

**A Hybrid Discourse Analysis of Client-Preferred Identity Co-Construction Within Brief
Narrative Single Session Therapy**

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Dissertation submitted to the Faculty of Education
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy in Education

Faculty of Education

University of Ottawa

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Abstract

Single session therapy (SST) is a form of psychotherapy that has been researched and practiced internationally since the 1980s. More recently it has been widely employed from the therapeutic modality of narrative therapy—more commonly known as brief narrative single session therapy. Narrative therapy—an internationally practiced psychotherapy in its own right—operates from a blending of social constructionist and Foucauldian/poststructural theory where therapists support clients to co-construct preferred identities amidst powerful discourses which constrain this process. While the co-construction of client-preferred identity is multilayered, studies within this field have historically leaned on social constructionist explanations of how this process occurs at the expense of the Foucauldian/poststructural perspective. This study blends these two perspectives, both conceptually and methodologically, to understand how client-preferred identity co-construction occurs in brief narrative single session therapy. From the social constructionist perspective, the preferred identity that narrative therapy seeks to foreground is viewed as something that is constructed within the session between the client and therapist rather than something that is fully formed prior to the session's start. Yet, from the Foucauldian/poststructural perspective this process also occurs within the culturally available discourses that are afforded to us. To highlight both perspectives I conducted a hybrid discourse analysis that included a macro-focused Foucauldian discourse analysis and a micro-focused element of discursive psychology, on five appointment-based sessions of brief narrative single session therapy. Immediately following the recording of each session clients and therapists filled out separate post-session questionnaires to share their impressions and experiences of these single sessions. The results of this study present rich examples of how working practitioners trained in brief narrative single session therapy support clients in the co-

construction of preferred identities in the context of constraining cultural discourses. In addition, alternative discourses that supported the work of client-preferred identity co-construction based within these sessions, and found within the fields of narrative therapy and the brief therapy movement, were identified. Comments from participant post-session questionnaires offer supplementary perspectives that add greater context to the findings from my analysis of sessions. Implications for the training, practice, and study of brief narrative single session therapy are discussed.

Acknowledgements

Completing this PhD was no easy task. Thank you to everyone who helped me cross the finish line.

Thank you Dr. David Paré. I feel so privileged to have been your final doctoral student. I could not have asked for a better supervisory experience. Thank you for your unwavering passion and excitement for this project. Thank you for your detailed feedback on every piece of writing that I gave you. Thank you for focusing me in our meetings on the practical side of getting this project up and running without stifling my love of theory. I am so grateful to have been able to co-construct this piece of research with you to contribute to the fields of narrative therapy, single session therapy, and brief narrative single session therapy. Thank you for helping me become a better writer, researcher, and therapist.

Thank you to the members of my thesis committee Dr. Cristelle Audet, Dr. Nick Gazzola, Dr. Richard Barwell, and my external examiner Dr. Michael Hoyt. Thank you Cristelle for your helpful comments throughout this project, especially your suggestions prior to submitting my ethics application at my proposal defence. Thank you, Nick, for all your help, especially your comments about being clearer on the definition of identity at my proposal defence. This helped sharpen the study significantly. Thank you, Richard, for your thought-provoking questions. Your question to me about my needing to figure out how to integrate social constructionist theory with Foucauldian methodology stayed with me throughout my writing process and helped especially in forming the study's blended conceptual framework and later, its hybrid methodology.

Thank you, Richard, Nick, and Cristelle for your feedback on the first draft of the dissertation and for your support in brainstorming, with David and I, about the final revisions to

the thesis. This meeting helped me re-organize my thoughts around my final chapters in a way that made the thesis stronger. I am very grateful for your collective insights and guidance.

Thank you to Dr. Michael Hoyt for agreeing to be an external examiner on my thesis committee, for your enthusiasm and shared interest in this work, and for your patience in waiting for the final draft of this thesis prior to defence. I have enjoyed reading your work immensely and I am honoured to have you be a part of this project.

Thank you to the University of Ottawa's University Excellence Scholarship and the Province of Ontario's Ontario Graduate Scholarship (OGS), which helped fund this study. Thank you to my former master's thesis supervisor Dr. Terry Gall, and Dr. Paré for your letters of reference which helped me secure OGS funding.

Thank you to Karen Young for your email correspondence, for your interest in this project, and for providing me with information about narrative therapy and its use in single session walk-in clinics across Ontario.

Thank you to Dr. Mahin Tavakoli for your encouragement in my early stages of writing and your advice that in later stages I would be writing for more hours than I could count. You were right.

Thank you to Dr. Deborah Gilman for your continual wisdom and guidance, especially your advice that "*the best part of your thesis is wherever you're at in your thesis.*" This was a calming mantra that I drew upon many times throughout my writing.

Thank you to Dr. Peter Milley for all your kind words of encouragement throughout my writing.

Thank you to Dr. Michael Guilfoyle for your writing and scholarship on narrative therapy. Thank you for responding to my email about your book a few years before I started this PhD. I was saddened to learn of your passing towards the later stages of my writing.

Thank you to H el ene Ndiaye at the University of Ottawa's Faculty of Education for organizing my defence, as well as for distributing my dissertation to all my committee members.

Thank you to Carole Ann Kelly, Anick Larose, and the many additional administrative staff at the University of Ottawa's Faculty of Education for helping with the administrative requirements of this degree. Thank you for your patience and kindness in supporting me through the process.

Thank you to Riana Marcotte, protocol officer at the University of Ottawa's Ethics Review Board, for being so helpful in preparing my ethics proposal to the university.

Thank you to Jason Moore and Amy Moyer for your countless years of hospitality. Thank you for letting me stay with you during my trips to Scarborough whether it be for New Years, or a summer long weekend. Visiting you was such a relaxing break between writing whether we were going to concerts, garage sales, or barbequing.

Thank you to Melissa and Jeremy Ames for your years of friendship through my completion of this thesis. Thank you for celebrating various milestones with me at different stages in the process. Thank you both for always asking about the project with such great interest and enthusiasm.

Thank you to Valerie and Garnet Mitchell, Vera Murray, and June Burgher for all your encouragement over these past several years.

Thank you to my parents Jane and David Henneberry for encouraging me and believing in me no matter what I do. Thank you, mom, for your support throughout this process, and for listening patiently while I would explain what I was writing about. Thank you, dad, for encouraging me to pursue as much education as I can, to never stop learning, and for modeling how I can learn by osmosis, trial and error, and by sheer stubbornness of will.

Thank you to all other friends, family, and loved ones without whom I would not have completed this PhD.

While I will not name it, to protect the confidentiality of the participants who took part, thank you to the agency that hosted this study. Thank you to its many directors, managers, and administrators who supported me in conducting this research.

Finally, thank you to the clients and therapists who participated in this study. It was a pleasure for me to transcribe your words and study them. Thank you to the clients who volunteered to participate. Your stories were powerful to listen to. Thank you to the therapists who participated. Your work was and is artful. I am forever grateful to have been given the chance to slow these sessions down and explore them more closely. Thank you for trusting me with your time together.

Dedication

To my parents.

I can remember being sat down at five-years-old and encouraged to, “*Get as much education as you can. It will open doors for you that you didn’t even know existed.*”

This work is the fulfillment of that advice, and a testament to your unwavering encouragement and support of all I do.

Thank you. I love you both.

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Chapter 1: Introduction

We seldom realize, for example, that our most private thoughts and emotions are not actually our own. For we think in terms of languages and images which we did not invent, but which were given to us by our society- Alan Watts, 1966, p. 64.

If I were to ask you, the readers of this paper, whether or not you possessed any personal properties like strengths and resources, it is my guess that a great many of you would respond in the affirmative: “Why, of course I have these things.” And if I was to ask you whether these personal properties are relevant to your identity, it is my guess that many of you would again respond in the affirmative: “Of course. But isn’t this true for everyone? These are the building blocks of people’s identity.” ...But these essentialist ideas about identity are relatively novel ideas, not just in the history of the world’s cultures but also novel in the history of western culture- Michael White, 2001, p. 37.

Our multiplicity insures that we are always, as Bakhtin puts it, ‘poised on the threshold’ ...between one way of knowing oneself and another- Michael Guilfoyle, 2014, p. 152.

Language creates reality. Words have power. Speak always to create joy- Deepak Chopra, October 18th, 2013.

In December of 2013, I was one of several therapists invited to attend a meeting between a host of different counselling agencies within Eastern Ontario to support the opening of a newly created multi-site walk-in counselling clinic. As these walk-in clinics were scheduled to open to the public in early January 2014, the various clinical directors, program administrators, and therapists from these different agencies met to strategically plan how the daily functioning of these clinics would roll out. In further preparation, several therapists (myself included) were also invited to attend training in brief narrative single session therapy—the therapeutic orientation of choice for the clinic—in early January 2014 and again in April 2014. As I attended these initial trainings, I became increasingly fascinated with many of the ideas found within narrative therapy—several of which are reflected in the above quotes which will be expanded upon throughout this thesis. Yet, I was also skeptical about how any therapy could be effective if only offered in a single session model. At the time, single session therapy was such a radical departure from anything I had been taught about psychotherapy leading up to that point. Fueling my

skepticism was a belief about psychotherapy that was engrained from graduate school: an increase in the quality of psychotherapy provided is directly tied to an increase in its frequency. This belief may have also been shaded by the fact that my first clinical supervisor was a practicing psychoanalyst.

Back in 2008—when I was initially training to become a psychotherapist—this psychoanalytically-inclined supervisor taught me general introductory clinical skills in my work with clients. Yet her psychoanalytic orientation indirectly shaped my view of therapy as being a long-term practice in the archeology of the psyche, where therapists worked to unearth their client’s deep-seated problems over a long-term therapeutic relationship. When discussing her psychoanalytic approach early on in our supervision together, she shared that she was both excited and anxious to increase the frequency of her meetings with one of her clients from two sessions per-week to three. Each of these appointments, she noted, was an hour long, and this shift from two to three sessions per-week marked the first time in her work with this particular client that they would be meeting so frequently. Her own supervisor, a more seasoned psychoanalyst, told her to expect to work at this new pace of three hour-long sessions per-week with this client for several years. While hearing about this example of her own clinical work so early on in my training, this psychoanalytic orientation indirectly influenced my view of therapy as a long-standing endeavor.

Despite my initial hesitance about single session work, when these walk-in clinics opened in late January of 2014, I ended up successfully hosting the first single session at one of the counselling agencies involved. Afterwards I remember feeling dumbstruck and thinking to myself, “*Huh!?! Well, that went pretty well...*” Following this first positive experience, my interest in both narrative and single session therapy skyrocketed. Over the next year, I read

everything I could get my hands on about brief narrative single session therapy, as well as narrative therapy and single session therapy, respectively.

To become better acquainted with single session walk-in work I read Slive and Bobele's (2011) edited volume, *When One Hour Is All You Have: Effective Therapy for Walk-In Clients*. During this time I also became especially interested in narrative therapy ideas around client identity after reading two seminal narrative books, *Narrative Means to Therapeutic Ends* (White & Epston, 1990), and *Maps of Narrative Practice* (White, 2007), as well as other notable offshoots (Freedman & Combs, 1996; Morgan, 2000). In particular, I became interested in narrative ideas described in these books such as: how cultural discourse influences one's language use and how one talks about themselves and their identity; how dominant cultural discourses are often reflected in the therapy room—resulting in client identities that become essentialized often to the point of pathology; how certain types of knowledge about who a client is (related to a client's problem and reinforced by a dominant cultural discourse) are given greater weight at the expense of other knowledges of the client; how these dominant discourses and their associated knowledges can be subverted within the therapy room in order to support clients to speak about their identities in more preferred ways; and how this process plays out between clients and therapists within a single session model of brief narrative therapy. Yet, as I dug more into the brief narrative single session literature, apart from a few authors (Cooper, 2014; Young, 2008, 2011) there seemed to be very little literature dedicated to the process of narrative therapy as applied to a single session model, and how this work supported client identity construction within a single clinical meeting.

In the trainings I attended, I kept hearing about how client problem stories and client identities were shaped by dominant discourses, and that through careful attention to language

use, clients and therapists could co-construct preferred identities that were aligned with a client's preferences, skills, abilities, and values. However, I kept thinking to myself during these trainings, *“Yes, but what do these discourses look like in single session work?”* and *“what does this process of client-preferred identity co-construction actually look like when applied to a single session of narrative therapy?”* I was hungry to learn more about the specific use of narrative therapy in a single session model as it related to client identity.

Thus, when the opportunity to pursue my doctorate arose, I decided to research the inner workings of brief narrative single session therapy in relation to client-preferred identity co-construction. I taped five appointment-based single sessions conducted by therapists trained in brief narrative single session therapy who had never met their clients prior to their involvement in this study. I felt compelled to study how single session and narrative fit together in the hopes of providing a solid teaching tool that would be of value to newer clinicians doing this work. My hope is this dissertation will shed light on this radical practice of brief narrative single session therapy, as it is becoming a burgeoning therapeutic modality used across Ontario.

The study itself is divided into six chapters. Following this introduction, Chapter 2 provides a review of the literature on single session therapy via walk-in and pre-booked appointment; the brief therapy movement; the study of identity as both a solely constructed and co-constructed phenomenon; brief narrative single session therapy; and the study of client-preferred identity co-construction within brief narrative single session therapy. In Chapter 3, I present the study's theoretical foundations and conceptual framework. Here I present the theoretical frameworks that make up narrative therapy—social constructionism and poststructuralism—followed by describing how their blending will act as the study's conceptual framework. From here, Chapter 4 presents the methodology and methods that were used to

conduct the study. The chapter outlines the methodology of discourse analysis that was used to analyze session transcripts, as well as highlighting the specific macro and micro approaches to analysis that were used. In Chapter 5, I present the results of my analysis of the five appointment-based single sessions of therapy. In it I look at both the discourses that showed up in these sessions as well as the narrative therapeutic practices that occur in the back-and-forth between clients and therapists in sessions that supported client-preferred identity co-construction. Additionally, I highlight participant post-session questionnaire responses that both client and therapist participants filled out immediately after their recorded single sessions. The purpose of this was to get participant impressions and to provide added context to my own analysis of sessions. Finally, in Chapter 6, I discuss the findings from my analysis of these sessions in greater detail as well as the participant post-session responses that provided added context to these sessions. I point to what stands out as noteworthy from both sets of findings, how these findings add to research in the field of brief narrative single session therapy, and where future research may go from here. Following this I present the study's conclusions and provide an overall wrap up of the thesis more generally.

Prior to beginning my literature review I must first add one caveat. While I present various narrative concepts and therapeutic practices throughout this dissertation, and while I cite a multitude of authors in the field of narrative therapy to help clarify these concepts and practices, of all these authors I most heavily quote Michael White (one of the co-founders of narrative therapy along with David Epston). White is by far the most significant contributor to narrative discourse. At the time of this writing—almost fourteen years since his death—he remains the richest source of detailed accounts of narrative therapy theory and practice.

Chapter 2: Literature Review

Single session therapy (SST) is a form of psychotherapy that has been researched and practiced internationally for over thirty years (Hoyt, 1994; Hoyt et al., 2018; Hoyt & Talmon, 2014; Talmon, 1990, 2012). More recently, a variation of narrative therapy known as brief narrative single session therapy (Cooper, 2014; Young, 2011, 2018) has been widely employed in single session work. Narrative therapy—an internationally practiced psychotherapy in its own right (White, 2007, 2011; White & Epston, 1990)—operates from a blending of social constructionist and poststructural theory where therapists support clients to co-construct client-preferred identities that occur amidst powerful dominant discourses which seek to constrain this process. Narrative therapy’s adaptation to a single session model has produced accounts from brief narrative single session therapists demonstrating how they have successfully facilitated the co-construction of client-preferred identities in a first—and only—therapeutic meeting (Cooper, 2014; Young, 2008). However, as the blending of single session therapy and narrative therapy has created a complex multilayered process for understanding the co-construction of client-preferred identity, this dissertation seeks a clearer understanding of how this process occurs. As such, my aim in this chapter is to review the pertinent research that has emerged from these converging fields to provide a foundation upon which to build my own study. To do so I will divide this chapter into seven parts:

First, I will review research pertaining to single session therapy that will include a discussion of: (1) single session therapy’s history within the contextual backdrop of psychotherapy more generally, (2) the discovery of unintentional single session therapy and subsequent research on planned single session therapy that occurred shortly thereafter, and (3) the development of planned single session therapy research via walk-in counselling clinic and

pre-booked appointment. Second, I will discuss the influence of the brief therapy movement on planned single session therapy and how this movement's leanings on social constructionism/social constructionist therapies has led to an increase in research on the concept of co-construction within planned single session therapy. Third, as my research is focused on the co-construction of client identity, I will provide an overview of research on the study of identity within the broader field of mental health distinguishing (1) mental health research that has studied identity as an individually constructed phenomenon, from (2) mental health research that has studied identity as a co-constructed phenomenon. Fourth, I will present the typical session structure seen in narrative therapy, including a review of several of the most common narrative practices and how these practices support client-preferred identity co-construction. Fifth, I will discuss narrative therapy research more generally, and how in addition to the social constructionist standpoint, narrative also understands the process of co-construction from a poststructural framework, and as such considers how the broader social context (or conversation at large) influences this process. Sixth, I will discuss how research on the co-construction of client-preferred identity has been made manifest in planned brief narrative single session therapy that leans heavily on social constructionist accounts of this process, and how my own study will increase the knowledge of how this process occurs from both a social constructionist and poststructural perspective. Seventh, I will provide a chapter summary.

2.1 Single Session Therapy

2.1.1 A Brief History of Single Session Therapy Within Psychotherapy

While single session therapy is a form of psychotherapy that has seen significant growth in its research output over the past thirty years (Dryden, 2021a; Hoyt et al., 1992; Hoyt et al., 2018; Talmon, 1990, 2012), it is not a new phenomenon as its origins and evolution run parallel

to the history of psychotherapy itself (Dryden, 2019). Sigmund Freud, perhaps best known as the creator of psychoanalysis—a long-term therapeutic treatment modality often lasting for months or years—adapted his psychoanalytic approach to fit into a single session model twice in his career: first in 1893 and again in 1910 (Dryden, 2019, 2021b). By the mid 1960’s additional modalities of psychotherapy—including person centred therapy, Gestalt therapy, and rational emotive behavioral therapy (REBT)—were adapted into single session form as a way of educating therapists in-training on how to conduct these particular therapeutic modalities via single session demonstration (Dryden, 2019). From 1965 through 2005 during his “Friday Night Workshops” (Dryden, 2019, p. 8) Albert Ellis—the founder of rational emotive behavioral therapy—conducted two thirty-minute single sessions of REBT per week to demonstrate his specific approach to psychotherapy over the course of this forty-year period (Dryden, 2019). Yet, the watershed moment for the more recent boom in research surrounding single session therapy occurred in the 1980s in northern California. It was here that the concept of unintentional single session therapy was accidentally discovered by Moshe Talmon (1990, 2012) and subsequent research into planned single session therapy began.

2.1.2 The Discovery of Unintentional Single Session Therapy and the Beginnings of Planned Single Session Therapy

Talmon—a clinical psychologist working at the Kaiser Permanente Medical Group in Northern California in the mid-to-late 1980s—stumbled upon the concept of unintentional single session therapy purely by “coincidence” (Talmon, 2012, p. 6). When reviewing statistics of psychotherapy dropout rates at Kaiser he noticed a pattern that an unplanned single session of therapy “was the most common length of therapy” (Talmon, 2012, p. 6) among all thirty therapists that worked within his department. Furthermore, Talmon discovered that many of the

families that he had personally worked with “did not return for a second session despite being offered one” (Dryden, 2019, p. 11). Rather than settling for a conventional explanation of this phenomenon Talmon called these 200 clients and asked them what had led them to seek only one session. Much to his surprise he heard “the positive outcomes of their single sessions” (Talmon, 2012, p. 7) with 78 percent noting “they had got[ten] what they wanted out of the single session and felt better or much better about the problem that had led them to seek therapy” (Talmon, 1990, p. 9). After retrospectively reviewing these cases Talmon collaborated with colleagues Michael Hoyt and Robert Rosenbaum at the Kaiser group on what was the first research study of planned single session therapy (Talmon, 2012). For this study Talmon, Hoyt, and Rosenbaum conducted “single session psychotherapy with 60 randomly assigned adults who appeared for non-crisis routine intake appointments” (Bloom, 2001, p. 81) at Kaiser. In the three to twelve months following these planned single sessions “58 of the 60 patients were reached by telephone for a follow up interview conducted by someone other than the patient’s therapist” (Bloom, 2001, p. 81). Results from these follow up calls found that

(1) [t]hirty-four of [these] 58 patients (58.6%) elected to complete their therapy in one session even when more sessions were available; (2) more than 88% of the one-session patients reported significant improvement in their original “presenting complaint” and more than 65% also reported “ripple” improvements in related areas of functioning; and (3) while not experimentally assigned to one-session or longer, on follow-up there was no difference in satisfaction and outcome scores between those who chose to stop after one visit (SST) versus those who continued for more sessions (Hoyt et al., 2018, p. 4).

While Talmon’s discovery of unplanned single session therapy and subsequent research into planned single session therapy led him to define single session therapy as “one face-to-face meeting between a therapist and patient with no previous or subsequent sessions within one year” (Talmon, 1990, xv), in more recent years this original definition has been considered “arbitrary” (Hoyt et al., 2018) as it was solely “used for research purposes” (Dryden, 2019, p. 5).

Hoyt et al. (2018) have subsequently stated that clients of single session therapy “may be seen more than once in a year...[with each session being] approached as though it could be the only (single) session, complete unto itself” (p. 18).

The years that followed Talmon, Hoyt, and Rosenbaum’s initial uncontrolled cohort outcome study saw a myriad of planned single session research that explored the use of single session therapy with a variety of clinical populations and in a range of different therapeutic settings. These included a randomized controlled trial that found planned single session therapy of benefit to victims of sexual violence in conflict-affected areas where psychological first-aid was deemed insufficient (Paul & van Ommeren, 2013), a critical review that showed the successful application of single session therapy to high performance athletes (Pitt et al., 2015), exploratory studies that highlighted the benefits of single session social work in hospitals (Gibbons & Plath, 2006, 2012), a randomized control study that showed that the use of single session music therapy reduced anxiety and nausea levels in bone marrow transplant patients (Rosenow & Silverman, 2014), two case studies of single session graded exposure therapy to assist problem gamblers (Tolchard et al., 2006), and six case studies of single session computerized cognitive behavioral therapy to treat patients with dental anxiety (Potter et al., 2016). Yet, as timely access to public mental health service has become a growing issue around the world (Miller & Slive, 2004) a major boom in planned single session therapy research has come from its use via walk-in counselling clinics and pre-booked appointments as a means of addressing this need (Campbell, 1999; Perkins, 2006; Young et al., 2012).

2.1.3 Planned Single Session Therapy Via Walk-In Counselling Clinic and Pre-Booked Appointment

Research on planned single session therapy via walk-in and pre-booked appointment suggests that “the majority of clients attending either previously scheduled or walk-in [single session therapy] find it sufficient and helpful” (Hymmen et al., 2013, p. 60). Planned single session therapy via pre-booked appointment “involves clients being offered a specific date and time that can be set from a few days to a month in advance; [while] single-session walk-in clinics offer one or more days a week when clients can see a counsellor for a single session without an appointment, after a relatively short wait” (Hymmen et al., 2013, p. 61). As public mental health systems across the world grapple with “resource-stretched community counseling and mental health programs” (Hymmen et al., 2013, p. 70) the adoption of planned single session therapy via walk-in and pre-booked appointment has provided “funders, program planners, and policymakers interested in cost-effective delivery systems” (Hoyt et al., 2018, p. 3) the means of providing greater public access to psychotherapy (Miller & Slive, 2004; Talmon, 2012) in less invasive and more cost-effective outpatient settings (Bloom, 2001).

In the Canadian context this push for greater accessibility in mental health care has led to an increasing number of mental health agencies offering single session therapy to individuals, couples, and families through walk-in counselling clinics (Hymmen et al., 2013; Slive et al., 2008) since being adopted in 1990 by the Eastside Family Centre in Calgary, Alberta (Miller, 2008; Stewart, et al., 2018). As of 2018, Ontario had at least 40 walk-in counselling clinics in operation, “more than in any other province or likely country” (Young, 2018, p. 59). Of these, most do not set a limit of sessions, but rather have a come-intermittently-when-you-need-it approach. These walk-in clinics operate out of various settings including children’s mental health

centres, and adult sectors such as family service agencies, family health teams, the Canadian Mental Health Association (CMHA), and on several university campuses (K. Young, personal communication, June 15th, 2017). A similar intermittent and as-needed approach has surrounded the practice of pre-booked appointment based single session therapy. For example, a family therapy centre that was an early adopter of single session therapy in Melbourne, Australia offered an appointment-based model of single session therapy to shorten their waitlist and had an “open door” policy for clients to return occasionally as needed (Boyhan, 1996). Thus, planned single session therapy via walk-in or pre-booked appointment “provides a significant opportunity to begin a new chapter” (Hymmen et al., 2013, p. 70) in planned single session therapy research. Yet, much of this research has been either controlled outcome studies where one cohort that is given single session therapy via walk-in or appointment is compared to a control group that does not receive single session therapy, or uncontrolled outcome studies—like what was initially done by Talmon (1990)—where a group is given single session therapy and studied afterwards to gauge their experience without a comparison group.

2.1.4 Planned Single Session Therapy Research

The literature on planned single session therapy via walk-in and pre-booked appointment has seen significant growth through both controlled (Barwick et al., 2013; Cait et al., 2017; Stalker et al., 2016; Tam & Bloom, 2015) and uncontrolled outcome studies (Campbell, 1999; Harper-Jaques & Foucault, 2014; Hopkins et al., 2017; Miller, 2008; Miller & Slive, 2004; O’Neill, 2017; Stalker et al., 2012; Stewart et al., 2018).

A controlled outcome study compared client experiences of planned single session therapy via walk-in clinic with client experiences of receiving a traditional wait list model of service delivery at two counselling agencies in two separate cities in southern Ontario (Stalker et

al., 2016). Stalker et al. (2016) used a mixed method design that included comparing results of the General Health Questionnaire (GHQ-12) measured at baseline and at two follow up points of both single session and waitlisted groups, as well as a qualitative analysis of post-session interviews from participants in each group. Results found that the clients at the agency who engaged in the single session walk-in model improved faster and were less distressed at the four week follow up point compared to clients at the agency who were waitlisted to receive a traditional model of therapy, while at the ten-week point both groups showed similar improvement (Stalker et al., 2016). While this study had a large sample size in both groups (729 individuals attending single session walk-in and 532 individuals in the control group who were waitlisted) both groups had a low percentage of participants engaged in the baseline GHQ-12 measure (49% for walk-in clients and 28% for waitlisted clients). Subsequent participation rates continued to decrease at the 4 and 10-week follow-up points. While Stalker et al. (2016) described their post-single session analysis in detail, their study design provided no indication of what happened in these sessions that was helpful for clients. Additionally, while post-session experiences focused on clients, Stalker et al. (2016) did not include any post-session interviews from therapists. Finally, they were unclear as to how many clients participated in post-session qualitative interviews.

Hopkins et al. (2017) conducted an uncontrolled outcome study of pre-booked appointment based single sessions for Australian youth and their families to support these young people's mental health. Two post-session evaluations—a Session Rating Scale (SRS) and an Outcome Rating Scale (ORS)—were given to participants immediately following these single sessions, and a second ORS was administered 4-5 weeks post-session (Hopkins et al., 2017). While the SRS measured “each participant’s sense of the usefulness and effectiveness of the

session” (Hopkins et al., 2017, p. 109), the ORS asked each individual family member to rate the youth’s state of functioning post-session. SRS data “completed by 71 young people, 92 mothers, 68 fathers and 34 siblings/others across 102 therapeutic sessions” (Hopkins et al., 2017, p. 109) found that all participants rated their single session experience consistently high, with “mothers tend[ing] to rate the session significantly higher than siblings or young people” (Hopkins et al., 2017, p. 109). Initial ORS data “collected in 107 of these sessions (238 participants)” (Hopkins et al., 2017, p. 109) rated the young person’s well-being as having improved immediately following the single session intervention, while the 43 individuals who had completed the second ORS measure across 37 sessions noted this improvement had continued 4-5 weeks post-session. However, despite the positive ratings found from these sessions there was no mention in the write up of what type of therapy was being practiced in these single sessions which led to such results.

Miller and Slive (2004) conducted an uncontrolled outcome study that evaluated client satisfaction post-single session via walk-in across 700 single sessions during a three-month period of initial data collection. Of these 700 sessions, Miller and Slive (2004) randomly selected 50 cases to participate in follow-up interviews with 43 clients participating (Miller & Slive, 2004). Follow-up telephone interviews conducted with these 43 clients between 3 to 6 months after they received their single session treatment found satisfaction with the service as “[t]he majority (67%) indicated some level of improvement, and 43% of participants [noted] their single session sufficient to address their concerns” (Miller & Slive, 2004, p. 95). Yet again, while Miller and Slive (2004) analyzed participant responses to post-session questionnaires, there was no actual presentation in the study of what was going on in these single sessions in-and-of

themselves. While helpful to get post-session evaluations of single sessions it still leaves a question of what went on in these sessions themselves that was so helpful.

Stalker et al. (2012) conducted an uncontrolled outcome study of client perceptions of the clinical effectiveness of single session therapy via walk-in counselling clinic in Kitchener-Waterloo, ON. After their session, clients filled out two follow-up questionnaires at one-month and four-month intervals following their single session (Stalker et al., 2012). Clients reported these single sessions were helpful in providing “a decrease in distress, improvement in general functioning, and decreased use of health services one month and four months after the walk-in visit” (Stalker et al., 2012, p. 38). However, this study was limited by a low response rate as only 28 of the 362 initial clients who were recruited for the study participated in the one-month follow-up questionnaire, while only 24 participated in the four-month follow-up questionnaire. In addition, while Stalker et al. (2012) noted that participating therapists were trained in various theoretical approaches which were used in these single sessions, including brief solution-focused therapy, brief narrative therapy, and brief cognitive behavioral therapy, they were unclear about how these specific theoretical approaches to single session therapy were helpful to clients, and in what ways.

O’Neill (2017) conducted an uncontrolled outcome study of post-session in-depth interviews with clients in a study of appointment based single session therapy in Australia. O’Neill (2017) conducted in-depth phone interviews with clients following single sessions of family therapy to “examine how clients interpret, construct and respond to the idea of SST” (O’Neill, 2017, p. 68). Of the 25 clients who participated in these post-session interviews, 19 or 76% of participants reported their single session was “helpful or very helpful” (O’Neill, 2017, p. 72). More specifically, O’Neill, (2017) found that “[t]hree experiences most frequently identified

as helpful were: everyone having an opportunity to speak in a neutral environment ($n = 6, 24\%$), the advice and expertise offered by the therapist ($n = 6, 24\%$) and the support and validation received from the therapist ($n = 5, 20\%$)” (p. 72). O’Neill (2017) noted that all therapists that had participated in this study were practicing single session therapists “influenced by a range of theoretical paradigms including solution-focused...narrative theory...relational trauma theory...and Milan systemic theory” (p. 69). Yet, these results were limited in that they did not go into the specifics of what types of therapies were being used when clients reported these single sessions to be helpful.

A drawback of these outcome studies is that while the use of post-session questionnaires, surveys, and/or post-session interviews show that planned single session therapy is helpful to clients, they do not show what occurred in these single sessions to better understand how these sessions were helpful. From a therapeutic perspective they tell us nothing about how to conduct single session therapy effectively. As such, my own study will have a different focus. Namely, I will record appointment-based single sessions of narrative therapy to better understand what occurs in these sessions, and how therapists trained in brief narrative therapy support the co-construction of client-preferred identities in a single session context. Additionally, I will also have both clients and therapists fill out post-session questionnaires following their sessions. However, unlike the above research, mine is not an outcome study. As such, my own use of post-session questionnaires will shed light on whether participants notice any changes in terms of how clients spoke, thought or talked about themselves, if there was anything in session that contributed to such change, and if the therapist did anything that contributed to this change. Prior to going into any further depth concerning the adoption of narrative therapy into a single session

paradigm, I will discuss the brief therapy movement (of which narrative is a part) which has significantly influenced research showing how single session therapy is done.

2.2 The Brief Therapy Movement's Influence on Single Session Therapy Research

While there are countless therapeutic approaches that have been applied to single session therapy including humanistic (Littrell, Malia & Vanderwood, 1995), psychodynamic (Bloom, 2001), rational emotive (Dryden, 2019; Ellis, 1989), cognitive behavioral (Dryden, 2019) and Gestalt therapies (Harman, 1995), in recent years planned single session therapy research via walk-in clinic and pre-booked appointment has been highly influenced by the brief therapy movement and its heavy leanings on social constructionism and social constructionist therapies (Hoyt, 1995, 2017). While social constructionism will be discussed in greater detail in the ensuing theoretical and conceptual framework chapter, to give some context here, social constructionism is a philosophy that notes the creation of any knowledge of the world is a shared construction “between people in the course of their everyday lives” (Burr, 2003, p. 4). It is particularly focused on people’s language use and how shared versions of knowledge become co-constructed through language (Burr, 1995).

Therapeutic modalities that draw upon this social constructionist perspective are commonly known as social constructionist therapies (Corey, 2016; Gergen, 1999; Hoyt, 2000), or sometimes referred to as construction therapies (Hoyt, 2017), and include solution focused therapy (de Shazer & Berg, 1992) collaborative therapy (Anderson, 1997, 2007; Anderson & Gehart, 2007), and narrative therapy (White, 2007; White & Epston, 1990). As the brief therapy movement emerged within the latter part of the twentieth century it shifted from “traditional psychotherapy’s claim to knowledge, therapist expertise, and interventive practices” (Thomas & Nelson, 2007, p. 22) to a more social constructionist paradigm dedicated to client knowledge,

expertise, and competence (Monk & Gehart, 2003; Thomas & Nelson, 2007), adapting the use of social constructionist therapies to brief settings in order to “bring about positive consequences in clients’ lives via attention to the social construction of preferred realities” (Hoyt, 2000, p. 2) in a relatively short period of time. In doing so the brief therapy movement generally disavows the more traditional role of therapist as “expert [for] a more collaborative or consultative stance” (Corey, 2016, p. 369).

While brief therapy has been distinguished by Talmon (2012) as ten sessions of therapy or less, the brief therapy movement is less concerned with the number of sessions noting that there “is no magic number of sessions that makes therapy brief—any figure would be arbitrary” (Hoyt, 2017, p. 17), and instead is focused on client possibility rather than an orientation towards correcting a dysfunction or healing a wound. In this way the brief therapy movement engages in a unique

appreciation of human agency and potential...[which] focuses more on the strengths and resources that patients/clients bring to the enterprise than on their weaknesses or limitations. Similarly, more emphasis is put on where people want to go than on where they have been. While not ignoring the painfulness and seriousness of some situations, the shift had been away from conventional psychiatric pathologizing and toward a more optimistic view of people as unique and resourceful creators of their own realities... [f]uller recognition is given to the powers of language and imagination plus the principles of collaboration and respect for clients’ competencies (Hoyt, 2017, p. 80).

As single session therapy “is closely associated with the brief therapy movement” having been called “the ultimate of brief therapies” (Talmon, 1990, xv), this appreciation of client strengths, potential, and competencies within brief therapy has led to a rise in social constructionist informed research focused on how acts of co-construction occur between clients and therapists in planned single session therapy.

The co-construction of client agency was explored in a single session of brief narrative therapy via walk-in clinic that focused on how client agency was co-constructed by the client and therapist through the co-crafting of therapeutic documentation (Cooper & “Ariane”, 2018). Cooper and “Ariane’s” (2018) paper gave a lovely presentation of co-construction of the writing of this article itself. Cooper devoted the bulk of the writing describing how their session supported the co-construction of client “Ariane’s” agency through the shared creation of a therapeutic document—“Ariane’s Manual for Young Caregivers” a document co-created by client and therapist in session documenting how the client cared for her ill stepfather while still caring for herself. Additionally, the paper concludes with reflections from “Ariane” on this same process. However, the paper reads as a case study with no clear method. This may be because Cooper plays a dual role as both author and therapist in the piece. While the paper provides an interesting account of how brief narrative single session therapists can support clients in co-constructing client agency through co-crafting therapeutic documentation, it does not include the back-and-forth between client and therapist of how this process of co-construction occurred.

Fullen (2019) conducted a study of the co-construction of therapeutic alliance occurring within single session therapy that did show this back-and-forth between client and therapist. Fullen (2019) conducted a conversation analysis (CA) of a single session of therapy of a previously recorded single session that was not her own. Using CA—a social constructionist informed methodology—she explored how turn-taking between the client and therapist’s talk led to the co-construction of therapeutic alliance within the single session. In the study Fullen (2019) provided several clear examples of the back-and-forth talk from the session transcript pointing to the co-construction of therapeutic alliance, including examples of the co-construction of genuineness, unconditional positive regard, empathy, goal agreement, tasks, bonds between

client and therapist, and client satisfaction at the session's conclusion (Fullen, 2019). However, the study is limited in that there was no specific mention of what modality of single session therapy was being practiced. While the author made several references to humanistic/person centred therapy (Rogers, 1957), this may only have been done because as the researcher was studying therapeutic alliance, references to unconditional positive regard—a staple of Rogerian person centred/humanistic therapy—could be expected in any study of therapeutic alliance.

While the literature on identity co-construction within brief narrative single session therapy has grown in recent years (Cooper, 2014; Young, 2008), most research on the topic of identity within psychological and mental health research more generally is not based in social constructionism, and thus not understood as something that is co-constructed. Prior to discussing research on the co-construction of client identity both more generally, and specific to the practice of brief narrative single session therapy, I will first discuss studies that hold a more conventional understanding of identity as something that is a sole construction.

2.3 Identity Construction Within Psychological and Mental Health Research

2.3.1 Psychology and the Historical Study of Identity as Solely Constructed

The psychological study of identity—understood as a process of individualized construction rather than one of dialogical *co*-construction—is rooted in a historical understanding of the word which has bled into how it has been researched. The Enlightenment brought with it the idea that to have an identity is to have a “special essence” found within; the “creation and production of the self-contained individual and its search for a singular, unifying fundamental governing principle” (Madigan, 1996, p. 150). Yet, the notion of one's identity “as a unified internal phenomenon has its roots in the word's etymology” (Benwell & Stokoe, 2006, p. 18) that pre-dates the Enlightenment, as the first recorded use of the word ‘identite’ was in

1570 meaning “the quality or condition of being the same in substance, composition, nature, [and] properties...absolute or essential sameness” (Benwell & Stokoe, 2006, p.18).

This historical study of identity reflects modern psychology’s search “for something that is essential and substantial about the thing-in-itself rather than the thing-in-relation” (Madigan, 1996, p. 153). Rather than seen as a function of relationship and dialogue, from this perspective “everything, including people, could be approached scientifically. Taking the natural sciences as a model for the social sciences implied that persons and societies were treated as natural (material) events of which the causes have to be observed” (Langenhoven, 1995, p. 14). This has resulted in the belief that measurable events—including identity— have an essential quality which occur, and can be observed, “inside humans” (Smith, Harré & Van Langenhove, 1995, p. 14). From this perspective, the researcher is thought to be able to be a detached and independent observer (Olseen 1991; Riessman & Speedy, 2007) capable of discovering knowledge about their research subject, where the researcher’s observations are indicative of some “essential nature” (Kenwood, 1999, p. 177) of the subject of which they are studying. This study of identity—understood as: (1) something internally located inside the individual, (2) something possessing a quality of essentialism, or an essential sameness that is stable across time, and (3) something that can be viewed by a neutral outside observer—became solidified within the psychological literature in a major way due to the research of psychoanalyst Erik Erikson (Gleason, 1983). While Erikson’s work perpetuated the belief in the ability of a detached researcher to discover a subject’s true “essence” as per their identity (Gleason, 1983), his influence also popularized research designs that were dependant on participants’ individually constructed accounts of themselves, whereby identity is solely portrayed through the research participant’s individually constructed account (Côte, 2018; Erikson, 1968). This view of the

study of identity as an individualized solely “internalized and [sometimes] evolving” (McAdams, 2001, p. 100) phenomenon is seen both in studies within developmental psychology, and in the field of mental health more generally. Broadly linked, these studies perpetuate this understanding that the construction of a participant’s identity is an individualized process of meaning making or storytelling rather than a product of relationship and dialogue.

2.3.2 Identity as Solely Constructed Within Developmental Psychology

Studies of identity within the field of developmental psychology frequently construct participant identity through individualized accounts of meaning making or storytelling via self report questionnaire and/or semi-structured interview (Adler et al., 2015; Becht et al., 2017; Carlsson et al., 2015; Carlsson et al., 2016; Hatano & Sugimura, 2017; McLean & Pratt, 2006; Negru-Subtirica et al., 2016; Pop et al., 2016; Syed & Azmitia, 2008; Syed & Azmitia, 2010; Zayas, 2001).

Such individualized accounts of identity construction are particularly prominent in longitudinal studies within developmental psychology. For example, a mixed methods longitudinal study of identity development of 144 children in Gothenburg, Sweden collected nine waves (interviews) of data from participants from the time they were 1-2 years old until the age of 29 to better understand how these participants reconstructed their identities in their late twenties, and how participant identity narratives became more stable over time (Carlsson et al., 2015). Participant identity constructions surrounding these topics were presented as an individual participant construction independent of the researchers who were involved in the study. However, Carlsson et al. (2015) did not disclose what questions they asked participants in these interviews nor why particular categories of occupation, romance, parenthood, work and family

were chosen in relation to better understand a person's identity. In addition, it was unclear what a first wave of data interviews looked like with these participants as young children.

Two separate longitudinal studies both explored the relationship between narrative identity (the constructing and telling stories of one's experience) and the mental health of two groups of participants: 89 adults in their mid to late 50's, and a second group of 27 adults in their late 50's to early 60's (Adler et al., 2015). In the first study, the 89 adults in their mid to late 50's each engaged in a 2–3-hour semi-structured life story interview, while in the second study participant identity narratives of participants with major physical illnesses were traced over a period of four years. In both cases Adler et al. (2015) found participants with identity narratives containing themes of fighting, agency and redemption showed greater mental health overtime compared to those that did not, suggesting that “particular ways of narrating one's life may play a protective role...in the wake of new [and] difficult experiences” (p. 492). Results from the first study found participant identity narratives with themes of redemption and agency were associated with more positive mental health, while results from the second study found similar themes associated with a positive mental health trajectory among participants fighting a major physical illness (Adler et al., 2015). However, it was unclear as to what specific questions Adler et al. (2015) asked in these semi-structured interviews to produce such identity narratives from participants.

McLean and Pratt (2006) conducted a longitudinal study focused on the development of identity for late adolescents as they turned into emerging adults with 896 adolescents from 16 high schools in central Ontario, Canada. The study focused on turning points in the development of adolescent identity using a 24-item Objective Measure of Ego Identity Status (OME-IS) questionnaire. After initial completion, the OME-IS was completed again by participants at two

and six-year intervals and focused on whether a person's identity was achieved in "the domains of occupation, religion, and politics" (McLean & Pratt, 2006, p. 717). The final OME-IS measure at the six-year mark also contained a turning point narrative where participants were "asked to write about an important transition or change with respect to their understanding of themselves, which constituted the turning point narrative" (McLean & Pratt, 2006, p. 716) related to their identity. Of the original 896 participants 200 completed the OME-IS at the six-year mark as well as the turning point narrative. McLean & Pratt (2006) found that meaning making was an important component in participant's turning point narratives related to their identities. However, it was unclear as to why the OME-IS and the specific categories of occupation, religion and politics were chosen to be explored with identity in these adolescents, and why this was paired with this turning point narrative at the end of the study.

2.3.3 Identity as Solely Constructed in General Mental Health Research

Outside of longitudinal studies within developmental psychology, the study of identity within mental health research more generally has also understood identity in a similar way as solely constructed by the research participant through individualized meaning making or story telling rather than as co-constructed through relationship and dialogue (Adler, 2012; Adler et al., 2012; Adler et al., 2016; Cho & Park, 2015; Crocetti et al., 2008; Cruwys & Gunaseelan, 2016; Dingle et al., 2015; Eaves, 2015; Lillevoll et al., 2013; Marcia, 2006; McAdams et al., 2013; Papa & Lancaster, 2016; Probst, 2014; Westen et al., 2011; Yip, 2014).

For example, this has been the case in research that explored the identity construction of chronic pain sufferers (Eaves, 2015), and in a study of the identity of social workers dealing with a chronic mental illness (Probst, 2014). Semi-structured qualitative interviews were conducted with 90 participants between 18 and 70-years-old in Tucson, AZ and Portland, OR about their

identities as chronic pain sufferers and their use of over-the-counter (OTC) pain medication (Eaves, 2015). Results from these interviews showed how participants constructed a “stigmatized other through which to define oneself as a ‘normal’ and ‘stoic’ person living despite pain [and] was a central theme in these participant narratives about pain medication. Key to this construction was the stance that OTC medication was not ‘real’ pain medication and therefore not harmful” (Eaves, 2015, p. 150). Yet again this study gives no sense as to what questions that the researcher asked interviewees to elicit these responses and particular identity constructions from participants.

Probst (2014) conducted a study of the identities of social workers who were living “in the hyphen, having received psychiatric diagnoses and/or been in therapy themselves” (Probst, 2014, p. 25) with 30 clinical social workers through their participation in hour long interviews. Probst (2014) found that social workers “who had received psychiatric diagnoses reported more enduring and pervasive struggles affecting [their] identity” (p. 28) with themes emerging about straddling their identity as a social worker and as a psychiatric patient from interviews that included “the benefits of the treatment/client experience on one’s professional work...the challenges of that experience...the question of whether, how, and when to disclose; and...the effect of the experience as a clinician on subsequent ability to enter the client role” (Probst, 2014, p .29). Yet again, with these interviews the researcher presented no sense of what these interviews looked like between researcher and subject and how the researcher’s questions contributed to the themes that emerged in participant answers about these identities. While more current research in developmental psychology and mental health research more generally, as well as historical psychological research has presented the study of identity as something that is solely constructed by the research participant and something that can be neutrally observed by the

researcher via interview, survey, or questionnaire, there has been a shift in social constructionist mental health research that has characterized the study of identity as something that is co-constructed between participant and researcher in dialogue and as a function of relationship.

2.4 The Study of Identity Co-Construction Within Social Constructionist Research

While the study of identity has historically been understood as an individually constructed phenomena created solely by the research participant, there has been a growth in research that takes a social constructionist bent towards the study of identity that understands participant identity as a co-constructed phenomenon emerging as a function of relationship and dialogue between researcher and participant or between research participants (Blume, 2010; Cloute et al., 2008; Dalberg et al., 1999/2007; Fivush et al., 2010; Gallardo & Mellon-Gallardo, 2007; Gini et al., 2007; Larsen, 2008; Parker-Rees, 2015; Radcliffe et al., 2016; Richards et al., 2016; Strong & Shadden, 2020; van de Van, 2020; Walstrom, 1999, 2000; Wang, 2015; Wever, 2015).

Gallardo and Mellon-Gallardo (2007) conducted an auto-ethnographic analysis of private and public language used between a stepmother and stepdaughter to understand how Gallardo's identity as a stepmother was co-constructed between herself and her stepdaughter (Gallardo & Mellon-Gallardo, 2007). While the auto-ethnography from the stepmother's perspective described her interactions with her stepdaughter in co-constructing this identity, the method presents a narrative account of the researcher's/stepmother's conversations with her stepdaughter rather than an actual transcript of these conversations. Thus, in reading the article it was hard to see how the two co-constructed Gallardo's identity as a stepmother as the analysis was skewed from the telling solely by the researcher herself.

Larsen (2008) conducted a study of how teenagers co-constructed their online identities on a Danish social networking website where focus group interviews were conducted with 15 and 16-year-old participants about their online identities (Larsen, 2008). Focus group interviews underscored the importance from the teens of being sincere when presenting their online identities and not being a “faker” (Larsen, 2008, p. 8). Additionally, Larsen’s (2008) use of ethnographic field notes highlighted how research participants co-constructed each other’s identities on this website, as friends would post loving messages on each others’ profile pages that were public and not hidden. Results found that friends helped co-construct each others’ online identities, with some even having their friends help design and edit a friend’s profile on the site. This was done in such a way that participants were reflected on this site in the most positive manner without being self-centred (Larsen, 2008).

van de Ven (2020) conducted an observational study of seven support groups for trauma survivors producing forty-one transcripts that were thematically analysed to better understand the co-construction of participant identity narratives following trauma. van de Ven (2020) studied how the interaction between group participants led to better understanding of how identity change and reconstruction was “collectively done” (p.1). These seven groups included three groups for adult survivors of childhood sexual abuse, one group for parents of children who were sexually abused, one group for parents who lost a child by suicide, one group for people who lost a partner to suicide, and one group for parents who lost a child to a traffic accident. Group members met for six meetings for 2.5 hours a time with four to nine participants in each group. Thematic analysis of transcripts focused on how individual participant identities were reconstructed together through peer support in these groups which led to a “cocreation of a recovery narrative, an[d] identity shift” (van der Ven, 2020, p. 1835). In this study van der Ven

(2020) showed excerpts of group sessions to present the back-and-forth between group facilitators and participants and how identity re-construction occurred. While narrative therapy takes a similar social constructionist stance (Freedman & Combs, 1996), understanding client identity as co-constructed and occurring as a function of relationship and dialogue, narrative therapy also views client identity as influenced by the broader conversation at large through the philosophy of poststructuralism.

Prior to discussing how narrative therapy research draws on social constructionist and poststructural philosophy in the study of client preferred-identity co-construction, I will first discuss the practice of narrative therapy more generally as related to client-preferred identity co-construction. In what follows I will present: (1) the typical narrative session structure that follows a problem-preference sequence, and (2) common narrative practices that occur within this sequence that support client-preferred identity co-construction.

2.5 Narrative Therapy: Typical Session Structure and Common Narrative Practices

2.5.1 Typical Narrative Session Structure: The Problem-Preference Sequence

While there are no hard and fast rules as to how therapists should engage in its practice, narrative therapy is typically portrayed sequentially, following a problem-preference sequence (White, 2007). The first part of this sequence is devoted to the therapist and client exploring the effects of a client's problem (White, 2005). Typically, clients present at sessions with problem-saturated descriptions of their lives, where the problem in question "embodies the person's present 'dominant story' of [their] life" (Payne, 2006, p.11), and which, in this first stage, the therapist and client discuss in depth. While the narrative therapist takes the client's problem-saturated description of life "seriously and accepts it...at the same time [they assume] that it is not likely to be the whole or only story...which reflects more accurately the idea that an initial

‘story’ inevitably omits certain forgotten or unnoticed elements of the person’s life” (Payne, 2006, p. 11), speaking to an underlying assumption in the work that clients can have an alternate or preferred identity story developed as a result of minimizing or reducing the influence of a dominant problem story. As a result, the second part of this sequence then focuses on the development of preferred developments (also called unique outcomes) (Madigan, 2019; Morgan, 2000) which are “events that stand against the problem’s influence” (Morgan, 2000, p. 51) that the therapist seeks to explore and expand with the client over the remaining course of their time together and that are more in line with clients’ preferred identities.

White (2005) has more formally termed this problem-preference sequence the Statement of Position Maps 1 and 2, respectively. The Statement of Position Map 1 engages narrative therapists with clients in a line of questioning that seeks to: (1) generate a client’s experience-near definition of the problem they are faced with, e.g. the client reports that depression takes their ability to focus away from them, (2) map the effects of this problem across several domains of the client’s life, e.g. how does the depression’s ability to “*take focus*” show up in the client’s home, work, and/or school life?, (3) have the client evaluate the effects of the problem across these various domains, i.e. “*How do you feel about the fact that depression ‘takes focus’ from you while at school?*”, and (4) have the client justify these evaluations, i.e., “*Why is/isn’t the depression’s ‘taking focus’ okay for you?*” Following this, White’s (2005) Statement of Position Map 2 repeats this exact line of inquiry as noted above but replaces all references to client problems with client preferences/preferred developments/unique outcomes. This problem-preference sequence is followed for several reasons.

First, it is partly about wanting to make sure that the person feels heard and provides an empathetic ear to a person’s sharing of their distress. Doing so provides an alternative to the

therapist jumping in too quickly to solution talk in a manner that might lead the client to feel unheard or to feel that their struggle is being underestimated. Second, as clients are often immersed in problem saturated stories at the beginning of their sessions, further exploration of the client's problem reflects a theoretical belief in narrative therapy that due to the power of a dominant problem discourse, clients may be unable to notice or name exceptions to their problems until given adequate time and space to explore them. Third, consolidating a description of a problem and its effects on a client will often lead to a conversational pivot where therapists support clients to "notice any event that contradicts the dominant [problem] story" (Carey & Russell, 2003, p. 3). Fourth, this sequence helps to consolidate client preferences as they are given an opportunity to survey the negative fallout of the problem and its impact on their preferred identity descriptions. Below I will discuss some of the more common narrative practices found within this problem-preference sequence and how these practices support client-preferred identity co-construction.

2.5.2 Common Narrative Practices

While not an exhaustive list, the following represent some of the more common narrative practices used by therapists when engaging with clients in this problem-preference sequence.

2.5.2.1 Externalizing Client Problems. Arguably the lynchpin of narrative therapy, externalizing is narrative's most well-known export, making "it possible for people to experience an identity that is separate from the problem; the problem becomes the problem, not the person" (White, 2007, p. 9). Externalizing allows narrative therapists to "use language embodying an implicit assumption that the problem is *having an effect on the person* rather than existing within or being intrinsic to [them]...The therapist says 'depression invaded your life' rather than 'you became depressed', or... 'You were both affected by stress' rather than 'You were

stressed.’...The aim is to help the person to separate [their] identity from [their] problems, and to conceive them as the product of circumstances or interpersonal processes rather than caused by [their] psychology or personality” (Payne, 2006, p. 12). Separating the person from their problem in this way encourages “persons to objectify and, at times, to personify the problems that they experience as oppressive. In this process, the problem becomes a separate entity and thus external to the person or relationship that was ascribed as the problem” (White & Epston, 1990, p. 38).

2.5.2.2 Deconstruction. Closely related to externalizing is the practice of deconstruction—a taking apart, or deconstruction, of “the beliefs, ideas and practices of the broader culture...that are serving to assist the problem and the problem story” (Morgan, 2000, p.45). Introduced by French philosopher Jacques Derrida, deconstruction “generally tries to demonstrate that any text (story) is not a discrete whole but contains several irreconcilable and contradictory meanings...[and] therefore, has more than one interpretation” (Madigan, 2019, p. 165). As applied to narrative therapy, the practice of deconstruction is one where the therapist “listens for any assumptions about life or relationship that may be in the interests of the problem and seeks to inquire about them” (Morgan, 2000, p. 47) and contributes to identity conclusions unaligned with persons’ values and purposes. For example, “two people who have come to therapy to consult a counsellor to talk about ‘sexual difficulties’ in their relationship. In this situation, both partners will come to therapy with particular beliefs and ideas about sexuality and relationships, influenced by ideas of the culture in which they live” (Morgan, 2000, p. 46). In this case, through deconstruction the therapist would explore how

either or both partners may be being influenced by particular assumptions about what constitutes a ‘healthy’ relationship. These might be based on individualistic or gendered assumptions. The therapist may ask questions about the history of these

beliefs and their effects on the life and relationships of the person consulting them (Morgan, 2000, p. 47).

As such, the practice of deconstruction allows for “the cultural beliefs that have assisted the problem to come into the person’s life, and the beliefs and ideas that are assisting in sustaining the life of the problem, [to] become more available for questioning and challenging” (Morgan, 2000, p. 45). This practice in particular supports narrative therapists in making visible “the effects of dominant discourses” (Monk & Gehart, 2003, p. 26) “by asking about [the] contextual influences” (Freedman & Combs, 1996, p. 68) of the problem on the person’s life and vice versa (Freedman & Combs, 1996).

2.5.2.3 *Soliciting Experience Near Descriptions.* The narrative therapy practice of therapists obtaining an experience near description from clients runs counter to normative and expert driven traditions that supplant persons’ voices. This practice enables the expression of persons’ local knowledge—their unique, context-specific experience—through narrative therapists using “the parlance of the people seeking therapy...based on their understanding of life (developed in the culture of their family or community and influenced by their immediate history)...[where] people’s unique knowledges, and skills become relevant and central to taking action to address their concerns” (White, 2007, p. 40). In soliciting such experience near descriptions, therapists seek to privilege their client’s local knowledge, meaning “therapists privilege the voices of the people consulting them in the attribution of meaning to selected events of their lives, in their interpretation of the links between these events and the valued themes of their lives, in the deduction about what this reflects in terms of what is important to them, and in their conclusions about what this suggests about their own and each other’s identities” (White, 2007, p. 82). As noted above, this narrative practice can be found in both statement of position maps as per related to a client’s experience of their problem or countering preferred

development. Soliciting experience near descriptions of a client's preference, preferred development, or preferred experience early on when engaging with the Statement of Position Map 2 can lay the groundwork for the further development of these preferences into thicker descriptions of preferred identity. For example, if the client states that while they currently feel depressed they have a preference to feel happy, the therapist may ask what happiness means to them.

