*I wrote this paper in 1996 as a response to a particular structuralist and functionalist uptake and import of narrative ideas into North America. I made a pitch for locating narrative therapy practice within a discourse of post-structural ideas. This was in line with the way I learned narrative therapy during my apprenticeship studying, writing, and living with Michael White and David Epston.

Madigan, S. (1996) The Politics of Identity; Considering the Socio-political and Cultural Context in the Relational Externalizing of Internalized Problem Conversations. Journal of Systemic Therapies: Special Edition on Narrative Ideas, Guilford Press, New York, London

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THE POLITICS OF IDENTITY: CONSIDERING COMMUNITY DISCOURSE IN THE RELATIONAL EXTERNALISING OF INTERNALIZED PROBLEM CONVERSATIONS

Learning takes place within communities of discourse whose members - even in dissent- are guided by and constrained by notions of right, proper and appropriate ways of saying, doing and thinking.
Stephen Tyler (1986)

There is nothing outside the text.
Jacques Derrida (1974)

The point is not that decisions about who is normal are riddled with personal biases and political considerations but rather that, by dint of a handful of influential professionals' efforts, those subjective determinants of diagnoses masquerade as solid science and truth.
Paula Caplan (1995)

Inhabiting an Ideology

The practice implementation of Narrative therapy from person to person, and place to place, can be viewed as radically different depending on what practice ideology a therapist inhabits[1]. I observe that the range of meaning therapists currently give the practice of *relational externalizing conversations* is vast and from what I experience - quite often situated in modernist language traditions of functionalism and structuralism (Madigan, 1991a).

[1] By inhabiting a particular practice position a therapist situates her/himself within a particular ideological view, which is eternally affected by the context of the dominant discourse, discursive practices and power relations surrounding the therapist.

I would guess that therapists who externalize problems from a structuralist[2] or functionalist[3] ideology predominate the field of Narrative ideas and therapeutic practice. In my experience, this is not the practice of narrative therapy Michael White and David Epston ever intended (personal conversation, White & Epston, Vancouver, Canada, 1994).

During a recent hospital 'case' conference on the in adult patient eating disorder ward I consult to (and run Anti-anorexia and multiple-family groups with), a psychologist colleague stated that "anorexia may be pushing the family around, however, anorexia is also pushing forth what we have always suspected about this family - that they are manipulative and dysfunctional – an over involved mother and under involved father". In reflection I realized that my colleague's purpose for using externalizing language was to support an especially *individualized* psychological approach to therapy. Narrative therapy takes an anti-individualist approach – preferring to view all aspects of relationships, problems and discourse as relational and contextual.

To my surprise, many others who were in attendance and - many of whom were beginning to try out narrative ideas - *nodded their agreement*. At the time, I made every attempt to unpack their nods to situate the meaning of their agreement within a theory that would support their intent. Their comments made me think about the dangers of therapeutically mixing together apples and oranges - in this case narrative practice ideas together with popular psychological traditions.

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[2] By the mid 20th century there were a number of structural theories of human existence. In the study of language, the structural linguistics of Ferdinand de Saussure (1857-1913) suggested that meaning was to be found within the structure of a whole language rather than in the analysis of individual words. For Marxists, the truth of human existence could be understood by an analysis of economic structures. Psychoanalysts attempted to describe the structure of the psyche in terms of an unconscious. In the 1960's, the structuralist movement, based in France, attempted to synthesize the ideas of Marx, Freud and Saussure. They disagreed with the existentialists' claim that each person is what he/she makes themselves. For the structuralist the individual is shaped by sociological, psychological and linguistic structures over which he/she has no control, but which could be uncovered by using their methods of investigation. Originally labeled a structuralist, the French philosopher and historian Michel Foucault came to be seen as the most important representative of the post-structuralist movement. He agreed that language and society were shaped by rules and governed systems, but he disagreed with the structuralists on two counts. Firstly, he did not think that there were definite underlying structures that could explain the human condition and secondly he thought that it was *impossible to step outside of discourse* and survey the situation objectively. Jacques Derrida (1930 -) developed deconstruction as a technique for uncovering the multiple interpretation of texts. Influenced by Heidegger and Nietzsche, Derrida suggests that all text has ambiguity and because of this the possibility of a final and complete interpretation is *impossible*.

[3] Functionalism finds expression in family therapy theory to suggest that a problem serves a function in the family – Johnny is acting out in order to bring his parents closer together.

