

Epistemology

It is not a word that is seen very often these days. Yet it was probably one of the most common preoccupations for family therapists for many years. But in the last decade or so we seem to have solidified our certainties. Of course, there are the post-modern perspectives which continue to maintain the relativistic stance in relation to knowledge though these positions seem very much in the minority. So, we come back to the word epistemology. I can remember in the 80s feeling that it was a much overused word. Bandied about by every wo/man and their dog to such an extent that the idea expressed was reduced simply to mean 'point of view'. As in, 'we all have our own epistemologies'. How then to introduce the idea that it is perhaps time again to talk of epistemology? Not the epistemology of points of view but the idea that how we come to know things, the rules that are accorded legitimacy for knowing, the politics of knowing, are current and significant factors in our current lives.

The issue of the journal that you hold in your hands does not on the surface appear, I would argue, to have much to do with the politics of knowledge. Some time ago I put out a call for people to write about their experience of research in their clinical settings. This came from my interest in trying to highlight the importance of locating research into therapy where therapy happens. So much of the research that governs decisions that are being made about what is 'good' or 'bad' therapy is done in settings and under conditions that bear very little resemblance to the real world. Obviously this is partly due to the fact that it is very difficult to do research using quasi-experimental and naturalistic designs. Nevertheless, I have always felt that, whatever the loss of internal validity, it is necessary to recognise that most clinical therapeutic outcome research does not require the methodological stringency of experimental methodology. Rather, there is more value in having designs for outcome research that has high external validity that can be generalised to the real world of clinical practice.

A lot has been written about the gap between research knowledge and implementation by clinicians. Very often what is written is by researchers and academics, and not by the clinicians themselves. As a long-time clinician prior to becoming an academic, I feel that I have a clearer understanding of this issue than most of the positions that I have read. To my mind, the gap is really one of understanding the different models of knowledge that are accorded relevance by the two groups. On the one hand, researchers and academics in this field tend to value that knowledge which is generated using research methodologies based on evaluation of groups of clients utilising various controls that allow for questions of causality to be evaluated. Clinicians, by way of contrast, value knowledge that is generated largely from their own experience, but also from the experience of other clinicians, in the actual practice of clinical work. Most clinicians, I

believe, consider outcome research, based on comparisons of groups using randomised controlled trials with highly selected populations of clients, to be largely boring and marginally relevant to what they actually do on a day-to-day basis. Obviously, this point of view is completely foreign to those academics and researchers who make their livings submitting grant applications to powerful and highly restrictive foundations where the concept of science has a definite and clear meaning. It is completely impossible to obtain money from the various funding agencies in Australia without accepting, and talking, the language of positivistic science.

Within this framework the clinicians view of what is useful information is considered the least useful form of information/knowledge. It is dismissed as anecdotal. A positivistic view of science requires that there is a hierarchy of knowledge. At the very top of the hierarchy comes knowledge that is generated by empirical/experimental methodologies. Down at the very bottom comes knowledge that is personally known or developed from personal experience. So, no wonder there is puzzlement as to why clinicians do not accept and embrace the knowledge that has been generated about clinical practice. The position that a clinician might take, that they trust their own judgment and their own experience, has no validity and no value. Equally, I suppose, the position of the academic/researcher is a puzzle to the clinician. It is hard to understand how knowledge generated through these experimental methodologies can be taken seriously. Who can believe that these restricted and narrow enquiries into the human experience have any real capacity to answer questions that are relevant to the lives of real people. If there is a hierarchy of knowledge, it is quite apparent to the clinician that the experimental divination of information is of a lower order when it comes to understanding the real people who present in our offices on a daily basis.

So, we come back to question of epistemology. I bet you wondered if I was ever going to get there? My interest in knowing about the experience of clinicians in research has been about trying to generate other ways of understanding, and other voices in, the discussion around knowing what works in therapy. We are currently in an era where the empirical knowledge of 'scientists' is valued more highly than the personal knowledge of clinicians. This is exemplified, at the current time, by the preeminence of evidence-based practice frameworks. However these are called, they focus on hierarchies of knowledge where the empirical/experimental is considered to be at the highest level and the clinical/experiential to be at the lowest level. Part of the challenge to this framework must come from more clinicians voicing their values and directly questioning the politics of knowledge that exists at the moment. Another part of the challenge comes from accepting the need to utilise empirical methodologies but

