CRITIQUES OF NARRATIVE THERAPY: A PERSONAL RESPONSE

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Abstract

This paper responds to some of the specific and the generalised challenges to narrative therapy from therapists of other persuasions. It discusses the long history of model rivalry and locates this debate in that process. It also takes up specific concerns of Isolationism, Desertion, Language, Sectarianism, Colonialism and ethical superiority. Throughout, I attempt to identify my thinking in relation to the criticisms, and to write transparently about why I understand things in the way I do. This is not a neutral paper – I see myself as a narrative therapist.

We had watched for an hour as a small clinical team of narrative therapists discussed their practice and interviewed each other about the effects of this work on their personal and professional lives. I had found the presentation true to my understanding of narrative ideas at the level of theory, practice and presentation style. I was about to thank them for such a lively and coherent workshop when another participant started criticising the presenters angrily for the 'superior' stance they had taken, for their 'extremist' positions, 'lack of integration' with other therapy styles and 'lack of acknowledgement' of systemic writers. Two other participants joined in the criticism, adding versions of their own around the same theme. I was perplexed. How could we have been at the same workshop and experienced it so differently?

This experience had me reflecting on other negative reactions I had witnessed or been on the receiving end of. Such criticisms may be minority responses but can arrive with considerable negative feeling and were familiar to me. I had read numerous papers

that were explicitly or implicitly critical of narrative ideas and the way they were presented (Leupnitz, 1992; Hart, 1995; Minuchin, 1998; Doan, 1998; Crago & Crago, 2000; Amundson, 1996, 2001). Hart, Stagoll, Doan, Pocock and Larner continued the criticism in the *ANZJFT's* symposium Flaskas, Stagoll, Larner, Hart, Doan, Weingarten, Loth, Hayward & Pocock, 2000), in which nine therapists wrote about the apparent divide between systemic and narrative approaches.

Why am I Interested?

It's curious to me that few narrative therapists seem interested in dialogue about models. As a Structural and then Milan therapist in the 1980s, I experienced the debates between models as gripping expressions of people's searches for effective and ethical practice. The large, clear and sometimes sudden shifts in my approach (from Structural to Milan to post-Milan to Narrative during twenty years in the field) have accompanied a passionate interest in the bigger territory of therapy. I was — and still am — excited by the promise of therapeutic re-positioning to alter my sense of identity at every turn. I believe that my availability for relocation owes itself to a persistent interest in what others are doing. And I have been, I hope, as interested in the critiques of my own preferred model as the critiques of other models — I would consider this to reflect an ethic of openness and broadmindedness. I know that I can talk to myself about the connections and distinctions between approaches, the whys and the hows of staying where I am or shifting, and these fundamental shifts in my ethics, position, attitude and action have been life changing.

In this paper I have tried to respond to some of the critiques that I have read of narrative therapy. I have done so by trying to:

1. Appreciate the sentiments and experiences behind the critiques

2. Act with generosity and to understand what was happening for those who felt criticised

3. Learn how I might be contributing to this process

Thus, I thought I might also comprehend alternative ways of teaching, talking and writing that could invoke some reciprocal understanding. I also want to support dialogue between approaches and this is intended as a contribution.

An important factor for me in this has been the recent breakdown of a highly valued long term teaching partnership with a loyal friend and colleague who has not shared my enthusiasm for narrative ideas. Letting this relationship fall apart has felt like an act of considerable carelessness that, I thought, greater understanding might have prevented. I would hope that an article like this one could have assisted in my friendship before it was too late.

As a narrative therapist, I do experience many of the critiques of narrative therapy as attacking and I have found myself reacting with defence and counter-attack. I am not neutral about considerations of therapeutic positioning and this paper is not even-handed. It has been different kinds of struggle at different times to keep writing. Sometimes it was lack of interest that held me up, sometimes indignation at the criticisms, and sometimes it was just a feeling that my time could be better spent studying the directions that narrative explorations were going in. But I do want to support dialogue between approaches, and this is intended as a contribution.