This paper proposes that a therapist's relational externalizing questions (Madigan, 1991b), and a client's problem story are shaped and influenced by a community of discourse[4]. Without an acknowledgment of the politics that make up this discourse, relational externalizing conversations might only prove to enhance and support pathologizing descriptions of persons - the very non-contextualized ideas externalizing conversations attempt to undermine (Madigan, 1992b).

The paper suggests that White and Epston's intent of relational externalizing problem conversations (White & Epston, 1990; Madigan, 1992a, White, 1995) considers problems *not* as privatized within persons bodies but rather influenced through a community of discourse. The community of discourse is mediated through a complex web of power structures which dictate, produce and reproduce an ever changing list of what is considered right or wrong, normal or abnormal etc (Foucault, 1984) I bring to mind that without considering the influence a community of discourse has in the shaping of the politics of identity, the use of relationally externalizing internalized problem conversations would be considered very limited.

I advise that there are presently many variations of externalizing practices among therapists, and argue that these very interpretations have real effects on persons and should not be exempt from *reflexive scrutiny*. I would like to outline a particular position of relationally externalizing internalized problem discourse, which I see rooted in community discourse and identity politics.

This particular interpretation and implementation of Narrative therapy is at the core of the Vancouver School for Narrative Therapy teaching and practice and - viewed as diametrically opposed to a practice of therapy utilizing externalizing conversations as a therapeutic technique or comprehends externalizing from a modernist tradition.

Negotiating an Externalized Story's Meaning

It has been argued that the therapeutic analogies we employ to frame our experience act to determine our examination of the world (Gergen, 1991, Keeney, 1983). The questions we ask about events and the realities we construct and practice determine the very distinctions that we pull out from the world. One only has to witness an event like the Olympics, be part of a political party, or witness a debate between two opposing family therapy practitioners to experience the bias between our own and another's experience (this paper is a case in point). Where one person experiences joy with one point of view, the other is outraged; where one practitioner "sees" pathology another "sees" strength.

Derrida (1991) suggests that the speaker speaks from a set of preexisting frames or what others like Heidigger have called pre-understandings. I am inclined to understand our utterances as shaped through a scaffolding of presuppositions (Madigan, 1991a, 1991b), i.e. what we know in our lived experience is shaped through the cultural weave of community discourse. For example, therapists who train within schools of Psychiatry, Psychology and Social Work or, within Solution Focused or Psychodynamic therapy, are affected in the way in which they come to make meaning and talk about problems, families and individuals.

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[4] Shotter (1990a) suggests that we never act out of our own inner scripts, plans - rather we are always sensitive in some way to the "opportunities and barriers" the "enablement's and constraints" afforded to us by our circumstances in community.

Each and every encounter a therapist has – is influenced by their discursive pre-training. We can change the specifics of the presuppositions we live through, but we can never fully escape the restraints to be completely free of presuppositions. It is therefore the interpretive strategies of the interpreter - in this case the therapist - which points us towards the situated knowledge of the therapist. This situated knowledge mediates the semantic intent of our relationally externalized conversations, i.e. what Michael White's brilliant externalizing response to encopresis involving the dialogic phrase *Sneaky Poo* means to one therapist could mean something entirely different to another.

At the heart of the paper it proposes that the meaning given to externalizing conversations is *directly mediated through the ideological structures we live in*. Thus, how each therapist creates meaning about externalizing problem conversations or how each person comes to know her/himself as problematic, is directly influenced by, and negotiated through, a myriad of political, cultural and psychological practices which she/he has come to believe in, and those that have been discarded along the way. A therapist's preferred meaning then - can be viewed as a type of practiced and politically preferred, hermeneutic cultural twist. Therefore a therapist's responsibility is positioned within the question - *of what psychological and political orientations do our questions, which externalize the problem, belong to?*

Post-humanist Considerations

Through careful consideration of a person's alternative stories, narrative therapists David Epston and Michael White (Epston & White,1990; Epston, 1995; White, 1990, 1995) along with a growing number of their colleagues (Byrd, 1995; Dickerson & Zimmerman, 1992, 1994; Epston & Roth, Gollan & White, 1995; Jenkins, 1990; Law & Madigan, 1994; Madigan, 1992b, 1991b; Madigan & Epston, 1995; Meyers Avis, 1995; Waldegrave & Tamasese, 1990) act to highlight and undermine dominant cultural knowledge's which act to specify, classify and subjugate a client's identity as fixed[5]. Our particular appropriation of Narrative ideas has lead us to what poststructuralist[6] feminist writer Judith Butler (1989, p. 602) would consider a *post-humanist consideration* of persons.

