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POLITICIZED NARRATIVE THERAPY
A Reckoning and a Call to Action

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Résumé de l'article

Cette oeuvre utilise une approche dite plurivoque et exige des associations coloniales une interrogation sur la thérapie narrative, ainsi que l'interruption de celle-ci (White et Epston, 1990). Elle exige également la cooptation de la thérapie narrative en psychiatrie sous couvert de la progressivité (J. Poole, Communication personnelle, le 31 janvier, 2017). La thérapie narrative se retrouve dans la réparation et la commercialisation géographique néolibérale où les problèmes sociaux sont enregistrés comme des problèmes individuels; où les histoires personnelles sont utilisées comme matériel de commercialisation de la santé mentale et où le fardeau du bien-être favorise la gouvernance psychiatrique (Costa et coll., 2012; Morrow, 2013; Poole, 2011). En nous fondant sur le cadre de travail discursif anticolonial, la théorie critique sur les races et les techniques de narration contraire de Sefa Dei et d'Asgharadeh (2001), ainsi que sur la pensée féministe noire et la théorie « anti-saniste » de Patricia Hill Collins (1990), nous explorons les possibilités de réimaginer la thérapie narrative aux fins politiques. Des techniques narratives sont utilisées dans cette oeuvre pour passer outre la compréhension individuelle de la détresse et pour rattacher les problèmes personnels aux contextes sociaux et politiques plus vastes. Nous y parvenons en ajoutant un angle politique aux quatre étapes prises lors d'une approche plus conventionnelle. Nous avons choisi d'utiliser des études de cas éclairées par nos propres expériences afin de souligner le potentiel du travail narratif. Cette approche ne rend pas incontestée la thérapie narrative et nous comprenons qu'en demeurant dans un cadre de travail narratif logé dans la pratique du travail social, nous ne pouvons pas réellement séparer notre approche de celle des soins dits coloniaux (Baskin, 2016; Lee et Ferrer, 2014). Au contraire, nous espérons lancer une conversation critique et transparente qui, elle, lancera la reconceptualisation de la thérapie narrative aux fins de déconstruire les discours dominants et rendre visible toute connexion coloniale.

POLITICIZED NARRATIVE THERAPY
A Reckoning and a Call to Action

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Taylor Thornton
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Abstract: Using a poly-vocal approach, this piece calls for the interruption and interrogation of narrative therapy's colonial associations (White & Epston, 1990), and the cooption of narrative therapy by psychiatry under the guise of progressiveness (J. Poole, Personal Communication, January 31, 2017). We locate narrative therapy in the neoliberal geography of recovery and marketization, where social problems are coded as individual struggles, personal stories are used as mental health marketing material, and the burden of wellness enables psychiatric governance (Costa et al., 2012; Morrow, 2013; Poole, 2011). Drawing on Sefa Dei and Asgharzadeh's (2001) anti-colonial discursive framework, critical race theory and its technique of counter-storytelling, Patricia Hill Collins' (1990) Black feminist thought, and anti-sanist theorizing, we explore the possibility of reimagining narrative therapy for political ends. Throughout this piece, we draw on narrative techniques to move beyond an individual understanding of distress, connecting personal struggles to the broader social and political context. We do this by extending a political lens to the four steps taken in a mainstream narrative approach. We have chosen to use case studies informed by our own lived experiences in order to highlight the potential that we see in narrative work. This approach does not leave narrative therapy unchallenged and we understand that by remaining in a narrative framework housed in social work practice we cannot truly separate our approach from colonial care (Baskin, 2016; Lee & Ferrer, 2014). Rather, we hope to start a critical and transparent conversation that begins to explore the reconceptualization of narrative

therapy for the purpose of deconstructing dominant discourses and making any colonial connections visible.

Keywords: Politicizing, narrative therapy, anti-colonial, resistance

Abrégé : Cette œuvre utilise une approche dite plurivoque et exige des associations coloniales une interrogation sur la thérapie narrative, ainsi que l'interruption de celle-ci (White et Epston, 1990). Elle exige également la cooptation de la thérapie narrative en psychiatrie sous couvert de la progressivité (J. Poole, Communication personnelle, le 31 janvier, 2017). La thérapie narrative se retrouve dans la réparation et la commercialisation géographique néolibérale où les problèmes sociaux sont enregistrés comme des problèmes individuels; où les histoires personnelles sont utilisées comme matériel de commercialisation de la santé mentale et où le fardeau du bien-être favorise la gouvernance psychiatrique (Costa et coll., 2012; Morrow, 2013; Poole, 2011). En nous fondant sur le cadre de travail discursif anticolonial, la théorie critique sur les races et les techniques de narration contraire de Sefa Dei et d'Asgharadeh (2001), ainsi que sur la pensée féministe noire et la théorie « anti-saniste » de Patricia Hill Collins (1990), nous explorons les possibilités de réimaginer la thérapie narrative aux fins politiques. Des techniques narratives sont utilisées dans cette œuvre pour passer outre la compréhension individuelle de la détresse et pour rattacher les problèmes personnels aux contextes sociaux et politiques plus vastes. Nous y parvenons en ajoutant un angle politique aux quatre étapes prises lors d'une approche plus conventionnelle. Nous avons choisi d'utiliser des études de cas éclairées par nos propres expériences afin de souligner le potentiel du travail narratif. Cette approche ne rend pas incontestée la thérapie narrative et nous comprenons qu'en demeurant dans un cadre de travail narratif logé dans la pratique du travail social, nous ne pouvons pas réellement séparer notre approche de celle des soins dits coloniaux (Baskin, 2016; Lee et Ferrer, 2014). Au contraire, nous espérons lancer une conversation critique et transparente qui, elle, lancera la reconceptualisation de la thérapie narrative aux fins de déconstruire les discours dominants et rendre visible toute connexion coloniale.