2.5.2.4 Positioning. Another narrative practice that can be found on both sides of the problem-preference sequence, positioning is a narrative practice which “establishes a context in which people...can be radically consulted about what is important to their lives. It is in the context of such consultation that people find opportunity to define a position on the problems of their lives and to have a stronger voice about the foundation of their concerns...[where] the therapist is not the author of people's positions on the problems and predicaments of their lives...[but] provides people with an opportunity to define their own position in relation to their problems and to give voice to what underpins them” (White, 2007, p. 39). Therapists invite clients to literally take a position on the influence of the problem on their life, or support to be literally positioned away from their problems and/or in line with their preferences. As a result, clients usually “decide to position themselves differently in relation to the problem and bringing this specific commitment into a verbal form assists them to embed the decision rather than for it to remain nebulous” (Payne, 2006, p. 14). For example, if I come to therapy because I struggle with depression, when engaging me in this practice of positioning, the narrative therapist may ask what do I think about the fact that depression keeps me bed-ridden for several days of the week? Is this a welcomed or unwelcomed development? Similarly, the therapist can engage me in positioning concerning a preferred development i.e. What is my position on the fact that

despite the depression's influence on certain days I can get out of bed? Is this a welcomed or unwelcomed development in my opinion? In this sense, our preferred identity can be understood as inscribed in the stances (and related actions) we take into all we encounter.

2.5.2.5 Re-Authored Conversations. The bulk of narrative practices that reside in the preference portion of the problem-preference sequence (Statement of Position Map 2) and concern themselves with the development of re-authoring conversations (Parry & Doan, 1994; White, 1995, 2007) which

involve the identification and co-creation of alternative story-lines of identity. The practice of re-authoring is based on the assumption that no one story can possibly encapsulate the totality of a person's experience, there will always be inconsistencies and contradictions. There will always be other story-lines that can be created from the events of our lives. As such, our identities are not single-storied – no one story can sum us up. We are multi-storied. Re-authoring conversations involve the co-authoring of story-lines that will assist in addressing whatever predicaments have brought someone into counselling (Carey & Russell, 2003, p. 2).

Narrative practices that support the development of re-authoring conversations between client and therapist include thickening, exploring the meaning and values behind specific client actions, and tracing the history and influence of client preferred qualities.

2.5.2.5.1 Thickening. The narrative therapy practice of thickening is one where therapists help people “to bring forth and thicken stories that do not support or sustain problems and are more aligned with client preferences/preferred identities. Through the thickening of “alternative story lines of client lives that...become visible as thin traces” (Madigan, 2019, p. 173), which can then counter the initial problem-related talk typically seen in the first half of sessions (White, 2005). For example, if I report that depression has left me bed-ridden everyday for the past week, yet despite the depression's weight I was still able to get up and feed my dog, this act of taking care of my dog despite the weight of the depression would be an alternative story-line emerging as a thin trace that the narrative therapist would want to thicken. In doing so

with the therapist, I may “begin to inhabit and live out the alternative stories...[and] live out new self images, new possibilities for relationships and new futures” (Freedman & Combs, 1996, p. 16).

2.5.2.5.2 Inviting Reflection on the Meaning and Values Behind Specific Client

Actions. The narrative practice of inviting clients to reflect on their values and meanings that drove particular actions, allow therapists to become interested in how client preferred developments are tied to “intentional states of identity...[which] explore the intentions, hopes, values and commitments that shape people’s actions” (Carey & Russell, 2003, p. 9) and which contrast internal states of identity. In so doing therapists can take a more active role “weave[ing] between questions asking about the landscape of action (what happened) and the landscape of identity (the meaning of what happened)” (Freedman & Combs, 2016, p. 222) with the idea that “[w]hen someone takes a new action, they are in a position to draw new meaning about their identity...from which they can derive further new identity claims” (Freedman & Combs, 2016, p. 222) and give clients the chance to reflect and “employ [their] meaning making resources” (White, 2007, p. 61). For example, I tell my therapist that I have a particularly stressful job where I often take my work home with me. I am glued to my phone, and answer emails late into the evening at the expense of paying attention to my young children. However, I also report to my therapist that one day, despite a particularly stressful meeting with my supervisor, I was able to leave my stress from work at the door when I returned home. I shut my phone off, played with my children, and gained a newfound sense of relief from my work stress from these interactions with my kids. From this the narrative therapist may ask what my decision to turn my phone off and be more fully present with my children says about who I am? What does this action tell me

about what I value? What does this value that I hold say about the kind of person I'm striving to become while I interact with my children?

2.5.2.5.3 Tracing the History and Influence of Preferred Qualities. Another narrative practice that supports to re-authoring conversations is that of the client and therapist tracing the history and influence of a client's preferred quality. Clients and therapists trace "the history of these qualities: explore how they came to be meaningful to the person...and link[ed] them to the person's values, hopes and commitments" (Carey & Russell, 2003, p. 9). Preferred developments/unique outcomes "are the doorways or openings to new and different stories...[t]he therapist attempts to trace the history of the unique outcomes, firmly ground them, make them more visible, and link them in some way with an emerging new story" (Morgan, 2000, p. 59). For example, adding to the previous example of my decision to turn my phone off and be more fully present with my children after work, my therapist and I may further uncover that this decision was driven by my preferred quality of "respect" i.e. I want to show my children that it is an important sign of respect to give your full attention to others, and I want to model that to them based on my interactions with them. The therapist may then wish to trace the history and influence of this quality of "respect" in and on my life. How long have I held this value of respect in my life? Who taught me that this was an important value to have with others? When did I start showing respect to others in a similar way to how I am now with my children? What made this an important value throughout my life?, etc. These questions would seek to bolster my preferred identity of being someone who is respectful of others, by tracing the history of this preferred development in my life.

2.5.2.6 Re-Membering Conversations. Re-membering conversations "can contribute significantly to richly describing the history of alternative stories. Significant figures in a

person's life are often the holders of memories of events in which the person consulting the therapist displayed certain skills, traits, and abilities" (Morgan, 2000, p. 78). As narrative therapists begin "to discover an event or events that stand outside of the problem's influence...they are curious to discover as much as possible about them...*Who else would know about this? Who else would know what this person stands for?*...The therapist wonders this because they are trying to identify the people who may be knowledgeable about this different story of this person's identity" (Morgan, 2000, p. 78) who have witnessed the client's preferred identity.

Additionally, the practice of re-membering is commonly used in narrative therapy to support a person with the death of a loved one, seeking to "strengthen a sense of what is not lost, with what gives comfort through being recalled and folded back into the lives of the living. Re-membering affirms the life of the deceased, rather than point[ing] to his or her absence. It takes advantage of the sense in which a person can be brought to life again through the stories told about them. Bereaved people often enjoy, and are comforted by, the chance to treasure moments of connection with a dead loved one" (Hedtke, 2014, p. 12).

2.5.2.7 Externalizing as Related to Preferred Developments/Unique Outcomes. While externalizing was previously noted to be used as a problem-focused narrative tool, in addition, externalizing conversations can also be used to externalize the more positive and preferred aspects of a person's life. Therapists can be tempted "sometimes just to internalise the good things. When someone says, 'I have good self esteem' and they are proud of this, sometimes it's tempting just to leave this alone. But... externalising 'the good things' means that these can become 'more richly described'" (Carey & Russell, 2002, p. 9). For example, if a client notes that despite recently being laid off they were surprised to find a sense of growing self esteem as

they apply for new work, the narrative therapy may inquire, “*How have you been able to nurture the self esteem through these more recent work-related challenges? Has the self esteem ever been challenged like this before either in the past or in other areas of life? If so, how have you and the self esteem gotten through this together? How do you support it and how does it support you?*”

2.5.2.8 Collaborative Documentation. The narrative therapy practice of collaborative documentation is one where therapists “transparently and deliberately” (Speedy, 2004, p. 25) introduce written documents into their sessions “sometimes creating them...and sometimes encouraging the person to create them. These documents summarize the person’s discoveries and describe the person’s own perceived progress...Their use as a device for consolidation is based on recognition that the written word is more permanent than the spoken word and, in Western society, carries more authority—here, the authority of the person rather than that of a professional” (Payne, 2006, p. 15). Examples of such collaborative documentation could be summaries of the session written collaboratively by both the therapist and client, letters of redundancy written by clients and therapists to a client’s externalized problem, and letters of therapist reflection to clients in-between sessions (Morgan, 2000; Payne, 2006) all of which support the documentation of client preferred identity.

2.5.2.9 Narrative Therapists Maintain a “Decentered and Influential” Therapeutic Stance. Despite the many narrative practices listed above, when following this problem-preference sequence narrative therapy encourages therapist fidelity to an overall therapeutic philosophy, or “way of being with the client” (Guilfoyle, 2014, p. 2), where therapists hold a narrative stance of being decentred and influential (Gaddis, 2016; White, 2005) rather than allegiance to any particular set of therapeutic practices.

The narrative stance of therapists being ‘decentred’ means that therapists seek to privilege the client’s own local knowledge and voice over the therapist’s expert knowledge (White, 2007), and influential meaning that narrative therapists seek to build

a scaffold, through [their] questions and reflections, that makes it possible for people to: a) more richly describe the alternative stories of their lives, b) step into and to explore some of the neglected territories of their lives, and to c) become more significantly acquainted with the knowledges and skills of their lives that are relevant to addressing the concerns, predicaments and problems that are at hand (White, 2005, p. 9).

To avoid running the risk of replacing a client’s problem identity with a therapist-constructed version of client identity, therapists respond to invitations to speak about preferences from clients following an in-depth exploration of the client’s problem.

While much of narrative practice is about supporting re-authoring conversations that help to develop client-preferred identity from a social constructionist stance, narrative therapy is also aligned philosophically with poststructuralism which views the co-construction of identity as occurring amidst a backdrop of powerful cultural discourses which shape this process. This poststructural influence that considers the broader conversation at large appears not only in the clinical practice of narrative therapy, but also in narrative research.

2.6 Narrative Therapy, Co-Construction, the Conversation at Large, and Research

2.6.1 Narrative Therapy, Co-Construction, and the Conversation at Large

As noted in the introduction of this chapter, narrative therapy is influenced by both social constructionist and poststructural philosophies, each of which has a different take on client identity. While I will discuss both philosophies in greater depth in the next chapter, for now I will briefly touch on these ideas to give context to the research on brief narrative single session therapy and client-preferred identity co-construction that I will present below. As previously noted, social constructionism, a philosophy comprising narrative therapy, understands client

identity as something that is co-constructed between the client and therapist through a back-and-forth of dialogue that is “relational”, “fluid”, and “co-evolving” (Combs & Freedman, 2016, p. 221). While social constructionism focuses on a micro understanding of identity; as something that is co-constructed in the back-and-forth of conversation, poststructuralism takes a macro approach understanding identity as constructed by the larger cultural and social discourse—the conversation at large as it were. From the poststructural perspective, client identity is mediated through expressions that “are shaped by the surrounding dominant cultural context” (Madigan, 2019, p. 38). In this way the therapy room “is a mirrored room that can reflect back only the discourses brought to it by the [client] and therapist...provided by the dominant discourses of the language community and culture” (Hare-Mustin, 1994, p. 19). While differing in their perspectives, the social constructionist and poststructural influence have both appeared in narrative therapy research (Kogan & Gale, 1997).

Kogan and Gale (1997) analyzed a recorded session between narrative therapy founder Michael White and a couple, using conversation analysis (CA), a social constructionist methodology exploring the back-and-forth of language between the couple and White. In addition to the micro focus used to analyze the session, Kogan and Gale (1997) also focused on the broader social, or macro, context of talk and how broader discourses influenced the more nuanced conversation between the couple and therapist. In particular, Kogan and Gale (1997) found how the couple’s language was influenced by the broader cultural discourses of masculinity and femininity, how these broader discourses affected how they described themselves as a couple, how they described their relationship in general, and how these discourses appeared in the back-and-forth of conversation between the couple and White. They found, for example, how in one instance when the wife gave up her turn to talk, the husband took

this turn, changing the narrator to one where the husband became the primary focus. Kogan and Gale (1997) noted how this example mirrored the dominant cultural narrative of the white, heterosexual relationship, and how White attempted to “de-centre” this dominant cultural discourse throughout the rest of the session.

While Kogan and Gale (1997) analyzed both the micro and macro aspects of talk within White’s recorded single session with this couple, the session itself was not initially recorded for research purposes. Rather, the session was recorded at a national family counselling conference where the couple was interviewed by White and two other therapists over a three-day period in front of an audience. Following the conference videotapes of this session were made available for commercial sale (Kogan & Gale, 1997). While an initial teaching tool created for therapists, that would be later used by Kogan and Gale (1997), this study was not an example of brief narrative single session therapy research in-and-of-itself. However, there is a growing body of brief narrative single session literature that addresses the specific use of brief narrative single session therapy via walk-in clinics and how its use in these settings supports client-preferred identity co-construction.

2.6.2 Demonstrations of Client-Preferred Identity Co-Construction in Brief Narrative Single Session Therapy

Brief narrative single session therapists Young (2008) and Cooper (2014) each presented accounts of their own sessions via walk-in clinic where both therapists helped their respective clients to co-construct that client’s preferred identity. Young (2008) presented a detailed account of a single session that she had with an eight-year-old boy who suffered from anxiety. In the session they countered his internalized problem identity of anxiety through the co-construction of this client’s “preference” (Young, 2008, p. 55) in relation to this problematic identity. Similarly,

Cooper's (2014) account of his own walk-in session with a 14-year-old suicidal male described how he supported this client in co-authoring/co-constructing his "preferred identity" (p. 24) by countering feelings of helplessness and suicidality and co-developing a counterstory of "self-redefinition counter to a limiting internalized understanding of one's self...to witness and respond to revived preferred identity" (Cooper, 2014, p. 23).

Both authors highlight the narrative practice of externalizing (White & Epston, 1990) in their respective articles. Young's article included several excerpts of transcripts detailing how she externalized the worry/anxiety from the boy's identity so that this worry was "no longer tied to who he...[was] as a person" (Young, 2008, p. 57), enabling him to make "a strong statement of his preference in relation to this Worry" (2008, p. 69) which was, in his words, to "lower down the Worry" (Young, 2008, p. 69). Comparatively, Cooper's (2014) article did not present transcripts of how this occurred in session. Instead, he narrated his own account of the progression of his session with his client while additionally weaving in questions to readers (who are presumably also brief narrative therapists) as to how they too can ask similar questions of clients in their own sessions.

While both articles unpack some successful work, these were not research studies of preferred identity co-construction per se. Young and Cooper's accounts of their walk-in sessions can be more accurately described as demonstrations of brief narrative single session method in action—as teaching pieces used to pick apart their own work for the benefit of other clinicians attempting to have roughly similar conversations—and not research studies of how client-preferred identity co-construction occurs within brief narrative single sessions.

2.6.3 Studying Client Preferred Identity Co-Construction From Both a Social Constructionist and Poststructural Perspective

While Young (2008) and Cooper's (2014) articles do a good job of looking at the back-and-forth of conversation from this social constructionist perspective, their analyses do not extend to the conversation at large—the poststructural strand of narrative therapy that explores wider cultural discourses and how these either constrain or facilitate the co-construction of client preferred identity. As both articles focus on the micro level of client-preferred identity co-construction without considering the broader cultural meanings impinging on this process, my dissertation seeks to specifically study the co-construction of client-preferred identity in a way that addresses both social constructionist and poststructural perspectives. Thus, in my study I am setting out to keep both the micro and macro dimensions of client-preferred identity construction visible by attending to exchanges in the room utterance-by-utterance, while simultaneously watching out for broader cultural discourses influencing the process. To do so, I will analyze five appointment based brief narrative single sessions of therapy from both a social constructionist and poststructural perspective. In the next chapter, “Theoretical Foundations and Conceptual Framework”, I will go into greater depth about how these social constructionist and poststructural philosophies converge within the clinical practice of narrative therapy, how both understand client-preferred identity, and how both understand the process of client-preferred identity co-construction within brief narrative single session therapy.

2.7 Chapter Summary

While single session therapy's history parallels that of psychotherapy more generally, its unintentional discovery in 1980's Northern California as a model of psychotherapy service delivery embraced by clients led to over 30 years of both clinical and research related growth.

Influenced by the brief therapy movement, and in particular the philosophy of social constructionism, single session therapy has seen an uptake in its use as a cost-effective form of psychotherapy used to increase public access to mental health services across the globe. In recent years, Ontario, Canada, has seen an increased use of brief narrative single session therapy offered at public mental health agencies across the province via walk-in counselling clinic and pre-booked appointment. While brief narrative single session therapy holds a social constructionist view that a client's preferred identity is something that can be co-constructed between the client and therapist within their brief time together, narrative therapy also holds a poststructural stance that the development of client-preferred identity occurs amidst the backdrop of culturally available dominant discourses. While narrative therapy and its understanding of client-preferred identity is based in the philosophies of social constructionist and poststructuralism, clinical examples of this work in the brief narrative single session literature highlight this social constructionist perspective at the expense of the poststructural perspective.

To that end, my next chapter "Theoretical Foundations and Conceptual Framework", will situate narrative therapy and its understanding of client-preferred identity co-construction in reference to both social constructionist and poststructural philosophies to lay the groundwork for how a blending of these philosophies will operate as this study's conceptual framework.

Chapter 3: Theoretical Foundations and Conceptual Framework

As previously noted, the practice of narrative therapy is theoretically influenced by both social constructionism and poststructuralism. As I am researching the co-construction of client-preferred identity in single session therapy with therapists who have been trained in brief narrative therapy, it will be vital to conduct this research in a way that draws on both theoretical perspectives. This will be important for two key reasons. First, an overview of the theoretical territory of the clinicians whose work is being examined will furnish readers with the vocabulary they will need for making sense of the findings. Second, integrating these theoretical perspectives into the study's conceptual framework will make it possible to analyze the material with the richness and nuance that it deserves. Thus, my aim for this chapter is to outline these two different theoretical perspectives before describing how their blending will serve as the basis for conducting this research. To do so I will divide this chapter into six parts:

First, I will describe the theoretical underpinnings of social constructionism and poststructuralism, describe each theory's take on the construction of knowledge and reality, and additionally describe each theory's understanding of the role of language, both in reference to the construction of the person, and in relation to the process of meaning-making. Second, as I am interested in how the concept of identity is constructed—in particular, preferred identity—I will discuss the concept of identity more generally as it is understood by both social constructionism and poststructuralism. Third, I will then turn to the concept of preferred identity, and how the construction of a person's preferred identity is reflected in the clinical practice of narrative therapy, as it draws on both social constructionist and poststructural schools of thought. Fourth, I will describe how a blending of social constructionism and poststructuralism will serve as the study's conceptual framework. Fifth, I will present my research questions and describe how my

blended social constructionist/poststructural conceptual framework will assist in answering them.

Sixth, I will present a chapter summary.

3.1 Theoretical Underpinnings of Social Constructionism and Poststructuralism

3.1.1 Social Constructionism: Knowledge, Reality, and the Process of Reification

Social constructionism notes that “rather than [being] grounded in an observable and definable external reality” (Burr, 2019, p. 118) any knowledge of the world is the product of human interaction. From this perspective, what is thought to be the truth about the world is dependent upon, and created through, our social relationships (Berger & Luckman, 1966). All our ideas, beliefs, practices, laws, customs, and habits making up “the social fabric of “reality” ...arise through social interaction over time” (Freedman & Combs, 1996, p. 23). Knowledge, from this perspective, “is not derived from the nature of the world as it ‘really’ is; rather, people construct [such knowledge] between them through their daily interactions” (Burr, 2019, p. 121). Through these interactions, people not only construct their shared versions of knowledge, but simultaneously construct reality as they live it (Burr, 2019).

However, this concept of reality is deceiving as people experience this social construction of knowledge as if it were some pre-given “objective reality” (Berger & Luckman, 1966, p. 60). This is due to the process of reification—a process by which the knowledges constructed as a result of social interaction are treated “as *if* they were something else than human products—such as facts of nature...Reification implies that man is capable of forgetting his own authorship of the human world” (Berger & Luckman, 1966, p. 89). Social constructionists note however, that reification seems to be an unavoidable necessity to communicate effectively. Without it, they argue, we “could take nothing for granted when we talk together” (Freedman & Combs, 1996, p. 22), always having to qualify and contextualize every statement we make. As such,

there does appear to be some benefit of experiencing the social construction of knowledge as objectively real through this process of reification. Yet, however unavoidable reification may be in the social construction of our knowledge, and experience of reality, social constructionists note that if left unchecked, reification becomes problematic. Through the process of reification, knowledges that are initially understood as being socially constructed become, over time, treated as if they are material (Berger & Luckman, 1966).

To help better understand this issue I will turn to the field of family therapy and the example of homeostasis. Within family therapy, the term homeostasis describes how a family system “over a period of time...develops certain repetitive, enduring techniques or patterns of interaction for maintaining its equilibrium when confronted by stress” (Riskin, 1963, p. 344). While this is a helpful social construct for therapists to draw upon in their work, if reified, it becomes problematic as it will significantly limit the therapist’s perception (Freedman & Combs, 1996). By treating the concept of homeostasis as if it were “part of some external, pre-existent reality” (Freedman & Combs, 1996, p. 25), it may control “the interactions of every family” (Freedman & Combs, 1996, p. 25) a therapist works with, rather than being a concept which may or may not inform treatment. Due to these concerns, social constructionists are understandably not “overly concerned with the nature of reality” (O’Reilly & Lester, 2017, p. 16). Dismissing any claims of objective truth in their construction of knowledge, they are instead interested in how knowledge is constructed “with language positioned as playing a pivotal role” (O’Reilly & Lester, 2017, p. 16).

From this perspective “[o]ur social interactions are capable of producing a variety of possible social constructions of events. What we regard as knowledge is, therefore, one possible construction among many” (Burr, 2019, p. 122). This influence of language on the social

construction of knowledge, and the reality we experience, has had a major impact within the field of psychology—in particular, social constructionist psychology—and in the process has challenged conventional psychology’s understanding of what it means to be a person.

3.1.2 Social Constructionist Psychology: Language and the Construction of a Person

While social constructionism has a long history in the disciplines of sociology, linguistics, and philosophy, it is relatively new as applied to the field of psychology (Burr, 2019). As many of the ideas making up social constructionism are based in sociology, and as the disciplines of psychology and sociology have been historically split since the early twentieth century, psychology has only more recently caught-up in its engagement with social constructionism (Craib, 1997). This engagement is usually dated from Kenneth Gergen’s paper *Social Psychology as History* (Gergen, 1973). Since emerging within social psychology in the 1970s and 1980s, social constructionist psychology presents a “radical challenge to mainstream psychology in both theory and research” (Burr, 2019, p. 118), challenging conventional psychology’s “individualistic, essentialist, and intrapsychic model of the person, [and] replacing it with a radically social account of personhood in which language is key” (Burr, 2019, p. 117).

As conventional psychology is modeled on the natural sciences, it “assume[s] the epistemological approach of positivism, the view that knowledge comes from objective, unbiased observation of the world and that there is a true or accurate description of people, events, and things that science endeavors to reveal” (Burr, 2019, p. 12). Social constructionist psychology takes a critical stance and contests such positivism. As language “is no longer understood to directly correspond to a segment of reality” (O’Reilly & Lester, 2017, p. 4), there is a destabilization of the “notion that language transparently paints a picture of the world” (O’Reilly & Lester, 2017, p. 4) including the language describing a person, or their experience.

Any description of a person is seen to be a construction of language—a knowledge or reality that speaks to this “constructive...function of language” (Burr, 2019, p. 124)—rather than as an objective, pre-existing, material reality.

For the social constructionist, it is through our language exchanges with each other “that people are constructed [for example] as mentally ill, [or] as masculine or feminine” (Burr, 2019, p. 124), and it is also through our language that we can change these constructions of ourselves and others. Such change invites the possibility of different constructions of who we are in our interactions with one another based on our language use. However, this process of the social construction of knowledge of a person through language use is more accurately described as a process of co-constructed meaning making (Gergen, 2015). Our understandings, or our understandings of our lived experience, including our experience of internal events, are always a function of relational meaning-making.

3.1.3 The Process of Construction: Language and the Co-Construction of Meaning

As social constructionism notes that any knowledge we have of the world, including knowledge of human beings, occurs between people, this also applies to the creation of meaning itself. Concepts that are all normally thought of as originating from within a person such as motivation, personality, attitudes, emotion (Burr, 2019)—even the very concept of the mind (Harré & Gillet, 1994)—are instead created between people through the co-construction of meaning surrounding these topics. This is a radical departure from mainstream psychology’s agenda “to discover universal principles of psychological functioning or ‘human nature’” (Burr, 2019, p. 121). Through this social constructionist challenging of “psychology’s individualistic, essentialist, and intrapsychic model of the person...structural features of the human psyche [are instead given a radically social account] ...achieved through social interaction and language”

(Burr, 2019, p. 118). Viewed this way, the act of meaning making itself, like any socially constructed knowledge, is not something that is located within separate individual bodies, but rather, is something that occurs between people and through language. Thus, from this perspective

meaning is not “in the head”...When you failed to hear me, my words mean nothing. My words only came into meaning when you said something in reply. And at that, their meaning could go in many directions, directions over which I have little control. In affirming my statement, you gave it life; in questioning it, you reduce it to a mistake. *At the same time*, however, your response only had meaning in light of what I said...You needed my words to make sense at all. In effect, neither of us can make meaning alone; it is in the coordination of our actions—or *co-action*—that meaning is born, sustained, or dies. The process of co-action is not simply an exchange of words alone. As we coordinate movement together we are also co-creating meaning (Gergen, 2015, p. 112).

This social constructionist idea of the co-construction of meaning has been highly influential on the practice of narrative therapy (Doan, 1997), which views therapy conversations as practices of conjoint meaning making where the client and therapist work together, through language, to co-construct meaning of a client’s experience. However, in addition to the influence of social constructionism, narrative therapy is also heavily influenced by the theory of poststructuralism (White, 1993; White & Epston, 1990).

3.1.4 Poststructuralism: A Reaction Against Structuralism

While social constructionism and poststructuralism overlap in many significant ways, narrative therapy is more often identified as poststructural (Combs & Freedman, 2004, 2012; Drewery & Monk, 1994; Tarragona, 2008;). Poststructuralism, a philosophy with roots in France, originated in the 1960s in response to another philosophy—structuralism—an intellectual movement that began in the 1950s and which rose in popularity through the 1960s and 1970s (Lundy, 2013). Structuralism sought to understand human activity scientifically by finding the so-called underlying rules, elements, and laws that govern human behavior (Dreyfus

& Rabinow, 1982/2013). Structuralists claim that human behavior is the result of structures—“‘real’ things underlying surface appearances” of human behavior (Combs & Freedman, 2012, p. 1035) that are generalizable, universal, and can be known and studied scientifically (Lundy, 2013). Structuralism’s rise coincided with the post-World War II rise of the social sciences, and the overall quest for “scientificity” (Lundy, 2013, p. 70) in the study of human behavior more generally.

Structuralism has been applied to a variety of disciplines (Lundy, 2013) including structuralist anthropology, as seen through the work of Levi-Straus, a professor of social anthropology who studied the indigenous peoples of South America (Belsey, 2002), and Jacques Lacan, a structural psychoanalyst who reinterpreted Freud with elements of linguistics and anthropology (Belsey, 2002). Structuralism’s search for the underlying structures of the object of its inquiry suggests a belief in the ability to know the underlying reality of the object in question, the goal being “to reconstitute an object in such a way as to reveal the rules by which the object functions” (Barthes, 1964, p. 214). Whether the object in question is an individual, as seen in Lacan’s structuralist psychoanalysis (Lundy, 2013), or a group, as seen in Levi-Straus’ structuralist anthropology (Lundy, 2013), human behavior from this perspective is understood to have “essential, [and] stable characteristics that can be grouped” (Combs & Freedman, 2012, p. 1035). Yet poststructuralists do not share this understanding. In reaction to these claims of the existence of underlying structures of knowledge, poststructuralists argue that structuralist claims of knowing governing principles of human behavior are produced (rather than innate) forms of knowledge (Davis, 2004). Like social constructionists, poststructuralists note that such knowledge is the result of a process of socially constructed meaning making. However,

poststructuralists also note that this process of socially constructed meaning making is influenced by our broader cultural discourse.

3.1.5 Poststructuralism: Language and the Politics of Meaning Making

To the poststructuralist, socially constructed meaning making is a product of the broader cultural meanings that “we learn and reproduce” (Belsey, 2002, p. 4). From this perspective language works only on the condition that we use it appropriately by “subscribing to the meanings already [found within it]” (Belsey, 2002, p. 3). For example, to correctly use the language of psychoanalysis suggests an understanding of the meanings of certain words such as “‘unconscious’, ‘repression’, [and] ‘transference’” (Belsey, 2002, p. 3). The pre-existent meanings of these words “are not ours to command” (Belsey, 2002, p. 4) but rather “inculcate obedience to the discipline inscribed in them” (Belsey, 2002, p. 4). As pre-existent meanings are embedded throughout our everyday language use, language transmits “the knowledges and values that constitute [our] culture” (Belsey, 2002, p. 4). Yet, the process of learning and reproducing these pre-existent meanings is one that is highly political and fraught with unequal power relations (Bruner, 1986). Meanings are always contested, and which ones dominate is a function of power differentials. These ideas are further developed in the writings of French philosopher Michel Foucault. As Foucault depicts this process of meaning making as it unfolds in our day-to-day lives, he contextualizes it as one that is political, steeped in power relations, and grossly inequitable.

3.1.6 Foucault: Dominant Discourse and the Process of Meaning Making

Michel Foucault played a large part in introducing the significance of discourse and power to lived experience. Through detailed historical study, he demonstrated how widely circulating ideas and practices can be understood as expressions of dominant discourse.

According to Foucault, these discourses originate in, and are supported by, cultural institutions. Such institutional support lends these discourses credibility, longevity, and a particular ‘heft’ in disseminating their dominant meaning over others. For example, Foucault describes how a discourse of pathology—which emphasizes “listening for signs and symptoms of disease” (Freedman & Combs, 1996, p. 43)—has been historically supported by several institutions including the prison, the asylum, and the hospital (Foucault 1963, 1965, 1977). Through the rise of professional disciplines within these institutions (including psychiatry, law, criminology, and medicine) this discourse of pathology proliferated. As these professional disciplines flourished, the language used by professionals working with populations within these institutions became reflective of this dominant meaning of listening for disease. This came at the expense of these professionals listening for other meanings outside of this dominant discourse, such as listening for people’s “frustration, dilemmas, [or] yearnings” (Freedman & Combs, 1996, p. 43).

For Foucault, as discourses (like the above) become more widely circulated their meanings are assigned greater weight and credibility over others. As such, dominant discourses become not only a unit of meaning but also a unit of power (Bruner, 1986), as they “powerfully shape [the] choices about what life events can be storied and how they should be storied” (Freedman & Combs, 1996, p. 43). Yet, in tracing the function of power on this process of dominant meaning making, Foucault challenges our conventional thinking about how power contributes to the construction of certain realities over others. From the Foucauldian perspective, “[a]t any point in time, there are a number of possible discursive frames for thinking, writing, and speaking about aspects of reality...[yet] as a consequence of the effect of power relations, not all discourses are afforded equal presence or equal authority” (Cheek, 2008, p. 365). Thus, it is Foucault’s re-conceptualization of power which helps us to better understand how certain

meanings and their associated discourses become dominant over others in the construction of reality.

3.1.7 Power/Knowledge, Meaning Making, and the Construction of Reality

For Foucault power is not seen as a top-down force imposed by the *powerful* onto the *powerless*. Nor is power understood as an act of state-imposed violence upon a citizenry through the taking away of rights. Instead, Foucault (1994) views power as (1) relational, and (2) productive. By relational, Foucault means that power is present within *all* relationships. Power is a ubiquitous force that expresses itself like a “web...[between all] social relations at the microlevel” (Ziai, 2013, p. 16). By productive, Foucault means that power is not merely “confined to a repressive function (e.g. limiting what can be said, outlawing practices, [or] censoring truths)” (Ziai, 2013, p. 16). Rather, power “enables certain knowledge(s) to be produced and known...[while simultaneously] constrain[g] what it is possible to know” (Cheek, 2008, p. 365). Foucault stresses such a “close relation between knowledge and power” (Ziai, 2013, p. 19) in fact, that he views them as one in the same. Terming this power/knowledge, he notes that the two directly imply each other as “there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations” (Foucault 1977, p. 27).

Reality then, from the Foucauldian perspective, is reflective of the power of discourses which carry dominant meanings. These dominant meanings are productive forms of knowledge which operate relationally, and which—by their very existence—restrict the production and circulation of any other knowledges which fall outside of themselves. Foucault shows how these concepts are at play in the construction of the person as “[t]he individual and the knowledge that may be gained of him [also] belong to this production” (Foucault, 1977, p. 194). In particular,

Foucault demonstrates how “from the nineteenth century onwards, knowledge [becomes] linked with strategies of social control” (Guilfoyle, 2014, p. 18). At this time, powerful forms of productive knowledge linked to dominant meanings and discourses begin to shape how people become constructed by others—or even how they construct themselves (Mills, 2004). These dominant knowledges (referred to by Foucault as expert knowledge) simultaneously marginalize alternative knowledges (referred to by Foucault as local or subjugated knowledge) that could otherwise be used in a person’s construction.

3.1.8 The Foucauldian Construction of the Person as a Means of Social Control: Expert Knowledge and the Subjugation of Local Knowledge

In Foucault’s (1977) history of the birth of the prison, he notes how the onset of mass incarceration shifted how power was used as a means of social control. Prior to this shift, the acts of discipline and punishment were public events that involved the display of power as a corporal act carried out on the body. With the growth of prisons, these acts of discipline and punishment shift to private events where it is knowledge—not torture—that becomes the “primary mechanism of social control” (White & Epston, 1990, p. 24). The formation and accumulation of knowledge of persons are “put into circulation” (Foucault, 1980, p. 102) through disciplines like psychiatry, psychoanalysis, criminology, economics, and medicine (Guilfoyle, 2014). These disciplines carry with them productive forms of knowledge which unveil particular truths when applied to a person, and in particular, specific populations these disciplines deem “troublesome: for example, criminals, the sick, the mad, wayward women and children, black persons, and homosexuals” (Guilfoyle, 2014, p.18). While the knowledge found within these disciplines is “portrayed as neutral and objective, it [is] anything but, and became a tool” whose use “justified all manner of interventions” (Guilfoyle, 2014, p. 18) to “fix” and “neutralize” (Foucault, 1977, p.

210) these populations. Separating, controlling, and rendering these populations predictable (Guilfoyle, 2014), “Foucault’s point is that knowledge came to function not as representation, but as intervention” (Guilfoyle, 2014, p. 18), including interventions of “exclusion (e.g., the exclusion of black persons in apartheid South Africa; the incarceration of the mad), rehabilitation (e.g. the criminal), or cure (e.g., the naughty child or the homosexual)” (Guilfoyle, 2014, p. 18).

As a result, Foucault notes that the application and intervention of such productive knowledge—which he calls expert knowledge—leads to the dominance of this knowledge over others in the construction of the person (White & Epston, 1990). This rise of expert knowledge simultaneously limits the expression of a person’s own local knowledge (Geertz, 1999) of who they are in the process of constructing themselves. Local knowledge is knowledge of a person that is “established by the individual from himself to himself, before [being] caught up in [this] social network” (Foucault, 1963, p. 65).

Prior to the influence of expert knowledge, Foucault notes there was a much more accessible and immediate relationship between a person and their own local knowledge. This relationship “was one of instinct and sensibility...performed immediately and blindly” (Foucault, 1963, p. 65). Foucault notes this rise in expert knowledge began “when writing and secrecy were introduced...[thereby establishing] the concentration of this knowledge in a privileged group, and the dissociation of the [previously] immediate relationship” (Foucault, 1963, p. 66) of local knowledge from the person being studied. Foucault (1963) finds the rise of expert knowledge and disregard of local knowledge problematic because as a person’s own knowledges that they had previously drawn upon becomes subjugated, pushed out, or flat-out ignored, under the influence of such expert knowledge, the person becomes a “docile” body with respect to their health and treatment (White & Epston, 1990, p. 20) and construction of who they are (Brown,

2007). While Foucault describes how a person is constrained by expert knowledge, he also calls for the resurrection of a person's subjugated or local knowledge. As will be discussed later on in this chapter, the resurrection of one's subjugated/local knowledge provides therapeutic possibilities when taken up by narrative therapy.

3.1.9 Foucault's Call for the Resurrection of Subjugated/Local Knowledge

Despite the power of dominant discourse in constructing us in ways that draw on productive forms of expert knowledge that reinforce dominant social meanings, Foucault nevertheless argues that we have the ability to resist these powerful dominant discourses—and the dominant forms of power/knowledge and meaning associated with them—through a resurrection of our subjugated local knowledge (White & Epston, 1990). For Foucault, subjugated knowledge is never fully eclipsed by more dominant knowledges, as “the elements or materials that power works upon are never rendered fully docile...there is always at least some resistance to the imposition of any particular form of subjectivity” (Pickett, 1996, p. 458). Foucault notes that supporting a person in the continual development of, and access to, their subjugated knowledge is an important part of any professional treatment they receive. He states that “through the re-emergence of these low-ranking knowledges, these unqualified or even directly disqualified knowledges such as that of the psychiatric patient, of the ill person...marginal as they are to the knowledge of medicine” (Foucault, 1980, p. 82) the person is no longer a docile body with respect to their treatment.

However, the resurrection of subjugated knowledges can only occur through “careful and meticulous scholarship, and in this resurrection, the history of struggle [of these knowledges] again becomes visible and unitary truth claims challenged” (White & Epston, 1990, p. 25). For the purposes of this study, I am interested in how knowledge of identity—and in particular

preferred identity—is constructed. Thus, I will now discuss this concept of identity more generally as it is understood by both the social constructionist and poststructural theoretical perspectives before discussing client-preferred identity.

3.2 Social Constructionist and Poststructural Understandings of Identity

Up to this point I have written about the construction of the person from the social constructionist and poststructural perspectives. However, as this study is centred around client identity, I must distinguish the term “identity” from “person” prior to proceeding. While this presents a challenge as the qualitative literature—especially the social sciences—often uses these terms interchangeably (Splitter, 2015), differentiating these terms quantitatively supports this needed clarification (Splitter, 2015). Quantitatively, I may hold numerous identities—a man, a friend, a son, a therapist—but I cannot be more than one person (Splitter, 2015). While multiplicity is an important factor in distinguishing the term “identity” from “person”, so too is language. My identity, or identities is/are “never a final or settled matter” (Jenkins, 2014, p. 18) and “can only be understood as a process of ‘being’ or ‘becoming’” (Jenkins, 2014, p. 18) that is “entirely dependent on language” (Splitter, 2015, p. 90). While people use language to construct their identities, logically this cannot work the other way around. i.e., an “identity” is not a thing in and of itself with the capacity to use language to construct a person. Yet, people are distinct “on account of their linguistic capacities, through which they have developed schemes for talking about their...lives” (Splitter, 2015, p. 90)—identity being one of them. Identity is also a form of knowledge. At a base level “identity is the human capacity – rooted in language – to know ‘who’s who’ (and hence ‘what’s what’)...knowing who we are, knowing who others are, them knowing who we are, us knowing who they think we are and so on” (Jenkins, 2014, p. 6). Identity is also “a matter of meaning, and meaning always involves interaction: agreement and

disagreement, convention and innovation, communication and negotiation” (Jenkins, 2014, p. 18). While “[m]uch writing about identity treats it as some thing that simply is” (Jenkins, 2014, p. 18) this “pays insufficient attention...to the social construction of identity in interaction” (Jenkins, 2014, p. 18). When understood as a linguistically constructed form of meaning making, one’s identity can also be understood as a form of social constructionist and poststructural knowledge. While social constructionism provides more of a micro view of co-construction occurring within an individual conversation, poststructuralism takes a broader view that is focused on how any co-construction occurring within an individual conversation is influenced by broader cultural discourse. For the purposes of this study, as I seek to understand the co-construction of identity from both social constructionist and poststructural perspectives, I will focus on both next.

3.2.1 Social Constructionism and Identity Co-Construction

As the dominant Western conception of identity is founded upon a particularly powerful, and culturally available discourse of a “relatively stable” (Wendt, 1992, p. 397) internal self, historically, psychology has not understood identity as something that is freely co-constructed between people. Rather, it has understood a person’s identity to be stable, enduring, and located within the individual (Smith et al., 1995). In this process, language is “implicitly...regarded...as an expressive medium, as a way of indicating and communicating to other people what is inside us, our thoughts and our feelings” (Burr, 2002, p. 117). Conversely, social constructionism diverts from this view.

From the social constructionist perspective, identity “is maintained, modified, or even reshaped by social relations” (Berger & Luckman, 1966, p. 194) and in this process language is seen as “the prime site of the construction” where fixed identities “can be changed or challenged

through language” (Burr, 2003, p. 53). An important contributor to this social constructionist understanding of identity was George Mead of the University of Chicago. Mead argued “that people construct and negotiate identities for themselves and others through their everyday social interactions with each other...[where] [l]anguage, as a system of socially shared symbolic meanings, is central to this constructive process” (Burr, 2019, p. 119). Mead said that people construct and negotiate their identities for themselves, with language acting as a system of socially shared symbolic meanings, which he noted is central to this process of identity co-construction. Identity, like all other forms of socially constructed knowledge, is subject to this process of co-constructed meaning making (Gergen, 2015), where our understandings and experience of our identity are a function of relational meaning making.

3.2.2 Poststructuralism and the Power of Discourse in Shaping Identity Co-Construction

Whereas social constructionism places heavy emphasis on the way that meaning emerges from conversation, poststructuralism canvases broader and points to the operation of discourses at the wider social level and their influence on individual and collective meaning making. From this perspective, identity co-construction is the product of the “discourses culturally available to us” (Burr, 2003, p. 106) with the language we use in this co-construction—dominant discourses and their associated dominant meanings and power/knowledges—determining “how people can self-identify in socially recognized and validated ways...[making] possible but also limit[ing] and exclude[ing] various kinds of identities” (Denton, 2016, p. 61). As such, these dominant discourses, meanings and knowledges influence our linguistic “parameters of talk... from which it is possible to speak about self and others” (Speed, 2011, p. 125). Thus, the poststructural perspective holds that any such co-construction of people’s identities is the product of dominant cultural discourse. However, this is not to say that poststructuralism discourages the possibility

of altering identity through talk. As I previously noted, Foucault's ideas on the resistance of dominant discourse through the resurrection of one's local knowledge allows for a thread within Foucauldian poststructuralism that sees possibilities of the projective revising of identities which is highly present in narrative therapy. I will address this further in the next section.

Additionally, while social constructionist and poststructural understandings are both at play in narrative therapy's conceptualization of client identity, the practice of narrative therapy adds an additional factor: preferences. Put another way, narrative therapists are focused on the co-construction of a client's *preferred* identity. Below I will discuss how narrative therapy understands expressions of client preferences to client identity, as a simultaneous expression of social constructionist and poststructural knowledge, and from the poststructural perspective how narrative therapy connects client preference to Foucault's idea of local knowledge.

3.3 Narrative Therapy and Client-Preferred Identity

3.3.1 Client Preferences and Client-Preferred Identity

Narrative therapy rejects any internal state understandings of identity (White, 2007) which conceptualize "specific elements or essences of a self that is to be 'found' at the centre of identity" (White, 2007, p. 103) noting this frequently manifests itself in therapy through clients who "seek therapy believ[ing] that the problems of their lives are a reflection of their own identity" (White, 2007, p. 9). As a result, these clients brand themselves "with mental deficits that come to characterise the essential nature of their character" (Kenwood, 1999, p. 117). Narrative therapists counter such internal state understandings of identity with their unique conceptualization of client identity that combines client preferences and intentions, termed *intentional state conceptions of identity* (Bruner, 1990; White, 2007). People's intentions, purposes, values, commitments, and beliefs all make up intentional state conceptions of identity

(Bruner, 1990). Intentional state conceptions of identity are distinguished “by the notion of casting people as the originators of many preferred developments of their own lives” (White, 2007, p. 101). As such, this focus on client “preference” supports versions of client identities that are more closely tied to what persons cherish and value. As stated above, the construction of client-preferred identity within narrative therapy is understood as both a social constructionist and poststructural form of knowledge (Augusta-Scott, 2007; Duvall & Béres, 2007). Within this narrative approach, the co-construction of preferred identity is an act of shared meaning making between clients and therapists which holds “intersubjective meaning within a cultural nexus of power and knowledge” (Brown & Augusta-Scott, 2007, ix). From the social constructionist perspective, the preferred identity that narrative practice seeks to foreground is viewed as something that is co-constructed within the session between the client and therapist, rather than something that is fully formed prior to the session’s start. From the poststructural perspective, this preferred identity occurs within the culturally available discourses that are afforded to us.

Though related, the Foucauldian perspective and narrative therapy are different, with the former describing the resurrection of local knowledge, and the latter referencing client preference. Below I will further connect Foucault’s idea of local knowledge on the one hand, and the narrative idea of preference on the other, cementing the narrative focus on client preference within a Foucauldian perspective.

3.3.2 Client Preferences With Foucault’s Local Knowledge

As clients note engagement “in actions or initiatives that reflect their values, beliefs, commitments, preferences, hopes and dreams... [narrative therapists become] curious about what people value and prefer for their lives” (Young, 2011, p. 154), as well as why certain preferences are important to them (Freedman & Combs, 1996). Such intentional state conceptions of identity

focus not on who a client is (i.e., an expression of an identity that is an internal static essence) but rather focus on who the client wants to be as is made manifest in their expressions and actions, drawing upon client preferences in the construction of these identities (Morgan, 2010). In drawing on this idea of client preferences and client-preferred identity, narrative therapy draws heavily from Foucault, and in particular equating client preferences to his idea of local knowledge. While Foucault himself was skeptical of therapy on the grounds that it would be a duplication of policing the self (Hook, 2003), White and Epston's (1990) work drew heavily on his writings in their development of narrative therapy, and in particular Foucault's idea of local knowledge in their development of client-preferred identity. To do so, narrative therapists ask questions "about how the person's defiance or refusal to perform in accordance with the requirements of the problem might have helped him to undermine the problem...provide a historical account of resistance...[and as such] the evaluation and classification of persons and relationships according to dominant 'truths'—can be effectively challenged. Docile bodies become enlivened spirits" (White & Epston, 1990, p. 31) where formerly subjugated local knowledges become brought to the fore in the support of client-preferred identity.

Through the back-and-forth of conversation, narrative therapists focus on the specific preferences of each client with whom they speak and seek an understanding of how these preferences provide avenues for constructing stories that draw on client local or subjugated knowledge. Despite occasional critique of Foucault's writing as depicting people as powerless (docile bodies), in the face of dominant discourse (White & Epston, 1990) narrative therapy finds a way to invite forward and consolidate people's choices etc. in defiance of dominant discourse.

Therapists help clients in stepping back from dominant problem discourse and identifying subjugated knowledge associated with client preference. This focus on "preferences" is a

departure from a normative approach which privileges expert knowledge and is more about getting clients to where they “should be” rather than helping them realise their preferences. From this Foucauldian perspective, narrative therapy’s focus on a client’s preferred identity is understood as a resurrection of the client’s subjugated knowledge surrounding their identity. This invites clients to critically reflect on “their choices and describe their motivation[s], and in the course of their explanations...have the opportunity to clarify and elaborate on their preferred directions” (Freedman & Combs, 1996, p. 131) in life and what makes these preferences important for them. In practice, this involves therapists keeping very open to the expression of preferences tied to a client’s local knowledge. In so doing, narrative therapists focus on client preferences that are the result of clients performing and consolidating their “preferred sense of self” (Neimeyer, 2002, p. 51)—or preferred identity— as a means through which problem stories and associated problem identities “can be transformed” (Neimeyer, 2002, p. 58), and where the therapist becomes an audience to the client’s “preferred self-narrative” (Neimeyer, 2002, p. 55).

As will be shown in chapter five, my results present some very lovely examples of participants amplifying client preferences and client-preferred identities in ways that draw on both social constructionist and poststructural schools of thought. As there is a blending of social constructionist and poststructural theory reflected both in the academic literature and clinical practice of narrative therapy, in this dissertation I will also blend these two bodies of theory to serve as a basis for my study’s conceptual framework in understanding the co-construction of client-preferred identity. Next, I will describe my blended social constructionist/poststructural conceptual framework in greater detail.

3.4 Conceptual Framework: Blending Social Constructionism and Poststructuralism

In fashioning a conceptual framework, researchers in the social sciences draw upon multiple, and often competing theories (Ngulube et al., 2015). In this way researchers act as “bricoleurs by adopting ideas from a range of theoretical resources” (Cobb, 2007, p. 29), working “between and within competing and overlapping perspectives” (Denzin & Lincoln, 2005, p. 6). Working in this way can help researchers explain their data with greater clarity, and with higher fidelity (Ngulube et al., 2015). Such is the case with this study as I will combine social constructionism and poststructuralism to better understand the co-construction of client-preferred identity in brief narrative single session therapy. Both theories have competing and overlapping perspectives as social constructionism and poststructuralism manifest in a range of positions in the literature (Burkitt, 1999; Dickerson, 2010). Critics of social constructionism suggest that it verges on relativism and appears to dismiss the possibility of any form of underlying reality (Cromby, & Nightingale, 1999; Willig, 1999). On the other hand, critics of poststructuralism view it as appearing to dismiss the possibility of human agency (Guilfoyle, 2014). Both of these critiques are aimed at positions to the edges of the spectrums associated with the two schools.

At the same time social constructionism and poststructuralism also provide useful complementary perspectives. The former helps to unpack the dialogic co-construction of meaning, while the latter keeps an eye on the role of cultural discourses impinging on that process. A blending of these theories already occurs in the clinical practice of narrative therapy, allowing for a co-existence of these differing theoretical perspectives. Narrative therapy is frequently characterized as both social constructionist and poststructuralist. While narrative therapy draws heavily on Foucault, it “could not function with such a docile view of the human

being, its alignment with Foucauldian post-structuralism notwithstanding. Agency has always been an essential part of narrative therapy's view of the person" (Guilfoyle, 2014, p. 5). As such, the narrative therapist views their client as both

a person who, in the first instance, has no choice but to exist in, and make sense of him or herself with reference to the constraining but also productive social network of power and knowledge dynamics; as one who is, in other words, socially constituted...[b]ut also [as] a person who possesses capacities, skills, knowledges, and the promise of a powerful value-base and set of personal commitments, all of which can help him or her deal more effectively with power and the ways in which it constructs him or her (Guilfoyle, 2014, p. 6).

Thus, co-construction can occur between clients and therapists despite the constraining influence of language and discourse on this process. While there is a co-existence of social constructionism and poststructuralism in the clinical practice of narrative therapy, there is a similar call from the social constructionist and poststructural academic communities for a blended understanding of these two theories within research (Burr, 2019; Fawcett, 2008; Wetherell, 1998). In particular, there is a call from within the social constructionist literature for an acknowledgement of Foucault (Burr, 2019; Gergen, 1999), sometimes referred to as "dark constructionism" (Burkitt, 1999), or the Foucauldian strand of social constructionism (Burr, 2019) as compared to "light constructionism" (Burkitt, 1999). Light constructionism "has been influenced by the linguistic turn of the social sciences...towards mutual coordination of language...[where] [c]onstructionists working in this vein emphasize the ongoing construction of meaning in...joint activities or relationships" (Burkitt, 1999, p. 69). Conversely, "dark constructionism" or the Foucauldian strand of constructionism

acknowledges the constructive power of language but sees this as bound up with material or social structures, social relations, and institutionalized practices. The concept of power is, therefore, at its heart...The way that discourses construct our perceptions and experience can be examined by "deconstructing" texts, taking them apart and showing how they work to present us with a particular vision of the world and of ourselves and thus enabling us to challenge it (Burr, 2019, p. 128).

Burkitt (1999) suggests that both perspectives are inadequate on their own and researchers must “reconstruct a version which is more shaded and nuanced in its analysis” (Burkitt, 1999, p. 70), taking into account discursive power relations that put “limits on human actions and yet to find ways of moving beyond them” (Burkitt, 1999, p. 71).

3.4.1 Conceptual Framework

As both a practitioner of narrative therapy and as an academic studying the process of narrative therapy, I too hold space for a blending of these social constructionist and Foucauldian/poststructural perspectives in my conceptual framework as I study the use of brief narrative therapy in the co-construction of client-preferred identity within single session therapy. As such my conceptual framework notes that the co-construction of client-preferred identity is something that occurs between clients and therapists in narrative therapy sessions, but that this co-construction occurs within the context of discourses which are always influencing this process of co-constructed meaning making.

3.5 Research Questions

The conceptual framework has been called the “golden thread” that appears throughout good quality research (Ngulube et al., 2015), and as such should inform the research questions, methodology, and analysis. While my conceptual framework will be reflected in my subsequent methodology and results chapters, I will now present my research questions which will incorporate my conceptual framework of social constructionism occurring within the context of the Foucauldian/poststructural perspective. My research questions are as follows:

3.5.1 Main Question

“How do therapists trained in brief narrative therapy facilitate the co-construction of client-preferred identity within the context of discourses which appear in single session

therapy?” Through my main question I will explore how the co-construction of client-preferred identity (social constructionist perspective) occurs in the context of discourses (Foucauldian/poststructural perspective) within single sessions. As the study revolves around how therapists trained in brief narrative therapy accomplish the co-construction of client-preferred identity, adopting this blended social constructionist/poststructural conceptual framework will allow me to incorporate both the intricate back and forth meaning making that takes place in this process, while also acknowledging the wider cultural discourses that influence this collaborative process.

3.5.2 Sub-Question

“What do clients and therapists say about their use of language in these single sessions and how does this contribute to the analysis of the therapeutic exchange?” My sub-question will also attend to this blended social constructionist/poststructural framework as I will incorporate the post-session perspectives from participants about their sessions. This added context to my own analysis of sessions will allow for some degree of co-construction of the research process between my own voice as researcher and the voices of participants that take part in the study. In this way, my sub question dovetails with the narrative approach of avoiding the imposition of my own expert knowledge as researcher, and to a limited degree gives participants some voice in the interpretation of recorded single sessions. However, the Foucauldian/poststructural perspective is also at play here because as the primary researcher, I will be making decisions throughout the writing of this thesis about how participant voices are ultimately presented in my results chapter. The complementary nature of the use of social constructionism and poststructuralism will be further developed in my next chapter, “Methodology and Methods.” In it I will describe my use of discourse analysis, a methodology which calls for a blending of poststructural and social

constructionist perspectives and how I will use a hybrid form of discourse analysis to analyse the data, language, and discourse behind client-preferred identity co-construction in these recorded single sessions. In this way the conceptual framework is well integrated with this methodology to make for a more coherent and epistemologically consistent package.

3.6 Chapter Summary

This chapter began with an overview of the theoretical foundations of narrative therapy—social constructionism and poststructuralism. Social constructionism notes our knowledge of the world is the product of our shared linguistic meaning making. This includes the knowledge used to construct who we are, our identities, and our understanding of ourselves in the world. Conversely, poststructuralist knowledge notes that this same shared linguistic meaning making is pre-existent and the product of broader cultural discourses. Foucault notes dominant discourses create powerful modes of knowledge that are backed by institutions, and which historically shape how we view ourselves, others, and our relation to the world around us. Narrative therapy keeps both of these philosophies in play regarding how the co-construction of client-preferred identity occurs. Narrative also takes a page from Foucault who notes that a person’s local knowledge can be resurrected in order to subjugate dominant discourse and in the process co-construct client-preferred identity.

As both theoretical perspectives are reflected in the clinical practice of narrative therapy, as well as called upon by those in their respective theoretical camps to be blended in research, my own study will have a blended social constructionist/poststructural conceptual framework to better understand how the practice of client-preferred identity co-construction occurs in brief narrative single session therapy. How this will occur will be addressed next in my “Methodology and Method” chapter.

Chapter 4: Methodology and Method

In this chapter I will describe how I designed my study to answer both my main and sub-question. I answered my main research question, “*How do therapists trained in brief narrative therapy facilitate the co-construction of client-preferred identity within the context of discourses which appear in single session therapy?*”, by conducting a hybrid discourse analysis of transcripts from recordings of five appointment-based single sessions of therapy. To answer my sub-question, “*What do clients and therapists say about their use of language in these single sessions and how does this contribute to the analysis of the therapeutic exchange?*” I had participants fill out post-session questionnaires (Appendix H and I) immediately following each single session. My use of these questionnaires afforded greater context of these sessions from the vantage point of the participants themselves.

In what follows, I will present the study’s methodology and methods used to support the creation of the research design by dividing this chapter into six parts. First, I will present a methodology section providing an overview of discourse analysis that will: (1) introduce discourse analysis as a methodology studying how shared linguistic meaning making occurs in text, (2) discuss how discourse analysis’ application to the field of social psychology—in a form of discourse analysis called discursive psychology—allowed for its growth and legitimization as an anti-essentialist qualitative research methodology used within social psychology and the social sciences more generally, (3) describe the resultant bifurcation of discourse analysis that occurred thereafter, establishing a spectrum of micro and macro forms of the methodology that align with both poststructural and social constructionist schools of thought, (4) provide further details on the macro Foucauldian, and (5) micro discursive psychology forms of discourse analysis that were used in this study, (6) contrast the different approaches that these forms of

discourse analysis take with respect to identity co-construction, (7) discuss the call from the discourse analysis literature for a blending of these micro and macro approaches, (8) present what this blending has looked like in previous studies of identity co-construction within psychotherapy, and of identity co-construction more generally, and (9) describe why my hybrid method, blending Foucauldian discourse analysis and an element of discursive psychology, was needed to support answering my main research question and my research on the clinical practice of brief narrative therapy. Second, I will present a section describing the broad principles of discourse analysis which influenced my decision-making process in crafting the study's design. These principles include: (1) the collection of naturally occurring data versus the collection of data contrived purely for research purposes, (2) issues of informed consent specific to discourse analysis, and (3) the purposeful vagueness found within the literature as to how one goes about conducting a discourse analysis. Third, I will present a methods section that will outline all the steps taken in this study—beginning with describing the research setting where my data collection took place through completion of my hybrid form of discourse analysis of session transcripts. Fourth, I will discuss the tensions that arose when I conducted my data analysis. These tensions included: (1) concerns that I pre-emptively identified narrative practices in these transcripts, and (2) concerns that I was imposing my own meaning on session transcripts when identifying the broader problem and alternative discourses that I found within sessions. Fifth, I will discuss how I tended to these above-mentioned tensions surrounding these issues of data interpretation by conducting my hybrid discourse analysis in a way that was both trustworthy and methodologically rigorous: (1) through my providing a convincing explanation of how I analyzed all sessions, and in particular through my keeping a “chain of evidence” document, (2) through my keeping of a reflexivity journal that narrated my process of data interpretation

throughout the whole study, (3) through the use of my thesis supervisor who served as a second discourse analysis supporting my analysis of all session transcripts, and (4) through my use of participant post-session questionnaires that added greater context to sessions. Sixth, I will provide a chapter summary.

