Stephen Madigan Handouts, 2011
Vancouver, Canada
narrative@telus.net
www.stephenmadigan.ca
www.therapeuticconversations.com

Reauthoring Conversations[1]

Re-authoring conversations (Epston & White, 1990) are a key feature in the practice of narrative therapy. Re-authoring conversations invite the client to help flush out some of the more neglected areas and events of their lives (often covered over by the problem story being told). These may include: achievements under duress, survival skills growing up, and qualities of themselves left out of their story such as generosity, ethical stances and kindness etc. These are very often stories that could not have been predicted through a telling of the dominant problem story being told. These untold stories can be sadly neglected in the telling of the problem story - by both client and the professionals involved with the client's story.

Neglected events in the client's life are viewed as exceptions or unique outcomes[2] that are utilized as a beginning point for reauthoring conversations and the development of alternative story lines. Often these conversations evoke a longer standing curiosity and appreciation about the story the client is telling. The telling of these alternative and often preferred recollections of their lives and relationships, shapes newly formed stories that can be further broadened and enriched.

Narrative therapists ask questions as a way to expand on the alternative or subordinate story by trafficking in what Jerome Bruner (1990, 1991) called the *landscape of action* and the *landscape of identity*[3]. Landscape of action questions center on events that happened in a person's telling of their lives and links these events through time - forming a plot line. These questions are organized through events, circumstance, sequence, time and plot (Michael White personal conversation, 1991, Adelaide, Australia). Landscape of identity questions are (in part) those that are asked regarding what the client *might conclude about the*

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[1] For an excellent resource on re-authoring conversations read Michael White's text Re-Authoring Lives: Interviews and Essays (1995).
[2] For a more in depth discussion on unique outcomes I recommend Epston's,1988 Collected Papers and White's 1988, Selected Papers published through Dulwich Centre Publications.
[3] For a more in depth discussion on Bruner's landscape of identity and landscape of identity questions please refer to Bruner (1990) and Epston and White (1990).

action, sequences and themes described in response to the landscape of action questions. Landscape of identity questions also bring forth relevant categories addressing cultural identities, intentional understandings, learnings and realizations.

Taken together the landscape of action and landscape of identity questions assist in re-authoring client lives and relationships by listening in to find the sparkling undergrowth and unique outcomes through the client's understanding of events. Therapist's take a full accounting of who was involved in the creation of the problem story, how the person came to know themselves in this problematic way, the life support systems of the problem, the possible losses involved in their lives and relationships in relation to the problem, the resistance they have noticed regarding their response to the loss and, what all these events mean to the person telling the story.[4]

During the first therapeutic conversation, the person coming to therapy usually becomes involved with the narrative therapist in two separate descriptions – 1) a problem saturated storyline and, 2) an alternative plot to the problem story (that lays side by side and is often preferred). In developing this scaffold of curiosity and questions, narrative therapists traffic in 1) landscapes of action questions (composing events, linked in sequence, through time, and according to the who what and where of the story) and, 2) landscape of identity questions (composing identity conclusions that are shaped by contemporary identity categories of culture – the person's conclusions about the story). (Bruner, 1990).

People's stories of life and of personal identity can be considered to compose *landscapes of the mind* (Michael White, personal conversation, Adelaide, Australia, 1992) which are constituted through landscapes of action and landscapes of identity. It is through narrative therapy questions that these alternative landscapes of the mind can be richly described and reauthored.

Reauthoring conversations act to re-invigorate a client's sense and meaning of the story by highlighting the gaps and refined understandings of this information. This newly recollected information results in a change within the problem saturated story being told. Questions continue to unearth an archive of relevant and

[4] Refer to Madigan workshop handouts, Therapeutic Conversations Conference, www.therapeuticconversations.com.

preferred local information about the client's abilities, hopes, dreams and commitments. The conversation shifts from one of a bored and over told rendition of the story, towards a fresh and vibrant retelling - complete with stories of competencies, agency and knowledge.