Mots-clés : Politisation, thérapie narrative, anti coloniale, résistance

Introduction

WHAT IF NARRATIVE THERAPY was political? From the onset of this project we have individually and collectively quarreled with this question. We have queried whether narrative therapy can be reconciled with, wrestling with the tensions imposed by narrative therapy's colonial

associations (White & Epston, 1990), and the co-option of narrative therapy by psychiatry under the guise of progressiveness (J. Poole, personal communication, January 31, 2017). Perhaps many of you have done the same, stepped away, and will now approach this article with skepticism and doubt. This article is designed to invite students, practitioners, users, and critics of narrative therapy into a conversation about the possibilities of reworking and reimagining narrative therapy for political ends. We set ourselves the challenge of reclaiming and returning to narrative therapy because we recognize the possibilities of thinking narratively. We engage in this work as a group of four students who are new to narrative therapy. For us, this has been a process of discernment, a space to report back on our first taste and critically reflect on our entrance into this practice. Theoretically, this piece is informed by Sefa Dei and Asgharzadeh's (2001) anti-colonial discursive framework, critical race theory and its technique of counter-storytelling, Patricia Hill Collins' (1990) Black feminist thought, and anti-sanist theorizing. Drawing on the work of Frantz Fanon, Sefa Dei and Asgharzadeh (2001) state:

> Decolonization is a calling into question of the whole colonial situation and its aftermath. This questioning is important, not as a resting place, but in order to make the connection between what is and what ought to be. Put differently, what we emphasize here is the need to combine discussions about what is possible with what exists. What exists matters in the sense of offering a critique of the social order and an awareness of our limitations. (p. 298)

Given that narrative therapy was born from the intersection of whiteness and social work (White & Epston, 1990), discernment is needed regarding the potential for narrative therapy to be characterized by anti-colonial workings (Lee & Ferrer, 2014). This should involve a strong critique of narrative therapy's current state, an awareness of our limitations as practitioners, and exploration regarding what is possible. This approach will not leave narrative therapy unchallenged and we understand that by remaining in a narrative framework housed in social work practice we cannot truly separate our approach from colonial care (Baskin, 2016; Lee & Ferrer, 2014). Rather, we hope to start a critical and transparent conversation that begins to explore the reconceptualization of narrative therapy for the purpose of deconstructing dominant discourses and making any colonial connections visible. For us, this involves acknowledging the contradiction inherent to housing an anti-colonial projecs within the academy, where so often local knowledges are silenced, minimized, and invalidated by white euro-western knowledge (Sefa Dei & Asgharzadeh, 2001). For this reason, we have chosen to engage with this piece using a poly-vocal approach, understanding that "to personalize is to interrupt" (J. Poole, personal communication, May 15, 2017), and to

politicize is to expose. By focusing on our own local experiences (Sefa Dei & Asgharzadeh, 2001), we aim to disrupt the normalizing function of euro-western discourse. Borrowing from mainstream narrative therapy, we see our diverse perspectives and combined participation as critical to forming our "team" (White & Epston, 1990), where we are all on side in developing an alternative story about narrative therapy.

> As a person who is African Canadian, I engage with narrative therapy as a way of reclaiming storytelling as a therapeutic process. An important part of African-Canadian communities is sharing knowledge and experiences within the community to help people better understand their lives, and demonstrate that they are not alone in their personal experiences. We must acknowledge the traditional healing processes of those we support, and question professional knowledges that are deemed authentic in western society. As Freedman and Combs (2009) explain, narrative therapy should be about listening for stories and not listening for symptoms. A focus on symptoms places emphasis on stories that are constructed by western medicine, thereby displacing and discrediting the power that individuals hold to author their histories, present and future. (Anthony)

> As a white settler social worker, it is my ethical and moral responsibility to own histories of harm and colonization in any therapeutic approach that I engage with. My motivation for developing this piece relates to my experience as a non-binary person who suffers from chronic vulvar pain, also known as vulvodynia. I understand chronic vulvar pain to have been constructed in relation to medical discourse that is both informed by and reinforces dominant and violent ideas related to gender, sexuality, race, and ability. My journey with vulvar pain, and my experience being psychiatrized and invalidated, has forced me to confront how these discourses operate on my body and are at times reproduced through my navigation of them (Dumaresque, 2017). I see the politicization of narrative therapy as providing a possible entry point for the interrogation of taken-for-granted truths in relation to chronic vulvar pain and the institutions that construct it. (Renee)

> Aaniin, Boozhoo! As a Anishinaabe'kwe and Kanien'Keha:ka woman, narrative therapy is a contentious topic for me. I feel that narrative therapy holds great value for therapeutic engagement with service-users. Conversely, I think it is a dangerous practice with sneaky and subversive colonial roots. I am intrigued with the power that this therapy has to externalize and re-author problem-saturated stories, freeing the person from problems that become so deeply entrenched within the self. I am driven to this topic for personal and professional reasons. As a social worker working in Indigenous child welfare, narrative therapy is often used as a way for Indigenous folx to re-author their experiences with colonization and intergenerational trauma within communities. Narrative therapy separates problems from the individual experiencing them and encourages an understanding of the dominant discourses

that produce and reproduce oppressive realities. I hope that through the process of unpacking narrative therapy and reapproaching it with my anti-oppressive and Indigenized lens, it can be shifted back into its intended audience with Indigenous folx in non-clinical settings. This paper is personal—it is a form of justice to my family and ancestors who have been silenced and stolen from. (Taylor)

