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From Interpretation to Commentary: Truth and Meaning in Psychotherapy

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Some of the epistemological consequences of adopting the narrative point of view in psychotherapy are explored. Attempts to apply principles and norms from the philosophy of science to psychotherapy are criticized, since psychotherapy is not a science, but a technique. In addition, those models, related to the acquisition of knowledge, that consider that knowledge could increase by apposition without transforming the subject who is knowing are discussed. Natural science and hermeneutic metaphors are not suitable for understanding the practice of psychotherapy. Traditionally, the interpretation of symptoms or problems to solve has been the main instrument in therapy. In other words, the therapist tries to look for the truth hidden under the symptom, which then becomes a sign. Our proposition is to substitute these metaphors for the paradigm of text commentary. Text commentary, instead of providing a unique truth, provides a set of meanings suggested by a commentary. Characteristics that allow one to distinguish a good and a bad commentary, and implications of the paradigm described for the training of psychotherapists, are discussed

KEY WORDS: epistemology; psychotherapy; narratives.

An increasing number of therapists have been using narrative as a theoretical framework within which to examine their practice in recent years (Vogel, 1996). Narrative has recently emerged as a good framework for therapists from different orientations such as psychoanalysis (Gill, 1994; Luborsky, Barber, & Diguer 1992; Schafer, 1976, 1986; Spence, 1982), cognitive therapy (Gonsalves, 1994; Guidano, 1991), experiential therapy (Greenberg, Rice, & Elliot, 1993) and systems theory (Efran, 1990; Hoff-

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man, 1987, 1990; Linares, 1996; McNamee & Jergen, 1992; Sluzski, 1992; White & Epson, 1990). It has also supplied a metatheory which integrate ideas coming from different schools into a coherent entity (Gold, 1996; Omer and Alon, 1997).

The main goal of this paper is to emphasize some epistemological consequences of adopting the narrative framework. My purpose is twofold. First, to criticize epistemological prejudices that operate in an incongruent way in our reflections about psychotherapeutic work. Second, to show the lack of adequacy of natural science and hermeneutic metaphors and then to propose the paradigm of text commentary as an alternative to these metaphors.

Before exploring the topic of this article, two epistemological assumptions must first be explicitly discussed. The first can be formulated without difficulty: psychotherapy is not a science. Not, however, as is sometimes argued, that it is still not a science due to its state of development (preparadigmatic). It is not a science, as medicine is not a science, because its goal is not knowledge, but the achievement of a social value: mental health. Those who practice psychotherapy, geared toward this goal, try to be guided by or to incorporate scientific knowledge from diverse disciplines (as plumbers and architects also do) and not by personal characteristics (like those that would convert one into a fortune teller) or the mere performance of a skill shaped by tradition (like artisans, witch doctors, and prostitutes), which gives such scientific knowledge a technological character, as stated by Tizón (1992), based on Bunge's and Quintanilla's concepts. Table I places psychotherapy, along with other technological fields, within a panorama of diverse disciplines.

If this is the immediate application of the principles and concepts of the philosophy of science to the practice of psychotherapy (or of psychiatry or medicine), even though we have repeatedly seen it attempted in the literature, it would only serve to further complicate the situation. Descriptions like those of Kuhn on scientific work, or normative suggestions like those of Popper, are not applicable, more than metaphorically, to our work. However, it is not unusual to find in the professional literature statements like ''our discipline is in a *preparadigmatic* state'' or ''it is necessary to formulate *falsifiable* hypotheses.''

The scientific position in the practice of psychotherapy, as in any other type of technology, implies (1) a careful look at the findings of scientific groups that work in related fields, such as psychology, to discover new practices or to challenge older practices, and, more importantly, (2) a continuing attempt to assess the efficacy and the utility of interventions and the rightness of their explicit or implicit assumptions.

The first of these points has rarely been studied by psychotherapists.

