*My friend Imelda McCarthy from Dublin Ireland invited me in 2007 to write a chapter for her book listed below. It gave me the opportunity to discuss some of the practices that I've been exploring like: counter-viewing questions (based in deconstructive methods), summits of remembering (letter writing campaigns) and further explorations of identity.

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Anticipating hope within written and naming domains of despair

Stephen Madigan

THE ANTICIPATION OF HOPE

Central to many psychotherapeutic services is the dual process of documenting client lives and relationships through the process of naming and writing practices. How and what we identify and document is organized through set institutional, political and economic structures (Foucault 1965; Madigan 1996). Therapy – at least in theory – attempts to offer symptom relief and to bring forth 'positive' change. However, therapy and the structures that support these practices can sometimes weaken a person's ability

to change and undermine any hope that change is possible (Gremillion 2004; Madigan 2003).

The idea of change, what constitutes change and what is considered change is under the direct influence of a therapy's conversational boundaries, linguistic territories, cultural structures and performance of theory. Therapeutic understanding, response, and action is shaped by and shaping of these discursive parameters, offering discursive 'life' to both hopeful and despairing ideas (sometimes simultaneously) concerning the possibility of change.

This chapter addresses the process of production and reproduction in therapy while also offering a possible alternative to present and specific institutionalized naming and writing therapy practices. It also addresses the effect these processes have on the hope for change. I will attempt to show a method of addressing change through the therapeutic importance I place on the *anticipation* of hope, and I will demonstrate this through a case story, highlighting a variety of writing and naming practices used in my version of narrative therapy. These include the use of counter-viewing questions (Madigan 2003), therapeutic letter-writing campaigns (Madigan 1997, 1999), and the creation of communities of concern (Madigan and Epston 1995).

NAMING AND WRITING PRACTICES

Frustrated with therapy's 'rabid desire' to label 'things' and thereby sever these 'things' from their relational contexts, Gregory Bateson (1979) invited the field of family therapy to simply 'stamp out nouns'. He insisted that the 'thing' was not in fact the

'thing' named. Many family therapists found Bateson's idea quite interesting but quite difficult to achieve since our discursive practices of therapy name, and have a history of naming central to the craft (Foucault 1965). Our educational, training and institutional settings encourage the establishment of set developmental 'norms' and meanings given to the naming of a 'client', 'woman', 'employee', 'father', 'child' and so on.

The field went further, giving fixed identities to persons and their experience, such as 'depressed client', ' anorexic woman', 'unruly employee', ' deadbeat father', and 'ADHD child'. Supplementary knowledge connected to the inscription of meaning also included cultural naming practices that marginalized and divided groups off from a 'mainstream' community of privileged others (see Madigan on Foucault 1992, 2003) such as 'single-parent client', 'native woman', 'gay employee', 'black inner city male', 'South Asian immigrant', 'migrant worker', 'working class father'. Names of this kind were negotiated, distributed, and meanings were accepted and documented - on some level by all our helping institutions.

The process of classifying persons and writing their histories into historical documents (files), through the template of 'soft' scientific research and investigation, acted to re-produce set cultural and institutional norms (Foucault 1973; Parker 1997; Spivak 1996). Helping professionals, finding themselves with an authority position to name 'others', were naming (labeling) from within pre-established institutional and cultural naming systems. What was re-produced within the name given was not only a newly inscribed identity politic but a verification (perhaps a valorization) that uplifted the legitimacy of scientific research and the status of the profession itself.

Within a name (for example, Obsessive Compulsive Disorder or Borderline), one's body is 'naturally' inscribed by 'rigorous' science and the privileged status given to the naming and writing context (Gremillion 2004; Grieves 1998). Unfortunately, the everyday act of professional naming and writing person's, and groups of persons', bodies into categories, is often a finalized, de-contextualized and pathologizing view of who they are and who they might become. The client is instructed to anticipate the limits of their life course in a particular and non-hopeful way.

Deciphering the person/problem named is usually a matter of interpreting and categorizing a 'cause' to explain the presenting problem. The cause (more often than not) is located and privatized within the person's abnormal body and genetically linked to other members of their family unit and their abnormal body(s). To uphold and support these modernist explanations for the cause of the problem, popular technologies of psychology (with the assistance of medicine, law, education, etc.) invented *interpretation* manuals to help decipher, name and locate symptoms. At the present time, there are over four hundred possible ways to be named psychologically abnormal (Caplan 1995). This affords the pathology-oriented professional numerous ways to plot a client's life story with the help of the professional 'naming book', the Diagnostic and Statistical Manual-Four (DSM-IV).