My motivation comes from personal experiences of discomfort in prac-tice. I was practicing social work as a "clinical" counsellor working with the Latinx community, where I was using a framework that stemmed from eurocentric and biomedical approaches. I was always seeking ways to "adjust" my practice. I searched for ways to resist and politicize psychological and clinical approaches that I was expected to use in my interactions with service users. These interventions stem from a colonial entity. Being in a setting that oftentimes labelled and "women blamed," service users motivated me to start looking for ways in which I could trans-form my practice. I started to search for a lens that acknowledged inter-generational trauma, histories of colonization, and the way systems of oppression create a violent environment for marginalized communities. Before looking to literature or academia, I worked through a lens that captured systemic violence and refused to place blame on service users for their traumas and the embodied experiences that have stemmed from these traumas. I am a Latinx woman who has been on both sides, as a service user and as a practitioner. Through my own experiences of navigating systems that continue to blame me for my trauma I continue to reach towards an approach that makes room for liberation and decol-onization. (Daniela)

For Sefa Dei and Asgharzadeh (2001), the "colonial … is conceptualized not simply as foreign and alien, but rather as imposed and dominating" (p. 300). An anti-colonial approach views institutions as operating to serve neoliberal ends and bodies in power. Local knowledge and colonized resistance is integral to dismantling structures of power and imposition. The anti-colonial discursive framework centres the experience of race and Indigeneity in every analysis of power and domination, while recognizing the interconnectedness of experiences based on all forms of oppression and viewing collective resistance as necessary to emancipation (Sefa Dei & Asgharzadeh, 2001).

While it is true that storytelling is traditional to many cultures and places (Lanigan, 1998), we recognize the privileging of interventions born from euro-western spaces and people, and are concerned that practices traditional to Indigenous and racialized communities gain legitimacy only after similar approaches are utilized by the authority of psychology and psychiatry. We draw parallels between politicized narrative therapy and Black, Indigenous, and racialized worldviews and practices not as a way to add legitimacy to narrative therapy (Baskin, 2016), but rather to position this work in relation to broader decolonial and racial

justice movements. As Baskin (2016) states, storytelling and oral traditions have deep roots in Indigenous histories, and today stories are critical to decolonial processes, resurgence, and insurgence. For Sium and Ritskes (2013), "stories in Indigenous epistemologies are disruptive, sustaining, knowledge producing, and theory-in-action. Stories are decolonization theory in its most natural form" (p. 2). This project comes on the heels of many traditions that have named the value of connecting individual and collective narratives to the broader social and political context.

A critical example of narrative engagement is found in the relationship between critical race theory and counter-storytelling, where social constructivism is employed to destabilize taken-for-granted truths, and the power of story is recognized for its capacity to both oppress racialized bodies and transform futurities. Situated at the merger of academics and activism, critical race theory expands on tenets of radical feminism and critical legal studies, providing a home to a movement of individuals working to understand and revolutionize the intersections of race and power (Delgado & Stefancic, 2017). Central to critical race theory is the valuing of community, and an appreciation of the material impact of stories in shaping place and person. Delgado and Stefancic (2017) assert:

> Our social world, with its rules, practices, and assignments of prestige and power, is not fixed; rather, we construct it with words, stories, and silence. But we need not acquiesce in arrangements that are unfair and one-sided. By writing and speaking against them, we may hope to contribute to a better, fairer world. (p. 3)

In this sense, the productive nature of storytelling can be understood as performative. Cloaked in neutrality, the intersection of story and power results in dominant narratives that categorize and control bodies through the marrying of micro and macro governing mechanisms (Delgado, 1989). Oppositely, by engaging counter-storytelling, narrative power can be utilized in resistance and reimagining for transformative and social justice ends (Delgado, 1989). By engaging art-informed practices and versatile storytelling techniques through a process-based model, counter-storytelling has also been used to develop allied responses to racial injustice (Bell, 2010).

Politicized storytelling can also be identified in relation to Black feminist thought, where individual and collective storytelling is claimed as pivotal to resistance and revolution, resulting in the creation of alternative knowledges that are based on lived experience and developed in community through dialogue (Collins, 1990). Collins asserts that knowledge production carries the potential for empowerment and social justice through the refusal of positivist validation processes and the creation of alternative truths that are always connected to social, political, and economic reality. Further borrowing from Collins, this

article has been informed by a focus on interlocking systems of oppression (Collins, 1990) that makes visible the interdependency and relationships between systems of domination. In her discussion regarding the matrix of domination, Collins (1990) names the individual, culture, and institution as sites where oppression (and stories) are both produced and resisted.

