



Re-contextualising conversations and rich story development

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Abstract

In contrast to more common understandings circulating in contemporary Western culture that de-contextualise the problems experienced by people and tether them to their bodies and beings, this paper describes a number of narrative practices that contribute to the rich description of the context in which problems emerge in a person's life. Therapeutic practices of double story development that provide a foundation for these re-contextualising conversations will also be described.

Key words: *narrative therapy, mental health, discourse, externalising conversations, power relations, therapeutic posture, rich story development, positioning theory*

My work as a member of the Narrative Therapy team within Country Health SA's Rural and Remote Mental Health Service provides me with opportunities to consult with people who have been admitted to an adult psychiatric ward and, upon discharge, have returned to their local rural community where they continue to be supported by a community mental health team. People are referred to our team by psychiatrists or community workers, and our service mandate is to provide narrative therapy for people who have been given diagnoses of depression, anxiety, post-traumatic stress disorder, or some sort of personality disorder diagnosis, and who have been subjected to childhood sexual abuse, sexual assault, domestic violence, or other trauma.

Discourses of biomedicine

In this context, biomedical discourses dominate understandings of mental illness and therefore shape and are shaped by the vast array of structures and practices that are in place to attend to people's experiences of mental illness. These biomedical discourses reflect notions of mental illness as being firmly located in the human mind and body as naturally-occurring entities which can be discovered with appropriate scientific methods, instruments, and knowledge (Epstein, Wiesner, & Duda, 2013). Claiming scientific neutrality and objectivity in these practices, this discourse elevates the importance of skilled practitioners ascribing the correct diagnosis so that the right evidence-based treatments can be administered, frequently including medication regimes (Cosgrove & Wheeler, 2013; Strong, 2012; Tomm, 1990).

The Diagnostic and Statistical Manual of Mental Disorders (DSM), currently in its fifth edition, is a key text of this biomedical discourse and since its first publication over sixty years ago it has grown in size, complexity, and influence (Simblett, 2013). This influence has been carried by pop psychology, the media, public health and humanitarian campaigns to extend well beyond the boundaries of the professional disciplines to permeate everyday life and language in contemporary Western societies and beyond, including responses to wars and natural disasters (Epstein et al., 2013; Pupavac, 2001; Simblett 2013).

Over the past five decades, the biomedical discourse of psychiatry, its DSM and accompanying practices, have faced substantial critiques from a range of perspectives, albeit with little effect on the expansion of its influence (Harper, 2013; Lafrance & McKenzie-Mohr, 2013). This history includes examinations by feminist writers of the truth claims of the biomedical discourse and the subsequent obscuring of patriarchy (Swartz, 2013), including psychiatry's participation in the pathologisation of femininity, the medicalisation of women's misery, and the regulation of 'difficult' women (Ussher, 2010). As White (1995a) observes, this obscuring of the unequal

power relations of culture enables people's problems to be regarded as aberrations, which enables us all to avoid facing our complicity in the maintenance of these structures of inequality. By locating problems within the individual and neglecting societal, cultural, and historical perspectives (Epstein et al., 2013), the attention of policy makers is also shifted away from attending to issues of inequality and injustice (Harper, 2013). This also evokes a historical perspective that the DSM, psychiatry, and biomedical discourses are predated by patriarchy and its oppressive social practices in relation to women's bodies, sexuality, and reproduction (Swartz, 2013).

Discourses of humanism

Biomedical discourses rely on, among other things, dominant humanist discourses for the legitimacy of their truth claims about mental illness. These discourses draw on the notion of human nature, which is said to determine how people live and act in the world. Although the 'nature' of human nature varies between philosophies, it commonly 'presupposes an essence at the heart of the individual which is unique, fixed, and coherent and makes her what she is' (Weedon, 1997, p. 32). It is thought of as remaining consistent throughout history and discoverable through scientific enquiry at the objective level and through philosophical introspection for the individual (O'Farrell, 2005).

These discourses make possible the construction of the notion of individual personality and, in the psychiatric realm, the notion of disordered personality. Prior to the DSM-5, 'personality disorders' were grouped together and classified separately from other mental illness diagnoses and, because by definition they were linked to a person's 'essence', were not widely regarded as a mental illness and therefore less worthy of intervention in a psychiatric system. A diagnosis of Borderline Personality Disorder, for example, which for many is 'the worst of psychiatry as a mechanism for regulatory control that is pre-disposed to find women defective and sick' (Lester, 2013, p.71); results in 'not only societal stigma but exclusion and disapproval from within mental health services' (SA Health, 2014, p. 14).

One introduction to Molly

In the swirl of these discourses, Molly was referred to our service by her community mental health worker, Liz, on account of narrative therapy being included in the plan that accompanied Molly's discharge from hospital one month earlier. The referral documentation included a summary of Molly's circumstances as described by the treating psychiatrist. From this documentation, I learnt that Molly had been involuntarily hospitalised following several days of what was described as having heightened mood, rapid speech,

increased energy and agitation, making grandiose claims, and yelling loudly outside her home. Police were called and she was taken to a local hospital where she was initially detained for 24 hours, before this was extended for another 10 days and she was transferred to a psychiatric inpatient unit for more specialist care.