Within the model of scientific naming and writing, the body of the subject/client (you and me) is viewed as the passive tablet on which disordered names are written. Entering a helping system like a psychiatric hospital, a child care centre or a therapy clinic, the client is often required, due to insurance company claims and third party billing, to accept a disordered name before therapy can proceed. The name is further secured by

the naming performance when 'it' is entered into professional filing sites (Foucault 1979) – for example, insurance, education, medical, judicial or corporate. The history of our life file is cumulative and sometimes lasts forever (see also Chapter 7 in this volume).

Naming: The canceling out of hope

Professional stories written and told about the person - to the person prescribed and to others – maintain the powerfully pathologized plot, rhetorically embed the problem name (and personal life), and assist in piecing together states of despair.

For the person looking for help and change, the naming and writing process of therapy used in North America can be both confusing and traumatic. Their answer to hope and possibility is to undergo further practices of therapeutic technology deemed hopeful and in concert with the practices of help offered to them by the very institution that named them. If they fail to change within the therapeutic parameters prescribed, the body will be further named. In this situation, the word 'chronic' is the name most often used – however, 'resistant' and 'unruly' are also not uncommon. This scenario presents a very difficult dilemma for clients. On the one hand they are named as chronic (no possibility for change) while on the other hand they are encouraged to change and blamed for not changing.

Perhaps the saddest flaw of this system of production is having to witness the full-on, heavy handed negative effect that a professional's technology, skill and power has on the person's anticipation of change. What is supported in the life of the client is a community acceptance of despair and a 'cancelling out' of hope.

Discursive identity

Identities and our remembrances of our identities are profoundly political both in their origins and in their implications (Madigan 1996). Our distributed and negotiated selves (Tomm 1995) and the selves we normally remember are influenced by *and* reproductive of cultural and institutional norms. As contributing members of this community of identity and discourse, we come to experience ourselves within the relational politics of these dominant norms (are we normal, do we measure up, are we an acceptable and worthy citizen).

'Identity', says feminist Jill Johnston, is 'what you can say you are, according to what they say you can be' (in Foucault 1989). The identity she is referring to is *not* a freely created product of introspection or the unproblematic reflection of a private inner self (Spivak 1996). Identities are conceived within certain dialogic ideological frameworks constructed by the dominant social order to maintain its interests. Poststructuralists argue for a consideration of a post-humanist and decentralized view of persons (Butler 1997; Hoagwood 1994). This position unsettles any essentialist psychological notions of the stable autonomous person, the original author (of problem conversations or otherwise), or a given reality of what constitutes the self.

As far back as the early 1930s, the Russian linguist and psychologist, Mikhail Bakhtin (1986), suggested that we are contributors to each other's identity. He wrote that 'I get a self that I can see, that I can understand and use, by clothing my otherwise invisible self in the completing categories I appropriate from the others image of me' (Bakhtin 1986: 18). Bakhtin's view incorporates how the other plays a central role in constituting the

individual self, and suggests that without the ongoing relationship to the other our 'selves' would be 'invisible, incomprehensible, and unusable' (Bakhtin 1986: 18). From this perspective, problems that persons encounter can be situated within a dialogic context and *not* placed under individual sovereignty. I would add that the professional viewpoint of clients or patients has been nurtured and influenced within the reigning dominant ideology of their profession and as such is considered immanent in the fields of worthy opinion and power relations.

A few narrative therapy understandings

In my view, narrative therapy attempts to demonstrate the post structural dialogic view of the self, by highlighting and undermining dominant practices which act to specify, classify and subjugate a person's identity as fixed. This is so that counterclaims and documentation of resistance can be made. In addition, there are attempts made by the narrative therapist to render the status of identity-based politics transparent in the life of the problem, to map the influence these discursive practices have had on the person's life and to bring forth how they and others have resisted and responded (Law and Madigan 1994; Wade 1997) outside the realm of the negative story being told.

To the narrative therapist, an identity is not viewed as fossilized within a problem. A person's identity is viewed within the politics and power plays of a manufactured and constituted self as discourse is produced (Law and Madigan 1998; Madigan 1996; Spivak 1996; Shotter 1991; White and Epston 1990). A narrative therapist's responsibility, then, lies in the question of what psychological and political orientations do our practice ethics and therapeutic performance belong to?