This approach is also strongly aligned with anti-sanist theorizing that rejects the psychiatrization of human experiences and pathologization of individual distress, making visible the violence enacted upon bodies who are consumed and victimized by the psychiatric gaze (Burstow & LeFrançois, 2014). Central to this analysis is an awareness that psychiatry is one of many institutions weaponized to sustain dominant discourses related to race, gender, sexuality, class, and ability (Burstow, LeFrançois, & Diamond 2014). Drawing on knowledge gained from anti-Black sanism by Meerai, Abdillahi, and Poole (2016), and Indigeneity, race, and madness by Tam (2013), our approach carries an understanding that violence is disproportionally and uniquely experienced by Black, Indigenous, and racialized bodies, who are subjected to over-surveillance, criminalization, appropriation, lack of support, and erasure. We are wary of efforts made by psychiatry to veil the co-option of radical alternatives and community language with discourses of inclusion and recovery (Burstow, 2013; Morrow, 2013; Poole, 2011). This approach locates psychiatry's integration of narrative therapy in the neoliberal geography of recovery and marketization, where social problems are coded as individual struggles, personal stories are used as mental health marketing material, and the burden of wellness enables psychiatric governance (Morrow, 2013; Costa et al., 2012).

Narrative therapy was born out of a need to counter traditionally biomedical therapeutic approaches that focus on individual pathology and essentialized origins of distress, locating problems within the individual (White & Epston, 1990). Informed by Foucauldian notions of power/knowledge (Foucault, 1980) and discourse, narrative therapists rejected claims of objective truth, and instead sought to harness the power of discourse for the purpose of understanding human experience and developing responses to distress. For Foucault, the relationship between power and knowledge is constructive, persistent, and based in discourse, where language is critical to shaping meaning (Foucault, 1984). Knowledge created by bodies in power results in taken-for-granted truth claims that discredit, displace, and silence subjugated knowledges, producing norms, defining deviance, and therefore governing lives (Foucault, 1984). Rather than something that is possessed, power is understood as multidirectional and embodied (Foucault, 1980), suggesting that ultimate control is produced when people, through self-surveillance, learn to govern themselves according to accepted ways of being (Foucault, 1979).

Narrative therapy recognizes language as political, acknowledging the impact that stories have on the subjugation of personhood, the organization and interpretation of experience, the construction of reality, and the positioning of futures. It recognizes that the narrative context in which individuals operate informs outcomes. By contextualizing experience in relation to the organizing function of discourse, narrative therapy has supported individuals to empower local knowledges and rearticulate their lives. While many narrative therapists believe alternative truths are silenced, subjugated, and erased by dominant systems of knowing (Brown & Tod, 2007; Brown, 2011), others reinforce dominant ways of knowing by failing to deconstruct dominant discourses and neglecting to interrupt or challenge conditions of possibility (Foucault, 1994) in relation to interlocking systems of oppression (Collins, 1990). For example, when working with neurodiverse children, narrative therapists often use narrative therapy to promote inclusion and externalize diagnosis (McParland, 2015). However, by remaining in a biomedical framework and failing to problematize diagnoses, therapists are complicit in reinforcing the violence inherent in the medical model.[1] As noted by Smith (2011), increased marketization of social services and the prestige associated with working in relation to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) often leaves mental health workers with few resources and little motivation to challenge problematic and ineffective approaches to helping.

Throughout this piece, we draw on narrative techniques to move beyond an individual understanding of distress, connecting personal struggles to the broader social and political context. We do this by extending a political lens to the four steps taken in a mainstream narrative approach. We have chosen to use case studies informed by our own lived experiences in order to highlight the potential that we see in narrative work. Our engagement with this process is attentive to the caution expressed by Brown & Tod (2007), who name the danger of reproducing oppressive power relations in therapy by supporting essentialized interpretations of the self, maintaining binary understandings of identity, and failing to unpack dominant discourses. Brown's (2011) critical and reflective approach to feminist narrative therapy also informs our understanding regarding the role of the therapist in and throughout this work as nuanced, power-laden, and participatory. We identify our position as political, operating not just as a function of control and surveillance, but also as critical in the process of facilitating transformative knowledges.

Step One—Identifying the Problem Story—Identifying the Dominant Discourse

Renee: *The case study discussed below is inspired by my personal experience navigating gender, sexuality, and medical support in the context of chronic vulvar*

pain. Narrative deconstruction has provided me with an opportunity to interrogate the discourses that have informed my problematic medical care, my identity, and my relationship with others. I began to understand and explore myself outside of fixed and binary understandings of gender and sexuality, and was able to redefine myself as a sexual vulvar pain sufferer— an ongoing project, but one that now excites me instead of shames me. I believe that a politicized narrative approach carries the potential for vulvar pain sufferers to rewrite their stories of struggle, identity, resistance, and survival. With respect to furthering critical practice, Judy E. MacDonald's (2008) work on chronic pain and social work has helped me to recognize the benefit of engaging a narrative approach to capture the personal experiences of health care professionals—where the personal and professional are collapsed and storied into clinical guidance. For reference on addressing sex in narrative therapy with heterosexual couples, I looked to Gershoni, Cramer, and Gogol-Ostrowsky (2008).

Within narrative therapy, the first step often involves identifying the problem story. This is based on an understanding that our realities are narratively constructed in relation to dominant ideas, values, and understandings about the world, individuals, and relationships (White & Epston, 1990). As stated above, narrative therapists draw on Foucauldian notions of power/knowledge (Foucault, 1980) and discourse that make visible the complex relationship between power and the production, transmission, and impact of knowledge. This relationship recognizes that the creation and operation of knowledge serves bodies in power and maintains systems of dominance. These systems assert neutrality and maintain an assumption of objective reality, claiming that there is one truth to be discovered, and that truth should act as a governing force. Universal truths are institutionalized in all aspects of the social fabric, impacting our values, relationships, laws, health care, and the beliefs we hold about our own self-worth and the worth of others. Hegemonic, dominant systems and institutions that produce knowledge and meaning simultaneously subjugate alternative truth and knowledge (Connell, 2007).