framing them so that they have external validity and relevance to the experience of clinicians. Yet another part of the challenge comes from working in the way that we know make sense to us and refusing to be structured and dictated to by systems of knowledge that are alien to clinical practice. Included in this must be writing about and describing what we consider to be our knowledge as clinicians. Ultimately, if you accept that clinical practice and clinical experience are evidentiary in themselves none of this is particularly concerning. However, if you accept the notion that clinical knowledge is of the least value, the above must be considered heresy. But, what is heresy in reality if not simply the expression of an alternative understanding of the world? In this situation, the heresy is the expression of an alternative understanding of how knowledge is generated.

Something can only be understood as a heresy if it is accepted that there is a point of view or a position that can dictate what is correct or true. We are at a point in the history of therapeutic practice where this is the case. Certainly, when I began to practice as a clinician I would have said that no one could dictate my practice; that how I chose to carry out therapy was essentially a matter of rational and historical factors. Rational in the sense that the approach to therapy that I use was one developed on the basis of reasoning from theories about therapy, rather than one based on empirically generated evidence. Historical in the sense that the approach to therapy that I use was based on what I had actually been trained in. Currently, I would have to argue, it is no longer the case that clinicians are free to choose how they will practise. This choice is constrained by institutions of training and by funding organisations that focus on the so-called evidence based approaches. It is not such a burden in Australia at the moment but it certainly appears to be a significant constraining factor in other countries. It is not hard to see that Australia will soon follow the path that it usually does, of mimicking the United States. Certainly when this happens it won't be possible to use the term 'heresy' so lightly. Hence, my interest in trying to generate some alternative understandings about these issues now.

I think that you will find in reading through the various contributions to this journal that there is a wealth of different knowledge of different understandings about the questions of clinical practice. Nick Drury introduces the intriguing and wonderfully poetic notion of the 'the delicate scientist practitioner'. In a deep and thoughtful exploration of the foundations of empirical knowledge, Drury raises the question of how the clinician can be a scientific practitioner. What ways of knowing can properly inform the ground of experience that the clinician walks on? He introduces the reader to ideas about empiricism that challenge the traditional historical understanding of empirical practice. This is an article that requires several readings as there are many

strands and many thoughts developed, but also an article that rewards careful reading by generating a range of new ways of understanding the questions that need to be asked about how we know as clinicians. In another very interesting article, Ingrid Wagner and colleagues describe their experience of the practice of family therapy within the current framework of the National Mental Health Standards. Their starting point is to notice how difficult it is to maintain family and systemic therapies within mental health services. Wagner and co provide an interesting and challenging critique of the National Mental Health Plan and its underlying assumptions, but go on to describe their own experience of working within the constraints of such a framework to achieve the establishment of sustainable family therapy practice. Peter Stratton and his colleagues then describe the basis for the development of an outcome measure specifically for family therapists. In this article they provide a description of the qualitative methodology utilised to begin the development of the outcome measure. In this way, they provide a good example of the involvement of clinicians in research from the very beginning. Finally, Frank Dattilio provides a discussion on the place of case-based research in family therapy. The current trend is to value large-scale group-based research. Yet, it is acknowledged within the evidence-based framework that single case studies are of value in the generation of meaningful knowledge. Dattilio explores some of the issues in relation to case-based research and encourages family therapists to utilise this approach in the generation of knowledge about the area. There is also an interview of Jeff Gerrard by Lorraine Read where Jeff explores the history of his own journey as a clinician. Finally, it is worth noting that the 'Letter from Britain' and the 'Research in Practice' sections both explore the theme of knowledge and how it might be validated within what frameworks, with what politics.

In concluding, as the guest editor of this edition of the journal, I believe that there are ranges of writings here that cover a breadth of views on the question of knowledge in clinical practice. None is specifically or particularly what I might write myself, but I suppose that has been my own learning in this role of editor. I might want to emphasise my views about a topic as an author but, as an editor, it is actually more important to help other authors to clearly emphasise their views. I have been fascinated to read the various manuscripts which have now come to publication, as well as those few that have not, and welcome their different ways of 'thickening' the vague notion that I originally started out with. I hope that you, certain reader, in reading these contributions will be able to hear the other voices, even if at times only faintly, and enabled to hear your own voice. Bonne chance.

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