Table I

Discipline	Goal	Foundations	Practitioners	Criteria
Science (physics, mathematics, biology, . . .)	Produce knowledge	Reason, observation, experimental evidence	Trained and recognized by the scientific community (university, publications, . . .)	Truth
Technology (architecture, medicine, psychotherapies, . . .)	Produce a social benefit	Proven effectiveness in the resolution of known problems; method to search for new solutions; contrast with current scientific knowledge	Qualified through scientific and professional training (university, scientific associations)	Effectiveness, efficacy, efficiency
Skilled labor (plumbing, mechanics, . . .)	Produce a social benefit	Proven effectiveness in the resolution of known problems	Qualified through a system of technical training	Effectiveness, efficacy, efficiency
Craftsmanship (pottery, weaving, . . .)	Produce a social benefit	Creation of a solution traditionally considered as suitable	Training in this tradition	Correctness
Esoteric practices (astrology, fortune telling, . . .)	Produce a social benefit	Acceptance of a belief shared with the client	Innate characteristics or those acquired through initiation rituals	Confidence

Academic psychology, which has realized important findings, has developed independently from clinical psychology and psychiatry, and vice versa. For example, it is interesting to note the scarce amount of ideas and discoveries of cognitive psychology that have been incorporated or have influenced what is known in the field of *cognitive* psychotherapies.

With respect to the second point, the demonstration of the efficacy and depuration of therapeutic factors has remained unaddressed to the point that Eysenck's (1952) claim that evidence of psychotherapeutic efficacy did not exist was only refuted, and not without criticism, in the 1970s (Lambert and Bergin, 1994; Fernández Liria, 1993, 1994). In addition, the first testing of psychotherapeutic interventions by clinical trial methodology to justify their existence—cognitive therapy for depression (Beck, Rush, Shaw, and Emery, 1979) and interpersonal therapy for depression (Klerman, Rousanville, Chevron, Neu, and Weissman, 1984)—were proposed in late 1970s and the 1980s.

We refer to an *attitude* when practicing psychotherapy. Even with this attitude, the goal is not to get knowledge—that is the purpose of science—but to give health, and the results of the therapy should be measured in terms of health. Therefore, adopting such an attitude does not turn psychotherapists into scientists, nor legitimize the application of ideas and theories created for science to psychotherapy, nor release us from the duty to focus more on the utility of psychotherapy than on the rightness of our observations.

There has been a great deal of literature in the recent years about the relationship between science and psychotherapy. The building of a psychotherapy based on the same principles as the principles of science (criteria of normative epistemologies from the Viena Circle and Popper) has constituted the base of behavioral, cognitive, and the initial systems theories. Other theoretical orientations (Althusser, 1970; Braunstein, 1980) have made similar attempts, and eclectic or integrative proposals (Lazarus, 1995; Fisher, 1996) have also incorporated the principles of science. In general, the main criticisms of these efforts relate to the applying of principles of natural science to human disciplines (Gold, 1996). Though this is true, we also agree with Rennie's statement that both natural and human sciences are rhetorical sciences (Rennie, 1995). This topic has been approached by an attempt to articulate a psychotherapy without foundations. Many authors (Stancombe & White, 1998; Botella, Pacheco, & Herrero, 1999; Caro, 1999; Gergen, 1995; O'Hara, 1995) consider that such an approach to psychotherapy is necessary and is the consequence of *the end of certainty* that derives from what they call *postmodernity*. Another point to be highlighted is that the laws guiding the practice of a technology are not necessarily the same as the laws regulating scientific activity. For example,

the theory of relativity has influenced little the practice of architecture. What we expect from architects is that they build useful, comfortable, nice, and solid buildings and we are not interested that they understand the universe. And this is not something to be ashamed of Geetz points out that "science owes more to the steel engine than the steel engine owes to science."

Stricker (1997) addressed this topic in a very sensitive way and offers the attractive proposal that psychotherapists act as *local clinical scientists*. But he explores the possible *commensurability* and not the identity or continuity between both activities. And the possibility of such commensurabilty has a lot to do with an attitude and much less with the identity of the aims and methods of both activities.