Model Trouble

Rivalry between models is hardly a new phenomenon. In the1980s and 1990s the differences in the UK between (mostly) Milan and Structural therapists aroused strong emotions. Szaz described family therapy models as 'just a collection of cults' with

prominent family therapists 'like so many protestant preachers, each with his own church' (in Simon, 1992, 61). Whilst the arguments were generally about theory and maps of the world, the emotion was largely induced, I believe, by ethics. Milan therapists were accused of being unethical (tricky, amoral, and irresponsible). Structural therapists were accused of being unethical (bossy, patriarchal and narrow minded). Therapists not aligning themselves to either camp accused them both of zealotry and forgetting the client, whilst themselves getting criticised for wishy-washyness and lack of coherence. Strategic therapists were vulnerable for the lot!

When I started family therapy training in the mid-1980s, structural family therapy was widely regarded as innovative and radical. It mounted fundamental paradigm challenges to established approaches, it advocated alternative explanatory and attitudinal positions and was, in the UK, frequently under fierce attack — particularly from psychiatry and psychoanalysis, whose advocates perhaps foresaw the erosion of their authority on psychological and relationship problems. Supporters of this new wave were often called disciples, and leaders became 'gurus' — it was an exciting movement to be aligned with.

Milan was more radical again. This Italian foursome were suggesting we shouldn't take a position about whether families should change but just ask endless circular questions, drawing more and more events, people, and ideas into the discussion until the systemic connections were clear to everybody. They even suggested there was no blueprint about how people should act or how families should conduct their relationships. 'At last', I thought, 'an ethical therapy!' But this was more than radical or exciting, this was dangerous — and I loved it. And I lost more than one collegial friendship to my shift of allegiance and learned to be discreet about my alignment with Milan ideas, to prevent new relationships getting off to an immediate bad start.

Family therapy models are much more than a set of connected ideas and practices. They contain a philosophy, a view of the world and a schema for relating to it. This therapist positioning reflects attitudes that embody principles, beliefs and values. These are commitments about what's important, how people should be treated and what's right. It should be no surprise, then that therapists are so committed to their models — it might represent something as important as a commitment to justice or equality. As an early structural therapist, I stood for accessible theories, jargon-free clarity and therapeutic leadership. In my days as a Milan therapist, I stood for neutrality and self-determination. Come post-Milan, I also stood for more collaboration and a disbelief in grand theories. And now, as a narrative therapist, I stand for transparency, for accountability, for social justice and for reducing hierarchy. These are not small matters and my commitments have never been small commitments. You might as well tell me not to be passionate about freedom as tell me not to be passionate about my preferred model. Such passion is, I feel, commonplace, and has kept competition alive between family therapy models for better ethics, better effectiveness and ascendancy.

Criticisms of Isolationism

'Family Therapy loves narrative therapy but narrative therapy is indifferent' says David Pocock (Pocock in Flaskas et al., 2000**:** 138). 'No field of knowledge can grow towards health if it refuses to dialogue with others', but is 'huddling together with those of like minds against a perceived hostile world'. Narrative needs 'the (belated) willingness to open itself to other traditions' (Crago & Crago, 2000: iii, iv). Narrative therapists have 'an increasing tendency to shun dialogue with family therapists who do not work from an exclusively narrative perspective' (Larner in Flaskas et al., 2000: 128), narrative therapy can have a 'lack of critical awareness' (Larner in Flaskas et al., 2000: 127) where 'each therapist's voice becomes self-legitimising' (Doan, 1998: 384) and 'stories told in the therapist's own words … do not have to plead to any

higher court or set of experts for authenticity' and 'attempts by other therapists to question the validity of such stories are themselves rendered illegitimate'"? (Doan, 1998: 384).

So why are other family therapists so interested in talking with narrative therapists? Perhaps because narrative therapists have initiated some bold and theoretically coherent practices that are sympathetic to systemic principles (e.g. externalising conversations, 'taking it back' practices, letter and document writing, re-membering conversations). Narrative therapists have also taken up and developed some of the issues that other systemic models were grappling with (e.g. transparency, reflecting teams, collaborative practices, postmodernism and social constructionism). Additionally, narrative therapy's attention to values and ethics appeals to therapists looking for a transparently principled practice.

