***Dr. Stephen Madigan** holds 2 Masters Degrees in Counselling (MSW, MSc) and a Doctorate Degree in Couple and Family Therapy. He is lifetime member of Family Mediation Canada, a Supervisor for the Canadian/American Association of Marriage and Family Therapy (AAMFT), sits on the Scientific Committee for the International Association of Marriage and Family Therapy (IFTA), and is a member of the American Family Therapy Academy (AFTA). In June 2007, the American Family Therapy Academy honored Dr. Madigan with their Distinguished Award for Innovative Practice in Couple and Family Therapy Theory and Practice (a first for Canada!). Dr. Madigan offered two full days of orientation to Narrative Therapy at the BCSCA October 2008 conference, and kindly agreed to this one hour interview at Yaletown Family Therapy, Vancouver, B.C., prior to the conference. Further information regarding Dr. Madigan and Yaletown Family Therapy can be found at www.stephenmadigan.ca.*

Some background about Narrative Therapy and it's applications to school counselling.

Dr. Madigan: Michael White and. David Epston shared a similar therapeutic approach in their respective counselling practices with children in Adelaide, Australia and Auckland, New Zealand during the early 1980's. It was during this time, at an Australian Family Therapy Conference, they met for the first time, and what we now know as Narrative Therapy formally emerged as a result of their shared insights. With the publication of their book Narrative Means to Therapeutic Ends (1990) and articles in Newsweek magazine and the Psychotherapy networker, narrative began to gain traction and popularity in North America in 1993-1994. I began the first set of international narrative therapy conferences in 1993 in Vancouver. I met Michael White at FootHills Hospital in Calgary in 1986 during a presentation he was giving at Karl Tomm's invitation – it was his second ever workshop in North America. I was then invited by Michael to study with him in 1991 and traveled to Australia and New Zealand where I lived and studied with both he and David Epston while completing my PhD in Marriage and Family Therapy. I then opened the first Narrative Therapy Clinic, Yaletown Family Therapy (Vancouver), in North America in 1992.

Narrative Therapy is different from all other counselling therapies in that it is not informed by psychological theory, but finds it roots in other disciplines including Anthropology, Literary Criticism, Feminism, Queer and Post-Colonial thinking. Common to these theories is the idea that the self is socially produce and therefore *problems are not viewed as privatized within the body of the person*. Central to the practice of narrative therapists is the belief that people come to understand and perform their lives through a myriad of influences, social structures, language and dominant ideas about who people should be. When children are brought to us in therapy there is usually a problem-saturated story already developed about them, and it is hard for them to escape that story particularly in places like schools where a child can be entered into a totalized reputation of who they are – ie., being given the label of ADD. Narrative therapists look at the problem's 'life support systems' - how other persons and beliefs in the child's life keep the problem story alive - and seek to examine alternative or subordinate stories that have been lived through by the child but to which the child has less access in terms of who s/he is, who s/he has been and who s/he might become. In Narrative Therapy the

child is separated from the problem – the child is the child, the problem is the problem. The role of the therapist is to work alongside the child's support systems to collectively bring forth other abilities and skills that have been pushed out of the child's life because of the problem. To explore the fuller context of where a child and his/her relationships may be influenced, Narrative Therapy examines the dominant culture in which the child finds him/herself, identifying such factors as money/privilege, race, gender, sexuality and where they are placed within the social order.

How did you get into this particular approach to counselling? What does you see as the benefits of this approach?

Dr. Madigan: Narrative Therapy allows me to combine both my personal and professional passions as I view therapy as a 'political act'. Both my parents worked with the poor and dispossessed, and as a young person I spent many evenings in their company helping out. My father was an electrician by trade but he was also the best group therapist I ever met as he was able to draw out the complex stories of lives affected by many turbulent circumstances and situations. Narrative Therapy concentrates on the *context of how problems and persons have been manufactured and how they have come to be in relationship*. We do not recognize the fixed labels that are produuced by professionals and inscribed on to people's bodies through the DSM-IV - instead we try to look at the broader social context of how people come to know themselves and understand their preferred stories of who they would like to be. Narrative therapy would stand behind the client's preferred ideas of self and against totalized and fixed descriptions of their personhood. Take, for example, a child (client) who is suffering from depression. Discussion with the mother might also bring to light that she is be a sole parent on social assistance with three children under the age of 10. Without inviting a full conversation around the politics of poverty might be viewed as unethical.