The specific delivery of therapy among those I have mentioned may have differences, however, we seem to agree with a post-humanist position. This position unsettles any essentialist psychological notions of the stable autonomous person, the original author (of problems or otherwise), or a given reality of what constitutes the self.

The focus of our therapy is to render transparent the discourse, structural inequalities and status of identity-based politics in the life of the problem (gender, race, class, sexuality), and the effects these discourse practices have had on the person's relationship life. Persons are not viewed as fixed within problem identities; *a person's identity is viewed within the politics and power plays of a culturally manufactured and constituted self (Madigan, 1992b).*

[5] See Madigan on Foucault and White1992.

[6] For a comprehensive summary on post-structuralism see Hoagwood (1993).

Therapists may be externalizing problems through a linguistic separation of the problem from person(s), i.e. by asking a question such as, "is the depression getting the better of you, or are you getting the better of it?" However, without furthering the externalized questions to situate the person in a community promoting of a depression lifestyle (i.e. abuse, poverty, racism, misogyny), the depression will ultimately stand as an isolated strip (Madigan, 1991b) outside of its culturally created community context. .

Communities of Discourse

A community of discourse[7] is a cultural creation, allowing for social norms to be dictated through a complex web of social interchange mediated through various forms of power relationships (Hare-Mustin & Maracek, 1995; Shotter, 1989, 1990a, 1990b). The discourse is not a neutral entity but does have potentially perverse effects on the lives of persons and problems within the community of its creators (Foucault, 1984). For example, in North America a multidisciplinary team is chosen to make decisions regarding what to include in our diagnostic testing technologies (Caplan, 1995). The group decides on the particularities of fixed categories of human life. They have the power to decide whether to include "Masochistic Personality Disorder" in this years' abnormal chart and whether or not to exclude "Homosexuality" as a classification.

What constitutes a community of discourse may include a veritable potpourri of influences. Discursive influences (Davies & Harre, 1990), from Jimmy Hendrix to Karl Marx, Jesus to Popeye, and Disney to Lennon - are sculpted through intricate and ritualized power plays, all of which are set up to control the discourse. All "knowing" within this community context is viewed as mutually shared and shaped. Hence, I create you, and you create me (Bahktin, 1989); governments shape us and we shape our governments (Foucault, 1984).

Without exception, all conversations of our community that have gone before us - *are us, affect us, and are participated in by us*. Persons take rhetorical positions on all issues, speaking or not speaking (Tyler, 1986). Each generation of speakers, from the founding "fathers" of government, the Freudians, the National Association of Women, punk musicians, and CNN - all make attempts to sway the discourse in particular directions and are of course - swayed along, to and fro, by the discourse.

As citizens living within communities of discourse, we seem to have an uncanny knack of knowing when, and if, bell bottoms or Doc Martin shoes are in vogue, who to support between warring countries and whether or not we should call people patients, clients, or just persons. However, this seemingly psychic knack is not merely a matter of being 'in tune', since circulating around and within us is a powerful rhetoric which dictates the ever changing community of discourse.

This discourse is shaped by and shaping of such grand narratives as capitalism, Christianity, and the patriarchy. Each narrative has its dissenters and its followers who constantly engage to argue for

[7] The word community discourse will be used in the context of this paper to include all the rules we make up and follow in formulating what is believed to be normal and what is not (Law & Madigan, 1992, 1994).

and against its legitimacy. Be it a matter of fashion or religion, wars are fought in the international, national and family arena over which discourse holds the "truth".

The discourse we use and therapeutic positions we take are affected by cultural traditions, supported through political structures, and instituted through mental health systems. The constitution of set institutionalized language rules affects our therapeutic language in every way. Discourse is affected at the level of *what can be said when, who can say what, and with what authority* (Madigan, 1992b*)*. For example, who decides on the criteria regarding which persons are invited (and who is left out) to medical rounds and case conferences; who is allowed to speak, and who has the rights to the story being told? (Law & Madigan, 1994b).

Where we position ourselves among the countless variety of psychological theories made available to us through the vast array of different mediums and institutions, requires us to be rigorously accountable[8] and responsible for the choices we make. The discourse involved in each therapeutic dialogue can be viewed as the 'ideological stuf' which influences and shapes a therapist's personal life and therapeutic practice vision and wisdom (Bakhtin, 1986; Law & Madigan, 1994a). For example, psychological theory enjoys a special status of power and knowledge and is often used as a vehicle, which reproduces cultural expectations and social norms (Madigan & Epston, 1995).