Conversely, what recent developments have systemic approaches made that are being widely adopted? It seems more likely that other family therapists adopt, by 'cherry-picking', those narrative ideas that they wish to incorporate. Externalising, for example has emerged as a recommended 'technique' in many behavioural and systemic approaches. Several recent therapy papers use the word 'narrative' quite liberally — incorporating it into the title and sprinkling the text with it — but often these approaches have little to do with post-structuralism or what I have come to understand as narrative therapy. The word has popular appeal but means many things.

Isolationism also seems linked to positioning. Positions inevitably have areas of mutually exclusivity and it is hard to take one without implicitly criticising those who take alternative positions. I have recently stopped eating meat but have learned not to say this unless cornered, as it seems to invite defensive and justifying position-taking from meat eaters. People only act defensively when they feel attacked or threatened, and vegetarianism can be experienced as an implicit attack on meat eaters, just as the

latter's irritated responses can be experienced as an attack on vegetarianism. No one intended criticism here, but this kind of attack/defend assumption-making and meaning-making delivered it. I experienced a similar process recently when talking about post-structuralism to a mixed group, without adequate appreciation of some of their long held theoretical positions. Minuchin says 'In response to new knowledge there is always the question of how to maintain oneself….it is a defensive position' (Simon, 1984: 84**),** and for me to promote post-structuralism is to perform a relative devaluation of structuralism (Payne, M., 2001, personal communication) and the self that structuralists might wish to maintain. When one idea or approach is abandoned in favour of another, the first approach is inescapably valued less. Those persons still attached to the first approach are implicitly linked to the lower value and can experience themselves as being criticised. There's an uncomfortable implication of not having moved on, lack of development or failure to keep up. This experience of criticism does not, I believe, operate so clearly when the persons concerned did not have a strongly held original stance, as no comparison has been made.

Criticisms of Deserting the Family

Are narrative therapists 'retreating from interactional work' and privileging 'the individual narrative over the social systemic interactional'? (Stagoll, in Flaskas et al., 2000: 125). Has the family disappeared from practice? Have 'social constructionists embodied the anti-family anti-patriarchal bias of radical liberation ideology'? (Minuchin, 1998: 399) Have we 'misplaced the family' and 'returned to an emphasis on individual psychology'? (Minuchin, 1998: 403).

When I hear the comment 'Narrative therapy isn't systemic' or 'Narrative therapy isn't family therapy' I wonder what effect is intended: to clarify difference, or to locate narrative approaches outside systemic territory? It's true that I now pay less attention to some systemic practices — e.g. hypothesising or circular causality. It's

also true that I am paying more attention to other systemic ideas — e.g. reflecting teamwork and social constructionism. And some systemic practices have remained — e.g. staying close to the feedback and trying to simultaneously entertain multiple points of view.

I ask some kinds of systemic questions less now — e.g. 'What would your father say about what your mother just said?' or 'How is this affecting your parents' relationship?' And I am asking other kinds of systemic questions more — e.g. 'What's it like for you to hear your children talking to me about these things?' or 'Who in your life might not be surprised that you could have done this?'

Few systemic ideas or practices are common to all models of family therapy. Think about the considerable differences in theory, philosophy, ethics, aims, therapist positioning, and language practices between Structural and Milan models but, like narrative therapy, both models attend to the nature, meaning, and effects of relational ideas and practices. Some systemic ideas are certainly not congruent with narrative practices (e.g. strategic interventions, functional hypotheses, structural intensification and enactment) but if, for example, I'm asking about identity construction, it is ideas of social constructionism that I hope will be guiding me. If I'm interviewing someone on his/her own, I want to keep in mind opportunities for outsider witnessing possibilities (White, 1995), for taking it back practices (White, 1998) for the witnessed performances of claims (White, 1991), and for re-membering conversations (White, 1997, Myerhoff, 1982). These are all systemic ideas and practices that narrative therapy has helped develop – they are all ways that the person's relationships can contribute to preferred developments. The old mechanistic metaphors that likened a family to the homeostatic processes of a central heating system (the cybernetic model) is only *one* way of thinking systemically. Therapies that prioritise the significance of relationship, connection, context and community in influencing thinking, action and meaning making (as opposed to, e.g. the unconscious, learning

theory or biological processes) are routinely called systemic. In this way, narrative therapy continues many traditions of systemic practice, and I regard many systemic skills (e.g. circular questioning, curiosity) as contributing to good narrative practice. The debate about whether narrative therapy is more, less, or differently 'systemic' reminds me of early claims by some adherents of the Milan approach that as they took extended social systems into account, theirs was more truly systemic than other approaches and, therefore justified being called 'Milan Systemic'.