I learnt that Molly had been subjected to childhood sexual abuse at age nine as well as experiences of date rape during her young adult years. The report stated she currently lived with her two secondary school age children and a few years earlier had separated from her husband, the children's father. The discharge report also mentioned some of the circumstances Molly had described that were surrounding her in the two weeks prior to being detained. These included some ongoing issues with her ex-husband, and seeing a news report about the rape and murder of a young girl in India. This news had upset Molly greatly and she subsequently had posted her response on Facebook, as well as details of her own experiences of childhood sexual abuse and sexual assault.

Other discourses

I am grateful that there are other discourses that I can draw on to shape my therapeutic conversations in this context, including the ones that lay ahead with Molly. These discourses include those that are in contrast to humanistic understandings of persons, as they set aside the belief in a subjectivity of essence and instead make subjectivity the product of the particular cultural, historical, and social relations of power (Burr, 2003). In taking up this poststructural view, narrative practice draws on the text analogy discourse from the social sciences (White & Epston, 1990) to propose that it is stories that shape our subjectivities, that sense of who we are as people. Narrative practice proposes that as we go through life, we carry with us stories which provide a frame for the meanings we actively ascribe to our experiences. This meaning-making influences how we experience life and how we proceed with life. Thus, the stories of our lives do not just reflect life, they also shape life (White, 1991/1992). These stories do not stand alone, but exist in relation to cultural stories that are available and plausible.

I am particularly supported by the idea that the rich experience of people's lives means that there are always events in the history of a person's life that contradict the problem stories of their lives. These events can be brought into storylines that can also be shaping of life. This practice of re-authoring can make it possible for people to re-familiarise themselves with a range of skills and knowledges of living, as well as what they give value to in life, and hope for, and stand for in life. This re-familiarisation can contribute to a person's sense of personal agency and provide new options for action in proceeding in life (White, 2007).

Beginning a rich acknowledgement of the problem

When I first met with Molly, accompanied by Liz, I asked for her understanding of how our meeting came about, and what she was hoping for from us meeting together. In response to the latter, Molly said that she felt 'very challenged by the lows I experience' and would 'love to be able to feel stronger and more confident in being able to deal with my mental health issues'.

In the narrative therapy literature, significant attention is given to the importance of generating a rich description of the externalised problem and its effects on the life of the person, family, or community consulting the therapist. This is evident since the early writings of Michael White (1984, 1985/1989), which describe practices whereby problems are objectified, enabling an exploration of both the influence of the problem in the life of the family, and the family's influence over the problem. These practices are in stark contrast to cultural practices of objectifying persons (White, 1988/1989, 2007), and this double description provides a basis for the family to take further initiatives to limit the interference of problems in their lives (White, 1986).

Over time, and in response to requests from others, White (2007) developed the Statement of Position Map to support practitioners to engage in and further develop externalising conversations, including negotiating with the person 'a particular, experience-near description of the problem' (p. 40) that moves the description away from biomedical discourse and instead privileges the person's languaging of the problem. So, I first wanted to clarify with Molly that when she mentioned 'my mental health issues', was it 'the lows' she was referring to, or something else? Molly explained that she had previously experienced post-natal depression and, about eight months earlier, she had been advised that the name for her condition was Pre-menstrual Dysphoric Disorder (PMDD). In an effort to make experience-near namings of the problem more available, I asked Molly what was going on for her when she was experiencing 'the lows' that others named as PMDD. She said she felt suicidal, 'disconnected from good things, and unable to do much at all'.

Informed by the concept of the 'absent but implicit' in narrative practice (White, 2000), Molly's expression provided options to explore different avenues into possible preferred storylines. However, at this point I was wanting to understand a little more about her view of the diagnostic categories that had been assigned to her, given that DSM diagnoses can easily become 'I am conditions' (Estroff et al., as cited in Guilfoyle, 2013, p. 86), that are collapsed onto and totalising of persons' identities (Tomm, 1990). My interest was also informed by understanding that, for some people, a psychiatric diagnosis

provides them with relief (that their experience has a name, and is treatable) and validation (that their experience is one that others share, and thus credible). Lafrance and McKenzie-Mohr (2013) point out that in Western culture, this experience of relief can be understood as a response to the exemption from blame and personal failure that would otherwise come from not achieving the venerated personhood, and that such labelling can actually be protective of a preferred identity. White (1995a) extends this by questioning what other possibilities might exist for people to not experience blame and personal failure in Western culture that do not require exemption on account of illness.

In this context, I proceeded to ask Molly what was it like to be given this name for her experience. She said that she had known the lows were 'hormonal' because she had experienced 'ten years of it', and that she preferred this term to what she had previously called herself – 'a manic depressive' – because PMDD confirmed for her she was not 'crazy' and that it 'might be easier to manage'. In response, some further options for lines of enquiry may have been:

- the history of naming herself as 'manic-depressive', the effects of this designation, and to invite her to take a position in relation to this as a possible entry-point into preferred identity descriptions
- what Molly had to 'manage' and the context around this, the skills and knowledges she has drawn on, and the social and relational history of these.

