patient who had never had a date in her life. Maybe she would qualify as paranoid. I told her to buy a singles newspaper and just look at the ads. I had another patient who was in a masochistic relationship with an unrewarding partner. I told her to get a singles newspaper, too. They had more in common than two paranoids, or two depressive, masochistic, if these categories really exist. I doubt that they do. (ZA)

> If you speak to a person in their own language, and they can find an exception to the problem in such as a way as to warrant a certain kind of task, then two people with different problems may have the same task. (Q)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Some clinicians viewed diagnosis with distaste and said that they never consider it:

> Once you start thinking of people in terms of their diagnosis, you're lost. (T)
>
> In my ideal world there would be no diagnosis. (V)
>
> I'm interested only in the politics of diagnosis. (R)
>
> I really don't think about diagnosis at all. (N)

Most of the people interviewed struggled with the demands of clinical practice in a time when managed-care and accrediting organizations require diagnoses, treatment plans, and symptom checklists. This is a special challenge for self-designated postmodernists who dispute the notion of categories and the idea that there is a unitary self that exists independent of the perceptions of others. Some of the ways in which they tackled this problem included discussing it with the client, seeing diagnosis as only one way in which to view patients, and using it as a form of communication. Because postmodern clinicians often espouse a "both-and" position and see these new ideas as more of a perceptual shift than a prescription for actual practice, it is possible for them to view diagnosis as a lightly-held idea to which they need not rigidly adhere:

> Some people find it helpful to have a diagnosis, particularly for a physical illness. That way you have something that you can get treatment for. If they want me to write a diagnosis, I'll write a diagnosis. I think it's useful in terms of a classification system. (M)
>
> Where I work, we're forced to discuss the treatment plan and diagnosis with the client. This is what I do, I say to the client, "Here's the diagnosis. What are we going to do about it?" (Q)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> I may have to come up with a diagnosis for somebody in order to get reimbursed. In our clinic, I see that as an administrative chore. I don't take it seriously. But if somebody is extremely depressed, I don't feel that it's right for me not to have them seen by a psychiatrist. That's if they fill the criteria for major depression. But if somebody's in the room with me, I don't take it seriously. (G)

> To the extent that I can, I ask people to choose their diagnoses and talk about the implications of choosing this one over that one and how it may affect their lives. (V)

Is Assessment Necessary?

Based on the foregoing ideas about diagnosis as an inevitable but somewhat odious and often unproductive demand of clinical work, it also becomes necessary to question the value of assessment in clinical practice. Mailick (1991) points out that it has been a universally agreed-upon tenet of clinical practice that it is necessary to gather some data about people in treatment in order to plan an intervention. In her examination of assessment in light of postmodern influences, she suggests that assessment when necessary may represent only a mutually shared approximation of reality co-created by client and worker. Each may bring a different meaning to what is known about the person's problem. Earlier, it was suggested that viewed from a postmodern perspective, diagnosis and assessment may constitute a kind of backward mapping that emerges only after the relationship with the client has developed. If these ideas of uncertainty and backward mapping influence clinical work, what kinds of things do clinicians do when they first interview the client? Do they postulate any dynamics or hypothesize about causes? How

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

do they gather data, or do they forgo inquiry? Do they make a tentative diagnosis or consider several options?

Few people rejected assessment all together, but most questioned the usefulness of making an initial diagnosis based on pathology or symptomatology. They were more interested in relationships and how the person interacted with their social environment:

> When I first meet with somebody, I try in the assessment interview to find out about their major relationships. I like to get a sample of people's object relations, have them describe their parents, and talk a little about their childhood. Their pathologies are definitely highlighted in those interviews, you know, like narcissistic and borderline themes. Whereas when you get to know someone, the picture becomes more muted and more interwoven into the complex picture of who they are and their inner world. (X)
>
> I've always been more interested in how people relate to things, how they do their relationships. It's in their relationships, not the diagnosis that the significant interventions take place. (R)

Yet some people believed that almost any assessment was outmoded and unnecessary. They felt that postmodern ideas about how the clinician should not be separate from the client militated against defining the client in specific ways, except for looking at context. Looking at context could be seen as privileging one criterion over another. Nevertheless, it fits in with the postmodern idea of fluid boundaries in which nothing is separate from the context in which it operates:

> Assessment is something that suggests that you have prior maps that show some kind of a blueprint or a template in order to make sense of somebody. Usually you're assessing somebody in an objective way along some set of criteria. We no longer are these sorts of objective observers, making sense

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> of someone else's behavior except in context. (M)
>
> I don't believe in assessment anymore. (N)
>
> When I meet someone, I keep an open mind. I don't make a diagnosis. I don't assess. It's hard to do. Inevitably, I might think, "This is a Borderline," or, "This person is depressed." But I don't let it guide me like before. I try to ignore myself, my preconceptions. There's a concept called "Gap," in Zen Buddhism. It suggests that if you leave an open space, there's room for wisdom. (R)

The Pathological Use of Pathologizing

If there are no diagnosis and little assessment, how does one know where one should focus one's clinical efforts? What do we think of as "healthy" and what do we think of as "unhealthy?" Unlike their fairly unified idea about most assessment being outmoded and unnecessary in order to preserve the subjective aspects of treatment, clinicians were more variable in their ideas about pathology. The idea of pathology evoked a more judgmental response from some of these clinicians. Particularly the idea of domestic violence, something that is in the forefront of feminist and social work concerns, evoked the most negative response:

> If the patient feels good about beating his wife, there's something pathological about it. I know that's not a postmodern term. (X)
>
> Pathology is a useful way of describing something. But I could go either way. It might be overused. (O)
>
> I would tend to use pathology in a negative way, like "wife beater," for example. (Y)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Nevertheless, most of the clinicians were conflicted about how they felt about pathologizing behavior--labeling it as destructive or bad. They believed that it had negative consequences for the self esteem and well-being of clients:

> There seemed to be a larger context to the problem. This guy's wife was pathologizing him. Everything he was feeling, his wife was making into a problem. I tried to move the conversation into a direction that would be more useful for them to look at. (F)
>
> I see the way that pathologizing clients has demoralized them. (X)

Most clinicians believed that having a nonjudgmental attitude was most useful for patients and it was particularly important for them not to be labeled as "patients."

> I don't tend to look at it as an illness, the medical model. I believe that patients are doing the best that they can and given what they've been through, it's no wonder that they have these problems or function this way. (Z)
>
> You just have to look at physically disabled people and see that you can have a life. So long as people don't make a patient out of you, you can get better. (J)
>
> There's so little difference between me and the patient. Why use language that divides us? (T)

Borderline: An Example of Categorical Name Calling

People were particularly interested in discussing their use of the diagnosis of borderline personality disorder, referred to most often as "Borderline." They felt that this diagnosis lent itself most readily to ideas about social construction and intersubjectivity.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Originally developed by theorists, such as Stern(1938) and Kernberg(1975), as a psychoanalytically-derived category that represented a person hovering permanently between psychosis and neurosis but appearing to be quite mentally ill, this diagnosis was meant to circumscribe a select group of patients who appeared schizophrenic but were, in actuality, much higher functioning. Over the years, many books have been written about this disorder. It has become a bonafide diagnosis, first in the *DSM-III* , and, most importantly, it has entered the common parlance in the psychology community (including psychiatrists, nurse clinicians, and clinical social workers) as a term for someone who is insufferable, full of rage, and a trouble maker. The *DSM-IV* includes impulsivity and unstable mood, among other manifestations, as some of its criteria. But common usage in the clinical setting has broadened its criteria to include clients who complain loudly about the therapist or the agency and who act out sexually or aggressively in ways that get them in trouble with the authorities or with the community. Although not part of the *DSM-IV* criteria, the dynamics postulated for the diagnosis imply that the person will split others into "bad" or "good" objects, thus making trouble among the two camps.

The clinicians interviewed felt strongly that postmodern ideas had influenced their view of this disorder. They no longer took the diagnosis for granted and became more interested in listening to what the client was complaining about. Based on their ideas about intersubjectivity and social construction, they began to look at what was contributing to the creation of the diagnosis:

> Let's say someone has a Borderline diagnosis. I would want to know what

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> he's angry about today and why he's angry at me, based on my previous conversations with him. Does he get angry like that at other people? Do my other patients get angry at me for the same reasons? (G)
>
> I hear this a lot when a patient is hospitalized: "I'll call you when we have a diagnosis." If she's a depressive, you can call her, but you can't visit her. If she's a borderline, you can't even call, because she will split the staff. I said, "Why would you want to split us? Aren't I a part of the team?" There's a wonderful article about Borderline as an iatrogenic myth. (N)

Even when clinicians accepted the overall category as valid, they were interested in looking more deeply into what dynamics created the condition, seeing it rather as a story that had similarities to other stories, not as a condition that was intrinsic to the patient:

> I recognize the cluster of symptoms that are called Borderline. Where I differ with *DSM-IV* is that I don't see that as a defect in the person, per se. I see them as a person [*sic*] who's had a life history that included abuse, betrayal, denial, distortion, manipulation, the whole gamut. That combination of life experiences has led them to live their life according to a certain story. (X)
>
> If I work with someone who's Borderline, I think of them as a person who has learned to manipulate, probably because someone manipulated them, and that's been the currency of their life. I also recognize that boundary issues are going to be a major thing. (O)

All concurred that Borderline was the worst diagnosis one could attribute, because it presupposed that the person was untreatable and unlikable. Steeped in the idea that diagnosis can often be a social construction meant to define what is and what is not socially acceptable, most avoided giving out that designation if at all possible:

> I've never written Borderline down for anyone, if I can find another diagnosis that will get paid. (Q)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> If I see a file that's this big [She stretches her arms out very wide] then I know that it's a borderline, meaning that this person is a pain in the ass. What I really want to know is what people think is such a pain in the ass about this person. (J)

In conclusion, respondents had a mixed views of how seriously to consider diagnostic categories and the idea of pathology in general. Most felt that postmodernism had influenced them to question the consequences of the diagnosis, such as in the category of Borderline Personality discussed above, and the actual construction of the diagnosis. A more fluid and contextual view of diagnoses led respondents to feel that diagnosis is often created by the interactions they had with their clients as well as their clients' interactions with others. For most people, the influence of postmodernism was that they seriously questioned the validity and reality of diagnosis, preferring to think that diagnosis is something to be taken lightly but to be considered seriously whenever used because of its ability to affect people's sense of themselves. Some operated from a both/and position that diagnosis was a necessary part of clinical work but that it didn't have to be taken as final truth about the person in treatment. Nevertheless, respondents couldn't evade their own preconceptions, prejudices, and judgments about people who performed behaviors, such as domestic violence, that went against their beliefs about what was right or wrong.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Therapeutic Goals and Change: What Is Mental Health?

Viewing pathology through a postmodern lens leads to questions about how respondents envision mental health and the goals of treatment. Because practice techniques and the role of the therapist will be discussed later on, it is important to have in mind an image of the purpose of treatment.

Ideas about chaos, multiplicity, cultural relativity, and social constructionism imply that there are no objective criteria for the "good life." If there are no objective criteria, then what do therapists aim for in their clinical work? Maturana, the Chilean biologist and contributor to constructivism, was once asked by a clinician why someone should perform psychotherapy if there were no objective way of determining mental health. His answer, according to Efran and Clarfield (1992) was, "because he or she wants to" (p. 205). They suggested that in the poststructural world, the ultimate reference for a person is him or herself. When interviewers asked Martha Graham, for example, why she choreographed, she replied, "So I would have something to dance" (p. 205).

If someone is the ultimate reference for their own idea of health, then the only source of knowledge about the client should be the client. In this case, it would follow that postmodern clinicians would leave it up to those in treatment to determine their own goals, their own outcome, and, therefore, to determine the end of treatment. This was not the way most of the clinicians interviewed, however, evaluated health and "healing" in their practice. Although all had been influenced by postmodern ideas about relativity and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the contextual nature of pathology, many had a clear idea about the nature of mental health. Although they eschewed ideas about causation, they believed that the end of therapy should be a mutually agreed-upon event. This seemed to fit in more with postmodern ideas of intersubjectivity and the co-construction of meaning in that both participants agreed on outcome measures. But it also demonstrated that although respondents espoused postmodernist ideas about practice, they retained certain traditional ideas about the role of the therapist in determining goals and outcome:

> So I look for indicators that the patient is starting to feel that they've [*sic*] had enough. I may say: " I think maybe there's enough going on here that you can take some time off." If they agree, they'll do just that. ©
>
> If I feel that the client has moved to a place where they [*sic*] feel that they have some mastery over their life and the particular dilemma that brought them in, I consider that a good outcome. If they feel empowered to make decisions in certain problematic areas of their life, then I feel comfortable terminating. (I)
>
> My sense of mental health is the ability to be in the moment, to be spontaneous, and to be able to feel strong affects, both negative and positive. People aren't necessarily going to feel happier. It helps people to become more complex, but not necessarily like better Americans or something. (Q)
>
> It's a collaboration. We both know when we're done. It's a kind of an aesthetic, in that it looks right. (ZA)

Some therapists were more symptom- and problem-oriented in that they determined the end of treatment strictly by the parameters set by the patient at the beginning of their work together. This reflected the idea that it was not up to the therapist to determine the goals of treatment. Much like the traditional social work imperative to

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

"start where the client is," this takes the process one step further in excluding other aspirations the clinician may have for the client's growth and development:

> So people are better when the problem they came in with has gone. If they come in with a new problem, fine. (R)
>
> You just start working on a goal that the person came in for without trying to figure out what created the problem. (H)
>
> When a client comes in, I'm not interested in straightening them out or telling them what I believe. It's only about their experience and their problems, as they define them. (S)
>
> My idea of change is that the client would have an idea at the beginning of therapy what the end of therapy would look like. And the end of therapy should be some close approximation, like the client's being satisfied with their having been a change in their way of acting with other people. (F)

It seems that the influence of constructionist and constructivist ideas has led some clinicians to place more emphasis on meaning in therapy rather than on behavioral or interactional change, such as relationships with others. Saari (1991) pointed out that meaning-making should be a central tenet of clinical social work treatment. The increased attention to the meanings clients ascribe to their interactions leads to the idea that change may be more in the area of perception than action:

> Perhaps no change is a change, because it may be that a person comes to therapy thinking that everything has to change. They leave feeling comfortable with who [*sic*] they are. (F)
>
> I think that therapy is a form of hermeneutics, the art of deciphering indirect meanings. I like to make clear what was once indirect, unclear. This opens up new possibilities. (I)
>
> The person's meaning of the situation is the heart of the matter. (B)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Based on radical postmodernist ideas about the futility of progress and the absolute relativity of values related to health and illness, it was inevitable that some respondents would eschew any hint of having constructed a goal or wanting to measure outcomes. Several people refused to speculate about the nature of mental health or the virtue of outcome measures:

> I'm a qualitative researcher as well as a therapist. So I don't measure outcome. (G)
>
> It's a form of patriarchal oppression to say that people should change. (ZA)
>
> Since I reject the idea of causality, I can't define mental health. ©

Postmodern Influences on Technique

The Role of The Therapist

After looking at how respondents' ideas about mental health and illness have been influenced by postmodern theory, the question arises as to how these clinicians go about achieving their goals--even if the goal is not to have one. Another question is whether the shift away from a mechanistic, reductionistic view of people-in-treatment toward a more evolutionary, holistic view has resulted in a different therapeutic style--or role. Since most postmodernists believe that the therapist is not a separate agent of change but, rather, a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

part of the observing system, how does this manifest itself in the therapeutic interaction?

Traditionally the role of those who treat one or more clients from an individual psychoanalytic perspective has been one of neutrality in which the clinician avoids acting in a warm or identifiable manner toward the client. This neutral stance has been defended as a way of protecting the person-in-treatment from the nonobjective feelings of the therapist. According to the traditional approach, this neutral position encourages client growth as well as elicits constructive anger toward the therapist for creating deprivation. If the therapist acts in a more directive manner, this is considered to be manipulative (Levenkron, 1982). Lacan (1977), however, ascribes this impassive, reserved stance in psychoanalysis to the role of a "dummy" in a game of bridge. The purpose of presenting a blank face is not simply to provide a mirror in which the patient's thoughts and dreams will be reflected or to hide one's hand by not revealing one's own thoughts and feelings--but rather to expose a third person in the game: the transference of the analysand. This silent partner of the analysand will be exposed in order to reveal his unconscious motives, which will be interpreted by the analyst. Nevertheless, there is one prescribed role for the therapist, and it is an unreadable demeanor.