Within mainstream narrative approaches, appreciation for the power of discourse results in an approach that places emphasis on the role played by stories people hold about themselves in shaping the way that they experience the world. With this comes the belief that people often unequally account for evidence that aligns with the story that they hold about themselves. For example, Sarah, a social worker and white cis woman who suffers from chronic vulvar pain arrived at narrative therapy and reported she feels dysfunctional, de-sexualized, and inadequate because of her vulvar pain, which keeps her from having sex with her partner as often as she feels that she should. Sarah reported that because she is disabled she feels she has failed as a partner to her husband Matt, a white cis male. Due to Sarah's negative belief that she is a failed partner, she will be more likely to recall and look out for moments that she

perceives as failures. Sarah will be less likely to recall moments where she feels sexual, adequate, and positive about herself as a partner because they do not fit with the story she holds about herself.

A reliance on narrative construction means that locating the "problem story" related to distress is an essential first step in rewriting a person's experience into an alternative story. A problem story is the negative narrative that people hold about themselves. It is a totalizing story that fails to account for nuance (White & Epston, 1990). Often, a person's problem story reflects dominant discourses and ideas in relation to race, ability, gender, sexuality, etc. However, underlying discourses are rendered invisible and are masked by a claiming of individual failure or shortcoming. When people first engage with narrative therapy, their problem-saturated story is not always visible. Instead, they enter therapy with a specific complaint or a symptom of the problem story. At this stage, narrative therapists must work with the service user to identify, unpack, learn, and understand the underlying purpose of their visit. This involves drawing out relevant themes in a presented feeling, emotion, or complaint. Here, we receive clues and notice patterns in the way a person describes themselves and their behaviours. In Sarah's case, her problem story is that she is inadequate, de-sexualized, crazy, and a failure.

In many instances of narrative therapy, the problem story is identified with service users, and steps are taken to destabilize the story. However, the dominant discourses operating and influencing the problem are not always identified. Taking this next step is critical to contextualizing distress, struggle, and resistance within broader social and political realities. Through this process, it is essential that the narrative therapist work with service users to collaboratively unearth the values, beliefs, and power structures influencing their reality. While some connections might feel obvious to the therapist, making assumptions might hinder the therapeutic process. One strategy to address this is to pay attention to the language used by a service user (Gershoni et al., 2008). Language influences, informs, and reflects dominant discourses in society. By paying attention to the language that a person uses to speak about their experience, we receive clues about what discourses and systems of power are operating. Asking questions about what specific language means to a person creates room for broader inquiry. For example, by asking Sarah what "de-sexualized" meant to her, it became clear that Sarah defined sex as penile-vaginal intercourse (Gershoni et al., 2008). Sarah elaborated by stating that her doctor diagnosed her with a sexual dysfunction, listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) as Genito-pelvic Pain and Penetration Disorder (Gabriel Tobia, 2013). This opened up a conversation about heteronormative definitions of sex and intimacy, and provided an opportunity to make visible discourses related to gender, sexuality, and mental health, where sexuality outside of intercourse is pathologized and psychiatrized. The narrative therapist worked with

Sarah to highlight the ways in which women's pain has historically been marginalized, invalidated, and understood according to professionalized and paternalistic interpretations (MacDonald, 2008). These conversations contextualized the environment that Sarah and her disability were operating in, and resulted in deeper conversations about how Sarah's class, race, sexuality, and gender identity further influence her experience with vulvar pain. This process made visible the problematic assumptions that influence the expectations that Sarah holds for herself and her relationship, and which inform the way she views herself and the way she is treated within a medical setting.

Step Two—Externalizing the Problem Story—Politicizing the Problem Story

Anthony: *The following case study is inspired by my personal experience growing up in the Canadian education system as a Black youth, where my histories were whitewashed, and where people who looked like me weren't expected to succeed. The story below highlights the potential of using narrative therapy in communities that are close to me in order to deconstruct dominant discourses that live out on bodies in harmful ways. Specifically, this case study demonstrates how narrative techniques can be utilized by Black and racialized youth to make visible the function of white supremacy in shaping their experiences of oppression. It is my belief that in sharing our stories, we can foster a culture of social change. "Historically, storytelling has been a kind of medicine to heal the wounds of pain caused by racial oppression" (Gillborn & Ladson-Billings, 2005, p. 56). Given that storytelling has always been used as a form of resistance in African Canadian communities, for me, it is critical that the process of politicizing narrative therapy involves crediting the origins of narrative refusal.*

The second step in traditional narrative therapy practice is externalization of the problem story. Individuals often enter therapy with problem-saturated stories that have become internalized over time. Internalization results in people believing their challenges and struggles are ingrained within them and a part of who they are (Brown & Tod, 2007). Generally, totalizing self-narratives make it difficult for people to view their challenges as something that exists outside of them, something they can control and gain distance from. This often causes individuals to experience feelings that negatively impact their life, such as blame, guilt, and isolation (White & Epston, 1990). For example, Kyle, a Black male youth, entered narrative therapy and reported he is "stupid." Kyle explained he dropped out of high school two years ago after a long history of failing to fit in, facing rejection from teachers, and not being able to relate to the material being covered in his courses. After repeatedly getting asked to stay after class to talk through his behaviour, Kyle was encouraged by his teacher to take a couple of years off of school to work and "smarten up." He explained that his lack of education and

work experience resulted in repeated rejection in the workforce. Kyle concluded there must be something wrong with him. His problem-saturated story negatively affected all aspects of his life and failed to capture the broader social, political, and historical context.