In June 2007, the American Family Therapy Academy honored you with their Distinguished Award for Innovative Practice in Couple and Family Therapy Theory and Practice.

Dr. Madigan: This was a great surprise. I was very proud to be nominated and happy my work at Yaletown Family Therapy had been recognized. Myself and my colleagues have worked very hard through the years within a method of therapy that was not too popular at first– but through time it has has become widely accepted in Vancouver, throughout BC and the rest of North America. We have been publishing and organizing conferences since 1993 and offering training in Narrative Therapy to (a) create a 'Narrative' community in North American and (b) as a reaction to presenting at larger international conferences where everyone looked like me…white, heterosexual, professional and middle class. I wanted there to be more 'room' for women, persons of color, queer and community activist speakers…to move people to be more vocal and active in their own communities and to model their conferences on the work we were doing here. Yaletown Family Therapy never backs down and is very clear in our support of people and our critique of the (counselling) field. In terms of creativity within our theory we view ourselves as only barely scratching the tip of the iceberg in

terms of what is possible. The problem with the field, as we see it, is that therapists seem to be hitching themselves to the wagon of hard science and pharmaceutical based solutions. As a result, I think that a grave injustice has been done to persons and communities because they have been labeled and divided off both socially and spacially. I think ADHD is a perfect example of that…there has been an explosion of identification of children with ADHD, backed by all orders of government and a very large pharmaceutical community. As a result our children are being chemically restrained through the taking up of this very successful pathology. For psychology and big pharmacology to come out with a quick and ready solution which is supported by all levels of government and institutions where the children have absolutely no voice and where the larger social context regarding how and where children learn is not considered; this is an outrage to me. And it carries on despite the fact that the Canadian Medical Association has now come out against the distribution of Ritalin. Perhaps there may be a very small percentage of children where there is a biological basis to ADHD and they can be necessarily treated within the educational system where we create different kinds of programs, different kinds of environments for learning, different kinds of ways in which they can not feel ostracized, pathologized and othered. Perhaps this so called problem might also consider school policy, perhaps we need to look at diets, poverty, class size, and supporting teachers, and dual income families and sole income mothers. We are not being nearly as creative as we can be. We need to support ideas which open us up and give us new ideas to support these children, their teachers and their families.

Could you describe how you would begin a therapeutic journey with a child or adolescent?

Dr. Madigan: Before we do anything we have to determine whether or not there is a problem. The whole first session with the young person is finding out, not so much what other people are saying about him/her, but where they feel the struggle is, and what it might be that is not working out in their lives. The child might feel that school refusing is the problem. We would define the problem and look at the negative effects of this problem. What is this problem taking away from their lives? I ask specific questions about whether this is a good thing or a bad thing; I often ask the question, "Why?" Why is it a problem that you don't attend class? Why would it be important to graduate? The protest against the problem <u>must</u> come from the child/adolescent his/herself. If the youth does not take a stand against the problem themselves then there is not much hope for a solution to emerge. Significant (therapeutic) time is spent inside the language of the child/youth. I would argue that all problems in terms of how we define them and how we interact with them are socially constructed, and they are constructed in such a way that they have certain practices that go along with the problem and there are practices that go along with how we treat people who we believe have these problems. I would encourage the client to identify all the times when he/she has stood against the problem or when the problem wasn't available to them. What was his/her life like? In broader terms, how will these children/youth stand up for a better idea of who they are and get better acquainted with their strengths and abilities? How can they return to what their life was like before these experiences? Each week when we meet we build on the fact of what their life was like before the problem existed. When the client grows free of the problem there is a ritualized celebration of their great

achievement, and a sharing of this information with those who need to know. Narrative therapy is used a lot in schools. It is a therapy of appreciation where the counsellor works as a team-mate to the child/youth to find ways to help the client connect with his/her teachers and classmates. Being a school counsellor is such an important place in the culture of education because I'm not sure if there is any more rapid time in identity development, particularly in high school, and the counsellor is right on the ground level of the experiences of our children.