I decided instead to ask Molly what it was that had her thinking she was 'crazy'; was it this earlier description of 'manic-depressive', or something else? She said it was because of 'all the chaos' in her life, including 'hoarding' and how this might be linked to 'what I have been through as a woman – the sexual thing ...'. I decided not to ask what she meant by this, as although I had some idea from the referral document, I was uncertain of what it might require of her to speak more about those experiences at this time in our conversation. I also decided not to ask her about 'the hoarding', or its link with 'the sexual thing', as I did not want to move too quickly into the details of the problem, thus potentially inviting a pathologising description.

Another introduction to Molly

It seemed time I started to provide Molly with a different place from which to speak about the problem, so I returned to my curiosity about what she felt disconnected from when the low feelings were present. Molly readily mentioned that the good things in her life include her home on a small rural property, her children, her enjoyment of music, being with friends, and being able to do routine things around the home. She did not have a preference for which of these we spoke about, so I invited

her to describe in what way her home was a 'good thing' in her life. She fondly described its history and heritage, its beauty, and its place in her family in recent generations. I asked about how this house had become her home, and who would be particularly pleased that she was caring for it. This brought her late father and grandmother into the conversation and, drawing on re-remembering practices (White, 1997, 2007), I heard about their contribution to her connection with home and land, and what they would be appreciating about her on account of this. In contrast with biomedical and humanist discourses, these enquiries are reminiscent of a spirituality that connects land and people of Māori, Pacific Island, and Aboriginal cultures (Waldegrave, Tamasese, Tuhaka, & Campbell, 2003; Wingard & Lester, 2001), and are also informed by the concept of 'place' in therapeutic enquiry (Denborough, 2008; Trudinger, 2006).

Drawing on practices of co-researching a person's experience of therapy (Denborough 2004; Morgan 2000; White 1991/1992), at the end of our first conversation I asked Molly if there was anything in particular that stood out for her from the conversation. She said that it was nice to focus on the positive aspects, rather than 'going straight into all the trauma', which is what she thought might happen. I suggested to Molly that if she was interested in conversations which were oriented around helping her manage the lows and feeling less disconnected from things that were important to her, then she would be most welcome to do so. Liz expressed that she had appreciated hearing Molly speak about some of the things that are important in her life, and we arranged to meet again in a couple of weeks.

Further acknowledgement of the problem and its effects

When we met a fortnight later, I was hoping to again get onto further descriptions of what was important to Molly; however, the intervening weeks had her feeling that 'everything seems difficult and overwhelming'. I find that asking for a more detailed description of such a totalising expression as 'everything' to be invaluable in putting some limits on the problem (White, 2011a). In doing so, my hope is that 'everything' becomes 'some things' and not 'all things'. I confirmed with Molly that the low feelings had continued to conspire to disconnect her from the good things in her life. I also asked Molly whether the low feelings also affected how she thought about herself or felt about herself as a person (White 2001a, 2007) – had it indeed become an 'I am condition' that was revealing of who she was as a person?

She said that these feelings had her hating herself. In an effort to again dismantle such a totalising description, I asked her which aspects of herself the low feelings had her hating. She said 'everything – all kinds of screwed up in my life'.

Again, I asked her when she referred to 'all kinds of screwed up', were there particular things that she had in mind? She spoke of feelings of regret that surrounded past decisions in relation to substance misuse, relationships with men, seeking professional help, and taking medication.

An opening into preferred territory

The effects of the low feelings were looming large in Molly's life, and in our conversation. There seemed a lot of heaviness in the room. Then Molly said to me, 'I feel really sorry for you Chris ... you're probably wondering, "How on earth do I help this person?"'. I knew there were many things to consider in understanding Molly's expression, and in expressing a response. First, I wondered whether there was something about my face or body movements that had led Molly to say this. If she had noticed something and was prepared to describe it, I could subsequently shape a response that would include seeking to understand the effects on Molly of noticing it, and somehow locate it in my own experience so as to inform Molly's meaning-making. This would be consistent with my interest in practices of accountability that seek to understand and respond to the real effects of therapeutic practices (White, 1991/1992, 1995b, 2011b).

I also wondered whether Molly's expression was a reflection of her experiences of previous therapeutic conversations, and her awareness of how these had adversely affected professionals who were seeking to help her. If so, this would not be surprising given the increasing prominence of discourses of 'vicarious trauma' and 'compassion fatigue' in the helping professions (Morrison, 2007). These discourses can invite people seeking consultations into feeling responsible for the wellbeing of the therapist and can add to previous experiences of shame and silencing in the context of abuse (Mann, 2005). There also exists the possibility that these feelings of responsibility are further shaped by the politics of gender and the discourses that invite men to avoid responsibility for their own social and emotional wellbeing, and invite women to step into that vacuum (Jenkins, 1990; McLean 1996). Also, because I was not thinking something akin to 'how on earth ...', I could, in fact, describe to Molly what I was thinking about. However, I did not want her to experience this as a form of denial that suggested to her I was unaffected by the conversations I have with people, particularly as my experience usually reflects a 'two-way account of therapy' (White, 1997, p. 130) that makes possible an acknowledgement of the contribution a person makes to my life and practice.