Problems, identities and what information a person perceives and remembers are constitutive of lives and relationships (Foucault 1972; White 1991). Persons and problems are constructed through an intricate dialogic interchange of power and community discourses and reproduced within institutions, families and relationships (Madigan 1996). As an initial step, practitioners introducing narrative ideas into therapy perceive that change occurs through recognizing and locating persons, practices, memories and problems within the dominant norms of the social domain.

Of central importance to those who practice narrative therapy is the bringing forth of re-remembered 'alternative' selves (White, 1991 might also say forgotten or unrecognized selves) and tracking alternative actions/thoughts/responses these selves took outside the realm of a specified problem identity. The spoken and written problem identity is not considered a fixed 'state', nor is it located within the person. The problem identity is viewed within the relational and political context of intricate negotiations that take place inside complex fields of power and discourse.

The consequence of an ideologically biased commerce of problems regularly finds a person's constructed identity very misrepresented and under-known by dominant knowledge and sets of agreed-upon 'thin conclusions' (White 1992). Both the process of spoken and written pathologizing, and the technologies imported to implement the discourse of pathology, speak volumes about the dominant signifying mental health culture, but little of the person being described.

For me, the narrative interview takes a therapeutic position to counter-view taken for granted ideas about problems, relationships and personhood (Madigan 2003), to rewrite

the written (Madigan 1991), to re-remember and re-member (Madigan 1996, 1998a; McCarthy 1999; Meyerhoff 1982, White 1991). A narrative therapeutic interview may be shaped by the following practices:

1) Questions about how the 'known' and remembered problem identity of a person has been manufactured over time.

2) Questions about what aspects of the social order have assisted in the ongoing maintenance of this remembered problem self.

3) Locate those cultural apparatuses that keep this remembered problem self restrained from remembering alternative accounts and experiences of lived experience.

4) Locate sites of resistance through questioning how the person can begin to re-remember alternative identities of self that live outside the cultural, professional and problem's version of them.

5) Influence how discursive space can give room for the possibilities of different kinds of discursive practices to emerge, by resisting and standing up for the performance of this re-remembered and preferred self.

6) Explore and find out who else in the person's life might be engaged to offer accounts of re-remembrance and provide the person safety in membership.

COUNTER-VIEWING AND NARRATIVE INTERVIEWING

In brief, I came up with the counter-viewing idea in 2001 after a lengthy watching of my therapy on video tape and realizing that much of the work involved 'raising suspicions' regarding the modernist/humanist accounts of the problem story being told,

looking for contradictions that could not be readily accounted for within the story being told, being curious as to how people could account for these differences, and appreciating and acknowledging these acts of cultural resistance. This method of 'close up' interviewing and relating to others 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 therapy is profoundly respectful as it attempts to do justice to the stories people tell about their distress, respect the experience they have with the problems of living, appreciate the struggles they are embarking on, and appreciate and document how they have responded to the problem. The 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 towards a sparkling undergrowth (White 1991) needing attention. Noting the 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. And 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 the branded 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 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. It does this in not presupposing 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 counter-viewing therapists and counter-viewing clients is to locate problems in cultural practices in order to comprehend the role of patterns of power that gives people the idea that they alone are to blame for these problems, they are helpless to do anything about these problems and they should not maintain much hope. 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 can rise again.

THERAPEUTIC LETTER-WRITING CAMPAIGN

I came up with the idea of the therapeutic letter-writing campaign practice after many long discussions, since 1991, with my friends, narrative therapists David Epston and Michael White. It was at this time, I had the good fortune to live and work alongside them in New Zealand and Australia during my time on a family therapy scholarship they had awarded me. The letter campaign idea was also influenced through the occasion of my mother's surprisingly early and sudden death in the late Fall of 1992. In brief, my immigrant Irish parents raised my two sisters and I in a working class neighbourhood of Toronto, Canada, where it seemed like our entire community was made up of an Irish Catholic diasporas. Along with the tradition of sending Mass cards at the time of the death, a few of her life long friends penned letters of love outlining the

profound importance my mother had played in their daily lives. The power of their written rememberances had an enormously helpful and hopeful effect on my family. A year or two later, I began running Anti-anorexic and multiple family groups two days a week at an Eating Disorder Unit through a hospital in Vancouver, Canada.

Merging all three experiences together – studying with David Epston and Michael White, my mother's friends' letters, and the eating disorder (ED) unit - I created the practice of therapeutic letter writing campaigns in response to the deadly effects the culture of anorexia and bulimia was having on the lives and relationships of the people I was encountering on the ED ward.