It might be difficult to conceive how our footwear and psychological theories are in any way connected to international rhetorical power plays. However, I invite you to consider how it was that Madonna ever became a multi million dollar recording artist, or what it was that allowed Johnny Bradshaw books to outsell all other family therapy books put together (apologies to Madonna and Bradshaw fans). To converse on a subject is to argue a point, persuade rhetorically and take a position either for or against. Conversation, like therapy, is not a neutral endeavour, which brings us to the shores of a most important reflexive therapeutic question - in our therapy practice *are we arguing on behalf of the person or the problem?*

Our therapeutic traditions, rituals and structures are mediated through a vast, hurly-burly, participatory landscape of community discourse that no person in language can possible avoid (Madigan, 1992a). We are the word and the world! So whether we are trying to purchase the latest fashion trends, puzzling over which Family Therapy conference to attend, or trying to figure out if U2's recent CD is hip or if it merely acts to chronologically date us, be aware that the textures of community discourse are operating on us.

Internalized Community Politics

With a recognition of the persuasive rhetorical politics involved in person and problem making, the work of externalizing practices is most clearly understood. I would suggest that if a therapist does not situate and recognize this community influence in problem making, the sociopolitical and cultural thrust of White, Epston, and their colleagues' externalizing practices will be lost and/or amalgamated into psychotherapy's dominant right wing system of individualized practice.

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[8] For an excellent overview of accountability practices see Dulwich Centre Newsletter Special Edition on Accountability 1994 Vol. #2, and Waldegrave (1990).

To recognize the community influence in our externalizing questions allows us the luxury of never having to view them as solitary or heroic. Rather, the therapeutic question is viewed as shaped by a myriad of conversations situated within the vast terrain of cultural and counter-cultural learning and traditions (Law & Madigan, 1994a, Madigan, 1992a) and can be considered as textual discourse (Shotter, 1990a). For example, when working with an indigenous person who views her/himself "less than worthy", the externalization of the problem considers how relationally, and through what contextual dialogic means, did this person come to know her/himself in this way? The therapist may give consideration to the politics of poverty, post-colonial invasion, racism and the loss of belonging with the cultural heritage.

Therapist attempting to externalize issues can often overlook the politics of the problem's context by omitting the colonizing affects the discourse of patriarchy, Christianity, and capitalism etc. has had on this person's identity making. It therefore becomes very difficult for a therapist to separate the person from the problem when the political shaping of identity and the discursive practices which support this identity context - are not addressed.

Rainbows of Discourse

Our therapeutic utterances do not connote therapist ownership to the particular externalized question, nor would they ever be considered as completely unique due to the community's involvement in any idea or action. Questions do, however, call forth speaker/community responsibility. A therapist's attention to reflexive scrutiny by way of situating comments (Madigan, 1992b), reflections (Lax, 1995) and transparency (White, 1995) can bring forth structures for therapist accountability (Waldegrave, 1996). Similarly, client problems are not viewed in isolation but do call forth accountability. The practice of male violence may act illustrate this further.

When a man beats his partner or child, I would perceive that this man is not acting totally alone, as he alone did not make up nor individually invent this violence. The man could be considered as having had a vast array of cultural and community trainings in 'power over' tactics and violence. Within the practice of violence he did not act individually but alongside and within the restraints of his male cultural trainings (White, 1992). This does not alleviate the violent man from being held responsible to the person and/or group of persons he was violent against, nor would it hold him less accountable to the many possible alternative ways of living that he might consider (see Jenkins, 1990).

Persons taking up a practice of Narrative ideas and therapeutic practice must give consideration to those discursive power relationships which influence how we have come to know ourselves as a part of a culture, gender, class, race, age, and problemed person/group. For example, Michael White might ask persons from a marginalized group how and in what ways has the community of discourse (i.e. white power and privilege) affected the maintenance and response to the problem over time (Gollan & White, 1995). In bringing this discourse of power forth he allows those political views he is in support of to become transparent in the therapy room. In doing so, White provides a conversational forum to deconstruct certain dominant cultural ideas and to privilege other marginalized/local practices. Whether a therapist is dealing with problems concerning violence, racism or depression, the context of a culture's discursive 'pre-trainings' (in power) which support the life of the problem must be considered.

With a knowledge of identity politics, a narrative therapist is always in dialogue with the powerful effects of community discourse throughout the session. As such, the therapist is not considered to be merely having conversations with single solitary individuals and/or families in a neutral conversational space (Madigan, 1991a, 1992b). A therapist is in conversation with a variety of discourses that have shaped persons towards certain ideas and away from others. Hence - we are never 'alone' with the persons who come to see us in our office.

