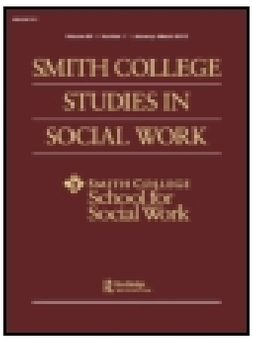

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THE SLIPPERY SLOPE OF CONSTRUCTIVISM

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Abstract

While constructivism as both a philosophy and a clinical practice is being embraced by many individual and family practitioners, it remains controversial. This paper examines the difficulties one encounters in trying to balance the client's "relative truths" with those around them, including that of the therapist. Through the use of clinical vignettes, the authors demonstrate the difficulties inherent in dealing with ambiguities in the clinical situation, balancing the client's perspective, with that of a predominant culture or biological "fact," and considering the issue of the client's "veracity." Particular attention is paid to the difficulties involved in work with trauma survivors, whose own recollections of events may be ambiguous. Finally, the authors discuss the implications that constructivism holds for research and social action and advocacy. In sum, the authors recognize significant promise in the constructivist perspective, but caution clinicians to consider the inherent difficulties in a theory that relies on the relativity of truth.

> "It is immoral not to seek the truth to the best of our ability. The fact that there are limits to that quest does not mean the quest should be abandoned." (Pols, 1992)

If we accept the premise of constructivistic philosophy that truth is relative, albeit that some truths may be more relevant than others, we must confront those consequences that pose significant dilemmas for practitioners and for all the helping professions. As Joan Laird aptly states, "It is important to maintain a critical and deconstructionist stance toward the constructionist metaperspective itself.... Constructionist philosophy implies a critical stance that must be willing to turn its gaze upon itself" (1998, p. 229). By loosening the therapeutic structures, questioning every theory, opinion, and research result, we are vulnerable to sliding into a therapeutic quagmire that shows itself in several important areas. Among them are (1) determining what to do to help our clients, i.e., the practice dilemma; (2) determining the effectiveness of our interventions (including the effectiveness of our therapeutic relationships), i.e., the research dilemma; and (3) determining how best to advocate for our clients in general, i.e., the advocacy dilemma.

THE PRACTICE DILEMMA

Most clinicians, particularly beginning clinicians, are eager for guidelines that will direct their interventions with clients. In some cases this leads to prematurely selecting a structured treatment approach without questioning its effectiveness in each particular clinical situation. Constructivism addresses this dilemma by providing an antidote against deifying one treatment approach over another. However, constructivism leads to another quandary: How do you translate an abstract philosophy into a clinical theory that provides guidance for practice? Bader (1997) effectively describes this dilemma, saying that

> ...whenever you think you know something, you don't. Whenever you have a hunch, question it. Whenever you want to tell the patient what's wrong, you have to do so modestly, understanding always that what you're saying is partial, contingent, limited, biased, and probably saying as much about you as about the patient. In critiquing the "analyst-knows-best" arrogance of traditional analysis, the postmodernist tends to idealize uncertainty. (p. 15)

In a sense, we can worship ambiguity to the point that we're useless in terms of effecting change in our clients and in our society. As Held effectively argues, "taken to an extreme, a constructivist perspective becomes systematically misleading and a poor guide to therapeutic intervention" (Held, 1995, p. 182).

We are most vulnerable to sliding down the extremist slope when we don't keep our therapeutic purpose in mind. Every clinician needs to keep some theoretical framework in mind in trying to make sense out of "a bewildering cacophony of social stimuli" (Nurius & Gibson, 1998, p. 191) and to intervene effectively. By now it should be evident that we realize the biases inherent in our theories and telegraph our expectations, perceptions, and interventions. Recent examples of the ways in which theoretical positions can negatively impact clinical work with clients and our capacity to conduct meaningful research include the treatment of autism and asthma. Throughout the 1950s and the decades following, the etiology of autism was associated with women with poor adjustments to motherhood. Based on that assumption, treatment interventions were often aimed at the mother, with the goal of reengaging her with her child and encouraging her maternal instincts. This theory of course, did not explain why the same mother might have three other children who were not autistic or why she would "want" to create a child who would require significant care beyond adulthood. Likewise, with childhood asthma, the "smothering mother" was