I have deserted some systemic practices, kept some on and acquired some new ones. I have also learned some interesting new ways to talk with individuals that privilege social and interactional process. These processes make assumptions about the significance of the connections between people to render any such connected grouping more than the sum of its parts. Thus I might call this practice systemic.

However, can this therapy adequately be described as a therapy of the family? Here in the UK, the national organisation added to its title "The Association of Family Therapy" the phrase "and systemic practice" in the 1980's to include the systemic work done outside family contexts. Narrative therapy – like most other systemic therapies – does not so much privilege family relationships as significant relationships.

Criticisms of Language

Narrative therapy stands accused of seeking to 'impose its own language' (Larner in Flaskas et al., 2000: 127), of being a language of 'psychological rhetorical overkill' (Stagoll, 1998**:** 67). Narrative therapy may 'speak from the heart' but can this 'also be a way of avoiding uncomfortable realities'? (Crago & Crago, 2000: iv).

Narrative therapists in general and Michael White's writings in particular have certainly taken up some different linguistic ways. Enormous care often seems to have gone into White's construction of ideas and terms of description so that highly specific but counter-cultural notions and wholly different ways of thinking can be apprehended using familiar words in unfamiliar sequences and juxtapositions. Ideas can get distinguished with a clarity that is not, in my view, achieved by those who, later on, write the interpretative and more accessible descriptions that we may more easily learn from. If we accept that language creates our perspectives as well as reflects them, then different language practices will be required to access different perspectives and to think outside of what is routinely thought (White, 1997). Cultures do not invent or sustain language to describe ideas and practices they do not recognise — there is no equivalent phrase, for example, for 'thin description' – and no need for one within a structuralist culture. When this kind of language is experienced as 'rhetorical overkill' or 'avoiding uncomfortable realities' I suspect they've understood something different from me. Language forms may be poetry to one person whilst being 'rhetorical overkill' to another.

Narrative language practices have also assisted my efforts at deconstruction, helping to expose the complexities and contradictions of popular language and highlighting alternative constructions and meanings. Externalising language, for example, can sound odd at first but implicitly challenges cultural assumptions about the location of problems. Externalising's frequent use of metaphor denotes meanings that would be unavailable in more literal language. Non-structuralist language that would, for example, consider 'confidence' or 'determination' as qualities that are 'used' or 'employed' (rather than being 'part of' the person) emphasises conscious purpose and implies they are available to everyone. This challenges assumptions about people having qualities (or deficits) and personality having an essence or a location. Deconstructions can expose cultural and other bias, making disadvantaging effects more visible (e.g. 'How did you come by the idea that women are natural mothers?').

These ways of speaking have been popularised by (but are not the sole reserve of) narrative therapy.

The popularity of accessible texts like Martin Payne's *Narrative Therapy* (2000) or Alice Morgan's *What is Narrative Therapy?* (2000) demonstrates that narrative ideas can be translated into everyday language. Some of the richness may be lost but they do provide a choice of access routes to narrative understandings.

Criticisms of Sectarianism

Do narrative therapists 'mimic the devotion shown to religious and political factions' (Doan in Flaskas et al., 2000: 131) where 'narrative commands evangelical fervour'? (Crago and Crago, 2000: iv.). 'I fear I can smell the incense of a new church, seeking converts not free-thinking therapists, and searching for salvation not wisdom' says Stagoll (1998**:** 67). Defending 'the "territory of their sacred beliefs"' (Doan, 2000**:** 131), 'fans' become 'fanatics' (Doan in Flaskas et al., 2000: 131)**.**

