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Introduction

Whatever sense we have of how things stand with someone else's inner life, we gain it through their expressions, not through some magical intrusion into their consciousness. It's all a matter of scratching surfaces.

—Clifford Geertz (*Works and Lives: The Anthropologist as Author*)

This book intends to unravel the mysteries of narrative therapy theory and practice by escorting the reader on a casual intellectual stroll through narrative therapy's personal, theoretical, and practice history. Australian therapist Michael White began his novel therapeutic work in the late 1970s in Adelaide, but he did not coin the term *narrative therapy* until 1990, when he published the seminal book *Narrative Means to Therapeutic Ends* (White & Epston, 1990).[1] By the early 1990s, narrative therapy ideas had a relatively small but passionate following throughout North

[1] Michael invited Canadian cum New Zealand therapist David Epston to coauthor the book.

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Narrative Therapy, Second Edition, by S. Madigan
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America and Europe. In 2019, narrative therapy is the primary therapeutic practice used by thousands upon thousands of therapists worldwide.

Renowned American cultural anthropologist Clifford Geertz (1983) wrote

> 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. (p. 229)

Geertz (1973, 1983, 1988) described a view of human identity that is considered relational, contextual, communal, discursive, and anti-individualist. Narrative therapy holds a similar point of view. At the heart of narrative therapy is an unswerving commitment to a relational/contextual/anti-individualist therapeutic understanding of persons, problems, and relationships. This relational/contextual/anti-individualist practice was founded on a therapy designed to counter the prevailing dominant psychological ideas regarding the skin-bound individual self.

Narrative therapy contends that to properly study a "self," a reader must understand how it is related to their concept of the self[2,3] (Madigan, 2004, 2007, 2011; Madigan & Nylund, 2018a). A narrative therapy point of view brings forth a multisited and multistoried idea of the subject.[2,3,4,5] Narrative therapy's approach to the self stretches out beyond

[2] During a conversation in Vancouver, Michael White stated that perhaps more than any other idea, he had organized narrative's therapeutic work through an anti-individualist theory and practice.

[3] This discursive self-perception plays a critical role in one's interpretation of meaning. Whereas different poststructural thinkers' views on the self vary, the self under study is said to be constituted by discourse(s) (Foucault, 1979).

[4] For example, in a poststructural approach to textual analysis, it is the reader of a text who replaces the author as the primary subject of inquiry. This displacement is often referred to as the *destabilizing* or *decentering* of the author (in our case, think of the therapist), although it has its greatest effect on the text itself (Derrida, 1991).

[5] In an unpublished interview, Michael White respectfully responds to a question regarding the limits of systems thinking by suggesting that, when considering systems thinking, one might consider a close-up review of the effects of modernist notions of the self; structuralism; science; individualizing problems; ethnocentric/eurocentric ideas of race, gender, sexual preference; family values; Parsonian ideas and so on.

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the more popular and generalized accounts of who persons are (e.g., dominant and individualized categories of personhood) and of who the person is stated or labeled to be by the expert of psychological knowledge (Madigan, 1997).

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

The hospital staff person explained that the therapy staff had "all but given up" on Tom—a 66-year-old, White, middle-class, able-bodied, married, heterosexual man. They said Tom had been living "off and on" as an "unsuccessful patient" within their hospital institution for just over a year. And although he had been administered a variety of psychiatric technologies of normalization, "nothing had worked."

Throughout the 12 months of hospital 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 alongside Tom throughout the year), Tom's "chronic" body had been attributed and situated within particular sets of psychological meaning (i.e., a severely depressed person). This helped lead me to imagine that Tom's body had fit categorically within the memorized moments of psychological history—read through the archives of certain expert others—and then transformed into professional documents regarding who, in fact, 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 by the staff within the confines of an essentialist, interior (modern) self. Our phone conversations, as well as the hospital's interpretations of

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Tom, translated through the case files, helped me locate the context of the staff's expertise of knowledge[6] about Tom.

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

Within the model of scientific medicine and understanding the psychiatric ward used to situate Tom, the body of the subject (in this case the body of Tom) was viewed as the passive tablet on which (his) disorders were inscribed (written onto). In other words, the hospital staff's knowledge was used to write pathologies 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.[7]

The process of Tom being inscribed into the *Diagnostic and Statistical Manual of Mental Disorder (DSM)*[8] text required a trained (i.e., highly specialized) professional who had been afforded the opportunity and privilege to unlock the secrets of Tom's disordered body. This specialized knowledge, mediated through specific sets of

[6] Michael White (1995a) wrote "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).

[7] With over 400 possible ways to be considered abnormal (Breggin, 1994; Caplan, 1995), plotting a person's entire life story within the text of the *DSM* is not that uncommon or difficult (for some) to achieve.

[8] Canadian psychologist Tom Strong (2014) suggested that for what he termed *brief therapists*, the *DSM*, and the evidence-based practices often administratively coupled with any diagnosis, present a conversational challenge. At worst, conversations with clients can be overtaken when this discourse of symptoms (and what should be done to treat them) is prescribed in ways that preclude the pragmatic ways in which brief therapists practice.