seen as suffering from severe separation anxiety that manifested itself in the child. One need only consider the context of the presentation of these children to question the theory that explains etiology and directs intervention by focusing exclusively on the mother. Mothers are typically the ones who bring children to the attention of medical practitioners. One can safely assume that the mother of a child who is having significant difficulty breathing is going to present as anxious, protective, and distraught about her child's well-being (and a lucky thing it is, given that asthma attacks can be life-threatening).

In both cases, autism and asthma, the theories regarding etiology and treatment reflect mid-twentieth-century American societal beliefs about the role and functions of mothers, the centrality of the mother-child relationship, and the manifestation of psychological conditions in the somatic realm. In the last decade of the twentieth century, the "decade of the brain," scientific advances suggest that the development of autism in a child is related to neurological disturbances. Contemporary treatment interventions reflect that position, although they are broadened to include interventions aimed at modifying the impact of the "illness" on the family and on the child's social functioning. In regard to childhood asthma, an illness now considered epidemic, research efforts have concentrated on the effects of the physical environment. No one now suggests that the number of "smothering mothers" is reaching epidemic proportions, and researchers are focusing on and emphasizing the importance of deteriorating environmental conditions.

Given that there are numerous case examples in which we believed our theories to be true, what are the dangers of heading in the opposite direction—of considering our theories biased to the point of irrelevance? Some theorists have responded to this dilemma by postulating that the clinician's expertise is as a "master conversationalist" (Anderson & Goolishian, 1988), not as an expert in interpreting or evaluating content. Held (1995) has argued that it is virtually impossible *not* to assess the content of our clients' stories. given that part of our task is determining severity of crises, potential of danger, etc.

A likely remedy to the pitfalls of deifying ambiguity, is clarity and comfort with what it is we do know. The fundamental issue seems to be that despite awareness of our limited access to and understanding of reality, we do need to act in the world with reality as we see it, however imperfect it may be. But in "our wish not to be arrogant, we shouldn't mistake open-mindedness with not being able to know another's mind" (Bader, p. 4). There are "truths" we do know. Held (1995) believes we risk deceiving

ourselves if we insist on presenting ourselves as humble ("simulated humility") in situations where we actually have strong beliefs. We do know some things; for example, we know sexual abuse and physical abuse are not desirable conditions for the emotional and physical development of children. We endanger enormous social gains if we relativize such behaviors and try to "reframe" them in morally ambiguous terms. Granted, we can work to understand what these behaviors may mean to the perpetrators and to the victims. However, the bottom line is that such behavior cannot continue while we work to understand its meaning. "It seems that the reality of at least those extreme situations conflicts with the anti-reality of constructivism" (Held, 1995, p. 243). It should be obvious that clients cannot be the only experts on treatment goals, given the possibility of harm to self or others. There are times when action is needed to protect clients, family members and ourselves, as well. We may make mistakes because of our biases, but conservative action is infinitely preferred over too little, too late. Given also that we are designated by society (despite whatever flaws society has) to be responsible for providing responsible treatment, we cannot abdicate our roles as authorities about the theory and practice of psychotherapy (Nichols, 1993). Accepting that one has authority does not mean telling people the "right" answers to their problems. It is possible to be the kind of authority figure who knows how to help people learn something about themselves and the world they live in: the impact they now have and the impact they could have on their worlds, and the impact their worlds have on them.