4.1 Methodology

4.1.1 Discourse Analysis: Shared Linguistic Meaning Making in Text

Discourse analysis is a qualitative research methodology involving “the study of language in use” (Gee & Handford, 2012, p. 1) to see how it accomplishes certain purposes. Arguing that words in and of themselves are “essentially meaningless” (Starks & Brown Trinidad, 2007, p. 1374) discourse analysts assert that it is through the “mutually agreed use of language...[that] meaning is created” (Starks & Brown Trinidad, 2007, p. 1374) and through which particular constructions of reality become forged (Starks & Brown Trinidad, 2007). For example, by unravelling “the process through which discourse is constructed” (Macnaghten, 1993, p. 54) discourse analysts can understand how language is used to create shared meanings (De Fina & Johnstone, 2015; Gee & Handford, 2012) around how things like “identities, relationships, and [even] social goods are negotiated and produced” (Starks & Brown Trinidad, 2007, p. 1373). To do so, discourse analysts examine the language found within texts. While “[a]ll spoken and written material...can be conceptualized as a text and subjected to discourse analysis” (Coyle, 2007, p. 101) the most common texts that are analyzed include transcripts of interviews, conversations that occur within institutions, and recordings of naturally occurring talk (Wiggins, 2017).

4.1.2 The Development of Discourse Analysis Within Social Psychology Research: An Anti-Essentialist Methodology

While discourse analysis' evolution can be traced back to the fields of both linguistics and literary criticism (Starks & Brown Trinidad, 2007), its breakthrough as a mainstream methodology used in qualitative research occurred through Potter and Wetherell's (1987) publication of *Discourse and Social Psychology: Beyond Attitudes and Behavior*. This was the first application of discourse analysis to social psychology in Britain in the late 1980s (Coyle, 2007) which the authors termed discursive psychology (Potter & Wetherell, 1987). Drawing on both poststructural and social constructionist thought, Potter and Wetherell's application of discourse analysis to social psychology challenged current psychological research methodologies at the time—such as phenomenology—by presenting “a novel vision of how research might be done” (Potter, 2012, p. 437) in an anti-essentialist way (Potter, 2012; Starks & Brown Trinidad, 2007).

While Creswell (2007) states the “basic purpose of phenomenology is to reduce individual experiences with a phenomenon to a description of the universal essence” (p. 58), a more nuanced reading of the literature on phenomenology, notes that not all forms of phenomenology (i.e., hermeneutic phenomenology) seek to understand the underlying and essential characteristics of an object of study (Wonjnar & Swanson, 2007). Thus, to put it more accurately, discourse analysis challenges those forms of phenomenology where “[t]he inquirer then collects data from persons who have experienced the phenomenon, and develops a composite description of the essence of the experience for all of the individuals” (Creswell, 2007, p. 58), understands a person's language as representative of “an essential, [and] perceive[able] reality” (Starks & Brown Trinidad, 2007, p. 1373), and encourages researchers to

produce thematic descriptions “of [such] pre-given ‘essences’ and structures of lived experiences” (Starks & Brown Trinidad, 2007, p. 1373). For example, Potter and Wetherell’s use of discourse analysis has challenged Husserlian descriptive phenomenological understandings (Christensen et al., 2017, Wojnar & Swanson, 2007), used to analyze open-ended interviews in social psychology research. From Potter and Wetherell’s (1987) perspective, the language used by participants in qualitative interviews was no longer understood as a means of gaining access to the inner world of an interviewee, but rather emphasized that “the interviewees talk would need to be analysed in the context of analysis of the talk of the interviewer” (Potter, 2012, p. 443). Thus, the language used between interviewee and interviewer was no longer seen as providing the researcher a means of “gaining access to [the interviewee’s inner] psychological” world (Coyle, 2007, p. 100) but rather was seen as the means of “constructing it” (Coyle, 2007, p. 99).

Since being applied to the field of social psychology (Potter & Wetherell, 1987), discourse analysis has expanded into other fields within psychological research including developmental psychology, health psychology, and counselling psychology (Coyle, 2007), in mental health research in the social sciences (Gewurtz et al., 2016), and as a qualitative methodology used widely throughout the social sciences more generally (De Fina, 2003; Gee & Handford, 2012; Johnstone, 2008). Additionally, discourse analysis has splintered into different micro and macro forms that present dissimilar interpretations of the meaning of the term discourse and its function. This has developed into differing understandings of how the process of making meaning through shared language use occurs—ultimately leading to different micro and macro constructions of reality based on poststructural and social constructionist schools of thought (Wiggins, 2017).

4.1.3 Micro and Macro Forms of Discourse Analysis: Social Constructionist and Poststructural Meaning Making

Micro and macro forms of discourse analysis each have a different understanding of the term discourse and its function in understanding the process of shared linguistic meaning making (Parker, 2015; Wiggins, 2017). This difference has created “a central point of tension...hinged around the distinction between the ways we are all constrained by discourse, and the ways we are shapers of discourse” (Strong & Paré, 2004, p. 3). From the micro perspective, the term discourse is understood as a verb—*something we do in conversation*—where meaning is something that is co-constructed through shared discursive process (Strong & Paré, 2004). From this micro perspective, discourse as a verb “looks at the activity of communicating and making sense; where understanding and relating is seldom static or fixed. It refers to how seemingly finalized meanings are often in conversational play or negotiation” (Strong & Paré, 2004, p. 4). Micro forms of discourse analysis are those “which are focused on the turn-by-turn organisation of talk and which situate the analytical context within the conversation itself...[also] referred to as ‘fine-grained’ approaches to discourse analysis” (Wiggins, 2017, p. 34) and include conversation analysis and discursive psychology. Conversation analysis aims to “identify the organizational structure of talk that underpins social actions in mundane and institutional settings” (Wiggins, 2017, p. 33) through an exploration of conversational turn taking and what this accomplishes in talk, while discursive psychology more generally examines “how psychological concepts are used and managed in discourse” (Wiggins, 2017, p. 33), as well as looks at the way language is used to get things done through a similar fine-grained focus on the intricacies within the conversation itself.

While these micro discursive perspectives ascribe to a social constructionist understanding of how meaning making can occur through shared language use (Burr 2003; Strong & Paré, 2004), discourse from the macro perspective is understood as a noun—as *meanings engraved in broader culture*—and holds a poststructural understanding of the process of meaning making through shared language use (Strong & Paré, 2004). From this macro perspective, the meanings that are derived from language are not constructed conjointly within discourse (as a verb) but are rather the product of discourse (as a noun) which influences how language is used within a conversation and how reality becomes constructed. This “noun view of discourse and words highlights how conversations give form to and privilege some ways of understanding over others” (Strong & Paré, 2004, p. 4). Macro forms of discourse analysis “engage with ideological aspects of discourses, that define discourse as more than talking or writing, including issues such as...ways of being in the world... and the socio-historical context of discourse” (Wiggins, 2017, p. 34) and include critical discourse analysis and Foucauldian discourse analysis. While critical discourse analysis seeks to “reveal the hidden ideologies that marginalize or oppress individuals or groups in society and to undermine these ideologies” (Wiggins, 2017, p. 33), Foucauldian discourse analysis seeks to “examine how discourse makes available particular truths about the world and how these influence people’s ways of being in and experiencing the world” (Wiggins, 2017, p. 33). Because for my purposes I was interested in how clients and therapists co-constructed client-preferred identity through their nuanced back-and-forth exchange, and also how this exchange is influenced by broader cultural discourse, I conducted a hybrid form of discourse analysis which included both a macro-Foucauldian discourse analysis and an element of micro discursive psychology, both of which I will now discuss in greater depth.

4.1.4 Foucauldian Discourse Analysis: Language, Discourse, and Constrained Meaning Making

Influenced by the writings of Michel Foucault (1963, 1965, 1977), Foucauldian discourse analysis draws exclusively on Foucauldian poststructuralism, exploring how the broader discourse (as a noun) found within texts makes “available different ways of being and speaking in the world” (Wiggins, 2017, p. 50). As such, the object of inquiry for the Foucauldian discourse analyst becomes discourse itself, meaning that the analyst should connect the text in front of them to the larger social process which produced it (Arriba-Ayllon & Walkerdine, 2010). From this perspective, we are always constrained by language in our self construction, and always under the influence of broader meanings that we may or may not be aware of as we employ language to make sense of the world and who we are in it (Cheek, 2008). The work done by the Foucauldian discourse analyst then focuses on how forces of language construct people (Burr, 2003; Fairclough, 1989). From this perspective, Foucauldian discourse analysts view clients and therapists as being under the influence of powerful dominant discourses which influence how client identity becomes constructed. However, while Foucauldian discourse analysts study how broader cultural discourses “make available particular truths about the world and how these influence people’s...ways of being in and experiencing the world” (Wiggins, 2017, p. 33), they also seek to discover how alternative discourses within the texts they examine enable alternative truths to be known about what they are studying, including who a person is and how they experience reality.

4.1.5 Discursive Psychology: Using Language and the Process of Conjoint Meaning Making

As noted above, discursive psychology is a type of micro discourse analysis which focuses on how people use language to *construct themselves* in discourse (Burr, 2003; Parker,

2015). Emerging from within 1980s social psychology (Wiggins, 2017), discursive psychologists focus on the performative function of language. Being heavily influenced by social constructionism (Edwards & Potter, 1992; Lester et al., 2018), discursive psychologists note that people can construct their realities (and in this study's case their identities) together through a conjoint process of meaning making. From this micro perspective, discursive psychologists understand people as having the ability to manipulate “language and discourse for their own purposes” (Burr, 2003, p. 126). As such—and in stark contrast to the Foucauldian approach—discursive psychologists ultimately understand people as having the ability to use language to “actively construct accounts” (Burr, 2003, p. 56) of their lived realities—including accounts of “defensible identities” (Burr, 2003, p. 56). Thus, discursive psychologists would look to how particular identities become “legitimated [by] or endorsed by others” (Burr, 2003, p. 56)—through talk.

4.1.6 Differing Perspectives on Identity (Co-)Construction

Discourse analysis is a particularly appropriate methodology for this study as it examines “the role of language in [constructing] identity” (Burr, 2003, p. 149) and is often used to analyze therapy conversations (Avdi & Georgaca, 2007; Lewis, 1995). While discursive psychologists treat “people as active users of discourse” (Wiggins, 2017, p. 50), as such they view clients as having the capacity to use language in a way that supports the co-construction of their identities with the support of their therapists. Foucauldian discourse analysts on the other hand note how clients’ “identities...are produced in particular ways in talk” (Wiggins, 2017, p. 41)—a nod to the role of broader social discourses in imposing meaning on the back-and-forth exchange. Yet, despite their differences, and because they offer micro and macro views of the process of identity co-construction in therapeutic dialogue, a combination of these two forms of discourse analysis

is well suited to the study at hand—a blending that is increasingly called for by scholars in the field (Fairclough, 1992, 1995; Wetherell, 1998; Wetherell & Potter, 1992).

4.1.7 Heeding the Call to Blend These Micro and Macro Forms of Discourse Analysis

As noted in the previous theoretical/conceptual framework chapter, there is a call from within both the social constructionist and poststructural literature for a blending of these theoretical perspectives. Social constructionist and poststructural theorists both note that because each perspective is inadequate on its own (Burkitt, 1999; Burr, 2019; Fawcett, 2008; Wetherell, 1998), it is only through a blending of their macro and micro theoretical perspectives that a “more shaded and nuanced...analysis” (Burkitt, 1999, p. 70) can occur. A similar call comes from the field of discourse analysis where scholars of both Foucauldian discourse analysis and discursive psychology call for a blending of their respective approaches to methodologically tend to both macro and micro perspectives when conducting such research (Fairclough, 1992, 1995; Wetherell, 1998; Wetherell & Potter, 1992). While Foucauldian discourse analysts and discursive psychologists differ in their understanding of how client identity construction occurs in therapy, discourse analysis has been adopted by social constructionists and poststructuralists alike (Angermuller, 2014; Burr, 2003; Glynos & Howarth, 2019) making it an appropriate methodology that dovetails nicely with this study’s blended social constructionist/poststructural conceptual framework. This call for a blended approach to discourse analysis is echoed from critical counselling psychologists who note that these “*micro* and *macro* processes are necessarily intertwined...[and] distorted if interpreted alone” (Burman, 1995, p. 470) and has been alluded to in research on identity construction more generally (Kavoura et al., 2015) and in the study of identity construction within psychotherapy (Avdi, 2005).

4.1.8 Hybrid Micro/Macro Discourse Analysis in Psychotherapy and Identity Research

While there have been a few studies that claim to blend macro and micro forms of discourse analysis in the study of identity, this blending has not been convincing. Avdi's (2005) study of how parents constructed differing accounts of their son's identity in therapy sessions alluded to a blending of macro and micro approaches to discourse analysis by: (1) tending to the macro perspective theoretically by citing Foucault in reference to finding a dominant medical/psychiatric discourse that resulted in these parents using language to construct a pathological identity of their son and, (2) tending to the micro perspective theoretically by citing social constructionism in relation to a finding that these same parents also had the ability to discursively negotiate "agency" (Avdi, 2005, p. 496) and use language to construct an alternative identity of their son that was outside of the influence of this dominant discourse. Yet surprisingly, any discussion of method by Avdi (2005) in this study only used the general term "discourse analysis" to describe how this research was conducted, failing to mention either Foucauldian discourse analysis or discursive psychology. Kavoura et al. (2015) was clearer in naming their methodology a Foucauldian discourse analysis in their study of how dominant discourses constrained identity construction of ten Greek female judokas. However, like the previous study, these researchers also described participants as "agentive individuals" (Kavoura et al., 2015, p. 89) who were able to negotiate and re-construct alternate identities in the face of dominant discourses (Kavoura et al., 2015). While methodologically clearer compared to Avdi (2005) in its identification with Foucauldian discourse analysis, Kavoura (2015) et al.'s study appears to blend in elements of a micro discursive analysis into their Foucauldian macro approach that ultimately goes unaccounted for. Thus, for my own study, I needed to be clear that both macro and micro forms of discourse analysis were used—Foucauldian discourse analysis to

tend to the broader discourses that either constrain or facilitate client-preferred identity co-construction, and an element of discursive psychology that allowed me to explore how clients and therapists used language within sessions to actively co-construct client-preferred identities. Thus, both were needed to answer my main research question and to accurately study the clinical practice of brief narrative therapy.

4.1.9 Blending Foucauldian Discourse Analysis With an Element of Discursive Psychology

Using this hybrid form of discourse analysis was particularly important to answer my main research question “*How do therapists trained in brief narrative therapy help facilitate the co-construction of client-preferred identity within the context of discourses which occur in single session therapy?*” as the Foucauldian discourse analysis allowed me to pay attention to broader discourses influencing the conversation, while discursive psychology assisted me in identifying ways in which therapists and clients co-constructed meaning, utterance by utterance, against the backdrop of broader dominant discourses. Tending to both these micro and macro perspectives was also of particular importance as this study explored the clinical practice of narrative therapy.

While the practice of narrative therapy is heavily theoretically influenced by the philosophy of Michel Foucault (Foucault 1963, 1965, 1977; Guilfoyle, 2014; White & Epston, 1990), the methodological adaptation of Foucault’s work into the macro focused Foucauldian discourse analysis does not fully capture the extent of Foucault’s philosophy, nor the extent of how this philosophy is used within narrative therapy. While Foucauldian discourse analysis has been useful in showing how broader societal discourses have influenced therapist language when working with HIV positive clients (Miller & Silverman, 1995), and how discourse effects the language used by both clients and therapist in a couple’s therapy session (Kogan, 1998), this sole macro focus, while important, misses a key piece of Foucauldian theory mentioned in the

previous chapter that is vital to the study of both the clinical practice of narrative therapy and to the study of client-preferred identity co-construction: Foucault's notion of our ability to resist dominant discourse and through this process resurrect our subjugated local knowledge (Guilfoyle, 2014; White & Epston, 1990). To methodologically account for this key piece of Foucauldian theory occurring between clients and therapists I had to conduct a micro focused analysis that used an element of discursive psychology—how clients and therapists used language to co-construct client preferred identities. Through co-construction—a linguistic back-and-forth between parties—the ability to negotiate an identity occurs through this social interaction (Duff, 2002) including contributions from both conversational partners.

While some discursive psychologists employ a fine-grained approach to the texts they examine through the use of conversation analysis, others take a less microscopic approach studying how the back and forth of language leads to shared meaning making. For the purposes of this study, the micro portion of my hybrid discourse analysis will use this more general element of discursive psychology that focuses on how shared meaning making occurs in text, and not apply a hyper-focused conversation analysis used by some discursive psychologist. My decision to have a more general focused micro portion of analysis was for the purposes of answering my main research question. Having too much of a micro focused analysis would undermine my research purposes of identifying the broader discourses that influence session transcripts and ultimately detract from answering my primary research question. In this way my more general use of this element of discursive psychology helped to highlight this key Foucauldian concept (resistance to dominant problematic discourse and the resurrection of a client's local knowledge) in a way that would not have been possible had my analysis only employed the solely macro focused Foucauldian discourse analysis. Before discussing how I

conducted this hybrid discourse analysis, I will first highlight three broad principles of discourse analysis which were adopted, and which framed the study's design, before turning to my methods section which will give a more detailed account of how these principals were put into practice.

4.2 Broad Principles of Discourse Analysis Which Framed the Study's Design

Three broad principles of discourse analysis which framed my decision-making process in both the design and execution of this study included: (1) collecting naturally occurring data versus contriving data purely for research purposes, (2) issues of informed consent specific to discourse analysis, and (3) a purposeful vagueness in the literature as to how one goes about conducting a discourse analysis.

4.2.1 Collecting Naturally Occurring Data Versus Contriving Data Purely for Research

Purposes

Discourse analysis, broadly speaking, typically favours the collection, and analysis of, naturally occurring data (Coyle, 2007; Hammersley, 2014; Hodges et al., 2008; Lester et al., 2018)—“data that would exist as a natural event if it were not recorded” (Lester et al., 2018, p. 587)—over analysis of data that is contrived for the sole purpose of supporting a research project. For example, whereas de Silva Joyce et al.'s (2015) discourse analysis of doctor-patient consultations at an Australian sexual health clinic would be considered an example of naturally occurring data, as these conversations would have occurred regardless of being recorded for research purposes, a discourse analysis of an interview between a researcher and one of the patients of this same clinic would not be considered naturally occurring data as this conversation would not exist outside of being recorded for the research at hand (Hammersley, 2014).

Discourse analysts are frequently able to collect and analyze naturally occurring data from counselling and psychotherapy sessions either because: (1) the counselling agency where research is taking place has a standard practice of on-site taping of all therapy sessions (Avdi, 2005; Lester et al., 2018), or (2) analysts perform a discourse analysis retroactively on a previously recorded naturally occurring counselling/psychotherapy session that was originally recorded and made public for teaching/training purposes (Friis, 2013; Kogan & Gale, 1997).

Despite knowing that the counselling agencies I planned to reach out to did not have a standard practice of recording their sessions, when originally conceiving of my study, I hoped to collect and analyze naturally occurring data from single sessions at these agency's walk-in counselling clinics. However, as I will discuss in further detail in my methods section, after speaking with my thesis supervisor, as well as the director of one of the agencies I reached out to, I was encouraged to alter my original plans of taping naturally occurring data and shift to taping pre-booked single sessions set up for the sole purpose of supporting this research project. While the collection of naturally occurring data would have been preferred, Lester et al. (2018) notes that "this does not mean that data collection methods that have a greater degree of researcher involvement are any less valid; rather, it is important to acknowledge that data collection is always situated. Therefore, a researcher should be transparent about how the data were collected and conceptualized" (Lester, et al., 2018, p. 587). As such, I will be explicit about how the data was collected and conceptualized in my ensuing methods section.

4.2.2 Informed Consent and Discourse Analysis

A second broad principle which framed my decision-making process for how this study was constructed and executed was the issue of informed consent as related to discourse analysis (Hammersley, 2014). More specifically, the issue of whether discourse analysts should inform

their research participants that the study they are involved in is a discourse analysis. Ultimately, after consulting the literature I decided not to inform participants of this. I will provide justification for this decision below.

While informed consent is a relative non-issue for discourse analysts who are analyzing publicly available texts after the fact of their initial recording, informed consent becomes a trickier issue for discourse analysts that have a greater degree of involvement in the research process (Hammersley, 2014). When the data being analyzed is not naturally occurring, and as such involves a greater degree of involvement on the researcher's part to set up—in this study's case, several pre-booked single sessions of therapy scheduled exclusively for this dissertation—discourse analysts are encouraged *not* to inform participants that they are taking part in a discourse analysis (Hammersley, 2014).

Hammersley (2014) notes that discourse analyses “are unusual in that they are not, generally speaking, aimed at gaining information about informants; experiences or opinion, nor are they usually designed to document their attitudes, but rather [to] obtain a sample of the discursive practices that they employ, with a view to studying the nature of these and how they function” (Hammersley, 2014, p. 532). In speaking about conducting a discourse analysis of interviews that the research themselves sets up, and takes place in, he further explains, “if those employing interviews for the purpose of constructionist discourse analysis were to try to inform interviewees about how what they say will be used, the response on part of most informants would be incomprehension” (Hammersley, 2014, p. 533). Additionally, he notes, “were informants to be told that the researcher is interested in the discursive practices they employ, it is likely that they would become self-conscious about the language they use, perhaps editing it on

the basis of some notion of ‘good talk’, or at least trying to avoid ‘bad talk’” (Hammersley, 2014, p. 532).

I would argue that the same could be said about my study of pre-booked single sessions of therapy. This broad principle influenced my study’s design and execution in that at no point in presenting recruitment material to participating agencies, counselling directors, therapists, or clients, did I explicitly tell participants that this was a discourse analysis. With the exception of the first letter of recruitment for this study that was sent to agency directors (see appendix A), which noted that the title of the thesis at that time included reference to the fact that it was a Foucauldian discourse analysis, all other recruitment material made no mention of the study being a discourse analysis. Rather, there was a more general telling of agencies, directors, and participants that the study sought to better understand how clients and therapists use language in these single sessions to support how clients talk about their identities. This was reflected in all recruitment material used to explain the study to the agencies I reached out to, informed consent forms given to client and therapist participants, and recruitment posters that advertised the study. These materials are further discussed in the methods section and can be found in the appendices section. In light of these above comments around the intricacies of informed consent as per discourse analysis, I wish to emphasize how critical informed consent is. In this study’s case it is just a question of the specificity of the description of analysis that I am discussing.

4.2.3 A Purposeful Vagueness Concerning the Analytic Process

A third broad principle which influenced how the study’s design was framed and executed is a general vagueness—arguably deliberate—in the methodological literature as to how to go about conducting a discourse analysis. Coyle (2007) notes “[w]hile it is relatively easy to expound the central theoretical tenets of discourse analysis, specifying exactly how one goes

about doing discourse analysis is a different matter because there is no rigid set of formal procedures” (Coyle, 2007, p. 9). Concerning this intentional vagueness, Harper et al. (2008) states, “[t]he caution about not detailing the processes behind analysis may be due to an understandable unwillingness to bow to methodolatry and produce a cook-book approach to analysis” (p. 193). As a result, learning discourse analysis becomes a complex process often leaving those new to the approach feeling frustrated, confused, and mystified (Harper et al., 2008). Yet, despite this lack of formal standardized steps of how to conduct a discourse analysis “the emphasis is placed upon the careful reading and interpretation of texts, with interpretations being backed by reference to linguistic evidence in the texts” (Coyle, 2007, p. 9) as well as “the development of practices of reflexivity...[to open] a space for researchers to detail at least one reading of the process of their analysis” (Harper et al., 2008, p. 194). As such, “one should expect clear documentation of the sources of information used and delimitation of data sources (including a description of decisions made with regard to selection of groups or individuals for interviews, focus groups, or observation) and, importantly, a description of the context of the study. The method of analysis should be clearly explained, including assumptions made and methods used to code and synthesise data” (Hodges et al., 2008, p. 572). How I analyzed session transcripts (through my use of both macro-Foucauldian and micro discursive perspectives), will be clearly explained in the ensuing methods section. Additionally, I will present how data was analyzed in a reflexive way. This will include: (1) my use of a reflexivity journal that documented my process of analysis, (2) support from a second discourse analyst in analyzing session transcripts which is clearly documented in a chain of evidence example that will be addressed later on in my methods section, and (3) the use of participant post-session questionnaires providing added context to my own analysis of sessions. I will now turn to my

method section to provide a detailed account of how I constructed and executed this study, including how I conducted the hybrid discourse analysis of single session transcripts.

4.3 Method

4.3.1 Research Setting

I conducted my research at a counselling agency in Eastern, Ontario that provides brief narrative single session therapy to the public through this agency's walk-in counselling clinic. This is one of several walk-in counselling clinics established in agencies across this region in response to a growing need for more accessible public mental health services. The creation of these walk-in counselling clinics occurred, in part, to relieve pressure placed on local hospital emergency rooms (ERs), where people seeking mental health care often wait for hours as ERs prioritize patient physical health above mental health. These walk-in counselling clinics were established as a space where people seeking mental health support could be seen promptly to not only reduce (ER) wait times but to expand alternatives beyond hospital ERs (Slive & Bobele, 2012).

4.3.2 Ethics Process and Approval

In January 2018, following completion of my doctoral research proposal, I began writing up my ethics application for the study. My completion of this ethics proposal was heavily influenced by discussions I had with both my thesis supervisor and a director of one of the counselling agencies I was looking to conduct this study at. During initial conversations with my doctoral supervisor about studying brief narrative therapy in the single session context, I had originally wanted to tape single sessions that occurred at these walk-in counselling clinics that would allow me to collect naturally occurring data from these walk-in sessions that would have occurred regardless of my taping of them for research purposes. However, we discussed the

potential difficulty of such a study being granted ethics approval. As these walk-in clinics frequently host single sessions where clients arrive in a heightened state of stress or crisis, our concern was that clients accessing the walk-in clinic in such a heightened state of stress could feel pressured to consent to having their single session audio recorded. For the same reason, my advisor and I acknowledged that single session therapists could also be hesitant to participate in a taped single session at the walk-in clinic out of a similar concern for the well-being of these clients.

A solution to this dilemma was suggested by the director of one of the counselling agencies that offered single session walk-in counselling. This director proposed that rather than taping walk-in sessions, which could put pressure on clients to participate, rather, the study recruit ongoing clients of the agency, offering them an appointment-based single session of therapy that would pair them with a single session therapist who was not their ongoing therapist. A benefit of structuring the research design this way allowed for a mechanism to screen for client safety, ensuring that any clients who were currently suicidal could be screened out of the study and ensuring that the clients seeing a single session therapist would have additional resources in place if needed following their single session (i.e., having an ongoing therapist to return to). My supervisor and I took the counselling director's advice and decided that the research design for this study would be appointment-based single sessions between therapists trained in brief narrative single session therapy who either currently, or previously, worked in the walk-in clinic, and who would meet with ongoing clients of the agency who had also signed up for the study. Studying appointment-based single session therapy between therapists and clients still allowed access to a single session of therapy between clients and therapists who had never met before.

The recorded appointment based single sessions were an hour-long (as opposed to the typical hour-and-a-half sessions that are practiced at walk-in).

Inclusion criteria for participating single session therapists included: being members of a professionally regulated college i.e. Registered Social Worker (RSW) or Registered Psychotherapist (RP); had been previously trained in a minimum of 20 hours in brief narrative single session therapy; currently or having previously worked the single session walk-in clinic at one of the agencies where therapists were being recruited for this study; and having had additional training in long-term therapy and crisis intervention. Exclusion criteria for therapists included that they must not have previously been the therapist of the client they were matched with as part of this study. Inclusion criteria for clients included: being 18 years of age or older; being a client of the agency currently in ongoing counselling or have previously done one single session of therapy at the agency's walk-in clinic and on the waitlist for ongoing counselling at the time of their participation in the study. Exclusion criteria included: clients who were currently suicidal; clients who had previously worked with the therapist that they were matched with as part of this study.

I submitted my ethics application to the University of Ottawa's Research Ethics Board (REB) on March 31st, 2018 and received ethics approval to conduct the study on May 3rd, 2018. Ethics approval was granted for one year, expiring on May 2nd, 2019. Following ethics approval, I began the recruitment phase of the study, soliciting therapists trained in brief narrative single session therapy and clients to meet for a first, and only, appointment-based single session of therapy.

4.3.3 Initial Recruitment of Counselling Agencies

Once I received ethics approval, I emailed separate recruitment letters (Appendix A) to several directors of counselling agencies across Eastern Ontario that offered single session therapy where therapists were trained in brief single session narrative therapy at agency walk-in counselling clinics. These letters introduced myself, explained the purpose of my research, and included any foreseeable risks and benefits to the agencies. I also attached three additional letters to this email. The first letter was directed towards therapists who provided single session therapy (Appendix B), the second was a letter of information about the project directed to ongoing therapists of the agency (Appendix C), and the third letter was directed towards clients (Appendix D). Each letter requested that clients and therapists email me directly should they wish to participate. I requested that the directors of the counselling agencies distribute these letters, first to all therapists who practice single session therapy, and second to ongoing therapists of the agencies so that ongoing therapists could inform their ongoing clients of the study.

Shortly after sending these recruitment letters to several counselling directors, some noted that after reviewing the documents, their agencies would not be participating. Others did not respond. As a result, while I had originally hoped to tape a total of six (6) single sessions between clients and therapists across several agencies, I ended up recording five (5) single sessions at the one agency that was willing to participate.

4.3.4 Meeting With the Counselling Director

Before formally starting client and therapist recruitment at this agency, I met with the agency's counselling director on May 30th, 2018. Together we reviewed all recruitment forms for ongoing clients and single session therapists, as well as information forms for ongoing therapists. Minor grammatical changes to these forms were requested by the counselling director.

Additionally, the counselling director requested that rather than having ongoing clients be told about the study by their ongoing therapists—as clients could feel pressured to participate—instead, a client recruitment poster be put up in the agency’s waiting room about the study. This client recruitment poster invited any ongoing clients of the agency to speak to their ongoing therapist for more information about participating in the study if interested (Appendix E). The idea behind this client recruitment poster, as noted by the counselling director, was that it would allow clients of the agency to freely inquire about the study, rather than having therapists solicit clients, and potentially putting them in a position where they felt they could not say no to their therapist. The counselling director said that once these changes were made, that they would take all recruitment forms for the study to the agency’s executive director to get final approval before beginning client and therapist recruitment. I received confirmation from the counselling director of the executive director’s final approval of all recruitment forms on June 26th, 2018.

4.3.5 Attendance at Counselling Unit Meeting

On June 28th, 2018, I attended this agency’s counselling unit’s administrative meeting. The meeting lasted approximately two (2) hours from 1 PM to 3 PM. I brought copies of all recruitment forms to the meeting for attending counsellors to review. Several of the counsellors in attendance had been trained in brief narrative single session therapy and were either currently doing this work at the agency’s walk-in counselling clinic or had previously worked in this walk-in counselling clinic. Other members of the team were ongoing counsellors who had no training in brief narrative single session therapy. During this meeting I spoke to the counselling team about the study, and reviewed recruitment forms for single session therapists and ongoing clients of the agency. In addition, I answered questions that the counselling team had about the study.

Towards the end of this meeting the clinical manager of the counselling team and I brainstormed aloud the sequence of participant recruitment along with the rest of the counselling team. I noted that following this meeting I would email copies of all recruitment forms to all therapists trained in brief narrative single session therapy and request that these therapists email me back at my University of Ottawa email address if they were interested in participating in the study. I also let the team know that client recruitment would begin once a list of participating therapists was confirmed.

4.3.6 Data Collection

Data collection for discourse analysis varies depending on what kind of text is being analyzed. Discourse analysis of interviews between researchers and participants vary including 10 interviews of Greek female Judo athletes (Kavoura et al., 2015), 12 interviews of nurses (Chambers & Narayanasamy, 2008), and 9 interviews of Sudanese female abuse survivors (Hamed et al., 2017). When analysis is of recorded therapy sessions, data samples are smaller. Researchers conducting a discourse analysis of therapy sessions analyzed one session of individual and couple's therapy (Kogan, 1998; Kogan & Brown, 1998; Ayashiro, 2016), one session of ongoing individual therapy (Lewis, 1995), or multiple (12) sessions between the same therapist and family (Avdi, 2005). Based upon my review of the literature I had found one study employing a critical macro-Foucauldian discourse analysis of a first intake session between a client and therapist (Lavie-Ajayi & Nakash, 2017), one study of a single session of therapy using a "micro" conversation analysis form of discourse analysis of single session therapy (Fullen, 2019), yet none that conducted a hybrid micro and macro discourse analysis of single session therapy.

Additionally, the literature on data collection for discourse analysis does not stipulate any rules about sample size. For research, discourse analysis “sample size does not equal the number of participants; rather, sample size refers to the amount of interactional data. The sample is the discourse itself rather than the people producing it” (Lester et al., 2018, p. 590). Thus, because sample sizes in studies of discourse analysis vary “[d]epending upon the purpose and scope of a given research study, a range of sample sizes can be justifiable” (Lester et al., 2018, p. 590). Thus, I recorded five (5) individual appointment-based single sessions of therapy between therapists trained in brief narrative single session therapy and clients of this same agency who were meeting for the first time, thus giving me five hours of recordings to analyze. Thus, while my sample size had 8 participants (5 clients and 3 therapists), my sample size for this study was five hours of interactional data that was created between participants.

4.3.7 Recruitment of Single Session Therapists

On July 2nd, 2018, I began recruitment of single session therapists by emailing all members of the counselling team who were trained in brief narrative single session therapy and attached the recruitment forms for single session therapists (see Appendix B). This email was sent to ten therapists on the counselling team. On July 3rd, 2018, I heard back from two therapists indicating they were interested in participating in the study. On July 7th, 2018, I heard back from a third therapist who indicated their interest in participating. This therapist would later drop out of the study prior to being involved in any taped sessions. On August 23rd, 2018, I heard from a fourth therapist who was willing to participate. These three therapists who were trained in brief narrative single session therapy ended up seeing five clients between them, as two therapists were taped twice, participating in two recorded single sessions of therapy with two separate clients.

4.3.8 Recruitment of Clients

On Monday July 16th, 2018, I sent an email to all members of the counselling team at the participating agency letting them know the client recruitment poster (Appendix E) would soon be posted at the agency inviting clients to speak to their ongoing therapists if interested in participating in the study. In the email I attached the letter of information to ongoing therapists (Appendix C) to the team of therapists to provide the therapists with background on the study should any of their clients inquire further. I also included the client recruitment form (Appendix D) in the email. I indicated that should any clients ask about the study to their ongoing therapists once the poster was put up in the agency, that clients could email me at my university email address for more information. On August 1st, 2018, two copies of the client recruitment poster were posted in the agency's waiting room (Appendix E). Following this, five clients contacted me to participate in this study between August 8th, 2018, and September 20th, 2018.

4.3.9 Information About Participants

As the data sample in a discourse analysis “is the discourse itself rather than the people producing it” (Lester et al., 2018, p. 590) I did not collect any demographic information by way of a demographic questionnaire about any of the study's participants (whether they be clients or therapists). Thus, any information about participants that I list in this section of the chapter came out of session transcripts. However, again I share limited demographic information both here and in my results chapter to protect the anonymity and confidentiality of all participants who were involved in the study.

In presenting information about participants, I found I had to strike a balance between providing the reader with information about the participants lives while also balancing their anonymity. This balance looked different for client participants compared to therapist

participants, because in meeting to participate in these single sessions, clients were already in a position to give up information about themselves, while therapists who were hosting these sessions were not. As such, due to the nature of these sessions being about the lives of participating clients, I am privy to much more information about the lives of clients who participated than the lives of participating therapists. Thus, any information I give about either client or therapist participants, either in this section, or when presenting the results of my analysis in the next chapter, is much more focused on clients and will present non-intrusive details of their private life that clients chose to share with therapists in the context of recorded sessions. Thus, I will offer limited context of who these clients are.

As noted above, eight participants signed up for this study. Five were clients and three were therapists. All clients and therapists were given pseudonyms which I will denote here as well as throughout the results chapter. Client participants included four females: “Emily”, “Anna”, “Suzie” and “Amélie”, and one male client “Jason.” At the time of the study clients “Emily”, “Anna” and “Suzie” were all ongoing clients of the agency participating in this study, while client “Amélie” had previously been an ongoing client who had learned about the study through accessing the agency’s walk-in clinic, but was not currently receiving ongoing therapy, while client “Jason” had learned of the study while accessing the agency’s walk-in clinic, and was on the waitlist for ongoing therapy. The age of client participants ranged from 22-years-old through 62-years-old. Again, this was not a specific question asked of clients, so it is only mentioned here because clients noted their age in their sessions.

All three participating therapists were female. Therapist participants included therapist “Melissa”, therapist “Jill” and therapist “Karen.” Again, because I did not collect demographic information on participants as part of the study and because the data from these sessions focused

on the lives of client participants, I have little-to-no demographic information about the participating therapists outside of what I know about these participants based on the contact I had with them to set up the recordings of the sessions they were a part of. Out of the three participating therapists, two were registered social workers (RSWs) and one was a registered psychotherapist (RP). Two were working at their agency's walk-in at the time of their participation in this study, while one had previously worked the clinic but was not at the time of the study.

4.3.10 Scheduling of Audio-Taped Single Sessions

A total of five (5) audio-recorded appointment-based single sessions took place between the three therapists trained in brief narrative single session therapy and the five clients who signed up for the study. None of the clients and therapists had met prior to participating in their single session together. As clients and therapists emailed me indicating their willingness to participate, I forwarded client contact information to participating therapists for therapists to schedule these single session appointments at their agency. Clients and therapists were matched on a first-come, first-served basis. Once a therapist and client scheduled their single session, the therapist informed me of the date so that I could attend to record the session. The first recorded single session took place on September 9th, 2018, the second on September 12th, 2018, the third on September 18th, 2018, the fourth on October 16th, 2018, and the fifth on November 8th, 2018.

4.3.11 Consent

I arranged to meet with each therapist and client moments before their session recording to complete the therapist and client consent forms (Appendix F and Appendix G). Once consent was received from both the client and therapist, the client was then provided the counselling agency's standard "Statement of Confidentiality and Informed Consent" form for the counselling

session. Once the client and therapist both consented to the study and the client had signed confidentiality for the session, I turned on my audio-recorder and left the room, allowing the client and therapist to have their single session. Each of the five single sessions were recorded on two separate recording devices: (1) a digital audio recorder, and (2) my personal laptop. Once interviews were transcribed, laptop recordings were immediately deleted and recordings from the audio recorder (which were saved on separate SD cards) were kept in storage.

4.3.12 Transcription

As there is variation within the field of discourse analysis regarding how detailed the transcription of recorded speech data can be (Gee, 2014; Harper et al., 2008), analysts must be mindful that transcription is “a powerful act of representation...affect[ing] how data are conceptualized” (Oliver et al., 2005, p. 1287). As a result, transcription can occur “in more or less detailed ways such that we get a continuum of possible transcripts ranging from very detailed (what linguists call “narrow”) transcripts to much less detailed (what linguists call “broad”) ones” (Gee, 2005, p. 106) along with “endless variations” (Oliver et al., 2005, p. 1273) in-between. As a result, the level of detail of transcription is determined by “purposes of the analyst...where [t]he validity of an analysis is not a matter of how detailed one’s transcript is...[but rather] a matter of how the transcript works together with all the other elements of the analysis to create a ‘trustworthy’ analysis” (p. 106). Discourse analysts must therefore make “judgements of relevance” (Gee, 2005, p. 106)—ultimately theoretical judgements about which details are included in transcription and which are excluded (Gee, 2005)—which stem from both the type(s) of discourse analysis one is engaged in (Du Bois et al., 1992), and the research question(s) being asked (Harper et al., 2008, p. 200). For the purposes of this study, I engaged in

a “broad” form of transcription where my own judgements of relevance about what to include and exclude in my transcription were influenced by the literature concerning discourse analysis.

My transcription was not “naturalized” (Oliver et al., 2005), or narrow (Gee, 2005). This type of transcription is commonly used by discursive psychologists employing a hyper-focused conversation analysis (Lester et al., 2014) that hones-in on minute details of speech in therapy, such as timing the length of pauses between words, or monitoring changes in vocal tone. Rather, because I was engaged in a hybrid macro/micro analysis focused on what broader discourses appeared in sessions and how co-construction occurred, my transcription reflected this theoretical positioning, reflecting what the literature calls a broad (Gee, 2005) or “denaturalized” form of transcription (Oliver et al., 2005). This type of transcription focuses on the removal of “idiosyncratic elements of speech (e.g., stutters, pauses, nonverbals, involuntary vocalizations)” (Oliver et al., 2005, p. 1273) through the process of transcription—the idea being that this cleaning up of speech-to-text as it were, allows a greater focus to be placed on the broader “meanings and perceptions created and shared during a conversation” (Oliver et al., 2005, p. 1277) at the time of analysis. This broad approach to transcription was influenced by the macro-Foucauldian perspective more specifically, which notes that Foucauldian discourse analysts should consider “a fairly minimal type of transcription...[as] adequate” (Oliver et al., 2005, p. 1278) and Fairclough’s (1993) point that discourse analysts cannot look to Foucault for support with transcription, because he never engaged in any form of transcription in his own work.

4.3.13 Outlining My Steps of Analysis

Lester et al. (2018) notes that “analysis of the data is a central practice within a [discourse analysis] study, and perhaps the most crucial and time-consuming aspect of the research process” (p. 591). As previously noted in the broad principles of discourse analysis section that influenced

this study's design, while the theory behind discourse analysis is clear, putting this theory into practice is often intentionally vague. While on the one hand the literature recognizes the "need for explicating the process for implementing [discourse analysis] in practice through a series of procedural steps" (Lester et al., 2018, p. 598), paradoxically it "does not espouse a step-by-step procedure in the traditional sense" (Lester et al., 2018, p. 598), but instead often involves a series of "overlapping stages" (Lester et al., 2018, p. 589). Below I will present these overlapping stages, all of which were primarily influenced by Aanesen et al.'s (2020) principle that any steps taken when conducting a discourse analysis are often an overlapping "reflexive dialogue between...researchers, the research material, and the research question" (Aanesen et al., 2020, p. 3). As such, the following steps that I took when analyzing session transcripts encompass this reflexive dialogue between myself as primary discourse analyst, the session transcripts themselves, input from my thesis supervisor as the secondary discourse analyst, and my primary research question itself which (as noted below) changed as the analysis went on. Below I will delineate my steps of analysis that occurred as I transcribed each session, as well as the supporting principles from the literature which drove these steps.

1. I began my engagement with the data through my initial listening, transcribing, and note taking of sessions. These initial notes sought to "build a corpus of examples...generally relate[d] to the identified phenomenon of focus" (Lester et al., 2018, p. 591). In this case, I began by making more general notes about what the possible discourses could be that were influencing the text, as well as the potential identities being generated in the text. Thus, my initial notes that occurred in parallel to my initial listening and transcribing sought to highlight all the possible discourses (as noun) that I thought were evident within sessions (e.g., see **appendix J, chain of evidence example, p. 277**). This initial

note taking followed Harper et al.'s (2008) strategy of note taking with "one piece of paper per category and then list all possibly related extracts underneath" (Harper et al., 2008, p. 202).

2. Upon fully transcribing a session, I then became more "intimately acquainted with the [transcript/text] by reading and re-reading [it]" (Harper et al., 2008, p. 202). As I engaged in this reading and re-reading of the session transcript, I began a second round of more detailed note taking. This time I focused more specifically on my primary research question. Rather than merely highlighting categories of discourse or identity that I thought could be present in transcripts, I engaged in a more focused highlighting of the discourses (as a noun) that I judged to be either facilitating or hindering client identity co-construction (see **appendix J, chain of evidence document, p. 278**). This second round of note taking followed Harper et al. (2008)'s principal that discourse analysis is "an iterative and recursive process with categories [from my first round of note taking] being developed...and then...re-categoriz[ed]" (Harper et al., 2008, p. 202).
3. Following these initial two rounds of note taking, I then embarked on a more focused hybrid discourse analysis of the session transcript. This included: (a) a macro analysis that explored how the words spoken by clients were linked to broader societal discourses that were linked to problematic constructions of client identity, and (b) a micro analysis of therapists' responses to these client-initiated problem discourses that showed how therapists and clients engaged in a linguistic co-construction that supported the development of client preferred identities. I completed the first draft of the hybrid discourse analysis of each single session transcript while consulting both sets of previously made notes. Throughout my analysis of each session, I inserted my own

comments in bold as per my initial analysis of notes throughout each session transcript. This was influenced by Harper et al. (2008)'s point of taking my more general notes that I developed in my first two rounds of analysis and integrating these notes throughout my transcripts, where my initial notes changed over time where some categories evolved while others were dropped as they became irrelevant (**e.g., see appendix J, chain of evidence document**). A more detailed description of this specific hybrid macro/micro analysis will be presented in the subsequent section.

4. Once I completed this more focused hybrid analysis of sessions, now with my own notes interwoven throughout the transcript, I then sent this first draft of the hybrid session analysis to my thesis supervisor who served as the study's secondary discourse analyst. Soliciting my supervisor's feedback from my analysis of sessions aligned with the above-mentioned point by Aanesen et al. (2020) that discourse analysis is a reflective process between the researcher, the data, and other researchers. Additionally, this step fits with Lester et al.'s (2018) point that discourse analysts "often participate in data sessions with others to collectively examine the detail of the data. By examining the data in conjunction with others, different perspectives and new ideas are generated" (Lester et al., 2018, p. 591).
5. I received feedback from my supervisor about this first draft of analysis. This feedback was the original transcript of the session that now contained both my own analysis and my supervisor's commentary on my analysis of the transcript (**see chain of evidence example, Appendix J, p. 279**).
6. A second round of analysis on full session transcripts then occurred (based on my supervisor's feedback) which involved the refinement of my primary research question,

leading to a parallel refinement of how the data became analyzed as a result (see **Appendix K, reflexivity journal, February 15th, 2019 entry, p. 299**). Based on this feedback from my supervisor, my primary research question was slightly altered to ask, *“How do therapists trained in narrative therapy facilitate the co-construction of client-preferred identities in the context of discourses which appear in single session therapy?”*

This narrowing of focus from studying client identity more generally to exploring client “preferred” identity occurred after discussions with my thesis supervisor and is quite common in discourse analysis. Lester et al. (2018) state that discourse analysts engage in “(re)developing research questions....unlike many other forms of research, research questions in [discourse analysis] evolve iteratively and are often more fully developed once the analysis process is well underway” (p. 591). This slight refinement of my main research question is referred to as a delimitation, meaning how a study becomes “deliberately narrowed by conscious exclusions and inclusions” (O’Leary, 2014, p. 76). Focusing on client-preferred identity rather than just client identity more generally allowed for a more accurate study of narrative practice. As narrative therapists are encouraged to support the co-construction of client-preferred identity, this was not reflected in my initial iteration of this question in my research proposal. Thus, this narrowing allowed me greater focus in my micro analysis of what narrative practices therapists used to highlight client preferences related to preferred identity. Additionally, the shift in focus on preferred identity allowed for a more honed focus in describing the macro-level discourses which influenced therapeutic talk.

7. I then went back and reviewed my session transcripts and both my own commentary and my supervisor’s commentary that was interwoven within the text and highlighted all the

discourses that I judged to be either facilitating or hindering the construction of client-**preferred** identity, informed by the clients' expressions of their intentions and preferences. I engaged in this same form of note taking focusing on specific phrases, or language used by both clients and therapists which pointed to client preferences, and preferred identities as well as specific narrative practices I believe the therapists were engaged in to support the co-construction of these client preferences and preferred identities.

8. I completed a second analysis of all five (5) single session transcripts that were sent to my supervisor for review.
9. I received feedback from my supervisor on this second analysis of all session transcripts.
10. I condensed the second analysis of all five session transcripts (ranging anywhere between 30 to 55 pages in length) to 10 pages each. These summaries were used as the basis to form the first draft of my results chapter (**see chain of evidence example, Appendix J**).
11. Following additional discussions with my thesis supervisor, just as I identified macro discourses that were associated with the construction of problem focused identities by clients, I also identified the macro alternative discourses associated with the co-construction of client-preferred identities that were occurring within my micro analysis of client and therapist talk (**see reflexivity journal, Appendix K, July 6th, 2020 entry, p. 311**). To do so, I re-examined my micro analysis, reviewing the linguistic back-and-forth between clients and therapists where I had identified several narrative practices that supported the co-construction of client-preferred identity between clients and therapists. I identified the alternative macro discourses that were initiated by therapists and performed by clients and therapists when engaged in previously identified narrative practices that

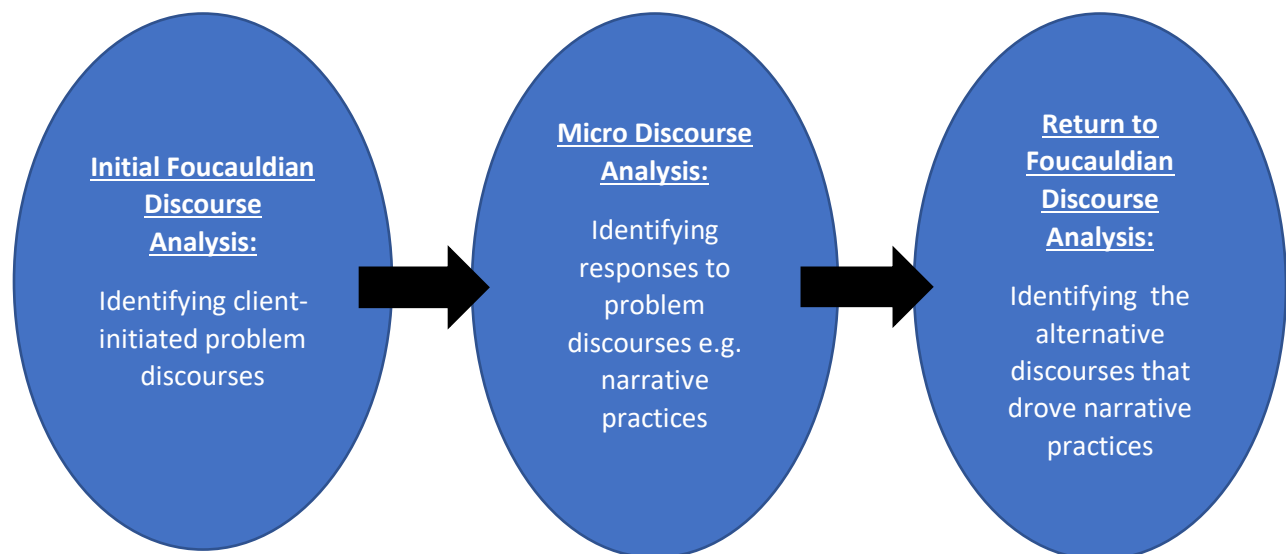
supported the development of client-preferred identity co-construction, and which countered previously identified client-initiated problem discourses. `

12. Following this addition to my macro analysis, the final analysis of session transcripts were complete and presented in the results chapter of the dissertation which I sent to my advisor.

13. My advisor and I agreed that the analysis was complete.

I will now provide a more detailed description of the hybrid macro/micro analysis that I performed on all five single session transcripts. This hybrid discourse analysis is further depicted below in **figure 1**.

Figure 1. Diagram Depicting My Hybrid Discourse Analysis



4.3.14 The Initial Macro Foucauldian Analysis: Identifying Client-Initiated Problem

Discourses

I initially tended to the macro-Foucauldian portion of my hybrid discourse analysis by identifying how client language from session transcripts was influenced by broader discourses, by asking, “*what discourses are relevant (and irrelevant) [as per co-constructing client-*

preferred identity]? *How are they made relevant (and irrelevant), and in what ways?*” (Gee, 2011a, p.110) and how these discourses either hampered or supported the co-construction of client-preferred identities. To do so I first focused on client language when reviewing session transcripts and found that clients initially used language that characterized themselves in a negative and/or problem focused way at the beginning of sessions. It should be noted that because I was conducting the macro-Foucauldian portion of my discourse analysis, I was not looking at how initial client language was used dialogically between clients and therapists as a back-and-forth exchange, but rather identifying what dominant macro discourse showed up at the micro level of talk.

Upon identifying this client language, I then worked backwards to identify what discourse drove a client’s specific language use, followed by an exploration of the particular identity claims these client-initiated problem discourses espoused. This occurred in two ways: first, in three cases I was aided in my ability to identify client-initiated problem discourses through my previous knowledge of texts that discuss which discourses can—and most often do—appear in therapy sessions (Gergen, 1999; White, 2007), and texts discussing common discourses that appear in our broader social context (Foucault, 1977), and how these discourses influence particular identity constructions. For example, when one client stated that their problem was, *“I’m isolating...It’s part of my personality”*, I traced this language back to White’s (2007) discourse of internal state conceptions of identity where people equate their problems as essential and problematic natures of their character. In a session where a client stated one of their family members needed “treatment” and “medication” for a mental health issue, I traced this language back to Gergen’s (1999) writing on medical model discourse of pathology which often occurs in therapy sessions. In another case, I traced a series of comments around client

statements of being “*not good enough*” and “*not fitting the mould*” to Foucault’s (1977) discourse of normalizing judgement that he first wrote about in his history of discipline and punishment in prisons. In all three of these cases, I did not pre-plan to reference the above texts, but rather did so organically when a client’s language or phrase reminded me of that specific discourse.

Second, in one case where a client’s initial language when speaking of themselves and their problem referenced a specific word (“co-dependent”), this prompted me to investigate the discourse behind this word. Rather than this client’s language reminding me of a discourse that I had previously read about as commonly occurring in therapy sessions, in this case the client’s language reminded me of a familiar discourse circulating in the psychological literature more generally—that of codependency. Again, I worked backwards and traced the history of the word “co-dependent”, researching how this word has been used in our broader cultural context to describe this psychological phenomenon, and how this dominant discourse constrained this client’s identity in a particular way. In all cases I documented the client-initiated problem discourses that I identified to give space to describe these discourses more thoroughly, including describing the specific identity claims associated with each. Following this, I turned my focus towards how therapists responded to these client-initiated problem discourses as they manifested in client speech. To do so I conducted the micro portion of my hybrid discourse analysis. This allowed me to identify how therapists supported clients in the co-construction of their preferred identities in response to client-initiated problem discourse.

4.3.15 Therapist Response: The Micro Discursive Analysis

As previously discussed, rather than conducting a pure form of discursive psychology that analyzed the microfeatures of talk between clients and therapists (such as turn taking, speech

inflection, or pauses between clients and therapists) my micro analysis leaned towards a more general element of discursive psychology—namely how clients and therapists engaged in a back-and-forth dialogue where language was used in a way that facilitated the co-construction of client-preferred identities in their single session. In tending to this micro analysis, I reviewed session transcripts and adapted Gee’s (2011a) “Identities Building Tool” which states, “[f]or any communication, ask what socially recognizable identity or identities the speaker is trying to enact or to get others to recognize...how the speaker’s language treats other people’s identities...[and] what identities the speaker is ‘inviting’ them to take up?” (Gee, 2011a, p. 199). As such, in reviewing session transcripts I asked, “*what socially recognizable identity or identities [is the therapist] ...trying to enact or to get [the client] to recognize...how [does the therapist’s] language treat [the client’s preferred] identities...[and] what identities [are therapists] ‘inviting’ [clients] to take up?*” (Gee, 2011a, p. 199). Reviewing transcripts with these questions in mind allowed me to zero in on therapist and client language that aligned with client preferences, and to explore how these preferences were linguistically co-constructed between the therapist and client, expanding them in the service of further developing a client’s preferred identity. Below I will provide some distilled examples of this back-and-forth co-construction that will be significantly expanded upon in the forthcoming results chapter.

In reviewing session transcripts from this micro-perspective, I found there was a dialogical call-and-answer between therapists and clients where therapist questions brought forth a client’s preference, or expanded the preference, in development of the client’s preferred identity as seen in the following examples: 1) Therapist: “*can you tell me a little bit about why you did that...What was important to you?*”, Client: “*Well because I always had a good heart you know.*” 2) Therapist: “*So, what does it say about you that you forced yourself to sit through*

that discomfort?”, Client: *“I think it takes a lot of courage and strength.”* In other cases, this back-and-forth co-construction occurred because of therapists offering clients language that aligned with the client’s preferences or preferred identity, that was later taken up by the client. For example: Therapist: *“How did you know to do that? To, like, because it’s a choice, right.”*, Client: *“I think it’s a choice. We have two choices, to speak up or to remain silent.”*

Once I traced how language that aligned with client preferences and preferred identities was co-constructed between clients and therapists through such linguistic back-and-forth, I then identified the narrative practices that therapists and clients engaged in during these moments of co-construction. To do so, I consulted various sources that described specific narrative practices in precise detail (Carey & Russell, 2002, 2003; Freedman & Combs, 1996; Hedtke, 2014; Payne, 2006; White, 2005, 2007), several of which were previously described in the dissertation’s literature review. In addition to consulting the above narrative literature, I was also influenced by both my own experience as a narrative therapist hosting single sessions, and prior knowledge of different narrative practices that therapists frequently engage clients in when facilitating the co-construction of client-preferred identities. Just as I understood client utterances as associated with wider discourses, so too did I understand therapist and client engagement with narrative practices as being driven by certain alternative discourses.