Conversely the role of the traditional or "first-order" family therapist or hypnotist has been to act directly with families or individuals in ways that are overtly manipulative. Family therapists have been instructed to actively seek alliances with different family members and to create paradoxical interventions that directly influence change (Haley, 1963; Watzlawick, 1978). Traditionally, however, both family and individual therapists, however, share the Newtonian, mechanistic view that the road to freedom from

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

symptoms--whether in individuals or aggregates--lies in objective understanding.

The Non-Expert Position According to the postmodern clinicians interviewed, however, the therapist does not stand apart from the therapeutic interaction, but stands within it. Offering a perspective on this new role of the therapist, Goolishian and Anderson (1992) have suggested that therapists should open a free conversational space in which the authoring of new stories can occur. The role of the therapist, in this case, becomes one of creating conversation rather than creating change. If the clinician takes a position of "not knowing," then the stance is one of genuine curiosity about the person-in-treatment's story. This role allows clients to examine their own world as they see it and thus encourages the clinician to reframe and interpret what each person says. The clinician and the client are continually reshaping the meaning of the experience.

Many of the clinicians interviewed translated their beliefs about postmodernism into a "not-knowing," "non-expert" role with clients. They preferred to work collaboratively with clients rather than in the "one-up, higher-status" position. Some of the postmodern influences for this stance come from Foucault's (1980, 1982) ideas about power and Hoffman's (1985) ideas about the de-emphasis of hierarchy. Believing, as Real (1990) has suggested, that the only behavior therapists can directly control is their own, these clinicians have taken a subjective, nondirective stance in which they consider how to position themselves differently within the therapeutic framework (Levine, 1994; Real, 1990). This often means that the clinician does not presuppose what the right answer is for a particular problem and does not give direct advice. More will be discussed about advice-giving later on. This, also, implies entering the situation with a non-expert,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

reduced-status, perspective that does not always need to be directly articulated to people-in-treatment, but is reflected in the kinds of questions the therapist asks and the manner in which the therapist responds--without judgment, without superiority, and without preconceptions about the answers. A by-product of this nonexpert stance is that most of the clinicians who practiced it felt more touched by patients and more able to enter their worlds with deeper understanding and compassion:

> Because I've relinquished the "expert" position, I think I enter the work with a lot more freedom. I feel I'm more touched by people when I don't make them into objects. There was this woman, for example, whose husband died at 49. She told me that she really hasn't felt sorry for herself, because she just feels so sorry for him, for what he's missed. I didn't encourage her to express her anger and grief more fully, as I would have done previously. I felt so blessed to be with this person. I felt her generosity, her love. These ideas create a stance that is more enriching in my own personal life. (O)

> I had this patient who would often look out of the window. She said, "I'm out there in the tree." I could have challenged her reality. What I did say was: "How come you need to be up there in the tree?" On some level, she wasn't in the tree either. I think we both kind of felt it So I learned a lot more about her inner world. (B)

> If I hear that someone's in a bad relationship, I don't jump to conclusions that the solution is for him or her to get out of it. Previously, I took a very active role to make the person more assertive. Now, I wonder what's going on, what's satisfying to the person. I look for strengths in the relationship. I'm not such a big busybody anymore. (ZA)

> I have no investment in privileging my way of seeing the world over someone else's. One time I had a mother who said to me that her child was evil. I asked her, "Could you help me understand how you came to see this child as evil? I want to understand." You know the honor of being able to see it her way was just incredible. (P)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Curiosity and Active Questioning. One of the ways this nonexpert stance is achieved is through the use of curiosity and active questioning. Although curiosity and active questioning can be an important part of a Newtonian, scientific world view, the use of such techniques in this context imply that the therapist does not have all the answers, does not presuppose the cause of the problem, and--most importantly--does not have a hypothesis of hidden dynamics in mind. Embedded in the context of the non-expert point of view, such questions give the person-in-treatment the message that they are the expert on their problems and on their dynamics :

> I had a kid who was caught with a gun (when I was working in the schools), and this is what I did. I accepted the fact that I couldn't control him. I took a position that encouraged him to control himself. I try to do this by having respect for the person, and I would try to show this by being actively curious about his decisions. "How did you decide to get this gun," for example. "What entered into your decision?" So I would try to find areas of confidence around decision making. I would try to develop of a view of him that was at odds with the popular one of him. (I)

> I was seeing an adolescent girl who thought she was too fat. I would get curious about where this idea was coming from. I would want to know what experiences did she have in her life that led her to have this belief that she was not thin enough. And I would want to know what ideas were out there in our culture that may have given her this idea. (K)

> I had a patient recently who had some very racist ideas. Of course, I was horrified. But I inquired further. I asked, "How did you get to these beliefs? Who influenced you in the shaping of these ideas?" In the past, I would have not challenged the patient directly, but I wouldn't have known what to do. Now I know that inquiry and curiosity will enlighten both me and the patient. (Z)

Mutuality and Closeness. Along with a curious, open-ended, conversational approach, several of the therapists interviewed see mutuality and closeness as part of their

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

role as postmodern clinicians. The collaborative therapeutic style of postmodern psychotherapy is intended to lead to a position of equality and mutual respect. Coleman (1997) likens this to a positive sibling exchange different than the parental interchange of psychoanalytic work. No longer interested in privileging themselves in a position of power and objectivity, they take the "non-expert" position one step further into the realm of feelings of oneness with or closeness to their clients. Reflecting, in part, the influence of feminist theory on postmodernism, in that feminists were among the first to question patriarchal values about distance and objectivity (Gilligan, 1982; Gorman, 1993; Sands & Nucio, 1992), this might include, in very select circumstances, the traditionally proscribed hug. Nevertheless, hug or not, these clinicians reported that they had witnessed a change in themselves and in the client as a result of this more intimate approach:

> Many of us don't talk about the things that go on in long treatments. Like, someone, who, for example, during a long treatment asked me to sit next to her on the couch and hold her hand or touch her. People who would ask for a hug on your way out during certain phases of treatment, I was not going to refuse. But the main thing is the new ability I have to remain closer to people who are full of anxiety instead of anxiously trying to detach myself. (A)
>
> So the kid's in the room with us. I'm supposed to teach her how to parent this difficult kid. Just at the moment that I feel this deep, almost tearful empathy with what this woman has been through and her strength and beauty and how in awe of her I am, she turns to me and says, "Look what he's playing with. Isn't that cute?" It was just unbelievable how when she felt loved and held, respected, adored, it was a natural thing for her to attune herself to him. Instead of my just teaching her how to play with him. (P)

Not everyone had a positive opinion of the nonexpert position and the idea of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

mutuality and closeness. Some respondents were openly critical of such practices and felt that they were ingenuous and overly noble, as well as unfair to clients. They did not think it was possible to "empty oneself" of power in the therapeutic situation, and they didn't think it was possible for clinicians to put themselves in such a disempowered position at all times. Efran and Clarfield (1993) concurred that it would be absurd to think that social constructionists, for example, never give advice or take charge of the therapy:

> I wonder what a feminist therapist would do with a woman whose goal is to become a better wife and mother. (L)
>
> I often take a strong position with clients. To me, this is more postmodern than modern, because Freudianism was so hands off. Z
>
> It's neither desirable nor possible for a therapist to empty himself of any power whatsoever. The role is defined socially. It's not egalitarian. It's controlled by the culture. (K)

The Both/and Position and Advice Giving

The different ways in which the clinicians interviewed looked at the expert position suggests that the role of the therapist as defined by most postmodern clinicians represents an attempt to integrate theory and practice within their own value system and frame of reference. The both/and approach described by Simon (1992) suggests that it is possible to do traditional therapy from a postmodern perspective. The notion that the therapist is part of the system changes drastically when the therapist steps out of the system to judge

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the client, observe symptoms, and comment on negative patterns of interaction. According to Efran and Clarfield (1993), this is not necessarily contrary to postmodern thinking. They contend that social constructionists, for example, can be defined only partly by their preference for conversation as a tool, just as Darwinians prefer to use natural selection as an organizing tool. Darwinians ,at other times, might utilize different methods to categorize the natural order. The postmodern approach does not preclude using diagnoses when necessary, giving advice, or presenting genetic (psychodynamic) explanations. There were, for example, many clinicians who gave advice when they deemed it absolutely necessary:

> If you're worried about the safety of their sexual practice or violence to their loved ones, you have to make a judgment call about what the effect will be of bringing that into the conversation. There are lots of ways, once you've formed a relationship, to say, "look I'm really troubled about your having unprotected sex." (B)
>
> Recently I urged a patient to go out and buy her wedding dress at a sale. She got a great bargain and was ecstatic, greatful. Of course, I wouldn't do it with someone who would become anxious by my intervention. (Z)
>
> One of the ways in which I take a stand is to share my own experiences with other clients. If someone is doing something outrageous, I will say something like, "One of the things I've learned from working with couples like yourselves is. . ." I'm offering a perspective in words that people can hear. (I)
>
> If I see that someone is really going off the edge, let's say a woman with a man, for instance. I might make a direct suggestion, like, "Try not to call him. Call me instead if you have the urge to call him." Some people respond well to this. Some people, a small amount, feel that is a disrespect of their autonomy. (ZA)

Some clinicians, however, were adamantly against giving advice in any form. They

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

believed that such practice was inevitably hierarchical (utilizing power differentially) and not in the best interests of people-in-treatment:

> Old-fashioned social work is advice-driven, but it varies. Giving advice is a form of social control. (ZA)
>
> I'm against pronouncements. ©
>
> If you direct people or tell them what to do, it has the effect of closing people down. They may end up thinking, "This person knows more than I do. My answer is probably wrong." (I)
>
> If you give advice, it will inevitably not be helpful to the person, because it will backfire. The process of self discovery will be lost. (ZA)

Postmodern Clinical Techniques

Family vs. Individual Therapists

In shifting from a mechanistic, hierarchical, objective role, to a more involved, intersubjective one, the postmodern clinicians interviewed adopted different techniques, depending on whether they were family or individual therapists. The family therapists became more neutral, and the individual therapists became more active. Conceptually, they reflected similar patterns of assimilation of the theories, as described earlier, but they differed in terms of actual technique. At times, it seemed as though they were speaking two different languages, with the family therapists' being much more conversant with postmodernist principles and practices. One of the respondents, an individual therapist and professor noted:

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> The family therapists early on were into cybernetics. When they developed a special language, it was a way to develop their own power and create a difference from individual therapy. In wanting to be on the edge of knowledge, they moved closer to cultural theory than other groups. (V)

Nevertheless, there has been enough overlap to justify the blurring of differences between the two groups in this study. As mentioned earlier, it is a tenet of postmodernism to cloud distinctions between categories and discrete entities, such as professional disciplines, as a way of eliminating dividing practices. It is, also, beyond the scope of this study to dissect the differences between the two groups, as well as militates against the purpose of the study, which is to look at general ways in which clinical social workers have been influenced by postmodernism. It may be sufficient to note that the techniques of circular questioning, bracketing, and narrative therapy have been the purview of family therapy, and the techniques of intersubjectivity and co-transference have been the contribution of individual therapy. Self-disclosure, political and gender issues have been the concern of both. Following is a more detailed discussion of how postmodern clinicians have utilized these techniques, although it should be noted that these are only a part of the clinical repertoire:

Bracketing

Based on postmodern ideas about deconstructing the influence of the therapist on the client or family, and the professed desire not to influence the flow of treatment by imposing one's own point of view, bracketing was often mentioned as a method of letting

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

people-in-treatment know the biases of the clinician. It is a way of unmasking the ideologies hidden in words (Middleman & Wood, 1993). According to White (1993), the transparency of the practitioner's beliefs challenges the assumption that therapy should be mysterious. Looked at from a psychoanalytic perspective, bracketing represents the transformation of what used to be called counter-transferential thoughts or unconscious ideas about the client into conscious ones. Lacan (1977), who represents a midpoint between structural and poststructural ideas about treatment questions the idea that the therapist's personality has no influence on treatment. He asks, "Who is the analyst? He who interprets, profiting from the transference? Or he who imposes his idea of reality?" (p. 232). Bracketing involves telling the person-in-treatment about the preconceptions of the therapist. A unique form of self-disclosure, which will be discussed next, bracketing does not imply telling the client one's life story or answering personal questions. It is, instead, telling about one's cultural standpoint or relevant experiences when such experiences may interfere with treatment. In some instances, it may involve simply being aware of one's biases:

> I will tell people if I'm biased in a direction that I think would make a difference, like about the welfare of children or abortion. (O)

> Recently a patient came to me who was convinced that she had been sexually abused as a child. She wanted hypnosis to uncover her memories. I told her that I was willing to do the hypnosis but that I had a belief that it may not be helpful to uncover such memories. In the past I would have done the hypnosis knowing that I didn't believe in it and not told the patient. You may ask, "Aren't you leading the patient anyway?" Yes, I am but I'm not pretending to believe one way and then act another. This leaves her free to challenge me directly and perhaps change my mind. (Z)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> Being able to park your theories and biases, or at least being credibly aware of them creates a context for someone to tell a story that is productive of making change. (M)
>
> I tell people where my ideas are coming from, so that they won't take them as truth. (N)

Self-Disclosure

Unlike the idea of bracketing, which has been largely relegated to the postmodernist enterprise and rarely used before in traditional therapy, the use of self-disclosure has been a much-contended issue in clinical work. The traditional view of therapy has been for the therapist to remain anonymous and abstinent (refraining from gratifying patients' requests for information). Embedded in this position is the belief that the therapist is an objective evaluator of the patient's experience and must eliminate his or her individual personality from the therapy process (Goldstein, 1997). On the other hand, the intersubjective perspective leads the therapist to strive for understanding of how their own personalities affect the flow of therapy in concert with the interactions of the client. Lacan (1977), who represents an essentialist but intersubjective perspective, suggests that "the unconscious of the subject is the discourse of the other" (p. 55). This would manifest itself in the analysis by the analysand's having expressed things about the therapist that were true but deeply hidden or never spoken. Or it would lead to other people in the therapist's practice acting in similar ways. He attributes this to the natural connection between people that cannot be avoided. Poststructuralists do not discern between other and subject in the same way. They agree that one affects the other, but they also believe

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

that something new is created that defies splitting into two categories of self and other.

Inspired by postmodern ideas of mutual influence and interconnectedness, the clinicians interviewed were more likely to use self-disclosure in both individual and family therapy, based on the belief that what they are thinking and feeling will inevitably produce an influence on the patient. Why not make the implicit explicit and reveal what will be known by the patient?

Another reason for self disclosing to the person-in-treatment is that it reduces the power differential and hierarchical relation that develops when one person in the relationship remains silent. This, according to Foucault (1980), speaks to the power relations that are often hidden in everyday discourse, in the quotidian things of life--and particularly in the structure of the therapy relationship. When one person is forced to talk and one remains veiled in secrecy, it suggests an obviously imbalanced situation meant to cast the silent one in the important position. Some analysts would suggest that silence can be interpreted in many ways--and only one of these is that the person who is silent is in a position of power. Postmodernists would argue that the symbolism in the discourse of silence and disclosure leads to the idea that the person who is speaking has less power than the person who is silent, because there is a differentiation between the two and because power is conferred by the general public onto the silent one.

