

Drawing on decades of experience, Stephen Madigan weaves a rich understanding of the history, philosophy, and clinical practice of narrative therapy. Whether you're a student, educator, or seasoned clinician, this book provides practical guidance for applying narrative therapy with diverse populations and in diverse clinical settings.

—**Janice Ewing, PhD, LMFT**, Founder, Narrative Initiatives San Diego, and Faculty, San Diego State University, San Diego, CA, United States

Stephen Madigan's third edition of *Narrative Therapy* is a powerful contribution to narrative practice in particular, and psychotherapeutic practice in general. He gives welcome recognition to the many ongoing international social and cultural contributions, which have helped keep narrative approaches relevant and important for the present day.

—**Makungu M. Akinyela, PhD, LMFT**, author of *Culture, Politics, Spirituality and Practice: A Book of Resistance and Critical Theory for Disturbing Times*

Dr. Madigan's book is a great read for therapists of all theoretical orientations who are serious about improving their craft. The book is an invitation for readers to consider the sociopolitical and therapeutic implications of accepting an individualistic frame of reference for understanding their work and the challenges clients present. Dr. Madigan provides a wealth of clinical examples that illustrate the therapeutic possibilities that such a reimagining affords. A helpful and important contribution to the therapeutic community's evolving conversation.

—**Darryl Grigg, EdD, RPsych**, Grigg & Associates Psychological and Consulting Services, Vancouver, British Columbia, Canada

Contents

Series Preface	<i>xi</i>
Preface	<i>xvii</i>
How to Use This Book With APA Psychotherapy Videos	<i>xxv</i>
Acknowledgments	<i>xxvii</i>
1. Introduction	3
2. Brief History	11
3. Theory	27
4. Narrative Therapy Practice	63
5. Evaluation	115
6. Recent Developments and Future Directions in Narrative Therapy	123
Summary of the Third Edition	169
Glossary of Key Terms	175
Suggested Readings	189
References	193
Index	207
About the Author	215
About the Series Editor	217

1

Introduction

The Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgment, and action organized into a distinctive whole and set contrastively against a social and natural background is, however incorrigible it may seem to us, a rather peculiar idea within the context of the world's cultures.

—Geertz, 1983, p. 229

The writings of American cultural anthropologist Clifford Geertz (1973, 1976, 1983, 1988) describe a view of human identity that is considered relational, political, contextual, communal, discursive, and nonindividualist. Narrative therapy holds a similar theoretical view of identity and is consistent with how the practice of therapy is demonstrated.

The historical trajectory of narrative therapy began in the mid-1980s, when my long-time teacher, supervisor, good friend, and mentor

<https://doi.org/10.1037/0000479-001>

Narrative Therapy, Third Edition, by S. Madigan

Copyright © 2026 by the American Psychological Association. All rights reserved.

Michael White (White, 1991; White & Epston, 1990) took a bold ideological and therapeutic step away from 100 years of internal state psychology. He began by questioning the culture of psychotherapy and its fundamental political and social constructs—constructs White suggested featured generalized truth claims about the human condition and universal facts about what constitutes identity. He interrogated dominant psychological constructs making claims regarding the true nature of persons and relationships without considerations of culture, race, ethnicity, class, gender, structural inequalities, circumstance, place, era, and so on.

White's intention was not to simply criticize the existing psychological order, but to hold the ideas up for reflexive scrutiny, and eventually, create a different framework of practice. He questioned the theoretical basis of individualism and essentialism, as well as psychology's focus on the individualized, essentialized, or medicalized self. White also questioned how the disembodied and decontextualized psychological idea of the self could possibly be viewed at the center of identity, personal knowledge, and the source of human meaning. He questioned sets of taken-for-granted power relations regarding the therapist or psychologist's position as the self-identified expert of psychological knowledge and understanding, as well as the noncontextualized totalizing of fixed client identities through psychological manuals such as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association, 2013).

White (White & Epston, 1990) was drawn more to poststructural philosophical concepts in which relational meaning-making and identity formation was viewed as coproduced through cultural, contextual, and social interactions, which are, in turn, shaped by specific sociocultural, political, and economic forces. As he continued his steps away from internal state psychological ideas of the self, narrative therapy began stepping toward a much different ecology of theoretical ideas and therapeutic practices. White envisioned a practice where the therapeutic receiving context of the therapist viewed individual, couple, family, and community relationships as fully embedded and under the direct influence of cultural contexts and dominant norms, rites, rituals, beliefs, expectations, obligations, responsibilities, political and financial structures, educational institutions, and mental health models.