Statistically, persons diagnosed with anorexia and/or bulimia experience the highest death rate of any 'mental illness' in North America (Madigan and Goldner 1999b). The people struggling are believed by the mental health profession to be 'very difficult' clients to treat, have pounds of pathologized papered files written about them, are given multiple diagnoses (borderline, depressed and obsessive compulsive disorder are the most common), are subsequently medicated to the gills and are often told - overtly and covertly - that they have very little chance for 'recovery'. My letter campaign was a structured attempt to create a *community of concern* (Madigan and Epston 1995) to help break with the despairing view of the person suffering and to assist in the re-remembering of unique aspects of their lives now restrained by cultural, professional and problem discourse. In short, the campaign was designed to bring forth the anticipation of hope and the possibility of a healthy life.

The logic behind the community letter-writing campaign was also an attempt at finding ways to respond to the problem identity growing stronger within the structures of the institution (see Gremillion 2003; Madigan and Goldner 1999b). There appeared to be a correlation between the person being cut off from hope and forgotten experiences of themselves and relationships that lived outside of their 'sick' identity, and the rapidly growing professional file of hopelessness. The thought was to counter-balance the issue by including a community of re-membering and loving others who held the stories of the client, while the client was restrained by the problem from their memories. These were stories that lived outside the professional and cultural inscription that defined the person suffering. They were also stories that stood on the belief that change was possible.

Together with the client I would write a letter to selected members of the family and friends (and other clients on and off the ward who they knew), and ask them to assist in a temporal re-remembering and witnessing process through lettered written accounts outlining their a) memories of their relationship with the client, b) their current hopes for the client, and c) how they anticipated their relationship growing with the client in the future. These written accounts were directed squarely at countering the problems' strategies and negative professional stories. They were *always* diametrically different to what had been written in the client file. They re-presented a *counter file*. Documenting alternative versions counteracted the infirming effects of the professional and cultural problem story, and the pathologized names inscribed on to their bodies.

I have found that these lettered accounts hold a tremendous potential for highlighting sites of resistance and performed a re-storying of person's lives and relationships

(Madigan 1999). After utilizing these strategies on the ED ward, I then began to use therapeutic letter writing campaigns, counter-viewing, and creating communities of concern in a variety of other despairing problem situations.

PETER'S STORY

The social work department of an in-patient adult psychiatric ward asked if I would 'see' Peter, a 38-year-old white, heterosexual, married middle-class, man who worked in the local film industry. This particular psychiatric ward often refers their patients and families to me. The referring social worker also knew that I am the primary therapist responsible for the film and television industry personnel in Vancouver. So it seemed from the social worker's point of view that Peter and myself were potentially a good therapeutic match.

Peter was described to me by hospital professionals as 'chronically depressed' and was given very little hope for change The pessimism was triggered as a result of recent attempts to kill himself while on the ward and having to be physically restrained for pushing a male orderly. The hospital's plan for health and change involved group and individual cognitive behavioral therapy together with numerous medications. Despite these attempts, the hospital described to me that 'nothing seemed to be working'. I was also informed that the staff was beginning to think that after six months ward time 'change was impossible'.

Peter had a total of eight visits with me over the course of five months. After the first six meetings he was able to return home from the hospital. All therapy sessions included

a performative and listening therapist reflecting team (Madigan 1991). On five of the visits, volunteers of the letter- writing campaign (including family members, longtime friends and his former partner, Caitland, whom he had separated himself from) were invited into therapy to 'perform' their written work 'live' in front of Peter.

The 'general' structure for reading and witnessing the letters in therapy is as follows:

1) All campaign writers are invited to the session (if this is geographically possible) and in turn are asked to read aloud the letter they had penned about the 'patient'. In this case it was in front of Peter, myself, the other writers of his community and the team.

2) After each writer reads aloud, the client (Peter) is asked to read the letter back to the writer, so both writer and client can attend to what is being said/written from the different positions of speaking and listening.

3) After each letter is read by the writer and discussed with the client, the community of others in the session (who are sitting and listening) offer a brief reflection of what the letter evoked in their own personal lives.

4) This process continues until all letters are read, reread, responded to and reflected upon.

5) Each reflecting team member (usually made up of professionals) then writes and reads a short letter to the client and his community. They reflect on the counter-view of the client offered up by them and their community, the hope that was shared and aspects of the letters that moved them personally.