In most cases, however, the clinicians in the study used self-disclosure selectively and with careful planning. It seemed, also, that although they did not believe that self-disclosure was wrong, they were cautious about letting themselves be known:

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> I might ask if the patient would like to hear what I'm thinking. (N)
>
> It's very important to me to share myself with my patients. I don't want them to see me as a blank screen, and I don't want them to be afraid of me. But there is a part of me that hesitates to share myself completely for fear that they will abandon me if they know my weaknesses, and then the therapy will be derailed. (X)
>
> I tell a lot of personal stories. (D)
>
> I think it's rude not to answer questions. I had a client who had a very traumatic life and was feeling very anxious. One day she just switched the subject to what I would be having for dinner that night. Of course, I told her. It opened up a good conversation, and she was able to calm down. (ZA)

Not everyone thought self-disclosure was a useful tool in therapy. One respondent felt that self-disclosure could be dangerous and self-serving:

> I rarely tell clients about myself, because I think that's an abuse of the therapeutic situation. Too many people focus on themselves instead of the client. (Y)

Co-transference: The Therapeutic Use of the Self

The intersubjective aspect of postmodern theory had a wide-ranging influence on the clinicians studied. The idea that there are mutual influences that cannot be delineated is reflected in quantum physics, which contends that all particles are related and influence one another at the same time (Zukav, 1977). Presenting a new way of looking at the therapy relationship, intersubjectivity as a technique (Stolorow, Atwood, & Brandchaft,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

1994) reveals that the person-in-treatment and the clinician influence one another, even if the therapist is unaware of how he or she is affecting the client. Since the countertransference or unconscious ideas of the therapist are not counter to the transference of the patient in this approach, some clinicians have referred to it as "co-transference." Saari (1993) pointed out that some clinical social workers who are reluctant to use the term transference because of its noninteractive nature, use the term "therapeutic use of the self" (p. 10) to refer to the interactive process in casework. Unlike Perlman (1979) who contended that the relationship was the context for treatment, Saari (1993) suggested that it may be the goal. Several clinicians described it as follows:

> More or less comes from the patient's past. More or less comes from the actual experience of therapy. I'm always open to how the patient is perceiving me. (N)

> The traditional view says that transference comes from the unconscious, intrapsychic conflict between the id and the ego, you know the Oedipal Complex. But there are many lived experiences that will be filtered through the person's subjective lens. And both of us will bring our own subjectivity. (U)

> I was treating an anorexic who didn't want to talk about her problem. We discussed other things, like our mutual interests in philosophy and literature, for example. It was important for her to construct the treatment in such a way as to avoid focusing on her problem. As the treatment progressed, I began to like her more and more and enjoy our intellectual discussions. Suddenly I noticed that she had gained about 20 pounds. I don't know why I didn't notice before, but I was trying hard not to focus on the disease or worry about it. She was very happy with her progress and thanked me. (ZA)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The Narrative Metaphor and Method

As postmodern clinicians look more deeply for meaning in client's lives via the intersubjective field and co-transference, they strive to find ways to make sense of the stories that people tell. It is as though the Freudian concept of transference can be transformed into a metaphor that is the symbolic tip of the iceberg beneath which resides the entire story of the person's earlier life. This collides at the point of contact with the entire story of the therapist's life, his or her countertransference. In addressing the question of the meaning that people bring to such interactions and events, Bruner (1990) contends that sometimes it is more important to understand what people think about their actions than what they actually do. Narratives act as mirrors through which people view themselves and through which they interpret the universe. According to White and Epston (1990), it is important to separate people from narratives that constrict and oppress them in ways that contribute to unhappiness and "dis-ease." Several of the therapists interviewed practiced narrative techniques that were meant to create distance between the client and the problem via the use of externalization--looking at the problem as a separate entity from the person--and by symbolically reviving people who had contributed in a positive way to the person's story about her or himself:

> I would ask how important people in someone's life would respond to the person or the behavior. I might say, " What do you suppose Grandma would say to you today?" (I)
>
> I might ask, "How is the problem influencing you and how are you

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> influencing it?" You sort of drive a wedge between you, who the person is, and this problem. (R)
>
> I had a client who had been traumatized by an event in which someone died indirectly because of her. She believed that all her problems stemmed from this moment. We were always focusing on her trauma. One day she came in telling a different story. She had read in the paper that obsessive-compulsive disorder was characterized by persistent thoughts of the same event. Maybe she was an obsessive-compulsive who was obsessing about what happened rather than a traumatized person, she wondered. The new story made her feel good as though she had been liberated. I don't care much for diagnosis, but I think it's cute when someone can use it to transform themselves in a positive way, kind of like a game. (J)
>
> Say that someone comes in and tells you a story about themselves that is absolutely horrible. You point out areas in which they have been strong or confident. When they look back, the story changes. (ZA)

Circular Questioning

Several therapists were just beginning to learn about narrative therapy and were much more conversant with circular questioning and solution-focused ideas. Some other clinicians were not aware of the technique but used similar ones to make their point. Circular questions (Fleuridas, Nelson, & Rosenthal, 1986; Penn, 1982) are based on the postmodern ideas of relationship and mutuality. Since nothing occurs in a vacuum, it is important to get families and individuals to look at the way their behavior is interactive with others and others' behavior is interactive with themselves. This may also include the environment. The shift in perception that results often leads to positive change (Greene, Jensen, & Jones, 1996). Some examples of circular questions might be, "Who agrees with Mom that this is the major problem in the family?" or "What happens to your sister when

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

your brother acts this way?" Respondents mentioned several examples of their own circular questions:

> I might ask, "Who in the family was the first to notice that you had made progress toward your goal?" (R)
>
> I ask a lot of questions about society and authority, trying to break it down. (Z)
>
> I'll ask "Who in the family is the first to notice that Johnny is having a problem?" It's not uncommon that when a person in the family hears how other people think, they say, "Gosh, I didn't know you thought like that." (W)

Political Questions

Political questions are similar to circular questions in that they involve looking at the effect that outside forces or people have on problem-formation. They are based, however, on the postmodernist idea of deconstructionism and unmasking the political nature of personal life. According to Greene et. al (1996), clients are often not aware of the complex ecological nature of their situations. Some of the clinicians interviewed used such questions to open up difficult subjects, to approach sensitive issues such as racial and gender differences between therapist and patient and to help clients become more aware of their capacity to change:

> She took a sip of booze and then decided not to do this and threw the rest away. I asked her how she knew it was a good idea to stop. Then I asked her what it would mean to her children. I asked one question from a semantic frame and one from a political frame. Sometimes politics means just thinking about one's effect on others. (F)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> Well, I might say something like, "I know that the church is very important in African American families. To what extent is this important to you?" (W)

> I've had clients say that they prefer a white worker or an African American one or a woman. It's better to kind of weave it in a sort of a conversational sort of way or to just ask, "How do you feel about working with a male therapist?" But you have to ask. (ZA)

> I asked, "So how have you helped your son deal with the larger society? Has he encountered any racism," in working with the mother of a mixed-race child. You have to put things on the table, not just pretend that you know what's going on. (Q)

Problems with Postmodern Techniques

Although many of the clinicians interviewed were enchanted with these new ideas, there were instances in which they struggled with some of the techniques and approaches as they interpreted them or saw them implemented by others. A common complaint was that narrative therapists seemed to be bullying people-in-treatment by pushing them in a certain direction for change. They experienced this as too interventionist despite the fact that they were, nevertheless, interested in learning these techniques:

> It seems that they're going after the patient, badgering them, like they know what's best for the patient. You can't be a deconstructionist without being in the expert position, which the constructivists believe you should give up. (L)

> I'm trying to figure out how to work narratively without being too aggressive. (ZA)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Another common area of confusion was how to implement the idea of multiplicity into clinical practice without confusing the person-in-treatment. In the reflecting team technique (Anderson, 1991), for example, clients witness different therapists discussing their cases from multiple perspectives. In individual therapy, when there is no one interpretation and no one solution to a problem, postmodernists have been known to present multiple views to patients. This has created problems for both the clinicians interviewed and their clients:

> I was treating a young medical student who saw me as a mentor. When I presented these alternative explanations for his problems, it discombobulated him. They were disconcerting to him. (Q)
>
> Sometimes I feel postmodern ideas let me off the hook, if I don't know what's going on. It makes me feel okay about being passive or ignorant, and I'm not sure that's a good idea. It may be a copout. (ZA)
>
> It's hard to feel secure about what I'm doing when there are so many perspectives to consider. (ZA)

Postmodernism and Clinical Logistics: the Convention of Hour, Time, Fee, and the Use of Names

One of the things that has been overlooked in postmodern clinical research (Levine, 1994; Stone Fish &, Piercy, 1993) has been the actual structure of practice: How practitioners carry out their work in terms of time of sessions, length of treatment, even the use of names--how clinicians refer to themselves and others--are interesting areas in

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

which to explore the influence of postmodernism.

The Use of Names

In most articles and books about clinical practice, there is little written about the use of surnames vs. first names in therapy. It is common practice wisdom in the traditional model that the clinical social worker calls the client by their last name--as Mrs. Smith, for example--and refers to him or herself in kind--as Ms. Jones, for example. Without undertaking a comprehensive ethnomethodological exploration of the use of names, which would be beyond the scope of this study, an analysis of the responses should look at the use of names to see whether postmodernism has had an impact on this practice. It might follow, for example, that if one were to take the deconstructionist-constructivist-based, non-expert position, one should call oneself by one's first name and one's clients by their last names. In fact, this did not happen, and respondents had never considered it. Many of the clinicians studied utilized the traditional standard of calling clients by their last names unless the clients called them by their first names. On a more modern, less formal note, some called themselves by their full names and let the clients choose what to call them:

> I do the old-fashioned social work thing, kind of tell people my whole name and then I let them choose. And then it organically happens. (A)
>
> Usually I address people by their last names but I feel more comfortable with using their first names. (B)
>
> If the clients call the social worker Mr. or Mrs. So and So, then the social worker should call the clients Mr. or Mrs. So and So. If the clients call the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> social worker by first name, then they should call their clients by their first name. (C)

It should also follow, based on postmodernist principles, that the manner in which clinicians referred to people-in-treatment would be affected by considerations of the political aspect of names and labels. In this respect, clinicians had given more thought to the issue and were more aware of the implications of different names. Furthermore, some people were interested in blurring the boundaries or eliminating the dividing practices that names represented:

> I prefer to call them people. (B)
>
> When I refer to my other patients, I call them people. It's important for the people who see me to hear me refer to others in a noncategorizing way. (ZA)
>
> I don't like to make such distinctions, but I definitely don't call them clients or consumers. (D)

Time of Sessions and Length of Treatment

Similar to postmodernism's influence on the use of names, the use of parameters for session time and length of treatment are, also, interesting areas for exploration. The traditional clinical social work model was based on the Freudian standard of the fifty-minute hour (Saari, 1991). Present-day agency practice has often been determined by the strictures of managed-care funding sources, such as Medicaid or Medicare, which specify exact times and lengths of treatment. Little, if any, has been written in the literature about

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

session time. Length of session is often predicated more on the exigencies and contingencies of practice and funding sources than on philosophical principles. Most clinicians in agency practice, for example, see patients for a prearranged amount of time that fits in with a funding protocol. If there is an emergency, the clinician might on occasion take longer. Or if one person comes in late to a session, instead of making the next one wait, the clinician may see the first for only a short amount of time. In psychoanalytic work, this becomes part of the proverbial "grist for the mill," or content of discussion for analysis. The postmodernists studied, however, were more likely to vary this arrangement even if they were in agency practice, and did so because of philosophical ideas about how these ideas should be reflected in practice:

> Because I'm a supervisor here and can do what I like and what I believe in, I see people for an hour and a half here. (L)
>
> I believe that therapy should be a collaboration. My sessions are around an hour, sometimes a little less, sometimes a little more, depending on what's going on. (I)
>
> One person said, "I could do this all day," and so we did. Sometimes people come in from Europe to work with us. We'll work with them three hours in the morning, three hours in the afternoon. (H)

There were some exceptions, however:

> Because I work in an agency, I can't be creative. Mostly I see people for 45 minutes. Sometimes I see them for 15 minute sessions, or less if I can get away with it. (L)
>
> My sessions are one hour on the dot. If the bell rings for the next person, it's over. (T)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

This same principle of applying postmodernist ideas to session time also applied to length of time between sessions. The clinicians interviewed were more likely to vary the time between sessions, not assume that therapy would be a once a week ritual, and take a more collaborative view. Despite previous training in the psychodynamic model of treatment, several clinicians restrained themselves from encouraging people to stay longer in treatment:

> But I think that what I do that's different from the traditional perspective is the spacing between sessions. I really try to go with the trouble shooting approach at the end of the session by asking whether the person would like to schedule another session. It's not inevitable that therapy is going to go on and on. (L)
>
> I try to see the process of therapy as a real collaboration between myself and the client, so I don't make unilateral decisions about when or if we should meet again. Sometimes I see people for a short period of time and sometimes for a long period of time. (I)
>
> This man has this coverage where he pays only ten bucks per session, and he wants to come in and talk for a while. Then he realize that the doesn't have any problems. He realizes he's very contented with his wife, and he got what he's paid for. And he's looking at me to say, "What have you got to say to that?" I said, "Fine," which kind of shocked him. But I wished we could have gone more deeply into his issues. (I)

Fees

The issue of charging a fee for psychotherapy is a much disputed one--particularly in regard to clinical social workers. Numerous books and articles have been written in which social workers have been criticized for participating in the capitalist project of controlling others (Payne, 1991). When a social worker charges a fee or maintains a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

private practice, this may give credence to the notion that professions are often established in order to promote their own interest rather than the interest of others (Ilich et.al, 1977). Nevertheless, even in agency settings, clinical social workers are often required to ask for a fee, and, certainly, in private practice, there must be a fee exchanged. The traditional arrangement has been for the clinician to have one set fee that applies to all clients. Sometimes in clinical practice, there have been fee negotiations based on a person's ability to pay and funding sources. Surprisingly, most postmodern clinicians didn't flinch at charging high fees and, because several were superstars in the pantheon of family therapy or hypnotherapy icons, they charged more than many psychiatrists:

> I have one fee-$200, no more, no less. (T)
>
> We will charge up to $200 per session but will go lower. (H)

There were some postmodern clinicians who felt strongly about the hierarchical aspects of treatment and sought to mitigate them by what they considered to be an enlightened practice of providing low fees or free therapy:

> I feel uncomfortable that there is a power structure, a hierarchy. So I try to be equally thoughtful about the fee. (I)
>
> I believe that in some cases, therapy should be free, or a very low fee. (M)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

ETHICS

In looking at many of the ways--both practical and logistical-- that postmodernism has influenced clinical work, one must consider the ethical implications of such practices and approaches. Many of the people interviewed raised this issue on their own without being prodded by questions or concerns. All were interested in this issue, but there were few easy answers or unified views. Some people believed that postmodernism by definition meant the disavowal of all previous ethical stances, because of its belief in a decentered truth and a flexible standard of morality that was culturally and individually generated. Because of the postmodern clinical view that therapy is essentially an interpretive activity, or hermeneutical, several of these people were adamant that a moral stand was unacceptable to such practice--although it could be said that inherent in some of these comments was an unconscious or disavowed moral position :

Nothing is a moral issue. I don't know what moral issues are. If a wife beater comes to me, the battery is an issue, if it creates a problem for someone. If it's not a problem, then it's not my problem. The only person I won't see is a pedophile, and only because it disgusts me too much. (T)

I do not believe in ethical stands, because ethics imply that we know the truth. If one works within a psychoanalytic frame, one is not attempting to tell a patient what is true. One is attempting to explain what a patient does. (C)

Since I reject the position as a matter of belief that the world is causal, then I cannot assume that I know what the patient is telling me. I can only

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

interpret in order to give the patient a different perspective. (D)

> One of the things that I remember from social work school is that one should follow the tenets of the institution in which one works--e.g., if you work for the church, you don't encourage abortion. In my opinion, it's unethical to take a stand one way or the other (X)

Other informants were opposed to this value-free stance and believed that it was unethical to take a morally neutral position. They believed that one should take a position for social justice-- not truth-- however. Although they agreed that there was no ultimate truth or unsocially-constructed morality, they felt strongly that a belief in justice should drive clinical social work:

> This postmodernism can be a bit like fiddling while Rome burns or like the movie *Cabaret*, which took place in Berlin. I don't want to call anyone a fascist or be flamboyant about it, but people are ignoring the effect of managed care on patients. It's a way of becoming extremely internally distracted while bad things are happening. (K)

> I think it's very freeing that one doesn't make rules for practice from truth, but from social justice. And you have to name it and take responsibility for it as a therapist. (M)

Other people were more conflicted and reflective about the issue of ethics. They wanted to find a "both-and" position that corresponded with their vision of social justice and, at the same time, their belief in the relativity of morality. For them, postmodernism represented a struggle to integrate and balance both aspects of practice:

> Does postmodernism meant that you have to make no judgement about what's moral, about what's ethical? So when you're dealing with this issue

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

in social work, you somehow have to grapple with this issue of morality. Postmodernism inevitably takes you to that place. (P)

I am very interested in the idea of ethical sensitivity and a constructivist position, which has less to do with decision-making ability than with how one interprets a problem. (B)

If you're working with someone who has done something for which they've gotten in trouble, you don't have to condone the behavior--but you do need to stay open and loving. Our work should be more of a calling than a profession. We should be advocates for people, not representatives of the state. (P)

Summary

The relationships between postmodern theory and social work practice were examined in this chapter. Postmodernist practice was associated with: a lack of enthusiasm for, and a questioning of, diagnostic categories; a reduced emphasis on pathology, or assessment; an awareness of the social construction of categories, and a view of them as part of the problematic of practice. Many therapists were interested in looking at their own contribution to diagnosis in the belief that reality is co-constructed between people. Other clinicians tended to focus their attention on the social relationships of their clients rather than on the nature of their so-called "disorders"--in concert with their perception of the client in context rather than as an isolated and individualized entity. Many practitioners regarded assessment as a dialogue between therapist and client, a term many eschewed. Nevertheless, several therapists were comfortable using pejorative or judgmental terminology to describe clients of whom they disapproved, such as "wife

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

beaters" and "child abusers."