These comments seem to denounce narrative therapists just as they appear to denounce those who actively link their lives to religious or political groupings. These comments mock faith and commitment as a basis for action and imply that thought and reason have been deserted. I don't experience narrative therapy as a religion or political party, or believe that thought and reason have been abandoned but narrative ideas and practices do seem to be something more than just another therapy model. Other models don't routinely step into the kinds of political alignments that narrative therapists do. Other models require less ethical exposure and tend to be more theory-based than value based. (E.G. The narrative approach to reflecting teams (White, 2000) that asks team members to situate their comments ('embodiment') represents a particular commitment to the value of accountability. This accountability is further developed in the 'Part 4' of narrative sessions where the team and family are

encouraged to ask the therapist to account for their questions/areas of interest/theoretical orientation etc. Additionally, White's ideas about 'scaffolding conversations' (White, 2002) describes an enquiry into peoples values as a critical step towards non-structuralist identity descriptions.) Narrative therapy may be theory based too but it is hard to imagine any new narrative practice developing that does not reflect values like transparency and collaboration or that does not make us accountable to those who consult us. Structural, Strategic, Milan, post-Milan, Solution Focused — none of these approaches is so limited by such considerations.

There are few spheres of life, other than the religious, where so many foundational commitments are held together so tightly, and when — as narrative therapy does — you link the personal, the political and the ethical to the therapeutic, significant professional commitments or sacrifices may seem to be required. For those who already have long histories with other therapeutic traditions, these may be career and status sacrifices, and I understand this to be part of the reason why experienced therapists can face the biggest step when contemplating taking up narrative practices.

Each model may be a different perspective on problems, but narrative therapy's perspective includes much more in the frame. Local cultures, histories of socialisation and community, political climates, psychotherapy traditions, the power and bewitchment of language, the construction of identities, oppressive discourses, philosophical proposals — few areas of life escape significance. This has commonly resulted in narrative therapists positioning themselves in relation to more areas of life than therapists of other persuasions. At a stretch, for example, you could have identified yourself as a Strategic, Structural or post-Milan therapist and maintained a left or right-wing political position, been for or against equality in society, valued neutrality or non-neutrality, centred or de-centred yourself as therapist, been knowing or not-knowing, adopted modernist or postmodernist, structuralist or poststructuralist frames. Narrative practices are available for anyone to use in whichever (ethical or

unethical) ways they like, but to identify yourself as a narrative therapist is to imply your alignment with fairly specific values, practices, politics, ethics and theories.

When, four years ago, I started exploring narrative ideas and locating myself freshly in relation to such positions, the hardships and struggles of learning were to do with lack of skills rather than the ideas not fitting with me. Ethically, narrative therapy felt like a logical follow-through and added to my sense of congruence. It was less a re-invention of myself and more a clarification. It is clearer to me now that the main reason for my early attachment to Milan and post-Milan approaches was their ethical appeal. Milan's interest in circular questioning, curiosity and its lack of any blueprint for how relationships fits my passion for respectfulness and autonomy.

And there's so much to learn about these ideas that I know I'm less interested in spending time on others. My abandoning a previous style may feel to some as a betrayal or as a criticism of their choice not to follow the same path. As one of a group of teachers, I sometimes sense competition for the minds of students. I cannot avoid the conclusion that I view the new-to-me ideas as better in many ways than the old ones. I have a shelf full of books and papers I no longer look at.

Criticisms of Colonialism and Ethical Superiority

Is it that narrative therapy 'dismisses systemic thinking as part of an oppressive discourse' (Larner in Flaskas et al., 2000**: 126**), with an 'inner-circle of therapists considered to be real and authentic' and other voices becoming marginalised and unheard? (Doan, 1998**: 382**). Does 'the pluralist position of the narrative therapist seem to stop at the consulting room door' (Amundson, 2001**: 175**)? Is narrative therapy enacting the 'same discursive violence it purports to locate in the monoculture'? (Larner in Flaskas et al., 2000**: 127**). Has narrative therapy 'produced a morality play' involving a 'narrative puritanism', and an 'intimation of superiority'

(Amundson, 2001: 176), with 'a felt sense that some things are wrong and some right' (Minuchin, 1999 in Amundson, 2001: 176)?