STORYTELLING RIGHTS

I received a call from a staff person at a local psychiatric ward asking if I would consider counseling Tom.¹ Tom was first described to me as “suicidal and chronically depressed” and a person with whom the hospital had “tried everything possible.” The “everything” they had tried included 40 electroconvulsive therapy (ECT) sessions within a 12-month period, six varieties of selective serotonin reuptake inhibitors and antipsychotic medication within a 12-month period, and a year’s worth of group and individual cognitive behavior talk therapy.

The hospital staff person explained the therapy staff had “all but given up” on Tom—a 66-year-old White, middle-class, able-bodied, married, cisgender male. They said Tom had been living “off and on” as an “unsuccessful patient” within their hospital for just over a year. They also said that although he had been administered a variety of psychiatric practices to help “normalize” his mental health situation, “nothing had worked.”

Throughout the 12 months of hospital inpatient contact, Tom participated in the hospital’s ongoing systematic creation, classification, and control of anomalies in his social body. From my discussions with the hospital staff (who had worked and cared for Tom throughout the year), Tom’s chronic body had been attributed to and situated within sets of individualized psychological meanings (i.e., a severely depressed person). Staff descriptions led to understandings of how Tom’s body had been disembodied from the surrounding relational cultural context of influence, categorized within memorized moments of psychological history and read through the archives of certain expert others—then transformed into professional written documents and files regarding who, in fact, the real nature of Tom was.

When I first met Tom, he weighed in with (and was described through) a 6-pound paper hospital case file. From the outside, Tom was unanimously described as having a chronic major depressive disorder. This suggested the documented Tom (or the Tom of-the-file) was viewed

¹The clinical material used in this book is adequately disguised to protect patient confidentiality.

by the staff within the confines of an essentialist, interior (modern) self where the identified problem (chronic major depressive disorder) was divided off, secured, located, and privatized inside Tom's body. Our phone conversations, as well as the hospital's interpretations of Tom, translated through the case files, helped me locate the context of the staff's expertise of knowledge² about Tom.

Respectfully, the obvious contradiction in my contact with the hospital was realizing that the hospital had fated Tom to a life of (chronic) identity death (in that *chronic* can often mean he [Tom] could not be helped; Madigan, 1999, 2008, 2019), while at the same time, paradoxically, the hospital desired him to recover through their psychiatric technology. Unfortunately, Tom was judged to be unfit because he could not please the hospital team (primarily because at this point, their specific psychological practices assigned had not assisted him). And as the hospital staff's description might suggest, Tom became both a cultural object and an intellectual product of the institution (Brinkmann, 2016; Madigan, 1996, 2017a, 2017b, 2019; Strong, 2014).

Within the model of scientific medicine and having some understanding of the methods used by the psychiatric ward to situate Tom, the body of the subject (in this case, the body of Tom) was viewed as the passive tablet on which (his individual) disorders were inscribed (written onto). In other words, the hospital staff's knowledge was used to write pathologies directly onto and about Tom's body. Deciphering the proper inscription to fit with Tom's body was a matter of determining a cause of the disorder and required an interpretation of the symptoms fitting within their prevailing diagnostic texts.

The process of Tom being inscribed into the *DSM* required a trained (i.e., highly specialized) professional who had been afforded the opportunity

²Michael White (1995a) wrote that "since the pathologizing discourses are cloaked in impressive language that establishes claims to an objective reality, these discourses make it possible for mental health professionals to avoid facing the real effects of, or the consequences of, these ways of speaking about and acting towards those people who consult them. If our work has to do with subjecting persons to the 'truth', then this renders invisible to us the consequences of how we speak to people about their lives, and of how we structure out interactions with them; this mantle of 'truth' makes it possible for us to avoid reflecting on the implications of our constructions and of our therapeutic interactions in regard to the shaping of people's lives" (p. 115).

and privilege to unlock the secrets of Tom's disordered body. This specialized knowledge, mediated through specific sets of agreed-upon power relations and those subsequent levels of professional status afforded (to mental health professionals), allowed a hospital professional to bring this forward as a meaningful (and taken-for-granted) description of Tom.

As mental health specialists, we are afforded specific story-naming/story-telling rights (Madigan, 1997, 1999) that are negotiated, distributed, and respected across a multitude of professional institutions (legal, medical, educational, etc.) and their archives (Foucault, 1972). The rights given to these naming procedures dictate the control of who gets to say what about (a) who is normal and (b) who is not (and what will be done as a consequence and with what authority; Madigan, 2003, 2017a, 2019). Central to the appraisal of the modernist psychological platform in narrative therapy (that includes cautious reconsiderations and questions regarding the use of *DSM* technology³) is the analysis of who should not be afforded legitimate speaking rights because they have not acquired the proper rational inquiry brought on because of systematic thought and orderly investigation (Caplan, 1995; Madigan, 2004, 2008, 2019; M. White 1991, 1995a, 1997).