Also prominent for me was the idea that Molly's expression was perhaps a 'reaching out towards the world of the other' (Jenkins, 2009, p. xiii) and an 'ethical striving' which produces initiatives despite a context of adversity (Jenkins, 2011, p. 35). I now wonder in what way was Molly's expression a form of

resistance to being positioned by the discourses of psychiatry, trauma, and therapy as a passive patient, simply in receipt of expert knowledge and talking-therapy intervention. My hope is that our conversations thus far had created a context that had contributed to this resistance being a possibility. Perhaps Molly's expression could also be considered a refusal to relinquish ways of being in the world that she gave value to, despite the prominence of what was problematic in her life. Such an exception to the influence of the problem within the therapeutic conversation can be readily regarded as a 'current unique outcome'. White and Epston (1990) suggest that 'the immediacy of these current unique outcomes is highly compelling, and they are directly available to persons for the performance of new meaning' (p. 59).

For me, it seemed important to find a way to acknowledge Molly's values and intentions in saying what she did, while privileging her take on her own sentiments and de-centring my evaluation (Mann, 2005). White (1991/1992) suggests that any designation of an event as a unique outcome remains tentative until such a status is granted by the person. The following is an edited version of the conversation that followed, taken from my notes:

Chris: Thank you for saying that; I appreciate you expressing that. In you saying that, it feels like you're offering me something. When you said that, I experienced it as an expression of empathy and compassion. I'm not saying that's what you would call it, or that's what you meant it to be, but that's how I experienced it.

Molly: [nods her head]

C: I guess it's standing out to me because you've been saying how in recent weeks there has been incredible sadness and low feelings that have been around for you, and which have really disconnected you from so many things that are important. Yet despite that, in our conversation, you've still found a way to offer me something, which I'm calling 'empathy and compassion'. Is it okay to call it that?

M: Yes, I like you saying that.

C: Do you? Why is that?

M: You're recognising what it is.

C: Right, so it is 'empathy and compassion'. Is this empathy and compassion something you've experienced – even in small ways – at other times during these weeks of sadness and low feelings?

M: Yes, it's what's stopped me from harming myself ... it's what I have had when I've been thinking of my mum and my kids ... not wanting to hurt them by hurting myself.

- C: So Molly, what might it say about you, that at different times you're able to find this 'empathy and compassion' to draw on, despite all the low feelings that are around?
- M: It says that even in the midst of all the sadness, I can still feel for someone else.
- C: You can still feel for someone else. Are you pleased that you are able to do that?
- M: I'm not sure if I'm pleased, but it is something that keeps me here.
- C: Okay. So what does it say to you about yourself, that even in midst of all the sadness, you can still feel for someone else?
- M: It confirms that I am a kind person ... and that what I'm feeling when I'm feeling good about myself is true, it's not a lie.

I asked some subsequent questions that explored this further. Molly described how when the low feelings were prominent, they convinced her that all the good things she thought about herself were a fabrication. Upon reflection, at this point, I could have contributed to a more nuanced conversation, leaving Molly space to describe the extent to which she was convinced of this. If she was less than completely convinced, what might she know about herself that had the low feelings unable to completely convince her that the good things about herself were untrue? Instead, as unique outcomes can facilitate the development of preferred storylines of people's lives (White, 1991/1992), I oriented my enquires into 'empathy and compassion' around the dual landscapes metaphor in narrative practice – the 'landscape of action' and the 'landscape of identity' within re-authoring conversations (White, 2007, p. 81).

Molly spoke of her financial donations to charitable organisations that work with children who have been subjected to abuse, or work to free young women from sexual slavery, or work towards providing communities with clean drinking water, or look after the earth and animals. I was interested here in making visible Molly's personal agency – that is, her actions and initiatives that were shaping of her own life in ways that were consistent with what she gave value to (White, 2005). I asked Molly some questions about what participating in these things had her feeling about herself, and what they might suggest about what else she also gave value to in her life. She described how these made her feel 'worthwhile' and 'a good person' and they said that what was important to her was 'looking after the earth, and children, and fellow creatures'. These enquiries into intentional-state understandings of identity are in sharp contrast to internal-understandings of identity that characterise humanist discourses (White, 2001b).

At the end of this conversation, Molly said that talking about these things felt like 'a reconnection' and had 'reminded me

of me'. When we again met a couple of weeks later, she remarked that the previous conversation was 'quite uplifting'. Molly said how speaking about the woman who founded the organisation that responds to young women in sexual slavery had supported her to still have hope for herself and others that it was possible to move forward after traumatic experiences.

Re-contextualising problems

Earlier, I outlined the biomedical and humanist discourses that dominate understandings of mental illness in Western culture. The implications of these discourses for people's lives are extensive, and include:

- obscuring the context of their experience, including their location within networks of power relations
- increasing people's experience of themselves as on 'the other side of knowledge' (White, 1995a, p. 113), constrained in the language they can use to describe and give meaning to their experiences
- inciting those seeking help to 'fervently look beyond themselves for "cure" and/or "salvation"' (Epston, 1999, p. 141) and therefore diminished in their own sense of personal agency
- medicalising and pathologising people's responses to events in their lives, even those responses consistent with preferred identities
- promoting readily available experiences of failure to achieve notions of normality and personhood as prescribed by these discourses (White, 2002).