Postmodern social work practice was viewed by practitioners as one in which the difference between therapist and patient was reduced and efforts were made to equalize power. The determination of the goals of therapy, criteria for the conclusion of therapy, and definitions of mental health, therefore, were often derived collaboratively--although it seemed as though the therapists were still making the final decision about what constituted a successful conclusion to treatment. This reflected a transition from an earlier method of practice, not a complete break. There were, also, some questions about how to handle violent and abusive clients. In such cases, practitioners were more apt to intervene directly and forcefully--despite the fact that these therapists attempted to understand the meaning systems of their clients without being judgmental. For the most part, they tended to adopt a "non-expert" position in which they were not exerting authority over their clients. They also valued and encouraged warmth and mutuality in their relationships with them. Although some therapists gave advice, they generally felt that advice-giving tended to violate their notions of equality and the subjective nature of treatment.

Postmodern therapy was characterized by the use of methods to keep the relationship between the therapist and client egalitarian, open-ended, and mutually interactive or "constructive." Techniques such as bracketing, self disclosure, use of the narrative method, and circular questioning were directed toward those goals. Postmodern therapists tended to be flexible on hours, length of sessions, and use of given or surnames, although none followed the implications of postmodernism to call the clients by their surname and themselves by their given name. Fee structures were a source of varied

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

responses, with many indicating little flexibility, while a few thought that fees should be based on ability to pay or should be free in some cases.

Finally, postmodernism has raised many questions about ethical issues in treatment. Because of it's emphasis on decentered truth and a flexible standard of morality, postmodernism implies that any judgements are inherently flawed by political and social influences. Some respondents were against making any kind of judgments, and some believed that the tenets of social constructionism and constructivism did not preclude taking a moral stand. Most wanted to find a both-and position that included a vision of social justice with a belief in the relative nature of morality.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Chapter VI

CONCLUSION, IMPLICATIONS, AND RECOMMENDATIONS

There has been much speculation and debate in the literature about how the postmodern philosophical movement, which includes social constructionism, constructivism, and intersubjectivity, among others, fits in with the goals of clinical social work. While theoretical discussions abound, it has not been clear how self-described postmodern clinical social workers have integrated these concepts into their practice. The purpose of this study has been to determine what the impact of postmodernism has been on the work of social work clinicians who have embraced it as a frame-of-reference for practice. Some other questions pursued in this study have included: What are the ways in which postmodernism differs from traditional social work clinical practice? How much have these practitioners changed their method of working, and how much have they remained true to their original theoretical orientation? It was, also, a consideration of this researcher to contribute to the ongoing dialogue and narrative in postmodern clinical social work.

In my literature search, I evaluated the few studies and investigations that pertained to postmodernism and its clinical implementation. What I found in the literature search was a surprising lack of specificity about what constituted postmodern practice in the clinical setting. Previous studies of constructivist and social constructionist practice

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

had not contributed to a better understanding of what postmodern practice entailed and how it had been experienced as different from previous practice. Some of these studies used questionnaires and the Delphi method to determine concurrence of thought among clinicians(Levine, 1994; Holland, Gallant, & Colosetti, 1994; Stone, Fisch & Piercy, 1987). Furthermore, many practitioners were unclear about what different concepts, such as constructivism, meant and how to incorporate them into their actual work. It was my intention to enter the world of self-identified postmodern practitioners via a qualitative study that looked beyond the surface(Light, Jr., 1983) at the deep structure of clinical practice as it was engaged in by postmodernists with the purpose of creating a thematic profile of the parameters and textures of such work. Qualitative methods allowed for delving more deeply into the work of these clinicians, because it involved an emphasis on theory and paradigm formation, as well as embodied a poststructural emphasis on the person being interviewed and the co-construction of meaning(Denzin & Lincoln, 1994).

SUMMARY OF THE FINDINGS

Thinking About Practice

The first chapter looked at what led the clinicians interviewed to consider postmodern ideas, how these ideas had influenced their view of truth, certainty, and context--central tenets of postmodernism, the way that they used or rejected theory, their transformed use of language and conversation, and how they saw themselves and others. It is important to note that this chapter reflected what the respondents thought about

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

practice-- not what they actually did.

The practitioners showed great interest in discussing the influences that had led them to postmodernism. Among these were the new epistemologies of constructivism and social constructionism; the negative and positive influences of psychoanalysis; the impact of cognitive theory and therapy; the work of Milton Erickson, Michael White, and the people associated with the Mental Research Institute(MRI); as well as their interest in issues of social justice and eastern philosophy. It was generally agreed upon that the idea of context was an important consideration for practice and that there was no one truth or objective vision of reality. Based on a belief in multiple realities and multiple truths, these clinicians agreed that certainty was often not helpful in the clinical setting and that taking a more collaborative, uncertain view might be more helpful to clients. Many of the people interviewed were committed to leaving themselves open to the possibility of chaos and tried not to impose premature closure on their understanding of the people with whom they worked in treatment. The most important shift in terms of their thinking was that reality was co-created and constantly evolving.

In discussing their use of theory, the respondents, for the most part, adopted a crystallized, multifaceted view of theory that included many theories but eluded identification with one theoretical system. Some people refused to consider any theories, and some leaned toward intersubjectivity or standpoint theory. Based on the belief that one does not have to be rational or consistent, most subscribed to a "both/and" position that allowed for multiple positions that could, at times, be contradictory.

From this chaotic position, where theory took on a diminished role, language took

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

on a more prominent role for these clinicians. They believed that reality was " languaged" in that it was determined by how language was used. For them, social structure, meaning, and value was embedded in language. Via consciousness raising, a therapist could become aware of some of the oppressive aspects of clinical language and avoid falling into habitual patterns of using language as a means of social control, such as terms about pathology, without thinking about it first. Another pitfall of language, according to these respondents, was its tendency to divide and separate subject from object, therapist from client, diagnoser from diagnosed. If hierarchical dividing practices were eliminated from the treatment situation, then it was suggested that the tone of a session would take on an informal note. It would become more of a conversation. Many people believed that a co-evolutionary relationship emerged out of discussion and conversation, that an emphasis on narrative in the conversational sphere could lead to interpretive change and become the springboard for positive outcome.

Finally most of these practitioners saw themselves and their clients as having multiple identities and multiple facets to their personalities, which no longer took on a cohesive structure. Several of them described the self as fluid and changeable, according to who they were with at the moment, as well as who they were with in the past. Almost all agreed that identity, which is the way one is portrayed to the outside world, was equally fluid and changeable. They did not want their own or their clients' identities to be fixed or constrained by the expectation of consistency.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Doing Practice

The chapter on practice focussed on how these clinicians translated the foregoing ideas into their clinical work. It started with an exploration of how they envisioned diagnosis, pathology, and assessment. Next, their concept of mental health and the goal of treatment were discussed as a foundation for an examination of clinical techniques, which included an evaluation of the role of the therapist from a postmodern perspective and how the traditional ideas of transference and countertransference have been influenced by postmodern approaches to practice. There was a discussion of the logistics of time, fees, and names and, finally, a brief discussion of the ethical considerations engendered by this approach.

Most of the clinicians interviewed took a "both/and" approach to diagnosis. Although they were against the use of diagnosis as a way of controlling or dividing people, they admitted to having to use diagnosis in their work. They approached this challenge in a variety of ways: Several people mentioned that they wrote down a diagnosis but didn't take it seriously; Some would ask clients to pick their own diagnoses, and; some would tell the client what their diagnosis was but want to discuss it further in a collaborative manner. There was, nevertheless, a shared awareness that diagnosis says as much about the person making the diagnosis as about the person being diagnosed. Since postmodernists believe that reality is co-created, they mentioned that they were more cognizant of the social and political contributions to diagnostic factors and that they were aware that a person could have a diagnosis that differed according to who they were with at the moment. The discussion of diagnosis led to questions about assessment and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

whether it was necessary. Few people threw out assessment all together--although some did--but most questioned the usefulness of making an initial diagnosis based on pathology and symptomatology. Some were more interested in relationships, and some were more interested in tasks as a means of assessing problems. Many questioned whether assessment was possible based on the subjective aspect of the treatment setting.

Unlike their fairly unified idea about assessment being somewhat outmoded, respondents were more variable in their ideas about pathology. Despite their attempts to be unjudgemental, they often felt justified in expressing extremely critical opinions of child abusers, wife beaters, and criminals. Although they acknowledged that pathologyzing behavior could have demoralizing effects on clients, they didn't restrain themselves from using pejorative terms, and they didn't apologize for it.

Their use of pathologizing terminology was variable, however. Many were interested in how postmodern ideas played out in regard to the Borderline Personality Disorder diagnosis. Several people mentioned how the diagnosis seemed to be related to social factors and not to anything intrinsic about the person. They wondered if their own feelings about the client could be a factor in how he or she was diagnosed.

Despite their ideas about the relativity of diagnosis, many of the respondents had a fixed notion about the nature of mental health and illness. Viewing health and pathology through a postmodern lens leads to the view that people interact with the world according to their own view of reality and the realities that other people have created for them. For many of these clinicians, however, their ideas about the outcome of treatment were directly related to their own values and goals. Although they did not make traditional

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

pronouncements about the nature of cure, they conveyed a firm notion of their own criteria--one person referred to it as an "aesthetic"--rather than the client's. This was manifested in therapists' deciding when it seemed right for therapy to end. Nevertheless, it can be said that they had all become more meaning oriented in their work and much less focussed on traditional categories of pathology or illness. For some, the goal of treatment was the relationship itself rather than the relationship's being a vehicle to promote change(Perlman, 1979). Taking the more traditional view one step further, some practitioners believed that it was through the co-creation of meaning within the relationship that the client's reality was restructured, "the narrative construction of the possible," mentioned in the literature section. .

One of the questions raised in the study was whether the shift away from a medicalizing, reductionistic view of people-in-treatment would lead to a more evolutionary, holistic view of the therapist's style of treatment. Since most postmodernists believed that the therapist was not a separate agent of change, it would be interesting to see how this played out in the way they conceived of their role. Although in many cases, it was a natural outgrowth of self-development over time and not a result of abrupt theoretical change, the people interviewed had become much less hierarchical in their role with clients. They adopted a curiosity-driven, nonexpert stance in which they asked a lot of questions and were not afraid to appear ignorant. As a result of this more intimate, subjective relationship with the client, they experienced feelings of mutuality and closeness that they had not allowed themselves to experience before.

Nevertheless, some considered it acceptable to give advice or admonish clients

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

when they were involved in dangerous behavior. They would often take over and exert firm limits when physical safety was compromised. This contradictory behavior did not seem to create a conflict for them, although several clinicians noted that they would never give advice or be directive. It was not clear whether this behavior represented a lack of integration of postmodern ideas or whether it fit in with postmodern notions of irrationality and lack of consistency, such as the "both/and" position.

Despite postmodernism's belief in the blurring of professional boundaries, there were clear distinctions in the study between family and individual therapists. Each seemed to be speaking a different language when it came to actual practice. The techniques of circular questioning, bracketing, and narrative therapy were the contribution of the family therapists. Intersubjectivity and co-transference were the contributions of individual therapists. Although each group was aware of the other, there seemed to be little overlap in technique with the exception of technical issues around self-disclosure and political and gender issues in the treatment setting. The themes that emerged around technical issues were a shared trend toward focussing more on meaning than on behavioral outcome, a tendency to be more open and self-disclosing, and a de-professionalized stance.

In the area of practice logistics, there was a lot of variability in the actual structure of the practice situation. Few people were thoughtful or philosophical about the use of names, for example, and many adopted a more traditional approach, such as calling the patient and themselves by their last names. This seemed to reflect an identification with an earlier model of practice. Times of sessions varied greatly as well as length of treatment. Some people believed that the client, not the therapist, should determine the amount and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

time of treatment. Others felt that time and length of treatment should be collaboratively decided. There were, nevertheless, some people who continued a traditional model of practice, with strict times set aside for treatment and between sessions. Several of these people were constrained by the demands and parameters of agency practice. The traditional model of practice was most evident in the discussion of fees. In this area, clinicians were most likely to charge higher fees than clinicians in general. This may have been related to the fact that several of the people interviewed were master practitioners with some degree of fame and many years of experience.

Finally, the discussion of ethics had an equally variable response. This has been the area of most controversy about postmodernism from all different arenas. A frequent comment by people opposed to these ideas is that constructivism and social constructionism imply a value-free response that precludes taking a stand for social justice. The people interviewed reflected this controversy: Some were opposed to taking an ethical stand about anything, and some were able to integrate a strong stand for social justice in a "both/and" position.

DISCUSSION

The purpose of this study was to look at the ways in which self-identified, experienced clinical social workers have been affected by postmodernism. Although the emphasis was on theory in practice versus theory in use(Argyris & Schon, 1974), it was equally important to look at how clinicians thought about or approached practice as to

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

understand how they carried out the actual work. Because postmodernism is a relatively new intellectual movement in the social sciences, its full impact cannot be measured until it has been further integrated into the practice literature, into social work teaching, and into the work itself.

Perceptual Shift

One of the questions raised in this study has been: Does postmodernism, as reflected in the work of these practitioners, represent a departure from traditional clinical social work practice? The answer is that one specific facet of postmodernism-- its view of how reality is created rather than discovered-- does differ radically from the traditional model of practice. In several other ways, it may not be so different. The view that we create our own world in concert with others is a major perceptual shift.

These clinicians reflected that change when they discussed their view of transference and diagnosis as co-created, and when they made their own biases known to clients via bracketing and self-disclosure. This demonstrated a contrast to the traditional model of practice in which a person's problems and self-presentation were seen only as the result of who that person was and what his or her life experiences had been. Traditional therapists, such as psychoanalysts, for example, often took the position that reactions to the treatment provider were based either on unconscious aspects of experience or on the resistance of the "patient" to solving his problem-- not on conscious or "real" characteristics of the clinician. This meant that they often refuted the notion that the clinician's personality style or thoughts had an impact on how the person-in-treatment

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

acted in the session. Furthermore, responses to the practitioner were often portrayed as distorted responses that would change if the inner dynamics of the person were clarified and dismantled via interpretation. Although the concept of countertransference was an attempt to address this issue, it focussed only on the unspoken responses--both unconscious and conscious--of the provider to the person-in-treatment. It provided an explanation for why there might have been treatment impasses, because of the unconscious conflicts of the therapist, who might have thwarted the treatment user's progress. It did not include an understanding of how the thoughts of the clinician might determine the dynamics of the person-in-treatment or that person's behavior in the session. DeShazer(1984) contended that prior ideas about resistance in treatment reflected the shared belief that if people did not get better, it was because they didn't want to, on some unconscious level, rather than that the treatment provider had not figured out what the person really wanted.

The awareness that a therapist is not only a part of the equation, but a creator of it at the same time, represents a dramatic change in perception. Postmodern clinicians believe that they contribute their own biases, personalities, perceptions, and influences to what they observe, and that they can share some of these thoughts or biases with the people they treat.. They believe that reality is mutually or co-created in the therapy session itself. Thus, what one is seeing in the clinical situation, such as a person with a personality disorder, may be a person who is mutually interacting with the therapist in such a way as to produce that effect. If the therapist or the person being treated were to change their perception, the dynamic would change. One could say that if the therapist, for example,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

were to change their opinion of the diagnosis, the person being treated might change.

This is a significant departure from the prior clinical social work model of neutrality, objective reality, and search for truth. Gergen(1993) agrees that some revolutions, like this one, take place without much fanfare, with little excitement or speeches, just a simple shift in perspective, "a new way of seeing what has always been there"(p.103).