Tom, for our purposes, was identified through the designated pathology and treated as a *person without knowledge* (Madigan, 2003). Judging from my contact with the hospital staff, Tom could only acquire legitimized speaking rights that mattered through a specified institutional matrix that distributes and negotiates (in this case, psychological or psychiatric) knowledge and power.

During our narrative therapy sessions, there were no otherworldly charms or scientific medicines used in helping Tom take his life back from a relationship with depression. Quite simply (as I reported back to the hospital staff), Tom stated he had experienced a lot of appreciation, compassion, and listening during our talks, along with the support of his partner and local backing from the letters he received from his large community of

³One difference between narrative therapy and the *DSM* is that narrative therapy has no consistent requirement that the everyday behavior used as diagnostic criteria actually be the result of mental disorder and not the result of other relational life experiences (Crowe, 2000; Strong, 2014).

concern. He also stated he liked the way we stepped “outside the hospital box” to get a better understanding of his relationship with the problem by reviewing values of living he cared for, historical memories outside the relationship with depression, views that the people he loved held of him, and stories of his life that could not be explained through either the problems or the hospital’s singular and pathologized individualist definition of him.

After my contact with the hospital professionals, I saw Tom in therapy for eight sessions over the course of 3 months. He left the hospital inpatient psychiatric ward after the fifth session during week 7 and never returned. Tom’s speech continued to be a bit slurred due to the 40 ECT sessions, but overall, he and his family members reported his comeback had been quite successful. In fact, his wife stated Tom “was flourishing again.” Our narrative therapy–informed conversations created a series of more preferred counternarratives and counterstories that began to relationally separate Tom from, and fashion a tension between, the hospital staff’s more totalized chronic identity conclusions (of major chronic depression). Tom relationally began to re-remember a more preferred view of himself that the problem and the hospital’s chronic identity conclusions had helped him remember to forget.

By week 12 of our therapy, Tom (under the supervision of a medical physician) committed to begin tapering off the psychiatric medications prescribed. He also began volunteering at a hospice facility, gardening a few vegetable plots, and having a lot of fun with his grandchildren. Tom also went on to become an antidepressant insider consultant to the narrative therapy training program at the Vancouver School for Narrative Therapy.

THEORY MEETS PRACTICE

Throughout this third edition’s foundational theoretical discussions (Butler, 1988; Deleuze, 1968; Foucault, 1973, 1979, 1980; May, 2005, 2006, 2014, 2017, 2019; Rose, 1989; Shotter, 1989; M. White, 1991, 2002, 2004), I will demonstrate how, unlike the formal systems of psychological analysis, narrative therapy does not seek to establish global accounts of life and

universal categories of human nature by constructing naturalized, generalized, and individualist theories of the self (Butler, 1988, 2006; Halberstam, 2011, 2018; Keating, 2013; Madigan, 2008, 2017a; Madigan & Nylund, 2018a, 2018b; Nylund, 2006, 2007; Nylund & Tilsen, 2012; Sampson, 1989, 1993).

Narrative therapy perceives formal diagnostic analysis producing flat monologic⁴ descriptions of psychological life that attempt to render events predictable (Bruner, 1986; Madigan, 1999; Sampson, 1993; Strong, 2014). White (personal communication, 1995) found that psychology's more formalized description of personhood championed the norm through generalizations regarding who people actually are, whereas the constructs supporting narrative therapy are based in relational encounters rendering the unexpected invisible and unique, so as not to be misled by the general.

For the first-time reader, entering the theoretical ideas outlined in this third edition (including explanation on how the ideas are transferred into narrative practice applications inside the therapy room) can sometimes feel like a difficult and daunting task. This is a common experience of teachers, students, therapists, trainers, and supervisors and, unfortunately, there is really no way around it. Fear not: Working alongside the extraordinary assistance of continental philosopher Todd May,⁵ this book makes every attempt to rescue the reader from as much theoretical discomfort as is possible. This is achieved by deciphering the intellectual precision and code existing between the poststructural theory–narrative therapy relationship and by placing the rigor and complexity of these theoretical ideas alongside numerous demonstrations and session transcripts of everyday narrative therapy practice examples.

In this third edition, I hope to transport the reader deep inside the interconnected ecology of ideas and values that shape the theoretical and practice receiving context of narrative therapy. I then offer specifics on exactly how all these complex theories translate into the practitioner's response back to the client—through one therapeutic question.

⁴Conventional psychological thinking supports the idea of a self-contained individual who is fundamentally monologic: "a hermetic and self-sufficient whole, one whose elements constitute a closed system presuming nothing beyond themselves, no other utterances" (Bakhtin, 1981, p. 273).

⁵Todd May is the author of 18 books on philosophy. He is the resident teaching philosopher and a faculty member with the Vancouver School for Narrative Therapy.