I have also given an account of my conversations with Molly that have been shaped by alternative discourses, which have included:

- establishing a context for collaboration through enquiries around Molly's hopes for the consultations
- inviting Molly to take a position regarding the psychiatric description of the problem
- constructing an externalised, experience-near naming of the problem
- richly acknowledging of the effects of the problem in her life
- drawing on 'the absent but implicit', and responding to a unique outcome in the therapy room, which provided entry points into preferred storylines of identity
- engaged in re-authoring conversations oriented by the dual landscapes metaphor
- preliminary co-researching of Molly's experience of the therapy at different intervals.

All of these areas of conversation contribute to providing a foundation for conversations that re-contextualise the emergence of problems in people's lives. This commitment to acknowledging the broader context of problems not only reflects narrative therapy's location within the family therapy field (White, 2001c), but also the particular significance it places on understanding the cultural context of problems (Munro, 1987). This has also been evident since the earliest writings of Michael White, for example in noting the prevalence of child sexual abuse and broader social issues as providing a context for understanding night-time childhood fears (Denborough, 2009; White, 1985/1989).

In relation to contextualising the emergence of problems, the existing narrative therapy literature includes descriptions of practices which:

- explore how people come to draw negative identity conclusions on account of the actions of others, the power relations complicit with these conclusions, and the person's resistances to being convinced by these conclusions (White, 1991/1992, 1995b, 2007)
- explore a person's recruitment into particular ideas, beliefs, and attitudes that support problems (Freedman & Combs, 1996; White, 1991/1992, 2011c)
- foreground a person's responses to trauma and its ongoing effects, and invite alternative meaning-making in relation to experiences of pain and distress (Beaudoin, 2005; Denborough, 2005; Denborough, Freedman, & White, 2008; Mitchell, 2005; White, 2003, 2004, 2005; Yuen, 2007, 2009)
- co-research the politics of abuse and its location in history and culture, and how problems, including mental health concerns and formal diagnoses, may be re-named as effects of abuse (Joy, 1999; Linnell & Cora, 1993; Mann & Russell, 2002; O'Leary, 1998)
- seek to understand the experiences of life that contribute to mental suffering, the relations of power that shape these experiences, and the discourses that inform meaning-making (de Valda, 2003; Dulwich Centre Community Mental Health Project, 1997; Newman, 2010; Siu-wai, 2004; White, 1995a).

There are three examples from my conversations with Molly that I will now focus on to discuss this re-contextualising of problems in the de-contextualising swirl of biomedical and humanist discourses, and what this makes possible.

The claims of the 'low feelings'

In the next couple of conversations, I came to understand more about how the 'low feelings' were very present in

Molly's life. She described them as 'pretty intense' and now more like 'a full-blown depression' which at times had her feeling 'overpowered and paralysed' and even 'not worthy of help'. What was now capturing my attention was the huge incongruence between the low feelings' accusations about Molly, and what I had come to appreciate about her. So I prefaced my question with a rich 'editorial' (White, 2007, p. 46) of what I had heard from her about what she gave value to and the ways these things found expression in her life. I then said that what was puzzling me was this: 'On what basis do the low feelings make claims about you being "not a good person" and "not worthy of help"? ... What on earth are such claims founded upon?'

I also asked Molly that, before I asked her more about this, were there other claims that the low feelings had also made about her as a person? She replied that there were enduring claims about her being 'lazy' and 'disorganised'. I asked Molly if it was upon these things that the low feeling's claims about her being 'not a good person' and 'not worthy of help' were based. She said that it wasn't based on those things, but other things. She said it went back to her childhood and what happened to her as a teenager and young woman – she said it went back to the sexual abuse. Ensuring that she understood I was not doubting what she was saying, I asked Molly how she knew this. She said she knew because when I asked her that question, she felt 'a hurt in my heart', and was taken back to a sense of being 'not a good person' and 'not worthy' at those times.

I was unsure about how Molly was evaluating such a link, so I firstly asked her whether she had made this link before and she said that she had not. She explained that since her early 20s, she had linked these claims back to her mother's 'low self-esteem' and 'worrying', and that her mother had projected these attributes onto her. This had affected Molly's view of her mother and their relationship. When I asked Molly about how it was to be now making this link to the abuse, she said it linked the low feeling's claims with 'something more definite' and showed that, with regard to her mother, 'it's not all her'. Molly said she was pleased about this, and it was good not to feel so much blame nor anger towards her. Molly's tears joined us during this part of the conversation. She said that these were 'tears of relief' and were accompanied by a sense that there was 'more understanding already'. It is not surprising that Molly would have linked her problems back to her mother, given the prominence of discourses of mother-blame in contemporary Western culture (Freer, 1997), and in the mental health realm in particular (Lafrance & McKenzie-Mohr, 2013). Experiences of alienation in mother-child relationships in a context of male-perpetrated childhood sexual abuse are also an effect of perpetrators' actions to shape perceptions of the mother and child about each other, to enforce secrecy, and to confuse responsibility (Laing & Kamsler, 1990).