To help us negotiate this philosophical quicksand, let's return to the obvious: What do our clients want? Simply stated, they want to feel understood—understood in terms of their experience and understood in terms of the ways they feel we can be helpful. It is not "modernist" to expect ourselves to find ways to systematize how we know whether what we say is empathic and helpful. We do have signposts (Bader, 1997) that indicate whether we are on track. Clients tell us with their words, their behavior, their affects, their memories, and their symptoms whether what we say or do is helpful. Unfortunately, postmodernism requires a skepticism about objective indicators that serves to perpetuate the either/or stance of that is so critical. The danger in converting to postmodernism is that it can change the expectation that we should be accountable and find ways of verifying whether we are being helpful. It would be a mistake to transform our fear of not being helpful into a vigilant acceptance of ambiguity and an idealization of complexity and obscurity. We are remiss if we do not continue to find ways of translating an "epistemological uncertainty" (Bader, 1997) into concrete clinical principles of technique. Not

necessarily into a one-size-fits-all knee-jerk rigid application of a trendy model, but into principles that allow for variation without overlooking the activity of clients and therapists, and the moral responsibility of the profession. Part of our moral responsibility is that despite our ambivalence about societal failings we have some obligation to society to evaluate our clients' stories.

Another practice dilemma alluded to earlier is how we negotiate our concern about the veracity of a client's story while grappling with the "reality" of the client's own version. We are familiar with numerous controversies about the different forms of memory. This, we believe, is at the heart of the practice difficulties encountered in the constructivist clinical position and the one that most readily put us on the slippery slope. The most confounding contemporary practice example, highly publicized, deals with the issue of the veracity of clients' retrospective reports of sexual abuse. This is not a new dilemma for psychotherapists; Freud struggled with it at the turn of the last century. Unfortunately, Freud's resolution was the invention of a one-size-fits-all solution; a theory that explained away sexual abuse as an unconscious wish-fulfillment. More recently, Paris writes,

> Recovered memories, even if they are factually false, create *narratives* that individuals may need to make sense of their experiences. In psychiatric patients, these narratives provide causal explanations for present difficulties. These attributions are strongly influenced by the social context, either in relation to therapist beliefs or to commonly held beliefs in the patient's culture. Inside psychotherapy, suggestion and expectation, even without overt prompting, shape the narratives of trauma.(1995, p. 208)

Contemporary arguments like the one about the alleged "false memory syndrome" or "recovered memories" can (and do) fill volumes (Loftus, 1993; Pope & Hudson, 1995; Bass & Davis, 1988). Our purpose here is not to examine these arguments in depth, but to deal with how the polar positions (essentially, believing the client or not believing the client) influence how therapists works with clients. We use the issue of sexual abuse to highlight the problems inherent in the struggle regarding the client's narrative truth vs. historical truth (Spence, 1982) because it illustrates the extreme ends of the continuum regarding veracity. Any clinician can cite dozens of examples of clients struggling with their recollections of the past as they try to piece together a more coherent understanding of multiple prior and present influences.

Does the constructivist position demand that social workers believe whatever clients say? Paris cautions all therapists (presumably not just those of the constructivist persuasion) that

> Since therapists are trained to be empathic, they usually accept, more or less unconditionally, what patients tell them about their lives. We need to be aware that what we hear from patients reflects as much a view of the world as a description of objective reality. (1995, p. 208)

Spence (1982) certainly would concur, believing that while narrative truth may be the critical element in helping client and therapist construct specific meaning, it is limited in its usefulness as a "general theory" (p. 33). Likewise, the process of meaning making in the therapeutic moment does not require the therapist to accept all content as gospel. Part of the narrative process involves commenting on inconsistencies and discrepancies in clients' stories. What an effective constructivist practitioner must do is negotiate the dance between believing all and believing nothing. Each part of the story must be continually evaluated by client and therapist for its coherence, its compatibility with current understandings about human behavior (Saari, 1991), and its viability (Kelly, 1955).