Combining the different landscapes, narrative therapy acts to:

1) Question how the 'known' and remembered problem identity of a person has been influenced, manufactured and maintained over time.
2) Question what aspects of the social order have assisted in the ongoing maintenance of this remembered problem self.
3) Locate those cultural apparatuses keeping this remembered problem self restrained from remembering alternative accounts and experiences of lived experience.
4) Locate alternative sites of resistance through questioning how the person can begin to re-remember subordinate stories of identity living outside the cultural, professional and problem's version of them.
5) Influence how discursive space can afford room for possibilities of many different discursive practices to emerge, by resisting and standing up for the performance of this re-remembered and preferred self.
6) Explore who else in the person's life might be engaged to offer accounts of re-remembrance and provide the person safety within the membership of a community of concern (Madigan and Epston, 1996)

Relative Influence Questions

From the outset of our narrative therapy history, the therapeutic interview involved relational externalizing, unique outcomes, unique accounts, unique possibilities, unique redescription[5] and unique circulation questions, as well as experience of experience, preference and historical questions. Everyday narrative therapy interviewing involves a process known as relative influence questioning which is comprised of two sets of questions - 1) one set maps the influence of the problem on the person and, 2) another set encourages persons to map their own (and others) influence in the life of the problem (White, 1988). Below is the frame and structure of a narrative therapy interview (that continues to live on and practice around the world to this day).

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[5] As a sampling of how questions help in the reauthoring of people's lives, Michael White (1988) writes that unique redescription questions assist in the revision of the persons relationship to themselves (eg. "in what way do you think these discoveries could affect your attitude towards yourself?", with others "how might this discovery affect your relationship with . . .? and with problems " in refusing to co-operate eih the proble in this way, are you supporting it or undermining it?" (pg. 7)

1) MAPPING THE INFLUENCE OF THE PROBLEM IN THE PERSON/FAMILY'S LIFE AND RELATIONSHIPS.

• That is: How does the problem affect the person(s)?

• Mapping the problems influence on the person/relationship helps to mutually develop an understanding of the experience-near problem-saturated story.

• It is crucial for the therapist to take enough time to develop this line of inquiry – in order for persons to feel their experience is "known" and for them to "know it" in a way that offers them a different, more detailed perspective on the problem's effects on their lives and relationships. Often I will track and question the losses that have occurred in the person's life while in relationship to the problem. For example, people in longstanding relationships with drugs, anorexia, anxiety etc will often report losses concerning relationships with friends, school, jobs, hobbies and family.

• A broad mapping at this stage of therapy opens multiple opportunities for exploring unique outcomes later. It also gives a rich sampling of people's language habits (Madigan, 2004) around the problem. Questions to ask may include:

• How does worry feature in your work life? In your life beyond work? Your relationships?

• When worry is having it's way with you, what happens to your dreams for the future?

• Are you satisfied or dissatisfied with the way the worry is as you stated "wrecking my relationship" and leaving you no time for friends? Why are you dissatisfied?

2) **MAPPING THE INFLUENCE OF THE PERSON/FAMILY IN THE LIFE OF THE PROBLEM**

• Through mapping the influence of how people may be problem supporting, they begin to see themselves as authors, or at least co-author's of their own stories. They can then begin to move toward a greater sense of agency in their lives.

• A broad mapping at this stage opens multiple opportunities for exploring unique outcomes later. It also gives a rich sampling of people's language habits (Madigan, 2004) around the problem.

- Are there ways in which you have unknowingly given worry the upper hand in your life? Have there been people or situations in your life that have helped you keep worry central to your life?

Unique outcome questions

• These questions invite people to notice actions and intentions that contradict the dominant problem story. These can pre-date the session, occur within the session itself, or they might happen in the future.

• Given over-responsibility's encouragement of worry, have there been any times when you have been able to rebel against it and satisfy some other of your desires? Did this bring you despair or pleasure? Why?

• Have there been times when you have thought -- even for a moment -- that you might step out of worries prison? What did this landscape free of worry look like?

• I was wondering if you had to give worry the slip in order to come to the session here today? What do you think it may have been that helped support the hope in yourse that helped you sidestep worry?

• Can you imagine a time in the future that you might defy worry and give yourself a break?

Unique account questions

Conversations develop more fully following the identification of unique outcomes and begin to demonstrate how they can become features in a preferred alternative story.