Externalizing the problem story involves locating problems outside of the individuals experiencing them. As stated by Sween (cited in Bacon, 2007), "the person is never the problem; the problem is the problem" (p. 72). Before externalizing the problem, it is very important that the service user and narrative therapist gain a clear and specific definition of what the problem is, based on the service user's description and experience of it (Combs & Freedman, 2012). This is followed by mapping the influence of the problem on the service user's life, such as when, where, and in what ways the problem is impacting the person, and how the problem has survived over time (White & Epston, 1990). Based on detailed description and exploration of the problem, the narrative therapist and the service user collaborate to identify a name for the problem that is external to the self. For example, after exploring the influence of Kyle's problem on his life, the narrative therapist and Kyle identified that Kyle often lacked a sense of belonging. Kyle reported that he has always felt out of place at school—none of the teachers looked like him, told him that he could succeed, or encouraged him to finish school when he talked about his decision to leave. In a mainstream narrative approach, Karl and his narrative therapist might have agreed to name the problem "sense of belonging"; however, in this case, the narrative therapist encouraged a deeper inquiry into the conditions of possibility surrounding Kyle's experiences of isolation and lack of confidence.

When working in mainstream narrative therapy, the structural causes of oppression and distress are not always exposed. Externalization of the problem can provide service users with opportunities to imagine their lives without current problems or stressors. However, simply naming problems does not interrogate or destabilize the political and social context that breeds oppression. We question whether a person can be fully liberated from their problems by simply engaging in the process of externalization, and suggest a more radical approach, such as politicizing the problem in order to gain a wider social understanding regarding the initiating causes. By taking narrative therapy one step further, work is done to politicize the problem after it is externalized. With respect to Kyle, the narrative therapist worked with Kyle and externalized (politicized) the problem story as "white supremacy," capturing the structural factors that contributed to Kyle's feelings of isolation, defeat, and lack of belonging. Creating this dialogue allowed for exploration regarding the systemic issues and power structures that influenced his experiences. Kyle began to recognize that his feelings of isolation and inadequacy were the product

of his being forced to engage with a racist and colonial education system that displaced his histories with those of white Europeans, devalued his presence in the classroom, and communicated low expectations for his success. It became clear to Kyle that the impact of his experiences in school trickled into many other areas of his life, impacting his sense of self-worth and the possibilities that he imagined for himself in the future. By politicizing his experiences as white supremacy, Kyle was able to divest himself of self-defeating beliefs of worthlessness and blame. In recognizing the impact of structural racism on his life, Kyle developed the confidence to imagine a future for himself characterized by belonging, success, and abundance. He enrolled in a college program to upgrade his high school education and secure a diploma. Kyle expressed a desire to help other Black and racialized youth navigate through systems, learn their histories, and recognize their full potential.

Step Three—Developing the Alternative Story—Developing Alternative Discourse

Daniela: *The case study below is inspired by a common narrative that I have experienced, and that I have witnessed members of my community experience as well. It is a narrative that captures the way women justify abuse and domestic violence within intimate cis hetero relationships in my community. This scenario demonstrates the manifestation of colonialism, patriarchy, and sexism in Latinx communities. The issues that arise are internalized due to the operating systems of oppression, and then we begin to blame ourselves. When I first started working with women who share a similar narrative to mine, I worked towards externalizing the issues. For me, the process of externalization is what first highlighted the potential of using narrative therapy. Gaining knowledge played a significant role in my process of understanding, externalizing, and rewriting my own alternative story, where I get to decide what my narrative is in relation to my identity. Through the process of learning to name what influenced the perceptions I had about myself, I began to feel empowered and was then able to speak out about patriarchy. Politicizing narrative therapy is a form of transformative practice and a step towards decolonizing our work, our interactions, and the way we understand our experiences and those of the people we work with as social workers.*

A Latin American woman named Sofia came to narrative therapy stating that she was a "bad wife." She disclosed that her husband would become abusive when he thought she did not do a good job of cooking and cleaning, or when he did not feel she put enough effort into her physical appearance. She reported that she should be a better wife and that she should try harder to please him. She internalized the abuse, was left feeling worthless, and felt as though the violence was justified. Her problem story was that she was worthless and lazy, that the abuse

was her fault, and that she needed to try harder. After working with Sofia to identify the dominant discourse in which she was operating, dominant ideas relating to whiteness, gender, heteronormativity, and productivity became clear. By politicizing Sofia's problem, her experience was framed as "machismo," or patriarchy, instead of worthlessness. First, her experience was externalized as being in an abusive relationship, which opened up critical conversations related to systems of power. This helped to identify the conditions that resulted in Sofia believing she was worthless and that her abuse was justified. During this process, Sofia and the narrative therapist discussed patriarchy and the gender binary as white colonial ideas (Lugones, 2007). They discussed the ways that white patriarchy operates to favour masculinity and white eurocentric beauty ideals. Sofia spoke about the ways that these ideas have contributed to her perceptions around beauty, gender, and her responsibility as a woman in the household.