Back to Basics

In other ways, which represent an ironic shift back to social work basics, postmodern clinical social work seems to resemble a more generic view of traditional social work, with its emphasis on integrating and understanding psychosocial factors and a concern for the impact of the environment and political climate on the problems of people-in-treatment. Several people mentioned that they had come to postmodern ideas as a way of re-integrating their original interest in social movements that predated their becoming clinicians. Others admitted that postmodernism reminded them of "brown shoe" social work, the more passionately involved, politically-sensitive model, perhaps mythologized, of early social work practitioners. This is significant in a number of ways: Because of a certain cultural bias related to the degraded social status of the social work profession, many practitioners had dis-identified with their roots in the social work discipline. In taking on a more traditionally recognized, higher-status role as a clinician, and identifying themselves as therapists, not social workers, they diverged from the more holistic model taught in social work schools. The clinical social work role, which is based on the role

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

that psychologists and psychiatrists have often occupied, has always been portrayed as more conservative and objectively distant from people-in-treatment. It was only after learning about the postmodernist emphasis on the social construction of meaning and the depolititization of hierarchical relationships that they returned to, or admitted to, practicing a more politically inclusive method of treatment.

Early social work literature was a testimonial to the inclusive, holistic nature of the profession. In her text on practice, Hamilton(1940) stated, for example, that the ethic of social work was founded on two principles :

> First, the human event consists of person and situation, or subjective and objective reality, which constantly interact, and the second is that the characteristic method of social work incorporates within its processes both scientific knowledge and social value in order to achieve its ends(p.1)

Although a strong proponent of the benefits of diagnosis, Hollis(1964) contended that a person could be known only by the "person-situation gestalt"(p.161). Both of these venerable contributors to social work theory demonstrated a profound awareness of the importance of outside factors in determining present reality.

Another important early contributor to social work practice, Garrett(1942) contended that there was no way to separate objective and subjective reality when it pertained to understanding how a client experienced his or her problems. Referring to the "rich interplay of one human mind with another"(p.5), she stressed the importance of subjective knowledge and the emotional involvement of the interviewer. This contrasted with the icy professionalism prescribed by the medical community at the time she was writing about the interviewing process. .

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The implications for postmodern practice are that it bears a striking resemblance to early social work practice, with the exception of its belief in the benefits of the psychodynamic, ego-oriented model and its emphasis on diagnosis. Similarities do not mean complete concurrence; but the tendency to incorporate social and political values into clinical work seems to reflect aspects of the postmodern critique that refute the existence of progress or real change. It speaks to the postmodernist idea that knowledge that is socially undervalued can be lost or subjugated(Foucault, 1980) unless it is socially resurrected. Thus, early social work practitioners, such as Florence Hollis(1940), Annette Garrett(1942) and Gordon Hamilton(1940), among others, contributed a necessary critique to the medical model of social work practice that overvalued objective diagnosis and assessment. They believed that context and relationship were essential components of clinical practice as well as professional style.

Thus, the postmodern critique would say that previously rejected elements of social work theory have been relabeled and revalued because of an intellectual movement and a social climate that has given them prominence. Gorman(1993) concurs that intuition, compassion, and wisdom are the buried treasures that social workers have "always had to offer"(p.248). Postmodern thought is a way of legitimating this indigenous way of knowing and being.

Mirroring

Another example of the legitimating function of postmodern theory has been the finding that postmodern theory reflected respondents' practices as they had already

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

evolved. It acted more as a mirror that articulated, in sharper focus, ideas that had already been operating as practice wisdom. Several people noted that they had been thinking these things all along and that their practice had begun to reflect a more informal, subjective stance toward clients. Social constructionism, intersubjectivity, and constructivism merely presented their ideas about practice in a structured, intellectually-coherent way. It was a relief for many of these clinicians to discover that there were theories that supported their normal way of practicing, which had been hidden. They were referred to as "the dirty little secrets" of practice.

Proletarianization and Postmodernism

As social work has become more debased as a craft(Fabricant, 1985), and the impact of managed-care and overarching systems for accountability has led toward the proletarianization of the social work profession in general, postmodern clinical social workers have raised the banner of a less mechanized practice with a more artistic, intuitive approach. A reaction or backlash to the increasingly constraining, short-term model of practice dictated by managed care, postmodernism supplies a badly needed palliative for "burnt-out" and harried clinicians. Although one respondent called it "fiddling while Rome burns," others saw it as a necessary contrast to the overly rigidified standards of HMOs and managed-care overseers. People were enchanted with these new ideas and felt that they had "liberating" potential, because they were a flight from the Tayloresque, industrialized notions of the managed-care initiative.

Taylor(Morgan, 1986) contended, for example, that managers should do all the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

planning and thinking related to how the work was designed. It was up to the workers to carry out the plan without thinking much about it. This was based on a scientific method that was used to determine the most efficient manner in which to tackle the task at hand. Then a worker was selected to implement the plan. This is very similar to the ways in which people-in-treatment are seen by managed-care companies. The case managers of a managed-care company utilize a national standard of care that determines the length and method of treatment best suited to a diagnosis. This is based on a scientific method of determining most efficient treatment for a particular diagnostic category. Then the worker(clinician) carries out the implementation of the plan.

What is demoralizing for clinical social workers who must carry out these treatment objectives is that little is left up to the practitioner. Individualized interventions and treatment decisions that are based on the specific needs of people-in-treatment have been eliminated in favor of more standardized units of care. Managed-care, which has been referred to as "managed-cost," leads to a mechanized, inflexible service that often does not meet the needs of people seeking help.

On the other hand, postmodernism, with its emphasis on fluid boundaries and intersubjective understanding is the antithesis of mechanization and modernism. A postmodern ethic of care refutes overcategorization of patients' complaints and values the specificity of each person's concerns. A welcome relief to the overstratified mandates of managed-care, postmodernism, nevertheless, runs the risk of being co-opted by it. Because of political and economic pressures to limit treatment length, postmodern clinicians may be forced to violate their own ethical standards by trimming treatment to fit

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

in with third-party payers' requirements. Under the guise of brief or solution-focussed therapy, postmodern clinicians may become purveyors of cost-control not care.

Both/And

For many of the clinicians interviewed, it seemed that postmodernism represented an evolutionary change rather than an abrupt realization and shift in practice. The ubiquitous appearance of the "both/and" position as a method for resolving the many contradictions inherent in this model may have represented the difficulty that people had in making a complete transition to a social constructionist or constructivist approach to practice. Some examples of these contradictions included the use of advice giving, resorting to pathological labeling of people who committed crimes, and the traditional manner in which people conducted their practices when it came to fee setting.

If postmodern clinicians are using a both/and view, it may be because they are still viewing the clinical setting through a Newtonian, mechanistic lens. One of the ways to understand this is from a perspective of logical levels of abstraction. As postmodern therapists continue to view new ideas through the lens of their original paradigm, they may be selecting alternatives from the same class of logical types. This is more like first-order change and a way of maintaining an equilibrium(Levine, 1994). As they continue to experience a shift in their awareness and practice to a more holistic model, these new ideas may be filtered through a new lens and, thus, understood differently. Once a lens has shifted, new information can be considered meaningful and will be processed differently. As this happens, postmodern clinicians may be able to choose from an expanded range of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

options for practice. Thus, according to ideas about the co-creation of meaning and paradigms, these therapists will develop their practice via an interactive feedback loop(Schon, 1983) that will create a new way of practicing. Dean(1994) contends that because clinical practice evolves over time, experienced clinicians will be able to reflect on their own work:

> Clinicians' reflections on clinical work would be different in the middle of a clinical encounter, if we could stop the action, from reflections occurring days, months, and years later, because ideas about practice shift, according to clinicians' interests, studies, readings, experiences, and contexts (p.283).

Nevertheless, the "both/and" position, which is supported by the belief in an irrational universe with an inconsistent nature, may play an important psychological role for these practitioners. It provides a solution to a number of difficult situations that could not otherwise be resolved. Looked at from a Freudian, structural perspective, it provides the incentive to relieve superego guilt and anxiety by giving inherent permission to be contradictory and disloyal to any one point of view. It removes the superego demand, based on the internalization of the patriarchal, categorizing ideal, to always be consistent. Looked at from a narrative perspective, it enables clinicians to free themselves from a previously constraining and oppressive discourse about coherence and rationality and opens up the possibility of being able to express themselves more fully. Postmodern clinical theory espouses the idea that psychological problems are often the result of constraining discourses that limit the expression of multiple ideas and multiple selves. The both/and position would allow, for example, a clinician in an agency setting to write a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

treatment assessment in a chart for accountability purposes but concomitantly ignore the conclusions of the assessment by focussing more on developing a relationship with the person-in-treatment in a more collaborative way. Another example of the "both/and"position would be for a therapist to maintain a postmodern practice style, such as disclosing one's biases to a client, while at the same time maintaining a strict adherence to time limitations in the session.

Advice and Constraint

The both/and position was most evident in certain in-session behaviors that respondents described in which they made strong pronouncements about behavior, gave advice, and imposed limits. In such cases, it seemed that the clinicians were acting more as agents of social control than agents for change or help. This may say less about the limitations of postmodern therapy than about the conflicting narratives of clients and therapists in the larger social context. According to Efran and Clarfield(1993) none of these therapeutic methods are contrary to postmodern theory. They contend that giving advice, arguing, and taking a stand are not anti-constructionist in any way. Envisioning postmodernism as a context within which therapy is contracted, they do not believe that it requires a prescribed regimen of "therapeutic" behaviors. Nevertheless, it would be interesting to see how such behaviors might change as the clinicians become more experienced in integrating postmodern thinking and techniques.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Speaking About Language

For these clinicians, social structure and meaning were embedded in language--yet their practice did not always reflect this belief. Often citing the role of language and conversation as transformative, they were not aware of--nor had they give much thought to--the language they used to negotiate the clinical contract, such as fees, and treatment plans. Although they disputed the validity of diagnosis, they did not discard it completely. Even those who said that they had abandoned the practice of diagnosing used medical terminology and followed practices that mimicked the medical-treatment situation, such as "acting like a doctor" in making pronouncements about the nature of the problem or the solution. This may again reflect the way in which postmodernism has been filtered through a first-order lens and has not been fully integrated into practice. The element of co-optation and incorporation into the larger social sphere may account for some of this. Clinical social workers operate in a larger system that values consistency, rewards the use of the medical lexicon, and promotes tightly-structured practice. Postmodernism suggests that problems are circular and that definitions in and of themselves may create problems. Gergen(1993), for example, blames the use of clinical language on the "scientizing" of human behavior in the modern era. It is the physicians who have generated a technical vocabulary that focusses on personal deficits. This language is then disseminated to the public who become "conscious" of the issue, thus engendering further perceptions of illness, "in a continuous spiral of infirmity (p.15)." Although postmodernism suggests that it is the use of medicalizing language that creates many of the problems that the general public faces, postmodern clinicians have not found a way around this dilemma. They still

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

operate within the medical-model system and are subsumed by it. One respondent suggested that this was not so bad, because language and practice need to fit into the present "cultural context for practice." A proponent of the both/and view, she believed that one needs to make sense out of culture, not operate outside of it.

Politics and Power

One of the knottiest questions of postmodern clinical practice is the proviso that the therapist should divest oneself of power and equalize the clinical setting. This seemed an almost impossible goal for practitioners, who most often took a both/and position of acting collaboratively at the same time as acting as an "expert" of change. This implies taking an objective role--outside agent of change--as well as a subjective one--collaborative partner. Although it was mentioned previously that postmodernism does not preclude both positions, but implies inclusivity of roles, it may speak to the inability of most clinicians to fully incorporate the postmodern practice ideal. It remains an unresolved question as to whether clinicians will change their practices over time, whether there will be an ongoing integration of these new ideas about practice, or whether the prevailing medical model will continue to dominate the clinical social work arena. Another question is whether it is possible for clinicians to continue to straddle the fence between a postmodern mode of practice and a medicalized one. Can a therapist act as though he or she has no power when the entire culture supports and defends that position, including calling psychotherapists of all disciplines into court as expert witnesses and using psychiatric diagnosis as a method of explaining the gamut of human behavior?.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The Relationship

Notions of decentered power and the non-expert position have had an impact on the role of the postmodern clinician. With the centrality of relationship to many forms of clinical social work, the question of how postmodernism affects the relationship between the therapist and the person-in-treatment becomes paramount. One of the most important implications of postmodernism for clinical social work practice, therefore, is its transformed view of the therapeutic relationship. Some of the ways in which the relationship is transformed include the following: When there are no underlying categories that determine action--when certainty is removed from the therapeutic dialogue-- what emerges is a therapeutic conversation. In the context of this conversation, meaning results from the relationship between the therapist and the person-in-treatment, and potential liberation results from letting go of the false split between practitioner and patient. This does not mean that all boundaries are summarily dissolved, but rather that a co-evolutionary relationship emerges out of discussion and conversation. Earlier, in the literature review, it was suggested that, viewed from a postmodern perspective, diagnosis and assessment may constitute a kind of backward mapping that emerges only after the relationship with the client has developed. Another implication is that inspired by postmodern ideas of mutual influence and interconnectedness, a clinical social worker can more readily use self-disclosure in both individual and family therapy, based on the belief that what he or she is thinking and feeling will inevitably produce an influence on the patient. Why not make the implicit explicit and reveal what will be known by the patient?

Another reason for self disclosing to the person-in-treatment is that it reduces the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

power differential and hierarchical relation that develops when one person in the relationship remains silent. This, according to Foucault(1980), speaks to the power relations that are often hidden in everyday discourse, in the quotidian things of life--and particularly in the structure of the therapy relationship. When one person is forced to talk and one remains veiled in secrecy, it suggests an obviously imbalanced situation meant to cast the silent one in the important position. Some respondents, for example, recommended that the power differential in the therapy relationship be transformed into a more egalitarian model of practice. Shifting the power arrangements in the therapy relationship has important implications for practice.

Presenting another new way of looking at the therapy relationship, intersubjectivity as a technique(Stolorow, Atwood, & Brandchaft, 1994) reveals that the person-in-treatment and the clinician influence one another, even if the therapist is unaware of how he or she is affecting the client. Since the countertransference or unconscious ideas of the therapist are not counter to the transference of the patient in this approach, some clinicians have referred to it as "co-transference." Saari(1993) points out that some clinical social workers, who are reluctant to use the term transference, because of its noninteractive nature, use the term "therapeutic use of the self"(p.10) to refer to the interactive process in casework. Unlike Pearlman(1979) who contended that the relationship was the context for treatment, Saari(1993) suggests that it may, also, be the goal

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

THEORETICAL IMPLICATIONS

The following section will review how postmodern clinical practice has been studied in the literature, compare the findings of this study with prior research, and discuss how this study compares with and adds to the existing knowledge base.

Argyris and Schon(1974) and Schon(1983, 1987) state that theories as we use them are fragmentary rather than comprehensive and "monolithic models." The fragments are incorporated into the clinician's personal and professional experience. It is this gestalt, according to Dean(1994), that creates the backdrop for a clinician's work--thus the interplay between theories that are espoused and theories that are used. Just as the problem definition changes over the course of clinical work(Anderson & Goolishian, 1988), a practitioners method of practice evolves over time. This is a context to understand the incorporation of postmodernism into these respondents' psychotherapy practice.

The preponderance of literature about postmodern clinical practice has been in the area of broad generalizations about the theoretical underpinnings of practice. Although there were several articles about the concept of postmodernism in social work (Gorman, 1993; Hartman, 1991; Pozatek, 1994), few translated this concept into a model of practice. The epistemologies of constructivism, social constructionism, and intersubjectivity have, also, been detailed in numerous theoretical studies. There were only three studies that investigated the effects of constructivism and social constructionism on actual practice (Holland, Gallant, & Colosetti, 1994; Levine, 1994; Stone Fish &

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Peircy, 1987), and none of these related to clinical social work or were qualitative in nature. Their studies involved family therapists of different disciplines. They found that, for the most part, a paradigmatic change took place in the realm of thinking about practice, but there was less significant change in the realm of actual practice. They found that therapists had become more "meaning oriented" (Levine, 1994) and less focused on the interviewing process. Some adopted a "both-and" position with regard to theoretical contradictions. The studies, also, highlighted the lack of clarity about the concepts and some confusion about their meaning.

Several writers, most notably DeShazer(1991) and White and Epston (1990), have written about aspects of postmodernism such as social constructionism and deconstructionism, while at the same time including clinical material in which it is possible to see the therapist's contributions. Nevertheless, their work seemed to focus only on the social constructionist aspects of postmodernism and not on its total vision, which includes a constructivist stance about health and illness. Their work is useful in drawing a picture of the postmodern practitioner *in vivo,* although they did not draw any conclusions and did not address issues of clinical social work.