A second assumption refers to the way in which knowledge is achieved. An error that is frequently made when thinking about theoretical work consists in imagining that the knowledge resulting from this work fills a void in which only ignorance existed. According to this interpretation, the new amount of knowledge, however defined, produces a decrease of ignorance or lack of knowledge. In the worst version of this myth, new knowledge combines with that already known, adding by apposition to it, coming from what is unknown.

This myth implies the naive concept of a "scientific community" in which each member provides his/her data, in English of course, according to the preestablished guidelines that allow such accumulation. This provides such members with the sense of participating in joint and impersonal scientific work.

But knowledge, generally, does not advance against ignorance, but instead against prejudices. At a given moment in history, the idea—quite useful in solving certain navigation problems—that the Earth is round did not shed light on the general public's ignorance about the Earth's shape. It challenged past knowledge, and it was enlightening because it refuted (or criticized) the idea (evidence) that the Earth was flat. This did not "add" anything to what was already known about geography or astronomy; in fact, it modified such knowledge and modified the relationship between humankind and these disciplines.

Psychotherapists should take note of this for two reasons. First, our thoughts, at least within each school (perhaps "*school*" means exactly that: the safeguarding of prejudices) are organized as if knowledge could grow by apposition. It is hard to believe that many psychotherapists from diverse schools have complacently practiced their profession or have attacked each other, accusing each other of heresy without having felt compelled to demonstrate the efficacy of their therapy. In addition, and most importantly, because the process of *gaining knowledge* could constitute in itself a thera-

peutic factor (and therefore the process of gaining it a therapeutic objective), understanding this process is particularly relevant. For example, the crucial issue may not be that the therapist designates new meanings, but rather assists the patient to remove *epistemological barriers* that prevent the patient from recognizing these new meanings.[3]

Our interest in the narrative perspective is a consequence of this concept. The different psychotherapeutic schools have learned to highlight their differences by discussing whether what truly takes place in the psychotherapeutic process is related to putting into play negated affects, questioning of irrational thoughts, or exposing, one way or another, certain stimuli. What the different psychotherapeutic models propose is that a hidden truth consisting of unconscious struggles, mistaken beliefs, and dysfunctional learning is lurking behind the appearance of every symptom. We have understood the therapist's work in terms of hermeneutics or interpretation, regardless of whether these terms have been used. The therapist can be effective because he/she relates the patient's apparent discourse with another, which supposedly produces therapeutic effects because it is true. The question that must be posed, which is known as the enigma of the Dodo bird[4] (the similar efficacy of different interventions based on incompatible theories), is how contradictory perspectives may be true or how interventions based on false assumptions may be systematically effective. The hypothesis of this paper is that the different explanations proposed by different schools concerning a mental health problem offer new versions (new narratives) of the problem that are useful not because they are true, but because they are different.

This concept assumes that interventions involved in psychotherapy cannot be characterized as interpretations (which relate the apparent with the true, of which the apparent is a sign), but instead are commentaries (which display a set of meanings suggested by a text) (Lázaro Carreter & Correa Calderón, 1990; Barthes, 1970; Foucault, 1963).

Clearly not all commentaries have the same value; there are good and bad commentaries. Commentaries, however, are not *true* or *false*, but useful or not. Such usefulness is measured in terms of their effect on those who receive them. This is exactly what occurs in psychotherapy.

[3]The similarities between psychotherapy and the Socratic method have been noted by many psychotherapists, particularly Ellis. Socrates himself compared his work with that of the midwife's. This perspective may also be appropriate for psychotherapy. The greatest difficulty in learning the practice of psychotherapy lies in its didactic process in which the therapist is more a facilitator than a guide. Freud said that learning the art of psychotherapy is similar to learning the art of chess, where in the manual "only the explanation of the opening and closing moves of the game can be systematically and completely described and the infinite variety of moves that can take place after the opening move challenges description."

[4]A character from Alice in Wonderland by Lewis Carroll, who says, "Everyone has won and all must have prizes" (Luborski, Singer, & Luborski, 1975).

Psychotherapy is effective whenever, through the joint efforts of the therapist and the patient, it brings to light a new meaning, one of the many possible meanings, from the patient's story, and the new meaning makes the symptom unnecessary.