• Unique account questions invite people to make sense of exceptions/alternatives to the dominant story of the problem being told (I *always* worry). These exceptions may not be registered as significant or interesting or different – however once uttered and uncovered they are held alongside the problem story as part of an emerging and coherent alternative narrative.

• Unique account questions/answers employ a *grammar of agency.*

• Unique account questions/answers locate any unique outcome in its historical frame and - any unique outcome is linked in some coherent way to a history of struggle/protest/resistance to oppression by the problem or an altered relationship with the problem.

• How were you able to get yourself to school and thereby defy worries prescriptions and the canceling out of possibilities?

• Given everything that worry has got going for it, how did you object against its pushing you around?

• How might you stand up to worry's pressure to get you worried again, to refuse its requirements of you?

• Was it easier to be worry free for those moments when you were simply watching that movie unencumbered?

• Could your coming here today be considered a form of disobedience of worry?

Unique Re-description Questions

These questions invite people to develop meaning from the unique accounts they have identified as they re-describe themselves, others, and their relationships.

• What does this tell you about yourself that you otherwise would not have known?

• By affording yourself some enjoyment, do you think in any way that you are becoming a more enjoyable person? Of all the people in your life who might confirm this newly developing picture of yourself as worrying less, who might have noticed this first? Who would support this new development in your life as a worry free person? Who would you most want to notice?

Unique Possibility Questions

These are viewed as *next step* questions. These questions invite people to speculate about the personal and relational futures that derive from their unique accounts and unique re-descriptions of themselves in relation to the problem.

• Where do you think you will go next now that you have embarked upon having a little fun and a little risk with life?

Is this a direction you see yourself taking in the days/ weeks/years to come? Do you think it is likely that this might revive your flagging relationship, restore your friendships, or renew your vitality? (this conversation can lead back to unique re-description questions).

Unique Circulation Questions

Circulation of the beginning preferred story involves the inclusion of others. Circulating the new story is important as it fastens down and continues the development of the alternative story.

• Is there anyone you would like to tell about this new direction you are taking?

• Who would you guess would be most pleased to learn about these latest developments in your life? Who do you think would be most excited to learn of these new developments? Would you be willing to put them in the picture?

Experience of Experience Questions

These questions invite people to be an audience to their own story, by seeing themselves, in their unique accounts, through the eyes of others.

• What do you think I am appreciating about you as I hear how you have been leaving worry behind and have taken up with a bit of fun and risk?

• What do you think this indicates to Hilda (her/his best woman friend) about the significance of the steps you have taken in your new direction?

Questions which Historicize Unique Outcomes

These questions represent any important type of experience of experience questions. Historical accounts of unique outcome allow for a new set of questions to be asked about the historical context. They serve to 1) develop the blossoming alternative story, 2) to establish the new story as having a memorable history, and 3) to increase the likelihood of the story being carried forward into the future. The responses to these produce histories of the alternative present (personal conversation, White 1993, Vancouver).

Of all the people who have known you over the years, who would be least surprised that you have been able to take this step?

• Of the people who knew you growing up, who would have been most likely to predict that you would find a way to get yourself free of worry?

What would X have seen you doing that would have encouraged him or her to predict that you would be able to take this step?

What qualities would X have credited you with that would have led him or her to not be surprised that you have been able to ....?[6]

Preference Questions

These questions are asked all throughout the interview. It is important to intersperse many of the above questions with preference questions so as to allow persons to evaluate their responses. This should influence the therapist's further questions and check against the therapist's preferences overtaking the clients' preferences.

• Is this your preference or not? Do you see it as a good or a bad thing for you? Do you consider this to your advantage and to the disadvantage of the problem or to the problem's advantage and to your disadvantage?

Consulting your consultants questions

These questions serve to shift the status of a person from "client" to "consultant". The insider knowledge the person has in relationship to their experience with the problem due to lived experience is viewed as unique and special knowledge. The insider knowledge is documented and can made be available to others struggling with similar issues (Madigan and Epston, 1995)..

• Given your expertise is the life-devouring ways of worry what have you learned about its practices that you might want to warn others about?

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[6] Once the therapist begins to get a grasp on the format and the conceptual frame for developing temporal questions (past, present or future), unique account questions, unique re-description questions etc. they become a bit more easy to develop and will eventually seem "ordinary" to the interviewer and the context.