At a subsequent session, Molly agreed that it was okay to return to our earlier conversation in relation to the history of the low feelings' claims. Following an editorial, I asked Molly what did linking the claims back to the abuse offer her. She said it 'freed up' her feelings and said, 'Maybe I could get angry at the men who did that, rather than feeling helpless and rather than it being about me taking on my mother's traits'. I subsequently asked Molly why she felt 'not worthy' on account of the abuse, and she said, 'If I was worthy, they wouldn't have done it to me'. I asked questions that provided a further acknowledgement of the effects of these identity conclusions on her earlier life, as well as descriptions of her preferred ways of being in the world.

In these conversations, I had been enquiring about the history of the problem and the foundation for the problem's emergence in her life. These conversations enabled Molly to locate the low feelings in time and with the abuse she had been subjected to. What made this more possible was an illumination of Molly's preferred territories of identity that brought the low feelings' claims into sharp relief. By requiring the low feelings' claims to 'come clean' on the basis for their accusations, they became untenable.

Highlighting relations of power

In a subsequent conversation, we traced how the effects of feeling 'not worthy' and 'not a good person' had continued to be present through Molly's life. At this time, Molly spoke of how she was not able to regard herself in a compassionate way. The following is an edited account, taken from my notes, of how the conversation continued:

- C: In saying that you didn't regard yourself in a compassionate way, do you think it was even possible to regard yourself in a compassionate way?
- M: Yes.
- C: What has you saying that?
- M: Well, some people would have more compassion.
- C: Is that speculation – if it is, that's fine, but I'm just wondering if that's something you know, or whether you are kind of imagining that could be the case?
- M: I know, because my friends had that compassion towards me; they felt that.
- C: What do you think they were understanding, that would make that compassion possible?
- M: Well, that when I was nine years old, nothing about that was my fault ... And if I wasn't so drunk when I was 15 and 22, then it wouldn't have happened either.
- C: Okay, so their compassion was on account of knowing that at nine years old that nothing about the abuse was

your fault. If the abuse at nine was the only experience of abuse, would that make compassion for yourself more possible?

- M: Yes.
- C: How come?
- M: Now that I have my children, I can see how innocent a child is and how screwed up my uncle was as an adult male to do that.
- C: So, what is really evident to you that has you saying that?
- M: Well, that he was responsible, he was in complete control of the situation.
- C: In what way, do you think?
- M: Inviting me on a holiday with him – he orchestrated the whole thing, arranging it with my parents. He made it all happen. [Molly paused, and then smiled slightly.]
- C: What are you thinking about right now?
- M: Those men who raped me when I was older, they were responsible; I was drunk, they had all the power.

As the conversation proceeded, I asked Molly some more about what became known as the 'practices of orchestration' enacted by the man who had perpetrated the sexual abuse and by the other men who had sexually assaulted her, and the implications of these practices for her sense of complicity in the abuse and assaults. At the end of the conversation, I asked Molly what had stood out to her. She said that when she was smiling, it was because, 'as I said those things about my situation as a child, I was realising that what happened when I was older was a similar situation'.

At the subsequent session, Molly said that those questions had her thinking about 'powerlessness and responsibility' and how 'it links to everything else'. I asked her what else it linked with in particular. She said that because she had taken drugs and had been drunk, she had carried the responsibility herself for being raped those times during her young adult years. She said our conversation had her thinking that the men (who she knew) were the ones who had the control and they had made the choice to assault her.

Drawing on the narrative metaphor, the events of abuse and assault that Molly was subjected to had then been linked in sequence, across time, according to common themes. Despite quite different circumstances, they became tangled by the obscuring of context. The power relations complicit in one event had obscured the power relations complicit in the others, fostering in Molly a sense of culpability. The untangling of these power relations was made possible through enquires about the context of those events through the eyes of others, who were able to offer Molly compassion that was previously less possible for Molly to offer herself.

A richer acknowledgement of a problem

During a later conversation, Molly also described a set of circumstances that had had her being concerned about the safety of her children. Besides taking some other practical steps in response to her concerns, she had also decided to speak with them, just before her hospital admission, about her own experience of childhood sexual abuse and the concerns she held. I asked her about the preparations she made for this conversation, her intentions in speaking to her children, how they responded to the conversation, and how she evaluated this step. Molly said that at the time she was pleased to be speaking with her children because it felt like together they were 'taking back our power' and not allowing the cycle of abuse to continue. She also commented that 'maybe it's what tipped me over' and further described feelings of anger and empowerment at the time – 'I felt like I was on speed'. She said, 'It got me into hospital and locked up for two weeks, and I really went downhill after that'.

I knew from earlier conversations with Molly that the period that preceded her admission to hospital was known as 'mania' and 'a manic episode'. I confirmed this with Molly, and then asked how was it for her to have that experience called 'mania', rather than 'anger', or 'empowerment', or something else. If 'mania' was the only description of her experience, what effect did that have? What did it obscure? Molly said that it 'weaves a sinister feeling and makes me feel crazy ... that all of it was false ... that I was lost'. She also described how the naming of her experience as 'mania' had her questioning, 'Is it really me, or the medication, or the illness?', when she was feeling good.