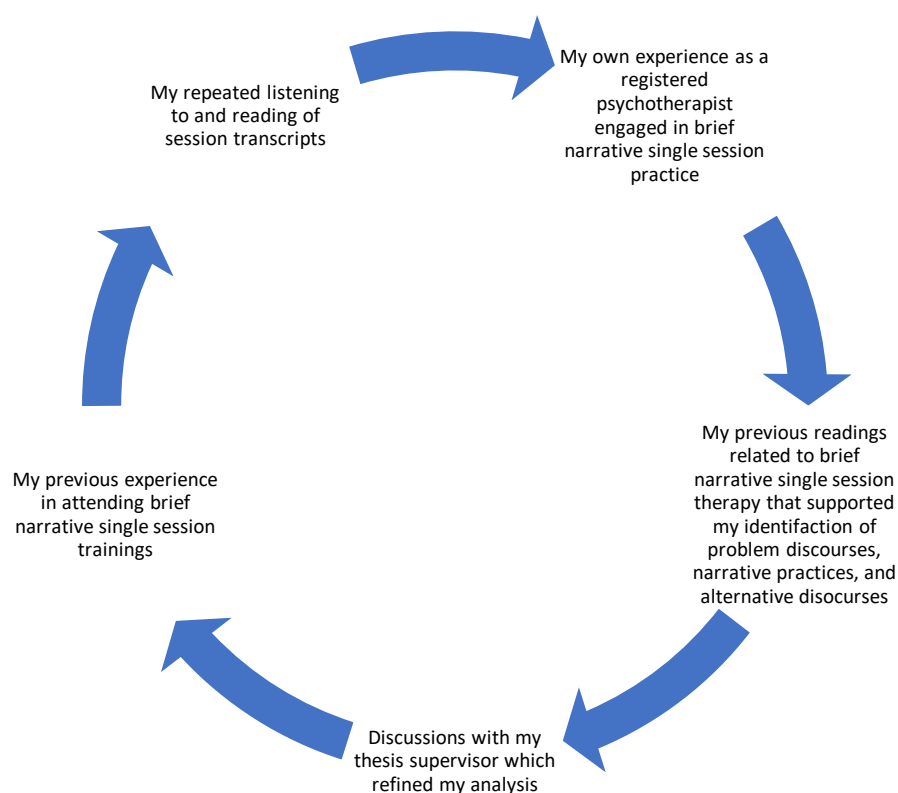
4.3.16 Identifying Alternative Discourses: Returning to the Macro Foucauldian Analysis

Following this micro-discursive analysis, I then returned to my macro-Foucauldian analysis to identify the discourses that drove particular narrative practices used by therapists and clients to support client-preferred identity co-construction. As I re-read through session transcripts focused on client and therapist language that occurred during specific narrative practices, I again asked, *“what discourses are relevant (and irrelevant) [as per co-constructing*

client-preferred identity]? How are they made relevant (and irrelevant), and in what ways?’’ (Gee, 2011a, p.110). In doing so, I realized that through their engagement in back-and-forth dialogues that linguistically co-constructed client-preferred identities using various narrative practices, clients and therapists simultaneously engaged with broader alternative discourses within narrative therapy that were founded on critiques of dominant, normative discourse.

My identification of these alternative discourses is reflected a hermeneutic circle (see **figure 2**) which focused on recognizing the alternative identity claims that were embedded within the specific narrative practices that clients and therapists engaged in.

Figure 2: Depiction of the Hermeneutic Circle That Informed My Analysis



These alternative identity claims juxtaposed, and provided symmetry to, the identity claims espoused by the previously identified client-initiated problem discourses. This process

was principally aided by my review of White's (2007) internal versus intentional state conceptions of identity, and subsequent discussion about this problem and alternative discourse with my thesis supervisor.

In my initial macro-Foucauldian analysis of one session, I had identified the appearance of a client-initiated problem discourse of an internal state conception of identity (White, 2007), whereby people equate their problems as essential and problematic natures of their character through a client's comment, *"I'm isolating...It's part of my personality."* In reviewing the therapist response to this problem discourse, *"so you did that thing that you do, right?...Isolating, withdrawing....It sounds like it was an effort to keep this relationship...safe"*, and the client response of, *"It is!"*, I sought to identify the identity claim espoused by this, and other, narrative practices. In doing so, I was reminded of White's (2007) writings on intentional state conceptions of identity, which contrasted his discussion of the client-initiated internal state identity discourse. According to White (2007), intentional state conceptions of identity do not understand client identities as inherently problematic but rather as fundamentally healthy and positive, where client action is understood by narrative therapists as often overlooked expressions of such positive and healthy identity (White, 2007). I identified this alternate identity claim to be embedded, not just within in the above-mentioned exchange, but between all client and therapist narrative exchanges within this session. This led to further discussion with my supervisor about using the above-mentioned process as a template for identifying other alternative discourses in the other four recorded sessions (**Appendix K, Reflexivity Journal, July 6th, 2020 entry, p. 311**). For example, in one session that began with a client-initiated problematic medical model discourse of pathology, I reviewed my micro-analysis of therapist-client interactions of various narrative practices that supported client preferred identity co-

construction in this session (e.g., Therapist: “*is there something in particular about your life, or something specific about your family that you would really like for us to talk about...?*”, Client: “*to be positive.*” Therapist: “*And how have those qualities that you possess, how have they helped you in your life?*”, Client: “*Well they did help me to be resilient*”) and identified that the above interactions as not informed by the medical model discourse of pathology that spoke of client identities as pathological and needing to be cured by the therapist, but rather through an alternative identity claim where the therapist’s questions spoke centering the client’s preferences. I found that by further reviewing the therapeutic literature that countered the initial medical model discourse of pathology, I identified an alternative discourse of “client knowledge, health, and expertise” (see results chapter). My identification of other therapist-initiated alternative discourses followed this similar hermeneutic process which focused on recognizing the alternative identity claims that were embedded within the specific narrative practices and which provided symmetry to the identity claims espoused by previously identified client-initiated problem discourses. These alternative discourses can be seen as rising out of a resistance to dominant pathologizing traditions as the key features of the narrative discourse can be understood as responses to problematic discourses associated with many traditional therapies.

4.4 Tensions in Conducting My Analysis at Both Micro and Macro Levels

Throughout conducting my hybrid discourse analysis, I experienced tension when engaged in my analysis at both micro and macro levels. Specifically, I struggled with a worry that at both the micro and macro levels of analysis I was engaged in a sort of confirmation bias as I was looking for narrative processes in these recordings and citing evidence from the scholarly literature to support my identified problem and alternative discourses.

4.4.1 Confirmation Bias at the Micro Level: Did I Project Narrative Practices Onto Session Transcripts?

In reading the findings from analysis that will be presented in the next chapter, some readers could argue that my view of these transcripts was clouded by a view for finding narrative practices within these session transcripts. Yet, to provide a counterpoint, my main research question, “*How do therapists trained in brief narrative therapy facilitate the co-construction of client-preferred identity within the context of discourses which appear in single session therapy?*”, implies that I am looking at these sessions in terms of narrative practice.

As reflected in this question, I chose practitioners trained in narrative therapy because I’m looking at how client-preferred identity—a concept within narrative therapy—occurs within these single sessions. As such, a certain level of narrative practices were to some degree anticipated, because the study was able to recruit therapist participants who were trained in brief narrative therapy, and because in my main research question I’m looking at the process of preferred identity co-construction. Given these factors, I wouldn’t expect to be highlighting something in the realm of, say, emotion focused therapy, because this therapy isn’t about client-preferred identity co-construction, whereas narrative therapy is.

4.4.2 Confirmation Bias at the Macro Level: Did I Impose My Own Meanings Onto Session Transcripts When Identifying and Describing Broader Problem and Alternative Discourses?

I found this tension was also present as I worried that I was perhaps imposing too much of my own meaning making onto these transcripts, when identifying macro problem and alternative discourses and then engaged in a conformation bias by selecting scholarly literature which agreed with my own meaning making.

While this argument is understandable, rather than imposing my own meanings onto these texts, it should be remembered that a big part of conducting a discourse analysis is interpretation, where making meaning of these texts is somewhat expected. Thus, there is an interpretative process within Foucauldian discourse analysis. As such, “[i]nterpretation requires not just a description of particular representations...within a discourse but a deeper contextualization within the larger structures of meaning of which they are a part” (Dunn & Neumann, 2016, p. 106). As “discourse analysis relies heavily on interpretation, one of the first steps must be to identify and locate the discourses under investigation” (Dunn & Neumann, 2016, p. 105) with some degree of analyst interpretation being inevitable.

So, while yes, it could reasonably be said that the macro-portion of my analysis relies heavily on my own interpretation, based within the methodological literature this is to a certain degree expected. Furthermore, with its heavy reliance on interpretation, Foucauldian analysis is “a plastic approach to discourse analysis...[that] seeks to uncover an organizing principle within a given discourse, often by using the technique of intertextuality (identifying connections of texts and meanings through reference to other texts)” (Dunn & Neumann, 2016, p. 104). As such “when undertaking discourse analysis, researchers are in a position to impose meanings on another’s text. The position of the researcher must there for be made explicit throughout the research process” (Cheek, 2008, p. 357). Below I will discuss how this was attended to.

4.5 Making the Data Meaningful: Data Interpretation and Enhancing the Study’s Trustworthiness and Methodological Rigor

As humans do not have access to the world “just as it is” (Gee, 2011b, p. 122) we rely on our interpretations of the world through language to “render [our realities] meaningful” (Gee, 2011b, p. 122). Similarly, in any qualitative analysis interpretation is “at the heart” (Willig, 2012,

p. 6) of this research process. Without interpretation we cannot “make sense of our data” (Willig, 2012, p. 6). In the context of discourse analysis where the “text is the data” (Cheek, 2004, p. 1146), my interpretation of the texts of these five single sessions was an act of “making meaning [itself]; or, to put it another way...[a process by which I added] meaning to the data” (Willig, 2012, p. 6) from these macro-Foucauldian and micro discursive perspectives. Yet, as discourse analysis is an interpretive process, a major challenge became how to represent my analysis to readers when it was nonlinear, iterative, and circular (Greckhamer & Cilesiz, 2014). Because of its recursive, hermeneutic process, it can be a challenge to present a discourse analysis and results that is accessible for readers. Much of the difficulty for the discourse analyst is figuring out how to represent their analytic process and results to the reader in a way that is both interpretable and accessible (Phillips et al., 2008). This required me to find ways to publicly disclose my data analysis “to demonstrate the rigor [and trustworthiness] of the analysis” (Greckhamer & Cilesiz, 2014, p. 428). To do so I engaged in several practices cited by the discourse analysis literature to ensure that my analysis was presented in a way that added to the study’s trustworthiness, transparency, rigor, and which provided appropriate evidence to the knowledge claims being put forth (Greckhamer & Cilesiz, 2014). These included: (1) providing a convincing explanation of how I analyzed sessions and the results which I presented, which included being transparent about my analytic method, providing concrete illustrations based on direct quotations from the session transcripts, and providing a chain of evidence of my analysis, (2) keeping a reflexivity journal to track and render transparent my subjective process as I engaged in analysis, (3) having my thesis supervisor act as a second discourse analyst, and (4) having research participants fill out post-session questionnaires to provide additional context to my analysis.

4.5.1 Providing a Convincing Explanation

A discourse analyst's "credibility depends on the coherence of [their] argument: Readers will judge the trustworthiness of the process by how the analyst uses evidence from the [transcripts] to support the main points and whether the building tasks of language converge toward a convincing explanation" (Starks & Brown Trinidad, 2007, p. 1376). As such, the aim in producing a trustworthy and methodologically rigorous discourse analysis is not to produce results that could be independently duplicated by another researcher under similar conditions, and whose trustworthiness would be measured according to constructs such as validity, reliability, or generalizability. Rather, from the perspective of discourse analysis, this means providing readers a convincing explanation of how I analyzed sessions, being transparent about my analytic method, providing concrete illustrations based on direct quotations from the session transcripts, and providing a chain of evidence of my analysis.

In terms of demonstrating a trustworthy discourse analysis, it is suggested that researchers "provide a chain of evidence to expediate how they moved from data to results" (Greckhamer & Cilesiz, 2014, p. 430). Thus, to do so I provided a detailed account of how I moved from my initial note taking when transcribing a session, to taking more detailed notes, to documenting the back and forth of analysis that occurred between myself and my supervisor in one of these single sessions (**see Appendix J**) to give readers a clearer sense of how this analysis process occurred. This provided a convincing explanation of how my hybrid discourse analysis occurred.

4.5.2 Enhancing Trustworthiness and Methodological Rigor: Keeping a Reflexivity Journal to Narrate My Process of Data Interpretation

In addition to adhering to the steps above, I also kept a reflexivity journal (see **Appendix K**) to increase the study's trustworthiness and methodological rigor. This reflexivity journal captured my thought process from my initial note taking when listening to each recorded session through to the completion of my results chapter. The use of this reflexivity journal enhanced the trustworthiness of this discourse analysis as it served "to explicate the analysis through narrating [my] interpretive process moving from raw data to concepts...and addressing the process-related challenges of discourse analysis" (Greckhamer & Cilesiz, 2014, p. 434). This narration of my interpretive process through my reflexivity journal enhanced transparency and enabled public scrutiny of my analysis by revealing the more intricate nuances of my decision-making process involved in my analysis that was not fully apparent in my final results (Walton, 2007). As readers explore the results chapter of this study, they are encouraged to consult this reflexivity journal to re-trace my own steps and thought process as I conducted my analysis.

4.5.3 Enhancing Trustworthiness and Rigor Through a Second Discourse Analyst

In addition to keeping a reflexivity journal, my doctoral supervisor served as a second discourse analyst throughout the analysis process. It is recommended that any discourse analysis have two or more analysts interpreting the data, as "agreement on the evaluation of functions of discourse elements among two or more analysts is important for enhancing discourse analyses' rigor" (Greckhamer & Cilesiz, 2014, p. 431). While my supervisor did not review all five raw transcripts in the same manner that I did, he did take on a secondary role where he responded to my analysis. In so doing we came to an agreement about the presence of discourses which occurred in these sessions, and through looking at the language use in sessions, how therapists

supported clients in the co-construction of client preferences and preferred identities. A final element to enhance the trustworthiness and methodological rigor of my discourse analysis was met through my use of post-session questionnaires.

4.5.4 Post-Session Questionnaires: Providing Added Context to My Analysis

As my hybrid discourse analysis is an interpretation of these single sessions, my use of post-session questionnaires gathered subjective input from participants to add additional context that was outside of my own analysis. To do so, immediately following the recording of each single session, I asked both clients and therapists to fill out separate questionnaires in separate rooms to better understand how each participant experienced their single session (see Appendix H & Appendix I). My presenting of participant post-session questionnaires within my results chapter, integrated participant responses and provided additional context as a backdrop to my own findings, adding nuance to the overall results. This use of post-session questionnaires helped answer my sub-question, *“What do clients and therapists say about their use of language in these single sessions and how does this contribute to the analysis of the therapeutic exchange?”*

In these questionnaires I asked clients and therapists if during their session they noticed any changes in how the client spoke about themselves. I also asked if there was a specific example from their session that stuck out to either participant about a change in how the client spoke of themselves. Finally, I also asked if either participant thought that the therapist did anything in session to contribute to a change in how the client spoke of themselves. I did not open these questionnaires from their sealed envelopes until I had completed, and my supervisor had reviewed, a first draft of my final analysis chapter on June 14th, 2019 (See appendix K journal entry).

While there were times when answers in these post-session questionnaires did not align with my own analysis of sessions in that participants cited additional content from session not presented in my own findings from my analysis, I did not alter my own findings based on what I found in these post-session questionnaires. Rather, these questionnaires shed additional context on my analysis of the sessions.

The use of these post-session questionnaires increased the study's rigor by providing additional context about these sessions outside of my primary analysis. These questionnaires brought forth the voices of therapists and clients to the reader, providing intertextuality between my analysis and their questionnaire responses. Again, this is consistent with the combined poststructural and social constructionist theoretical and conceptual framework of the study in that it allowed for the notion of co-construction occurring in this research design.

This additional data contributed to the overall analysis of the project and embodied some degree of co-construction of the research findings where the researcher and subjects became co-participants in the construction of knowledge (Harré & Gillet, 1994). However, "[t]he notion of intertextuality does not suggest that just any voice has equal opportunity to inform authoritative and powerful discourse" (Blackledge, 2012, p. 617). Co-construction in this case did not imply symmetrical contributions from myself and participants, as I primarily facilitated the research process. More to this point, I wish to underscore here that by including the voices of participants post-session, I wish to dispel any impression that these post-session voices are in any way joining with me in the analysis of these same sessions, or of the data if you will. The participant voices contribute to some degree to the meanings made from what occurred in these sessions, but the participant post-session voices are not being included as analysts of the data by any means.

The contextual input from the clients and therapists' post-session questionnaire responses shed light on my data, but it should not be regarded as either confirming or disconfirming the "truth" of my findings. Ultimately, the reader will gauge what Bruner (1986) called the "verisimilitude" of this study—its lifelikeness as a story, its plausibility based on readers' evaluations of the material presented—based on the combination of my analysis and the commentary of participants. My use of participant post-session questionnaires in the study's design added another layer of methodological rigor to the analysis of the data by providing a triangulation between my own voice as the primary researcher, the voices of clients and therapists, and you the reader, to interpret these different voices and to make your own conclusions.

4.6 Chapter Summary

In this chapter I discussed how my use of a hybrid discourse analysis, which included a macro-Foucauldian analysis, and a micro element of discursive psychology, orchestrated my analysis of five brief narrative single sessions of therapy to fit with my blended social constructionist/Foucauldian poststructural conceptual framework. Discourse analysis is a qualitative research methodology which studies how language is used in texts to achieve certain purposes. My use of a macro-Foucauldian analysis helped me to understand how language used in these sessions was the result of broader cultural discourses, while my use of a micro element of discursive psychology helped me to understand how the language used by clients and therapists in these sessions supported the co-construction of client-preferred identities. Additionally, my use of post-session participant questionnaires provided added context to my own analysis of sessions. In addition to my own analysis of sessions, my study's design included my thesis supervisor who served as a secondary discourse analyst, and a "chain of evidence"

document and reflexivity journal. These elements of my study design enhanced my analysis' trustworthiness and methodological rigor that is called for within the literature. In the following "Results" chapter I will present the findings from my analysis of these five sessions, as well as participant post-session questionnaire responses.

Chapter 5: Results

Findings from my hybrid discourse analysis were unconventional to say the least. While I was not shocked to find that client-preferred identity co-construction occurred within all five single sessions—this was interesting to see in-and-of-itself and will be on full display in the pages to come—I was surprised however, at *how* this process of client-preferred identity co-construction collectively unfolded across all sessions. In what follows, I will trace at both micro and macro levels, how therapists supported clients (and vice versa) in the work of client-preferred identity co-construction within these sessions, and how this process progressed in many curious and exciting ways. To do so, I will present the findings from my analysis in five parts.

First, I will present the beginnings of each session. As sessions commenced, I found, as expected, that all clients began their sessions with problem focused talk. At the micro level this problem talk was influenced by broader macro-level cultural discourses which did not support client-preferred identity co-construction. In this section I will present the findings of my initial macro-Foucauldian analysis of how this initial client problem talk manifested across all five sessions, and how this talk was linked to broader problem discourses that were unsupportive of client-preferred identity co-construction. Second, I will detail how following this initial client problem talk, all sessions shifted abruptly in several curious and interesting ways. These unexpected shifts included: (1) a noticeable absence of the narrative practices of externalizing client problems and of deconstruction, (2) a deviation from more conventional narrative practice seen through the absence of the typical narrative problem-preference sequence, (3) therapeutic talk not reflecting client-initiated problem discourses, thus unexpectedly limiting the role of my initial macro-Foucauldian analysis, (4) a deviation from more conventional client problem talk

through the way that client preference talk initially surfaced across all sessions prior to sessions fully transitioning into client-preferred identity talk, and (5) the bulk of sessions then being devoted to client preferred-identity co-construction thereafter. Third, I will then present, session-by-session, how client-preferred identity co-construction occurred between clients and therapists. I will begin by presenting, at the macro-level, the alternative discourses that clients and therapists engaged in, which both supported client-preferred identity co-construction and countered initial client problem discourses. Following this, I will present how these alternative discourses were made manifest at the micro level of talk via specific narrative practices that clients and therapists engaged in to support the co-construction of each client's preferred identity. Following my chronicling of each session's specific process of client-preferred identity co-construction, I will then present each session's corresponding post-session questionnaire responses. As previously noted, these post-session questionnaires were filled out by clients and therapists immediately following their time together. Placing these post-session responses immediately after reporting how each client's preferred identity was co-constructed will provide added context from the vantage point of participants and will allow for some degree of co-construction of the study's findings. I will provide brief commentary following these post-session responses to situate these responses adjacent to the findings from my session analysis. A more detailed discussion of these post-session responses will occur in the ensuing discussion chapter. Fourth, I will discuss additional findings that arose from further reflection on my analysis more generally. Fifth, I will provide a chapter summary.

5.1 The Opening of Sessions Adhered to the Conventional Focus on Client Problems

I invariably noticed that the beginnings of all sessions were taken up with client talk that was focused on problems, and that this problem talk was influenced by broader cultural

discourses. These discourses characterized client identities in problematic ways, leading clients to construct negative identity conclusions about themselves. Below I will present each client's initial problem talk, how this problem talk at the micro level was a simultaneous performance of a client-initiated problem discourse at the macro level, and describe the identity claim made by each specific problem discourse.

Prior to presenting these discourses, I should add that I am categorizing these as “problem” discourses as understood from a narrative therapy perspective. As such, I do not mean to make a meta judgement of whether these discourses are ultimately harmful or helpful to the clients who are using them. Rather, my calling these initial client-initiated discourses “problem” discourses is more a case of demonstrating how they are incongruent with the development of client preferred identity. In other words, these discourses can be seen as problematic from *within* a narrative therapy practice in that they do not support the co-construction of client-preferred identities in these single sessions, but this is not the same as making a universal claim about them being inherently problematic. These client-initiated “problem” discourses include: a discourse of internal state conceptions of identity, a discourse of normalizing judgement, a discourse of co-dependency, and in two cases a medical model discourse of pathology.

5.1.1 Client Jason Performs a Problem Discourse of Internal State Conceptions of Identity

The problematic influence of the discourse of internal state conceptions of identity occurred in the single session between client Jason and therapist Melissa. When asked by Melissa what he wanted to focus on in his single session, mid-40's former college professor Jason, stated “*the idea of...I am very isolating.*” This statement was the first in a series by Jason that marked his performance of language that was influenced by this problem discourse of

internal state conception of identity. Jason's words "I am" preceding "very isolating" self-categorized his behavior as a "truth" about the essential nature of his character.

He continued stating, *"I tend to isolate myself. And it's not, I don't know if it's something. I think it's part of my personality. I'm an introvert. I know about that."* These statements added to his performance of this problem discourse as he noted that his isolation and introversion were both part of his personality, and something he "knows" about. His performance of this problem discourse then continued with an increasingly negative tone as he stated, *"you know the idea of, you don't belong"* and *"You know, that there is something wrong with me."* In using this language, Jason's performance of this problem discourse constructed a negative identity conclusion which was unsupportive of constructing his preferred identity.

This problem discourse of internal state conceptions of identity portrays "human action as a surface manifestation of specific elements or essences of a self that is to be 'found' at the centre of identity" (White, 2007, p. 101). From this discourse's perspective human expression is "interpreted as a manifestation of any number of unconscious motives, instincts, needs, desires, drives, dispositions, [and/or] personality traits" (White, 2007, p. 101) such that these internal state conceptions diminish one's "sense of personal agency [as]...people's lives are lived by the[se] elements and essences of the self" (White, 2007, p. 104). As a result, internal state conceptions of identity tend to isolate the person as "human expression is conceived as one of a singular self, [and] not as an expression of life that is the outcome of the story of one's life being linked with stories of the lives of others" (White, 2007, p. 105). This discourse is often initiated by clients when beginning therapy as these internal state understandings can lead to a totalizing description of how the person understands themselves. This can often lead the person to construct a negative identity conclusion as "many of the people who seek therapy believe that the

problems in their lives are a reflection of their own identity or the identity of others...lead[ing] people to even more solidly believe that the problems of their lives are a reflection of certain ‘truths’ about their nature and their character [and] that these problems are internal to their self’ (White, 2007, p. 24). This problem discourse was also briefly performed by client Anna in her single session with Melissa when she stated, *“I’m very co-dependent.”* Like Jason’s statement *“I am very isolating”* this statement by Anna self categorized her codependent behavior as a “truth” about the essential nature of her character that was driven by this problem discourse.

5.1.2 Client Emma Performs a Problem Discourse of Normalizing Judgement

In her single session with therapist Jill, forty-year-old Emma began by telling Jill that she is a mature student having returned to university to complete her B.A. in psychology with the eventual goal of becoming a therapist. Emma stated, *“The idea of being a counsellor is my dream!”* However, as Emma began talking in greater depth of her experience as a mature student, she performed the problem discourse of normalizing judgement. When describing her experience as a mature student, Emma was concerned with how others perceived her value stating, *“I think that um...other people’s input...or ideas of maybe how they operate, affect my own feelings of my worth, and I’m not good enough. Um, I can’t meet the expectations, I don’t fit the standard where I’m at in life. I’m forty and I’m a student and, you know, sitting in class with twenty-year-olds.”* Further to this she added, *“And feeling, my time-line doesn’t fit the mould.”*

The identity claim of this problem discourse is that people must meet certain societal norms or standardizations of life, and if they do not meet these, or fall outside of these expected norms or standardizations of life then they are to be punished. Normalizing judgement “is any kind of judgement that locates a person on a normal curve and is used to assess intelligence, mental health, or normal behavior. Because these kinds of judgements claim to be objective

measures, they are difficult for individuals to resist and are usually internalized” (Corey, 2013, p. 411). Normalizing judgement has been discussed at great length through the writings of Michel Foucault (1977) who contributed richly to descriptions of how it is understood as operating throughout society through its association with institutional forces that prescribe particular ways of being while casting others to the margins of society. Foucault noted that social categories carry with them explicit or implicit prescriptions for ways of being. Normalizing judgement, he noted, is “a gaze, a surveillance that makes it possible to qualify, to classify and to punish” (Foucault, 1977, p. 184) those that do not follow the script of dominant or normative discourse. This “gaze” is ubiquitous, as we are constantly “under [its] scrutiny at all times in relation to...[societal] norms” (White & Epston, 1990, p. 70) of how and/or who we should be.

As norms produce gaps between people, they carry with them a penalty in the creation of binaries—those whose existence fits within the boundaries of the norm, and those whose existence lies outside of it (Foucault, 1977). As such, we immediately encounter the “gaze” of normalizing judgment in our day-to-day lives as we are constantly influenced by dominant or normative discourse about our identities. The process that we go through in determining whether our identity exists within the boundaries of a particular norm or social category leads to a self discipline (Foucault 1977). Being continuously under the “gaze” of such normalizing judgement, we are “constantly visible” (Foucault, 1977, p. 200) in relation to these dominant discourses and the norms operating within them. As a result, Foucault notes that we come to impose this normalizing judgement on ourselves—a form of self surveillance. We subject ourselves to our own internalized “gaze” about whether we fit within a particular norm, which becomes a powerful practice in our own definition and classification of our identities.

Emma performed this problem discourse of normalizing judgement through her statements, “I’m not good enough”, “I don’t fit the standard”, and “I can’t meet the expectations” of others. Additionally, Emma’s focus on her age as a forty-year-old in a classroom full of twenty-year-olds is a performance of this discourse of normalizing judgement as she noted her “time-line doesn’t fit the mould.” The norm in this case is that undergraduate university students are typically thought to be in their twenties. Emma’s performance of this problem discourse created a negative identity conclusion that did not support construction of her preferences or preferred identity at this point in the single session.

5.1.3 Client Anna Performs a Problem Discourse of Co-Dependency

A problem discourse of co-dependency appeared in the single session between therapist Melissa and client Anna. Anna, a woman in her forties, noted she had recently finished group therapy that used a dialectical behavioral therapy (DBT) approach. Anna noted her participation in this group led to major changes in how she started caring for herself.

At the time of her session’s recording, Anna noted she was separated from her husband and in the process of deciding whether to give her marriage another shot. At the same time, she reported she was enjoying seeing a new man. Anna noted that she had kept in touch with group members as her DBT group continued to meet as a “grad group” for continued support. Anna noted this group was life changing because, prior to joining the group, she was not taking care of herself which she attributed to being “co-dependent.” On this point she stated, “*um, I decided to do the group, and I shared, I’d been struggling with um, um, I’m very co-dependent.*” At this point Anna performed a problem discourse of co-dependency. Despite Anna noting the significant amount of therapeutic work that she had done up to this point, her statement “I’m very co-dependent” was in the present tense, reflecting this as a current problem for Anna at the

time of her session. As such, Anna's performance of this discourse of co-dependency did not support her preferences, or preferred identity and instead created a negative identity conclusion.

According to Bacon et al. (2020) codependency "is a complex and contested concept, which has been used over the years by mental health professionals to inform their practices...[and] has had a strong presence in the psychological self-help literature" (p. 755). In her famous book, *Co-Dependent No More: How to Stop Caring for Others and Start Caring for Yourself*, Melodie Beattie traced that the development of the concept of codependency was influenced "by the perspectives associated with the Alcoholic Anonymous' (AA) communities in the USA during the 1960–1970s. The influence of the AA culture in shaping the concept of codependency as an illness offered the idea that people who were close to the substance user were themselves suffering from an illness....These people were viewed as enablers and coalcoholics" (Bacon et al., 2020, p. 755).

Historically the term codependent has been used to refer to partners of alcoholics, as professionals "had long suspected something peculiar happened to people who were closely involved with chemically dependent people" (Beattie, 1992, p. 28). Following the birth of Alcoholics Anonymous "a group of people—primarily wives of alcoholics—formed self-help support groups to deal with the ways their spouses' alcoholism affected them. They didn't know they would later be called codependents. They did know they had been directly affected by their mates' alcoholism...The basic thought then, and in 1979 when the word codependency emerged, was codependents (co-alcoholics or para-alcoholics) were people whose lives had become unmanageable as a result of living in a committed relationship with an alcoholic" (Beattie, 1992, p. 28). Following this codependency "began to appear more prominently in the clinical and popular literature from the 1980s onward. Three models came to the forefront in this period,

providing different viewpoints in codependency” (Bacon et al., 2020, p. 755). Co-dependency was characterized as a disease a person was living with, a part of one’s personality, and a way of interacting with others (Bacon et al., 2020). While the word codependency is commonly used to refer to partners of alcoholics, Beattie (1992) notes that this definition has since expanded to include one’s relationship with “a child, an adult, a lover, a spouse, a brother, a sister, a grandparent, [or] parent” who is an “alcoholic, a drug addict, [or] a mentally or physically ill person” (p. 29).

Co-dependency has also been described as “a profound lack of clear sense of self, an enduring pattern of extreme, emotional, relational, and occupational imbalance, and an attribution of current problems in terms of parental abandonment and control in childhood” (Bacon et al., 2020, p. 763). This discourse is performed by client Anna at the beginning of her single session as she stated, “*I’m very co-dependent.*” This problem discourse constrained construction of Anna’s preference of caring for herself in a way that is outside being co-dependent and on her focus on being alone as a means of caring for herself.

Additionally, this problem discourse of co-dependency is not without criticism. The concept of co-dependency has been criticized by feminist scholars who note that under this discourse of co-dependency, it is women more than men, who are at greater risk of being subject to normalizing the “process of ‘losing’ one’s identity to an over focus on another person or relationship” (Krestan & Bepko, 1991/2013, p. 49). According to critical feminist scholars

the codependency movement forces us to explore the power of language and story to shape our views of reality and our definitions of ourselves. It challenges us to look again at the political and economic forces that often underlie concepts of mental health and sickness. It forces renewed awareness of the concerns of the minority that most often inherits labels of pathology, that is, women (Krestan & Bepko, 1991/2013, p. 50).

5.1.4 Clients Amélie and Suzie Each Perform a Problematic Medical Model Discourse of Pathology

The client-initiated problematic medical model discourse of pathology appeared in both sessions hosted by therapist Karen with clients Amélie and Suzie. The medical model discourse of pathology “pervades most traditional forms of therapy and counselling” (Gergen, 1999, p. 169), constructing client identities based on themes of illness and therapist cure. Clients performing this discourse in psychotherapy sessions do so by pathologizing and objectifying either their own or other’s bodies, “through the location of, and classification of, disorders within these bodies” (White, 2007, p. 25). This medical model discourse is commonly performed by both clients and therapists in psychotherapy, where assessment and diagnosis of mental disorder is relieved through professional treatment and rehabilitation, and where therapists are seen as having “expert knowledge...to dictate the direction of therapy” (Gergen, 1999, p. 169), rooting out and removing the cause of a client’s illness, and providing the client relief or cure (Gergen, 1999).

In the beginning of her single session with therapist Karen, 62-year-old client Amélie performed the problematic medical model discourse of pathology. Early in the session Amélie stated, “*Well I’m a mother of two kids. One of twenty-nine and one of twenty-seven*”, and immediately followed this up with a description of her family members that were based solely in pathology—in particular, a need for her daughter to receive treatment for manic depression. Amélie stated, “*And also, umm...my husband is Asperger’s. And my son’s Asperger’s. And my son’s schizophrenic. And my daughter is manic depressive, moderate. And she doesn’t take any medications. She doesn’t follow therapy.*” Amélie’s language appeared totalizing, equating these family members to their pathology. After therapist Karen restated this information to make sure

she heard it correctly, Amélie reiterated her concerns for her daughter through this medical model discourse, stating “*she doesn’t believe in it [manic depression] and ah, she doesn’t follow therapy, and she doesn’t take medications for it.*”

Amélie’s initial focus on her daughter’s need for treatment she has yet to seek points to a further performance of this dominant medical model discourse within psychotherapy where assessment, and diagnosis of mental disorder is relieved through professional treatment which brings honour in cure and rehabilitation (Foucault, 1977). Amélie’s performance of this discourse may be helpful as a means of supporting her daughter who is dealing with a very real mental health issue and who may benefit from both medical and therapeutic treatment. Yet, Amélie’s singular focus on her family’s mental health is a performance of the medical model discourse—in particular, her statements that her daughter’s manic depression can be ameliorated by professional treatment that the daughter has yet to seek—is not *necessarily* a problem discourse, as she stated later in the session, “*it will solve a lot of problems if she has a therapist and medication, you know*” and “*because she has challenges and she doesn’t get treated.*”

From Amélie’s point of view, she may believe that her daughter should be buying into this medical model discourse and is not. However, Amélie’s performance of this medical model discourse is problematic in that it constrains the expression of Amélie’s own preferences and preferred identity—preferences which, when further developed between Amélie and therapist Karen later in the session, act as a significant source of support for her daughter, and which were not present during Amélie’s performance of this medical model discourse. This will become clearer later on in the chapter once I show readers where this conversation went.

The influence of this medical model discourse of pathology was also present in the single session between client Suzie and therapist Karen. Suzie, a twenty-two-year-old female, stated wanting to use her time in the session to talk about “*my living conditions right now...I’m a bit annoyed with them*”, and wondered aloud, “*is it worth sticking it out for a little longer or...should I be thinking about moving soon.*” At the time of her recorded single session Suzie noted that her mother had died from cancer ten months earlier. Not being able to afford the rent in their home following her mother’s death, Suzie was forced to move out of this home and rent a room inside a new house.

Suzie described wanting to be able to leave her room more and interact with her housemates, yet experienced problems with doing so. Suzie attributed her actions of staying in her room through a performance of this problematic medical model discourse of pathology.

Suzie: Um, but, my problem is, is I have trouble like, so, it’s a shared kitchen, right. And, like, I suffer from anxiety and depression a lot. So on my bad days, you know, the idea of bumping into someone in the kitchen while I’m trying to cook, or something like that, it really doesn’t sit well with me. Especially since, I find it hard to get up those days and even think about things like eating and stuff like that. So, like, its another barrier...

Karen: It’s another barrier to what?

Suzie: It’s another barrier to take care of myself when I’m in those places

(...)

Karen: And what is that thing that keeps you in your room?

Suzie: Just, it’s my mind. And my, inability to feel like I nee, wanna be social or, and I guess the the inability of being caught in feeling as down as I do.

As therapist Karen asked for clarification about what staying in her room was a barrier to Suzie stated, “*It’s another barrier to take care of myself when I’m in those places.*” Soon after Suzie attributed her mind as being the cause of her problematic behavior of wanting to stay in her room when feeling depressed and/or anxious. Suzie’s attribution of being unable to interact

in her communal kitchen due to her stated suffering from “depression and anxiety”, and due to her mind, is a performance of this medical model discourse of pathology.

Suzie’s performance of this medical model discourse of pathology caused her to pathologize and objectify herself, noting that her actions of staying in her room and not wanting to interact with her housemates was due to her “*suffering from anxiety and depression*” and that this was a “*barrier*” towards taking care of herself which she then attributed as a problem with her “*mind.*” Brinkmann (2016) states that because of an “ongoing cultural process of pathologization...many traits and behaviours that used to be considered normal human problems (sorrow, melancholia, guilt, shyness etc.) are now conceptualized as mental disorders that can be diagnosed and treated medically and therapeutically” (Brinkmann, 2016, p. 90). As “today’s citizens have become active consumers of diagnoses...disorders have become constitutive of people’s identities” (Brinkmann, 2016, p. 105). Suzie’s focus on her own self-pathology as her reason for suffering and not wanting to interact with her housemates is what Furedi (2008) calls “medicalization from below” (p. 101). Brinkmann (2016) notes such “language of suffering...[characterized by] the diagnostic language of psychiatry...has become very influential in defining human distress” (Brinkmann, 2016, p. 46). This is not to say that Suzie’s performance of this medical model discourse of pathology “is useless or illegitimate, but rather that it is simply one among a large range of languages that are valuable in enabling us to understand various dimensions” (Brinkmann, 2016, p. 46) of her suffering.

Additionally, as the session progressed, therapist Karen learned that there were other important reasons Suzie stayed in her room that exist outside this medical model discourse of pathology including Suzie’s reporting that her actions of staying in her room made her feel safe, comfortable, in control of her environment, and connected her to her recently deceased mother.

As well, Suzie reported at times that her housemates (her landlady and the landlady's adult son) argued, sometimes resulting in the son punching holes in the walls. Thus, Suzie also noted a practical safety reason for her decision to stay in her room out of fear of not wanting to be a victim of this housemate's anger. While Suzie did note that there were times when she did feel safe to go outside of her room when she wanted to socialize with these housemates, she was unable to do so due to suffering from depression and anxiety, this initial performance of this medical model discourse of pathology obscured other accounts more in keeping with her preferred identity.

5.2 How These Sessions Unexpectedly Progressed After Initial Client Problem Talk

Prior to beginning my hybrid discourse analysis, I expected the first half of these sessions to be more problem focused. As these sessions were the first and only meetings between these therapists and clients, I had expected the therapeutic talk to be heavily problem focused in the first half of sessions and more preference focused in the second half. However, this was not the case.

Once clients initially brought up their problems, all conversations moved into territories not consistent with typical characterizations of narrative therapy session sequencing. These included: (1) an absence of the narrative practices of externalizing client problems and of deconstruction, (2) an absence of the conventional problem-preference sequence that is typically portrayed in the narrative literature, (3) therapeutic talk not reflecting broader client-initiated problem discourses that I identified as influencing initial client problem talk, and limiting the role of my initial macro-Foucauldian analysis, (4) client preference talk initially surfacing across all sessions prior to a full transition into client-preferred identity talk, and (5) the bulk of all sessions then being devoted to client preferred-identity co-construction thereafter.

5.2.1 A Noticeable Absence of the Narrative Practices of Externalizing Client Problems and of Deconstruction

While I expected that clients would begin their sessions with problem talk that was influenced by broader cultural problem discourses as noted earlier, I then expected therapists to engage with clients with these problems through the narrative practices of externalizing client problems and of deconstruction. However, these practices were curiously absent. Given that previous literature cited in my literature review demonstrated how the externalizing and deconstructing of client problems at the beginning of sessions support the co-construction of client-preferred identity, I was surprised by the lack of these frequently used narrative practices at the beginning of these sessions. I had expected the openings of sessions to be rife with examples of therapists inviting clients to externalize the problems that they brought to sessions, thereby creating a vacuum for client-preferred identities to be co-constructed afterwards. However, this was not the case.

Therapist Melissa did not invite client Jason into an externalizing conversation about the effects of “the isolation and introversion” across various domains of his life, nor did she invite client Anna to do the same for “the co-dependence.” Likewise, therapist Karen did not invite client Suzie to mull over why she disliked that “the anxiety and depression” kept her isolated in her room, nor did therapist Jill invite client Emma to explain why she was not okay with how “the lack of value” ran her life the way it did.

While there was a noticeable lack of externalizing of client problems at the beginning of sessions, in each of therapist Karen’s sessions (with clients Amélie and Suzie) she engaged in an externalizing of each client’s initial problem talk later on in these sessions. These later externalizations included: (1) two mid-session statements that externalized the problem of client

Amélie's daughter's untreated manic depression (*"it's the manic depression that gets in the way of expressing herself"*), and *"It takes things from her doesn't it"*), and (2) an externalizing statement about how Suzie could stand up to the *"little worries"* that kept her in her room when she wanted to go to her communal kitchen that occurred towards the end of her session after Suzie referred to this anxiety as her *"little worries."* While both Amélie and Suzie agreed with these externalizing statements made by therapist Karen, in neither case did these statements lead to an in-depth and fully formed externalizing conversation between therapist Karen and these clients.

In addition to a lack of externalizing client problems at the beginning of these sessions, I also noted a lack of therapists engaged in the narrative practice of deconstruction—the unpacking problem discourses and analyzing their sources—to pick apart of broader belief systems that kept client problems alive. For instance, therapist Melissa did not ask Anna where she first learnt of the idea of "co-dependency", nor did therapist Jill ask Emma how long she's felt like she needed to fit the mould/standard when comparing her life to others.

Even though I was surprised by the lack of externalizing and deconstructing of client problems at the beginning of sessions, I was even more surprised by how these sessions focused mostly on client preferences as they rolled out more generally. Not only did therapists not initially externalize or deconstruct client problems, therapists barely engaged in any problem talk with clients at all. Instead, for the most part, therapists were able to jump straight into preference talk with clients, thereby skipping the conventional problem-preference sequence common to the practice of narrative therapy.

5.2.2 Skipping the Problem-Preference Sequence: Complete Disengagement From, or Minimal Engagement With, Client Problem Talk

In three of these five sessions therapists did not engage in problem talk and instead jumped straight into preference talk. This included: (1) therapist Melissa declining to talk about client Jason's initial comments that his isolation and introversion were negative parts of his personality, and shifting their conversation to preference talk about how these were instead positive/preferred aspects of who he was, (2) therapist Melissa declining the invitation from client Anna's initial problem statement that she was "*very co-dependent*", shifting the conversation to preference talk that described Anna as "an assessor", and discussing Anna's relationship with her preferred "self," and (3) therapist Karen declining the invitation from client Suzie's initial problem talk that her isolating in her room was due to her suffering from "*anxiety and depression*", and re-directing the conversation towards how staying in her room was an act of self care.

In the two other sessions therapists Karen and Jill both responded minimally to client Amélie and Emma's initial client problem talk—each giving a one-line response—before dropping this brief problem talk and switching gears to preference talk. Therapist Karen responded to Amélie's concerns for her daughter's untreated mental health by asking, "*Mm...and what's that like for you [Amélie] to...*" before quickly shifting the therapeutic talk to focus on Amélie's "positivity." Likewise, therapist Jill responded to client Emma's initial problem talk of being perceived by others as having a lack of value, and of not "fitting the mould" as a mature student by stating, "*it's almost like the perception that you feel that other people are having over you has a huge impact on you, and it doesn't sound like you're okay with that*" before similarly shifting their conversation towards preference talk by discussing how

Emma does have value. While therapist Karen's comments had hints of exploring the effects of the problem of Liz's daughter's manic depression on Liz, and therapist Jill's comments to Emma had hints of externalizing and deconstruction, as previously noted both conversations quickly jumped towards preference talk after each therapist minimally engaged with this problem talk.

5.2.3 Therapeutic Talk Did Not Reflect Broader Cultural Discourses Limiting the Role of My Initial Macro Foucauldian Analysis

At the macro level, therapist disengagement from initial client problem talk resulted in an unexpectedly limited role of my initial Foucauldian portion of my analysis as the majority of therapeutic talk did not reflect broader cultural discourses related to initial client problem talk. In addition to the lack of externalizing and deconstruction, and relatively minimal focus on the problem side of the general problem-preference sequence in narrative therapy, conversations did not dwell on client problems for very long—if at all. From the macro perspective the therapeutic talk that occurred between clients and therapists did not reflect the broader cultural discourses that I had identified as driving initial client problem talk. As a result, this ended my initial macro-portion of my analysis just as it started. This resulted in the relegation of the initial macro-Foucauldian portion of my analysis to identifying these broader discourses that were initiated by clients through their problem talk, yet not seeing these discourses at play between clients and therapists within their therapeutic talk. While my identification of problem discourses plays a role and it is helpful, I had thought these discourses would remain more evident throughout the conversation. However, this was not the case.

As I marveled at how quickly therapists across all five sessions shifted the therapeutic talk into the realm of client-preferred identity co-construction, I became increasingly curious as to how therapists avoided getting caught up in problem talk. At first, I had thought the swiftness

of the shift from problem to preference was due to the equally fast-paced nature of single session work. Since the clients and therapists who volunteered for this study had never met before—and only had a single one-hour session together—perhaps this time-limit pushed therapists to quickly develop alternative narratives with clients, thereby forcing them to disregard the typical problem-preference sequence, disengage from client problem talk, and dive headlong into preference talk. Yet, as I gave these findings a closer look, I realized that the immediate shift by therapists into alternative discourses and narrative practices that supported client-preferred identity co-construction (and the general side-stepping of initial client problem talk and non-engagement with client-initiated problem discourses) occurred because of clients *themselves* alluding to their preferred developments/unique outcomes and general preferences much earlier than usual, thus deviating from conventional narrative practice or narrative conversation sequencing as represented in the literature.

5.2.4 Early Client Allusions to Preferred Developments/Unique Outcomes

In a fascinating turn of events, not only were therapists able to skip the problem-preference sequence that is typical of narrative therapy, but clients arguably took the lead in switching to preferred identity talk by introducing underdeveloped traces of preferred identity. These early traces of client preference talk all appeared on the heels of initial client problem talk. In some cases, clients challenged their own initial problem talk voluntarily without therapist intervention, while in other cases early client allusions to their preferred developments arose from very minimal therapist intervention.

In four sessions clients alluded to their preferred developments while engaged in initial problem talk. These preferred developments provided therapists with an immediate starting point for conversations in support of client-preferred identity co-construction. These included: (1)

Jason’s statement that his isolation and introversion were both positive and a “*protection mechanism*”, that Jason noted immediately after stating his isolation and introversion was problematic, (2) Emma’s statement, “*I think there is a huge discrepancy of how I think others value me, and how I value myself. And my desire is to feel fully valued, at least most of the time (chuckle)*”, that she noted immediately following her initial problem talk of not feeling she fit the standard or mould compared to her other university peers, (3) Anna’s statement that she was trying to care for herself by “*trying to spend time on my own.*”, that she stated immediately after noting she was “co-dependent”, and (4) Suzie’s description of secluding herself in her room as an act of care as her room was her “*comfort zone*” that appeared immediately after she noted that staying in her room was the result of her suffering anxiety, depression, and because of her “mind.” In all four of these cases these client preferences/preferred developments all came immediately on the heels of each client’s initial problem talk, thus immediately countering this same problem talk after introducing it, and all without therapists explicitly inquiring about preferred developments.

In client Amélie’s session with therapist Karen, Amélie alluded earlier than expected to her preference/preferred development—being positive—following light solicitation from therapist Karen about what the focus of their session should be. Following Amélie’s initial telling of her concern for her family’s (and specifically her daughter’s) mental health, therapist Karen simply asked Amélie what she wanted to focus on in their time together in session, to which Amélie replied, “*It’s hard to be positive...but most of the time I’m positive.*”

These early illusions to client preferences/preferred developments shifted the centre of “gravity” of client language from an implicit problem discourse hovering in the background, to the potential beginning of an alternate discourse taking up space which then became solidified

through therapist responses. Thus, therapists did not merely skip over client problem talk and re-direct these conversations to preference talk being directive and insensitive of initial client concerns. Rather, therapists were sensitive and attuned to client talk that focused on their identities in more preferred ways.

5.2.5 The Bulk of All Sessions Were Devoted to Client Preferred Identity Co-Construction

As clients alluded to their preferences/preferred developments earlier than expected following their initial problem talk, this allowed therapists to be selective, and take up this preference talk with clients rather than expanding initial client problem talk. Therapists maintained this collaborative process by inviting client input, and by directing curiosity towards this content *brought forward by the clients*, which when taken up by therapists led to different types of conversations. While I was not surprised that this co-constructive work happened, I was surprised at how soon it happened, and how it remained the focus of talk for the bulk of all five sessions thereafter as this deviated from the conventional sequence of narrative talk reflected in the literature.

In what follows I will present session-by-session how the clients and therapists engaged in these specific narrative therapy practices which simultaneously allowed them to engage with alternative discourses which supported the development of client-preferred identity throughout these sessions.

5.3 How Client-Preferred Identity Co-Construction Occurred

I will present what this client preferred identity co-construction looked like session-by-session, first highlighting from the macro perspective the alternative discourse(s) which clients and therapists engaged in that supported preferred identity co-construction, and second, presenting how engagement with these alternative discourses occurred at the micro level through

the various narrative practices that were present in the dialogical back and forth between clients and therapists throughout these sessions. Through these narrative therapy practices therapists were able to foreground client preferences and preferred identities while simultaneously keeping client expressions influenced by previously mentioned problem discourses at bay.

While therapists did not take up these problem discourses with clients, they responded by engaging with clients in alternative discourses which made counterclaims about these same client's identities. Generally, these alternative discourses drew on both narrative therapy and the brief therapy movement and claimed that client identities were not related to problems but instead were constructed identities in relation to preferences rather than problems. While clients began sessions performing problem discourses which made certain claims about their identities that get played out in *society* and centred around the idea that the problems of their lives were a reflection of their identities, therapist and client engagement with alternative discourses made alternative claims about client identities that were played out in *therapy*—in the room in the interaction with the client and therapist.

Client-preferred identity co-construction occurred simultaneously at both macro and micro levels. I will present each macro and micro level per session. First, I will present from the macro level, the alternative discourses that clients and therapists engaged in that supported client preferred identity co-construction and which countered the initial client problem discourse more generally. Following this I will present how these alternative discourses appeared at the micro level through the dialogical back and forth between clients and therapists when engaged in narrative practices that were influenced by these specific alternative discourses. Additionally, following this presentation of each session I will present the participant post-session questionnaires for each single session.

5.3.1 Co-Constructing Jason's Preferred Identity: Therapist Melissa and Client Jason Engage With an Alternative Discourse of Intentional State Conceptions of Identity

In response to Jason's performance of this **problem discourse of internal state conceptions of identity**, therapist Melissa did not perform this problem discourse with him but engaged with an **alternative discourse of intentional state conceptions of identity**. The identity claim made by this alternative discourse is that one's identity can be conceptualized not with respect to some internal or essential element within, but instead is distinguished by intentional acts of personal agency which cast people as "the originators of many of the preferred developments of their own lives" (White, 2007, p. 103). From this perspective people live their lives "according to the intentions that they embrace in the pursuit of what they give value to in life" (White, 2007, p. 103). Thus, rather than being at the mercy of some internal, immovable and static essence at the centre of one's identity, one's engagement with their own personal intentions allows them to be "active mediators and negotiators" (White, 2007, p. 103) in their lives. This is especially helpful when a person makes an "effort to address obstacles and crises, and mak[ing] it possible for them to come to terms with a range of predicaments and dilemmas that confront them in everyday life" (White, 2007, p. 104). In their session Melissa's language drew out the intentions behind Jason's actions concerning his isolating and introverted behavior and framed his actions as an expression of personal agency when discussing this behavior rather than it being understood as something internal and negative.

Throughout the session Melissa and Jason's engagement with this alternative discourse allowed Jason not only to focus on the intentions behind his isolating and introverted behavior but also to understand previous behavior he initially described as negative, instead as being acted out from his intentions. Not only did this allow Jason to see his isolating and introverted

behavior as an expression of his agency, but it also allowed for a re-framing or change in meaning-making about the behavior itself.

This will be seen below through Melissa and Jason's engagement of the narrative practices of: (1) positioning Jason in relation to isolation/introversion as a positive development, (2) re-authoring via thickening through offering up the language of "choice" in relation to a story of introversion presented by Jason, (3) re-authoring via reflection on the meaning and values behind Jason's actions of introversion, (4) reinforcing Jason's preferences/preferred identity in the face of his return to problem talk, and (5) thickening Jason's specific preferred identity of being an introvert.

5.3.1.1 Positioning: Isolation and Introversion as a Positive Development. While performing the **problem discourse of internal state conceptions of identity** concerning his isolating and introverted behavior with statements such as "*I am very introverted...I know about that. It's part of my personality*", and with increasingly negative statements such as "*you know there is something wrong with me*", Jason also stated, "*But I also see that as um, um as a protection mechanism that I have*" and, "*as I thought about this topic I could think about the positive aspects of it, but also negative aspects of it.*" In response, Melissa deliberately positioned Jason in line with his comments that characterized his isolation and introversion as positive and self-protective. In doing so therapist Melissa engaged with Jason in the **alternative discourse of intentional state conceptions of identity**. In the example below, Jason vacillated between performing the problem discourse of internal state identity and making statements that further aligned with his stated preference that there were positive and protective aspects to his introversion/isolation. Therapist Melissa did not take up his statements that were influenced by this problem discourse, and instead invited Jason to position himself in relation to his statements

that were aligned with his preference of positivity regarding his isolating and introverted behavior thus inviting him to perform this alternative discourse with her.

Jason: You know, that, there is something wrong with me.

Melissa: Mm.

Jason: Um, why I don't, like, why don't I behave like other people do sometimes?

Melissa: So thinking of this as just you maybe

Jason: But on the other hand, I feel that, for example, like when there is, like conflict, I'm not the kind of person who's gonna be fighting with you

(...)

Jason: I accept the way you are, the things, the way things are. And I just don't feel like interacting with you.

Melissa: So you might step away from conflict and isolate.

Jason: Exactly.

While Jason's statement "why don't I behave like other people sometimes?" is a brief performance of the **problem discourse of normalizing judgement**, soon after Melissa's statement "you might step away from conflict and isolate" actively invited Jason to position himself in relation to his stated preference that his isolating and introverted behavior is a positive and self-protective action. Additionally, this statement "you might step away from conflict and isolate" and Jason's response of "Exactly" marked the beginning of the co-construction between Melissa and Jason of re-negotiating the meaning of Jason's introverted and isolating behavior in line with his stated preferences and is a performance of the **alternative discourse of intentional state conceptions of identity** which Melissa and Jason engage in throughout their session.

Through Melissa's narrative practice of positioning Jason in line with his stated preference, Jason's actions were being understood as supportive of this preference of being non-conflictual, and in-line with his previous statements that his introversion and isolation are both positive and self-protective.

5.3.1.2 Re-Authoring Via Thickening: Offering Up the Language of “Choice.”

Following her statement “*you might step away from conflict and isolate*” that positioned Jason in line with his stated preference that his isolating and introverted behavior is both positive and self-protective, Melissa then thickened this preference by offering up the word “choice.” This occurred as Jason recounted a story of when he was a college professor and how he stepped away from conflict in a meeting with a former work colleague/friend who was disrespectful towards him. While Jason told this story of being disrespected at this meeting with other faculty and students present, Melissa’s language of “choice” sought to highlight that Jason made a choice to engage in his isolating and introverted behavior, thus thickening his preference that such behavior was positive and self-protective. To do so, Melissa began by asking Jason when his colleague was rude to him and he remained silent, what he was thinking about, to which Jason replied he was thinking that he did not want to give her rude actions attention, and rather let others judge this friend for being rude. This led to the following exchange:

Melissa: So you, in your silence, in remaining silent, you were choosing to give others the space to make their own...

Jason: Exactly! They can make their own judgement.

Melissa: Right. How did you know to do that?

Jason: Huh?

Melissa: How did you know to do that? To, like, because it’s a choice, right

Jason: It’s a

Melissa: you made to remain silent, to allow others the space to make their own decisions about the colleague?

Jason: I don’t know where I’ve learned that.

Melissa: Is there someone...

Jason: I think it’s a choice. We have two choices, to speak up or to remain silent...I, it wouldn’t lead anywhere if I said, well, I could have said you’re being inappropriate.

In this example Melissa thickened Jason’s preferred account of his isolation and introversion as positive and self-protective through her use of the language of choice—that Jason’s act of remaining silent was a choice made in opposition to the disrespect he received: first, through her statement, “in your silence, in remaining silent, you were choosing”, and second, from her statement “because it’s a choice, right you made to remain silent.” Through her language of “choice” Jason’s earlier statement that his isolation and introversion are aligned with his preferences of positivity and self protection became “thickened”, allowing further engagement with the **alternative discourse of intentional state conceptions of identity**. Melissa’s language that Jason’s actions were a “choice” continued the process of characterizing his introverted and isolating behavior as an act of personal agency, reflected in Jason’s response where he too started using the word “choice” as he stated, “I think it’s a choice. We have two choices, to speak up or to remain silent.”

5.3.1.3 Re-Authoring Via Reflection on the Meaning and Values Behind Jason’s Act of Isolation. Encouraging reflection on the meanings and values behind Jason’s actions occurred in the single session between client Jason and therapist Melissa. Following his telling of the story of being publicly insulted by this friend/work colleague Jason told an additional story of dealing with this same difficult friend/work colleague when the two were on vacation together. In recounting this story Jason noted how he purposely locked himself in his room to isolate himself from this friend when she was being difficult. Upon hearing this story Melissa used it as an opportunity to reflect on the meaning and values that Jason was enacting that were in line with his previous comments that this behavior was both positive and protective, and continued their engagement with the **alternative discourse of intentional state conceptions of identity**.

