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### ***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<sup>1</sup> (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 narrative 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<sup>2</sup>.

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

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<sup>1</sup> 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).

<sup>2</sup> 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)

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:

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- 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<sup>3</sup> 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

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<sup>3</sup> 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 avoid reflecting on the implications of our constructions and of our therapeutic interactions in regard to the shaping of people’s lives. (pg. 115)

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)

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 their 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*<sup>4</sup> 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.

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<sup>4</sup> 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.

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.