I asked Molly whether, at the time, she regarded what she was experiencing as 'mania'. She said that at the time, 'I didn't know that's what it was', but she had felt like she could conquer all of her problems and that no-one could ever hurt her again. I did not continue to trace the history of the naming of her experience as 'mania', as I was drawn to her subsequent sentiments. Molly went on to describe how during the period that became known as 'a manic episode', she had initiated a healing ceremony with some local women friends who had also experienced suffering. She said the purpose of this ceremony was to 'reach out to others who had suffered to help them through their difficulties', and that helping others experience healing was important to her. Molly described this event as being significant for her and the other women. I also asked Molly, if this was what it being named as 'mania' obscured, what was the effect of this obscuring? She said that it made her cringe, feel ashamed, and 'not connected with something really special'. I asked Molly how was it for her to be speaking about her experience of that time of her life in different terms. She said it brought with it less stigma, and 'less possibility of it happening again' and

of again being hospitalised. She also said that 'it takes away the shame'. Sometime later, Molly further described to me the significance of these conversations. She said that a naming of her experience as 'flipped out' had 'changed how I felt about the whole experience' as 'it allowed me to acknowledge the good things and not have them covered in shame'. Molly also described how she had taken some further action in asking some close friends to put aside other descriptions they used for her experience, and join with her in this re-naming.

Other areas of enquiry we entered into included some aspects of Molly's experience of hospitalisation, and the effects of this on herself and those around her. During our next conversation, Molly described how she was recently in the city one evening and decided to go to the hospital grounds because it was nine months exactly 'since I flipped out'. She told me how she sat under a large gumtree and then went for a walk through the grounds 'just to have a look'. She described this time as 'really special, with layers of experience'. Molly said that during this time at the hospital grounds she had written a poem. Molly said that the poem had 'just landed on the page' in an amazing way and after she had read it to me, I asked her some questions about her history of writing poems, and her experience of writing and re-reading the poem. She said that she was especially proud because it is 'clever, funny, and weaves together everything I want there in a positive way', including her experience prior to being hospitalised. I asked Molly about what it perhaps meant to her, that she could write about her experience in that way. She said that it showed that 'I can look at it now, and not feel so much shame and sadness, that there is some beauty in what happened'. I asked Molly how this movement between shame and beauty came about. She said that some of the questions I had asked her had her thinking about what that experience represented to her in terms of what she valued and what she was connecting with. She also commented that it was 'good to take the experience and give it a new name'.

In these conversations, an experience-near naming of mania became possible through the rich description of context. This included descriptions of Molly's experience of her experience, as well as rich descriptions of the initiatives she took during that time. Also of significance was an exploration of the effects of the naming of her experience as 'mania'. All of these enquiries are made possible by an understanding of the relational nature of all descriptions, which is in contrast to the more common understanding that there is a direct relationship between words and what it is they are describing. Instead, a relational understanding proposes that words serve the purpose of dividing and separating one concept from another, that they establish borders between privileged meanings and other meanings that are subordinated (White, 2003). These avenues of conversation made it possible for Molly to develop meanings for her experience that were otherwise subordinated.

In this section, I have described therapeutic conversations that have attended to the re-contextualising of problems:

- enquiries into the history of the low feelings' claims about Molly's identity, the foundation for these claims, and the stark contrast with stories of preferred identity that made them untenable
- drawing on Molly's knowledges in relation to her experience of childhood sexual abuse as an abuse of power, which enabled the power relations of further experiences of sexual assault to also be made visible
- inviting a rich description of the circumstances surrounding the emergence of the problem known more widely as 'mania', which brought forward possibilities for an alternative naming of Molly's experience.

I will now turn to considering the ethics reflected in these and other enquiries.

Considering the ethics of practice

Hare-Mustin (1994) suggests the therapy room is a 'mirrored room' reflecting dominant discourses which serve to constrain the options available for meaning-making and the storying of experience. These discourses remain invisible and unquestioned unless the therapist takes up their responsibility to support the availability of subordinated discourses that can provide alternative frames for meaning-making. Winslade (2005) observes that challenging societal discourses is not usually the pressing concern of people who present for therapy, and he cautions about the ethics of therapeutic practices that focus on social change in a way that sidelines the particulars of the person's experience. As a therapist, I am part of the network of power relations in the lives of the people who consult me and this, plus my own privileged location in culture in various planes of identity, requires my vigilance in keeping the person's experience at the centre of the conversation while responding to discourses that I am not wanting to be complicit in perpetuating. Two practices supportive of this ethic were reflected in my conversations with Molly. The first of these involved a number of skills, such as noticing discourses that may be pertinent to the problem the person is facing, discerning the helpfulness of making these discourses visible, and finding ways to bring these to the notice of the person so they can evaluate their effects. Space can be created for alternative discourses that enable a more agentic position for the person (Drewery, 2005).