The findings of this study supported some of the previous findings that postmodern practitioners had undergone a paradigmatic shift in thinking--that the world is created not discovered-- but less of a shift in practice principles and techniques. It demonstrated similarities with Levine's(1994) findings that practitioners were more meaning-oriented and more interested in a collaborative model of treatment. There was, also, concurrence with her finding that clinicians were apt to act directively and aggressively as agents of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

social control when a client's physical safety was at risk. These clinicians were similar to the earlier ones studied in that they adopted a "both/and" perspective in which they included both traditional and nonlinear approaches.

Some notable differences were that the therapists in this study reported having changed some in-session behaviors in accordance with postmodern theory. Techniques like bracketing and political questions were new additions to their repertoire of skills. The new concept of co-transference, based on intersubjectivity, represented a more experience-near method of addressing the transference and seemed to indicate that the therapists felt more subjective and less like outside observers of treatment. Another notable difference was that these clinical social work practitioners demonstrated an awareness of their return to an earlier ethic of practice that reflected social work's concern for mutuality, closeness, context, the personal, and the political. Clinicians in this study were more apt to use pejorative terminology when speaking about patients who acted aggressively, but were more likely to see diagnosis as a mutual creation in less highly charged scenarios.

The reason for some of the similarities with the previous studies, which just focussed on family therapists, may have been that postmodernists are a rarified group and tend to cluster in the family therapy arena. Although this study specifically focussed on social workers, many of the respondents fit into both camps--family therapy and social work. There were, also, several academicians in the study. These respondents were well schooled in both the family therapy and the individual therapy model, as well as aware of the history and ethics of social work practice.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The reason for some of the differences again harkens back to the sample, which included individual clinicians and specifically targeted clinical social workers. These clinicians were more likely to address issues of violence and criminal behavior in their work in the public sector, and, therefore, have a range of feelings about these issues. Some may have a reduced tolerance level for so-called "bad" behavior, and some may feel that social justice ethics and standpoint theory require a strong stand against wrong doing.

Because this was a qualitative study, it provided more of an opportunity to understand the experience of these clinicians. Another difference from the previous studies was that these respondents described some of their struggles with postmodern practice--the tendency to feel overwhelmed by many points of view, and their conflicts about becoming either too aggressive or too passive.

LIMITATIONS

There were several problems with the study that may have interfered with its goal of entering into the deep structure of postmodern therapy and eliciting more about the experiences of these clinicians. It seemed to stay on the surface despite the long interviews, and it did not yield enough hoped-for insights and contributions to practice. Furthermore, the small sample precluded any major generalizations about postmodern clinical social work. Following are some of the limitations noted:

1. It was difficult to understand exactly what went on in the actual treatment experience. People were unable to convey their method of practice clearly and often

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

referred to the work of another practitioner, such as Michael White, in order to describe what they did with patients. It was hard to pin them down in one interview, and it was hard to get them to trust the researcher enough for them to risk an open evaluation of their work.

In addition, no interview with a practitioner can substitute for the *in-vivo* experience of client and therapist in the treatment setting. Reports of practice must be inherently flawed in that they involve memories and are received through the intervening web of internal signals and associations of both interviewee and interviewer.

2. Another problem involved the accessibility of the subjects themselves. Since these were often full-time professors or full-time clinicians, they were very busy and unable, for the most part, to give longer interviews. They lived in distant places that were difficult to visit. Several of these respondents lived in Australia and Canada, for example.

3. There was a problem getting people who were affiliated with certain subgroups of the family therapy community to be interviewed, which was an unexpected problem. According to Lofland and Lofland(1995), this problem may have been the result of *factions* among the groups of people identified as postmodernist. Internal dissent, which is a universal in human settings, may have made it difficult to gain access to certain people. In addition, there were controversies and mistrusts between individual and family therapists, as well as systemic vs. nonsystemic therapists.

4. Another more obvious limitation of the study was the small, nonrandom sample that made it difficult to generalize from the results. The fact that the respondents were all clinical social workers or former clinical social workers may have led to a fairly unified

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

translation of postmodern ideas, because of their shared lexicon and context for practice that is common in professional disciplines..

5. A major sampling problem was that many(10) of the people interviewed were social work professors. This skewed the sample in expected and unexpected ways. It would be expected that these people were intellectual, aware of the issues, and able to expound on them. In some cases, they expounded too well without being able to ground the data and give substance to the ideas that they were expressing. This led to interviews where most of the conversation centered around the interplay of these new ideas and postulations about their effect on practice rather than actual descriptions of practice.

6. Because of the limited time to carry out this endeavor, the researcher's interviewing techniques did not improve rapidly enough to elicit the kinds of responses that would yield the most in-depth information. This would have entailed more probing of superficial answers and more emphasis on specific treatment

7. The original intention of the study to investigate only master practitioners was waylaid by a lack of available and appropriate respondents, as well as the observation by the researcher that people with less experience gave more information-rich and thoughtful interviews. The study evolved, therefore, to include respondents with only a few years of postmasters experience or little present clinical experience and a lot of knowledge about postmodernism. This led to some problems in their description of the integration of techniques into practice, because they had just entered practice or had stopped practicing and had little to say about how their practice had changed.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

8. Another limitation of the study is the fact that the thoughts of the people being treated with these techniques is reflected only in the language of the respondents. Because the essence of postmodernism is the interplay of one person with another, it seems that studying only the practitioners and not the people being treated presents an artificial dichotomy that is only one half of the treatment equation.

RECOMMENDATIONS FOR FURTHER RESEARCH

Because so much has been written in the academic arena about constructionism, intersubjectivity, and constructivism, it would be helpful to divide up these concepts and study each one separately as it has been translated into clinical work. The area of postmodern theory has expanded more rapidly than its integration into the practice research. Such a study would look into how practitioners understood the concept chosen and look closely at how it had affected their work

. In contrast, a quantitative study would be useful to investigate outcome from postmodern techniques. Single subject design or traditional methods using a large sample would illuminate whether these methods are objectively helpful. Until recently, there has been a dearth of research on these practice concepts. Practice research has focussed mostly on cognitive therapy and short-term therapy models, some of which are based on postmodern notions of solution and problem-focussed interventions.

Another study could examine the relationship between postmodern ideas and issues of physical safety and criminal behavior. In this study, respondents often set strong

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

limits and acted as agents of social control. Although some theorists disagree that such actions fly in the face of social constructionist principles(Efran & Clarfield, 1993), such a study would shed light on how therapists engage in their role within the context of the larger culture and its expectation of the role of the therapist.

A more general study could look at how clinicians' ideas about practice effect their work in general. In other words, it would sample clinicians from a variety of perspectives--behavioral, cognitive, postmodern, to name a few--in order to see how their theoretical orientations affect actual in-session behaviors. This would add to the dialogue about theory-in-practice vs. theory-in-use and contribute to further research by generating a larger theory that could be applied to individual research, such as the one reported here.

It has been a long standing interest of this researcher to study the people-in-treatment themselves from a qualitative perspective. A major obstacle to such research, which has been engaged in by this researcher on a small scale, has been getting the approval of the committee on human subject review and meeting the standards of confidentiality and lack of exploitation necessitated by such a study. It would generate a great deal of useful knowledge if people-in-treatment were studied to see how they have been affected by postmodern techniques and to see how they respond to an increased subjectivity in the treatment situation and de-emphasized professional stance of the therapist. This would contribute to the ongoing dialogue about postmodern process in the way that Schon(1987) recommends--providing an interactive feedback loop in which all participants learn from one another.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

IMPLICATIONS FOR CLINICAL SOCIAL WORK PRACTICE

There are several major challenges for clinical social workers in the postmodern age. Among them are how to address the problems of people-in-treatment who are trying to retain unitary identities that fit in with a societal model of gender, social and political coherence in a fragmentary, multimedia world that assaults notions of moral and individual consistency. Another is that the postmodern model of thinking and practicing presents a direct contrast to increasingly mechanized, economically-generated standards for treatment that ignore the complexity of people's life issues . Several of the people interviewed had contracts with managed-care companies, which imposed economic limits on their work, or directed managed-care entities, while at the same time maintaining a private practice. These people were adamant that managed-care, although not completely deriled by them, was driven only by notions of cost control, not the needs of subscribers. Thus, as managed-care has envisioned treatment as rational, containable, and limited, postmodernists have envisioned treatment as irrational, open-ended, and collaboratively directed. This has not been as much of a problem as it initially poses. In one sense, for example, some postmodern therapies can be said to have sprung up from this speeded-up demand of insurance providers. Several of the solution-focussed, problem-focussed, and brief therapies have been formulated on postmodern, constructivist and deconstructivist philosophies, but operate on the reduced therapy principle. Nevertheless, even practitioners of these therapy styles complain about the limitations of managed care and dispute its command that all people within a diagnostic category act the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

same, thus requiring a fixed amount of treatment.

Despite these constraints, clinical social workers are challenged to provide a form of treatment that must not repeat the constraints of the larger culture and its language systems. If language contributes to identity formation, as postmodernists contend, then clinical social workers must be vigilant about avoiding language that further crystallizes oppressive notions of pathology and illness--the medical model of treatment, decried by social workers since the early days of social work practice. The postmodern model forces practitioners to look at their own word choices when speaking to or about people-in-treatment. Name calling implies categorization and objectification. If postmodernism is a form of subjectivity and union, then psychotherapy--whenever possible--should mirror this by avoiding the dividing practices of diagnosis and prescription--although it could be questioned whether or not this can ever be completely avoided..

Of course, this presents an almost impossible, unattainable goal during a time of increasingly industrialized practice and time limitations. Perhaps the both/and position presents the best compromise because of its provision that "if you can't do it, think it." In other words, if therapists can't approximate their ideal vision of practice and have to resort to categorical, dividing practices, then they shouldn't take such practices seriously. They should work toward contributing to the larger narrative on an ongoing basis by disputing such notions and avoiding them as much as possible in their dialogue with the larger treatment community, and--when possible--they should make every attempt to avoid perpetrating practices that contrast with their own values.

Based on these principles, a postmodern code of ethics for clinical social work

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

practice would entail:

1. Look at knowledge as socially-constructed and variable. Therefore, it would be important for clinicians to avoid overvaluing or reifiying concepts and theories that have been taught in social work schools, postgraduate programs, or on-the-job training. This would include: family therapy training, which often appears to be on the cutting edge but changes rapidly as new ideas are integrated into its practice model; psychoanalytic training, which appears to have an interpretative focus, but which often contains fixed notions of internal structure; and, short-term therapy training, which exists in the context of the managed-care climate, which has an economic focus. Adhering to any fixed notions of mental health and treatment is contrary to the tenets of postmodernism, which values an idea of the flexible, contextual nature of truth and understanding.

This would lead to the awareness that diagnostic categories should be questioned. It is important to avoid being convinced about diagnostic entities that appear to have the veneer of truth but may be so contextually embedded in current thinking that their interactive components remain obscured. If clinical social workers share a lexicon and participate in a culture that values coherence, it is inevitable that diagnosis will take on the patina of a fixed reality for them. It is always better to look more closely at ones own contributions to the relationship aspects of diagnosis and to question whether societal ideas about appropriateness and treatment etiquette have entered into the formulation of a diagnosis.

2. Create a system for evaluating one's ongoing practice from a reflexive position in which one values the interactive feedback of people-in-treatment and incorporates that

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

feedback into an evolving method of treatment that is constantly responding to the intersubjective field.

3. Remember that ethical guidelines for treatment are contextually based and should be treated with the same standard of self-reflexivity and questioning that is reserved for looking at knowledge, diagnosis, and methods. Ethical standards change with time, and ideas of social justice may have embedded standards that privilege one group over another. The treatment of children and families involved in the foster care system, for example, have undergone rapidly cycling changes that may vary from year to year. At one time, parents of children who have been removed from home are seen as pathological and needing deep structural change in the form of psychoanalysis. At other times, such parents are seen as victims who must be counseled on how to re-unite their families, such as in the family preservation movement. Depending on the political climate, parents of children in foster care may be mandated to receive treatment or considered beyond the pale of treatment--with the stated goal of helping them adjust to the loss of their children. It is important for clinicians to remember that rules for ethical practice are often not determined by clinicians themselves but by accrediting bodies who may be responding to economic or political pressure. The challenge of postmodern practice is how to follow expected guidelines for professional practice and, at the same time, follow a reflexive standard of practice that values self-reflection, flexibility, and responsiveness to the definitions that people-in-treatment ascribe to their problems.

4. Share in the ongoing dialogue or narrative about treatment in the therapy community. Case conferences, staff meetings, telephone consultations with managed-care

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

companies, for example, are all opportunities to contribute a different perspective on truth, diagnosis, treatment, and problem formation.

5. In addition to looking closely at therapy practices, look closely at the economic parameters of treatment, such as fee arrangements. It is important to ask whether these aspects of treatment reflect a postmodern idea that individualizes and contextualizes the problems of people-in-treatment. If all therapy is not the same, why should all fee schedules remain the same? What is the place for free therapy in the postmodern world where economic conditions have become wildly divergent--with some people making stratospheric amounts money living in the same zip code with people who are living below the poverty level? An important question is to ask whether practice standards reflect a clinician's own ethics and values or the values of the overarching therapy community. What is the discourse about fees in that community? In some clinical settings, for example, the discourse is that a person undervalues him or herself if fees are too low. The nature of discourse is that it is mutually created by everyone in a culture. This contributes, therefore, to the discourse that people-in-treatment adopt, in that they may value only clinicians who charge higher fees. Because this argument is self-serving for the economic well being of clinicians it does not get subjected to the same kind of scrutiny that is applied to practice issues. Although this is a complicated issue that is impacted by economic considerations of competition, parity with other disciplines, and lifestyle issues, it demands closer investigation and a more flexible approach.

6. Think of postmodern clinical social work as fluid and flexible, open to new interpretations, and not given to rigid parameters of practice that need to be defended.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

7. Revise outmoded notions of the professional, objectified therapeutic stance in regard to the therapy relationship. Whenever possible, strive for an equal power differential in the treatment interaction. This may be the most difficult challenge for postmodern psychotherapists, who want to retain the power and privilege conferred by the medical-model of practice that values distance, not closeness, with people-in treatment.

In conclusion, postmodern clinical social workers can make an important contribution to the ongoing dialogue in the therapy community. They can critique certainty and rigid ideas about truth and reality. Bolstering their ideas with postmodern theoretical and philosophical arguments, they can present both themselves and their clients in a different light--the light of context and fluidity--to their colleagues. And they can use their practice to undo some of the negative influences that have affected people-in-treatment as well as to co-create new opportunities for change and self-acceptance.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX

Figure I

Initial Statement to Enlist Participation

My name is Anne Rosen Noran, and I am a doctoral student working on my dissertation at Hunter College School of Social Work. I am calling you (or speaking to you) to ask for your participation in a study of postmodernism and clinical social work. My study will look at how postmodernism gets translated into actual clinical work. Because of your publication on ....or your reputation as... a postmodernist and a clinician, I would be very interested in speaking to you in person in order to learn more about your ideas about clinical practice. Your identity will remain completely confidential. The study will involve my interviewing you in an open-ended way, and I will be able to meet you wherever you feel it would be most convenient for you. With your permission, I would like to tape record the interview. (Oral permission will be recorded on tape.)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Figure II

Letter to Potential Respondents

Dear :

I am working with a doctoral student who is interested in looking at the effects of postmodernism on clinical practice. Her work will make a contribution to understanding how practice and practitioners have changed, as well as provide a more grounded view of what actually happens in the postmodern clinical interaction. Her name is Anne Rosen Noran, and she would like to interview you at some future time that would be convenient for you. She will be following up this letter with a phone call. I hope that you will agree to speak with her or suggest someone else with whom she can speak.

Sincerely,

Florence Vigilante

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Figure III

Oral Consent to Begin Interview

I'm here to interview you about postmodernism and clinical social work. I am interested in the nature of your practice, such as what techniques you use and how you think about your work. The objective of my study is to discover what postmodernists actually do. Your identity will be kept completely confidential. With your permission, I will tape record our interview. (Permission was recorded but the name of the participant was not used during the interview. Names were coded for later use.)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Figure IV

Interview Guide

1. I'd like to begin by presenting you with some vignettes and ask you to respond to one or several. The purpose of the vignettes is to help us begin to discuss how you engage in practice, what you actually do and what your thoughts are about your work. Examples from your own clinical experience would be very helpful.