6) Copies are made of each letter and given to every one in attendance.

7) I then follow up the session with a therapeutic letter addressed to everyone

who attended the session including the client, the community and reflecting team. In this case, letters were also forwarded to the hospital team working with Peter.

During the first interview, Peter explained that eleven months prior to our talk, his 3 year old daughter (whose mother was his former partner Caitland) had died in a tragic swimming accident. He stated that initially he had only felt 'bitter and angry', and 'cut off' from the 'real meaning to life' and 'turned down support from anyone that mattered'. He stated that he responded by 'barricading myself away from the world' - 'I blamed myself' - and shortly thereafter separated from his marriage 'to be alone'. Peter had virtually removed himself from anyone who cared about him. He was eventually admitted to the ward after a neighbor 'by the grace of God' found him 'in the garage with the motor running'.

The problem, which he referred to as 'an inability to go on', had taken over his daily life. He let us know that he was 'haunted day and night' and 'couldn't remember much of his life' from before the day his daughter Mara died. He said that he 'felt hopeless' and could not remember the 'sound of Mara's voice'.

Briefly, I have outlined below some therapeutic counter-viewing questions that Peter and I engaged in:

1) Do you think a 'giving up on hope' is the way in which your conversations with hopelessness find a way to help you believe that 'giving up' is a good answer – the only answer?

2) How do you think the community looks on a father who has lost his 3 year

old daughter?

3) Do you think it is fair that everyone keeps telling you to 'get over it'?

4) Do you believe that these people believe that there is a proper time-line for a grieving father?

5) Are there places of past hope that you can remember that are currently blocked out by hopelessness and despair?

6) How is this hope possible?

7) Do you find any hope in the fact that Dave, your neighbour, pulled you out of the garage before death took you?

8) Do you feel that it is a fair accusation to blame yourself for Mara's death?

9) Was the hospital accurate in diagnosing you as depressed or do you think it might be about your experience of not knowing 'how to go on'?

10) Why do you think the hospital gave a grieving father so much medication?

11) Are there people in your life, including the hospital staff, that you believe blame you for Mara's death?

12) Has this deep sorrow you've explained to me been a sorrow that you could share with anyone else?

13) Is there any one person or any one idea that promotes a life of hopelessness within your day to day living?

14) Is there anyone in your life, looking in on your life, that you think holds out hope for you by holding your hope for you until you return to it?

15) If for a moment you could imagine that hope could be re-discovered in your life, what present qualities in you would give it staying power?

16) Was there ever a time that you disputed your internal conversations of blame and hopelessness?

17)   Is the love you hold for Mara in any way helpful to the restoration of hope

        in your life?

After three sessions Peter, myself and the team drafted a letter to his community of
concern. He chose a dozen people to mail the letter out to. The letter read:

Dear friends and family of Peter

*My name is Stephen Madigan and I am a Family Therapist working alongside
Peter. Since Mara's tragic death Peter has let me know that 'he hasn't known how
to face the world'. Up until recently a sense of 'hopelessness' has pretty much
taken over his life, to the point that it almost killed him. Another debilitating
aspect of this profound loss is that Peter can't 'remember much of his life' since
before Mara's death. Peter also feels in an 'odd way responsible for Mara's
death', even though he knows 'somewhere in his mind' that he 'was out of town the
day of the accident'. Peter believes that there is a 'strong message out there' that
he 'should just get on with his life'. Peter says he finds this attitude 'troubling'
because each 'person is different' and he believes that he 'might never get over it
but eventually learn to live with it'.*

*We are writing to ask you to write a letter in support of Peter explaining a)
memories of your life with Peter, b) what you shared, c) who Mara was to you, d)
how you plan to support Peter while he grieves, e) what Peter has given to you in
your life, and f) what you think your lives will be like together once he leaves the
hospital.*

Thank you for your help,

Peter, Stephen and the team

I personally found the reflections and readings with Peter, and the eight members of his community who attended, extremely profound. Our letter writing campaign meetings sometimes lasted two and three hours (we schedule them at day's end). There is no longer space in this chapter to include the campaign and reflection letters sent and read to him – but suffice to say that the texts written by the community of concern acted upon Peter's anticipation of hope, and his willingness to further live his life.

Four weeks after Peter left the hospital, free of medication and concern, he and Mara's mother Caitland entered into therapy with me to try and restore their marriage. They brought the letters. They anticipated the possibility that they could reconstruct their marriage. Hope is a wonderful potion.

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