By separating the problem from the self, naming it, and gaining an understanding regarding the impact of the problem, a space opens up to recognize the ways in which the problem does not have control. During this process, the narrative therapist works with the service user to identify "unique outcomes," moments when the problem holds less control, or when the problem is not present (White & Epston, 1990). Identifying exceptions is not easy work, because problem-saturated stories dominate memories and filter experiences. During this stage, it is useful to explore both historical and recent experiences. When unique outcomes are identified, the details can be used to reframe and build an alternative story about an individual's experience, challenge, or distress (Combs & Freedman, 2012). Clients are able to think of their identities, lives, and relationships without the problem, and are able to begin exploring new and preferred ways of being in the world. Given the impact that dominant stories have on our lives, relationships, view of the self, and treatment by others, identified problematic stories and discourses must be replaced by an alternative narrative. One way to explore this new and preferred sense of self involves asking the service user to imagine what their life would look like and how they would view themselves existing without the problem. Through this process, narrative therapists give clients the opportunity to re-author their lives around new and preferred descriptions of self (White & Epston, 1990). By taking narrative therapy one step further, alternative stories can be used to formulate alternative discourses. In this case, alternative discourses are differentiated from alternative stories by their politicization and attention to power structures. Alternative stories often provide an opportunity to create new meaning for an individual, whereas alternative discourses challenge dominant social conversations with ideas informed by subjugated knowledge and values.

When working with Sofia, she identified unique outcomes in moments when she didn't feel worthless under the impacts of patriarchy.

These included moments when she was surrounded by strong Latinx women in her life. Specifically, she recalled being engaged in community organizing and witnessing other women demonstrate resilience and passion. The narrative therapist worked with Sofia to identify the ways that those experiences countered her feelings of worthlessness. Sofia reported that memories of community organizing with other women made her acknowledge all of her skills, passion, and labour, which go unappreciated and undervalued in much of society and in her home. It also provided her with an opportunity to recognize her strength and worth outside of traditional gender relations and gender roles imposed by white colonial patriarchy. Eventually, Sofia was able to construct a story about her experience that spoke to her resilience and survival. In Sofia's new narrative, she is a strong and hard-working mother who respects her capacity and holds space for self-compassion. She realized that not being able to clean the dishes sometimes does not make her a bad mother or a bad wife. Sofia has begun to break away from the pressures imposed by eurocentric notions of beauty, and has started to embrace her body, natural hair, and complexion, and celebrate her self-expression. Her alternative story captures her worth and names her abuse in the context of patriarchy. Sofia is contributing to an alternative discourse based in feminist decolonization, centring the experiences of Latinx women and femmes. By engaging with an alternative lens to view her experience, Sofia has come to recognize dominant ideas of beauty, gender, and worth as colonial violence.

Step Four—Thickening the Thread—Making it Collective

Taylor: *The case study below is inspired by my personal experience as an Indigenous person who arrived at Indigeneity as a young adult. The narrative process helped me to subvert the impact of shame and guilt on my identity and sense of cultural pride. In starting to work with my community, I have discovered that my experience is common to Indigenous peoples of Turtle Island due to colonial legacies and intergenerational trauma. For Indigenous communities, I see healing power in Indigenizing narrative therapy, by making visible the ways that narrative healing is connected to Indigenous oral traditions rather than simply a product of western interventions.*

Julia entered narrative therapy shortly after she became involved with child welfare for concerns around substance use. Julia reported she is Canadian and Irish. When asked what "Canadian" means to her, she stated she has "Native blood" but does not identify as Native because she is non-status. Julia explained that growing up she was surrounded by negative stereotypes of Indigenous peoples as "lazy" and "unmotivated." Julia reported that her grandmother, out of fear and shame, encouraged her to avoid identifying as Native, and supported the request by telling Julia that she wasn't "full-blooded anyways." Julia stated that her

grandmother was called awful words, such as "squaw," and did not want Julia to experience the same hardships. Julia explained she is at a place in her life where she wants to identify with the Native community, but carries shame and guilt that has been passed down intergenerationally, as well as the feeling that she is too white-passing to identify as "Indian." Julia internalized colonial definitions of identity born out of the Indian Act (Lawrence, 2003), resulting in a problem story that she was either too Indian or not Indian enough. At first, Julia's experience was externalized as "shame," and through the process of politicization, Julia began to identify her problem as "colonization." The narrative therapist worked with Julia to name dominant discourses related to eurocentrism and settler colonialism as paramount in shaping her experience of shame and displacement. Julia and the narrative therapist unpacked the notion of "full-bloodedness" as a categorization practice critical to the colonial process (Lawrence, 2003). Through the narrative process, Julia began to develop an alternative story that captures the nuances of her identity. In Julia's new story, she understands herself as an Irish-Indigenous person whose embodiment reflects both traditional and contemporary influences. Julia now recognizes there are many different ways to be Indigenous, and acknowledges the resilience that she has practiced in coming to reclaim her identify in spite of systemic and governmental erasure. In developing an alternative discourse, Julia began to identify her experiences in relation to decolonization and Indigenous resurgence.