In this approach, the therapist's goal is not to know something that is given (which would be similar to scientific work), but to create with the patient a new version of the story that gives meaning to the symptom for which the patient consulted the therapist (precisely a version that removes the need for the symptom).

But the work of the patient and the therapist can be characterized as narrative construction. Individuals who reach to therapy bring a story to tell, and the therapist is faced with a story to reinterpret. However, interpretation in psychotherapy does not involve revealing something that exists on its own outside the observer's view. It is the co-creation by the therapist and patient of a new meaning or a myriad of new meanings. By contrast, in the traditional perspective, the psychotherapeutic process of interpretation is considered as a gradual substitution of the patient's ''unhealthy,'' ''dysfunctional,'' or ''untrue'' meanings for the therapist's ''true'' or ''healthy'' interpretation; the therapist's comments replace the patient's doubts and creations (Villegas, 1995).

Through this process of joint construction, a transformation occurs in the dominat stories of the patient/family, which allows for the inclusion of new experiences, meanings, and (inter)actions. This transformation also results in a reduction of the thematic cohesion of all the stories on the problematic behavior (Sluzki, 1992).

The change occurs as a result of the new narratives and the new opportunities to handle problems differently. This new narrative is capable of retelling events in our lives and giving them a different meaning. In this manner, psychotherapy can be viewed as a semiotic process of creating meaning through a collaborative discussion (Villegas, 1995).

The therapist's main work must be helping the patient, family, or group to create out of the old stories alternative stories that they can call their own and that can provide access to new solutions. The therapist should listen to the patient's story and provide access to this transformation through negotiation and agreement. In this undertaking, he/she should use interpretive or technical schemata taken from cognitive, behavioral, systemic, or existential perspectives. The limitless possible variations within this general framework are what make the therapeutic experience an idiosyncratic experience (Sluzki, 1992).

The new story should be similar enough to the original one in order to be accepted by the patient or family, but different enough so as to make unnecessary the symptom or to make manageable the problem to solve. It

should combine sufficient elements from the patient's world to allow the patient to anticipate, plan, and solve life's problems without being questioned. The patient and the therapist must also find the narrative credible and compatible with the values within the patient's social network. This version cannot be prepared by the therapist to be passively accepted by the patient. The therapist's task is not to create a new version of the problem, but to challenge the consistency of the version originally provided by the patient and to help him/her explore possible alternative meanings of the elements within such version (Table II summarizes these characteristics).

Accepting this idea requires revising the fundamentals of our theory and practice. It presents the possibility that each psychotherapeutic school offers a specific model with which to create commentaries about the patient's story (in terms of cognitive schemata, family histories, and learning processes). It requires, for example, reorienting lectures and skill acquisition processes for psychotherapy students so they that will learn more from the literary disciplines from which psychotherapists of past generations learned *unsystematically*. It requires the creation of new procedures for evaluating psychotherapeutic activities, procedures that would be less restricted by specific models of commentary than psychological school currently offer. It also requires the establishment of the possibility of a common methodology to evaluate psychotherapies from different schools. All these goals are not easy tasks.

On the other hand, the use of this approach open the opportunity to be creative and to explore the introduction of unusual concepts and tools in our psychotherapy practice. White and Epson (1990), Gold (1996), and Omer and Alon (1997) have done it already. In addition, this viewpoint offers a theoretical framework which allows us to explain the effect of

Table II. Characteristics of a Valid Alternative Narrative

A valid alternative narrative must:
* Be *different* enough from the patient's original narrative so as to make the symptom unnecessary
* Be *similar* enough to the original so that it can be believed and accepted by the patient
* Integrate *sufficient elements from the patient's world* to allow him/her to anticipate, plan, and solve the problems raised by the challenges of his/her world without it being questioned
* Be *creditable* to the patient and therapist
* Be *compatible* with the patient's value system

This narrative cannot be prepared by the therapist and then offered to the patient to be passively accepted; the therapist's task is not to create a version of the patient's story, but to question the consistency of the story offered by the patient and to help him/her explore possible alternative meanings of the elements within such a version

therapeutic strategies from different schools and to guide their use with patients.

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