Most western therapists would probably agree that ideas like transparency, collaboration and accountability are ingredients of good practice, but the kinds of actions required to follow through on these principles are demanding. Such actions might include putting favourite theories and texts up for public scrutiny to help demystify expert knowledge and authority, or giving up those private clinical discussions of 'cases'. 'Hearing the consumers' voice' (a fashionable idea in theory) would require our learning how to listen better and how to assist others in giving voice to their views. Whole professional value systems might have to be abandoned. Accountability structures — perhaps like those of the Just Therapy Centre in New Zealand (Waldegrave, 1990) might be called for, imposing hierarchical upheaval on agency caste systems. What constitutes knowledge and expertise would be up for revision. Clinical skills would be subjected to evaluation by our customers. Our positions, clinical hierarchies and traditional professional structures would be vulnerable. It could feel like a professional revolution or even professional suicide to those whose lives and livelihoods have been constructed on the back of these manifestations of power. Many western therapy practices would not stand such scrutiny, and for us to promote practices of transparency, collaboration and accountability threatens all these things and is — by implication at least — deeply critical of those who do not 'follow through' on such 'good practice'.

Because these principles have a kind of self-evident morality, when I speak of them as commitments to follow through on (rather than merely values to keep in mind) I am bringing an ethical lens to bear. This can feel to some people like imposing a moral judgement, and blame can become shame. I should not be surprised to be accused of occupying the high moral ground when I speak in ways that result in others feeling shamed. It is one thing to situate my comments, self-reflect and position myself in

relation to others, quite another to imply (even unintentionally) that this is how conversations should happen or therapy should be done. Such actions ignore the ethical positions and interests of others and create new normalising judgements.

Show and Tell

Critiques of narrative therapy have caused me to look closely at my own teaching practice, trying to understand which practices generate negative criticism and which generate understanding and enthusiasm.

A common part of family therapy training in my agency is to interview families with groups of students observing and constituting a reflecting team. In this context I interviewed Jamie (eight years), his brother Steven (thirteen years old) and their mother, Judy, with a reflecting group of six trainees who were two weeks into a foundation level family therapy training program. The trainees were glued to the unfolding story behind the one-way screen and there was no conversation between them. During the interview Jamie's tempers became externalised as 'The Raging Bull', the effects of the raging bull on Jamie's life were drawn out and he explained where he stood in relation to these effects. Jamie pointed to 'the big emptiness' in his chest since his dad had left, and Steven described (to his mother's surprise) how he had known about this 'by putting two and two together'. Judy expressed her pleasure at hearing what Jamie felt and her surprise at Steven's understanding. When we swapped rooms, the reflecting team guidelines were carefully followed by the trainees. One trainee described her own experiences as a single parent with two boys, another was openly tearful as so many of her own experiences had been evoked, others commented on the striking bond between family members and wondered how Judy had maintained this. Behind the screen Judy was absorbed in their discussion. When we switched rooms again, Steven spoke of how well the team seemed to understand and the importance of reflecting on what was happening.

The trainees had been captivated and their lives implicated in the unfolding story. They had been active and transparent in acknowledgement, their contributions openly valued by the family and the effects had moved them to a different position. I was struck by how the trainees and I had achieved a different engagement, they had witnessed something of what these practices could achieve. Now I could talk with the group about some of the ideas I was using — externalising, the Statement of Position Map (White, 1999a) and staying close to the feedback. They had seen some theory-in-action, experienced its effects and wanted their own practice to include it.

For trainees in family therapy courses, the learning from training clinics can often be both greater and more resilient than learning from seminars. So why spend so much time on theory so early on? Cultural notions of how-to-teach promote the 'banking' mode (Freire, 1985) where deposits are made, assets accrue, and sufficient resources allow deposits to be made in other accounts. These commercial and mining metaphors of structuralist thought support the teaching of theory as a deposit. The 'midwife' account of teaching (Belenky, Clinchy, Goldberger & Tarule, 1986) where learning is brought forth, where students can move from the known to the possible to know (White, 2002a) is more in keeping with narrative and post-structuralist ideas. I have found that when trainees view videotape extracts, observe live clinical work, undertake experiential exercises, are interviewed themselves or participate in reflecting teamwork, their experience of the ideas or practices is less likely to lead to concerns about the therapy or the therapist's isolationism, sectarianism, desertion of the family, language style or ethical superiority. Teaching from practice to theory, demonstrating (rather than advocating) the principles, enquiring about trainees' intentions, hopes, commitments and values and the kinds of practices that would best reflect them — these are the kinds of ways that, I am realising, run less risk of incurring distancing and rivalry.