The final step in the narrative process is to thicken the alternative story. Typically, this involves developing strategies for the purpose of reinforcing service users' alternative stories or ways of viewing themselves. One example of this is provided by Carey and Russell (2003), who encourage the use of "remembering conversations," which invite service users to identify the people in their life who can positively contribute to the further development of their alternative story. For example, by asking "is there someone who would recognize and appreciate what your commitment to hope means to you?" (p. 67). Other examples include affirming art work, support groups, or investing deeper in new knowledge that has been raised through the therapeutic process. Politicizing this step involves thickening the individual alternative story and broader alternative discourse by making it collective. In a mainstream narrative approach, thickening the thread often focuses on reinforcing individualized narratives. In politicizing this step, individual experiences of oppression should be connected to the broader community or communities of people experiencing similar struggles. In Julia's case, the narrative therapist supported Julia in connecting with other community members. In doing so, Julia began to realize her experience is common within Indigenous communities, where histories of colonization separate individuals from their families, communities, and culture.

In euro-western practice, building a team often consists of imagining what others in a service user's life would say to support their new narrative. Confidentiality is seen as paramount in social work practice, and at times prevents stories from being shared with outside supports. A culture of care that promotes individual interventions limits the potential for collective healing and resistance. Within Indigenous communities, narrative therapy often incorporates community members who witness peoples' narratives. As stated by Bacon (2007):

> Outsiders listen to narratives, reflecting on the stories and retelling or writing about the personal impact these stories have had on them. The story heard evolves into another, which is retold in different Aboriginal communities. The process is endless—leading to strong connections between communities. (p. 73)

By engaging with community and participating in Talking Circles supported by Elders and traditional medicines, Julia was able to connect her narrative process with traditional healing. By sharing her story with multiple listeners, Julia's personal experience was validated and transformed into a communal teaching.

Conclusion

In the pages above, we have explored how narrative techniques can be used in a variety of contexts to deconstruct violent discourses. In order to demonstrate the potential impact of this approach from start to finish, we thought it would be helpful to revisit Sarah's case from step one and walk through the remaining steps. After exposing some of the discourses influencing her experience with vulvar pain, Sarah and the narrative therapist worked to externalize and then politicize the problem, naming it "heteronormativity." By removing the problem from her identity and connecting her experience to violent social structures, Sarah was able to challenge her previous belief that she was sexually inadequate. She developed an alternative discourse about vulvar pain sufferers that aligned with queer and anti-sanist theorizing, interrogating hetero/cis-normativity in health care (Bauer, Hammond, Travers, Kaay, & Hohenadel, 2009) and psychiatric control (Diamond, 2015). As stated by MacDonald (2008), "experiences/stories of people with (dis)Abilities and sufferers of chronic pain need to be welcomed into the discourse on chronic pain, a discourse that has been predominantly occupied by biomedicine" (p. 138). Through this process, Sarah came to recognize that her lived experiences with pain and disability can benefit her work as a social worker, interrupting previously held beliefs that her practice should be distinctly separate from her personal experience. Sarah became interested in exploring new forms of sexual expression, intimacy, and desire, and started a support group for vulvar pain sufferers that fosters

collective resistance, and where her alternative discourse about vulvar pain is supported, questioned, and extended by others.

The case studies and examples outlined above demonstrate how to put politicized narrative therapy into practice through interaction with service users. Although we have placed the steps in a particular order, we hope to interrupt the pull towards linearity and urge the use of creativity in bringing this approach to life. We see politicized narrative therapy as carrying transformative potential through the provision of critical knowledge. Critically, we suggest a move away from individualized approaches to therapy that fail to connect personal experiences to broader social and political narratives. By working with service users to expose dominant discourses that contribute to the subjugation of their problem stories, bodies, and communities, it becomes possible for individuals to unhinge internalized messages that negatively shape their lives and filter their memories. By dislocating struggle from the self, people have the opportunity to reframe their experiences and access empowerment through a process of politicization, where individual distress is connected to broader struggle. Through the process of mass epistemological refusal, individual alternative stories harness the power to energize, embolden, and authorize alternative discourses for the purpose of social change.

Facilitating this work requires a commitment to engaging with critical perspectives, and ongoing critical reflection regarding the impact that our work has on the people and communities we engage with. Despite our attempts at disrupting mainstream narrative therapy, we recognize that our approach may not feel safe or accessible to certain bodies and communities who have and continue to be harmed by therapeutic surveillance and psychiatric domination. We envision this application of narrative therapy will be situated in social work and social justice work as a means to support anti-colonial, anti-racist, and critical therapeutic practices. This method provides users of narrative therapy with tools to support and empower individuals experiencing distress, while simultaneously engaging them in the political practice of discursively transforming futurities. Moving forward, we will carry these ideas with us into our communities and practice with caution and discernment, and are eager to tune this approach based on critique, experience, and collective contemplation. We propose to you, the reader, a move towards responsible and ethical (re)engagement with and reclamation of allied narrative resistance. This involves ensuring that your narrative practice functions to visualize societal injustice and dominion, for the purposing of interrupting, discrediting, and displacing whiteness, colonization, and other forms of oppression. In doing so, your work will be performative for its potential to rewrite and transform the future.

END NOTES

1   In relation to mental health and disability, the medical model reflects a system that locates and responds to distress in relation to the individual's pathology, rather than experiences of oppression, societal inequality, and trauma. By prioritizing the knowledge of doctors, psychiatrists, and other healthcare professionals, individuals with lived experience become enrolled in complex and multi-directional power relationships that are operationalized through processes of labelling and diagnosis, treatment and self-surveillance (Brown & Tod, 2007; Withers, 2012; Clare, 2017).

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