To help illustrate this point, we might consider a quick look at a *rainbow*. A rainbow is a relationship of colours and light, where the relationship of all colours and space are directly affected through a relationship of recursion; simply put - everything is affecting everything else within a specified context. We believe, for example, that when we look up to the sky we can separate out and and *see* green. What we are actually viewing is green interacting with the blurring of a colour spectrum (the influence of blues and yellows on the green), the pollution context, our physical position in relation to the rainbow, and our social constructions of rainbows, colour etc. This fixing of green into space gives us the illusion of a single colour unaffected by the physical and construction context - however we do not really see green. We see only a blurring of yellows and blues and we temporarily allow ourselves and others the luxury of separating the green out from its context.

To translate the rainbow metaphor onto a particular problem in therapy, eg. Johnny is school refusing - a therapist might get caught constructing the particulars of the problem in the same way we see the colour green in the rainbow. Taking this position on the problem is in concert with popular practice ideology. The difficulty in this position is forgetting to put the green (problem) back into the context of the rainbow and surrounding environment. Hence school refusing little Johnny is treated as an isolated strip, set apart from a context and what follows is that the boy's body is often privatized with the problem and labeled with an individualized pathology. The vast over usage of ADHD diagnosis on children is a clear example of therapists seeing green and not rainbows.

It is important that narrative practitioners consider the political rainbow of problem and person making by viewing the problem as blurred and not totalizing of the person. Without a consideration of the cultural and sociopolitical context of the problem, the externalizing of internalized problem stories would be considered as merely *reproductive of culture and its institutions, and as such - uncritical*. In other words, our relational externalizing practice could act to solidify normalized traditions and techniques of power, i.e. not addressing issues of gender within the problem of anorexia, which, as David Epston is prone to state "would act to co-produce the problem".

Externalizing Internalized Community Discourse

I propose that the purpose of relationally externalizing the problem is to open space for the therapist and client to become linguistically radicalized within the discourse of the community (Madigan,1991a&b). Therapy can be used to create a space for challenging the myriad of cultural myths, which dictate and influence the life of the problem.

The cultural myths we come to know ourselves through are restrained and created within a conservative individualized discourse. This discourse, which establishes community norms, was

never intended to be democratic. It was set up as a means for a powerful patriarchal few to control and dictate the lives of the many. For example, the meanings behind identities given to us such as father, mother, psychiatric patient, aboriginal, therapist and adolescent have been manufactured to fit within the corporate needs of production. Their needs help to shape and dictate the rules of who we are, who we should be, how we should act, and how we should think and feel.

Accountability and responsibility within a therapeutic context may mean generating conversations, which publicly recognize the possible effects that a restrained, and possibly unchecked, community of discourse has had on the life of the problem and the person. For instance, questioning how the discourse of other mental health systems has influenced the life of the problem in the life of the family might provide space for questioning the rhetoric of these powerfully professionalized stories, and leave room to discuss and take up alternative accounts. I am sure that anyone who has ever attended a case conference or hospital rounds has witnessed a problem story in the making that, in the absence of the client, is quite disrespectful. Many meaningful professional nods will often act to create a 'reality' context to which the client has no relationship to, except through the relationship to the professional context itself. This context can assist an internalized identity-death by association.

Without considering the constitutive nature community discourse has on therapeutic concerns, persons will be privatized with the problem. For example, after a therapist has completed an evaluation and assessment of a person, the person's identity will often become known through terminology reflecting only the voice of the evaluator. The description of the client represents only a coloured shade of who she/he is as she/he is totalized and transformed into "Borderline", "ADHD", "Alcoholic", "Bulimic" identities.

In circumstances of assessment, clients rarely become known through their healthy qualities not mentioned in the diagnosis. Nor does the person get known as separate from, or in relationship to, the problem's context.

As far as I can tell, problems and persons do not live, nor are they created in isolated, solitary confinement (Madigan, 1992b). However, the vast array of psychological discourse which supports pathologized and totalized descriptions of a person-identity-as-problem often pushes these persons to live in solitary, isolated confinement (Madigan & Epston, 1995).

Through relational externalizing conversations, narrative practices outlined in this paper do not want to merely "fix" or "eliminate" the problem as a Solution Focused, Ericksonian or MRI based brief therapy might. They would first give consideration to and situate the problem within the broader cultural contexts of restraint (Madigan, 1992a). They would consider the situating of problems as reflective of their ideology and a measure of accountability of therapist practice.