Jason: The only thing is that I started staying in my room and not willing to come out and talk to her, to see her, you know. But I didn't want to offend her, so I stayed there. And it happened, once, twice, and then I had a panic attack inside the room.

(...)

Melissa: Because it sounds like this was a friend of yours who was staying

Jason: Yes

Melissa: you had, there was an issue with her behavior

Jason: Yes

Melissa: And, so you did that thing that you do, right? That sort of

Jason: Yes

Melissa: Isolating, withdrawing.

Jason: Yes

Melissa: Um. And on one hand, this produced a bit of anxiety in you

Jason: Exactly

Melissa: It sounds like, on the other hand this was an effort, and tell me if I don't have this right

Jason: Mm-hm

Melissa: It sounds like it was an effort to keep this relationship

Jason: Yes...

Melissa: safe.

Jason: It is!

Melissa: Because you said, you said you didn't want to have the conflict with her

Jason: Exactly

Melissa: You wanted to keep her feelings

Jason: Yes

(...)

Melissa: And so, you took the step of isolating.

Jason: Yes.

Melissa's statements "you took the step of isolating" as a way of Jason reducing the conflict between him and his friend, "to keep her feelings" and to "keep this relationship safe" all

spoke to highlighting the meaning and the values that were driving Jason's actions to which Jason agreed. Melissa's wonderings again invited Jason to reflect on the values and meanings behind Jason's action in this story and further supported the co-construction of Jason's preferred identity that his isolation and introverted behavior was both positive and of himself and of his friendship.

5.3.1.4 Therapist Melissa Reinforced Jason's Preferences/Preferred Identity When He Returned to Problem Talk. In a return to the story of being insulted by his colleague/friend at university, Jason spoke of feeling weak for not being more assertive and responding to this friend/co-worker who was rude to him.

Melissa responded by engaging in a conversation that changed the meaning of Jason's actions that was supportive of Jason's preferences/preferred identity, and in which she uses the language of "conscious decision", echoing her earlier language that Jason made a "choice" to remain silent amidst the backdrop of **the alternative discourse of intentional state conceptions of identity.**

Jason: It's I often feel guilty about not being, mmh, assertive?

Melissa: Mm-hm. Right.

(...)

Jason: For being...

Melissa: Being silent and not being

Jason: Exactly.

(...)

Jason: Um, I know many people are like that. But it's not just me. But I feel guilty about it. I think I should be stronger. I feel weak.

Melissa: Like, I should have. I should have said something.

Jason: Yes.

Melissa: And maybe I should have stepped forward. What I'm hearing is this conscious decision making [Jason] around the person you are and what you're willing to give your energy to, and what you're willing to give airtime to.

Jason: Mm-hm.

Melissa: Right, so when you talk about that experience about the colleague in front of the students, it sounds to me like there's a lot of power

Jason: Maybe a mature decision.

Jason's language of "I should be stronger" and "I feel weak" is a return to his initial problem talk. Yet, in response, Melissa continued her engagement with the alternative intentional state identity discourse by reinforcing that his actions of remaining silent were positive and self-protective through her statement, "What I'm hearing is this conscious decision making..." This sought to change the meaning of Jason's actions to align with his preference, his intentions, and away from this problem talk. In a very quick turn around, Melissa's language of "conscious decision making" of who Jason is, was echoed by Jason through his statement "Maybe a mature decision." Melissa reinforced Jason's preferred identity as someone who made a conscious choice through this behavior to remain silent that was in line with his preferences. In addition, Melissa's use of the word "power" may have been an attempt to thicken Jason's action of remaining silent as a "conscious decision" or "choice" in-line with his preferred identity. While Jason did not take up her word "power", he continued to engage with the alternative discourse of intentional state conceptions of identity with Melissa through his language being reflective of a "mature decision." Jason's language of "mature decision" is a lovely example of the discourse shifting in session where he seems to be more fully adopting this alternative discourse which is in line with his preferred identity.

5.3.1.5 Re-Authoring Via Thickening Jason's Specific Identity as an Introvert. Melissa also supported the co-construction of Jason's preferred identity via invoking Jason's specific

language of being an introvert, that Jason mentioned at the beginning of his session. Jason initially stated at the beginning of the session, in addition to being “isolating”, “*I’m an introvert. I know about that*” and alluded to both positive and negative aspects of his isolating and introverted behavior. As Melissa and Jason more fully co-constructed the preferred aspects of Jason’s behavior based in the co-constructed language of “choice”, and through Melissa highlighting Jason’s preference of being in non-conflictual and safe relationships, Melissa specifically addressed Jason’s stated identity of being an introvert more explicitly to further reinforce this positive positioning. Specifically, Melissa used the language of Jason’s identity as an introvert as someone who has strength and power in his actions associated with introversion. Melissa combined Jason’s language of being an introvert with the idea of Jason’s behavior as being assertive. Additionally, Melissa also used “we” language including herself in this description of introversion alongside Jason.

Melissa: Um, we, we as introverts are not, going to be the one’s necessarily running forward to necessarily have words with someone. Or, or have a conflict. It doesn’t mean its not assertive. Because I think there’s an assertiveness in holding our ground.

Jason: Mm-hm.

Melissa: In not responding.

Jason: Right.

Melissa: In allowing someone to talk with no, with it going nowhere. And that’s a different kind of power and strength position.

(...)

Melissa: but, assertive doesn’t always mean responding. Assertive can be not responding.

Jason: Right

Melissa: Silent resistance. We have lots of examples of this...quiet, um, position, where we, we don’t give our energy to the other. We don’t give the other’s comments air-time. Perhaps they’ve been insulting.

Jason: Mm-hm.

Melissa: We simply don't respond. We don't, I think the phrase is um, dignify the response with an answer, right?

Jason: Yeah

(...)

Jason: It makes sense. Yeah.

Melissa: It may not be how you experience it.

Jason: It's not only a weakness. It's not a weakness. It's just a different type of decision, right?

This last statement from Jason shows a lot of movement in this position of remaining silent and not responding to his colleague/friend's insulting comment. He moved quickly from stating "it's not only a weakness" to it not being a weakness, to it being "just a different type of decision." Again, Melissa uses language that categorizes Jason as both an introvert, and as someone who is strong, and who exhibits strength more generally in choosing to respond how he did. Thus, there was a co-construction of meaning-making of Jason's identity that aligned with his preferences of being positive, protective, and safe with respect to his isolation and introversion through the therapist's invocation of this specific identity in the context of the **alternative intentional state identity discourse**.

5.3.2 Post-Session Questionnaire Responses From Therapist Melissa and Client Jason

a) In some cases, counselling conversations change the way clients/people see, think and/or talk about themselves. Would you say that happened in this conversation and if so how would you describe that change?

Therapist Melissa: *I think that there was a shift in the way the client saw his current and former actions/behavior/thoughts. Shift was from negative to positive interpretation. I don't necessarily think that a shift in his naming of the problem "isolation" was made but I think a seed was planted for future reflection. The client made several responses such as "Exactly!" or "I'm glad we are talking about this" which indicated and interest/readiness for a new interpretation/positive identity conclusion.*

Client Jason: *Yes. I will think about the positive side of my actions.*

b) Can you give an example of anything you talked about in the conversation that contributed to this?

Therapist Melissa: *The client's comments, as noted in question #1, were indicators. I think it was helpful for the client to further unpack his intention and values behind his behavior, which gave him the opportunity to reframe and re-story his response. In particular, we discussed his decision to remain quiet after a colleague insulted him. We identified why this choice was important, what he was hoping for in choosing this response and what others might have concluded about his response.*

Client Jason: *The idea that my actions, even those causing problems, suffering were motivated by a good/positive cause. E.g., My behavior towards my friend and students was motivated by the will to preserve relationships.*

c) Were there any moments in the session where you noticed you and the client/you and your therapist began to speak/think/talk about the client/yourself in a different way?

Therapist Melissa: *The client changed from storytelling about "the problem" to making links between his experiences and how he might have learned to think/act the way he does. The focus broadened from "what's wrong with me" to "I understand why that was important to me." This happened particularly when the client spoke of his experience as a child and how his ability to be "easy" and quiet were valuable contributions to the family; he grew up to be a quiet and non-confrontational adult. The client shifted from negative self-evaluation to an exploration of self and meaning making.*

Client Jason: *Nothing evident but the fact the session was being recorded was evident.*

d) Was there anything that the therapist said that you believe helped make this happen?

Therapist Melissa: *I asked about what he was thinking at the time of behavior (e.g. insulting colleague) and the impact of his actions on other (known or hypothetical). I also invited the client to consider the values at play during his decision-making and behavior. I called his actions "efforts" and "initiatives." I used phrasing like "sounds like you were listening to..."*

Client Jason: *Nothing I noticed.*

Melissa and Jason's post-session commentary highlights the importance that their time together had on re-framing Jason's understanding of his isolated/introverted behavior as based in a choice that was aligned with his preferences. Both participants responses point to a shift in Jason's understanding that re-categorize his actions associated with his preferred and positive intentions.

5.3.3 Co-Constructing Emma's Preferred Identity: Therapist Jill and Client Emma Engage With an Alternative Discourse Deconstructing Normalizing Judgement

In response to client Emma's initiation of the **problem discourse of normalizing judgement** in which she compared her value to others, and which was not aligned with her preferred identity, therapist Jill first countered this problem discourse by engaging with Emma in an **alternate discourse deconstructing normalizing judgement**. This alternative discourse deconstructing normalizing judgement claims that people's identities are not based in comparison to any norms but instead are separated out from any notions of norms completely. Counselling scholar Gerald Corey (2012) discusses this discourse of deconstructing normalizing judgement, stating that while all "social constructionist [counselling] theories emphasize listening to clients without judgement or blame, affirming and valuing them, [n]arrative practice goes further in deconstructing the practices of normalizing judgement that are found in medical, psychological, and educational discourse" (Corey, 2012, p. 411). This was done by therapist Jill through the narrative practice of positioning Emma in relation to her normalizing judgement. This discourse of deconstructing normalizing judgement "involves turning the tables and inquir[ing] about what clients think of the judgements they have been assigned. Narrative practitioners might be said to invite clients to pass judgement on the judgements that have been working them over" (Corey, 2012, p. 411). This was seen through therapist Jill's statement, *"Um, and correct me if I'm wrong but it sounds like the, its almost like the perception that you feel that other people are having over you has a huge impact on you, and it doesn't sound like you're Okay with that."* Thus, by separating Emma from these norms and her judgement of herself for not meeting them, this allowed Jill and Emma to engage with the additional alternative discourse celebrating persons' difference, uniqueness, and creativity immediately

following this narrative practice of positioning. Unlike the example in Jason and Melissa's session where Melissa positions Jason in line with his preference, this is the one and only example (across all five sessions) where therapist Jill uses the practice to position Emma against her problem of not feeling fully valued due to the influence of the dominant discourse of normalizing judgement.

5.3.3.1 Therapist Jill Positions Emma Against the Problem of Not Feeling Valued.

After Emma started her session by performing the discourse of normalizing judgement through her initial problem talk stating, *"I think that um...other people's input...or ideas of maybe how they operate, affect my own feelings of my worth"*, and *"I'm not good enough. Um, I can't meet the expectations, I don't fit the standard..."*, Emma also voluntarily alluded to her preferences stating, *"And I think there is a huge discrepancy of how I think others value me, and how I value myself. And my desire is to feel fully valued, at least most of the time (chuckle)."*

Contrasting these comments in relation to Emma's previous statements influenced by the problem discourse of normalizing judgement, therapist Jill invited Emma to take a position on her problem of being concerned with how others perceive her value. In doing so Jill and Emma engage at the macro level with the **alternative discourse deconstructing normalizing judgement** by tentatively positioning Emma against her initial problem talk and problem discourse.

Jill: Yeah. Okay. Okay. This is an interesting topic that we can talk about for sure. Um, and correct me if I'm wrong but it sounds like the, its almost like the perception that you feel that other people are having over you has a huge impact on you, and it doesn't sound like you're okay with that.

Emma: Like I'm almost in tears right now. Yeah?

Jill: Yeah. Yeah, so it...

Emma: Like I know it's fine...

Jill: ...hits deep...

Emma: but it's like a huge thing for me. Yeah.

Jill's statement "it doesn't sound like you're okay with that" tentatively positioned Emma against this problem of others not perceiving her value and invited Emma to stand against the problem discourse of normalizing judgement. In response, Emma displayed ambivalence stating, "it's fine", but also that she was on the verge of tears and that it was a "huge thing." By positioning Emma against this problem of not feeling valued by others, Jill and Emma began the process of co-constructing Emma's preferred identity in line with her preference of "feeling fully valued."

5.3.4 Co-Constructing Emma's Preferred Identity: Therapist Jill and Client Emma Engage With an Alternative Discourse Celebrating Emma's Difference, Uniqueness, and Creativity

Following their engagement with the alternative discourse deconstructing normalizing judgement, Jill and Emma engage with a second alternative discourse—the **alternative discourse celebrating peoples' difference, uniqueness, and creativity**—that was present between therapist Jill and client Emma throughout the rest of their time together through various narrative practices that will be discussed below.

This alternative discourse celebrating peoples' difference, uniqueness, and creativity is present in both the brief therapy movement and in narrative therapy, and directly challenges the problem discourse of normalizing judgement by questioning any focus on what is "normal" in terms of a person's identity and who they are. Narrative therapy taps into this alternative discourse by focusing on people's abilities to resist normalizing judgement by exploiting people's "sites of resistance, unpacking and constraining aspects of our self-stories and resurrecting the suppressed voice by recognizing and emphasizing the agency and creativity available to individuals in re-authoring their identities" (Brown & Augusta-Scott, 2007, xvii). In

a similar vein, Hoyt's (2017) writings on brief therapy engage with this alternative discourse celebrating peoples' uniqueness, individuality and creativity by encouraging brief therapists to

[b]e careful about "normal." "Neurosis," "psychosis," and "normosis" are all diseases. We may all be "more human than otherwise," as Harry Stack Sullivan said, but we're not all the same—and don't need to be. Moreover, much of what psychology teaches about "normal development" and "normal family structure" is based on studies of white Europeans and their descendants, a still largely invisible ethnocentric monoculturalism...Healthy solutions may be different for different people (p. 225).

While Foucault's notion of normalizing judgement can cause great stress for people both in and out of the therapy room, resistance to this problem discourse in relation to a person's identity allows for exploration of their "creativity, and the uniqueness of the person" (Olseen, 2008, p. 96) which allows for the "genuine possibility of free agency and creativity" (Olseen, 2008, p. 111). From this alternative discourse celebrating peoples' uniqueness, individuality and creativity, therapists and clients can disengage from the discourse of normalizing judgement and instead emphasize "the elevation of the client's and clinician's creativity and humanity within the therapeutic relationship; on the importance of focusing on strengths and competencies, more on what is possible than what is not; and on the skillful use of language in the construction of preferred realities" (Hoyt, 2017, xi). This occurs between Jill and Emma all through re-authoring conversations, including thickening of Emma's story of having value, reflecting on the meaning and values associated with Emma's ability to sit through her class during a panic attack, reflecting on the history and influence of Emma chasing her dreams of attending university, and thickening Emma's specific preferred identity of being a therapist.

5.3.4.1 Re-Authoring Via Thickening Emma's Preference of Having Value. Following Jill's tentative positioning of Emma as "not being OK" with the problem of others not perceiving her value, Jill supported thickening Emma's desire "to feel fully valued" by exploring the meaning of the word "value" as applied to Emma herself.

Jill: Do you mind if we talk about um, what your expectations of yourself are...

Emma: No.

Jill: and what you deem as what gives me value?

Therapist Jill's question sought to thicken Emma's account of her own value, and in response Emma recounted a story that spoke to this value—how she successfully went to college in her twenties. In telling this story, Emma spoke of her dream of going to university and getting her degree purely for herself regardless of the perceptions of others. Thus, Jill's focus on thickening Emma's language of "value", and what this word specifically meant to Emma, supported the co-construction of Emma's preference and preferred identity of "being fully valued" while simultaneously engaged with the **alternative discourse celebrating peoples' difference, uniqueness, and creativity.**

Emma: (crying, sniffing, long pause) In my early twenties...I didn't know if I was smart enough

Jill: Mm-hm

Emma: (crying) to go to university

Jill: Mm. Mm-hm.

Emma: (sniffs) Instead I went to college. I thought it would be easier.

Jill: Mm.

Emma: It was hard and I did well. (Breathes in and out). And when that door was open for me. When I saw the marks... (long pause) I felt it was possible, and I began having my...dream of going to university. Getting that degree because...(long pause) (sniffs) ...I wanna prove to myself that I can do it (crying).

Jill: Mm-hm

Emma: (crying) Nobody else, it doesn't matter

Jill: Mm-hm

Emma: what anyone thinks.

Emma's statement, "it doesn't matter what anyone thinks" spoke in defiance of her previous performance of the discourse of normalizing judgement and was aligned with the

construction of her preferred identity of valuing herself and of being fully valued. This process of “thickening”, introduced by therapist Jill, brought forth this story from Emma that she did well in college and noted her reasons for going to university. Through this story there was a thickening of Emma’s preference of being “fully valued” as she began to live out this alternative story.

5.3.4.2 Re-Authoring Via Reflection on the Meaning and Values Associated With Emma’s Action of Sitting Through Her Class. Emma and therapist Jill further developed Emma’s preferred identity of “being fully valued” through reflecting on the meaning and values behind Emma’s actions of staying in her class despite going through a panic attack. After hearing Emma’s story of having a panic attack in one of her classes, and of her ability to remain in the class despite this panic attack, therapist Jill used the story as an opportunity to invite Emma to reflect on her values and the meaning behind these actions, thus continuing their engagement with the **alternative discourse celebrating peoples’ difference, uniqueness, and creativity.**

Emma: That fighting was one hell of a determination because I’m like, if I get up I may not come back. And if I don’t come back, I’m missing something huge. The material, but not only that...I’m going to have such a conditioned response of fear to sit here next week.

Jill: Mm-hm.

Emma: I’m like, if I do that, I may...if I quit this, I’ll never be able to do it.

Jill: Mm-hm. So, what does it say about you that you forced yourself to sit through that discomfort?

Emma: I think it takes a lot of courage and strength. Man, if I heard someone did that, I’d be like damn!

Jill’s question “what does it say that you forced yourself to sit through that discomfort?” invited Emma to reflect on the meaning and values that drove her decision to remain seated through this panic attack, and helped co-construct Emma’s further qualities of “courage and strength” in support of her preferred identity of feeling fully valued. Additionally, Jill’s question “what does it say about you that you...” is a meaning making question helpful in updating

Emma's identity to fit with her developing alternative story, again happening between client Emma and therapist Jill continuing their engagement with the **alternative discourse celebrating peoples' difference, uniqueness, and creativity**.

5.3.4.3 Re-Authoring Via Tracing the History and Influence of Emma's Preferred Quality of Chasing Her Dreams. Tracing the history and influence of a client's preferences also occurred between client Emma and therapist Jill. At one point in her session therapist Jill became curious about the history of Emma's dream of going to university to become a counsellor, again continuing their engagement with the **alternative discourse celebrating peoples' difference, uniqueness, and creativity**.

Jill: Where did you...get that...idea? Where did that come from, that I do deserve to pursue my dream?

Emma: When you say it like that, I say, man, how ironic. That I'm gonna feel bad about myself and my worth and value, and yet I continually stand up for myself.

Jill: And what allows you to do that?

Emma: My passion. My faith. Um, I'm really close with my mother. And I'll always, felt she believed in me. Very strong support. Loving relationship.

Jill's questions "where did you get that idea?", "where did that come from?" and "what allows you to do that?" further traced the history of Emma's dream of being in university by tying in the influence of additional qualities of passion, faith, and her relationship with her mother. This is a further co-construction through Jill's questions and Emma's answers that support Emma's preferred identity of having value outside of the influence of others.

5.3.4.4 Re-Authoring Via Thickening Emma's Specific Preferred Identity as a Future Counsellor. Once Emma's preferred identity of being valued was more fully co-constructed towards the end of their session, therapist Jill then invoked Emma's preferred identity as a future therapist, drawing on the language that Emma used at the beginning of their session, "*Um, so I'm actually a psychology student. The idea of being a counsellor is my dream!*" This invocation

of Emma's preferred identity as-counsellor allowed Jill to engage in a new line of questioning with Emma around her preferred identity of being "fully valued" as a final way of combating Emma's problem of being concerned that other's do not perceive her value. Again, this is a further performance between the two of the **alternative discourse celebrating peoples' difference, uniqueness, and creativity**. In this case Jill and Emma very much tap into Emma's creativity of imagining her future counsellor-self.

Jill: I have a question about this future counsellor, when you are, um, sitting on the other side, um, of someone, what if it were you now sitting there? What would this counsellor, years in the future, be telling you about how to deal with this

Emma: (breathes out)

Jill: perceiving other people's...

Emma: So, I'm in your chair, and I'm also in this chair?

Jill: Yeah.

Emma: I like that (sniffs).

Jill: (chuckles)

Emma: (pause) ...Oh, man I would pump that person full of so much confidence. I would pump me with so much confidence.

Jill: What would you be, what kinds of things would you be saying?

Emma: (long pause) ...no matter...what anyone says, or does, or thinks...of your value... (voice becomes shaky) your value will never change... (crying) because it is always perfect.

By Jill further inviting Emma to engage from this identity of a counsellor through her questions, "What would this counsellor...be telling you about how to deal with this?", and "what kinds of things would you be saying?", the co-construction of Emma's preferred identity is very strong at this point as Emma replied that her "value will never change...because it is always perfect." This is a very different description of herself from what she initially described based on the discourse of normalizing judgement and instead occurs through the alternative discourse celebrating peoples' difference, uniqueness, and creativity.

5.3.5 Post-Session Questionnaire Responses From Therapist Jill and Client Emma

a) In some cases, counselling conversations change the way clients/people see, think and/or talk about themselves. Would you say that happened in this conversation and if so how would you describe that change?

Therapist Jill: *[Emma] began by describing herself as someone who worried about others' perceptions about her and the equal impacts of this such as diminished self-worth and hiding and being hard on herself.*

Throughout the conversation [Emma] was able to connect with skills, values she felt proud of, and possibility of meeting future goals when she shifts her attention to these aspects of herself. She was able to recognize strength, creativity, bravery, and passion which she felt letting hide was a detriment to her goals.

Client Emma: *Yes. The change came about because the conversation was re-directed toward the positive points after discussing negative feelings. The therapist was positive and supported and validated my feelings that I described. This allowed me to be led toward positive change in dialogue.*

b) Can you give an example of anything you talked about in the conversation that contributed to this?

Therapist Jill: *We talked about growing up and feeling it was not OK for her Dad to verbally abuse her and explored this inner knowing that it wasn't deserved. Discussed what it takes to go back to school at 40 with people half her age. Explored perceptions both positive and negative of friends and family and which were useful to give space to and which are not. Discussed what as a counsellor she may say to herself.*

Client Emma: *I described my dad as being verbally abusive. Through the exchange, I was led to discuss his positive points and it encouraged me to feel better about what I had said and allowed me to feel a sense of relief to focus on the positive.*

c) Were there any moments in the session where you noticed you and the client/you and your therapist began to speak/think/talk about the client/yourself in a different way?

Therapist Jill: *Almost immediately we began to externalize this negative perception as being something that she does not wish to have around. Having this position allowed us to explore what she knows about herself and what others know. She was able to say by the end of session "I'm proud of myself...I feel I'm capable of anything" which is very different from "I'm not worthy."*

Client Emma: Yes. Somehow the focus became about my passion and drive and feelings of worth, I began to feel empowered and even my posture changed when I spoke positively about myself.

d) Was there anything that the therapist said that you believe helped make this happen?

Therapist Jill: I used questions which explored the part of her that has always had wisdom of her worthiness. Using this from early on it made me curious about the role of this part of herself and how it may be useful in her preferred identity. Using remembering conversations about what her parents hope for her helped her see more possibilities than looking at damage caused by parents negative behaviors toward her.

Client Emma: She directed the conversation toward the positive aspects of what I was saying. She encouraged me to discuss the positive aspects more in depth. She discussed my passion about the future which got me excited, inspired, and empowered.

Jill and Emma's post-session responses both seem to agree about many points of content deemed important. More generally, they also seem to agree with the shift in Emma's experience. While Jill characterizes this as Emma experiencing a shift towards worthiness, Emma herself notes a more general shift towards positivity. While Jill references Emma's ability to connect with her skills, abilities, and values, Emma notes Jill's ability in session to re-direct their conversation towards a positive change in dialogue.

5.3.6 Co-Constructing Client Anna's Preferred Identity: Therapist Melissa and Client Anna Engage With an Alternative Discourse of Healthy Relationships With Self and Others

To counter Anna's problem discourse of co-dependency and its claim that Anna's identity lacks a sense of self by getting tied into unhealthy relationships with others, therapist Melissa and client Anna engaged with an **alternative discourse of healthy relationships with self and others**. Instead of claiming Anna's identity to be unhealthily co-dependent this alternative discourse claimed Anna's identity to be independent and healthy in her relationships with both herself and others. Rather than responding to Anna's statement of "I'm very co-dependent" therapist Melissa leaned into Anna's next statement "so I'm trying to spend more

time on my own” and highlighted how she did this through this alternative discourse of healthy relationships with self and others. In doing so therapist Melissa followed the brief therapy movement’s notion that “presenting problems and symptoms are relevant, of course, but no more so than a person’s resources and capacities to grow and change; endeavor to see ‘life beyond the problem’” (Hoyt, 2017, p. 224). Rather than focusing on how Anna is co-dependent, therapist Melissa focused with Ann on how spending time on her own manifests in her relationship with herself. In their work together in this session, and by each buying into this alternate discourse of health in relationship with self, therapist Melissa supported client Anna to align with this preference of “trying to spend more time on my own” and disregarded her statement “I’m co-dependent.” In this sense therapist Melissa focused on Anna’s “strengths and abilities, not weaknesses and deficits” (Hoyt, 2017, p. 89) and rather than correct Anna’s behavior that was co-dependent instead encouraged Anna’s efforts to be independent. In this way the therapist “[s]earches for and amplifies client competencies...[while avoiding] a vocabulary of deficit and dysfunction” (Hoyt, 2017, p. 89).

Therapist Melissa and client Anna engage with this **alternative discourse of healthy relationships with self and others** by first focusing on Anna’s development of healthy relationships with others, before turning to Anna’s relationship with herself. This alternative discourse is based on a claim that Anna’s healthy relationships with self and others is based “more on ideas of a relational self and as a result...[pays] more attention to what goes on between people rather than within them (Richert, 2002, p. 96).

Traditional Western notions of the “self” and personhood were adopted by Rogers (1961, 1977) and include seeing the client’s self as internally located, viewing the client’s self as being

knowable to the therapist, and viewing the client's self as something that can be improved upon with the influence of the therapist. Rogers (1961) stated that

during therapy the concept of the self becomes more congruent with the concept of the ideal self; during and after therapy the observed behavior of the client becomes more socialized and mature; during and after therapy the client increases in attitudes of self-acceptance, and this is correlated with an increase in acceptance of others (p. 228).

Rogers noted that it is through this therapeutic process which allows the client to accept themselves and their problems as they are, to reach an ideal self, and to ultimately become the person that they are fully capable of being (Rogers, 1989). While Anna and Melissa's session may be supporting Anna in reaching an "ideal self" the way they are speaking about this is through the narrative therapy practice of externalization. Narrative therapists "as social constructionists...view 'self' not as a core or essential or preordained entity, but as something that we constitute in relationship with other people" (Freedman & Combs, 1996, p. 268). In this way narrative therapists turn "away from prevailing psychological, psychiatric, systemic, and all other theoretical and practice views informed by humanism, structuralism, and individualism...and [move] in the direction of specific post structural theories that made the move toward ideas about the 'self' as a relational identity" (Madigan, 2019, p. 12). Therapist Melissa engaged with Anna in this alternative discourse through the narrative practices of re-authoring via thickening through offering up language of Anna as an "assessor", and through externalizing Anna's preferred "self."

5.3.6.1 Re-Authoring Via Thickening: Offering Up Language of Anna as an "Assessor." Immediately after Anna performed the problem discourse of co-dependency when she stated, "*I'm very co-dependent*", she also stated "*Um, and so, I'm trying to spend time on my own*" and noted historically not "*looking after myself really well*" prior to starting her DBT group. Anna's statement "*I'm trying to spend time on my own*" contrasted her previous

statement that she is co-dependent. In supporting this preference of spending time on her own and looking after herself in a way that existed outside of being co-dependent, therapist Melissa offered up the language of Anna as an “assessor.”

In the excerpt below, Anna noted how she was separated from her husband and was trying to decide whether to re-enter this relationship, or to continue seeing someone she was dating since their separation. Melissa invited Anna into the identity of an “assessor”, using this language to thicken her preference/preferred identity as someone who is taking care of herself on her own, outside of being co-dependent, outside of the problem discourse of co-dependency, and engaging this **alternative discourse of healthy relationships with self and others**.

Melissa: So, a wish for the relationship to, if it, if it can

Anna: If it can

Melissa: to go to a better place I guess.

Anna: Yeah. And then um, in that same time, this person that I've been dating, I know he's not good for the long-term for me, cause we are...two entirely, well, just, ah there's a lot of differences

Melissa: Mm

Anna: and I'm not

Melissa: Sounds like something you've assessed.

Anna: Yeah. And, any...I've been trying to let go of that relationship for a while. Um, and that one's on a hiatus

(...)

Anna: But eventually it will meet and end.

Melissa: Sounds like, in that assessment, you, you know something about the nature of that relationship and the nature of your needs.

Anna: Yeah. Yeah.

Anna's agreement here spoke to a co-construction of Anna's identity as an “assessor” in line with her preference—as someone who can take care of herself and focus on her own needs

rather than being co-dependent. Melissa continued to use this language of Anna as an “assessor” as Anna discussed potentially getting back together with her husband whom she is now separated from. Below Anna recounted a previous traumatic event involving the husband.

Anna: he started to hit stuff and I asked him to stop and

Melissa: Yeah

Anna: he didn't and um, and I know there are other things in our relationship that really bothered me was, that he, he worked, um, he was more concerned, very concerned about his job all, all the time. Worked extra hours, always worried about losing his job.

(...)

Melissa: It sounds like part of the place you're in [Anna] is this trying to tease out an assess like, what might be different this time around, you know? Is there an ability for [name of ex-partner] to maybe operate differently, understand differently?

Um, and if so, where might that lead you? And if not, where might that lead you? Right? And that's, and you yourself being in that evaluative place, of sort of, you know, you're exploring where can this relationship go.

Anna: Yeah, definitely, yeah.

Again, with these words that characterize Anna as an “assessor”, as well as Melissa’s words that Anna is in an “evaluative place”, Melissa and Anna are co-constructing Anna’s preferred identity of caring for herself outside of being co-dependent, and in-line with her previous comments of “trying to be more on my own.” In this case Melissa’s language of Anna as an “assessor” thickened this preference.

Like Jason’s adoption of Melissa’s language of “choice”, as the session continued Anna began using Melissa’s word “assessment” in reference to figuring out her identity.

Anna: And part of, mh, while I'm going through this assessment process trying to discover, to be aware, more aware of what my um, likes, dislikes

Anna then took up Melissa’s language of being an assessor, stating “I’m going through this assessment process trying to discover...my um, likes, dislikes” aligning her preferred

identity through the continued engagement with the **alternative discourse of healthy relationships with self and others.**

5.3.6.2 Externalizing Anna's Preferred "Self." While the narrative practice of externalizing client problems was virtually non-existent across all sessions, following the thickening of Anna's preferred identity through the language of Anna as an "assessor", Melissa then engaged Anna in an externalizing conversation about Anna's preferred "self" that lasted for the bulk of the second half of their session together. Following their discussion of Anna as an "assessor", therapist Melissa capitalized on Anna's earlier phrase "*I'm trying to spend time on my own*" by externalizing Anna's preferred "self" and making this the focus of the second half of their session. After Anna took up Melissa's language of Anna as an "assessor", Melissa began performing this narrative practice of externalization by characterizing Anna's preferred "self" as a thing that she is in relationship with. In this case Melissa and Anna externalized and objectified the positive and preferred version of Anna's "self" as a thing that she is in relation to. This practice of externalization of Anna's preferred "self" supported the co-construction of her preferred identity between Anna and therapist Melissa and continued to foreground the **alternative discourse of healthy relationships with self and others.**

Anna: And part of, mh, while I'm going through this assessment process trying to discover, to be aware, more aware of what my um, likes, dislikes

Melissa: Mm

Anna: things are. Um

Melissa: Mm. This relationship with self.

Anna: Yes. Yes.

Melissa: Mm-hm. Is that what you would call it?

Anna: Totally!

Melissa: Okay

Anna: That's totally it. To thine own self be true (chuckles)

Melissa: Oh, great phrase! (chuckles)

(...)

Melissa: It sounds like this work, tough as it is, is something you are um, dedicated to. Would that be the right word? Like, committed, dedicated, like that sense of what you owe to self.

Anna: Yeah

Melissa: What you want for self.

Anna: I've spent a lot of time not looking after myself

Melissa's phrases "This relationship with self", "what you owe to self" and "what you want for self" all speak to the externalizing of her preferred self. Additionally, there is a further externalization of Anna's preferred self through therapist Melissa's statements "this new...focus on yourself", "you're valuing the connection with yourself", and "You're valuing and learning more about yourself" as seen below.

Melissa: I wonder what has, um, what has changed for you with this new, newer um, sort of focus on yourself. I called it commitment, but this process that you're in, where you're valuing the connection with yourself. You're valuing learning more about yourself. What has been the impact of that? This, this sort of new place.

In response Anna also performed this externalizing conversation noting she "wants to be best friends" with herself, thus continuing the engagement with the **alternative discourse of healthy relationships with self and others.**

Anna: Yeah, I wanna master it. I want to. I wanna be able to live in there. I wanna be comfortable with myself.

Melissa: Mm-hm

Anna: I will be with myself for the rest of my life, right?

Melissa: Wherever you go, yes!

Anna: (laughs)

Melissa: (laughs) That's the thing.

Anna: I wanna be best friends with myself. That's the goal.

Anna's statements, "I wanna be comfortable with myself", "I will be with myself for the rest of my life", and "I wanna be best friends with myself" spoke to this language that Anna's externalized "self" and is an example of a positive externalization of Anna's preference/preferred identity that she is in relationship to and with.

Towards the end of the session Melissa again performed this narrative practice of externalizing Anna's preferred self as a place that she is moving closer to.

Melissa: Um, its such a nice feeling, considering that that's on the agenda for yourself. And not in a, the distant future, but like, everyday it sounds like. You know, you're moving further, or, excuse me, closer to this place.

As the session continued, Melissa then spoke of Anna's positive and preferred externalized "self" as something she is in relationship with and as a space she is creating for this "self", and juxtaposed this with the other relationships that Anna had spoken of in session and is a further engagement with the **alternative discourse of healthy relationships with self and others** rather than the problem discourse of co-dependency.

Melissa: And now you're in this in-between time.

Anna: (laughs)

Melissa: (laughs)

Anna: It feels like a really weird place to be.

Melissa: It probably is, right? You've got sort of [name of more recent partner] over here, and you've got [name of ex-partner] over here, and you've got self. This space that you've created for self. That, maybe it's more new, but it's very welcome. And so, betwixt and between, right?

While externalizing conversations usually involve externalizing a problem, this was not the case here.

5.3.7 Post-Session Questionnaire Responses From Therapist Melissa and Client Anna

a) In some cases, counselling conversations change the way clients/people see, think and/or talk about themselves. Would you say that happened in this conversation and if so how would you describe that change?

Therapist Melissa: *I think that the client was able to connect with valuing her process and her efforts towards a better relationship with herself. I also think she was able to connect with a deeper understanding of her needs.*

Client Anna: *Yes it did occur in this conversation. I was able to pinpoint at the beginning of the session of what exactly I needed to speak about. I often try to go on intuition. My clarity of mind is not as clear as I would always like it to be. After speaking about several problems I was having I was able (with the therapist's assistance) to talk about my journey in developing my identity in working through codependents anonymous. She helped me pinpoint the actual struggles through paraphrasing and validating my concerns. I spoke more honestly and clearly about what I am working on. I was able to see more positives as the session continued.*

b) Can you give an example of anything you talked about in the conversation that contributed to this?

Therapist Melissa: *(1) Her process of recovery, including the DBT group. (2) Her decision to choose her sponsor for codependents group and to trust him. (3) "To thine own self be true" - a phrase the client introduced. (4) Description of what she learned in family of origin vs. what she now knows is important re: effort.*

Client Anna: *As I spoke more about my journey and struggles with the relationships in my life I was able to find more self compassion as I made progress in self growth. The positive of mentioning and identifying the amount of effort I put into things I care about was particularly uplifting.*

c) Were there any moments in the session where you noticed you and the client/you and your therapist began to speak/think/talk about the client/yourself in a different way?

Therapist Melissa: *(1) When we discussed her decision to choose a male sponsor for her recovery. (2) When we discussed her idea of being in alignment with her values even if her current situation was out of alignment (when she talked about the fact that her two partners didn't know about each other (towards end of session))."*

Client Anna: *Yes, after I spoke about things for a bit she paraphrased what I said back to me and then added more clear insight that I was able to use to further the discussion of the topic I was on. It allowed me to talk about myself more freely in a non-judgemental way.*

d) Was there anything that you/your therapist said that you believe helped make this happen?

Therapist Melissa: (1) I asked about whether her decision to choose the male sponsor was part of her commitment to self, to being able to trust her own evaluation of needs. (2) I suggested that the idea that knowing what your values were and moving towards them, even slowly was being in alignment with values. They were not separate things. (Demonstrated this with my hands I-----I).

Client Anna: When she pulled out certain important/pertinent areas of truth in what I was explaining. This helped immensely. When she pulled out the positives in my progression in self as well.

Melissa and Anna's post-session responses both reference a shift towards Anna's preferred identity. Therapist Melissa notes their processing led to Anna having a better relationship with herself, while Anna notes how the many details that they spoke about led to a shift towards positivity and self growth. While therapist Melissa reflects several key topics of conversation, Anna appears to speak about the session in more general terms.

5.3.8 Co-Constructing Suzie and Amélie's Preferred Identities: Therapist Karen, Suzie, and Amélie Engage With an Alternative Discourse of Client Knowledge, Health, and Expertise

To counter both Suzie and Amélie's performances of the **problematic medical model discourse of pathology**, in both cases therapist Karen engaged with them in an **alternative discourse of client knowledge, health, and expertise**. This alternative discourse took the opposite position of the problematic medical model discourse of pathology where instead of the focus being on a person's underlying pathology the focus becomes the person's underlying health

in the sense that if the [therapist] relates to the pathology, it is likely that what grows in the treatment will be the pathology whereas, if the focus is on healthy aspects of the client's identity without naively ignoring pathology, then these healthy aspects are what will grow (Saari, 2000, p. 7).

Additionally, unlike the medical model discourse of pathology, the key to this health, rather than being seen as held by the therapist is held by the client. While the medical model

views the main source of cure of client pathology as dependent on the knowledge of the therapist, in this alternative discourse the main source of access to client health is based on the knowledge from clients themselves. Hoyt et al. (2018) notes that this is “competency-emphasizing therapy...[where] [therapists] should endeavor to function as mental-health, not mental-illness, professionals” (Hoyt et al., 2018, p. 157). As such, rather than being defined by pathology or medical disease people are assumed to be healthy, empowered, and knowledgeable.

This discourse is particularly strong within the brief therapy movement and social constructionist therapies such as brief narrative therapy, where therapists seek to create a “context of competence” (Hoyt et al., 2018, p. 13) that supports the client “to apply his or her skills to solve the problem that has brought them to therapy” (Hoyt et al., 2018, p. 13), again not on the basis of the therapist’s expertise but rather on the client’s, where it “is the client whose existing skills, abilities, and competencies are seen as primary in making a difference...[and] the strong focus is on whatever the client brings to the session that can be utilized to help the client achieve his/her/their goals...their own pre-existing (albeit sometimes overlooked) abilities” (Hoyt et al., 2018, p. 15). Where therapist knowledge is concerned, “therapists use their expertise primarily to help clients better use their own expertise” (Hoyt et al., 2018, p. 14). This is a different form of therapist expertise, not focused on therapist expertise that pathologizes a client, as seen in the medical model, but rather a therapist expertise that draws out the client’s own expertise. From this alternative discourse “*[t]herapist expertise holds no more prominence than client expertise*. Drawing on work by Foucault, Narrative therapists such as Michael White highlighted the issue of how psychological knowledge and diagnoses often reproduce dominant cultural values that serve to marginalize the wisdom of those who are socially excluded and viewed as outsiders. By reframing the therapeutic encounter as one to which each participant

brings his or her own expertise, therapy is seen to become more ethically and morally sound” (Walsh, 2010, p. 23). Thus, from this discourse, client identity is seen as healthy—not pathologized, and the role of the therapist is to empower the client by drawing out their own knowledge and expertise. As such the therapist puts greater value on the client’s own knowledge to the point that “[t]he more we suspended our own knowing the more room there was for a client’s voice to be heard and a client’s expertise to come to the forefront” (Anderson, 1997, p. 63). This alternative discourse of client knowledge, health, and expertise appears continuously in the various interactions between therapist Karen in her sessions with clients Suzie and Amélie, where Karen’s questions to Suzie and Amélie privilege their own expertise, knowledge and health over Karen’s own knowledge and expertise throughout both of these sessions. In what follows I will discuss the co-construction of Suzie’s preferred identity before turning to what this work looked like with Amélie. Narrative practices that occurred between therapist Karen and Suzie when engaging with this alternate discourse include Karen soliciting an experience near description of Suzie’s “comfort zone”, having a re-remembering conversation with Suzie, and reinforcing Suzie’s preferences/preferred developments when she returned to problem talk.

5.3.9 Co-Constructing Suzie’s Preferred Identity

5.3.9.1 Soliciting an Experience Near Description of Suzie’s “Comfort Zone.”

Therapist Karen obtained an experience near description in her single session with client Suzie and in so doing both engaged with the **alternative discourse of client knowledge, health, and expertise**. Rather than performing the problematic medical model discourse of pathology with Suzie, following Suzie’s initiation of this problem discourse with her comments that her staying in her room was a “barrier” to taking care of herself due to her suffering from “anxiety and depression” and her “mind”, Karen engaged with this alternative discourse by seeking out an

experience near description of Suzie's additional comments that she stays in her room because it is her "comfort zone."

Karen: And what is that thing that keeps you in your room?

Suzie: Just, it's my mind. And my, inability to feel like I need, wanna be social or, and I guess the in, the inability of being caught in feeling as down as I do.

(...)

Suzie: Like, it's not something I want other people to see first of all. And second of all, I don't want something bad to happen to me because I decided to leave my comfort zone.

Karen: Mm-hm. And your comfort zone is?

Suzie: Is my room.

Karen: It is your room.

Suzie: It is the room that I have in the house.

Karen: Yes. Tell me when you're in your comfort zone

Suzie: Yeah

Karen: can you describe for me so that I have a sense of, what that, what your comfort zone is like. How do you feel when you're in your comfort zone? What do you, what do you experience in your comfort zone?

Suzie: Um, I feel safe. But I tend to feel safer when I'm in my bed and I'm covered and stuff like that.

Karen: Yeah

Suzie: But I feel like almost everything is within my reach and that, um, I don't, that, I have complete control over everything in the area

In asking Suzie "can you describe...", "How do you feel..." and "what do you experience..." Karen's experience near description questions about Suzie's comfort zone shifted their conversation away from Suzie's performance of the medical model discourse of pathology, and into the alternative discourse of client health, knowledge, and expertise. This engagement with this alternative discourse shifted the meaning of Suzie staying in her room from one of self-

diagnosed pathology, which Suzie described as a literal “*barrier to take care of myself when I’m in those places*” to an act of self-care and safety when in her room.

5.3.9.2 A Re-Membering Conversation With Suzie. This narrative practice of re-membering occurred in the single session between client Suzie and therapist Karen and brought forth continued engagement with the alternative discourse of client knowledge, health, and expertise.

As Suzie and Karen spoke about Suzie’s mother, Karen invited Suzie to have a re-membering conversation about Suzie’s mother and how her mother has had a continued influence on Suzie’s life, supporting the co-construction of Suzie’s preference of caring for herself. Through Karen’s practice of re-membering, the meaning of “comfort zone” for Suzie was expanded, not only to include staying in her room but also included Suzie’s continued relationship to her deceased mother.

Following discussions of Suzie staying in her room as it is her “comfort zone”, Suzie went into greater detail around the circumstances which led her to either stay or leave her room. In their conversation, Suzie noted to therapist Karen that sometimes she will want to leave her room to socialize with her housemates but is unable to do so at times because of: (1) feelings of anxiety and depression, (2) wanting to stay in her room because she feels safe, comfortable and in her “comfort zone”, or (3) wanting to go outside of her room but feeling the need to stay inside her room when her housemates argued, making her feel unsafe for her to leave her room. As Karen and Suzie spoke about these differing circumstances as to why Suzie stays in her room, Suzie stated how she was “doing [her] best” to make the most of her living situation before she began to speak about her mother and their life together prior to her passing. This led to a more in-depth conversation between Karen and Suzie about Suzie’s mother, where Karen invited

Suzie to have a re-membering conversation about how her mother continues to influence Suzie's life. The re-membering conversation began after Suzie stated, "*I'm doing my best to make myself as comfortable as I possibly can in that home, right?*" After therapist Karen repeated this back to Suzie and asked what its like to know that she is doing her best, Suzie replied that it is hard because "*(crying) I just want my mom.*" Once Suzie spoke about missing her mom, and she gave further details about what her life was like since her mom died, therapist Karen immediately began performing the narrative practice of re-membering.

Suzie: (deep breath, crying) It's really hard being on my own after being with her

Karen: (softly) Yeah

Suzie: for...twenty-two years (crying) I don't, I don't know anything else. And I kind of walked into, a middle ground sort of bad place, and I don't know (crying) what else the world has to show

Karen: Yes

Suzie: (crying) but, it used to be a case of, no matter what, I had my mom with me, and now I don't (crying).

Karen: And what would your mom bring you, or offer you that would help you figure out what was before you? What did she bring to you?

Suzie: She was my comfort zone and

Karen: (softly) she was your comfort zone.

Karen responded by performing the narrative therapy practice of re-membering through her questions "what would your mom bring you...?", "what did she offer you?" and Suzie responded that her mom was her "comfort zone." Karen's re-membering questions and Suzie's answers again foregrounded the alternative discourse of client knowledge, health, and expertise. Thus, Suzie's previous description of her comfort zone being her room expanded in this exchange to include her relationship with her mother. In response to Suzie's statement that her mother was her comfort zone, Karen continued her performance of this narrative therapy practice of re-membering in order to more fully support the construction of Suzie's preference/preferred

identity of caring for herself, by connecting her previous description of her room as her “comfort zone” with Suzie’s continued relationship with her deceased mother.

Karen: Would it be alright if I said something?

Suzie: Yeah

Karen: I don’t know you

Suzie: (breathing heavily)

Karen: but you’ve told me in our very short time together, that you have made yourself a comfort zone. You just, when I asked you to describe your room the first word you said was comfortable and safe

(...)

Karen: And then you’re telling me you’re doing your best. Are those things that you learned from your mom?

Suzie: Yeah.

Karen: Yeah. And if your mom was here, and she saw that you were able to make yourself a comfy space, and you were doing your very best, how would she, what would she say to you? About what you’ve been up to?

Suzie: I know she’d be proud of me.

(...)

Karen: She’d be proud? What would she say?

Suzie: (breathes out) I don’t know exactly what she’d say, you know, I just know she’d be proud of me. And I know she worries. She’d be worried about me. But I know that, you know, overall she’d be so proud of what I’ve done.

Through this narrative practice of re-membering therapist Karen supported client Suzie in having a moment of connection with her deceased mother.

5.3.9.3 Therapist Karen Reinforces Suzie’s Preferences/Preferred Developments in the Face of Her Return to Problem Talk. Therapist Karen also persisted and refused to take up a return to problem talk in her session with Suzie, and helped Suzie make new meaning of her actions to align them with her preferences/preferred identity rather than Suzie’s problem talk.

After engaging in a re-membering conversation that assisted Suzie in speaking about her mother being her “comfort zone”, Suzie returned to problem talk of how she felt she was not where she wanted to be in her life since her mother’s death stating, “*I’m not making progress forward anymore.*” In response, Karen challenged the meaning of Suzie’s language of progress to align with her preference/preferred identity of caring for herself and to offer the view that she *is* progressing, again occurring within the context of the **alternative discourse of client knowledge, health, and expertise.**

Suzie: I just, I keep hitting barriers and I feel at, like now I’m not making progress forward anymore. And I just don’t know, like, what to do. Like, I don’t want that feeling of being trapped in my own home. I never had that before and I don’t like it.

Karen: You, you, you said a phrase, and I’m wondering if I could ask you a little bit about it? You said you’re not making progress anymore, and I don’t know what that means. Would it be alright if you explained that to me? Because I feel a little bit lost when I heard you say that.

Suzie: So, before my mom passed away, um, she passed away from cancer. So...I spent a lot of time with her, running back and forth to the hospital from the house we lived in. Like, going all the way from [area of city] to the [name of hospital] by bus everyday. I...I really, you know, went from someone who literally did almost nothing all day to, you know, somehow pushing myself to be there for her everyday and (breathes out)...And then, after she passed away I got my shit together still, and instead of wallowing, I got myself a new place to live, and I, I did my best to keep pushing forward because I know she’d want that, and stuff like that.

But, like, now I feel like, I don’t have work to go to, I don’t have school to go to, I, I’ve been working on my home and now I don’t, I don’t know what to do. Like, I want to continue doing something and I feel like I need to continue working with my home.

(...)

Karen: I think you’re, I think that, I think, I think you’re figuring it out. Like, I hear you say that you’re not doing anything and not progressing, like I hear you saying that

Suzie: Yeah

Karen: But...like I hear those words come out of your mouth. But I [Karen] hear you’re considering, reflecting, contemplating, ah, really taking a look at what a, your home life is like. What you want for yourself. This feeling of trapped. Like...for me, only me, that feels like a lot.

You are thinking, and planning, and contemplating, and trying to figure out if, if it’s something more that you want for yourself, and you know that there’s this experience of trapped-ness, and

you've labelled it as being trapped that you don't like. And you wanna be able to go to the, to a kitchen if you have a bad day. So, you also want those things for yourself.

Suzie: Yeah

Karen: So, to me [Karen], those...are doing things. That is progressing. So, I understand it as you don't see it as progressing, right?

Suzie: Yeah

Karen: But I do. Is it alright if we disagree?

Suzie: Yeah

Karen used Suzie's language that she feels she is not making progress as a way to invite Suzie to step into the opposite identity conclusion—an invitation to take up an identity that Suzie is someone who is making progress, based both on her actions which align with her preference/preferred identity, and despite the challenges she described in her living situation. Through Karen's disagreement, she invited Suzie to be re-positioned in dialogue as someone who is making progress.

Karen: Okay (quick breath out.) Okay. Thank you. So I will disagree, because it feels to me as if you're doing something, that you're doing a lot of big something. And you said to me "I'm working really hard."

Suzie: Yeah

Karen: So if you're working really hard, you're working hard, you're doing something, so, whatever it is your mind is telling you, you're not progressing, I, I, I, I'm not gonna a...I, I, there's nothing in my personhood that can say, oh, like, I'm gonna say

Suzie: (light chuckle) I agree with you on that, yeah you can't say that. I get that.

Karen: Why do you get that?

Suzie: Um, I guess cause like hearing me say those things and stuff like that, I mean, I guess knowing is the first part, right? In to like, that does, knowing, even though its not physically doing something its still doing something. Right?

Karen: Mm-hm

Suzie: And

Karen: What is it doing? If it's not physically doing something, and you and I both agree, its doing something.

Suzie: Yeah

Karen: What is it doing?

Suzie: It's preparing me I guess in a way to like, I can't move forward if I don't know how to move forward, right?

Karen's questions "why do you get that?" and "what is it doing?" invited Suzie to alter the meaning of her actions. Enacting the alternative discourse of client knowledge, health, and expertise, Karen offered the interpretation that Suzie is making progress. As a result, Suzie steps into the alternative identity conclusion that Karen invites her into—that her actions are reflective of someone making progress. Additionally, Karen's language changes from the client and therapist disagreeing to agreeing with one another. Her question, "*What is it doing?*" which she repeated twice, allowed Suzie to step into the identity that the therapist is inviting the client to take up and co-construct in which Suzie states that her own "*knowing*" is "*preparing [her]...to move forward.*"

5.3.10 Post-Session Questionnaire Responses From Therapist Karen and Client Suzie

a) In some cases, counselling conversations change the way clients see, think and/or talk about themselves. Would you say that happened in this conversation and if so how would you describe that change?

Therapist Karen: *Yes; the client during the conversation changed from describing herself "not progressing" to "planning" and this shift was noted to be helpful by the client. The client at the beginning spoke of not being able to go in the kitchen on a bad day and at the end she was considering how she might go into the kitchen.*

Client Suzie: *Today's conversation had me seeing my bad days in a new light. When I normally have bad days I hide from everyone which can sometimes stop me from doing simple things like cooking and/or eating. [Karen] made me see it in a new light. Just because I'm depressed one day doesn't mean I fundamentally change. I still feel I treat people with respect should I bump into them. I may feel like hiding but the reason shouldn't be that I will mistreat someone in my haze.*

b) Can you give an example of anything you talked about in the conversation that contributed to this?

Therapist Karen: *The client identified she was “doing her best” and “working hard” and those actions- (self agency) generated a shift. The identified “planning” state supported the client.*

Client Suzie: *Well, when [Karen] asked kind of how I saw her even though we were strangers, why I felt comfortable with. When she did the same, gave me her impression of me then asked about what I brought to the table. It made me understand that, that doesn't change on my bad days.*

c) Were there any moments in the session where you noticed you and the client/you and your therapist began to speak/think/talk about the client/yourself in a different way?

Therapist Karen: *Yes. (1) “Planning”, (2) What she could bring to stand up to the “little worries” (stopped getting to kitchen).*

Client Suzie: *Near the end, it kinda all came together in a new light. I thought of bad day me in a new way. Also the moment in question 2. It kinda made me look at myself from the outside instead of inside, like normal.*

d) Was there anything that the therapist said that you believe helped make this happen?

Therapist Karen: *I said I disagreed with her statement that she was doing nothing (= “not progressing”).*

Client Suzie: *I felt like [Karen] had a way of picking up words I said and kinda overlooked. She made me think twice which isn't something I normally do. Though in answer to this question, it really came together and happened when we took a moment to look at each other, two strangers, and share how we felt about our first impressions. As someone that often finds herself thinking about what other people might be thinking about me. This moment really shines through and hits home.*

Karen and Suzie's post-session responses appears congruent with Karen noting a shift in Suzie from not progressing to planning. Suzie speaks more generally that the session allowed her to view her bad days in a new light. Additionally, Suzie's reference to a moment when she and Karen spoke of their first impression of each other highlights an additional example of her experience of a positive shift that occurred because of this single session.

5.3.11 Co-Constructing Amélie's Preferred Identity

As noted above, therapist Karen and client Amélie also engaged with the **alternative discourse of client knowledge, health, and expertise** to counter the problematic medical model discourse that was initiated through Amélie's initial problem talk that was focused on her daughter's resistance to treatment for manic depression. Karen and Amélie engaged with this alternative discourse at the micro level through various narrative practices, including: gaining an experience near description of Amélie's experience of her daughter's depression, inviting Amélie to set the agenda for the conversation, re-authoring via thickening Amélie's preference of positivity, re-authoring via inviting reflection on the meaning and values associated with Amélie's action of buying clothes for her sisters, re-authoring via tracing the history and influence of Amélie's preferred qualities, re-authoring via thickening Amélie's preferred identity as a mother, and engaging in the narrative practice of collaborative note taking via co-constructing a session note together.

5.3.11.1 An Experience Near Description: Amélie's Experience of Her Daughter's Depression. This practice of gaining an experience near description was seen in the single session between therapist Karen and Amélie in relation to how Karen asked about Amélie's own experience of her daughter's manic depression. Rather than performing the medical model discourse of pathology by lingering with Amélie over the fact that her daughter is not seeking treatment for her manic depression, therapist Karen instead, influenced by the **alternative discourse of client knowledge, health, and expertise** sought an experience near description of Amélie's problem and how it specifically affected her.

Karen: And your daughter has manic depression?

Amélie: Yes, but she doesn't believe in it and ah, she doesn't follow therapy, and she doesn't take medications for it.

Karen: Mm...and what's that like for you [Amélie] to...

Amélie: Well, its hard. Its hard for my daughter, you know because as, she has highs and lows...like ah...she's not realistic when she's manic depressive. Like she's not treated, right?

Karen's question "and what's that like for you [Amélie]" sought an experience near description of how this problem effected Amélie. In response, it is unclear if Amélie's first statement "it's hard" was Amélie speaking about her own experience, her daughter's, or both. Yet, Karen's question invited Amélie to speak from her own knowledge and expertise when describing Amélie's own understandings and experience of her daughter's manic depression. As such, Karen's question privileged Amélie's local knowledge of her experience. Karen's question "what's that like for you [Amélie]?" focused on the construction of Amélie in relation to the problem of her daughter's mental health, rather than the issue of the daughter's mental health itself. This is a subtle difference, but an important one, as it allowed therapist Karen not to get drawn in to performing the dominant medical model discourse of "pathology" with Amélie but rather from the alternative discourse of client health, knowledge, and expertise.