I have experienced how talking of theory can alienate the listener and feel competitive to both listener and speaker. Generalised claims are too easy to make when contextual specificity is lacking. Value can be asserted by teachers rather than judged by students. Notions of territory may be invoked as positions are mapped and perspectives are elaborated. Meanings are too easily given rather than felt or experienced. What is to be learned can get prescribed rather than discovered. But still we can't just teach the practice without the theory — unless we know *why* a therapist said something, how do we know when to say the same thing ourselves?

And I have also experienced destructive criticism when showing less-than-great videotaped examples of my practice to therapists with other approaches. These presentations were, I now believe, taken as an invitation for others to offer the kind of supervision that involves suggestions, interpretations and negative value judgements. If I do this again, I would want to agree beforehand the kinds of practices necessary for us to constructively engage together in videotape review. If it's deemed a good thing for therapists to be open about their practice, then respectful observing positions that support the therapist's preferred skill developments are necessary. These positions do not include invitations to judge or interpret another's practice (White, 2000b). Presenting clinical work rather than clinical theory may offer more options for responding but it is not a licence to say *anything*.

Conclusion

Martin Payne writes:

> I have some sympathy with people who see Narrative Therapy as obscure, self-justifying and
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> exclusive. But its obscurities can be explained in direct language, its self justifying is legitimate
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> because it has important and fresh ideas and practices to propose, and its exclusivity is mythical —

narrative therapists offer courses and write books and articles. It just seems exclusive to those who hold different positions (Payne, 2001).

However, when my (narrative) attitude is experienced as moralising, my language as inaccessible and my practices as sectarian or isolationist, then I am probably forgetting the importance of context (i.e. who I'm talking with and the kind of space I'm talking into). Telling stories of, or showing, my practice is a safer and more reliable way to generate curiosity, but practice without theory makes skills and knowledge too context-specific and less transferable to others' practice situations.

My sense is that most narrative therapists have now stepped back from regular dialogue with other therapists, and restrict themselves to occasional individual responses to specific critiques. The differences between the approaches are great and narrative therapists are, in any case, interested in different things. Narrative therapists are busy exploring links with folk psychology (White, 2001), with linguistics (Epston, 2002) with personal failure and modern power (White, 2002b) with developing maps of practice (White, 2002a) with memory theory and responses to trauma (White, 2002c). I started this paper as a contribution to a hoped for dialogue that would keep a vibrant connection between approaches alive in the UK and there are numerous examples of such dialogue. Many journals publish papers from the different approaches (e.g. *Context*, *The Journal of Systemic Therapies*, *Family Process*) and many books span these different approaches (Hoffman, 2002; Denborough, 2001; Beels, 2001). Each different journal, each book and each family therapy conference or training programme makes a different accommodation of these ideas.

In the meantime I am striving to be more careful with language. As family therapists, we know the merits of dialogic language. Whilst some of the criticisms of narrative ideas that I have referred to undoubtedly reflect frustration, the frequently combative language used to describe narrative therapy (e.g. narrative therapists language can be

'coercive and represent a form of terrorism' (Doan, 1998:394) 'colonisation' (Larner in Flaskas et al., 2000: 127) 'discursive violence' (Larner in Flaskas et al., 2000: 127) 'puritanism' (Amundson, 2001**:** 176) 'fanatics' (Doan in Flaskas et al., 2000: 131**.** 'factions' (Doan in Flaskas et al., 2000: 131**.** 'evangelical fervour' (Crago and Crago, 2000: iv.) contributes to the distance between us. Such distance seems to lead to some angry systemic shouting and some narrative deafness. (Of course, the metaphor of family therapy 'territory' (**'**The map is/is not the territory'**)** is itself problematic, inviting claim-staking and limiting alternative visions of land and space usage.)

Conversely, descriptions and accommodations couched in generous language are more than mere rhetoric — they elicit wholly different responses, they bring the effects of my words in line with my intentions they reduce the chances of distinctions becoming denouncements and will make further adaptation easier when the next approach (as surely there will be one) tries to find its place in the field.

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