Considering the Cultural Context of Anorexia and Bulimia

In order to show the important distinction between a practice of externalizing the problem which locates a problem within a cultural and sociopolitical context, and one that uses a more psychologized tradition of externalizing, I will use the example of working with women suffering with the effects of anorexia and bulimia.

For a woman struggling with the effects of anorexia and/or bulimia, her identity is ascribed according to the manner of the embedding community of discourse - in her own and in the discourse of professional others (Madigan & Epston, 1995). Within the professional discourse of anorexia and bulimia (which includes: journals, research grants, supervision, therapy sessions, conferences, hospital rounds, self help groups, the popular press and the recovery talk shows etc), I have heard women described as manipulative, controlling, immature, narcissistic, stubborn, pathological and power hungry. It follows, that if therapists covet this particular view of anorexia and bulimia in women, their externalizing questions would correspond accordingly.

However, if we were to consider that in North America millions of women are affected by anorexia and bulimia; that anorexia and bulimia affects women 95% of the time (Bordo, 1993); that a higher than average percentage of women taken by anorexia and bulimia have been sexually abused (see Special Double Issue on Eating Disorders and Sexual Abuse, Eating Disorders : Journal of Treatment and Prevention, Vol. 1, Nos 3,4, Fall and Winter, 1993); that the average North American girl goes on her first diet by grade three; that children in daycare are worried about their tummies being too fat; and that anorexia and bulimia are predominantly found in Euro-North American countries (Bordo, 1993), therapists might want to include these knowledge's in our externalizing conversations.

Given the above, our discourse of relational externalizing conversations might extend beyond the boundaries of the woman's body to include the evolving community discourse of gender, consumer capitalism, perfectionism, the specification and policing of women's bodies, a 'never-quite-measuring-up-to' culture, power relations, media, and a culturally produced preference for thinness. These factors may influence a therapist to consider an analysis of culture, power and gender into our anorexic/bulimic externalizing equation.

White and Epston's intent to relationally externalize conversations represents a major departure from predominant therapeutic themes entrenched in functionalism and structuralism. To use an externalizing conversation by posing the question, "Is that you speaking or is it the anorexia pushing you around?" is not yet problematic. It is, however, problematic if the externalization is used by the therapist without a post-structural theoretical posture, which would act to contextually separate the person from the problem. Without this post-structural consideration the question runs the risk of further pathologizing the person by internalizing the problem within the person. The intent of externalizing internalized problem conversations acts to objectify problems, not persons.

I invite the reader to read the following (brief) questions from a variety of theoretical perspectives. I will demonstrate a series of questions that may act to unpack the cultural co-production of anorexia and bulimia. These questions act to de-privatize the *dismembering* affects of anorexia and bulimia. In questioning the pro-anorexic/bulimic context a person can begin the process of being re-membered into a community of concern (Madigan & Epston, 1995), and begin to move away from problem culture that kills.

Deconstruction of Culture Questions

- What life support systems in popular culture feed an anorexic/bulimic 'not-measuring-up-to' lifestyle?

-If a woman wanted to make a public protest over the devastating effects of anorexia/bulimia, what would you suggest she do?
-Why is it that anorexia/bulimia tends to primarily affect the women of Western culture?
-Do you think that it is fair that anorexia and bulimia 'pushes its way' onto women, or do you think that it could be better described as a fascist occupation?
-Why is it that we professionals on the hospital ward overlook your best qualities?

Alternatively, I might want to assist in the unpacking of gender biases of anorexia and bulimia by situating my externalizing questions within the following ideological grammar:
Gender Based Questions
-Is the violence that anorexia/bulimia perpetuates on your body similar to or different from male violence against women?
-What is it that our society promotes that leaves most women with a distorted sense of their own bodies?
-Why do you think the 'voice' of anorexia/bulimia is almost always reported to be male?
-Why is it that anorexia/bulimia turns women's intelligence against themselves and towards complete confusion and chaos?

This class of externalizing questions acts to situate the speaker away from popular therapeutic traditions and to bring forth an alternative practice belief, which considers the influence of community discourse on persons and problems.

Wrapping Remarks
There are no words that belong to no one!
Mikhal Bakhtin 1986

I believe that all behaviour, including our own thoughts about ourselves, is conducted in an on-going argumentative context of criticism and justification. The grammar of language itself is set up to identify and argue for or against something - it can *never* be neutral. As citizens we debate ourselves (and others) within the restrained parameters and fragmented stories that shape us. We of course in turn shape our stories that are shaping us which sets up a practice recursion - a union.