• As a veteran of worry and all that the experience has taught you, what counter-practices of fun and risk would you recommend to other people struggling with worry?.

The structure of the narrative interview is built through questions that encourage people to fill in the gaps of the alternative story (untold through a repeating of the problem saturated story). The structure assists people to account for their lived experience, and exercise their imagination and the remembered stories meaning-making resources. This therapeutic process is often engaging of the person's fascination and curiosity. As a result, the alternative story lines of people's lives are thickened (Turner, 1986) and more deeply rooted in history – ie.,the gaps are filled, and these story lines can be clearly named.

Part Two
Madigan Handouts 2011
Vancouver, Canada
www.stephenmadigan.ca
www.therapeuticconversations.com

COUNTER-VIEWING QUESTIONS

I only ask questions in therapy – or at least I ask questions 99% of the time. For the experienced narrative therapist questions are *not* viewed as a transparent medium of otherwise *unproblematic communication.* It is a common practice for narrative therapists to be deeply committed to the ongoing investigation and location of therapeutic questions within community discourse – as a way of figuring out the history and location of *where our questions come from* (Madigan, 1991a, 1993a, 2007). Discovering the influences that shape therapeutic questions and discussing *why* we use them and choose them as tools to work with the people we talk with in therapy, is viewed as a practice of therapist accountability[7] (Madigan, 1991b, 1992a, 1992b). Questioning therapists about their therapeutic questions is also used as a framework for narrative supervision (Madigan, 1992b).

Experiencing a close-up re-reading of therapy allows the idea of *counter-viewing questions* (Madigan, 2004, 2007) to emerge. A therapy organized around counter-viewing questions speaks to narratives therapy's deconstructive therapeutic act. Narrative questions are designed to both respectfully and critically *raise suspicions* about prevailing problem stories - while undermining the modernist, humanist and individualizing psychological project[8].

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[7] For a further reading on accountability practices, see Hall, R, Mclean, C., & White, C. 1994. and Tamasese and Wldegrave, Dulwich Centre Publications, Nos. 2 &3, 1994).
[8] For a clear example of counter-viewing see the APA six-part DVD live session set of Stephen Madigan's narrative therapy work. Available in March, 2010)

Narrative therapy counter-viewing also creates therapeutic conditions to:
1) explore and contradict client/problem experience and internalized problem discourse through lines of questions designed to unhinge the finalized talk of repetitive problem dialogues and create more relational and contextual dialogues,
2) situate acts of resistance and unique accounts that could not be readily accounted for within the story being told,
3) render curious how people could account for these differences,
4) appreciate and acknowledge these as acts of cultural resistance and
5) re-build communities of concern.

Narrative therapy's method of 'close up' deconstructive counter-viewing engages the relational world of therapeutic interviewing in the following way:

1) Counter-viewing is an intensely critical mode of reading professional systems of meaning and *unraveling* the ways these systems work to dominate and name.
2) Counter-viewing views all written professional texts (files) about the client as ways to lure the therapist into taking certain ideas about the person for granted and into privileging certain ways of knowing and being over others.
3) Counter-viewing is an unraveling of professional and cultural works through a kind of anti-method which resists a prescription. It is looking for *how a problem is produced and reproduced* rather than wanting to pin it down and say this is *really* what it is.
4) Counter-viewing looks for ways in which our understanding and room for movement is limited by the lines of persuasion operating in discourse.
5) Counter-viewing also leads us to explore the ways in which our own therapeutic understandings of problems is located in discourse.
6) Counter-viewing allows us to reflect on how we make and remake our lives through moral-political projects embedded in a sense of justice rather than a given psychiatric diagnosis.

Counter-viewing and narrative therapy—the issue of respect

Counter-viewing in narrative therapy is profoundly respectful. The method attempts to 1) 'do justice' to the stories people tell about their distress, 2) respect the experience they have with the problems of living, 3)

appreciate the struggles they are embarking on, and 4) value and document how they have responded to the problem.