Suppose a client tells a story or acts in ways that are at the fringes of believability or "normal" ways of interacting in a therapeutic setting. We are all familiar with clients who have been misjudged based on culture, ethnicity, or social class. Nonetheless, there are situations that are unfamiliar to us not because of cultural differences, but because they are odd and eccentric. Now, the clinician cannot suspend belief and enter into a world that would, at the very least, cause legal problems. One thing the constructivist clinician can do, however, is ask, "How does this story or behavior help you?"; "In what ways does it get in your way?"; and "Is there a way this behavior or story changes your present life and/or your future?" In such instances, the clinician is riding the fence when it comes to believing exactly what the client says. We are cornered if a client demands to know "Do you believe me?" To be honest, we may not. Constructivism does not demand that we believe naively. We may be in the position of saying that the behavior or story would be met with skepticism anywhere else. In this relationship our job is to figure out what is important about it to the client. Such situations remind us of Held's (Held, 1995) discomfort with our need to convince clients of the merits of postmodern thought. At times, it does seem necessary to ask clients to suspend their vehement need for literal confirmation, because we cannot deliver it, nor should we.

For some clients the issue of being believed becomes part of the therapeutic discussion, that is, "What does being believed mean?"; "What does it mean if you feel I don't believe you?"; "Is this a familiar situation or feeling—not being believed?"; "How would things be different if you felt I did believe you?" For some clients not being believed allows them to preserve a feeling of being different. For other clients the experience of being believed is transformative. In making such evaluations it is critical to hold onto what we know about development, and about the formation of schemas and attributions.

THE RESEARCH DILEMMA

We are frequently confronted, then, with confusion about the veracity of both the client's story (the "data") and the theories we use to examine the data. Given that confusion, we often turn to research for guidelines. We might think it is imperative to do so. However, this presents a difficult dilemma for the constructivist practitioner whose theory and technique emerged in opposition to the empirical positivist position. However, in attempting to understand something about the individual client and the problem she presents, we do need to consider what clinical researchers have found to be helpful. For example, consider again the situation of recovered memories of childhood sexual abuse in adult clients. Herman (1981, 1992) and others (Brown & Finkelhor, 1986) propose that "trauma *usually* leads to the repression of memories and that, for this reason, uncovering repressed childhood trauma memories is central to the practice of psychotherapy (Paris, 1995 , p. 201). The reasoning for this position is coherent and consistent with recent clinical and sociocultural perspectives. It also reflects both clinical and research findings. More recently, however, in a review of that research, Paris finds it flawed (1995, 2000), noting that many people who have been abused do not go on to develop psychiatric symptoms. Certainly, if a clinician is operating under the assumption that all trauma survivors will relive the trauma, her view of the client's story will be influenced.

If we subject the constructivist practitioner to scrutiny about the slippery slope in the clinical realm while simultaneously insisting that research is a necessary resource for practice, we must also scrutinize constructivist research. Drawing on work done by Berkenkotter (1993), Grinnel et al. (1994), and Thayer (1986), Rodwell (1998) contends that "It is at the rigor level that most criticism is lodged against alternative ways of knowing" which "appear to be extensions of the

paradigmatic/philosophical discussions where there can be no conclusion because there probably can be no consensus" (p.95). She suggests, that "constructivist rigor must be considered on two dimensions, one that is in response to the general expectations of traditional research, trustworthiness, and another that is congruent with the alternative expectations of constructivism, authenticity" (p.95).

The former is familiar to us all and includes established standards for validity, reliability, objectivity, and internal and construct consistency. Constructivist research, also known as qualitative research, is often considered inferior when held to the standard of positivist research. It is obvious that constructivist research will not hold up to this traditional standard and in all probability, should not be expected to. Because qualitative research has different goals as well as different methods, comparing them is similar to comparing apples and oranges. An exhaustive review of the spirited debate about qualitative vs. quantitative research is beyond the scope of this discussion and has been covered exhaustively in the literature (Grinnel et al., 1994; Guba, 1990; Heineman Piper, 1985). In this manuscript, we are concerned about the limitations of the constructivist research for practitioners.