Within the therapeutic context we hear the threads of discourse traditions and oppositional themes being debated, agreed upon and informed by ideological tenets. The tenets have been trashed, honoured and forgotten through our culture's long history of curious and imaginative rhetorical positions. We are left with only fictions, and we scramble fitfully to figure out - is this live or simulacrum?

As mental health professionals (sic) our culture awards us tremendous privilege and power in our story telling rights regarding persons and problems. How therapists choose to make use of a relationally externalized language will have differing effects on the past, present and future story of the client. The externalizing stories we choose to circulate about our clients are in no way neutral. However, the stories do tell us volumes about the therapist's rhetorical position and therapeutic ideology (Madigan, 1991b).

Bruyn (1968) writes: *Language, if left unstudied and unsupervised, may even come to control its creators. The social scientist may well become like the sorcerer's apprentice; he (sic) can weave a magic spell with his words about society which can take the shape of myths having a force on the minds of men not unlike the myths of ancient times.... language then, must be studied not for its own sake, as in linguistics, but also for other reasons, including the necessity of reducing the magical power that comes with use and misuse of language in social and political life. (p.125)*

I would add that it is not only those words that seem powerfully magic or the magical power of words that heeds our attention. It is the world of the mundane; the discourse unnoticed, the words of everyday therapeutic description that demands our *vigilance*. If our therapeutic discourse is allowed to go unchecked we might be in danger of promoting, circulating and recreating the very contexts that have assisted the problem stories we are attempting to eliminate.

I invite you to view the practice of externalizing internalized problem discourse not only as our instrument for art or - our paintbrush, our keyboard, or pen. I invite you think about externalizing discourse as our vehicle for protest; our placard, our resistance, our peace march. It is in the performance[9] of these externalizing conversations that persons are required to participate socially and are transformed. Externalizing questions asked (and not asked!) represent the interpretive turns, which a therapist and counseling team constructs, and those others they are restrained (Bateson, 1979) from taking.

These interpretive externalizing turns situate the therapist 'inside' a myriad of stratified landscapes of community discourse and rhetorical form. They spotlight a theory of choice, a political persuasion, gender, race, sexual and class biases, and a cultural identity. Relational externalizing conversations act to show the receiving context (listener/other), a therapist's purposefully chosen semantic path, or discursive practice[10] .

Discourse is never neutral - nor are the effects of the performance of languaged traditions (ie. sexual abuse, anorexia, religious institutions, violence, therapy). We position ourselves in therapy, both as client and therapist, along rhetorical lines of right and wrong. Choosing our semantic posture is shaped through an ethic of what we consider responsible and attached to a political ideology.

Politics is not only the work of our government representatives and newspaper reporters - we live it, shape it, and are shaped by it. Therapy is discourse, and discourse is the stories of rhetoric, and rhetoric is political. *Narrative practice can be viewed as disputing the rhetoric of problems and the political scaffolding that supports them*.

As therapists we must invite ourselves, each other, and our clients to question the ideology that sits behind our practice beliefs of externalizing conversations. To participate with a therapeutic language of responsibility, we must question what and which analogies, presuppositions, restraints,

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[9] For a comprehensive summary on the idea of performance and meaning see Turner (1986).
[10] A discursive practice is viewed as all the ways in which we create social and psychological realities.

cultural knowledge's, rhetorical flips and other historically situated beliefs are involved in the questions, comments, and practices of relationally externalizing internalized problem discourse.

REFERENCES

Bakhtin, M.M. (1986). Speech genres and other late essays. Trans. by Vern McGee. Austin, Texas: University of Texas Press.

Bateson, G (1979). Mind and nature: A necessary unity. NewYork:Dutton.

Bordo, S. (1994)/ Unbearable Weight: Feminism, Western Culture and the Body. Berkeley: University of California Press.

Bruyn,S. (1986). The Human Perspective: The methodology of participant observation. Englewood Cliff, NJ: Prentice Hall.

Bird, J. (1995). Keynote address, Narrative Ideas and Therapeutic Practice Conference. Vancouver, Canada.

Caplan, P. (1995). They say you're crazy: how the world's most powerful psychiatrists decide who's normal.New York:Addison-Wesley Publishing.

Davies, B. & Harre, R.(1990). Positioning: Conversaion and the production of selves. Journal for the theory of social behaviour, 20, 1:43-63.

Derrida, J.(1991). A Derrida Reader: Between the Blinds. Peggy Kamuf (Ed.). New York:Columbia University Press.

Dickerson,V., Zimmerman, J. (1992). Families and adolescents: Escaping problem lifestyles. Family Process, 31: 341-353.