The therapist's task is to work within these descriptions and acknowledge the complexity of the story being told so that contradictions can be opened up and used to bring forth something different (by sustained reflection), moving towards a 'sparkling undergrowth' needing attention (White 1985). Noting a stories contradictions, allows for the elaboration of competing perspectives as the person's story unravels. These different competing perspectives seem to lie side-by-side and fit together, but there is a tension between them as they seem to try and make us see the world in different ways at one and the same time.

A *one-perspective story* holds the person in the grip of the problem's/professionals' point of view. Against this professional standpoint there is the perspective that flows from the client who is simultaneously trying to find ways of shaking the problem and perhaps escaping a branded diagnostic name altogether. To be respectful to the differing viewpoints does not mean abandoning our own standpoint, but it does mean *acknowledging where we stand.*

Counter-viewing and narrative therapy—the issue of critique

Counter-viewing in narrative therapy is intensely critical of many therapy practices which are embedded in images of the self and others, that systematically mislead us to the *nature* of problems. Narrative practice does not presuppose a self, which lies 'under the surface' as it were. Counter-viewing also alerts us to the ways that dominant ideas of the self get *smuggled* into therapy under the disguise of 'helping' others.

Dominant narratives of mental distress can all too quickly lock us back into the problem at the very moment we think we have found a way out. The task of a counter-viewing therapist, client and interview, is to locate problems in (cultural) discursive practices in order to comprehend how patterns of power/ knowledge[9].

[9] Michael White (1995) writes: " . . .since the pathologizing discourses are cloaked in impressive language that establishes claims to an objective reality, these discourses make it possible for mental health professional 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 person's 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

provides people with the idea that they alone are to blame for these problems, that they are helpless to do anything about these problems, and they should not maintain much hope (Madigan, 2008). In counter-viewing practices, change is seen to occur when we are working collaboratively through the spaces of resistance opened up and made available by the competing accounts and alternative practices. It is here that hope may rise again.

Travels with Tom

By way of introducing you to Tom (Madigan, 1999), I will remind you that after the psychiatric ward referred him to me and during the first time I met him, Tom, through a slurred medicated speech, relayed he had ended up on the ward because he been feeling "depressed" since his retirement at age sixty-five, one and a half years earlier. He also let me know that he had twice tried to "off" (kill) himself "without success" (once before his admittance into hospital and once during his stay in hospital).

At the beginning of the first interview I asked Tom if the word depressed/depression was a term of his own or did it belong to someone else. He relayed that it was a "hospital word" and what he was "really feeling" was "*bored and unaccomplished*". In the first session I asked Tom a few of the following counter-viewing questions (Tom's answers are in brackets):

Tom do you think this bored and unaccomplished sense of yourself is a final description of yourself? (Maybe not)

Tom why do you think this bored and unaccomplished sense of yourself may not be a final description of yourself? (It might be the shock treatment, because it makes me slow and I can't remember much. I retired and didn't know what to do and I feel like a rock on the end of a piece of rope).

What does feeling like a rock on the end of a rope feel like? (Lousy, like I have nowhere to turn – just hanging here).

Is there some place you would rather be? (As the bumper sticker on my car says – I'd rather be gardening).

And what would you grow? (I'm not sure the hospital would let me grow anything).

Tom if you get back to growing things in your life what would you grow? (I'd like to grow heirloom tomatoes again and see all their weird colours and shapes and maybe first I'd grow bits of myself again)

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avoid reflecting on the implications of our constructions and of our therapeutic interactions in regard to the shaping of people's lives. (pg. 115)

If you were able to take this step to grow a bit of yourself back what do you believe you might be stepping towards? (I'd get myself out of the madhouse!).

Is there one particular aspect of yourself that most wants to move out of the mad house? (The part of me that wants to be free).

Can you remember a time in your recent or distant past when you felt that you were free? (Yes, many times like when I garden and when I was playing hockey with my old friends on Tuesday nights or even just shoveling the snow off the drive way).

The session continues:

Tom is the hospitals description of you as a chronically depressed person an accurate description of you? (I think they helped me get worse.)

In what ways do you feel that the hospital has made you feel worse about yourself? (Well being with them a year or so I haven't gotten any better and I think that they are giving up - this is why they sent me to you [laughs] – you're the last stop and they weren't much help anyway - most of them are nice but you know.)