The second practice supportive of a commitment to 'using language ethically' (Morris, 2014, p. 67) can be described through the concept of discursive positioning. Winslade (2005) writes that as people make utterances in conversation, they position themselves in relation to discourse. These

utterances do not just represent discourse but also produce and perpetuate discourse. Not only does the speaker position themselves, they also call the other person into a position in relation to discourse from which to respond. The discourses that inform the utterances offer only a limited range of possible positions for the conversational participants to occupy, and people who are familiar with being situated within dominant discourses routinely take up these positions. Discourses not only shape utterances, but also listening, as people also notice or not notice another person's expressions based on what the dominant discourse suggests is worthy of attention (Simblett, 2013). However, there are possibilities for conversational participants to refuse positions offered by discourses and take up alternatives (Winslade, 2005). In fact, what also becomes possible is that the discursive space itself can be transformed, opening up entirely new positions for all conversational participants (Simblett, 2013).

Given the influence of poststructuralist thought on narrative practice (Besley & Edwards, 2005; Thomas, 2002) in understanding how identity is shaped by social relations of power, then what is 'uttered' matters significantly. I believe the concept of discursive positioning lends theoretical support to my commitment to collaborative, de-centred, and influential practice (Morgan, 2006; White, 1997), which I hope helps lessen my participation in what Madsen (2005) has called 'inadvertent disempowering practices' (p. 62). I have sought to describe these two aspects of practice – responding to dominant discourses pertinent to the problem, and attending to the inadvertent implications of utterances – throughout this paper.

There are particular areas of conversation which reflect an ethic to transform the discursive space, and position Molly and myself beyond what might be required by the biomedical/humanist discourse. These include:

- inviting Molly to evaluate others' naming of her experience in biomedical terms, and inviting her to take a position in relation to this, thus honouring her experience and knowledge
- enquiring in a way that evoked increasingly detailed descriptions of the problem in an effort to untangle its intangibility, and call Molly into a position of authority and knowledge about what was problematic in her life
- asking Molly to clarify the basis for her own knowledge, and taking care that this did not position her as an unreliable witness to her own life, but rather positioned me as a seeker of understanding
- taking care not to invite Molly into describing her experience of sexual abuse prior to her describing other aspects of her identity, which would risk totalising her in the shadow of the abuse and its effects

- taking care in my enquiries not to inadvertently invite Molly into pathologising descriptions of herself by implying a causal link between hoarding and experiences of sexual abuse
- creating space for an alternative naming of ‘mania’ without imposing or proposing labels but privileging Molly’s descriptions of her experience
- practising accountability through co-researching Molly’s experience of therapy during, and at the conclusion of, conversations.

Of course, avenues of enquiry that elevated the contexts surrounding the problem in Molly’s life, as well as those that enabled the rich descriptions of Molly’s preferred identity, also served to ease the power relations of therapy offered by dominant discourse. In responding to Molly’s sentiments of feeling sorry for me, I earlier detailed a number of considerations that reflect attention to the power relations of therapy and the politics of gender, as well as to the discourses of the helping professions that may have shaped Molly’s sentiments. I have also provided accounts of practices which sought to respond to dominant discourses that were pertinent to the problem. I embarked on enquiries that sought to make visible the complicity of the politics of abuse in the problems Molly was contending with. Upon review, it may have also been useful to invite Molly, perhaps through further considering men’s ‘practices of orchestration’, to unearth dominant discourses including those in relation to gender, children, and sexual abuse that work to obscure the politics of abuse in Western culture. My enquiries into the history of the ‘low feelings’ claims was partly shaped by noticing the presence

of the mother-blaming discourse and exploring its effects on Molly’s life and relationships. In reviewing this conversation, these enquiries could have been extended by inviting Molly to name this discourse and further explore its reach into other aspects of her life and the lives of others.

Concluding remarks

In narrative practice, the contextualising of problems is regarded as making it possible for people to develop contrasting understandings to those circulating in contemporary Western culture that locate problems within people’s bodies and lead them into negative and limiting conclusions about themselves. Instead, through narrative practices, it becomes possible for people to see that the problems they are facing arose in particular social and historical contexts and are not capturing of their identity. I regard these practices as making it more possible for people to re-connect with their own sense of personal agency, to be able to act in the world in ways consistent with what is important to them, and to join with others and respond to shared concerns. In this paper, I have sought to give an account of my conversations with Molly that were shaped by these practices. These led to the rich description of both the context in which problems emerged in her life, as well as her preferred stories of life and identity. Molly’s evaluation of these conversations has provided encouragement for me to continue to be interested in this area of narrative practice, and to seek to understand further what characterises these conversations, and what they offer the people with whom I consult.

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A reflection on this paper from Molly

I found the process of reading through this paper and learning more about the amount of thought that goes into each narrative therapy session, both very interesting and quite moving.

I hope that the people reading this will appreciate just how important it is to choose carefully which questions you ask a client. How you conduct or guide your sessions really has such a strong impact upon a person's life.

Establishing an identity outside of the 'thing that happened' has allowed me to continue with these sessions and helped me to remember that I am more than the event, more than a diagnosis.

Building trust within our sessions, with regular check-ins to ask how our talks are going, has allowed for a sense of security I've not experienced before in therapy.

Helping me to look at my experiences in different ways, inviting me to consider things such as the balance of power in different situations, has been quite literally, life-changing for me.

I am so grateful that I have the kind and steady relationship with Chris within our narrative therapy sessions. I hope that anyone who has experienced trauma will have the benefit of a kind and wise soul to help them through.



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