5.3.11.2 Inviting Amélie to Set the Agenda for the Conversation. Aside from gaining an experience near description, therapist Karen and client Amélie also engaged with the **alternative discourse of client knowledge, health, and expertise** early on in their session by inviting Amélie to set the agenda for their conversation in relation to what Amélie thought the focus of their single session should be.

Karen: And so, um, could you help me a little bit in terms of, is there something in particular about your life, or something specific about your family that you would really like for us to talk about, or think about during our time together today so that this can be the most helpful use of your time?

Amélie: Well, umm...it's hard to be optim...positive, you know? It's hard to be positive. And um...but most of the time I'm positive you know.

Rather than assuming the focus of the single session to be on her family's medical and mental health issues, through her question "is there something in particular about your life, or something specific about your family that you would really like for us to talk about...?" therapist Karen invites Amélie to set the agenda, and in so doing both further engage with this **alternative discourse of client health, knowledge, and expertise**. Extending this practice of allowing Amélie to set the agenda for their single session allowed Karen to hear Amélie's preference of being positive and allowed the continuation and development of Amélie's local knowledge to be held at the forefront of this conversation.

5.3.11.3 Re-Authoring Via Thickening Amélie's Preference of Positivity. Therapist Karen thickened Amélie's use of the word "positive" after Amélie stated this preference/preferred identity in response to Karen's question of what the focus of the session should be. As a result, Karen (and Amélie following suit) both disregard the issue of Amélie's daughter's mental health concerns (for the time being), and the focus shifted entirely around "thickening" Amélie's stated preference of being positive. Karen began this practice by tentatively asking if the quality of positivity is something she and Amélie could talk about.

Karen: Would you mind [Amélie] if I asked you what it is about being positive that's important to you. Why is positive?

Amélie: Well because ah, life is easier and you're more happy you know?

Karen: Life is easier and you're more happier when you're positive.

Amélie: Yes.

Karen: How, how have you come to know that to be true?

Amélie: Well, a long time ago though...

Karen: Tell me.

Karen's tentative questioning of Amélie's language of positivity invited further explanation from Amélie to trace the history of this quality and continued their engagement with this **alternative discourse of client knowledge, health, and expertise**. As Karen asked questions that began tracing the history of Amélie's knowledge of her preference of being "positive", this led to alternate stories associated with Amélie's positivity which resulted in the construction of additional qualities that supported the thickening, and thus co-construction, of Amélie's preference of positivity. Amélie answered Karen's question "how have you come to know that to be true?" by telling a story of how her practice of prayer (both as a young child and currently) acted as a means of supporting her preference of positivity.

As Amélie and Karen spoke about Amélie's historical use of prayer as a means of staying positive when Amélie was a little girl, this led to a thickening of this preference of positivity through the co-construction of the additional quality of "hope."

Karen: And when you prayed it brought you something.

Amélie: Yeah.

Karen: Yeah.

Amélie: It brought me hope.

Karen: It brought you hope.

In this exchange therapist Karen started off the co-construction but client Amélie added the specifics of "hope." Here we see that co-construction genuinely involves contributions from *both* partners even though the process might be *led* by the therapist. It is enriched and sometimes takes on new directions because of the contributions of the client. Therapist Karen's focus of thickening Amélie's preference of positivity brought forth this alternate story of the history of Amélie's positivity expressed through prayer and which brought Amélie hope. This practice of

thickening the alternative story of Amélie's positivity allowed Amélie to begin living out this alternative storyline that went beyond Amélie's initial concern for her daughter's mental health problems.

5.3.11.4 Re-Authoring Via Inviting Reflection on the Meaning and Values Behind Amélie's Actions of Buying Her Sisters Clothes. In the single session between therapist Karen and client Amélie, as the two spoke in greater detail of Amélie's preference of positivity, and thickened this positivity with the additional quality of hope, Amélie then told a story of caring for her younger sisters and buying them clothes when she was fifteen. As a means of further co-constructing Amélie's preference of being positive, therapist Karen used Amélie's story as an opportunity to invite Amélie to reflect on the values that drove her actions in this story, again foregrounding the **alternative discourse of client knowledge, health, and expertise.**

Amélie: when I was fifteen, it became better. Fifteen-years-old. Because I worked at the post office, and it was really good pay. And I was working Friday night from five to ten. Saturday all day. Eight hours. Sunday, all day eight hours.

And I was studying high school from Monday, Tuesday, Wednesday and Thursday. I had good marks too you know. And um, I brought a lot of money at home. And I dressed myself well, because I had the money you know.

Karen: Yes

Amélie: And I dressed my two little sisters, two little sisters younger, you know. And they didn't have any money, my mom didn't have any money to dress them. So, when I used to buy a pair of pants, I'd buy two pairs of pants for my sisters you know. And, like and my mom didn't have any money to buy food sometimes, so I gave her money, you know.

Karen: [Amélie]...

Amélie: Yes

Karen: What you just shared with me, my mind is thinking about so many things and I'm just struck with, um, I have this vision of this fifteen-year-old-girl working so hard at school and having these really good marks and then spending your weekends working at the post office...

Amélie: Mm-hmm...

Karen: Yeah...what um...and then when you went home you would buy extra pairs of pants for your sisters.

Amélie: And sweaters.

Karen: And sweaters. And...can you tell me a little bit about why you did that?

Amélie: Well...

Karen: What was important to you?

Amélie: Well because I always had a good heart you know. I always have empathy for people, you know. I was told when I was younger that I was very charitable, you know.

Karen: Hwww....so you know that you are a very empathetic person.

Amélie: Yes.

Therapist Karen's questions "why did you do that?" and "what was important to you?" invited Amélie to reflect on the values behind these actions of supporting her sisters and allowed Amélie the chance to reflect and engage in a process of meaning making with respect to these actions. In response Amélie described herself as having a "good heart", as someone who is "charitable", and as someone who has "empathy" for others. Thus, these questions from therapist Karen and responses from Amélie further facilitated the co-construction of Amélie's preferred identity of being "positive" by adding these additional qualities of being charitable, empathic, and good-hearted to her preference of being positive.

5.3.11.5 Re-Authoring Via Tracing the History and Influence of Amélie's Preferred Qualities. In addition to enquiring into the values and meanings behind Amélie's actions, therapist Karen also traced the history and influence of Amélie's preferred qualities in further support of the co-construction of her preferred identity. This led to the creation of even more preferences in further support of Amélie's preferred identity.

In Amélie's session with therapist Karen, the two began tracing the history of Amélie's preferred identity of positivity early on in session. This led to the co-construction of the further qualities of "hope" (as described through Amélie's praying), "empathy", "compassion" and "good heartedness" (as discussed through Amélie's story of supporting her younger sisters when

she was fifteen). Following the co-construction of these additional preferred qualities, therapist Karen summarized these qualities and traced their history and significance with Amélie in support of the further co-construction of Amélie's preferred identity of positivity, continuing their engagement with the **alternative discourse of client knowledge, health, and expertise**.

Karen: So, um...I know we're not gonna know each other for a very long time, but would it be Okay if I just sort of said to you, like, I hear that you're a very empathetic person?

Amélie: Yes.

Karen: A really hopeful person.

Amélie: Yes.

Karen: A very caring person.

Amélie: Yes.

Karen: A very generous person.

Amélie: Mm-hm.

Karen: These are the things that you're telling me about yourself?

Amélie: Yeah.

Karen: Wow...And how have those qualities that you possess, how have they helped you in your life?

Amélie: Well, they did help me to be resilient. To becoming resilient, you know.

Karen's question "And how have those qualities you possess, how have they helped you in your life?" further traced the history and influence of these preferred qualities on Amélie's life. In response Amélie adds the additional quality of her resilience. As their conversation continued therapist Karen lingered in tracing the history of these qualities of "resilience" and "empathy" with Amélie. More specifically, she inquired as to how Amélie's preferred qualities of empathy and resilience have helped Amélie as per her concern for her family that she mentioned at the beginning of their session.

Karen: Mm-hm. Yeah, empathy. Resiliency. A big part of your life. Yeah. And, you must use those qualities now with your family?

Amélie: Oh Yes! Like I do, like I, for my daughter you know when she's, she has her ups and downs eh, because she's not followed by a doctor, and she doesn't take medication.

Karen: Yes.

Amélie: So I go down, I go up. I go down, I go up with her. I follow her, you know.

Karen: Yes. You follow with her?

Amélie: Yes. Just to give support. Like, ah, I will show you um, just a sec here. I wanna show you something.

Karen: Yes please.

Amélie: (reading text message from her phone): "You're too kind to me. Thanks a million." That's my daughter who wrote that to me.

This led to a new understanding between therapist Karen and Amélie about Amélie's relationship with her daughter, Amélie's concern for her daughter's mental health, and how Amélie supports her daughter with her mental health which was not present when Amélie originally performed the problematic medical model discourse of pathology. Karen's question "And you must use those qualities now with your family?" based in the **alternative discourse of client knowledge, health, and expertise**, traced the influence of Amélie's preferred qualities of empathy and resilience with her current family situation. In response this provided a thick and rich description of her relationship with her daughter. Thus, the relationship between Amélie and her daughter was being described by Amélie in a different way than what was first seen from the medical model discourse of pathology, and now more in line with her preferred identity of positivity.

5.3.11.6 Re-Authoring Via Thickening Amélie's Specific Identity of Being a Mother. In Amélie's single session with therapist Karen, Amélie initially stated, "Well I'm a mother of two kids", before noting all the mental health problems her family currently faced through her performance of the medical model discourse. Towards the end of their session after Amélie and

Karen spoke about Amélie's resiliency, Amélie read a text message from her daughter to Karen, stating "'You're too kind to me. Thanks a million.' That's my daughter who wrote that to me."

Once Amélie shared this text, Karen then invited Amélie to take up this specific identity as a mother, now in reference to how Amélie supports her daughter's mental health challenges, and after the co-construction of Amélie's preferred identity of being "positive" had been further developed through the additional qualities of Amélie being empathic, compassionate, warm-hearted, and resilient. This then spilt over into creating a different description of Amélie's relationship with her daughter that was not seen earlier in session due to the influence of the medical model discourse of pathology, continuing their engagement with the **alternative discourse of client knowledge, health, and expertise**.

Karen: Yeah. Yeah...And you say, "Oh yes", so you absolutely know it's the, it's the manic depression that gets in the way of expressing herself.

Amélie: Oh yes.

Karen: It takes things from her doesn't it.

Amélie: Mm-hm.

Karen: Yeah. You can see that as her mom.

Amélie: Mm-hm.

(...)

Amélie: Yeah. And, ah...I keep an eye on her, you know.

Karen: By texting her...

Amélie: Texting her a lot. And ah, sometimes she, she asks me at the last minute if I wanna go for a tea with her or something, and I do go. Even when I'm busy with something else I cancel my other things and I go for it with her.

Karen: You do? Wha! Why is it that you do that [Amélie]? Can you tell me?

Amélie: Well because she's my daughter.

Karen: But what does that, I mean, that means something to you. You say, because she's my daughter, I can see...what does that mean to you?

Amélie: I'm very maternal, maternal, maternal, ma-ter-na-lis-tic, you know. Yeah.

Karen: And so, because you're maternalistic, what is it that you say that, what is it that you value? Because you said that, even if you have other plans, you'll cancel them to be with your daughter if she calls last minute.

Amélie: Yeah.

Karen: Tell me about that. Like, what does it mean to you to be with her?

Amélie: That's why she wrote the text to me yesterday that I read to you, you know.

Karen's questions "what does that mean?" and "why is it that you do that?" allowed Amélie to make meaning of her identity as a mother in support of her daughter. These questions from Karen also allow the construction of a different description of Amélie's relationship with her daughter and the daughter herself than was initially seen in the session. It is once again a practice of soliciting an experience near description from the client by asking Amélie to reflect on the meaning of these actions to spend time with her daughter. Specifically, Karen's invitation to Amélie to focus on the meaning of her actions in relation to Amélie's identity as a mother further foregrounds the **alternative discourse of client knowledge, health, and expertise**.

Karen: "You're too kind to me. Thanks a million." What was that like as a mom to receive that text?

Amélie: Well it's a nice text. She's a very nice ah, she writes poetry...I told you she's very smart, eh? She sketches and...she writes poems in French without mistakes and she writes poems in English without mistakes.

(...)

Karen: Yeah, "You're too kind. Thanks a million." What did that bring to you [Amélie?]

Amélie: Good, good...warm the heart. Yeah.

By inviting Amélie to reflect on her identity as a mother in relationship with her daughter, the discussion shifted initially from one of it being hard for Amélie that her daughter does not seek treatment to one where we get a richer description of the mother and daughter relationship in line with Amélie's preferred identity of being positive, now seen in the context of supporting her daughter's mental health challenges.

5.3.11.7 Collaborative Documentation: Karen and Amélie Co-Construct a Session

Note. At the end of their single session therapist Karen asked client Amélie about her own views of her progress in session and how she was feeling about their conversation, to which Amélie replied “*Very good!...it helps me to clarify my life. It helps me to clarify the situation. It helps me to be positive.*” Once Karen got a sense of Amélie’s impressions of their session, she then introduced this practice of collaborative documentation and sought to put Amélie’s words on paper, continuing their engagement with **the alternative discourse of client knowledge, health, and expertise** with Amélie.

Karen: In every counselling session there needs to be a counselling note because I have a regulated college and its important that we, I write a note about our counselling session. Would it be alright if I asked you to help me write the note together?

Amélie: Yes.

Karen: It’s my preferred practice.

Amélie: Yes.

(...)

Karen: So, if I were to ask you to take a deep breath and reflect upon our conversation today, and then to share out loud what stands out for you, what was noteworthy, what might be helpful for you to hang on to or what did you bump up against in our conversation? And if you say it out loud, I will write it down and I’ll read it back, and then that becomes our note.

Amélie: Mm-kay.

Karen: Okay.

Amélie: Um, (long pause) it helped me to ah, say I’m not more or not less than anybody else on this earth. (Long pause- therapist writing this down). Okay, and ah, it helped me to ah, to realize how much I have empathy in my life and how much I was lucky to receive that love, that I’m lucky. Not that I was, I am lucky to receive that love I receive from my kids and my husband.

And umm (long pause- therapist writing) just my resilience (long pause- therapist writing). And ah, it helped me to have ah, hope....in the future, in the present, in the presence and the future. (Pause- therapist writing). And to keep going (Pause- therapist writing). And em... (long pause-

therapist writing) it helped me to realize that prayers is really helping me (pause- therapist writing). I guess that's about it.

Karen: Thank you. May I read it back to you?

Amélie: Yeah, sure.

Karen: It helped me to say that I am no more or less than anyone on this earth. It helped me realize that I have empathy in my life, and that I've received love from my kids and my husband. And to, to know that I have resilience. It helped me to have hope in the future, and in the present, and to keep going. It helped me to realize that prayers are really helping me.

Amélie: Mm-hm. That's good!

Karen: That's good?

Amélie: Yeah!

Karen: Why is it good?

Amélie: Well, ah...that's a good, ah, a good ah, resumé, you know? Yeah.

Karen: Yeah. Thank you for coming.

Amélie: I'm happy.

Once more, therapist Karen's questions "That's good?" and "Why is it good?" allow client Amélie further reflection on her thoughts through engagement with the **alternative discourse of client knowledge, health and expertise** as they completed their session note together.

5.3.12 Post-Session Questionnaire Responses From Therapist Karen and Client Amélie

a) In some cases, counselling conversations change the way clients/people see, think, and/or talk about themselves. Would you say that happened in this conversation and if so, how would you describe that change?

Therapist Karen: *I don't think the conversation changed the way [Amélie] sees herself. However, I do think our conversation provided an opportunity for her to linger in and experience a heightened awareness of qualities/skills and abilities and resources she has in her life.*

[Amélie] identified personal qualities of resilience, empathy, high IQ that may be helpful in thinking about her ‘burdens.’

She also spoke about the resource of her husband and how much happiness and caring he has brought to her life and the heightened acknowledgement of resources may increase hope which is important to [Amélie].

Client Amélie: *Yes. It made me realize that I was quite lucky to have the skills that I have to help me in my life.*

b) Can you give an example of anything you talked about in the conversation that contributed to this?

Therapist Karen: *Talking about resilience, the role her husband plays in her life and the benefit of hope she receives from praying.*

Client Amélie: *My fifteen-year-old teenage years with my sisters. My 20-year-old philosophy.*

c) Were there any moments in the session where you noticed you and the client/you and your therapist began to speak/think/talk about the client/yourself in a different way?

Therapist Karen: *I don’t think [Amélie] changed the way she views herself. I do think that spending time talking about her capacities lifted her mood and generated the experience of hope which [Amélie] said is important to her.*

Client Amélie: *Not really.*

d) Was there anything that the therapist said that you believe helped make this happen?

Therapist Karen: *No.*

Client Amélie: *N/A.*

Therapist Karen and client Amélie’s post-session responses appear congruent in that each comment about how the conversation allowed Amélie to tap into her skills as well as recalling previous experiences in her life that support her preferences. Additionally, therapist Karen notes that she felt their conversation did not generate a change in how Amélie experienced herself. This seems congruent with Amélie’s comments on the third question of the post-session questionnaire. I will comment on this further in the discussion chapter.

5.4 Additional Findings Based on a More General Reflection of My Analysis

Additional findings based on a more general reflection of my analysis of these five single sessions include: (1) narrative practices were transferable across sessions regardless of the problem discourse they were combating or the alternative discourse they were supporting, (2) therapists sustained preference talk by holding a decentered and influential narrative stance, and (3) some practices may be more prevalent in brief narrative single session settings.

5.4.1 Narrative Practices Were Transferable Across Sessions Regardless of the Problem Discourse They Were Combating or the Alternative Discourse They Were Supporting

Another striking finding from looking at my analysis was that many sessions shared the same narrative practices, regardless of the differing alternative discourses these practices were supporting, or the differing problem discourses these narrative practices helped stand against. For example, client Jason, Emma, and Amélie's sessions all prominently featured re-authoring conversations via the practices of thickening preferred stories. In some cases, this thickening occurred through a therapist offering up language to help develop a client's preferred identity following the client telling a story aligned with their preferred identity (e.g., therapist Melissa offering up the language of Anna as an "assessor" or offering up the language of "choice" to Jason to thicken up his preferred identity of the positive aspects of his insolation/introversion). In other cases, the development of client-preferred identity resulted from the therapist asking about the definition of a particular word that was important for a client as it supported the client's preferred identity (e.g., therapist Karen asking Amélie what the term "positive" means for her, or therapist Jill asking Emma what gives her "value"). In these cases, therapists are drawing on the same narrative practice but supporting different alternative discourses and standing up to differing problem discourses. This makes me speculate that perhaps re-authoring via the

narrative practice of thickening may be one of the more accessible narrative practices for clinicians engaged in single session work.

5.4.2 Therapists Sustained Preference Talk by Holding a Decentered and Influential Narrative Stance

Perhaps the most remarkable finding from my analysis of these sessions was the therapeutic talk between clients and therapists was almost exclusively focused on client preferences and the development of client-preferred identity. I believe this occurred because of a combination of clients alluding to their preferences/preferred developments much earlier than expected (as previously discussed), and therapists leaning into, and engaging with clients, about these preferred developments/preferences, through the plethora of narrative practices used to expand these preferences into more fully developed expressions of client-preferred identity.

This work was decentered because the initial expression of client preferences were initiated by clients. However, given that there are many stories available (multistoried), therapists chose to respond to some (client preferences/preferred developments) and not to others (client problems), thus portraying the influential dimension of the expression “decentered and influential.”

5.4.3 Some Practices May Be More Prevalent in Brief Narrative Single Session Settings

A final reflection on the findings from my analysis is the idea that perhaps some narrative practices are more prevalent in single session therapy compared to narrative therapy more generally. For example, while not narrative practices in the literature per say, in both Melissa’s session with Jason, and therapist Karen’s session with Suzie, therapists Melissa and Karen both reinforced client preferences during Jason and Suzie’s respective return to problem talk. While this practice is not explicitly stated in the narrative literature it makes me think that it is a

practice that may be more common in single sessions due to the time urgency often experienced by single session therapists to have conversations shift earlier to constructive talk despite the often-oppressive weight and space of client problem talk/problem stories often experienced by clients and therapists at the beginnings of single sessions. Likewise, in therapist Karen's session with Amélie, rather than engage with Amélie in her initial problem talk, Karen invites Amélie to set the agenda for their conversation. Again, while this may not be a narrative practice in the general narrative therapy literature per se, I suspect it would be a prevalent practice seen in the use of brief narrative single session therapy both as a means of quickly tapping into client preferences/preferred developments/alternative stories outside the influence of problem talk/discourses, and as a means of the narrative therapist being decentred and influential as the single session commences. Young (2006) notes that while setting the agenda in therapy sessions is not a practice unique to narrative therapy, it is one that allows for "inquiry into the person's hopes and wishes about what to converse about and to identify the conversational territory... Therefore, while setting the agenda, listening with 'poststructuralist curiosity' and taking care to create connection to possible subordinate storylines provides a place to start the conversation that can then expand as the questions move people into unusual conversational territories" (Young, 2006, p.5).

5.5 Chapter Summary

In this chapter I presented the findings from my hybrid analysis and post-session participant responses. While all sessions began with an expected problem focus, findings from my analysis highlight how these sessions deviated from more common narrative session structure. As client preference talk surfaced earlier than expected, all sessions were able to make an earlier pivot towards clients and therapists developing client-preferred identities throughout

these single sessions. Client initiated problem talk that was influenced by broader problem discourses was short-lived, as client and therapist engagement in a plethora of narrative practices backed by alternative macro discourses supported client-preferred identity co-construction. Post-session participant questionnaire responses displayed an overall positive shift towards the development of client preferences, preferred developments, and co-construction of client-preferred identity.

Chapter 6: Discussion

In this chapter I will discuss the results of my study in greater depth. To do so I will divide this chapter into seven parts. First, I will discuss the most significant findings from the macro portion of my discourse analysis. These include: (1) the curious absence of dominant problem discourses across all sessions, and (2) the presence of alternative discourses, and how narrative literature has little to say about them. Following this I will discuss how both findings point to a need for future trainings in brief narrative therapy to be explicit about how these macro aspects of therapeutic talk appear at the micro-level. Second, I will discuss the most significant findings from the micro portion of my analysis. These include: (1) that clients alluded to traces of preferences/preferred developments amidst their initial problem talk, and by doing so, (2) therapists were able to immediately and continuously support the development of client-preferred identity throughout these sessions. I will speculate as to why sessions progressed in this manner. Following this, I will then discuss that these findings are significant because: (1) they present somewhat of a role reversal whereby clients assisted therapists in shifting the conversations away from problem talk, (2) they highlight the importance of the therapeutic relationship within single session therapy, (3) they present the process of client-preferred identity co-construction from a vantage point not typically seen in the brief narrative literature, and (4) they deepen our understanding of the clinical practice of narrative therapy as related to Foucauldian theory. Third, I will discuss how findings from participant post-session questionnaire responses provide more nuanced understandings of how a shift toward client-preferred identity was experienced by participants. Fourth, I will discuss the study's strengths and limitations. Fifth I will present the study's contributions to knowledge. Sixth, I will discuss how my study lays fertile ground for future research in how client-preferred identity is developed

in brief narrative single session therapy. Seventh, I will provide a chapter summary and an overall wrap up of my thesis.

6.1 Discussion of the Most Significant Findings From My Macro Foucauldian Analysis

Findings from the macro-Foucauldian portion of my analysis challenged my original conception of what I thought doing this discourse analysis would look like. Prior to commencing my analysis, I thought engaging with this macro portion of my methodology would reflect a more traditional understanding of narrative therapy session structure within the collected data. However, these expectations were subverted due to two findings in particular: (1) the curious absence of dominant problem discourses, and (2) the unexpected presence of alternative discourses. Following a discussion of each of these findings, I will argue that despite their never explicitly being named in sessions, both dominant problem and alternative discourses each had a noticeable presence. Additionally, findings point to a need for a further discussion within brief narrative trainings around the deliberate consideration of how macro discourses (problem and alternative) might serve in guiding therapy processes related to client-preferred identity co-construction.

6.1.1 Neither Dominant Nor Problematic: The Curious Absence of Dominant Problem Discourses Across All Sessions

When I first envisioned conducting this study, I imagined a finished product whereby my initial macro-Foucauldian discourse analysis—that traced the dominant discourses influencing client problem talk—would play a much larger role than it ultimately did. My initial speculation of what my use of this macro portion of my methodology would reveal was influenced by my own eight years of training and ongoing work in the field as a brief narrative therapist. Since 2014 I have hosted thousands of single sessions from a brief narrative framework, and I assumed

(incorrectly) that I would find a somewhat parallel process reflected in my macro-Foucauldian discourse analysis of the data that was collected for this study.

I expected the data would mirror specific challenges that I found when hosting my own sessions, including: (1) how therapists provide support to a client who is stuck in problem talk influenced by a dominant problem discourse that occurs throughout a session, (2) that clients and therapists can maneuver around a dominant problem discourse only after great collective effort, and (3) how therapists handle times when clients unexpectedly returned to talk that is influenced by a dominant problem discourse after it seems like this problem talk (and discourse) has been eradicated. While these dominant problem discourses did show up through initial client problem talk as expected, following this they were not the formidable presence for clients and therapists that I expected them to be. Unlike what I have experienced when hosting my own sessions, the dominant problem discourses represented in this study were neither dominant, for any great length of time, nor did they appear to be all that problematic.

For better or for worse, my findings from my macro analysis of the data did not point to examples of a client's dominant problem discourse occurring continuously throughout sessions. Nor did my analysis find examples of participants struggling to subvert said dominant problem discourses. There were, however, a few minor examples in the data concerning my third-mentioned above point that showed how therapists re-directed client talk back towards preferred developments following a client's return to problem talk.

Dominant problem discourses faded quickly: (1) because in most cases clients were already referencing preferred developments during their initial problem talk, and (2) this allowed therapists to lean into, and expand, initial client expressions of preferred development through various narrative practices. By leaning into these preferred developments, and expanding them,

clients and therapists created another set of unexpected conditions that I had to contend with in my macro analysis—the identification of alternative macro discourses.

6.1.2 Stepping Into Unknown Macro Territory: Alternative Macro Discourses Supporting Client-Preferred Identity Co-Construction Were Not Explicitly Evident

Another unexpected turn concerning my use of my macro-Foucauldian analysis that I could not have predicted prior to its application on the collected data, was my need to identify the alternative macro discourses which drove the plethora of narrative practices that clients and therapists engaged in throughout these sessions. While my identification of client-initiated problem discourses was relatively straightforward, as was identifying the narrative practices which countered these problem discourses, I found identifying the alternative discourses that were behind narrative practices posed a much greater challenge. Even though the narrative literature describes practices for developing alternative storylines (many of which were adopted by the therapists in these sessions), rarely does the literature name alternative discourses. As previously noted in my methodology chapter, the one exception to this was the alternative discourse of “intentional state conceptions of identity”—a sort of meta-discourse as it relates to identity.

This alternative discourse appears in the narrative literature, primarily as articulated by Michael White; however, the other alternative discourses that I identified do not. For example, the medical model discourse of pathology and the discourse of normalizing judgement that were present in sessions are both powerful cultural discourses that appear inside and outside of the therapy room. Yet, the alternative discourses that were engaged in response to these problem discourses—the alternative discourse of client health, knowledge, and expertise, and the alternative discourse celebrating peoples’ difference, uniqueness, and creativity—are not

explicitly named in narrative culture/literature. This then raises a question going forward in both the fields of brief narrative therapy, and of narrative therapy more generally: why isn't more time and space allotted to the dissemination of alternative discourses at both the theoretical and practical levels? There are two reasons which I will discuss below.

First, problem stories are closely linked to wider cultural discourses, but preferred stories typically are not—or certainly not nearly as often. Thus, I believe identifying the macro-alternative discourses was such a challenge because they do not have the broad cultural reach that problem discourses do. Unlike problem discourses, they do not have that same macro feel in the sense that they are not discourses we are bombarded with through social media, or supported by our cultural institutions, etc. in our day-to-day lives. While we are not inundated for example, by a broader cultural discourse of client knowledge, health, and expertise, we are bombarded by one of pathology. While we are not barraged culturally by a discourse celebrating our uniqueness, we are flooded by one of normalizing judgement. Conversely, these alternative discourses seem to have a less global reach; they are prevalent with narrative and brief therapy but are focused on local knowledge and do not have the same history and institutional backing to extend their reach. As such, identifying these alternate discourses was difficult because they did not jump out at me in the narrative literature the way that problem discourses or narrative practices did.

Second, my identification of alternative macro discourses was difficult because therapies that fall under a postmodern umbrella (narrative therapy included) try to avoid Grand Narratives. Perhaps refraining from the explicit promotion or categorization of any alternative discourse is narrative therapy's way of protecting itself. This could be seen as the field's attempt to stave off merely substituting one dominant way of thinking for another. However, I believe my

identification of both problem and alternative discourses can stimulate important discussions in the training of clinicians who are learning to do narrative work.

6.1.3 Macro-Focused Teaching: The Need for Training That Explicitly Discusses Both the Presence and Influence of Dominant Problem Discourses and Alternative Discourses

During my own initial trainings in brief narrative single session therapy, my curiosity was piqued during discussions surrounding the presence of dominant problem discourses that most often influence initial client problem talk. At one training in particular, I remember the facilitator briefly discussed the presence of the dominant medical model discourse as often driving clients to come to therapy in the first place. I scanned the room and saw several clinicians nodding in agreement. While I too agreed, I was also curious as to what this medical model discourse looked like if it were to be further unpacked in future brief narrative trainings. When the clinicians who were nodding in agreement with the presenter experienced a problem discourse in their own sessions with clients how did it show up? How did they subvert it with their client? What narrative practices did they draw upon to subvert this dominant discourse and support the client's preferred identity co-construction? Rather than merely skate over these theoretical concepts and questions, findings from my analysis delve into this macro perspective in a way that can richly enhance future narrative trainings.

In all sessions but one—client Anna's session where she named the problem discourse of "co-dependency" at the beginning of her session—problem and alternative discourses weren't explicitly named. Thus, they remained hidden from view. As such, my naming of them was vital. There is an important pragmatic value in my explicitly naming the problem and alternative discourses that appeared in these sessions for teaching purposes. These findings can stimulate important discussions amongst clinicians in narrative therapy trainings to give more deliberate

consideration as to how problem and alternative discourses might serve in guiding therapy processes at the micro level. Such discussions could include explicit mention of both the presence and influence of the problem and alternative discourses that therapists are likely to encounter in their clinical work. While narrative therapy teaches that there are dominant discourses that influence client problem talk, narrative trainings rarely point to how these dominant problem discourses appear at the micro level of therapeutic talk. Thus, my naming of these discourses in this study allows practitioners doing similar work to think about their own single sessions in more macro terms, paying attention to how the discourses lurk in the background of therapy sessions.

Doing so might provide insight into how macro problem discourses may be negatively influencing discussions with clients at the micro-level. In addition, keeping an ear open to alternative macro discourses of preferred identity might open opportunities for constructive therapeutic talk. Specific changes to practices in trainings suggested by the thesis may include working with trainees to review session transcripts or tapes of sessions and identifying with trainees both the problem and alternative discourses that surface in the conversational exchanges.

Critics may argue that narrative therapy—already highly theoretical as it is—does not need to add yet another layer of theory to its trainings. I disagree. As was shown in my results chapter, discussions of both the dominant problem and alternative discourses that drive clinical interactions only serve to enhance our understandings of the practice of brief narrative single session therapy at the micro level. There is great value in having discussions with clinicians who are learning to do brief narrative single session work about what likely dominant problem discourses their clients may bring to session, their alternative macro counterparts, and how these alternative discourses drive specific narrative practices that they may use in sessions. Being

explicit about the influence of macro problem and alternative discourses is not only welcomed, but needed, as these discourses are rarely explicitly visible themselves within therapeutic dialogue. We get taught to execute certain narrative moves, yet the discourses informing these moves are not clearly laid out. Being more mindful about how macro discourse informs how we talk about client problems, and what alternative discourses inform our interventions, could support these interventions in coming to us more readily. Whether these discussions occur via clinicians reading about these ideas in a thesis such as this, or in real-time clinical trainings, both formats are equally important. `

6.2 Discussion of the Most Significant Findings From My Micro Analysis

Two of the most significant findings from the micro portion of my analysis were closely related, with one appearing on the heels of the other: (1) the finding that client preferences/preferred developments were alluded to by clients earlier than expected (and for the most part without therapist assistance), and (2) that because of these early-mentioned client preferences, therapists were able to immediately and continuously support clients in the co-construction of their preferred identities throughout the entirety of these sessions. Below I will speculate as to why sessions unfolded in this manner before further discussing their significance.

6.2.1 Speculation as to Why Sessions Unfolded as They Did

While it is striking that all sessions were characterized by the very quick introduction of preferred material and the sustaining of said material across all sessions I am less clear about how to account for this. However, I speculate this may have occurred for several reasons. First, the study's focus on identity may have primed clients to talk about themselves outside of their problem stories. Because clients were aware that the study was on how their identities get talked about in single sessions, this could be one explanation for why their preference talk surfaced so

early. Additionally due to the study's focus, therapists may also have been primed to lean into the development of client preferences and narrative practices that support the development of client-preferred identity more than they would have otherwise. Had the study been about brief narrative single session practice more generally for example, perhaps these conversations wouldn't have unfolded in the same manner. Therapists may have spent more time in problem talk with clients rather than quickly jumping to preference talk. Perhaps preference talk from clients may not have happened at all. Additionally, it is noteworthy that the five clients who participated in the study were either ongoing clients of the agency, or on the waitlist to receive ongoing therapy after having previously accessed the agency's walk-in clinic. As a consequence, there may have been less urgency to their presenting problems than with a sample of clients who had not previously received therapy prior to their participation in this study.

Additionally, prior to the start of their session's recording several client participants remarked to me that they were excited to be a part of this research. As such, the fact that clients were being recorded for research purposes may have actually led to their showing up in a somewhat more relaxed state compared to those clients who show up for a walk-in or pre-booked single sessions with a problem at the fore.

Regardless of my speculation, the fact that sessions unfolded in the manner they did is significant for several reasons. First, that clients assisted therapists so early on in sessions by shifting their discussion away from their initial problem talk and towards their preferences challenges a taken for granted assumption in psychotherapy that it is clients who are dependent on therapists for support. Second, that therapists were able to immediately and continuously support clients in the co-construction of their preferred identities highlights the importance of the therapeutic relationship within single session therapy. Third, that therapists were able to

continuously engage with clients in talk about their preferences/preferred developments throughout these sessions allowed for a different presentation of how this process of client-preferred identity co-construction can occur that is not typically reflected in the brief narrative literature. Fourth, this different perspective of how client preferred identity co-construction occurred allows for a deepened understanding of the practice of brief narrative therapy as related to Foucauldian theory.

6.2.2 Flipping the Script: Clients Assisted Therapists in Moving Sessions Away From Problem Talk

In somewhat of a role reversal from what is normally noticed in therapy sessions, it was clients who assisted therapists early on in shifting talk away from a problem focus. While these sessions were not swayed at the macro level by broader-problem discourses, I could not have predicted that the initial reason for this, at the micro level of talk, was because of *clients* not getting caught up in their own initial problem talk. Not only did clients not dwell on problem stories, in many cases they challenged these same problem stories by presenting their preferences/preferred developments much earlier than expected.

This finding not only challenges the previously mentioned problem-preference sequence common to narrative therapy session structure, but it also challenges conventional ideas about the roles played by clients and therapists in psychotherapy more generally. A conventional critique of single session work is that therapeutic change rests on the development of a therapeutic relationship—one that is inescapably the product of repeated and extended contact where the subject matter is primarily focused on therapists assisting clients with their problems. By demonstrating the active role that they can play in the co-construction of client-preferred identity—a view not often highlighted in literature more often focused on therapist

interventions—these findings show that clients don't necessarily always need to dwell on problem stories, and if given the space, may opt not to.

6.2.3 Highlighting the Importance of the Therapeutic Relationship in Single Session Therapy

In addition to a flipping of the script which occurred by clients assisting therapists by their early allusions to preferences, the sustained focus on this preferred material by clients and therapists throughout the bulk of all these sessions arguably points to a sound and productive therapeutic relationship. This contradicts the notion that nothing substantial can happen in therapy without the long-term development of the therapeutic relationship. A conventional critique of single session work is that therapeutic change rests on the development of a therapeutic relationship, and relationship is inescapably the product of repeated and extended contact. This study suggests otherwise. It seems plausible (and worthy of further study) that the persistent orientation to a person's values and preferences may quickly construct the kind of relationship that achieves therapeutic change. These single sessions demonstrated how constructive change is a collaborative achievement, with clients and therapists assisting each other in this process.

6.2.4 A Different Vantage Point Regarding How the Process of Client-Preferred Identity Co-Construction Occurs

As therapists were able to support clients regarding the development of their preferred identities immediately, and throughout the bulk of these sessions, this provided a different vantage point for how this process unfolds that is not typically visible in the brief narrative literature. Narrative therapy literature more generally, and specifically the work of Michael White, shows some brilliant work of how therapists can separate clients from problem stories and support client stories related to preferred identity. White's work gives an equal amount of

focus to both. Yet, because clients typically engage in highly pronounced problem focused talk at the beginning of single sessions via walk-in clinic, or pre-booked appointment, the brief narrative literature (Cooper, 2014; Young, 2008) tends to showcase externalizing conversations at the expense of re-authoring conversations.

What was remarkable about these sessions in addition to the fact that clients alluded to their preferred developments earlier than expected, is that by doing so, therapists could engage in re-authoring conversations, re-remembering conversations and other narrative practices associated with White's (2005) Statement of Position 2 Map that are not typically seen in brief narrative literature.

6.2.5 A Deeper Understanding of Narrative Therapy as Related to Foucault: Witnessing the Shift from “Docile Bodies” to “Enlivened Spirits”

That clients didn't get swept up by their own initial problem talk, alluded to their preferred developments earlier than expected, and thereby created the conditions that supported therapists in the development of client-preferred identities throughout these sessions is also significant because it allowed me to gain a deeper understanding of the practice of narrative therapy as related to the theory of Michel Foucault. Specifically, Foucault's concepts of “docile bodies” and “enlivened spirits.”

As previously discussed in the theoretical framework chapter, the narrative literature, drawing on Foucault, emphasises the oppressive weight of dominant discourses and frequently describes how these act to “subjugate” people. This perspective is powerfully captured by Foucault, who used the term “docile bodies” to characterize such oppression. Yet, in the five sessions I examined in detail, this docility was not present. Instead, I noticed a lot more of a different phenomenon described by Foucault—the emergence of “enlivened spirits.” My analysis

suggests this was because the conversations were mostly devoted to preferred identity construction.

For example, in Amélie's session with therapist Karen, her initial problem talk around her frustrations with her daughter's decision to not get support for her mental health challenges put Amélie in the position of a "docile body" with respect to this problem. However, by the end of the session Amélie's preferred identity of positivity had been further developed. As we get a different sense of who she is in relationship to her preferred identity of being positive, and how living from this preferred identity gives us a different story of her relationship with her daughter where Amélie is a source of support, Amélie comes across in the session transcripts as an "enlivened spirit" even stating at the end of the session that she is happy. A similar shift from "docile body" to "enlivened spirit" can be traced in Emma's session with therapist Jill, where Emma's initial problem talk caused her to describe herself as a "docile body" not feeling fully valued in the eyes of her peers at university, to an "enlivened spirit" who is able to imagine talking to her present self from her future therapist self with a message that her value is and always will be perfect. These, and other examples, allow readers to trace the progression of clients as fully embodied "enlivened spirits" as their preferred identities become more fully developed throughout the course of these sessions.

6.3 Discussion of Findings From Post-Session Questionnaires

While findings from participant post-session questionnaires provided additional context to help better understand client and therapist experiences, they also provided some more nuanced ways of understanding how participants experienced shifts towards client-preferred identity development. These nuanced responses include: (1) participants noting a shift in identity more generally, (2) participants attributing any client change to the contributions of their

conversational partners, (3) preferred developments celebrating the status quo pointing to an implicit shift towards preferred identity, and (4) participants pointing to a re-construction of preferred identity.

6.3.1 Nuanced Understandings of a Shift Towards Client-Preferred Identity

6.3.1.1 Post-Session Responses Point to a Noted Shift in Identity More Generally. After reading participant responses to post-session questionnaires, I was immediately struck by how—despite my not directly asking about identity in these questionnaires—there were three instances where participants described a change in client identity that occurred during the session. I found this surprising because reflecting on my process of creating these post-session questionnaires, I deliberately chose not to ask participants about any change in client identity after a meeting with my supervisor and thesis committee a few months prior to my thesis proposal defence.

At this meeting we discussed wanting to avoid potentially confusing participants by directly asking about changes to client identity in these questionnaires. The thought process behind this was that there was concern that the word “identity” would potentially confuse client participants as it is not a term always used in day-to-day conversations. There was also concern that my use of the term could potentially confuse therapists, as it was anticipated at this time (in the early stages of crafting my thesis proposal) that therapists would vary as to their degree of affiliation with narrative ideas and practices. Thus, being asked about a change in client identity following their session could potentially backfire with therapists who were not as narratively inclined in their practice. However, after reflecting on the post-session responses it may have been beneficial to ask directly about identity as participants did reference the term in three cases.

One of these references was from client Anna, who noted that she was able to speak about her journey in developing her identity with her therapist’s assistance. The other two

references to identity came from therapist Melissa, who noted a shift in client Jason towards a new interpretation of his isolation and introversion/positive identity conclusion, and therapist Jill, who noted that her questions to client Emma may have been useful in developing Emma's preferred identity. These comments from therapists speak not only to their use of the term identity, but also to their familiarity with the narrative therapy talk surrounding identity as they spoke of a shift towards "preferred identity" and a "positive identity conclusion."

Upon further reflection, I believe these comments around identity appeared despite my not directly asking participants about the term because: (1) therapists were familiar with narrative therapy's understanding of identity and client-preferred identity as a way of explaining their work and what occurred in their sessions, and (2) clients and therapists alike may have been indirectly primed to discuss identity in these post-session questionnaires because these terms were presented to participants in recruitment emails, as well as when going over informed consent for the study just prior to their session's recording. As such, I believe these factors may have contributed to participants being more open to referencing the term identity despite not being asked directly about it in post-session questionnaires.

6.3.1.2 Participants Referred to Their Conversational Partner's Contributions. An additional way that post-session questionnaires presented a more nuanced understanding of the process of client-preferred identity development was that participants referred to their conversational partner's contributions to their discussion, rather than their own contributions, or to any shared form of co-construction. For clients this manifested in post-session responses that focused on the positive contributions of therapists rather than a positive outcome that they co-constructed with their therapist. For instance, following Emma's session with therapist Jill, Emma stated that therapist Jill being positive in the session not only validated her own

experience, but this also led to positive change in their dialogue together, and additionally that Jill directed Emma to the positive aspects of her experience and supported the discussion of this in greater depth. Anna's reflections on her session with therapist Melissa similarly attributed a shift towards positivity due to therapist Melissa's interventions. It is perhaps not surprising that clients referenced what therapists did in sessions as clients may think of themselves as in their therapists' hands. While some of these post-session client responses can be directly attributed to the final post-session question "was there anything that therapists did to make this change happen?" this theme of clients noting a shift towards greater positivity due to specific therapist intervention was seen throughout their post-session responses.

For therapists their post-session responses seemed focused on client contributions to their sessions—more specifically their client's capacity to tap into their own values, skills, and abilities during their time with the therapist. Reflecting on her session with Anna, therapist Melissa reported Anna connecting to her values. While reflecting on her session with client Jason, Melissa again referenced Jason connecting with his values around his introverted behavior as re-storying the meaning of his actions.

While therapists focused on client contributions in their post-session questionnaires rather than referencing their own contributions to these conversations, or to a process of "co-construction", some therapists spoke in their post-session questionnaires about how the "conversation" supported clients in discussing their skills, abilities, and values. Upon further reflection perhaps this focus on their "conversation" is a slight nod to a process of co-construction without using this term. Concerning this, therapist Jill stated her conversation with Emma connected her to her skills and values, while therapist Karen similarly cited the conversation she had with Amélie allowed her to linger in her skills, abilities, and resources. This

therapist focus on the contributions of client skills, abilities, and values in session may be a carry over of the decentred and influential narrative stance that therapists took throughout these sessions. Even in post-session questionnaires therapists were not centering their own contributions to sessions but rather highlighting the contributions of clients.

6.3.1.3 Preferred Developments Celebrating the Status Quo: An Alternate

Understanding of Client Change and an Implicit Identity Shift. Another nuanced way of understanding this shift towards client-preferred identity came from client Suzie who reported a favorable *lack* of change in reference to her session with therapist Karen. Suzie reflected her conversation with Karen had her seeing her bad days in a new light. She noted that just because she is depressed one day doesn't mean she fundamentally changes. Suzie's comments appear to describe a novel experience of realizing she does not change despite her dealings with depression. Rather than a shift in identity being tied to a new event or different action associated with a new event, as was seen in examples from other sessions, here Suzie is speaking about the same event she started the session with (staying in her room and interacting with her roommates when leaving her room) but with a different meaning attributed to it.

Her comments align with the narrative literature's description of preferred developments occurring in the landscape of meaning (White, 2007). Narrative therapy frequently characterizes unique outcomes or preferred developments in the landscape of actions (White, 2007). We expect to see actions that are exceptions to the status quo to be developed. But in this case the unique outcome being developed between Suzie and Karen is located conversationally in the landscape of meaning. In this way, Suzie's preferred development is not a novel action, but an alternate meaning ascribed to the action she describes. Her revelation around not fundamentally changing despite her depression appears to be an implicit shift towards her preferred identity.

6.3.1.4 An Understanding of Client-Preferred Identity as Something That is Re-Constructed. A final nuanced way of understanding the shift towards client-preferred identity development came from therapist Karen and client Amélie and can also be understood as occurring in the landscape of meaning. Their post-session comments seemed to suggest that Amélie's preferred identity was re-constructed during their time together rather than co-constructed. When reflecting on any change in how Amélie spoke of herself in session, therapist Karen stated she didn't think Amélie changed the way she viewed herself, but that supporting her in talking about her capacities helped generate the experience of hope. Karen's comments seem to be congruent with Amélie's who also reported the session helped her realize the many skills she has in her life, but that there weren't any moments in the session where Amélie noticed talking, speaking or thinking about herself in a different way. Karen and Amélie's comments also make me think that perhaps in some cases client-preferred identity is not only co-constructed between the client and therapist, but re-constructed, meaning that clients and therapists are re-constructing preferred parts of client identities. While clients may already be aware of their preferred identity, it may become temporarily forgotten due to the problem's hold on their life. Related to this, I found myself being struck by both Amélie and Karen's post-session comments that Amélie really did not speak of herself differently in this session, and that there was no change that occurred during the course of their time together. I think I was so struck by this because getting to be an audience member to this session, it stands out to me as such a strong example of the development of Amélie's preferred identity of positivity. However, what I think is being distinguished here is that both Karen and Amélie are acknowledging that speaking about Amélie's preference towards being positive is nothing new for Amélie in how she knows herself. Thus, while Amélie and Karen are depicted as co-constructing Amélie's preferred

identity of positivity, perhaps this is more accurately described as a re-construction for Amélie as this is something she already knows about herself, despite therapist Karen hearing about it for the first time.

6.4 Strengths and Limitations

6.4.1 Strengths

One of the greatest strengths of this study is how thoroughly it captured brief narrative single session work. As I was able to work with full transcripts from five sessions, I got a rare glimpse into single session work from a brief narrative perspective. In addition, this study presents this dynamic narrative-informed practice in a way that is deeply theoretical, and theoretically consistent with the practice of narrative therapy. The study contributes to a better understanding of how these brief narrative single sessions operate from both a social constructionist and poststructural framework—both conceptually and methodologically. Yet, the strong theoretical basis to this thesis evolved over time.

When I had initially written my thesis proposal, I had envisioned my conceptual framework as purely social constructionist and my methodology as purely a Foucauldian discourse analysis. Yet, as the study progressed it naturally evolved and widened to be more reflective of the practice of narrative therapy. The result was a conceptual and methodological framework that was more theoretically reflective of narrative therapy. This allowed me to examine these therapy conversations with an eye to utterance-by-utterance conversational events while not losing sight of the broader social discourses influencing the exchange. It also allowed my analysis to focus on the practice of brief narrative therapy as it related to client-preferred identity co-construction at both micro and macro levels. Additionally, from the macro perspective, my exploration of the broader problem and alternative discourses give additional

context to the reader not typically seen in studies of brief narrative single session work. My micro analysis allowed me to present dynamic, narrative-informed practice that will be helpful to clinicians looking for concrete examples of single session work. In addition, my use of post-session questionnaires gave a rare glimpse into the experience of both clients and therapists about their impressions of these sessions which added greater context to my own findings from my analysis of these sessions.

6.4.2 Limitations

In terms of limitations of the study, there are a few. First, because I was unable to record across multiple sites, as I had originally anticipated, I taped all sessions at one location. As a result, all participants came from the same agency. This may have implications in terms of what showed up in the data. For example, in both of therapist Karen's sessions she engaged in the same alternative discourse. Had I recorded at multiple locations this may have led to more of a variety in the alternative discourses that therapists drew upon that would have appeared in my macro analysis. Additionally, I was unable to recruit clients and therapists for the study on a one-to-one ratio. Thus, it may be a limit that I was only able to recruit three therapists for this study while I recruited five clients. As two of these therapists each recorded two sessions as part of the study, this may have led to a repetition of particular types of narrative practices that surfaced in the data over others. For example, the most common narrative practices were those associated with re-authoring conversations (e.g., thickening client preferences, tracing the history of preferred qualities), while there was only one example of a re-membering conversation. Perhaps if I would have been able to recruit additional therapists to participate in the study there would have been even more of a variety of narrative practices that were demonstrated.

6.5 Contributions to Knowledge

The dissertation presents several contributions to the scholarly literature. First, the findings inform an understanding of process within brief narrative single session therapy (i.e., the “how” of client-preferred identity co-construction). Second, the study offers a unique blending both theoretical and methodological of social constructionism and poststructuralism that offers possibilities for diverse applications in discourse analytic research. Third, the study adds theoretical contributions to the study of narrative therapy itself. Specifically, it offers a heightened focus on the poststructural Foucauldian influence on the practice of narrative therapy, and how this Foucauldian influence is manifest clinically within single session settings.

In addition to the contributions of knowledge that this dissertation brings to the scholarly narrative therapy and brief narrative single session therapy literature, the study itself contributes to the practical knowledge of clinicians who do this single session work. For example, results from my analysis present a multitude of narrative practices that clinicians can draw upon in their own work. There are several examples not just of different types of narrative practices, but how clinicians engage clients in these specific practices. For example, in one session that was there is an example of collaborative note taking (that was highlighted in the results chapter) that clinicians can use as a model in their own work with clients. In other cases, we see the practice of thickening a client’s preferred story through the multitude of questions that the therapist asks to develop the client’s preferred story, while in another case thickening a preferred identity is shown by the therapist offering their own word in relation to hearing a client’s story. Additionally, as these clinical examples occur in real-time and were not edited, we see examples where a therapist’s questions or comments do not initially land with clients until only after a second attempt. Thus, these narrative practices didn’t always go smoothly throughout these

sessions. Presenting session excerpts in this way has practical value to clinicians who may read this thesis, much more so than presenting an excerpt that has been heavily edited to show the “perfect” example of narrative practice in action.

6.6 Future Research

This study plants seeds for future research. As narrative therapy shuns manualized, linear approaches and is improvisational in nature, similar studies would likely generate additional perspectives on the practice. It would be interesting to see future research that presents a different mix of brief narrative therapists conducting single sessions and how a different array of therapists might demonstrate the performance of additional narrative practices.

The study’s use of a hybrid discourse analysis which focused on both macro and micro aspects of these sessions could also be employed in future research projects. For example, it would be interesting to see a study of how different discourses of identity (preferred identity or problem identity) are reflective of specific therapeutic populations within brief narrative single session therapy—trauma clients, clients noting depression, clients noting anxiety—and what specific discourses may facilitate or hinder preferred identity co-construction within these specific clinical populations.

While this study explores the preferred identity co-construction of client’s more generally in brief narrative single sessions, future research around how this work is conducted with specific clinical populations would be interesting. For example, exploring what problem and alternative discourses arise within brief narrative single sessions with LGBTQ+ clients or clients who are refugees, and what narrative practices arise when supporting client-preferred identity co-construction with these specific populations.

Additionally, as the study found that there was such an early focus on preferred developments as introduced by clients, shifting the focus of sessions to not dwell on problem stories, it would be interesting to see if similar results occurred in a study of preferred identity co-construction in a cohort of long-term therapy, or a study comparing results of how preferred-identity co-construction occurs in long-term therapy versus single-session therapy. For example, what are the similarities, what are the differences, where is there overlap, and what results appear to individualize based on either therapeutic format? With its focus on less time, single session therapy itself may have a built-in mechanism whereby this reduced timeframe focus quickly pivots to client-preferences as a function of this limitation. Yet, a study of how the process of client preferred-identity co-construction occurs in a brief narrative single session setting compared to the use of narrative therapy in a more longstanding setting would be interesting.

6.7 Chapter Summary and Thesis Wrap-Up

In this chapter I discussed the most significant findings from my analysis of sessions in greater depth. The most remarkable feature of this thesis is the way all five sessions were devoted almost exclusively to preferred developments and preferred identity construction. This was striking because my research questions anticipated more explicit presence of problem discourses. This was also striking because the literature tends to portray narrative therapy conversations as preoccupied with problem discourses. These findings manifested both at the macro and micro levels as per my hybrid analysis of sessions. Findings from my macro analysis point to an overall need for future brief narrative training to be explicit about the presence and influence of both problem and alternative discourses. I believe this would assist therapists to engage more readily in preferred identity co-construction. Findings from my micro analysis allowed for the display of a different vantage point of client-preferred identity co-construction

not typically reflected in the brief narrative single session therapy literature. This different vantage point also allowed for a deepened understanding of brief narrative therapy as related to Foucauldian theory. Additionally, participant post-session questionnaire responses afforded a more nuanced understanding of the process of client-preferred identity co-construction.

My dissertation was born out of curiosity when I was first learning how to conduct brief narrative single session therapy at a walk-in counselling clinic. I became both incredibly interested in learning how broader cultural discourses show up in these single sessions, and how within the context of the discourses which appear, therapists support clients in preferred identity co-construction.

While there has been a boom in recent years in the field of single session therapy, much of the research is outcome studies. In these, clients and therapists tell researchers about the effectiveness of single session therapy post-session, but the reader is left without practical examples of what actually unfolds in effective sessions.

As noted elsewhere, there is a dearth of literature that examines therapeutic interactions at both the macro and micro levels. The hybrid macro/micro discourse analysis employed here allowed me to identify both the broader discourses that appeared in the five sessions I recorded, while providing a view of the dialogic back-and-forth that contributed to client-preferred identity co-construction.

Results did not reflect the typical narrative therapy session structure that is commonly portrayed in the literature. Rather, because clients alluded to their preferences and preferred developments earlier than expected, often challenging the same problem talk they began their sessions with, therapists were able to support clients with the co-construction of their preferred identities throughout the bulk of all sessions. These findings were significant in that their greater

preference focus provided a different vantage point of how client-preferred identity co-construction occurs in brief narrative therapy. The macro analysis showed that problem discourses were barely present, and it identified alternative discourses throughout sessions. This points to a greater need in brief narrative trainings to discuss the presence and influence of macro problem and alternative discourses and their influence at the micro level of talk. This study paves the way for future research in brief narrative therapy, single session therapy, and client-preferred identity co-construction.

References

- Aanesen, S.M., Notøy, R.R.G., & Berg, H. (2020). The re-shaping of bodies: A discourse analysis of feminine athleticism. *Frontiers In Psychology, 11*(1751), 1-9.
<https://doi.org/10.3389/fpsyg.2020.01751>
- Adler, J. M. (2012). Living into the story: Agency and coherence in a longitudinal study of narrative identity development and mental health over the course of psychotherapy. *Journal of Personality and Social Psychology, 102*(2), 367–389. <http://dx.doi.org/10.1037/a0025289>
- Adler, J. M., Chin, E. D., Kolisetty, A. P., & Oltmanns, T. F. (2012). The distinguishing characteristics of narrative identity in adults with features of borderline personality disorder: An empirical investigation. *Journal of Personality Disorders, 26*(4), 498 –512.
- Adler, J. M., Lodi-Smith, J., Philippe, F. L., & Houle, I. (2016). The incremental validity of narrative identity in predicting well-being: A review of the field and recommendations for the future. *Personality and Social Psychology Review, 20*(2), 142–175. <http://dx.doi.org/10.1177/1088868315585068>
- Adler, J.M., Turner, A.F., Brookshier, K.M., Monahan, C., Walder-Biesanz, I., Harmeling, L.H., Albaugh, M., McAdams, D.P., & Oltmanns, T.F. (2015). Variation in narrative identity is associated with trajectories of mental health over several years. *Journal of Personality and Social Psychology, 108*(3), 476-496. <https://doi.org/10.1037/a0038601>
- Anderson, H. (1997). *Conversation, language, and possibilities. A postmodern approach to therapy*. Basic Books.
- Anderson, H. (2007). A postmodern umbrella: Language and knowledge as relational and generative, and inherently transforming. In H. Anderson, & D. Gehart (Eds.), *Collaborative therapy. Relationships and conversations that make a difference* (pp.7-19). Routledge.