Dickerson, V., Zimmerson, J. (1994). Using a narrative metaphor: Implications for theory and practice.

Epston, D.(1994). The Problem with Originality. Adelaide. Dulwich Centre Publications, Vol.4, 1994 Newsletter.

Epston, D. & Roth, S.(1995). The Reflecting Team in Action. Stephen Fiedman (Ed.), New York: Guilford Publications.

Foucault, M. (1982). The subject and power. In H. Dreyfus & P.
Rabinow (Eds.) Michel Foucault: Beyond . Chicago Press.

Gergen, K.(1991). The Saturated Self: Dilemmas of Identity in Contemporary Life. New York:Basic Books.

Gollan, S. & White, M.(March,1995). The Aboriginal Project. Presented at the Family Networker Conference, Washington, DC.

Hall, R, Mclean, C., White, C. (1994) Special Edition on Accountability. Dulwich Centre Newsletter, Vol. 2, Adelaide, Australia.

Hare-Mustin, R. & Maracek, J. (1995). Feminism & Postmodernism: Dilemmas and Points of Resistance. Dulwich Center Newsletter #4,
13-19. Adelaide, Australia.

Hoagwood,K. (1993). Poststructuralist Histoticism and the Psychological Construction of Anxiety Disorders. The Journal of Psychology, 127(1), 105-122.

Keeney,B.(1983) Aesthetics of Change. New York: Guilford Publications.

Law, I., Madigan, S. (1994a). Discourse not Language: the Shift from a Modernist View of Language to the Postmodern Analysis of DIscourse in Family Therapy. Dulwich Newsletter #1, p.31-37, 1992. Adelaide, Australia.

Law,I.,Madigan,S.(1994b).Power and Politics in Practice. Dulwich Newsletter, Special Edition, Law and Madigan (Eds.) Vol.#1.Adelaide, Australia.

Madigan & Epston (1995). From Spy-chiatric Gaze to Communities of Concern: from professional monologue to dialogue. The Reflecting Team in Action(1995). Stephen Fiedman (Ed.) New York:Guilford Publications.

Madigan,S.(1992a) Questions about questions: situating the therapist's curiosity in front of the family. Therapeutic Conversations, Chapter 11. Gilligan,S. & Reese, P.(Eds.). Norton Publications, New York.

Madigan,S.(1992b). The application of Michel Foucault's philosophy in the problem externalizing discourse of Michael White. Vol. 14, No.3, AUgust 1992. Journal of Family Therapy. Blackwell Publishers,
Oxford ,UK.

Madigan,S.(1991a). Voices of De-Mystification: Questions as Performative Texts - a Poststructural Analysis. Unpublished Dissertation. NOVA Southeastern University.

Madigan,S.(1991b).Discursive Restraints in Therapist Practice. Dulwich Newsletter, Special Issue on Deconstruction and Therapy. Fall 1991, Adelaide, Australia.

Myers Avis, J.(1995). Keynote address Narrative Ideas and Therapeutic Practice Conference. Vancouver, Canada.

Shotter,J.(1989). Social accountability and the social construction of 'you'. In K. Gergen & J. Shotter(Eds.) Texts of identity. London: Sage Publications.

Shotter, J.(1990a).The Social Construction of Remembering and Forgetting. Collective Remembering. In D. Middleton and D. Edwards(Eds.). London:Sage.

Shotter,J.(1990b). Social Individuality Versus Possessive Individualism: The Sounds of Silence. Deconstructing Social Psychology. In Ian Parker and John Shotter(Eds.). London:Routledge.

Special Double Issue on Eating Disorders and Sexual Abuse. Eating Disorders: Journal of Treatment and Prevention, Vol.1, Nos 3, 4, Fall and Winter, 1993.

Turner, V.(1986).The anthropology of performance. New York: PAJ Publications.

Tyler,S.(1986). The Unspeakable: Discourse, Dialogue and Rhetoric in the Postmodern World. Madison, WI. University of Wisconsin Press.

Tamasese, K., Waldegrave, C. (1990). Social Justice. Dulwich Centre Newsletter, Vol. 1, Adelaide, Australia.

Waldegrave, C. (1996). Keynote speach, International Narrative Ideas and Therapeutic Practice Conference. Yaletown Family Therapy, Vancouver, Canada.

White, M., & Epston, D. Narrative Means to Therapeutic Ends. New York:Norton Publications.

White, M.(1995). Re-authoring Lives: Interviews and Essays. Adelaide, Australia. Dulwich Centre.