A. A psychiatrist in your community refers a young African- American woman to you. He has started her on antidepressant medication and thinks that therapy would be a useful adjunct to her treatment. He says that she is depressed. She says that she's not sure she's depressed but she gets angry a lot. She would like you to help her feel less angry. (Some prompts for this vignette include: How would you enter into this treatment? What is your formulation? What would you say to her?)

B. A managed-care company sends you a referral of a psychotic man who believes that his house is about to blow up. They tell you that you must treat him within twenty sessions.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

(Some prompts for this case include: What would you say to the insurance company about his diagnosis? How would you structure the treatment? What would you say to this person as you began treatment?)

C. A woman is referred to you by your local crisis center. She has been beaten by her husband but refuses to leave him, press charges, or stand up to him in any way. A Jehovah's Witness, she says that she wants help in becoming a better wife.
(Some prompts include: What do you think about the religious aspects of this case? Would you try to get her to take legal action? Would you continue to treat her if she refused to change in any way toward him?)

D. A heroin-addicted college professor finds your name in a directory. He says that he wants some help with his depression, but he will not under any circumstances seek help for his addiction.
(Some prompts include: Would you agree to treat him and why or why not? What do you think about his chief complaint? How would you proceed?)

2. I'd be interested in hearing other (if some offered earlier) vignettes from your clinical practice.
(Can you give me examples of actual dialogue, including your interventions? What was the outcome? How did the person-in-treatment respond?)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

3. How would you describe your method of clinical practice?

(Prompts include asking about different theoretical and philosophical bases, training experiences, people who have influenced practice, paradigmatic shifts, ideas about time of treatment, length of treatment, parameters in the clinical setting, relationship with people in treatment, self-disclosure, use of self in general)

4. If this is a change from your former orientation, how does that former orientation influence your practice now?

(Prompts include questions about changes in technique and degree or quality of change)

5. What does it feel like to be this kind of practitioner? Are there any tensions or conflicts that arise and, if so, how do you resolve them?

6. Can you describe your relationships with the people you treat?

(Can they call you by your first name? Who ends the session? Who decides the length of treatment? Who makes the rules in the treatment setting--you or the person in treatment? How are fees decided?)

7. How would you describe your ideas about mental health and illness?

(Does the practitioner use diagnoses, report diagnoses to managed-care companies, use diagnosis as a basis of treatment, see prognosis or even consider it as a variable? What

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

does the clinician believe constitutes change? What is their fondest hope for patients' well being or outcome? How does that fit in with societal norms?)

8. What do you think about the concept of the self and how does that effect your clinical work?

(Do you think people are genetically or societally programmed, do personalities change over time, is there a distinct self, do you think you have a distinct self that interacts with the client?)

9. What does the term postmodernism mean to you?

(Prompts include asking about personal definitions of constructivism, social constructionism, deconstruction, power relations, rationality vs. irrationality, multiplicity, inclusivity)

10. What do you think about the impact of postmodernism on clinical social work in general?

(Has the field changed? Has teaching of clinical practice changed and in what ways? What would you like to see?

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

BIBLIOGRAPHY

American Psychiatric Association(1980). *DSM-III.* Washington, DC: author.

American Psychiatric Association(1994). *DSM-IV.* Washington, DC: author.

Anderson, H. Goolishian, H. & Winderman, I..(1986). Problem determined systems: Towards transformation in family therapy. *Journal of Strategic and Systemic Therapies*, 5, 1-14.

Anderson, H. & Goolishian, H.(1987). Language systems and therapy: An evolving idea. *Journal of Psychotherapy*, 24, 529-538.

Anderson, H. & Goolishian, H.(1988). Human systems as linguistic systems: Preliminary and evolving idea about the implication for clinical theory. *Family Process*, 27, 371-391.

Anderson, H. & Goolishian, H.(1990). Beyond cybernetics: some comments on Atkinson and Heath's "Further thoughts on second-order family therapy." *Family Process,* 29, 157-163.

Anderson, H. & Goolishian, H.(1993). The client is the expert. In Sheila McNamee and Kenneth Gergen(Eds) *Therapy as Social Construction.* London: Sage.

Anderson, T.(1987). The reflecting team: Dialogue and meta dialogue in clinical work. *Family Process*, 26, 415-428.

Anderson, T.(1991). *The Reflecting Team*. New York: Norton.

Argyris, C.(1976). Theories of action that inhibit individual learning. *American Psychologist.* 31(9), 638-654.

Argyris, C. & Schon, D.(1974). *Theory in Practice*. San Francisco, CA: Jossey-Bass.

Atherton, C.(1993). Empiricists versus social constructionists: Time for a cease-fire. *Families in Society,* 74(10), 617-24.

Atwood, G. & Stolorow, R.(1984). *Structures of Subjectivity: Explorations in Psychoanalytic Phenomenology.* Hillsdale, N.J.: The Analytic Press.

Bateson, G.(1979). *Mind and Nature*. New York: Dutten.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Beck, A.T., Rush, A.J., Shaw, F.B. & Emery, G.(1979). *Cognitive Therapy for Depression*. New York: Guilford Press.

Benjamin, J.((1988). *The Bonds of Love: Psychoanalysis, Feminism and the Problem of Domination.* New York: Pantheon Books.

Bergin, A. & Garfield, S.(1994). *The Handbook of Psychotherapy and Behavior Change*. New York: John Wiley & Sons, 270-379.

Berlin, S.(1996). Constructivism and the environment: A cognitive-integrative perspective for social work practice. *Families in Society*.77(6), 326-336.

Berzoff, J.(1989). From separation to connection: Shifts in understanding women's development. *Affilia*, 4, 45-58.

Bograd, M.(1990). Scapegoating mothers: conceptual errors in systems formulations. In Mirkin(Ed.) *The Social and Political Contexts of Family Therapy*. New York: Allyn & Bacon.

Bohm, D.(1980). *Wholeness and the Implicate Order*. London: Routledge.

Bruner, J.S.(1986). *Actual Minds, Possible Worlds*. Cambridge, MA: Harvard University Press.

Bruner, J.S.(1990). *Acts of Meaning*. Cambridge, MA: Harvard University Press.

Burke, P. (1991). Identity Processes and Social Stress. *American Sociological Review*. Vol. 56 (December): 836-849.Cade, B. & O'Hanlon, W.H.(1993). *A Brief Guide to Brief Therapy*. New York: Norton.

Capra, F.(1982). *The Turning Point*. New York: Bantum Books.

Cecchin, G., Lane, G. & Wendel, R.(1993). From strategizing to nonintervention: Toward irreverence on systemic practice. *Journal of Marital and Family Therapy*, 19, 125-136.

Chambon, A.(1994). Postmodernity and social work discourse(s): Notes on the changing language of a profession. In *Essays on Postmodernism and Social Work*. Toronto: Canadian Scholars Press, 63-72.

Chambon, A. & Irving, A.(1994). *Essays on Postmodernism and Social Work*. Toronto: Canadian Scholars Press.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Coleman, D.(1996). Positive sibling transference: Theoretical and clinical dimensions. *Clinical Social Work Journal.* 24(4),377-389.

Cutler, C.(1991). Deconstructing the *DSM-III. Social Work.* 36(2), 154-157.

deGeorge, R. & deGeorge, F.(Eds.)(1972). *The Structuralists from Marx to Levi-Strauss.* Garden City, N.Y.: Anchor Books.

Dean, R.G.(1992). Teaching clinical theory and practice through a constructivist lens. *Journal of Teaching in Social Work,* 6(1), 2-20.

Dean, R.G.(1993). Revisioning social work education: A social constructionist approach. *Journal of Teaching in Social Work,* 8(½), 55-77.

Dean, R.G.(1994). Commentary: a practitioner's perspective on qualitative case evaluation methods. In Sherman, E. & Reid,W.(Eds.) *Qualitative Research in Social Work.* New York: Columbia University Press.

Dell, P.(1982). Beyond homeostasis: Toward a concept of coherence. *Family Process,* 21, 21-42.

Denzin, N.K. & Lincoln, Y.S.(1994). Introduction. *Handbook of Qualitative Research.* Thousand Oaks, CA: Sage.

Derrida, J.(1976) *Of Grammatology,* tr. G.C. Spivak. Baltimore, MD:Johns Hopkins University Press.

Derrida, J.(1978). *Writing and Difference,* tr. A. Bass. Chicago: University of Chicago Press.

DeShazer, S.(1982). *Patterns of Brief Family Therapy: An Ecosystemic Perspective.* New York: Guilford.

DeShazer, D.(1985). *Keys to Solution in Brief Therapy.* New York: Norton.

DeShazer, S.(1984). The death of resistance. *Family Process.* 23(1), 11-17.

DeShazer, S.(1991). *Putting Difference to Work.* New York: Norton.

DeShazer, S.(1994). *Words Were Originally Magic.* New York: Norton.

Deutsch, D.(1997). *The Science of Parallel Universes—and Its Implications.* New York: Allen Lane/The Penguin Press.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

DSM IV(1994). The American Psychiatric Association.

DSM IIIR(1993). The American Psychiatric Association.

Efran, J. & Lukens, M.(1985). The world according to Humberto Maturana. *Family Therapy Networker*, 9, 22-28.

Efran, J. & Clarfield , Leslie, E. (1993). Constructionist therapy: sense and nonsense. In Sheila McNamee and Kenneth J. Gergen (Eds). *Therapy as Social Construction.* Newbury Park: Sage.

Elkam, M.(1990). *If You Love Me, You Don't Love Me*. New York: Basic Books.

Englehardt, T.(1994). The morphing of the american mind. *The New York Times.* December 24, Op-Ed, 25.

Epston, D.(1993). Internalized other questioning with couples: The New Zealand version. In Stephen Gilligan and Reese Price. *Therapeutic* Conversations. New York:Norton.

Erickson, M.H.(1975). Foreword. In R. Bandler and J. Grinder. *Patterns of the Hypnotic Techniques of Milton Erickson, M.D.*.Cupertino: Meta Publications.

Estes, C.P.(1992). *Women Who Run With the Wolves.* New York: Balantine Books.

Fabrega, H.Jr. & Silver, D.B.(1973). *Illness and Shamanistic Curing in Zinacantan: an Ethnomedical Analysis.* Stanford: Stanford University Press.

Fabricant, M.(1985). The industrialization of social work practice. *Social Work.* 30(5), p. 389-395.

Finkielkraut, A.(1995). *The Defeat of the Mind.* New York: Columbia University Press.

Fish, V.(1993). Poststructuralism in family therapy: Interrogating the narrative/conversational mode. *Journal of Marital and Family Therapy.* 19(3), July, 221-231.

Flax, J.(1990). *Thinking Fragments: Psychoanalysis, Feminism, & Postmodernism in the Contemporary West.* Berkeley, CA: University of California Press.

Foerster, H. Von(1985). Apropos epistemologies. *Family Process.* 24:517-521.

Foucault, M.(1978). *The History of Sexuality.* New York: Random House.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Foucault, M.(1980). *Power/Knowledge*. New York: Pantheon.

Foucault,M.(1982). The subject and power. In H.Dreyful & P. Rabinow(eds.) *Michel Foucault: Beyond Structuralism and Hermeneutics*. Chicago:University of Chicago Press.

Freire, P.(1982). *Pedagogy of the Oppressed.* New York: Continuum.

Garfield, S. & Bergin, A.(1986). *The Handbook of Psychotherapy and Behavior Change*. New York: John Wiley & Sons.

Garrett, A.(1942). *Interviewing.* New York: Family Service Association of America.-

Geertz, C. (1983). *Local Knowledge.* New York: Basic Books.

Gergen, K.(1985). The social constructionist movement in modern psychology. *American Psychologist*, 40, 266-275.

Gergen, K.(1991). *The Saturated Self.* New York: Basic Books.

Gergen, K. & McNamee, S.(1993). eds. *Therapy as Social Construction*. Newbury Park, CA: Sage.

Germain, C. & Gitterman, A.(1986). The life model approach to social work practice revisited. In Francis Turner(Ed.). *Social Work Treatment: Interlocking Theoretical Approaches* (3rd. edition), 618-643. San Francisco: Jossey-Bass.

Gilligan, C.(1982). *In a Different voice: Psychological Theory and Women's Development*. Cambridge, MA: Harvard University Press.

Gilligan, S.(1987). *Therapeutic Trances: the Cooperation Principle in Ericksonian Hypnotherapy.* New York: Bruner Mazel.

Glaser, B.G. & Strauss, A.L.(1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research.* Chicago: Aldine.

Glace, J.(1987). *Chaos: Making a New Science.* New York: Penguin Books.

Glace, J.(1987). *Chaos: Making a new science*. New York: Penguin Books.

Golann, S.(1987). On description of family therapy. *Family Process*, 26, 331-340.

Golumb, L.(1986). Rivalry and diversity among Thai.. curer-magicians. *Social Science*

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

and Medicine. 22(6),691-697.

Goldstein, E.(1994). Self-disclosure in treatment: What therapist do and don't talk about. *Clinical Social Work Journal*. 22(4), Winter, 417-435.

Goldstein, E.(1997). To tell or not to tell: the disclosure of events in the therapist's life to the patient. *Clinical Social Work Journal*. 25(1), Spring, 41-59.

Goldstein, H.(1990). The knowledge base of social work practice: Theory, wisdom, analogue, or art? *Families in Society: The Journal of Contemporary Human Services*, 21, 32-43.

Goldstein, H.(1993). Field education for reflective practice: A re-constructive proposal. *Journal of Teaching in Social Work*. 8(½),165-183.

Goolishian, H. & Anderson, H.(1992). Strategy and intervention versus nonintervention: A matter of theory? *Journal of Marital and Family Therapy*, 18, 5-15.

Gorman, J.(1993). Postmodernism and the conduct of inquiry in social work. *Affilia*, 8(3), fall, 247-264.

Greene, J.G., Jensen, C., Harper Jones, D.(1996). A constructivist perspective on clinical social work practice with ethnically diverse clients. *Social Work. 41(2)*, March, 121-240.

Habermas, J.(1971). *Knowledge and Human Interests*.(tr. Jeremy J.Shapiro). Boston: Beacon.

Haley, J.(1963). *Strategies of Psychotherapy*. New York: Grune and Stratton.

Haley, J.(1967). Commentary on the writings of Milton Erickson, M.D. In J. Haley(Ed.). *Advanced Techniques of Hypnosis and Therapy: Selected papers of Milton H. Erickson, M.S.* New York: Grune & Stratton.

Hamilton, G.(1940). *Theory and Practice of Social Casework*. New York: Columbia University Press.

Hare-Mustin, R.(1994). Discourses in the Mirrored Room: A Postmodern Analyses of Therapy. *Family Process*. March. 33(1), 19-35.

Hartman, A.(1991). Words create worlds. *Social Work*, 36(4), July, 275-276.

Heineman, M.B.(1981). The obsolete scientific imperative in social work research. *Social*

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Service Review. September, 371-397.

Hoffman, I.Z.(1983) The patient as interpreter of the analyst's experience. *Contemporary Psychoanalysis*. 19:389-422.

Hoffman, L. (1985). Beyond power and control: toward a 'second order' family systems therapy. *Family Systems Medicine*, 3: 381-96.

Hoffman, L.(1988). A reply to Golann. *Family Process*, 27, 65-68.

Hoffman, L.(1990). Constructing realities: An art of lenses. *Family Process*, 29,1-29.

Hoffman, L.(1993). A reflexive stance for family therapy. In Gergen & McNamee(Eds) *Therapy as Social Construction*. Newbury Park, CA: Sage, 69-86.

Holland, T.P., Galant, J.P., & Colosetti, S.(1994). Assessment of teaching a constructivist approach in social work practice. *Arete*, 18(2), Winter, 45-60.

Holland, T.P. & Kilpatrick, A.C.(1993). Using narrative techniques to enhance multicultural practice. *Journal of Social Work Education*, 29(3),Fall, 302-308.

Hollis, F.(1964). *Casework: A Psychosocial Therapy*. New York: Random House.

Holstein, J.A. & Gubrium, J.F.(1994). Phenomenology, ethnomethodology, and interpretive practice. In Norman Denzin & Yvonna Lincoln(Eds.). *Handbook of Qualitative Research*. Thousand Oaks: Sage, 262-273.

Horner, E.(1995). The meeting of two narratives. *Clinical Social Work Journal*. 23(1), Spring, 9-21.