- Anderson, H., & Gehart, D. (2007). Preface. In H. Anderson, & D. Gehart (Eds.), *Collaborative therapy. Relationships and conversations that make a difference* (pp. xvii-xxiv). Routledge.
- Angermuller, J. (2014). *Poststructuralist discourse analysis*. Palgrave Macmillan.
- Arribas-Ayllon, M., & Walkerdine, V. (2010). Foucauldian discourse analysis. In C. Willig, & W. Stainton-Rogers (Eds.), *The SAGE handbook of qualitative research methods in psychology* (pp. 91-108). Sage.
- Augusta-Scott, T. (2007). Letters from prison. Re-Authoring identity with men who have perpetrated sexual violence. In C. Brown, & T. Augusta-Scott (Eds.), *Narrative therapy. Making meaning, making lives* (pp. 251-267). Sage.
- Avdi, E. (2005). Negotiating a pathological identity in the clinical dialogue: Discourse analysis of a family therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 78(4), 493-511. <https://doi.org/10.1348/147608305X52586>
- Avdi, E., & Georgaca, E. (2007). Discourse analysis and psychotherapy: A critical review. *European Journal of Psychotherapy & Counselling*, 9(2), 157-176. <https://doi.org/10.1080/13642530701363445>
- Ayashiro, H. (2016). Reproducing dominant discourses for therapy: Discourse analysis of a Japanese client's therapy. *Journal of Systemic Therapies*, 35(1), 39-53. <https://doi.org/10.1521/jsyt.2016.35.1.39>
- Bacon, I., McKay, E., Reynolds, F., & McIntyre, A. (2020). The lived experience of codependency: An interpretative phenomenological analysis. *International Journal of Mental Health and Addiction*, 18 (3), 754-771. <https://doi.org/10.1007/s11469-018-9983-8>
- Barthes, R. (1964). *Essais critiques*. Éditions du Seuil.

- Barwick, M., Urajnik, D., Sumner, L., Cohen, S., Reid, G., Engel, K., & Moore, J. E. (2013). Profiles and service utilization for children accessing a mental health walk-in clinic versus usual care. *Journal of Evidence-Based Social Work, 10* (3), 338-352. <https://doi.org/10.1080/15433714.2012.663676>
- Beattie, M. (1992). *Codependent no more: How to stop controlling others and start caring for yourself*. Hazelden Publishing.
- Becht, A.I., Nelemans, S.A, Branje, S. T, Vollebergh, W. A., Koot, H. M., & Meeus, W.H.J. (2017). Identity uncertainty in commitment making across adolescence: Five-year within-person associations using daily identity reports. *Developmental Psychology, 53*(11), 2103-2112. <http://dx.doi.org/10.1037/dev0000374>
- Belsey, C. (2002). *Poststructuralism. A very short introduction*. Oxford University Press.
- Benwell, B., & Stokoe, E. (2006). *Discourse and identity*. Edinburgh University Press.
- Berger, P., & Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. Doubleday.
- Blackledge, A. (2012). Discourse and power. In J.P. Gee, & M. Handford (Eds.), *The Routledge handbook of discourse analysis* (pp. 616-627). Routledge.
- Bloom, B.L. (1997). *Planned short-term psychotherapy: A clinical handbook* (2nd ed.). Allyn & Bacon.
- Bloom, B.L. (2001). Focused single-session psychotherapy: A review of the clinical and research literature. *Brief Treatment and Crisis Intervention, 1*(1), 75-86. <https://doi.org/10.1093/brief-treatment/1.1.75>
- Blume, T. W. (2010). Counseling for identity renegotiation. *Identity: An International Journal of Theory and Research, 10*(2), 92-105.

- Boyhan, P. A. (1996). Clients' perceptions of single session consultations as an option to waiting for family therapy. *Australian & New Zealand Journal of Family Therapy*, 17(2), 85–96.
<https://doi.org/10.1002/j.1467-8438.1996.tb01078.x>
- Brinkmann, S. (2016). *Diagnostic cultures. A cultural approach to the pathologization of modern life*. Routledge.
- Brown, C. (2007). Talking body talk. Merging feminist and narrative approaches to practice. In C. Brown, & T. Augusta-Scott (Eds.) *Narrative therapy. Making meaning, making lives* (pp. 269-302). Sage Publications, Inc.
- Brown, C., & Augusta-Scott, T. (2007). Introduction: Postmodernism, reflexivity, and narrative therapy. In C. Brown, & T. Augusta-Scott (Eds.). *Narrative therapy. Making meaning, making lives*, (pp. ix-xxxix). Sage Publications, Inc.
- Bruner, J. (1986). *Actual minds, possible worlds*. Harvard University Press.
- Bruner, J. (1990). *Acts of meaning*. Harvard University Press.
- Burkitt, I. (1999). Between the dark and light: power and the material contexts of social relations. In D. Nightingale, & J. Cromby (Eds.), *Social constructionist psychology. A critical analysis of theory and practice* (pp. 69-82). Open University Press.
- Burman, E. (1995). Identification, subjectivity, and power in feminist psychotherapy. In J. Siegfried (Ed.), *Therapeutic and everyday discourse as behavior change: Towards a micro-analysis in psychotherapy process research* (pp. 469–489). Ablex Publishing.
- Burman, E. (2001). Minding the gap: Positivism, psychology, and the politics of qualitative method. In D.L. Tolman, & M.B. Miller (Eds.), *From subjects to subjectivities: A handbook of interpretive and participatory methods* (pp. 259-275). New York University.
- Burr, V. (1995). *An introduction to social constructionism*. Routledge.

- Burr, V. (2002). *The person in social psychology*. Taylor & Francis, Inc.
- Burr, V. (2003). *Social constructionism* (2nd ed.). Routledge.
- Burr, V. (2019). Social constructionism. In P. Liamputtong (Ed.), *Handbook of research methods in health social sciences* (pp. 117-132). Springer. https://doi.org/10.1007/978-981-10-5251-4_57
- Cait, C.-A., Skop, M., Booton, J., Stalker, C. A., Horton, S., & Riemer, M. (2017). Practice-based qualitative research: Participant experiences of walk-in counselling and traditional counselling. *Qualitative Social Work, 16*(5), 612-630.
<https://doi.org/10.1177/1473325016637910>
- Campbell, A. (1999). Single session intervention: An example of clinical research in practice. *Australian and New Zealand Journal of Family Therapy, 20*(4), 183-194.
<https://doi.org/10.1111/j.0814-723X.1999.00128.x>
- Canella, G. (2015). Introduction: Engaging critical qualitative sciences. Histories and possibilities. In Canella, G., Pérez, M., & Pasque, A. (Eds.), *Critical qualitative inquiry. Foundations and futures* (pp. 7-28). Routledge.
- Carey, M. & Russell, S. (2002). Externalizing: Commonly asked questions. *The International Journal of Narrative Therapy and Community Work, 2*(2), 76-84. Retrieved February 7th, 2020, from <https://narrativepractices.com.au/publications/recent-publications-translated-articles>
- Carey, M. & Russell, S. (2003). Re-authoring: Some answers to commonly asked questions *International Journal of Narrative Therapy & Community Work, 3*, 60-71. Retrieved February 7th, 2020, from <https://narrativepractices.com.au/publications/recent-publications-translated-articles>

- Carlsson, J., Wängqvist, M., & Friséén, A. (2015). Identity development in the late twenties: A never ending story. *Developmental Psychology*, *51*(3), 334-345.
<https://doi.org/10.1037/a0038745>
- Carlsson, J., Wängqvist, M., & Friséén, A. (2016). Life on hold: Staying in identity diffusion in the late twenties. *Journal of Adolescence*, *47*, 220–229.
<http://dx.doi.org/10.1016/j.adolescence.2015.10.023>
- Chadderton, C. (2011). Not capturing voices: A poststructural critique of the privileging of voice in research. In G. Czerniawski, & W. Kidd (Eds.) *Student voice handbook: Bridging the academic/practitioner divide* (pp. 73-85). Emerald Group Publishing.
- Chambers, D., & Narayanasamy, A. (2008). A discourse and Foucauldian analysis of nurses health beliefs: Implications for nurse education. *Nurse Education Today*, *28*(2), 155-162.
<https://doi.org/10.1016/j.nedt.2007.03.009>
- Cheek, J. (2004). At the margins? Discourse analysis and qualitative research. *Qualitative Health Research*, *14*(8), 1140-1150. <https://doi.org/10.1177/1049732304266820>
- Cheek, J. (2008). Foucauldian discourse analysis. In L. Given (Ed.), *The SAGE encyclopedia of qualitative research methods. Volumes 1 & 2* (pp. 355-357). Sage.
- Cho, D., & Park, C. L. (2015). Cancer-related identities in people diagnosed during late adolescence and young adulthood. *British Journal of Health Psychology*, *20* (3), 594 – 612.
<http://dx.doi.org/10.1111/bjhp.12110>
- Chopra, D. (2013). [@DeepakChopra]. (2013, October 18). *Language creates reality. Words have power. Speak always to create joy.* [Tweet]. Twitter.
<https://twitter.com/DeepakChopra/status/391256134536790017>

- Christensen, M., Welch, A., & Barr, J. (2017). Husserlian descriptive phenomenology: A review of intentionality, reduction and the natural attitude. *Journal of Nursing Education and Practice*, 7(8), 113-118. <https://doi.org/10.5430/jnep.v7n8p113>
- Clegg, J., & Slife, B. (2009). Research ethics in the postmodern context. In D.M. Mertens, & P. E. Ginsberg (Eds.), *The handbook of social research ethics*, (pp. 23-38). SAGE Publications Inc. <https://dx.doi.org/10.4135/9781483348971.n2>
- Cloute, K., Mitchell, A., & Yates, P. (2008). Traumatic brain injury and the construction of identity: A discursive approach. *Neuropsychological Rehabilitation*, 18(5/6), 651-670.
- Cobb, P. (2007). Putting philosophy to work: Coping with multiple theoretical perspectives. In F. K. Lester (Ed.), *Second handbook of research on mathematics teaching and learning* (pp. 3–38). Information Age.
- Combs, G., & Freedman, J. (2004). A poststructuralist approach to narrative work. In L. Angus, & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory and research* (pp. 137-155). Sage.
- Combs, G., & Freedman, J. (2012). Narrative, poststructuralism, and social justice: Current practices in narrative therapy. *The Counseling Psychologist*, 40(7), 1033-1060. <https://doi.org/10.1177/0011000012460662>
- Combs, G., & Freedman, J. (2016). Narrative therapy's relational understanding of identity. *Family Process*, 55(2), 211-224. <https://doi.org/10.1111/famp.12216>
- Cooper, S. (2014). Brief narrative practice at the walk-in clinic: The rise of counterstory. *The International Journal of Narrative Therapy and Community Work*, 2, 23-29.

- Cooper, S. & “Ariane” (2018). Co-crafting take-home documents at the walk-in. In M.F. Hoyt, M. Bobele, A. Slive, J. Young, & M. Talmon (Eds.), *Single-session therapy by walk-in or appointment* (pp. 260-269). Routledge.
- Corey, G. (2012). *Theory and practice of counselling and psychotherapy* (9th ed.). Brooks Cole.
- Corey, G. (2016). *Theory and practice of counselling and psychotherapy* (10th ed.). Brooks Cole.
- Côté, J.E. (2018). The enduring usefulness of Erikson’s concept of the identity crisis in the 21st century: An analysis of student mental health concerns. *Identity: An International Journal of Theory and Research*, 18(4), 251-263. <https://doi.org/10.1080/15283488.2018.1524328>
- Cowan, H.R., Mittal, V.A., & McAdams, D.P. (2021). Narrative identity in the psychosis spectrum: A systematic review and developmental model. *Clinical Psychology Review*, 88 (August 2021) 102067. <https://doi.org/10.1016/j.cpr.2021.102067>
- Coyle, A. (2007). Discourse analysis. In E. Lyons, & A. Coyle (Eds.). *Analyzing qualitative data in psychology* (pp. 98-116). Sage Publications Inc.
- Craib I. (1997). Social constructionism as a social psychosis. *Sociology*, 31(1), 1–15. <https://doi.org/10.1177/0038038597031001002>
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Sage Publications Inc.
- Creswell, J.W. (2007). *Qualitative inquiry and research design: Choosing among five traditions*. (2nd ed.). Sage Publications Inc.
- Crocetti, E., Rubini, M., & Meeus, W. (2008). Capturing the dynamics of identity formation in various ethnic groups: Development and validation of a three-dimensional model. *Journal of Adolescence*, 31(2), 207–222. <http://dx.doi.org/10.1016/j.adolescence.2007.09.002>

- Cromby, J., & Nightingale, D. (1999). What's wrong with social constructionism? In D. Nightingale, & J. Cromby (Eds.), *Social constructionist psychology. A critical analysis of theory and practice* (pp. 1-19). Open University Press.
- Cruwys, T., & Gunaseelan, S. (2016). "Depression is who I am": Mental illness identity, stigma and wellbeing. *Journal of Affective Disorders, 189*, 36 – 42.
<http://dx.doi.org/10.1016/j.jad.2015.09.012>
- Davis, B. (2004). *Inventions of teaching: A genealogy*. Lawrence Erlbaum Associates.
- Dahlberg, G. Moss, P. & Pence, A. (1999/2007). *Beyond quality in early childhood education and care: Postmodern perspectives*. Falmer Press.
- De Fina, A. (2003). *Identity in narrative. A study of immigrant discourse*. John Benjamins Publishing Company.
- De Fina, A., & Johnstone, B. (2015). Discourse analysis and narrative. In D. Tannen, H. E. Hamilton, & D. Schiffrin (Eds.), *The handbook of discourse analysis. Vol. 1* (2nd ed., pp. 152-167). Wiley Blackwell.
- De Jong, P., Bavelas, J. B., & Korman, H. (2013). An introduction to using microanalysis to observe co-construction in psychotherapy. *Journal of Systemic Therapies, 32*(3), 17-30.
- Denton, J.M. (2016). Critical and poststructural perspectives on sexual identity formation. *New Directions for Student Services*, June 2016 (154), 57-69. <https://doi.org/10.1002/ss.20175>
- de Shazer, S. & Berg, I. (1992). Doing therapy: A post-structural re-vision. *Journal of Marital and Family Therapy, 18*(1), 71-81. <https://doi.org/10.1111/j.1752-0606.1992.tb00916.x>
- de Silva Joyce., H., Slade, D., Bateson, D., Scheeres, H., McGregor, J., and Weisberg, W. (2015). Patient-centred discourse in sexual and reproductive health consultations. *Discourse & Communication, 9*(3), 275-292.

- Dickerson, V. (2010). Positioning oneself within an epistemology: Refining our thinking about integrative approaches. *Family Process*, 49 (3), 349-368. <https://doi.org/10.1111/j.1545-5300.2010.01327.x>
- Dingle, G.A., Cruwys, T., & Frings, D. (2015). Social identities as pathways into and out of addiction. *Frontiers in Psychology*, 6: 1795. <https://doi.org/10.3389/fpsyg.2015.01795>
- Doan, R. (1997). Narrative therapy, postmodernism, social constructionism, and constructivism: Discussion and distinctions. *Transactional Analysis Journal*, 27(2), 128-133. <https://doi.org/10.1177/036215379702700208>
- Drewery, W., & Monk, G. (1994). Some reflections on the therapeutic power of poststructuralism. *International Journal for the Advancement of Counselling*, 17(4), 303-313. <https://doi.org/10.1007/BF01407746>
- Dreyfus, H., & Rabinow, P. (1982/2013). *Michel Foucault: Beyond structuralism and hermeneutics*. London.
- Dryden, W. (2019). *Single-session therapy (sst): 100 key points and techniques*. Routledge.
- Dryden, W. (2021a). *Single-session therapy and its future. What sst leaders think*. Routledge.
- Dryden, W. (2021b). *Help yourself with single-session therapy*. Routledge.
- Du Bois, J., Cumming, S., Schuetze-Coburn, D., & Paolino, D. (1992). Discourse transcription. In J. Dubois, S. Cumming, D. Schuetze-Coburn, & D. Paolino (Eds.). *Santa Barbara papers in linguistics. Volume 4*. Department of Linguistics. University of California, Santa Barbara. Retrieved from, <https://www.linguistics.ucsb.edu/sites/secure.lsit.ucsb.edu.ling.d7/files/sitefiles/research/papers/Working%20Papers%20Vol%204.pdf>

- Duff, P. (2002). The discursive co-construction of knowledge, identity, and difference: An ethnography of communication in the high school mainstream. *Applied Linguistics* 23(3), 289-322. <https://doi.org/10.1093/applin/23.3.289>
- Dunn, K.C., & Newmann, I.B. (2016). *Understanding discourse analysis for social research*. University of Michigan Press.
- Duvall, J., & Béres, L. (2007). Movement of identities: A map for therapeutic conversations about trauma. In C. Brown, & T. Augusta-Scott (Eds.) *Narrative therapy. Making meaning, making lives* (pp. 229-250). Sage.
- Eaves, E.R. (2015). “Just Advil”: Harm reduction and identity construction in the consumption of over-the-counter medication for chronic pain. *Social Science & Medicine*, 146 (December 2015), 147-154. <https://doi.org/10.1016/j.socscimed.2015.10.033>
- Edwards, D., & Potter, J. (1992). *Discursive psychology*. Sage.
- Edwards, J.A. (2008). The transcription of discourse. In D. Schiffrin, D. Tannen, & H.E. Hamilton (Eds.) *The Handbook of Discourse Analysis*, (pp.321-348). Blackwell Publishers.
- Ellis, A. (1989). Using rational-emotive therapy (RET) as crisis intervention: A single session with a suicidal client. *Individual Psychology*, 45(1-2), 75-81.
- Erikson, E. H. (1968). *Identity: Youth and crisis*. Norton
- Fairclough, N. (1989). *Language and power*. Longman Inc.
- Fairclough, N. (1992). *Discourse and social change*. Polity Press.
- Fairclough, N. (1995). *Critical discourse analysis: The critical study of language*. Longman.
- Fawcett, B. (2008). Poststructuralism. In L. Given (Ed.), *The SAGE encyclopedia of qualitative research methods. Volumes 1 & 2* (pp. 666-670). Sage.
- Foucault, M. (1963). *The birth of the clinic: An archeology of medical perception*. Routledge.

- Foucault, M. (1965). *Madness and civilization. A history of insanity in the age of reason*. Random House.
- Foucault, M. (1977). *Discipline & punish: The birth of the prison*. Vintage Books.
- Foucault, M. (1980). Two lectures. In C. Gordon, Ed. & Trans.; L. Marshall, J. Mepham, & K. Soper, Trans., *Power/knowledge: Selected interviews and other writings 1972-1977*, (pp. 78-108). Harvester Wheatsheaf.
- Foucault, M. (1994). The subject and power. In P. Rabinow, & N. Rose (Eds.). *The essential Foucault. Selections from essential works of Foucault, 1954-1984* (pp. 126-144). The New Press.
- Freedman, J., & Combs, E. (1996). *Narrative therapy: The social construction of preferred realities*. Norton.
- Friis, J. (2013). The influence of the therapist's activities on clients' subject positioning in relation to gender in narrative couples therapy [Unpublished masters thesis]. Rhodes University.
- Fullen, C.T. (2019). The therapeutic alliance in a single session: A conversation analysis. *Journal of Systemic Therapies*, 38 (4), 45–61. <https://doi.org/10.1521/jsyt.2019.38.4.45>
- Furedi, F. (2008). Medicalisation in a therapy culture. In D. Wainwright (Ed.), *A sociology of health* (pp. 97-115). Sage.
- Gaddis, S. (2016). Poststructural inquiry: Narrative therapy's de-centered and influential stance. In V. Dickerson (Ed.). *Poststructural and narrative thinking in family therapy* (pp. 9-27). Springer International Publishing.

- Gallardo, H., & Mellon-Gallardo, D. (2007). Stepmothering and identity. A co-constructed narrative. *Journal of Divorce & Remarriage*, 48 (1-2), 125-139.
- https://doi.org/10.1300/J087v48n01_07
- Gee, J. P. (2005). *An introduction to discourse analysis: Theory and method* (2nd ed.). Routledge.
- Gee, J.P. (2011a). *How to do discourse analysis: A toolkit*. Routledge.
- Gee, J.P. (2011b). *An introduction to discourse analysis. Theory and method*. (3rd ed.). Routledge.
- Gee, J. P. (2014). *How to do discourse analysis. A toolkit* (2nd ed.). Routledge.
- Gee, J., & Handford, M. (2012). Introduction. In J. Gee, & M. Handford (Eds.), *The Routledge handbook of discourse analysis* (pp. 1-7). Routledge.
- Geertz C. (1999). *Local knowledge*. Basic Books.
- Gergen, K. (1973). Social psychology as history. *Journal of Personality and Social Psychology*, 26(2), 309-320.
- Gergen, K. (1999). *An invitation to social construction*. Sage Publications Ltd.
- Gergen, K. (2015). *An invitation to social construction* (3rd ed.). Sage.
- Gergen, K., & Gergen, M. (2007). Social construction and research methodology. In W. Outhwaite, & S. P. Turner (Eds.), *The SAGE handbook of social science methodology* (pp. 461-478). Sage Publications Ltd.
- Gewurtz, R., Moll, S., Poole, J.M., & Rebeiro Gruhl, K. (2016). Qualitative research in mental health and mental illness. In K. Olson, R. A. Young, & I. Z. Schultz (Eds.), *Handbook of qualitative health research for evidence-based practice* (pp. 203-224). Springer.

- Gibbons, J., & Plath, D. (2006). "Everybody puts a lot into it!" Single session contacts in hospital social work. *Social Work in Health Care*, 42(1), 17-34.
https://doi.org/10.1300/J010v42n01_02
- Gibbons, J., & Plath, D. (2012). Single session work in hospitals. *The Australian & New Zealand Journal of Family Therapy*, 33(1), 39-53. <https://doi.org/10.1017/aft.2012.5>
- Gini, M., Oppenheim, D., & Sagi-Schwartz, A. (2007). Negotiation styles in mother—child narrative co-construction in middle childhood: associations with early attachment. *International Journal of Behavioral Development*, 31(2), 149-160.
- Gleason, P. (1983). Identifying identity: A semantic history. *The Journal of American History*, 69(4), 910-931. <https://doi.org/10.2307/1901196>
- Glynos, J., & Howarth, D. (2019). The retroductive cycle: The research process in poststructuralist discourse analysis. In T. Marttila (Ed.), *Discourse, culture and organization: Inquiries into relational structures of power* (pp.105-125). Palgrave Macmillan.
- Greckhamer, T., & Cilesiz, S. (2014). Rigor, transparency, evidence, and representation in discourse analysis: Challenges and recommendations. *International Journal of Qualitative Methods*, 13(1), 422-443. <https://doi.org/10.1177/160940691401300123>
- Guilfoyle, M. (2014). *The person in narrative therapy. A post-structural, Foucauldian account*. Palgrave MacMillan.
- Hall, S. (1989). Ethnicity: Identity and difference. *Radical America* 23, 9–20.
- Hamed, S., Ahlberg, B-M., & Trenholm, B. (2017). Powerlessness, normalization, and resistance: A Foucauldian discourse analysis of women's narratives on obstetric fistula in eastern Sudan. *Qualitative Health Research* 27(12), 1828-1841.
<https://doi.org/10.1177/1049732317720423>

Hare-Mustin, R. (1994). Discourse in the mirrored room: A postmodern analysis of therapy.

Family Process, 33(1), 19-35. <https://doi.org/10.1111/j.1545-5300.1994.00019.x>

Harman, R. (1995). Gestalt therapy as brief therapy. *Gestalt Journal*, 18, 77-85.

Harper, D. J., O'Connor, J., Self, P., & Stevens, P. (2008). Learning to use discourse analysis on

a professional training programme: Accounts of supervisees and a supervisor. *Qualitative*

Research in Psychology, 5(3), 192-213. <https://doi.org/10.1080/14780880802314320>

Harré, R., & Gillett, G. (1994). *The discursive mind*. Sage Publications.

Hatano, K., & Sugimura, K. (2017). Is adolescence a period of identity formation for all youth?

Insights from a four-wave longitudinal study of identity dynamics in Japan. *Developmental*

Psychology, 53(11), 2113-2126. <http://dx.doi.org/10.1037/dev0000354>

Hedtke, L. (2014). Creating stories of hope: A narrative approach to illness, death and grief.

Australian and New Zealand Journal of Family Therapy, 35(1), 4-19.

<https://doi.org/10.1002/anzf.1040>

Hodges, B.D., Kuper, A., & Reeves, S. (2008). Qualitative research: Discourse analysis. *British*

Medical Journal, 377(7669), 570-572.

Hook, D. (2003). Analogues of power: Reading psychotherapy through the sovereignty

discipline-government complex. *Theory & Psychology*, 13(5), 605-628.

<https://doi.org/10.1177/09593543030135006>

Hopkins, L., Lee, S., McGrane, T., & Brabara-May, R. (2017). Single session family therapy in

youth mental health: Can it help? *Australasian Psychiatry*, 25(2), 108-111.

<https://doi.org/10.1177/1039856216658807>

- Hoyt, M.F. (1994). Single session solutions. In M.F. Hoyt (Ed.), *Constructive therapies* (pp. 140–159). New York: Guilford. Reprinted in M. F. Hoyt, *Brief therapy and managed care* (pp. 141–162). Jossey-Bass.
- Hoyt, M.F. (1995). *Brief therapy and managed care: Readings for contemporary practice*. Wiley.
- Hoyt, M.F. (2017). *Brief therapy and beyond. Stories of language, love, hope, and time*. Routledge.
- Hoyt, M.F. (2000). *Some stories are better than others. Doing what works in brief therapy and managed care*. Brunner/Mazel.
- Hoyt, M.F., Bobele, M., Slive, A., Young, J., & Talmon, M. (2018). Single-session/one-at-a-time walk-in therapy. In M.F. Hoyt, M. Bobele, A. Slive, J. Young, & M. Talmon (Eds.), *Single-session therapy by walk-in or appointment* (pp. 3-24). Routledge.
- Hoyt, M.F., Rosenbaum, R. L., & Talmon, M. (1992). Planned single-session psychotherapy. In S. H. Budman, M. F. Hoyt, & S. Friedman (Eds.), *The first session in brief therapy* (pp. 59–86). Guilford.
- Hoyt, M.F., & Talmon, M. (2014). Chapter one. Editors' introduction: Single session therapy and walk-in services. In M.F. Hoyt, & M. Talmon (Eds.), *Capturing the moment: Single session therapy and walk-in services* (pp. 1-26). Crown House Publishing.
- Hymmen, P., Stalker, C. A., & Cait, C.A. (2013). The case for single-session therapy: Does the empirical evidence support the increased prevalence of this service delivery model? *Journal of Mental Health*, 22(1), 60–71. <https://doi.org/10.3109/09638237.2012.670880>
- Jenkins, R. (2014). *Social identity* (4th ed.). Routledge.
- Johnstone, B. (2008). *Discourse analysis* (2nd ed.). Blackwell Publishing.

- Kavoura, A., Ryba, T.V., & Chroni, S. (2015). Negotiating female judoka identities in Greece: A Foucauldian discourse analysis. *Psychology of Sport and Exercise*, 17(Complete), 88-98.
<https://doi.org/10.1016/j.psychsport.2014.09.011>
- Kenwood, C. (1999). Social constructionism: implications for psychotherapeutic practice. In D. Nightingale & J. Cromby (Eds.), *Social constructionist psychology. A critical analysis of theory and practice* (pp. 176-189). Open University Press.
- Kogan, S. M. (1998). The politics of meaning making: Discourse analysis of a ‘postmodern’ interview. *Journal of Family Therapy*, 20(3), 229-251. <https://doi.org/10.1111/1467-6427.00085>
- Kogan, S.M., & Brown, A.C. (1998). Reading against the lines: Resisting foreclosure in therapy discourse. *Family Process*, 37(4), 496-512. <https://doi.org/10.1111/j.1545-5300.1998.00495.x>
- Kogan, S.M., & Gale, J. (1997). Decentering therapy: Textual analysis of a narrative therapy session. *Family Process*, 36 (2), 101-126. <https://doi.org/10.1111/j.1545-5300.1997.00101.x>
- Krestan, J.-A., & Bepko, C. (1991/2013). Codependency: The social reconstruction of female experience. In C. Bepko (Ed.). *Feminism and addiction*, (pp.49-66). Routledge.
- Larsen, M. C. (2008). Understanding social networking: On young people’s construction and co construction of identity online. In K. Sangeetha (Ed.), *Online networking - connecting people*. Icfai University Press.
- Lavie-Ajayi, M., & Nakash, O. (2017). “If she had helped me to solve the problem at my workplace, she would have cured me”: A critical discourse analysis of a mental health intake. *Qualitative Social Work*, 16(1) 60–77. <https://doi.org/10.1177/1473325015604043>

- Lester, J., Wong, J., O'Reilly, M., & Kiyimba, N. (2018). Discursive psychology: Implications for counseling psychology. *The Counselling Psychologist*, *46*(5) 576–607.
<https://doi.org/10.1177/0011000018780462>
- Lewis, B. (1995). Psychotherapeutic discourse analysis. *American Journal of Psychotherapy*, *49*(3), 371–384. <https://doi.org/10.1176/appi.psychotherapy.1995.49.3.371>
- Lillevoll, K. R., Kroger, J., & Martinussen, M. (2013). Identity status and anxiety: A meta-analysis. *Identity: An International Journal of Theory and Research*, *13*(3), 214–227.
<http://dx.doi.org/10.1080/15283488.2013.799432>
- Littrell, J. M., Malia, J. A., & Vanderwood, M. (1995). Single-session brief counseling in a high school. *Journal of Counseling & Development*, *73* (4), 451–458.
<https://doi.org/10.1002/j.1556-6676.1995.tb01779.x>
- Lundy, C. (2013). From structuralism to poststructuralism. In D. Benoît, I. MacKenzie, & R. Porter (Eds). *The Edinburgh companion to poststructuralism* (pp. 69-92). Edinburgh University Press.
- Macnaughten, P. (1993). Discourses of nature: Argumentation and power. In E. Burman, & I. Parker, (Eds.) *Discourse analytic research: Repertoires and readings of texts in action* (pp. 52-72). Routledge.
- Madigan, S. (1996). Inscription, description and deciphering chronic identities. In I. Parker (Ed.) *Deconstructing psychotherapy* (pp.150-163). Sage Publications Ltd.
- Madigan, S. (2019). *Narrative therapy* (2nd ed.). American Psychological Association.
- Marcia, J. E. (2006). Ego identity and personality disorders. *Journal of Personality Disorders*, *20*(6), 577–596. <http://dx.doi.org/10.1521/pedi.2006.20.6.577>

- McAdams, D. P. (2001). The psychology of life stories. *Review of General Psychology*, 5(2), 100–122. <https://doi.org/10.1037/1089-2680.5.2.100>
- McAdams, D. P., & McLean, K. C. (2013). Narrative identity. *Current Directions in Psychological Science*, 22 (3), 233–238. <http://dx.doi.org/10.1177/0963721413475622>
- McLean, K. C., & Pratt, M. W. (2006). Life's little (and big) lessons: Identity statuses and meaning-making in the turning point narratives of emerging adults. *Developmental Psychology*, 42(4), 714–722. <https://doi.org/10.1037/0012-1649.42.4.714>
- Miller, G., & Silverman, D. (1995). Troubles talk and counselling discourse: A comparative study. *The Sociological Quarterly*, 36(4), 725–747. <https://doi.org/10.1111/j.1533-8525.1995.tb00462.x>
- Miller, J. K. (2008). Walk-in single session team therapy: A study of client satisfaction. *Journal of Systemic Therapies*, 27(3), 78 –94. <https://doi.org/10.1521/jsyt.2008.27.3.78>
- Miller, J.K., & Slive, A. (2004). Breaking down barriers to clinical delivery: Walk-in family therapy. *Journal of Family Therapy*, 30(1), 95-103. <https://doi.org/10.1111/j.1752-0606.2004.tb01225.x>
- Mills, S. (2003). *Michel Foucault*. Routledge.
- Monk, G., & Gehart, D. (2003). Sociopolitical activist or conversational partner? Distinguishing the position of the therapist in narrative and collaborative therapies. *Family Process*, 42(1), 19-30. <https://doi.org/10.1111/j.1545-5300.2003.00019.x>
- Morgan, A. (2000). *What is narrative therapy? An easy to read introduction*. Dulwich Centre Publications.

- Neimeyer, R. A. (2002). The relational co-construction of selves: A postmodern perspective. *Journal of Contemporary Psychotherapy*, 32(1), 51-59.
<https://doi.org/10.1023/A:1015535329413>
- Negru-Subtirica, O., Pop, E. I., Luyckx, K., Dezutter, J., & Steger, M. F. (2016). The meaningful identity: A longitudinal look at the interplay between identity and meaning in life in adolescence. *Developmental Psychology*, 52(11), 1926–1936.
<https://doi.org/10.1037/dev0000176>
- Ngulube, P., Mathipa, E.R., & Gumbo, M.T. (2015). Theoretical and conceptual framework in the social sciences. In E.R. Mathipa, & G.T. Gumbo. (Eds). *Addressing research challenges: Making headway in developing researchers* (pp. 43-66). Mosala-MASEDI Publishers & Booksellers.
- O'Connor, M., Nikoletti, S., Kristjanson, L.J., Loh, R., & Willcock, B. (2003). Writing therapy for the bereaved: Evaluation of an intervention. *Journal of Palliative Medicine*, 6(2), 195-204.
<https://doi.org/10.1089/109662103764978443>
- O'Leary, Z. (2014). *The Essential Guide to Doing Your Research Project* (2nd ed.). Sage.
- Oliver, D.G., Serovich, J.M., & Mason, T.L. (2005). Constraints and opportunities with interview transcription: Towards reflection in qualitative research. *Social Forces*, 84(2), 1273-1289.
- Olssen, M. (1991). Producing the truth about people: Science and the cult of the individual in educational psychology. In J. Morss, & Linzey, T. (Eds.). *Growing up: The politics of human learning*. Auckland: Longman Paul Ltd.

- Olseen, M. (2008) Foucault as complexity theorist: Overcoming the problems of classical philosophical analysis. *Educational Philosophy and Theory*, 40(1), 96-117.
<https://doi.org/10.1111/j.1469-5812.2007.00406.x>
- O'Neill, I. (2017). What's in a name? Clients' experiences of a single-session therapy. *Journal of Family Therapy*, 39(1), 63-79. <https://doi.org/10.1111/1467-6427.12099>
- O'Reilly, M., & Lester, J. N. (2017). *Examining mental health through social constructionism: The language of mental health*. Palgrave Macmillan.
- Papa, A., & Lancaster, N. (2016). Identity continuity and loss after death, divorce, and job loss. *Self and Identity*, 15(1), 47– 61. <http://dx.doi.org/10.1080/15298868.2015.1079551>
- Parker, I. (2015). *Critical discursive psychology*. Palgrave Macmillan.
- Parker-Rees, R. (2014). Playfulness and the co-construction of identity in the first years. *The SAGE Handbook of play and learning in early childhood*, (pp. 366-377). SAGE.
- Parry, A., & Doan, R. (1994). *Story re-visions. Narrative therapy in the postmodern world*. The Guilford Press.
- Paul, K. R., & van Ommeren, M. (2013). A primer on single session therapy and its potential application in humanitarian situations. *Intervention*, 11(2),8 –23. DOI: [10.1097/WTF.0b013e32835f7d1a](https://doi.org/10.1097/WTF.0b013e32835f7d1a)
- Payne, M. (2006). *Narrative therapy: An introduction for counsellors* (2nd ed.). Sage Publications.
- Perkins, R. (2006). The effectiveness of one session of therapy using a single-session therapy approach for children and adolescents with mental health problems. *Psychology and Psychotherapy: Theory, Research and Practice*, 79(2), 215–227.

Phillips, N., Sewell, G., & Jaynes, S. (2008). Applying critical discourse analysis in strategic management research. *Organizational Research Methods*, 11(4), 770–789.

<https://doi.org/10.1177/1094428107310837>

Pickett, B. (1996). Foucault and the politics of resistance. *Polity*, 28(4), 445-466.

<https://doi.org/10.2307/3235341>

Pitt, T., Thomas, O., Lindsay, P., Hanton, S., & Bawden, M. (2015). Doing sport psychology briefly? A critical review of single session therapeutic approaches and their relevance to sport psychology. *International Review of Sport and Exercise Psychology*, 8(1), 125-155.

<https://doi.org/10.1080/1750984X.2015.1027719>

Pop, E.I., Negru-Subtirica, O., Crocetti, E., Opre, A., & Meeus, W. (2016). On the interplay between academic achievement and educational identity: A longitudinal study. *Journal of Adolescence* 47(1), 135-144.

Potter, C.M., Jensen, D., Kinner, D.G., Tellez, M., Ismail, A., & Heimberg, R.G. (2016). Single-session computerized cognitive behavioral therapy for dental anxiety. *Clinical Case Studies*, 15(1), 3-17. <https://doi.org/10.1177/1534650115583672>

Potter, J. (2012). Discourse analysis and discursive psychology. In H. Cooper (Ed.), *APA handbook of research methods in psychology: Vol. 2. Quantitative, qualitative, neuropsychological, and biological* (pp. 111-130). Washington: American Psychological Association Press

Potter, J. (2012). Re-reading discourse and social psychology: Transforming social psychology. *British Journal of Social Psychology*, 51 (3), 436–455. <https://doi.org/10.1111/j.2044-8309.2011.02085.x>

- Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behavior*. Sage Publications Ltd.
- Probst, B. (2014). In the hyphen: Perceptions, benefits, and challenges of social workers' dual identity as clinician-client. *Families in Society: The Journal of Contemporary Social Services*, 91(1), 25-33. <https://doi.org/10.1606/1044-3894.2014.95.4>
- Radcliffe, E., Lowton, K., & Myfanwy, M. (2013). Co-construction of chronic illness narratives by older stroke survivors and their partners. *Sociology of Health and Illness*, 35(7), 993-1007.
- Richards, J., Holtum, S., & Springham, N. (2016). How do “mental health professionals” who are also or have been “mental health service users” construct their identities? *Sage Open*, 6(1), 1-14.
- Richert, A.J. (2002). The self in narrative therapy: Thoughts from a humanistic/existential perspective. *Journal of Psychotherapy Integration*, 12(1), 77-104.
<https://doi.org/10.1037/1053-0479.12.1.77>
- Riessman, K., & Speedy, J. (2007). Chapter 17. Narrative inquiry in the psychotherapy professions: A critical review. In D. Jean Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology*. (pp. 426-457). Sage.
- Riskin, J., (1963). Methodology for studying family interaction. *Archives of General Psychiatry* 8(4), 343-348. doi:10.1001/archpsyc.1963.01720100033004
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Psychotherapy: Theory, Research, Practice, Training*, 44(3), 240-248.
- Rogers, C. (1961). *On becoming a person. A therapist's view of psychotherapy*. Boston: Houghton Mifflin Company.

- Rogers, C. (1977). *Carl Rogers on personal power: Inner strength and its revolutionary impact*. Delacorte Press.
- Rogers, C. (1989). The person in process. In H. Kirschenbaum, & V. Henderson (Eds.). *The Carl Rogers reader*. Houghton Mifflin Company.
- Rosenow, S.C., & Silverman, M.J. (2014). Effects of single session music therapy on hospitalized patients recovering from a bone marrow transplant: Two studies. *The Arts in Psychotherapy, 41*(1), 65-70. <https://doi.org/10.1016/j.aip.2013.11.003>
- Saari, C. (2000). Therapeutic dialogue as a means of constructing identity complexity. *Smith College Studies in Social Work, 71*(1), 3-17. <https://doi.org/10.1080/00377310009517611>
- Slive, A., & Bobele, M. (2011). Walking in: An aspect of everyday living. In A. Slive, M. Bobele (Eds.), *When one hour is all you have. Effective therapy for walk-in clients* (pp.11-22). Zeig, Tucker, & Theisen.
- Slive, A. & Bobele, M. (2012). Walk-in counselling services: Making the most of one hour. *The Australian and New Zealand Journal of Family Therapy, 33*(1), 27-38. <https://doi.org/10.1017/aft.2012.4>
- Slive, A., McElheran, N., & Lawson, A. (2008). How brief does it get? Walk-in single session therapy. *Journal of Systemic Therapies, 27*(4), 5–22. <https://doi.org/10.1521/jsyt.2008.27.4.5>
- Smith, J. A., Harré, R., & Van Langenhove, L. (1995). Introduction. In A. Smith, R. Harré, & L. Van Langenhove, (Eds.). *Rethinking psychology* (pp. 1-9). Sage.
- Speed, E. (2011). Discourses of acceptance and resistance: Speaking out about psychiatry. In M. Rapley, J. Moncrieff, & J. Dillon (Eds.) *De-medicalizing misery. Psychiatry, psychology, and the human condition*, (pp. 123-140). Palgrave Macmillan.

- Speedy, J. (2004). The contribution of narrative ideas and writing practices in therapy. In G. Bolton, S. Howlett, C. Lago, & J.K. Wright (Eds.) *Writing cures* (pp. 25-34). Brunner-Routledge.
- Splitter, L. (2015). *Identity and personhood: Confusion and clarifications across disciplines*. Springer.
- Stalker, C.A., Horton, S., & Cait, C.-A. (2012). Single-session therapy in a walk-in counselling clinic: A pilot study. *Journal of Systemic Therapies, 31* (1), 38-52.
<https://doi.org/10.1521/jsyt.2012.31.1.38>
- Stalker, C. A., Riemer, M., Cait, C.-A., Horton, S., Booton, J., Josling, L., Bedggood, J. & Zaczek, M. (2016). A comparison of walk-in counselling and the wait list model for delivering counselling services. *Journal of Mental Health, 25*(5), 403–409.
<https://doi.org/10.3109/09638237.2015.1101417>
- Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372-1380. <https://doi.org/10.1177/1049732307307031>
- Stewart, J., McElheran, N., Park, H., Oakander, M., MacLaurin, B., Fang, C. J., & Robinson, A. (2018). Twenty-five years of walk-in single-session at the Eastside Family Centre: Clinical and research dimensions. In M. F. Hoyt, M. Bobele, A. Slive, J. Young, & M. Talmon (Eds.), *Single-session therapy by walk-in or appointment: Administrative, clinical, and supervisory aspects of one-at-a time services* (pp. 72-90). Routledge.
- Strong, K. A., & Shadden, B. B. (2020). The power of story in identity renegotiation: Clinical approaches to supporting persons living with aphasia. *Perspectives of the ASHA Special Interest Groups, 5*(2), 371-383.

- Strong, T., & Gale, J. (2013) Postmodern clinical research: In and out of the margins. *Journal of Systemic Therapies*, 32(2), 46-57. <https://doi.org/10.1521/jsyt.2013.32.2.4>
- Strong, T., & Paré, D. (2004). Striving for perspicuity. Talking our way forward. In T. Strong, & D. Paré (Eds.) *Furthering talk: Advances in the discursive therapies* (pp. 1-14). Kluwer Academic/Plenum Publishers.
- Syed, M., & Azmitia, M. (2008). A narrative approach to ethnic identity in emerging adulthood: Bringing life to the identity status model. *Developmental Psychology*, 44(4), 1012-1027.
DOI:10.1037/0012-1649.44.4.1012
- Syed, M., & Azmitia, M. (2010). Narrative and ethnic identity exploration: A longitudinal account of emerging adults' ethnicity-related experiences. *Developmental Psychology*, 46 (1), 208–219. <http://dx.doi.org/10.1037/a0017825>
- Talmon, M. (1990). *Single-session therapy. Maximizing the effect of the first (and often only) therapeutic encounter*. Jossey-Bass Publishers.
- Talmon, M. (2012). When less is more: Lessons from 25 years of attempting to maximize the effect of each (and often only) therapeutic encounter. *The Australian and New Zealand Journal of Family Therapy*, 33 (1), 6-14. <https://doi.org/10.1017/aft.2012.2>
- Tam, J. A., & Bloom, K. (2015). Walk-in services for child and family mental health. *Journal of Systemic Therapies*, 34(1), 61-77. <https://doi.org/10.1521/jsyt.2015.34.1.61>
- Tarragona, M. (2008). Postmodern/poststructuralist therapies. In J. L. Lebow (Ed.) *Twenty-first century psychotherapies: Contemporary approaches to theory and practice* (pp. 167–205). Wiley.

- Thomas, F. N., & Nelson, T. S. (2007). Assumptions and practices within the solution-focused brief therapy tradition. In T. S. Nelson, & F. N. Thomas (Eds.) *Handbook of solution-focused brief therapy: Clinical applications* (pp. 3-24). Haworth Press.
- Tolchard, B., Thomas, L., & Battersby, M. (2006). Single-session exposure therapy for problem gambling: A single-case experimental design. *Behavior Change*, 23(2), 148-155.
- van de Ven, P. (2020). The journey of sensemaking and identity construction in the aftermath of trauma: Peer support as a vehicle for coconstruction. *Journal of Community Psychology*, 48(6), 1825-1839. <https://publons.com/publon/10.1002/jcop.22373>
- van Dijk, T.A. (1992). Principles of critical discourse analysis. *Discourse & Society*, 4(2), 249-283.
- Van Langenhove, L. (1995). The theoretical foundations of experimental psychology and its alternatives. In A. Smith, R. Harré, & L. Van Langenhove, (Eds.) *Rethinking psychology* (pp. 10-23). Sage.
- Wade, A. (1997). Small acts of living: Everyday resistance to violence and other forms of oppression. *Contemporary Family Therapy*, 19(1), 23-39.
- Walsh, T. (2010). *The solution focused helper: Ethics and practice in health and social care*. Open University Press.
- Walstrom, M.K. (1999). "Starvation...is who I am": From eating disorder to recovering identities through narrative co-construction in an internet support group. [Unpublished Doctoral Dissertation]. University of Illinois at Urbana-Champaign.
- Walstrom, M.K. (2000). "The eating disorder is not you": Applying Bakhtin's theories in analyzing narrative co-construction in an internet support group. In N.K. Denzin (Ed.). *Studies in Symbolic Interaction (Studies in Symbolic Interaction, Vol. 23)* (pp. 241-260).

Emerald Group Publishing Limited, Bingley. [https://doi.org/10.1016/S0163-2396\(00\)80040-](https://doi.org/10.1016/S0163-2396(00)80040-)

[X](#)

Walton, C. (2007). Doing discourse analysis. In E. Lyons, & A. Coyle (Eds.) *Analyzing qualitative data in psychology* (pp. 117-130). Sage Publications Ltd.

Wang, S. I. (2015). *Third culture kids: The co-construction of third culture identity*.

[Unpublished Doctoral Dissertation] San Diego State University.

Watts, A. (1966). *The book: On the taboo against knowing who you are*. Collier Books.

Wendt, A. (1992). Anarchy is what states make of it. *International Organization* 46:391–426.

<https://doi.org/10.1017/S0020818300027764>

Westen, D., Betan, E., & Defife, J. A. (2011). Identity disturbance in adolescence: Associations with borderline personality disorder. *Development and Psychopathology*, 23(1), 305–313.

Wetherell, M. (1998). Positioning and interpretative repertoires: conversation analysis and poststructuralism in dialogue. *Discourse & Society*, 9(3), 387–413.

<https://doi.org/10.1177/0957926598009003005>

Wetherell, M., & Potter, J. (1992). *Mapping the language of racism: Discourse and the legitimation of exploitation*. Columbia University Press.

Wever, C. (2015). Beyond psychological truth: Deconstructing western deficit-oriented psychology and the co-construction of alternative psychologies in narrative practice. *International Journal of Narrative Therapy & Community Work*, (1), 11-25.

White, M. (1993). Deconstruction and therapy. In S. Gilligan, & R. Price (Eds.) *Therapeutic conversations* (pp. 22-61). W.W. Norton & Company.

White, M. (1995). *Re-authoring lives: Interviews and essays*. Dulwich Centre Publications.

White, M. (2000). *Reflections on narrative practice*. Dulwich Centre Publications.

- White, M. (2001). Narrative practice and the unpacking of identity conclusions. *Gecko: A Journal of Deconstruction and Narrative Ideas in Therapeutic Practice*, 1, 28-55.
- White, M. (2005). *Workshop notes*. Retrieved from <https://dulwichcentre.com.au/michael-white-archive/writings-by-michael-white/>
- White, M. (2007). *Maps of narrative practice*. W.W. Norton.
- White, M. (2011). *Narrative practice. Continuing the conversation*. W.W. Norton.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. W.W. Norton & Company.
- Wiggins, S. (2017). *Discursive psychology: Theory, method and applications* (pp. 31-58). London: SAGE Publications Ltd. <https://dx.doi.org/10.4135/9781473983335>
- Willig, C. (1999). Beyond appearances: a critical realist approach to social constructionist work. In D. Nightingale, & J. Cromby (Eds.), *Social constructionist psychology: A critical analysis of theory and practice* (pp.37-51). Open University Press.
- Willig, C. (2012). *Qualitative interpretation and analysis in psychology*. McGraw Hill.
- Wonjnar, D., & Swanson, K.M. (2007). Phenomenology. An exploration. *Journal of Holistic Nursing*, 25(3), 172-180.
- Yip, T. (2014). Ethnic identity in everyday life: The influence of identity development status. *Child Development*, 85 (1), 205–219.
- Young, J., Weir, S., & Rycroft, P. (2012). Implementing single session therapy. *Australian and New Zealand Journal of Family Therapy*, 33(1), 84-97. <https://doi.org/10.1017/aft.2012.8>
- Young, K. (2006). When all the time you have is now: Narrative practice at a walk-in clinic. Retrieved from, <https://www.windzcentre.com/publications>

- Young, K. (2008). Narrative practice at a walk-in clinic: Developing children's worry wisdom. *Journal of Systemic Therapies*, 27(4), 54-74. <https://doi.org/10.1521/jsyt.2008.27.4.54>
- Young, K. (2011). Narrative practices at a walk-in therapy clinic. In A. Slive, & M. Bobele (Eds.) *When one hour is all you have: Effective therapy for walk-in clients* (pp. 149-166). Zeig, Tucker, & Theisen.
- Young, K. (2018). Change in the winds: The growth of walk-in therapy clinics in Ontario, Canada. In M.F. Hoyt, M. Bobele, A. Slive, J. Young, & M. Talmon (Eds.), *Single-session therapy by walk-in or appointment* (pp. 59-71). Routledge.
- Zayas, L.H. (2001). Incorporating struggles with racism and ethnic identity with adolescents. *Clinical Social Work*, 29(4), 361-373.
- Ziai, A. (2013). *Developmental discourse and global history: From colonialism to the sustainable development goals*. Routledge.

Appendices

Appendix A

Organizational Recruitment Letter to Director of Counselling Unit

Dear Director of Counselling Unit,

My name is Jesse Henneberry and I am a PhD candidate in the Faculty of Education at the University of Ottawa. The title of my doctoral dissertation is "*A Foucauldian Discourse Analysis of the Co-Construction of Client Identity within Single Session Therapy*" and I have been awarded an Ontario Graduate Doctoral Scholarship for the 2017-2018 academic year to conduct this research. My research is being supervised by Dr. David Paré, Full Professor in the Counselling and Psychotherapy program within in the Faculty of Education.

Please accept this letter as an expression of my interest in conducting research at your counselling agency. My research seeks to gain a clearer understanding of how therapist and client language can influence descriptions of client identity within single session therapy.

As single session therapy is a relatively new model for providing therapy, my research will specifically focus on therapist contributions in discussions with clients, to see the influence of therapist language on the co-construction of a client's identity.

I seek to tape a total of two (2) single sessions of therapy between two therapists who have been trained in brief narrative therapy, with two individual adult clients. These two sessions between individual clients and therapists will be audiotaped and later transcribed.

Following taped sessions, I will ask clients and therapist to fill out a brief questionnaire taking approximately twenty (20) minutes asking each about their experience in this single session. Their answers to these questionnaires will be sealed in envelopes and used later on as data to inform the analysis of their recorded session.

Both therapists and clients who are interested in this study will be required to voluntarily consent to participate, and both parties will be informed that they may withdraw consent at any time should they choose to do so. Both clients and single session therapists will be compensated for their time and involvement in this research project. Participants (clients and single session therapists) will each be given a \$30 gift card from XXXXXXXXXXXX. Participants will be fully compensated if they choose to withdraw from the project.

It should be emphasized that this is not a study into the efficacy of practice, but instead seeks to see how single session unfolds in real time. I would like to provide you with information about the study and invite you to participate. Should you have follow-up questions about the study please feel free to contact me at the address below and I can provide you with more detailed descriptions of the project.

I have attached three letters for recruitment that I would ask you to distribute at your agencies. The first letter is directed to therapists trained in single session narrative therapy. The second letter is directed to ongoing therapists. This study is seeking to study appointment based single sessions of therapy. As such I would not be looking to tape sessions of single session walk-in as this may make clients accessing this service uncomfortable. Rather, I would like to have therapists trained in single session therapy book a single session of therapy with an ongoing client of the agency who is not their own client.

To recruit ongoing clients, I have prepared a letter of recruitment for clients that can be given to them by their ongoing therapists. In addition, I have prepared a letter of information about the study for ongoing therapists of your agency. Having ongoing therapists help recruit clients for this study will help ensure that clients meet the requirements for participation. In addition, there would be no charge to the client to have this additional single session.

Inclusion criteria for clients wanting to participate will include: (1) being a current client at your counselling agency, (2) consenting to be audiotaped in a single session of therapy as part of this study (3) not being in any immediate crisis or risk i.e. suicidal ideation, in line with your agency's standard practice of confidentiality, (4) not currently or previously be an ongoing client of the therapist that they will speak with in this single session.

In addition to researching the process of single session therapy, I have also worked in this field and have supervised therapists in this field. As such, to ensure there is no coercion or undue influence in this research project I will only be recruiting interested single session therapists who I do not currently supervise.

As single session therapy is a growing therapeutic modality, getting a better sense of the process of how this type of therapy works will be of benefit to both therapists currently working in this setting, and those therapists who are new to single session therapy.

I would ask that interested clients and therapists email me directly at XXXXXXXXXXXXXXXX if they are interested in being a part of this study. Please feel free to email me as well if you have any additional questions.

Thank you very much for your time and I look forward to hearing from you.

Sincerely,

Jesse Henneberry
Doctoral Candidate
Faculty of Education
University of Ottawa

Appendix B

Letter of Recruitment to Single Session Therapists

Dear Single Session Therapist,

My name is Jesse Henneberry, and I am a Doctoral student at the University of Ottawa's Faculty of Education. This is my invitation to you to participate in a study that will hopefully deepen our understanding about single session therapy at a time when that mode of service delivery is increasingly widespread. My research, which is supervised by Professor David Paré and funded by the Ontario Graduate Scholarship Program, looks at the process of single session therapy between clients and therapists and the effect that the language used in these sessions has on client identity. It should be emphasized that this is not a study into the efficacy of practice, but instead seeks to see how single session unfolds in real time. I would like to provide you with information about the study and invite you to participate.

Purpose of Study: The purpose of this study is to examine how the language occurring between clients and therapists in single session therapy influences the co-construction of client identity. It will focus on single session work that is informed by therapists who have been trained in brief narrative therapy.

Participation: Participation would involve audio recording one appointment based single session of therapy between yourself and an individual adult client at your counselling centre who would also be signing up to volunteer for this study. Interested clients and therapists will be matched on a first-come-first-served basis. In addition, there would be no charge to the client to have this additional single session.

Following the session, I will ask both client and therapist to fill out a brief questionnaire that will take approximately twenty (20 minutes) asking each about their experience in this single session. Answers to these questionnaires will be sealed in envelopes and used later on as data to inform the analysis of the recorded session.

Inclusion criteria for clients wanting to participate will include: (1) being a current client at your counselling agency, (2) consenting to be audiotaped in a single session of therapy as part of this study (3) not being in any immediate crisis or risk i.e., suicidal ideation, in line with your agency's standard practice of confidentiality, (4) not currently or previous be an ongoing client of the therapist that they will speak with. I will be sending out letters of recruitment to ongoing clients to be distributed by their ongoing therapists to ensure that clients meet the above requirements for the study.

In addition to researching the process of single session therapy, I have also worked in this field and have supervised therapists in this field. As such, to ensure there is no coercion or undue influence in this research project I will only be recruiting interested single session therapists who I do not currently supervise.

Please note that your choice to participate in this study will have no repercussions on your employment within the agency or relationship with the researcher.

Both clients and single session therapists will be compensated for their time and involvement in this research project. Participants (clients and single session therapists) will each be given a \$30 gift card from XXXXXXXXXXXX. Participants will be fully compensated if they choose to withdraw from the project.

Informed Consent: On the day of your scheduled single session with a client I will meet with you half an hour before your scheduled single session to answer any questions you may have. You will also be asked to sign a consent form at this time. I will also be present when you first meet your client to review informed consent for the study, and to allow you to review your clinic's standard of confidentiality form with the client. Once consent has been given by the client I will turn on my audio-recorder and leave the room allowing you to participate in the single session with the client. As part of this process, clients will be reassured that their participation is completely voluntary.

If at any point you perceive that a client is in severe distress, immediate crisis, or would in any way be negatively impacted by participating in the study, I would ask that you use your clinical judgment in deciding whether to continue recording the single session. The wellbeing of yourself and the client would be of primary importance.

Benefits: As single session therapy is a relatively new modality of providing psychotherapy, few studies exist highlighting the process of what this work looks like between clients and therapists. By contributing to a greater understanding of the language used between clients and therapists in single session therapy and how this may influence how both parties speak about client identity, this study has the potential to benefit counsellors and agencies offering single session therapy by shedding light on how this process occurs in real time. Participating also has the potential to deepen your understanding of single session work, as well as contributing to the well-being of your client.

Risks: In terms of risks, participating may be a minor inconvenience and having your session audiotaped could elicit some discomfort; however, every effort would be made to minimize interference with your work and to reduce any discomfort. In addition, if you feel uncomfortable at any point during the audiotaping, or perceive your client to be uncomfortable with said taping, you would be free to use your clinical judgement and stop taping if necessary.

Confidentiality: All information gathered would remain confidential and be used only for the purposes of the research study and related publications and presentations. Any identifying information, such as names and places within the data would be removed or altered in the writeup so as to protect the anonymity of counsellors, clients, and the agency.