Tom do you think the hospital staff has hope for you in coming to see me? (Well they told me you helped someone else like me, so yes.)

Why do you think, they think, that I can help you and they can't? (Because I don't think they know what they are doing and I get mad at them for shocking me as much as they did.)

Jane (Tom's partner of 40 years) are you mad at them for shocking Tom as well? (Yes I am mad and I am glad we are here because my sister's niece told her that you were different.)

Tom, do you think Jane thinks there is hope for you overcoming this unaccomplished boredom? (Yes)

Can I ask you why you think Jane believes this? (Jane always says I'll get better but I don't know).

Are there other people in your life that you think might be pinning there hopes on you beating this boredom. (Probably)

Can you name a few of these hopeful people? (Well my kids, and the neighbors and I don't know, Jane, and the occupational therapist.)

Do you have any ideas what all of these people witness and remember in you that you have somehow forgotten about in yourself? (The shocks have made me forgetful but maybe they could tell you a thing or two.)

Tom do you feel that there might be aspects of who you are - as a man and a husband, father, employer, friend, worker, and gardener that you once enjoyed but now these other you's have somehow fallen into silence? (Maybe, yes they are there - but like hidden.)

It was through sets of discursive counter-viewing questions that certain hospital *certainties* as well as the problem's saturation were undermined as a means to open space for other possibilities and discontinuities constituting the storied inscription of Tom. The therapeutic re-authoring conversations between Tom, Jane and myself, tracked the threads of the institutions discursive practices and destabilized the hard chronic conclusions placed on Tom's body. In *taking away expert knowledge from the site of the hospital*, we enlarged the degree to which alternative other knowledges (Tom and Jane's, family etc.) might be taken up, re-told and performed.

Throughout our sessions Tom and Jane began to inscribe themselves back towards local, historical, cultural and social knowledges lost to them within the problem and professional discourse, and through the cultural discourse surrounding the person who retires. With their guidance, I witnessed how subversive responses were possible under even the most oppressive conditions. Our conversations afforded forms of resistance and transformation that *were* historical processes. We analyzed and counter-viewed various discourses and began to situate the discursive threads of "retirement", "shock treatment", "men's identities", "psychiatry", "fatherhood", "relationships".

Foucault emphasized that power relations are never seamless - but always spawning new forms of culture and subjectivity and new opportunities for transformation. Where there is power, he came to see, there is also *resistance* (Dreyfus & Rabinow, 1983). Dominant forms of knowledge and the institutions that support them are continually being penetrated and reconstructed by values, styles, and knowledges that have been developing and gathering strength at the margins.

The more our (Tom, Jan, myself and others) readings of the dominant/normative textual tellings were investigated, the more we seemed to position against the grain of the popular, the taken-for-granted and chronic. As we moved away from the disciplinary practices of living as a retired depressed/hospitalized person, the more Tom began to gain back aspects of himself once forgotten through the "shock" of retirement, the subsequent boredom after having had a work identity since he was thirteen years old, and the loss of his remembered alternative self being replaced with strong feelings of an unaccomplished life.

Tom's *rediscovery*[10] was helped along, in part, through counter-viewing narrative interviews and a very intense 30 person therapeutic letter writing campaign (see description below in chapter). It was through sets of discursive counter-viewing questions that certain hospital certainties were undermined as a way to open space for other possibilities and discontinuities constituting the storied inscription of Tom.

The therapeutic conversations between Tom, Jane and myself, tracked the threads of the institutions discursive practices and destabilized the hard chronic conclusions placed on Tom's body. In taking away expert knowledge from the site of the hospital we enlarged the degree to which alternative other knowledges might be taken up and performed. One day about six months after he released himself from the psychiatric hospital Tom brought me a gift he had designed for the Vancouver School for Narrative Therapy. The charcoal painting read – Negative Imagination Only Remembers Negative Events. Tom continues to garden his heirloom tomatoes and has now included a particularly spicy salsa garden.

[10] Rediscovery is a word I learned from the Vancouver Anti-anorexia League. It was through words like this that League members attempted to re-invent their own language – in this case they wanted to take back the word 'recovery' and substitute it with what they called a less encumbered or *cleaner word* which they named rediscovery.