Hoy, D.C.(1985). Jacques Derrida. In Q. Skinner(Ed.). *The Return of Grand Theory in the Human Sciences*. New York: Cambridge University Press.

Hunter, K.M.(1989). A science of individuals: Medicine and casuistry. *Journal of Medicine and Philosophy*, 14, 193-212.

Ilich, I., Zola, I,.McKnight, J.,Caplan, J., Harley Shaiken(1977). *Disabling Professions*. London: Marion Boyars.

Janesick, V.(1994). The dance of qualitative research design: metaphor, methodolatry and meaning. In Norman Denzin and Yvonne Lincoln(Eds.) *Handbook of*

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Qualitative Research. Newbury Park, CA:Sage.

Kaplan, A.G. & Surrey J.L (1984). The relational self in women: developmental theory and public policy. In L.E. Walker(Ed.) *Women and Mental Health Policy.* Beverly Hills,CA: Sage, p.79-94.

Kegan, R.(1982). *The Evolving Self.* Cambridge: Harvard University Press.

Kernberg, O.(1976). *Borderline Conditions and Pathological Narcissism.* New York: Jason Aronson.

Keys, P. & Ginsburg, L.(1988). New management in action: A case study. *New Management in the Human Services.* Wash.D.C.: NASW. Ch.9.

Kirk, S.A. & Kutchin, H.(1994). Is bad writing a mental disorder? *The New York Times.* Op.Ed. June 20.

Kohut, H.(1982). *How Does Analysis Cure?* Chicago: University of Chicago Press.

Kristeva, J.(1982). *Desire in Language.* (Tr. L.Roudiez). New York: Columbia University Press.

Kristeva, J.(1987). *Tales of Love.* New York: Columbia University Press.

Kondrat, M.E.(1995). Concept, act, and interest in professional practice: Implications of an empowerment perspective. *Social Service Review.* 69(3), September, 405-428.

Lacan, J.(1977). *Ecrits.* New York: Norton.

Laird, J.(1993b). Family-Centered Practice: Cultural and Constructionist Reflections. *Journal of Teaching in Social Work.* 8(½), 55-77.

Lax, W.D.(1993). Postmodern thinking in clinical practice. in Sheila McNamee and Kenneth Gergen(Eds) *Therapy as Social Construction.* Newbury Park, CA: Sage, 69-86.

LeBon, G.(1899). *The Crowd.* New York: Penguin.

Levenkron, S.(1982). *Treating and Overcoming Anorexia Nervosa: the classic guide.* New York: Warner Books.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Levine, L.(1994). *The Integration of Constructivism and Social Constructionism in Family Therapy.* Unpublished Doctoral Dissertation.

Lifton, R.(1993). *The Protean Self.* New York: Basic Books.

Light, Jr., D.(1983). "Surface data and deep structure: Observing the organization of professional training." in John Van Maanan(Ed.) *Qualitative Methodology.* Newbury Park, CA: Sage.

Lofland, J & Lofland, L.(1995). *Analyzing Social Settings.* Belmont, CA: Wadsworth.

Lyotard, J.-F.(1993). *The Postmodern Condition: A Report on Knowledge.* Minneapolis: University of Minnesota Press.

Lyotard, J-F(1992). *The Postmodern Explained.* Minneapolis: University of Minnesota Press.

McCracken, G.(1988). *The Long Interview.* Newbury Park, CA: Sage.

McNamee, S.(1993). Reconstructing identity: The communal construction of Crisis. In Sheila McNamee and Kenneth J. Gergen(Eds.). *Therapy as Social Construction.* Newbury Park, CA: Sage.

Mailick, M.(1991). Re-assessing assessment in clinical social work practice. *Smith College Studies in Social Work.* 62(1), p. 3-19.

Maturana, H.(1978). Biology of language:The epistemology of reality. I G. Miller & E. Lenneberg(Eds.) *Psychology and Biology of Language and Thought.* New York: The Academic Press.

Maturana, H.(1980). Autopoiesis: Reproduction, heredity, and evolution. In M. Zeleny (ed.)*Autopoiesis, Dissipative Structures, and Spontaneous Social Orders.* Boulder,Co:Westview.

Maturana, H.(1988). Reality: The search for objectivity or the quest for a compelling argument. *Irish Journal of Psychology*, 9, 25-82.

Maturana, H. & Varela, F.(1987). *The Tree of Knowledge: The biological roots of human understanding.* Boston: New Science Library.

Middleman, R. & Wood, G.G.(1993). Revisioning social work education: a social constructionist approach. *Journal of Teaching in Social Work.* 8(½)129-147.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Miles, M.R.(1979). Qualitative data as an attractive nuisance: The problem of analysis," *Administrative Science Quarterly*. December, 24, 590-601.

Millstein, K.H.(1993). Building knowledge from the study of cases: A reflective model for practitioner self-evaluation. *Journal of Teaching in Social Work*, 8(½),255-281.

Moi, T. (1985). *Sexual/Textual Politics.* London: Methuen.

Morgan, G.(1986). *Images of Organization.* Newbury Park: Sage.

Nicholson, L.J.(Ed.).(1990). *Feminism/Postmodernism*. New York: Routledge.

Ong, W.J.(1982). Oral remembering and narrative structure. In D. Tannen(Ed.). *Analyzing Discourse: Text and Talk*. Washington, DC: Georgetown University Press, 12-24.

Ornstein, P. & Ornstein, A.(1980). Formulating interpretations in clinical psychoanalysis. *International Journal of Psycho-analysis*. 61,203.

Paglia, C.(1990). *Sexual Personae*. New York: Vintage Books.

Paglia, C.(1992). *Sex, Art, and American Culture*. New York: Vintage Books.

Pare, D.A.(1995). Of families and other cultures: The shifting paradigm of family therapy. *Family Process.* 34:1-19.

Patton, M.Q.(1990). *Qualitative Evaluation and Research Methods*. Newbury Park, CA: Sage.

Payne, M.(1991). *Modern Social Work Theory: A Critical Introduction*. Chicago: Lyceum Press.

Perlman, H.H.(1957). *Social Casework.* Chicago: The University of Chicago Press.

Perlman, H.H.(1979).*Relationships: The Heart of Helping People.* Chicago: University of Chicago Press.

Piele, C.(1993). Determinism versus creativity: Which way for social work? *Social Work.* 38(2), 127-134.

Pozatek, E.(1994). The problem of certainty: Clinical social work in the postmodern era. *Social Work. 39(4), 396-403..*

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Prigogene, I. & Stenger, I.(1984). *Order Out of Chaos.* New York: Bantam.

Real, T.(1990). The therapeutic use of self in constructionist/systemic therapy. *Family Process*, 29, 255-272.

Remondet, J. H., Hanson, R.O., Rule, B. & Winfrey, G. (1987). Rehearsal for Widowhood. *Journal of Social and Clinical Psychology*. 5:285-297.

Richards, T. & Richards. L.(1994). Using computers in qualitative research. In Denzin & Lincoln(Eds.). *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage.

Richardson, L.(1988). The collective story: Postmodernism and the writing of sociology. *Sociological Focus*, 21, 199-207.

Richardson, L.(1994). Writing a method of inquiry. In N.K. Denzin and Y. S. Lincoln(Eds.). *Handbook of Qualitative Research.* Thousand Oaks, CA: Sage, 516-530.

Rosenau, P.M.(1992). *Postmodernism and the Social Sciences.* Princeton, NJ: Princeton University Press.

Saari, C.(1991). *The Creation of Meaning in Clinical Social Work.* New York: The Guilford Press.

Saari, C. (1994). An exploration of meaning and causation in clinical social work. *Clinical Social Work Journal.* 22(3), 251-263.

Saleebey, D.(1992). *The Strengths Perspective in Social Work Practice.* New York: Longman.

Sands, R. & McClelland(1994). Emic and etic perspectives in ethnographic research on the interdisciplinary team. In Edmund Sherman and William J. Reid(Eds.) *Qualitative Research in Social Work.* New York: Columbia University Press, 32-42.

Sands, R. & Nuccio, K.(1992). Postmodern feminist theory and social work. *Social Work*, 37(6), November, 489-494.

Sanville, J.(1995). Editorial. *Clinical Social Work Journal.* 23(1), Spring, 3-9.

Schon, D.(1983). *The Reflective Practitioner: How Professionals Think in Action.* New York: Basic Books.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Schon, D.(1987). *Educating the Reflective Practitioner*. San Francisco: Jossey-Bass.

Schwandt, T.A. & Halpern, E.S.(1988). *Linking Auditing and Metaevalution: Enhancing Quality to Applied Research.*Newbury Park, CA: Sage.

Simon, G.(1992). Having a second-order mind while doing first-order therapy. *Journal of Marital and Family Therapy*, 18, 377-388.

Smith, H.(1989). *Beyond the Postmodern Mind.* Wheaton, IL: Theosophical Publishing House.

Stern, A.(1938). Psychoanalytic investigations and therapy in the borderline group of neuroses. *Psychoanalytic Quarterly, 7, 467-489.*

Stern, D.(1989). The representation of relational patterns: Developmental considerations. In A.J. Sameroff & R.N. Emde(Eds.) *Relationship Disturbances in Early Childhood: A developmental approach.* New York: Basic Books, 52-69.

Stolorow, R.D., Atwood, B.& Brandchaft, G.E. (1994). *The Intersubjective Perspective.* Northvale, N.J.: Jason Aronson.

Stone Fish, L. & Piercy, F.(1987). The theory and practice of structural and strategic family therapies: A Delphi study. *Journal of Marital and Family Therapy,* 13, 113-125.

Strobe, W., Strobe, M.S., Gergen, K. Gergen, M. (1982). The Effects of Bereavement on Mortality: A Social Psychological Analysis. In J. R. Eiser(Ed.) *Social Psychology and Behavioral Medicine*. New York: Wiley: 527-560.

Tanner, R. & Athos, A.(1981). Zen and the art of management. *The Art of Japanese Management.* New York: Simon and Shuster, 41-56.

Toulmin, S.(1990). *Cosmopolis: The Hidden Agenda of Modernity*. NewYork: Macmillan.

Turner, F.(Ed.).(1986). *Social Work Treatment: Interlocking Therapeutic Approaches (3rd Edition)*. New York: Free Press.

Varela, F.(1984). The creative circle: Sketches on the natural history of circularity. In Paul Watzlawick(Ed.)*The Invented Reality.*New York: Norton.

Watzlawick, P.(1978). *The Language of Change.* New York: Basic Books.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Watzlawick, P.(1984). *The Invented Reality*. New York:Norton.

Weakland, J.(1993). Commentary on Hanlon, W.H.(1993). Possibility therapy: from iatrogenic injury to iatrogenic healing. In S. Gilligan and R. *Price. Therapeutic Conversations.* New York: Norton, 18-22..

Wetzel, J.(1986). A Feminist World View Conceptual Framework. *Social Casework* 67(3), 166-173.

White, M.(1993). Deconstruction and therapy. In Steven Gilligan and Reese Price(Eds.). *Therapeutic Conversations.* New York: Norton.

White, M. & Epston, D.(1990). *Narrative Means to Therapeutic Ends*. New York: Norton.

Widdershoven, G.A.M.(1993). The story of life: Hermeneutic perspectives on the relationship between narrative and life history. In Ruthellen Josselson and Amia Lieblich(Eds.). *The Narrative Study of Lives* .Newbury Park, CA: Sage.

Wittgenstein, L.(1958). *Philosophical Investigations(3rd Ed.)*. (G.E.M Anscombe, Trans.) New York: Macmillan.

Wittgenstein, L.(1965). *The Blue and Brown Books: Preliminary Studies for the "philosophical investigations."* New York: Harper Books.

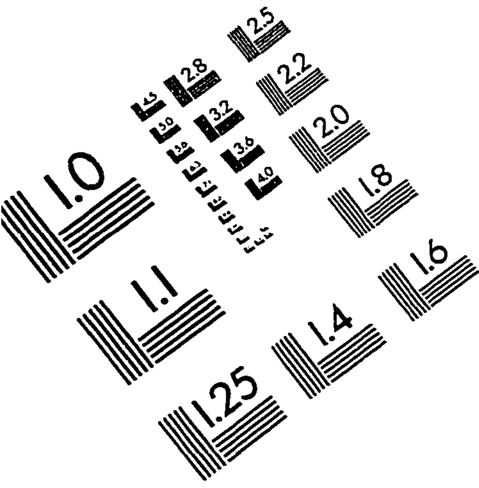
Wylie, M.S.(1994). Panning for Gold. *The Family Therapy Networker,* Nov/Dec, 40-49.

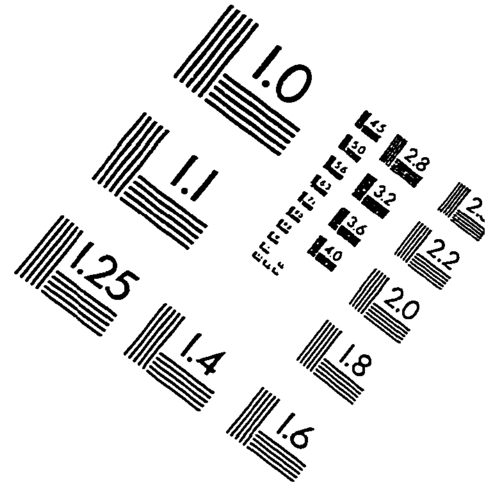
Yalom, I.(1980). *Existential psychotherapy.* New York: Basic Books.

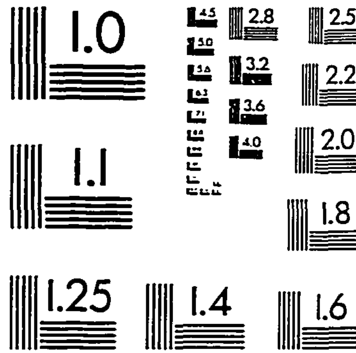
Zukav, G.(1979). *The Dancing Wu Li Masters: an overview of the new physics.* New York: Morrow Quill.

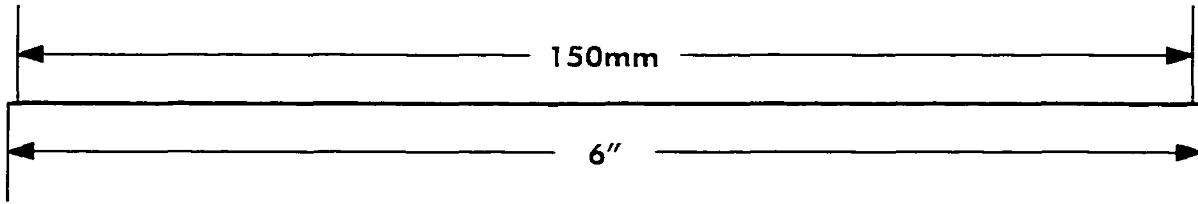
Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

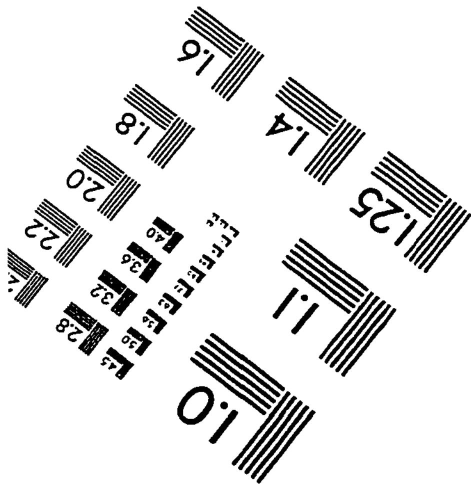
IMAGE EVALUATION TEST TARGET (QA-3)





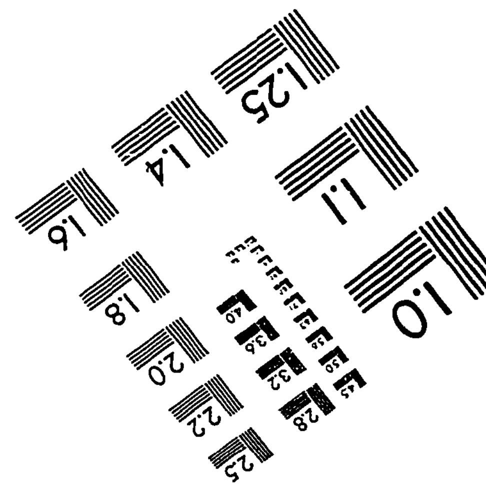






APPLIED IMAGE, Inc
1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989

© 1993, Applied Image, Inc., All Rights Reserved



Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.