The primary issue for practitioners is that of generalizability, what Rodwell (1998) labels "authenticity." Proponents of constructivist research make no claims that data yielded or inferred from a constructivist study meet the traditional standard of generalizability—a hallmark of quantitative inquiry. Rodwell goes on to differentiate between generalizability and transferability, which "allows for the possibility that information created and lessons learned in one context can have meaning and usefulness in another" (p. 101). Constructivist research design is analogous to the case study method with which clinicians are familiar. In case studies, practitioners do not assume that the case will be identically replicated, but assume that a specific example may hold significance for aspects of other similar cases. Rodwell offers several design and procedural guidelines intended to minimize problems with credibility for the constructivist researcher. For example, she recommends prolonged engagement between researchers and subjects, persistent observation, triangulation (cross-confirmation with several "measures"), peer debriefing, and member checks for convergent validation.

If the data yielded from constructivist research can stimulate further thinking, extend or discourage clinical hypotheses, or stimulate conceptual development, they can be of significant use in practice. The practitioner needs to keep in mind that qualitative research findings are inferences,

rather than "proof of fact." This is consistent with the overarching principles of constructivist philosophy that favor the notion of multiple, context dependent truths. Accordingly, qualitative research results are idiosyncratic. They are not meant to demonstrate the existence of one, pure, objective truth.

The debate about the relative superiority of quantitative vs. qualitative research will continue. Who is right and who is wrong is not the question, at least from a constructivist perspective. We need to be clearer about what clinical questions and social problems can be explored through which research designs. We must also submit both kinds of research projects to scrutiny regarding the theoretical and conceptual ideas that generate them, and the socially constructed influences that prejudice them. It is also important to emphasize that research protocols, and agenda of either type are not immune to fictitious or socially constructed influences. We caution ourselves to remember that even if we believe in the possibility of objective, non-changing "truth," we have to consider that good empirical research is subject to flaws based on its conceptual scaffolding or design. It may be flawed simply because we don't have all the pieces *and don't recognize that we don't have all the pieces.*

If the reader will pardon our soapbox, we want to mention one other concern we have about the slippery slope of constructivist research. Because this kind of research is often conducted by advanced practitioners and doctoral students, the excitement of being able to look at subjective clinical material can eclipse any interest or appreciation of outcome studies. The Garfield and Bergin text (1994) is a prime example of the enormous amount of research devoted to refining our understanding of clinical issues; that is, therapist and process variables that are important to good outcomes, the impact of cultural differences on treatment, the effectiveness of various modalities, etc. These clinical issues should continue to be at the forefront of psychotherapeutic research and should also be combined with what we are learning from qualitative studies. Clinical practice will benefit from the results of both quantitative and qualitative studies. Equally important, however, is what we could do to provide better care for clients, particularly those who are marginalized, if we were to use the generalizability of our research findings to impress and influence policy makers and funding sources. Effective advocacy efforts depend on our ability to maximize all research venues.

THE ADVOCACY/ACTION DILEMMA

The treatment literature is full of clinical illustrations in which clients of a given culture expect the therapist to have clinical expertise to use on their behalf. Typically, such clients are not especially interested in the modern social work political agendas of empowerment, etc. We seem to be so afraid of unfairly judging our clients that we careen into the area of thinking we don't know anything. In contrast, Bader (1997, p. 7) argues that "there's no danger to thinking you're 'right,' as long as you're open to changing your hypothesis in response to new data." How frustrating it must be to seek out help or concrete services, perhaps surmounting innumerable obstacles, and to have your clinician focus on "meaning making." "Affirmative postmodernism is an Anglocentric paradigm which may be of little use to diverse groups in the United States and elsewhere." Moreover, "aspects of postmodernism can oppress and marginalize as much as any modernist world view ever did, especially those clients who speak in other paradigmatic dialects." (Gonzales, 1998, p. 367). For example, suppose a recent immigrant family from Southeast Asia is having difficulty negotiating employment for the parent, adjustment to school for the children, and language barriers for all. We know from research studies as well as from our clinical experience the tremendous toll immigration takes on families and individuals. This family certainly would appreciate attempts to understand their experiences, but more importantly, they need tangible advocacy within the school system to allow for their children's smoother academic, social, and emotional transitions. This is not to say that a constructivist practitioner would overlook the obvious advocacy needs. It does, however, highlight the importance of knowing about the immigration experience, the local educational system, and how to prioritize interventions. Meaning making and/or externalizing the problem is not enough, in and of itself, but may be helpful once tangible support is offered. If the children in this family were of adolescent age and were trying to "individuate" in a manner consistent with the predominant western culture, the therapist would need to consider his or her own views about the development of self. Discounting the familial self that is primary in some Asian cultures, would guide the therapist toward ineffective interventions that would further marginalize the family in their new environment.