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agreed-upon power relations and those subsequent levels of professional status afforded (to us professionals), allowed a hospital professional to bring this forward as a meaningful (and taken for granted) description of Tom.

Our professional story-naming rights are negotiated and distributed through the professional institution and its archives (Foucault, 1972). This naming procedure dictates the control of who gets to say what about who is normal and who is not, and what will be done as a consequence and with what authority (Madigan, 1997). Central to the narrative therapy critique of the modernist psychological platform (which includes a critique of *DSM* technology[9]) is the analysis of who should not be afforded legitimate speaking rights because they have not acquired the proper rational inquiry brought on as a result of systematic thought and orderly investigation (Madigan, 2008).

Tom, for our purposes, is now known as the *person without knowledge* (Madigan, 2003). The psychologized/individualized view held that he was operating without a context (thereby viewed as living in a relationally disembodied context), but classified within gender, race, age, ability, sexual orientation, and "dysfunction." Judging from my contact with the hospital staff, Tom could only acquire legitimized speaking rights through a specified institutional matrix that distributes and negotiates (in this case psychological/psychiatric) knowledge, power, and his storytelling rights.

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 ward after the fifth session during Week 7 and never returned. His speech continued to be a little bit slurred due to the ECT sessions, but overall he and his family members reported his comeback had been quite successful. Our conversations concentrated on relationally separating Tom from the hospital's totalized chronic identity description of major chronic depression and, helping him to re-member aspects and abilities of his life that

[9]One of the many differences narrative therapy has with the *DSM–5* is that the manual 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 life experiences (Crowe, 2000).

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lived outside the parameters of the problem's identity conclusions that had helped him *remember to forget*.

During our eight sessions of narrative therapy, there were no otherworldly charms or scientific medicines used in helping Tom take his life back from depression. Quite simply (as I reported back to the hospital staff), Tom had stated he had experienced a lot of relational appreciation, compassion, and listening during our talks, along with the support of his partner and local support of therapeutic letters from his community of concern. He also stated he liked the way we stepped "outside the box" to get a better understanding of his relationship with the problem by reviewing aspects, qualities, values, memories, and stories of his life that could not be explained through the problems and the hospital's definition of him.

Tom (under the supervision of a medical doctor) committed to begin getting off the psychiatric medications prescribed to him by Week 12 of our therapy. He also began volunteering at an AIDS hospice, gardening a few vegetable plots, and having "a lot of fun" with his grandchildren. Tom also became an anti-depression consultant to the Vancouver School for Narrative Therapy's narrative therapy training program.

For the first-time reader, entering into the theoretical ideas raised in this book (and their application to therapy) can sometimes be a difficult and a somewhat daunting task. Fear not. This is a common experience for most persons and there is really no way around it. The book makes every attempt to rescue the reader from as much discomfort as possible by deciphering the intellectual precision and code of the post-structural theory/narrative therapy relationship—by placing the rigor of theory alongside the imagination of common everyday narrative therapy practice examples.

Throughout the book's theoretical discussion, I demonstrate that 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 and essentialist notions of the self (Madigan, 1992, 1996, 2008; Madigan & Nylund, 2018a, 2018b). Narrative therapy finds no cause or reason to diagnose and/or label a person's lived experience.

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Narrative therapy perceives that all formal diagnostic analysis produces flat monologic[10] descriptions of psychological life that attempt to render events predictable (J. S. Bruner, 1986; Parker, 2008; Sampson, 1993; Strong, 2014). White found that psychology's more formalized description of personhood championed the norm through generalizations regarding who people actually were, whereas narrative metaphors were based in a dialogic encounter rendering the unexpected invisible and unique, so as not to be misled by the general (M. White, personal communication, 1992[11]).

The second edition continues to explore several key poststructural concepts that provide a foundation for narrative therapy practice. These concern the relationship between power and knowledge, intersectionality, structural inequalities, the textual identity of the dialogic relational person, the social location of the multisited person, the influence prevailing cultural discourse has on the shaping of how we view persons, values, and problems, and questions the origin and location of problems.

By way of numerous case examples, the book demonstrates how poststructural theory finds a congruent fit within a practice of narrative therapy. The book explores a few key questions pertinent to the construction of narrative therapy practice regarding (a) who determines what gets to be said in therapy (e.g., about persons and problems, and how this intersects with other institutions like medicine, the judiciary, psychiatric wards, school systems, families, media) regarding a person's identity and problems, (b) who gets to say what about people and problems in therapy, and (c) under what professional and cultural influences.

Finally, a primary question I attempt to raise in the book is based on a rather simple question: *Who has the storytelling rights to the story being told?*

[10] Conventional 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).

[11] Throughout the book, I refer to particular personal conversations I have had with people who influenced my work. These dialogues were part of an ever-growing fabric of up-close conversational learnings and are not necessarily found in books or articles. To experience an extensive sample of these public dialogues on a wide range of topics, visit https://tctv.live/