There are two other dangers with adopting postmodernism as a framework for guiding practice. One is overemphasizing the social constructions of identity, gender, normalcy, etc. to the extent that the individual's idiosyncratic intrapsychic world is overlooked. We may ask our clients to alter

the meaning they make of oppressive environments, but we can't dismiss or discount that they have actively interacted with this environment to co-create their world. This is not to say they have created abuse, etc., but that they continue to develop in ways that reflect how the abuse has affected their perception of the world. To assume they only are passive recipients of the social world does our clients grave injustice. The exciting part of our work is finding ways to engage and understand how clients are and can be active agents.

Consider the example of Sally, a 25-year-old single woman from a very small, rural, northern area where her family has lived in diminishing poverty over a period of generations. She presented for treatment following the suicide death of one of her older brothers one month earlier. She began by saying: "I can't bear to see my parents crying about him; he was so cruel to me and they knew it." She goes on to report that the deceased brother had abused her sexually and physically over the course of 15 years. She described herself as a loner and presented as unkempt, clingy, depressed, and morbidly overweight. She had also developed a well-established routine of physical self-harm. Over the course of several months, Sally made few changes. She presented very passively and the therapist often found herself frustrated by the client's passivity and lack of initiative in any arena, including psychotherapy. The therapist spent a lot of time trying to understand Sally, and trying to help Sally understand her complicated feelings related to the long-term abuse, her brother's suicide, and her parents mourning. Together, they also identified a long-term pattern of sexual abuse perpetrated by brothers on sisters over the course of three prior generations. While all of this seemed significant to the therapist, and to a considerably lesser degree to Sally, it wasn't until Sally began a session by describing her suspicions that her first cousin was abusing his step-daughter that she began to indicate any movement toward change. The therapist was wary that Sally might be displacing the affect related to her own history onto this young girl, but Sally was insistent on "taking action." With the therapist's assistance, Sally decided to raise her concerns directly with the girl's mother. The following week she reported that the girl's mother had confirmed her suspicions. Sally then helped the mother schedule an evaluation for the girl at the community mental health center, and make alternative housing arrangements through the Women's Crisis Center.

In this case, the therapist's advocacy took the form of coaching her client about how to advocate for her young cousin, and by so doing, rework her own responses to her own history. One could argue that the

earlier efforts at meaning making paled in comparison to the more active advocacy that allowed the client to become an active participant in her own story. Based on what we know from qualitative and quantitative research, most likely it was a combination of meaning making, the treatment relationship, and the therapist's willingness to help her client develop an advocacy plan, that contributed to the client's improved behavior and self-concept.

In the clinical venue, we encourage clients to use their histories, their personal and cultural narratives, and the therapeutic relationship, in an effort to make meaning of their lives. This development of meaning then allows the client an opportunity to consider alternative responses and behaviors to the challenges of complicated personal and social situations. The therapist's role is a complicated one which involves a willingness to join the client in discovering her understanding of her life situation, while simultaneously considering a variety of social and cultural influences. The "slippery slope" of constructivism must be negotiated with careful attention to both inner and outer realities including all aspects of the client's life.

Just as we do not expect our clients to negate their pasts when they consider alternative narratives, negotiating the slippery slope of constructivism entails retaining the knowledge we have from clinical experience, as well as what we discover when we consider other possibilities.

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