The recordings would only be used to transcribe the conversations that take place and would only be viewed by the researcher and his supervisor. All other data gathered would be conserved for five years in a locked filing cabinet, after which it would be shredded.

Voluntary Participation: Your participation in the study is entirely voluntary and your consent can be withdrawn at any point throughout the recording of the session and filling out the questionnaire. Please note that withdrawal that results from recorded sessions and questionnaire cannot occur once the primary researcher's thesis is submitted to the University of Ottawa for defence.

If you are interested in participating in this study, or if you would like to follow up with further questions, please inform Jesse Henneberry (XXXXXXXXXX) or Professor David Paré (XXXXXXXXXX) by (Day/Month/Year). We would also welcome any questions or concerns you may have. Thank you for your time and consideration.

Sincerely,

Jesse Henneberry
Doctoral Candidate
Faculty of Education
University of Ottawa

Appendix C

Letter of Information for Ongoing Therapists

Dear Therapist,

My name is Jesse Henneberry and I am a Doctoral student at the University of Ottawa's Faculty of Education. My research, which is supervised by Professor David Paré and funded by the Ontario Graduate Scholarship Program, looks at the process of single session therapy between clients and therapists and the effect that the language used in these sessions has on client identity.

I am providing you this letter of information and an attached letter of recruitment for your ongoing clients which you can distribute to any ongoing clients who you believe would meet the requirements of this study.

The purpose of this study is to examine how the language occurring between clients and therapists in single session therapy influences descriptions of client identity.

Client participation would involve audio recording one appointment based single session of therapy between an ongoing client with a therapist who practices single session brief narrative therapy at your centre. I will also be recruiting single session brief narrative therapists who work at your counselling centre who would also be invited to volunteer for this study. It should be emphasized that this is not a study into the efficacy of practice, but instead seeks to see how single session unfolds in real time. I would like to provide you with information about the study and invite you to participate. Interested clients and therapists will be matched on a first come-first served basis. In addition, there would be no charge your client to have this additional single session.

Inclusion criteria for any clients wanting to participate include: (1) being a current individual client at your counselling agency, (2) consenting to be audiotaped in a single session of therapy as part of this study (3) not being in any immediate crisis or risk i.e. suicidal ideation, in line with your agency's standard practice of confidentiality, (4) not currently or previously having been an ongoing client of the therapist they will be speaking to as part of this study.

Following the session, I will ask both clients and therapist to fill out a brief questionnaire taking approximately twenty (20) minutes, asking each about their experience in this single session. Their answers to these questionnaires will be sealed in envelopes and used later on as data to inform the analysis of their recorded session.

Please note that clients could understandably feel coercion or undue influence to participate in this study if they are being requested to do so by their ongoing therapist at the agency where they receive counselling. Should you inform an ongoing client about this study, please inform them that any participation of clients in this research study is completely voluntary and that any potentially recruited clients will not face any negative consequences either from their ongoing therapist or the counselling agency where they attend therapy for not wanting to participate in

this research study. This will be reiterated to clients throughout the recruitment process by the primary researcher.

Should any of your ongoing clients meet the criteria for this study please invite them to email me at XXXXXXXXXXXX. Once I know which single session therapists and which of you ongoing clients are interested, I will schedule appointments with interested participants.

Please see the attached letter of client recruitment for more information. In addition, if you have any question or concerns please feel free to contact me. Thank you for your time and consideration.

Sincerely,

Jesse Henneberry
Doctoral Candidate
Faculty of Education
University of Ottawa

Appendix D

Letter of Recruitment to Clients

Dear Client,

My name is Jesse Henneberry and I am a Doctoral student at the University of Ottawa's Faculty of Education. My research, which is supervised by Professor David Paré and funded by the Ontario Graduate Scholarship Program, looks at the process of single session therapy between clients and therapists and the effect of the language used in these sessions on clients' experiences of their own identities. I would like to provide you with information about the study and invite you to participate.

Purpose of Study: The study is focused on single session therapy—in other words, therapy where a client meets with a therapist for just one meeting. The purpose is to examine how the conversation in single session therapy influences descriptions of clients in the session.

Participation: Participation would involve having a single one-hour session with a volunteer therapist trained in single session therapy. The session would be audiotaped for analysis purposes. The recording and the transcript will be destroyed after the study ends. In addition, there would be no charge your to have this additional single session.

Inclusion in the study is limited to people who: (1) are already clients at your counselling agency, (2) consent to be audiotaped in a single session of therapy as part of this study (3) are not in any immediate crisis or risk i.e. suicidal ideation, in line with your agency's standard practice of confidentiality, (4) are not now and have not been previously a client of the therapist you will be speaking to.

Following the session, I will ask both clients and therapist to fill out a brief questionnaire taking approximately twenty (20) minutes, asking each about their experience in this single session. Answers to these questionnaires will be sealed in envelopes and used later on as data to inform the analysis of their recorded session.

Both clients and single session therapists will be compensated for their time and involvement in this research project. Participants (clients and single session therapists) will each be given a \$30 gift card from XXXXXXXXXXXX. Participants will be fully compensated if they choose to withdraw from the project.

Should you be interested in participating in this study please email me at XXXXXXXXXXXX. Interested clients and therapists will be matched on a first come-first served basis. Once I know which therapists are interested in participating, the single session therapist will email you to schedule an appointment at your counselling centre.

Informed Consent: On the day of your scheduled single session with the therapist, I will meet with you and the therapist. I will answer questions you may have and also present you with a research consent form to sign. The therapist will also review with you the agency's standard

form of confidentiality with you. Once your consent has been given, I will turn on my audio-recorder and leave the room, allowing you to participate in the single session with the therapist.

If at any point during the recording of the single session you feel uncomfortable and wish the recording to stop please note that this will be respected and not deter you from participating in this session with the therapist. The therapist might also ask you if you want to stop the recording if they feel it would not be appropriate to continue audiotaping. Your wellbeing will be of primary importance and overrule anything else.

Benefits: As single session therapy is a relatively new modality of providing psychotherapy, few studies exist highlighting the process of what this work looks like between clients and therapists. By contributing to a greater understanding of the language used between clients and therapists in single session therapy and how this may influence how both parties speak about client identity, your participation in this study will benefit current and future therapists and clients of single session therapy by shedding light on how this process occurs in real time. Additionally, participation in the study will give you access to a therapy session free of charge, with the usual potential benefits of such a conversation.

Risks: In terms of risks, participating may be a minor inconvenience and having this single session audio recorded could elicit some discomfort; however, every effort would be made to minimize interference with your counselling session and to reduce any discomfort. In addition, if you feel uncomfortable at any point during the audiotaping you are free to ask your therapist to stop taping the session.

Confidentiality: All information gathered would remain confidential and be used only for the purposes of the research study and related publications and presentations. Any identifying information, such as names, places and quotes within the data would be removed or altered in the writeup so as to protect the anonymity of therapists, clients, and the agency.

The recording would only be used to transcribe the conversations that take place and would only be viewed by the researcher and his supervisor. All other data, in which your identity would appear as a pseudonym to protect your anonymity, would be conserved for five years in a locked filing cabinet, after which time it would be shredded.

Voluntary Participation: Your participation in the study is entirely voluntary and can be withdrawn at any point throughout the recording of the session or in your completion of the questionnaire. Additionally, data can be withdrawn up until the researcher's thesis is submitted to the University of Ottawa.

If you are interested in participating in this study, please inform Jesse Henneberry (XXXXXXXXXX) or Professor David Paré (XXXXXXXXXX) by (Day/Month/Year). We would also welcome any questions or concerns you may have. Thank you for your time and consideration.

Sincerely,

Jesse Henneberry
Doctoral Candidate
Faculty of Education
University of Ottawa

Appendix E

CALL FOR RESEARCH PARTICIPANTS

Are you a client receiving ongoing counselling at [name of agency]? Would you be interested in participating in a free single counselling session as part of a research study?

A Study of Language in the Co-Construction of Client Identity within Single Session Therapy

Purpose of Study: The study is focused on single session therapy—in other words, therapy where a client meets with a therapist for just one meeting. The purpose is to examine how the conversation in single session therapy between you and your therapist influences and affects your view of yourself.

Please note, this research is not a service of [name of agency] but an independent research study at the office of [name of agency].

Participation: Participation would involve having a single one-hour session with a therapist from [name of agency] who is trained in single session therapy. This single session would be audio recorded. Following the session, clients and therapists will be asked to fill out a brief questionnaire taking approximately twenty (20) minutes, asking each about their experience in this single session.

There would be no charge to have this additional single session and participants will be compensated for their time.

If you are interested in participating, please speak to your ongoing therapist at [name of agency] who will give you more information.

This research is being conducted by Jesse Henneberry, Doctoral student within the Faculty of Education at the University of Ottawa and supervised by Dr. David Paré, Adjunct Professor within the Faculty of Education at the University of Ottawa.

Appendix F

**Therapist Consent Form**

Project Title: A Study of Language in the Co-Construction of Client Identity within Single Session Therapy

Names of researchers and contact information

Henneberry, Jesse	Paré, David, Ph.D.
Doctoral Candidate	Professor
Faculty of Education University of Ottawa	Faculty of Education University of Ottawa
Email: XXXXXXXXXXXX	Email : XXXXXXXXXXXX

Invitation to Participate: I have been invited to participate in a research project conducted by Jesse Henneberry under the supervision of Professor David Paré as part of Mr. Henneberry's Doctoral thesis.

Purpose of the Study: The purpose of the study is to learn more about how therapists and clients talk about a client's identity in a single session of therapy. Through focusing on the language that therapists use in these sessions, this research will be an education tool for future therapists doing single session work. It should be emphasized that this is not a study into the efficacy of practice, but instead seeks to see how single session therapy unfolds in real time. I would like to provide you with information about the study and invite you to participate.

Participation: My participation will consist of 1. Being part of an audiotaped hour-long single session of therapy with a client who will have signed up for this study. 2. Filling out a brief questionnaire that will take approx. 20 minutes following the single session.

I will be compensated for my time and involvement in this research project and given a \$30 gift card from XXXXXXXXXXXX. I will be fully compensated even if I choose to withdraw from the project.

Assessment of risks: My participation in this study entails no foreseeable risks. However, if I experience any discomfort, Jesse Henneberry has assured me that he will make every effort to minimize this discomfort.

Should I feel that the client I am speaking to is experiencing discomfort during the taped session and wishes to stop being recorded I can ask them if they would like to stop the recording at any time. I do understand that I can withdraw consent for my participation in this study at any point during the recording of the single session or completion of the questionnaire. Additionally, I do understand that the data that has been used as a result of my participation cannot be withdrawn once the thesis has been submitted for defense.

Benefits: By participating in a taped single session between myself and a client, as well as a follow-up questionnaire, I will contribute to an increased knowledge as to how therapist language contributes to the co-construction of client identity in single session therapy. This contributes to the potential of practice being incorporated into future therapist training. Participation will also potentially contribute to my own learning and to the well-being of the client.

Privacy of participants: I have received assurance from Jesse Henneberry that the information I share will remain strictly confidential. My anonymity will be protected, as will the anonymity of my client, following transcription of this session. Any potentially identifying information of quotes about me or the client I speak to client will be removed or altered to preserve confidentiality.

Completed transcribed sessions will be numerically coded to preserve the privacy of participants and kept secure in the primary researcher's office within the Faculty of Education at the University of Ottawa. Only the primary researcher and supervisor will have access to the recorded session, transcript and participant questionnaires. Questionnaires will also be coded and kept secure in the primary researcher's office.



Confidentiality and conservation of data: The data will be used for the purpose of Jesse Henneberry's Doctoral Thesis and subsequent publications and dissemination. I have been assured that the audio recordings of our interview will be kept in a locked cabinet in the researcher's office during the course of the research and during the conservation period. The data will be kept secure for five years by Mr. Henneberry. After the thesis is submitted, all material data will be kept for five years. After five years all materials will be shredded, and electronic data will be securely erased. All electronic data will be password protected.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of

withdrawal will be destroyed. Data will not be included if the client in my audio recording withdraws.

Acceptance: I, _____ [*Name of participant*], agree to participate in the above research study conducted by Jesse Henneberry as part of his Doctoral research, at the Faculty of Education, University of Ottawa under the supervision of Professor David Paré

If I have any questions about the study, I may contact the Mr. Jesse Henneberry or Dr. David Paré at the above contact locations.

If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research Ethics and Integrity, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's name	Signature	Date
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Researcher's name	Signature	Date
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Appendix G

Client Consent Form

uOttawa

Faculté d'éducation
Faculty of Education

Project Title: A Study of Language in the Co-Construction of Client Identity within Single Session Therapy

Names of researchers and contact information

Henneberry, Jesse	Paré, David, Ph.D.
Doctoral Candidate	Professor
Faculty of Education University of Ottawa	Faculty of Education University of Ottawa
Email: XXXXXXXXXXXX	Email: XXXXXXXXXXXX

Invitation to Participate: I have been invited to participate in a research project conducted by Jesse Henneberry under the supervision of Professor David Paré as part of Mr. Henneberry's Doctoral thesis.

Purpose of the Study: The purpose of the study is to learn more about the language that therapists use with clients in a single session, and the influence this may have on descriptions of client identity. It should be emphasized that this is not a study into the efficacy of practice, but instead seeks to see how single session therapy unfolds in real time. I would like to provide you with information about the study and invite you to participate.

Participation: My participation will consist of being part of an hour long audiotaped single session of therapy with a therapist of the counselling agency. Following this, my therapist and I will be asked to fill out a brief questionnaire about my experience of the single session.

I will be compensated for my time and involvement in this research project and given a \$30 gift card from XXXXXXXXXXXX. I will be fully compensated even if I choose to withdraw from the project.

Assessment of risks: My participation in this study entails no foreseeable risks. However, if I experience any discomfort, Jesse Henneberry has assured me that he will make every effort to minimize this discomfort. Should I feel that while speaking that am experiencing discomfort during the taped session and wish to stop being recorded, I can ask the therapist to do this at any time. I do understand that I can withdraw consent for my participation in this study at any point during the recording of the single

session or completion of the questionnaire. Additionally, I do understand that the data that will be used as a result of my participation cannot be withdrawn once the thesis has been submitted for defense.

During my taped session, should I request, or the therapist I speak to feel that I may benefit from additional resources, these will be provided to me.

Clients wanting additional support following their taped single session will be given the numbers to XXXXXXXXXXXX and XXXXXXXXXXXX (XXXXXXXXXXXX).

Benefits: By participating in a taped single session between myself and the single session therapist, as well as a follow-up questionnaire, I will contribute to an increased knowledge of how therapist language contributes to the co-construction of client identity in single session therapy. This contributes to the potential of practice being incorporated into future therapist training.

Privacy of participants: I have received assurance from Jesse Henneberry that the information I share will remain strictly confidential. My anonymity will be protected, as will the anonymity of my therapist, following transcription of this session. Any potential identifying information, including quotes about myself or the therapist I speak to will be removed or altered to preserve confidentiality.

Completed transcribed sessions will be numerically coded to preserve the privacy of participants and kept secure in the primary researcher's office within the Faculty of Education at the University of Ottawa. Only the primary researcher and supervisor will have access to the recorded session, transcripts and participant questionnaires. Questionnaires will also be coded and kept secure in the primary researcher's office.



Confidentiality and conservation of data: The data will be used for the purpose of Jesse Henneberry's Doctoral Thesis and subsequent publications and dissemination. I have been assured that the audio recordings of our interview will be kept in a locked cabinet in the researcher's office during the course of the research and during the conservation period. The data will be kept secure for five years by Mr. Henneberry. After the thesis is submitted, all material data will be kept for five years. After five years all materials will be shredded and electronic data will be securely erased. All electronic data will be password protected.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative

consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be destroyed. Additionally, data will not be included if the therapist in my audio recording withdraws.

Acceptance: I, _____ [*Name of participant*], agree to participate in the above research study conducted by Jesse Henneberry as part of his Doctoral research, at the Faculty of Education, University of Ottawa under the supervision of Professor David Paré

If I have any questions about the study, I may contact the Mr. Jesse Henneberry or Dr. David Paré at the above contacts.

If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research Ethics and Integrity, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's name	Signature	Date
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Researcher's name	Signature	Date
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Appendix J: Chain of Evidence Example

The following appendix provides readers “a chain of evidence to explicate how [I] moved from data to results” (Greckhamer & Cilesiz, 2014, p. 430) in an example of how this was done in the recorded single session between client “Amélie” and therapist “Karen.” To do so, I display how I moved from (1) initial note taking when transcribing this session, to (2) taking more detailed notes when re-reading my completed transcription of this session, to (3) documenting the back and forth of macro and micro analysis of this single session that occurred between myself and my thesis supervisor. Doing so will give readers a clearer sense of how my process of analysis for this session occurred prior to its presentation in my results chapter. As such, this demonstrates the gradual refinement of my analysis allowing for greater trustworthiness and methodological rigor.

1. Initial Note Taking When Transcribing This Session from September 9th-12th, 2018

Notes taken while transcribing the first session. The numbers in the notes below document the time during the hour-long session when a topic was discussed.

- Discourse of “we’re in therapy” can talk about my high IQ, don’t have to be humble. Humble is important but wouldn’t talk about my IQ on the street—Discourse.
- Research discourse @ beginning and influences quality of empathy, influences the talk.
- “Say as mom”—Therapist positions—client goes back to “challenges” –but back to love
- Medical discourse, psychiatric discourse – effecting her life with son, and historically.
- Discourse of mom versus psychiatric discourse
- Move from problem—burden to identity of resilience in caring for children.
- Medication and therapy discourse.
- Discourses of family, caretaking, medicine and psychiatry may be influencing the conversation and possibly the expression of the client’s identity.
- Identity re: social category of parent (mother), normalizing judgement (burden), subjugated (resiliency)—connected then to the social category of client as mother.
- 33:19- Discourse of client as mother—Therapist sets up what daughter thinks of client as mother and client shuts down this positioning.

- 33:31—Client notes she doesn't talk about her resilience too often.
- Humble discourse—not to my friends. IQ thing too.
- Twenty-something wisdom discourse.
- 40:29 – Therapist discourse influences humble
- Glue
- Analyze it—therapy discourse. Help people.
- 41:47—Help others discourse.
- Self-esteem discourse
- 44:15 pass things to son and daughter
- 45:42- medical discourse- DSM, discourse.
- Discourse of dealing as mother
- Discourse of Mental Health treatment effects and impinges on client identity as hard to be positive and potentially strained relationship with family.
- Response of “resilience” in this mental health discourse talks about positivity in the face of the discourse and a different identity as their mother.

2. Taking More Detailed Notes While Re-Reading My Completed Transcript of This Session on September 24th, 2018

- Identity of therapist and client co-constructing identity of client as resilient, from burden to positive or resiliency.
- Burdens- to positivity (text with daughter) and relationship with son (nails painted). Co-construct.
- Identity- re: IQ and humble. Discourse of therapy helps to speak differently than on street (p. 13).
- Discourse of mental health subverted by text message.
- Identity (p. 24). Humility is externalized, have to be humble. But not in therapy and let it aside.
- Early in session- therapy is a space where we don't have to humble for the client. Later then, therapist and client expand on this.
- Client's identity is initially constructed as primary caretaker, burdened by family struggling with mental illness. Coping through the use of religion and resiliency = hope and a different identity construction.
- p. 4. Therapist, “Would it be OK if we allowed about praying to stay positive?”

- Discourse of mental health, made relevant by therapist, re: son needs meds. Discourse of mental health made irrelevant, try to subvert it with “challenges they are up against” to soften the burden. Softer language here by therapist.

-Later the conversation switches to a discourse of religion which the client notes is helpful to be positive. The therapist and client co-construct client’s identity within this discourse to develop qualities of resiliency, hope, empathy, and charitableness.

-These above mentioned qualities are then applied by the client and therapist to subvert the dominant mental health discourse and focus more on the relationship between her family and in light of the client’s qualities of resiliency, hope, empathy, etc. allowing her to describe her family in a way that is outside of their mental health problems.

- The conversation re-caps the client’s categories later on...

3. Documenting the Back and Forth of Analysis of this Single Session that Occurred Between Myself and my Thesis Supervisor

(a) Excerpts from the Second Round of Transcript Analysis Containing Both My Own and My Supervisor’s Comments From February 13th, 2019

C1: And my daughter is manic depressive, moderate. And she doesn’t take any medications. She doesn’t follow therapy.

T1: Mm...alright. So your husband and your son both have Asperger’s?

C1: Yes.

T1: And your daughter has manic depression?

C1: Yes, but she doesn’t believe in it and ah, she doesn’t follow therapy, and she doesn’t take medications for it. **The client describes her husband, son, and daughter all having their own mental health challenges.**

T1: Mm...and what’s that like for you [name of client] to... **The question of “what’s that like for you” is meaning generating question, allowing the client and therapist to co-construct the meaning of her family’s mental health challenges for the client.**

David Paré, February 13th, 2019:

Not sure how these two comments (“The client describes...” and “The question of...”) fit with the analysis plan.

C1: Well, its hard. Its hard for my daughter, you know because ah, she has highs and lows...like ah...she’s not realistic where she’s manic depressive. Like she’s not treated, right?

Again, this meaning generating experience question allows for the client to use her own language to describe their experience rather than the therapist just assuming this circumstance to be “hard” for the daughter or the client herself.

David Paré, February 13th, 2019:

This comment (“Again, this meaning generating...”) fits better for me as it is tracking whose meanings are being privileged in the co-construction.

T1: I see....So you’re a mom, and a wife, and people in your family have some obstacles that they’re up against. **In response, the therapist seems to bring back the client’s identity categories of mother and wife and re-cast or reposition the client and family in a different way in relation to this “discourse of family mental health”. While the client uses language describing the experience as “hard” in reference to this “discourse of family mental health”, the therapist offers a re-positioning through the use softer language of “obstacles” that the family is “up against” which may be a way of the therapist re-positioning the client, or client’s family as standing up to this “discourse of family mental health.”**

David Paré, February 13th, 2019:

I didn’t quite follow...I see the externalizing here which separates client seems the obstacles are the illness, not a discourse of mental health...if you don’t see a “claim” as it were not sure you can be justified in saying a discourse is present. What is the claim in relation to family mental health?

If the client was portraying the family as substandard as a consequence of the mental health, or heroic in the face of it, those would clearly be more discursive, no?

T1: And so, um, could you help me a little bit in terms of, is there something particular about your life, or something specific about your family that you would really like for us to talk about, or think about during our time together today so that this can be the most helpful use of your time? **The therapist does not assume that this “family mental health discourse” is something that the client wants as the focus of the session, but rather asks the client what the focus of the session should be in light of these topics that have already mentioned.**

C1: Well, umm...it’s hard to be optim...positive, you know? It’s hard to be positive. And um...but most of the time I’m positive, you know? **The client answers, noting it is hard to be positive, perhaps in reference to the previously mentioned “family mental health discourse.”** The language that the client uses here that, “I’m a positive, you know?” is juxtaposed with her previous statement “It’s hard to be positive”, possibly again in reference to the hovering influence of the “family mental health discourse.” The client’s language of being “positive” may speak to the clients preferred positioning of being a

“positive” person, or a preferred identity of being a “positive” person, within the hovering influence of this “family mental health discourse.”

T1: Mm-hm.

C1: Like, um my family, well, I sort of support...I pray a lot you know. **Here, the conversation shifts from the client wanting to be positive, to a more detailed description of the influence of prayer and religion as something that helps the client to remain positive as a means of supporting her family. This dialogue seems to be influenced by a “discourse of religion.”**

David Paré, February 13th, 2019:

I have a similar comment here to the one above...what is the claim being made? See my note on this issue which is about the issue of identifying discourses in the text.

If she said “God will see us through” then I can see that as a manifestation of a discourse. Because she prays we know that she ascribes to some religious discourse but is that the same as the discourses presenting itself in the moment in the conversation. Not sure about that.

This discourse of religion seems to be made relevant in the conversation, or made legitimate by the client and therapist as this exchange allows the client to describe prayer as a means of staying positive and as a way of supporting her family with their mental health challenges. Here I believe we are seeing the influence of these two hovering dominant discourses of “family mental health” and “religion” influencing the talk between the client and therapist.

(...)

T1: So, um...I know we’re not gonna know each other for a very long time, but would it be OK if I just sort of said to you, like, I hear that you’re a very empathetic person?

C1: Yes.

T1: A really hopeful person.

C1: Yes.

T1: A very caring person.

C1: Yes.

T1: A very generous person.

The therapist adding “person” to these above mentioned qualities, may be further inviting the client to take these qualities up in reference to the client’s identity. Perhaps as well the co-construction of a preferred identity.

C1: Mm-hm.

T1: These are the things that you're telling me about yourself? **The therapist checks here that these above mentioned qualities are correct, to which the client agrees: a fairly pronounced example of naming qualities of identity.**

C1: Yeah.

T1: Wow...And how have those qualities that you possess, how have they helped you in your life?

C1: Well they did help me to be resilient. To becoming resilient, you know. And um, I was resilient when I was seventeen taking care of my sister, you know? **Again, the word "resilient" seems to be an important co-construction throughout this single session, this time in reference to the "discourse of family mental health" where the client historically took care of her sister.**

(...)

C1: Yeah. And, ah...I keep an eye on her, you know.

T1: By texting her...

C1: Texting her a lot. And ah, sometimes she, she asks me at the last minute if I wanna go for a tea with her or something, and I do go. Even when I busy with something else I cancel my other things and I go for it with her.

T1: You do? Wha! Why is it that you do that [name of client]? Can you tell me? **Performed identity/fluid identity- Freedman and Combs (2016)...Again, these "why" questions around these actions by the client support the co-construction of the meaning of these actions for the client which are termed "landscape of identity questions."**

C1: Well because she's my daughter.

T1: But what does that, I mean, that means something to you (**Meaning question- the landscape of identity**). You say, because she's my daughter, I can see...what does that mean to you? Therapist further asks about the meaning of this action for the client, as this then further clarifies the co-construction.

C1: I'm very maternal, maternal, maternal, ma-ter-na-lis-tic, you know. Yeah. **The meaning of this act/identity = maternalistic. Maternalistic is co-constructed here. While the identity of "mom" (identity as social category) has been previously established, "maternalistic" as a quality of the client's identity has now been co-constructed.**

This celebration of the client as being maternalistic flies in the face of longstanding traditions of mother-blaming in psychotherapy.

T1: And so, because you're maternalistic, what is it that you say that, what is it that you value? Because you said that, even if you have other plans, you'll cancel them to be with your daughter if she calls last minute.

C1: Yeah. **Identity construction of client "values" gets dropped in client's answer**

T1: Tell me about that. Like, what does it **mean** to you to be with her? **The therapist then focuses on the “meaning” of being “maternalistic” to be client and the client being with her daughter. Identity and the co-construction of knowledge, identity is an exercise in meaning making that is shared by the client and therapist.**

C1: That’s why she wrote the text to me yesterday that I read to you, you know. **(Client references the text from the her daughter that she showed the therapist earlier in the session that said “Thanks a million. You’re too kind to me”).**

(...)

T1: You’re too kind to me. Thanks a million. What was that like as a mom to receive that text? **Therapist asks a similar question that was seen above, concerning the meaning of receiving this text in relation to the client’s identity as a mother, and in response we start to see a different description from the client about her daughter, one that speaks to someone who is more than just someone suffering from “manic depression and needing treatment.” In addition there may be a further re-positioning of the client within “discourse of family mental health” showing an alternate construction of the client’s identity as a mom and caregiver that is not “burdened” as she mentioned she was earlier on in the session.**

C1: Well it’s a nice text. She’s a very nice ah, she writes poetry...I told you she’s very smart, eh? She sketches and...she writes poems in French without mistakes and she writes poems in English without mistakes.

(b) Excerpts from Revisions of the Second Round of this Single Session that Took Place Between Myself and my Thesis Supervisor on February 26th, 2019. These Excerpts Were Later Added to my First Draft of my Results Chapter.

To provide some additional context to the reader, the client in this first session is French. This may account for some speech patterns that arise in this transcript as the client and therapist conducted this single session entirely in English.

Research Question: “How do therapists trained in brief narrative therapy facilitate the co-construction of client-preferred identity within the context of discourses which appear in single session therapy?”

1. (a) “What discourses are relevant (and irrelevant) [as per contributing to client-preferred identity]?”
- (b) How are they made relevant (and irrelevant), and in what ways?”

(a) “What discourses are relevant (and irrelevant) [as per contributing to client-preferred identity]?”

In this session I believe there are narrative therapy discourses of the “client as expert” and “privileging client local knowledge” which hover throughout the session, and which are made relevant by the therapist who invites the client to engage in these discourses as they support the client’s stated preferred identity of being a positive person.

David Paré, February 27th, 2019:

J, unless you have a specific idea why would you distinguish these two (“client as expert” and “privileging client local knowledge”)? I would make them one thing. It’s not immediately obvious to me what distinguished them. There are many phrases and ways of describing NT that end up referring to essentially the same thing (e.g., exception, unique outcome/preferred story, counter story, counterplot).

David Paré, February 28th, 2019:

Wondering if this is more like performing a discourse in the practice (e.g. inviting client to name things with their own words as performing a client as expert discourse) rather than “inviting a client to engage in a discourse”. Here they are asking the client about evidence of them being a positive person, perhaps that is closer to engaging in that discourse. (“the client is a positive person.” I realize this may be confusing, but I think it’s a distinction that needs to be kept clear.

As we discussed, seems there are different levels of discourses or different orders of discourses as play. Some of the discourses are not the subject matter of the conversation, but they inform how the therapist engages in the conversation. At other times they are talking about a discourse that the client has brought into the room. So, the therapist can be performing a NT discourse while simultaneously discussing a discourse brought into the session. I wonder what you’re seeing in the research—do you see distinctions between discourses evident in what is being talked about versus discourses informing how a therapist or interview proceeds?

Wondering if it’s a false distinction to talk about a discourse influencing a conversation or “informing” a conversation versus a discourse being “performed.” We should probably talk about this soon.

In addition, these discourses are relevant as they support the construction of other preferred identity qualities such as the client being hopeful, empathic and resilient which These preferred identities help the client in the face of supporting her children’s mental health challenges.

As well, I believe there is some sort of pathological/medical model discourse (discourse as verb, but unsure if discourse as noun) that is in play when the client first speaks about her family's mental health concerns at the beginning of the session, which is not relevant in supporting the client's preferred identity.

In particular, at the beginning of the session the client references her daughter as needing treatment for her mental health, which leads to a very thin description of the client's own experience in supporting her daughter with this challenge. If this is a discourse as a noun, it may be a dominant discourses circulating in society that has recruited the client to believe that mental health requires professional or "expert" treatment.

David Paré, February 28th, 2019:

Delineating precisely the dividing point between discourse as noun vs. verb will be important and seems related to the above. You can talk 'about' something (noun?) without 'performing it' in the moment (verb?). If I as client mention that church's critique of me for living with a woman out of wedlock, that seems like an example of the first. If I say "I am a sinner because my partner and I are not married" that seems like the latter....?

T1: And your daughter has manic depression?

C1: Yes, but she doesn't believe in it and ah, she doesn't follow therapy, and she doesn't take medications for it.

T1: Mm...and what's that like for you [name of client] to...

C1: Well, its hard. Its hard for my daughter, you know because ah, she has highs and lows...like ah...she's not realistic when she's manic depressive. Like she's not treated, right? **Again, there seems to be a focus for the client on her daughter's lack of treatment and how hard this is. There may be a sense from the client that "expert" treatment is needed for her daughter and is lacking.**

David Paré, February 28th, 2019:

If you don't point to her implying this, it is less persuasive. DA is still "empirical" research in this respect (and rhetorical too!). It would work better to say "The client is implying that her daughter has a disorder that could be ameliorated by professional treatment." This would be a statement of the discursive claim built into her utterance.

Yet, the response from the therapist seems to emerge from a narrative therapy discourse of that “client as expert” and “privileging client local knowledge”, which runs throughout the session, and allows the therapist to get a sense of the client’s preferred identity of being positive when supporting her family with their mental health challenges.

David Paré, February 28th, 2019:

Yup, and this is what I was (tentatively!) calling “performing” that discourse, which could be happening while they are talking about another discourse (such as talking about her daughter in terms of diagnosis and treatment).

T1: And so, um, could you help me a little bit in terms of, is there something particular about your life, or something specific about your family that you would really like for us to talk about, or think about during our time together today so that this can be the most helpful use of your time?

C1: Well, umm...it’s hard to be optim...positive, you know? It’s hard to be positive. And um...but most of the time I’m positive, you know?

Prior to answering this question, the client was speaking about the mental health challenges faced by her son (Asperger’s and schizophrenia) and her daughter (manic depression). With the above question the therapist does not assume that these mental health challenges are something that the client wants as the focus of the session. Rather, the therapist asks the client what the focus of the session should be in light of these topics that have been mentioned.

David Paré, March 2nd, 2019:

This is the kind of thing that deserves mention but probably not too much attention. If you notice the therapist is generally still handing it back to the client rather than assuming direction, then than speaks to client as expert/local knowledge/decentred etc.

Thus, the therapist is influenced from a discourse that is often seen in brief narrative therapy single session therapy of “client as expert/privileging client local knowledge/experience” which is used to privilege the lived experience and knowledge of the client, over the so-called expertise of the therapist. This discourse of “the client as expert” likens the therapist’s posture in session to an investigative reporter (White, 2007).

David Paré, February 28th, 2019:

Grammar. Would be influenced by (not “influenced from a discourse”).

Interesting though to speculate about the difference between being “influenced by” as discourse versus “performing” a discourse.

In addition to the preferred identity of positivity that is specifically referenced by the client at the beginning of the session, during the therapist and client co-construct several additional identity qualities that are relevant in supporting client preferred identity.

As the conversation unfolds, many of the questions that the therapist asks seem to invite the client to make meaning of her experiences, leading to the co-construction of several identity “qualities” in support of client preferred identity, including the client as hopeful, empathic, good-hearted and resilient. Again, the co-construction of all these identity “qualities” in this conversation continues to be influenced from the hovering influence of these narrative therapy discourses of the “client as expert” and “privileging client local knowledge” that support client preferred identity.

(c) “what socially recognizable identity or identities the [therapist] is trying to enact or get [the client] to recognize...how the [therapist’s] language treats [the client’s] identities...[and] what identities the [therapist] is “inviting” them to take up.”

The socially recognizable identity that the therapist gets the client to recognize, or “invites” her to take up is the client’s identity of the mother of her children, as noted in previous examples.

While this has been previously used by the therapist in support of what the client knows or notices as a mother in describing how she client supports her children’s mental health concerns, there are also times in the session where the therapist invites the client to reflect on her identity as a mother in relation to her children more generally.

As a result there seems to be a richer description of the client’s relationship with her children that is not entirely focused on their mental health challenges. In the example below the client recounts how she supports her daughter through texting her:

C1: Yeah. And, ah...I keep an eye on her, you know.

T1: By texting her...

C1: Texting her a lot. And ah, sometimes she, she asks me at the last minute if I wanna go for a tea with her or something, and I do go. Even when I’m busy with something else I cancel my other things and I go for it with her.

T1: You do? Wha! Why is it that you do that [name of client]? Can you tell me?

C1: Well because she's my daughter.

T1: But what does that, I mean, that means something to you. You say, because she's my daughter, I can see...what does that mean to you?

C1: I'm very maternal, maternal, maternal, ma-ter-na-lis-tic, you know. Yeah.

T1: And so, because you're maternalistic, what is it that you say that, what is it that you value? Because you said that, even if you have other plans, you'll cancel them to be with your daughter if she calls last minute. **This question seems to further invite the client to reflect on her identity as a mother in support of her daughter.**

(...)

How does the therapist's language treat [the client's] identities...

As noted previously, the therapist in this session has, at multiple times, invited the client to reflecting on the meaning stories that she shares about who she is and why she does what she does. From this discussion there is a clearer picture of the client that is in line with client preferred identity of client as someone who considers herself to be empathic, hopeful, having a good heart, and being resilient. In the example below the therapist's language repeats this language to the client to further co-construct these identity qualities.

T1: So, um...I know we're not gonna know each other for a very long time, but would it be OK if I just sort of said to you, like, I hear that you're a very empathetic person? **Again, the question here allows the client to be the expert on whether or not they agree with the therapist saying the client is an empathic person, to which the client agrees below.**

C1: Yes.

T1: A really hopeful person.

C1: Yes.

T1: A very caring person.

C1: Yes.

T1: A very generous person.

The therapist adding "person" to these above mentioned qualities, may be further inviting the client to take these qualities up in reference to the client preferred identity.

C1: Mm-hm.

T1: These are the things that you're telling me about yourself? **The therapist checks here that these above mentioned qualities are correct, to which the client agrees. I believe this is a fairly pronounced example of naming qualities of identity from the contextualized backdrop of a narrative therapy discourse of the "client as expert" and "privileging client local knowledge"**

Appendix K: Reflexivity Journal

September 24th, 2018

As I am analyzing the first transcript, I wonder am I analyzing from the point of view of more of a researcher, or as a therapist. Sometimes I feel like I look at the transcript as someone who is trained in narrative therapy. But can I fully separate my therapist self from my researcher self as I conduct this project?

Sept. 24th, 2018 @ 11:42AM

As I am going through my analysis of the transcript of my first session between therapist one and client one, I had at first looked at analyzing with two distinct categories in mind:

1. Exploration of discourses i.e. “What discourses are relevant (and irrelevant) in the situation? How are they made relevant (and irrelevant), and in what ways?”
2. How therapists position clients in discourse and what effect this has on the co-construction of client identity.

As I am analyzing with these two categories of inquiry in mind, I’m realizing that I can’t just present them as two separate things to the reader. i.e. Here are the discourses, and here is how the client is positioned. Rather, as I’m reading the transcript I believe these two things are overlapping throughout the transcript.

As such, I feel that I should present the results of my analysis as such when presenting this. i.e., We start out with the therapist and client speaking of client identity defined by social category (mom, family), then dominant discourse of mental health appears and how this effects client identity, and then the therapist’s attempt to position the client in this discourse.

This process doesn’t seem linear but it’s making clear the Hall (1989) quote that I found:

Identity “emerges as a kind of unsettled space, or unresolved question in that space, between a number of intersecting discourses...Identity is a process...Identity is not a fixed position but an ambivalent point. Identity is also the relationship of the Other to one’s self” (Hall, 1989, p. 9).

Also, as I am reading this transcript I am reminded of Bahktin’s “Inner Unfinalizability.” These concepts will be helpful in the discussion section of the thesis, as well as my referencing of Narrative therapy’s “de-centred” influence that can be seen at play in the session.

September 24th, 2018 @ 4:14PM

Therapist questions that are open-ended in session one, like “What does that mean to you?” When the client has described a quality in line with a preferred identity, such questions seems to allow the therapist and client the space to further co-construct this client identity in the therapeutic discourse utterance by utterance.

September 24th, 2018 @ 4:36PM

Perhaps I should put in the appendices (if there is room), the full transcripts of sessions with my initial round of analysis for readers to refer to, and thus allow me to be more transparent in my analysis.

September 25th, 2018

Once I am done my first analysis of session one, I will send it to David. As well, I will read the original transcript again to see if other discourses and co-constructions of identity stand out to me, in addition to my initial round of comments in this first analysis.

I have also dug up an article on discourse analysis that I found from my proposal that talks about the discourse analyst needing to be transparent, rigorous and needing to help the reader navigate the research process. This reflexivity journal is an attempt to do this, and in addition, I will be re-reading this article and adapting it to my methods chapter as needed.

September 25th, 2018

Today I finished my first round of analysis of the first single session. Tomorrow I will start on the first round of analysis of the second session. So far with the three sessions I have transcribed I think I will transcribe each one first before going back and re-reading for a second round.

September 27th, 2018

Today I did a bit more work on my methods chapter. I have two more potential single sessions to record. This would bring the total number of recorded sessions to five. That would be great! I'm unsure if I'll get a sixth, but five would be great. For now, I will start my first round of analysis on the second session.

September 28th, 2018

As I am analyzing the second session for the second day (first round of analysis), I'm reflecting that this session is different than the first recorded session in that there seems to be less multiple discourses hovering (mental health and religion), but rather there seems to be a hovering dominant discourse of identity itself and in the session I think an attempt by the therapist (and client) to subvert this dominant discourse of identity ("What's wrong with me?") and intentional state conceptions of client identity based on client choice in line with preferred identities.

While reviewing my notes from yesterday, I will be imputing comments again in bold in the session transcripts and also consulting my notes from Michael White's "Maps", where he talks about dominant and subordinate discourses and their effect on identity co-construction between the client and therapist in this second session.

September 30th, 2018

As I am adding to my methods chapter I am thinking more about transparency in the discourse analysis process. Specifically, the need to give context when I am showing a piece of discourse and interpreting it in a certain way. The literature says to be transparent and rigorous, one needs to provide additional context of the text around this point that I am presenting so it can be

situated within this greater context and so it can be challenged to another reading as discourse analysis is not trying to be the definitive final say on any piece of text and is always up for further interpretation.

October 2nd, 2018

I just finished analysing my first draft of the third session. Noticing what I think is a problem discourse of normalizing judgement in some of the statements the client made in session.

October 8th, 2018

Today I am completing my methodology/methods chapter about I am using Foucauldian Discourse Analysis in my study. I am working in a section on qualitative research as an interpretation of data, which will lead into an account of discourse analysis and Foucauldian Discourse Analysis being its own interpretation of the data which is the text of these sessions.

On Saturday, while visiting friends for Thanksgiving, I was telling one friend about my analysis from the Foucauldian approach. He then asked, "How do you make the analysis objective?" I believe I answered his question noting that my analysis cannot be objective, but this Foucauldian discourse analysis is looking to show how certain things occur in text, providing an account to the reader that is trustworthy. I think my further readings into this research as interpretation will help clarify my own positioning as I engage in this analysis.

Also, last night I received feedback from David as per my first analysis of the first recorded session. I think we are both happy with how it's shaping up, but I think he is right in his suggestion to be clearer in how I go from therapist's questions to client answers and how this is about "identity." Also, I like his suggestion in the first session that I need to keep the lines clear between dominant discourse that is in the room because it can be seen to be imbedded in the exchange versus a discourse that's "out there" but which may not be showing in the exchange. I will keep these points in mind as I do my second round of Foucauldian Discourse Analysis on this first transcript.

As well, I think the interpretation section I will write about now in my methodology/methods chapter will be critical to return to when I write my results and discussion chapters down the road.

October 13th, 2018

While printing off the second draft of my methodology/methods chapter for review. I had a thought about co-construction. Not only am I studying the co-construction of client identity in recorded single sessions, and not only is there a degree of co-construction present in the research design through the use of client and therapist questionnaires that give research participants greater voice in the co-construction of knowledge claims, but ALSO the results of the study will also be a co-construction of the analysis process between myself and my supervisor. This idea that the results of this Foucauldian Discourse Analysis is itself a co-construction of knowledge is something I feel I will need to discuss further in my discussion chapter!

October 22nd, 2018

I have recently completed transcribing the fourth recorded single session and made initial notes. I have now printed off a hardcopy of this session and will read through it now more thoroughly and take more detailed notes about which discourses are present in the session and what language is used in the co-construction of client identity.

My initial thoughts as I start this process is there were many times when I was listening to the session recording when I was reminded of Alan Wade's 1997 article "Small Acts of Living: Everyday Resistance to Violence and Other Forms of Oppression." I think reviewing this article will help with figuring out the discourses in this session, especially as there was a part in this session where the client notes they feel they are "not making progress forward anymore", to which the therapist seems to note that the client's actions speak otherwise.

This might be a different discourse and different co-construction of client identity. Discourse of progress.

Tuesday October 23rd, 2018

Yesterday I completed a through reading of the 4th single session transcript and took corresponding notes, Today I am beginning initial analysis on the fourth transcript. As I am focusing on which discourses are made relevant and irrelevant as per Gee (2011), I will think of the following definition of discourse as I read and analyze:

From the Foucauldian perspective, while there "are a number of possible frames for thinking, writing, and speaking about aspects of reality, as a consequence of the effect of power relations, not all discourses are afforded equal presence or equal authority" (Cheek, 2008, p. 365).

November 16th, 2018

As I have made initial notes while transcribing the fifth session, one thing that stands out in my thinking as I make more detailed notes is how the client and therapist co-construct the client's identity around space for the client's individual self- which creates space for the client to assess their needs and wants outside of co-dependent relationships.

Thus, I also think there is something here about discourses of the self and discourse of relationships, and where the client is positioned in relation to the discourse of co-dependency, and the client and therapist's re-evaluation of the client's positioning within this discourse.

November 26th, 2018

Today I am starting my second round of analysis on my first recorded single session, after receiving feedback from my thesis supervisor.

As I read and analyze this first transcript for a second time, I will be thinking more about the implicit and explicit discourses in the session as well as tweaking how I account for some things in terms of "identity."

Additionally, I'll think about how clients and therapists might be influenced by similar or different implicit/explicit discourses. I will also be thinking about discourse as both a noun and verb in relation to the co-construction of client identity.

For example, in this first recorded session, in my first analysis I referred to a discourse of "mental illness." However, after speaking to my advisor this discourse may not be showing in the exchange. It may be "out there" but not showing in the exchange. i.e. Implicit versus explicit discourse.

November 27th, 2018

As I was doing the second analysis of my first recorded session, yesterday I re-read Combs and Freedman's 2016 article "*Narrative Therapy's Relational Understanding of Identity*." In the article the authors pose different questions that narrative therapists can pose with clients in terms of speaking of client identity as relational, distributed, preformed, and fluid.

As I am going through the first transcript, I can think of some of the questions they list to assist in answering how the therapist in this session positions the client in discourse, and what effect this has on the do-construction of client identity.

In particular, Combs and Freedman's examples of relational identity questions seem to appear in the session when there is re-remembering going on in the session. There also seems to be sections of the transcript which reflect "Fluid notions of identity", where there are questions which weave between asking a client about landscape of action questions (what happened), and the landscape of identity (the meaning of what happened) for the client.

I believe reviewing this and seeing where these questions show up, will help me in figuring out "what socially recognizable identities the [therapist] is trying to enact of get [the client] to recognize...how the [therapist's] language treats [the client's] identities...[and] what identities the [therapist] is "inviting" them to take up"

I will also re-read "*Constructing Unfinalizability*", an article about therapeutic subject positioning which I believe will help in this regard, by Michael Guilfoyle.

December 4th, 2018

As I am continuing to do the second analysis of my first recorded session, I am noticing that the therapist seems to be speaking about the client's identity in terms of the word "qualities." Throughout the session the therapist and client speak of the client's quality of empathy, or quality of resiliency.

This language of qualities spoken between the two seems to assist the therapist to enact, or get the client to recognize these specific qualities as an important part of the client's identity, and invited the client to further describe these "qualities" in session.

December 6th, 2018

As I am completing my second analysis of the first recorded session I was reflecting on how the language used in session positions the client in discourse. I noticed early on in session the client uses the language of “burden” to describe their position in relation to a discourse of family mental health problems, as the client is a caretaker for her two adult children.

Further on in the session however, I noticed the therapist and client co-construct the client qualities of identity as someone who is “empathic” and “resilient.” The therapist and client then use this language of empathy and resilience to position the client as having such characteristics in relation to the discourse of family mental health. Therefore, the client is re-positioned in this discourse with these qualities of identity that have been co-constructed.

December 13th, 2018

Today I am starting the second round of analysis on the second transcript. I will be re-reading the transcript with David’s comment in mind and incorporating his feedback into this second analysis.

I am thinking about how my discussion of the first session will focus on meaning related questions, “How?” and “Why”, that contribute the landscape of identity for the client. In the second session discussion of analysis, I am thinking about how I will structure the write up in terms of focusing on White’s internal vs. intentional state conceptions of identity that are present in the session between client and therapist, as well as Alan Wade’s article about discourses of resistance.

Perhaps structure the discussion of analysis, or presentation of analysis into bigger chunks of important exchanges between clients and therapist’s in transcripts related both to discourses and identity. For the first transcript I’m thinning of the major parts of discourse of family mental health and discourse of religion, and how this effects identity construction initially, and later identity co-construction in this session. Additionally adding to the discussion the Combs and Freedman article that can be seen in the questions the therapist asks.

In the second transcript I’m thinking about presenting analysis based on examples of internal state conceptions of identity and examples of intentional state conceptions of identity and clearly showing every time this happens. Additionally adding to the discussion the definitions of internal vs. intentional state identity by White, as well as the Article by Wade. Perhaps give brief nods to Wade here and then further develop Wade’s argument in reference to the article in the discussion chapter.

December 14th, 2018

Yesterday I finished reading over my transcript of the first analysis of the second session containing David’s track changes. At one point in the transcript David made a comment about Alan Wade and Cathy Richardson’s work in response-based therapy. While not narrative, it is an approach that is similar in that it looks at the language around how we respond to events in our lives. For example, in the second session the client originally seems to categorize being silent as

doing nothing, but later the client and therapist re-position this being silent as a “choice” the client has made to respond, and then expand the meaning of this choice/response.

This morning I have printed off five articles by Alan Wade/Cathy Richardson, some of which look at language use in therapy in response based practice. I will likely use some of these article in my analysis, but more likely I will cite these articles to add to my discussion chapter.

December 15th, 2018

Today I am completing my second analysis of my second session transcript. I am editing quotes out as well that are helpful, but that I think will be more appropriate in the discussion chapter.

For example, I believe this quote by Michael White:

“The evolution of the concept of a “self” as an essence that is understood to occupy the centre of personal identity, Although this idea of a self is a relatively novel idea in the history of the world’s cultures, it has been a hugely successful idea and is today quite taken for granted in the West” (White, 2007, p. 101-102)

is better placed in the discussion chapter once I finish all of my analysis. In particular, I think this quote could be used in reference to highlight the phenomenon that happened in many of the recorded sessions where after co-constructing a preferred identity with the client, the therapist notes that this identity, or the qualities that make up this identity exist within the client. This line of thought by the therapist may very well reflect the above quote by White.

December 17th, 2018

Today I am re-reading Alan Wade’s article about small acts of resistance to violence in everyday life. It has me thinking about my second session when the therapist terms the client as expressing “silent resistance” in the meeting he recounts with his college. The idea of Wade’s resistance and his linking it to narrative therapy as he does in this article could also be combined with Bakhtin’s notion of “unfinalizability” and Guilfoyle’s notion of embodied resistance in Narrative therapy, it terms of the client in the second session resisting a finalizing definition of himself that is based in a discourse of pathology. These readings could also serve as a basis for discussion of identity co-construction in the other recoded sessions as well. I am making a note of highlighting these readings to go back to them in my discussion chapter.

Dec. 20th, 2018

I am now re-reading the second transcript and looking at the expression of values in relation to the co-construction of client identity. The word “values” is mentioned a lot by the therapist who also names several values attached to the client’s actions. Throughout the session it appears that the client agrees with the therapist’s naming of client values, until towards the end of the session where the client starts naming their own values i.e. The client stated he was proud of himself. This conversation around values may also highlight the subtle scaffolding in this conversation between client and therapist that leads to identity co-construction.

December 22nd, 2018

“Bruner...proposed that stories are principally composed of two landscapes—a “landscape of action” and a ‘landscape of consciousness.’ The landscape of action is the ‘material’ of the story and is composed of the sequence of events that make up the plot...The landscape of consciousness is composed of ‘what those involved in the action know, think, or feel do not know, think or feel’ (Bruner, 1986, p. 14). This landscape features the consciousness of the protagonists of the story and is significantly composed of their reflections on the events of the landscape of action—of their attribution of meaning to these events, or their deductions about the intentions or purposes that are shaping of these events, and of their conclusions about the character and identity of the other protagonists in light of these events” (White, 2007, p. 78).

This may be similar to both in session 1-therapists actions and “how” questions...and here...the values or reflection of action questions/comments.

January 16th, 2019

Today I am beginning my second analysis of the third session. David noted in his comments to me that he didn’t revise anything “earth shattering”, so I think that this data analysis may not take too long as compared to the others so far.

January 18th, 2019

Today as I am completing my second analysis of third transcript in light of David’s comments I am highlighting two comments David made and trying to incorporate them into the analysis.

Frist, he pointed out in this first session how the therapist attributes the word “deep” to the client’s tears in relation to others not valuing her/she not valuing herself. He noted that this “deep” comment could be equated with a humanist position in therapy. This sounds like it fits, however it’s interesting that this “deep” comment is still happening in a hovering discourse about the client’s value. In addition perhaps the “deep” comment itself is a dominant humanistic discourse seen in therapy. Perhaps I will add this point to the analysis and ask for his take on it.

Second, early on in the session the therapist seems to qualify the client’s language in terms of a protest or resistance, against her father’s emotional abuse. Here the therapist uses language of “Excuse me? You’re wrong!” which the client seems to agree with and which seems to set the stage early on in terms of re-positioning the client against the dominant discourse of not being valued.

January 21st, 2019

Today I am continuing my second analysis of the fourth single session. Over the last few days, I have re-read the transcript and taken in David’s feedback on my first analysis of this session. One of the biggest points that he made was early on in the session I speak of a discourse that the client brings up of living conditions. David’s comment to me was “I think this issue has come up before: Is it not a stretch to talk about the discourse when it isn’t really manifest yet.” I will be re-reading the session today with this comment in mind. I think the discourse could be flagged as potentially there at some points, but I will try to be clearer about when I think the discourse has manifested itself more concretely.

As I'm re-reading the transcript, I'm noticing the topic of "living conditions" comes up soon after the therapist asks the client, what she would like to focus on as she states, "If I were to talk about anything it would probably be, ah, my living conditions right now." Perhaps all the other discourses I speculate are connected to this: loss of mother/grief/bereavement, aren't quite yet in play so early on, but become manifest as the session progresses. I feel I need to be clearer when these other discourses of grief and bereavement manifest as I conduct this round of analysis and as I feel they tie into the topic of the client's current living conditions.

7:15PM- I have just finished re-reading the fourth transcript and made additional notes that I will incorporate into the second analysis. One of the big takeaways is something that David noted to me at the end of the session, which was that perhaps I could make out when the client is staying in the room and this is spoke about through a problem discourse, versus times where the client stays in her room and this is seen as coming from an agentive discourse. I think this will help pick up different stands of narrative practice.

In addition, I will be moving my early comments about grief and bereavement discourse into later on in the session as my initial notes now read as premature as the bereavement discourse had not full materialized until later on in the session.

January 22nd, 2019

As I am continuing my second analysis on the fourth session, I am now moving my earlier comments about a grief and bereavement discourse that I initially said was occurring, to a clearer point in session when this discourse appears to manifest. I believe earlier on this discourse is flagged perhaps but not active. Once the client notes that she misses her mom, it seems like the discourse is manifest and it combines with other discourses of control, safety and comfort. I will be looking at the combination of these discourse at this moment it seems manifest in light of my questions of discourse and identity.

Also, I'm remembering an article about grief and bereavement and identity that may be helpful for this session's analysis and discussion. I will review my references and dig it up.

January 24th, 2019

As I continue my second analysis of the fourth session, I have re-read an article by O'Connor et. al (2003), entitled "Writing for the bereaved: evaluation of an intervention" in the *Journal of Palliative Medicine*. In the article the authors state that "[b]ereaved person's talk about having to reconstruct their personal identity and find meaning" (p. 195).

I am thinking that perhaps in this session, the client is doing this in reference to not only reconstructing personal identity and finding meaning in relation to the loss of the client's mom, but also reconstructing personal identity in relation to safety, comfort and living situation—which appear to be discourses which intersect in the session with the grief and bereavement discourse. I will put this quote and comment in the analysis for my advisor to review. However, I am not sure if this idea is more appropriately placed in the discussion chapter rather than analysis.

January 25th, 2019

While continuing my second analysis of the fourth session I am reading Lorraine Hedtke's 2014 book. Re-membering, around grief and bereavement. I believe there is something here about the memories of loved one's who have past and how they influence the bereaved person's identity, in the case of the session I am analyzing, how the client's identity was influenced by her mother and how her mother brought her safety, comfort and control through living together, and through the re-membering questions in the session the therapist offers a re-positioning that the client is re-negotiating their identity now without the client's mother being physically present but having important influence on these qualities of safety, comfort and control that the client is now trying to create in their life as influenced by her mother.

January 31st, 2019

Today I am beginning the second analysis of my fifth recorded session. I will be incorporating my supervisor's comments from having read my first analysis of this session.

February 1st, 2019

As I continue my second analysis of the fifth session, at one point in the session the client explicitly comments on their identity without any prompting from the therapist. I noted in the analysis, but I feel I will have to further comment in the final write up of the thesis that this at times may not be naturally occurring talk, but could be influenced by the therapist and client having met me and noting that the research looks at identity co-construction in these sessions. There have been other times in other recorded sessions where both therapists and clients openly talk about the term identity and how it applies to the client in the session and in their live. Again, I will be commenting that while this gives as sense how identity is co-constructed in the discourses occurring in these single sessions, there is also an element of this language being used as a function of the research taking place.

February 3rd, 2019

As I am completing my second analysis of the fifth session transcript, I find I am thinking ahead to sending my second round of analysis of my sessions to my supervisor David. While walking outside this morning I had a thought that when I get feedback on these second analyses and we are in agreement on the analysis of sessions I will then start opening the questionnaires from the client and therapist. Originally, I thought this would be a way to give context to my own analysis in terms of how the participants view their experience in session, and not just my own interpretation as researcher. However, this morning I was thinking what if I led the presentation of my analysis with the questionnaire data from the client and therapist participants as Foucauldian discourse analysis is also about privileging the voices of research participants. If I led with the questionnaire data, I could also do what I had originally planned which was to compare and contrast my own analysis with the direct words of participants.

This is something that I will speak to my supervisor David further as we get closer to opening the questionnaire envelopes.

February 15th, 2019

I just had a meeting with David where we were discussing my second analysis of my first session. David noted that I was noting that there were discourses there such as religion, and family mental health that aren't back up by any claims from me. We discussed going over the transcript again in greater detail with my research questions in mind i.e. which discourses are relevant and irrelevant in the situation, and being clearer as to why I believe a discourse is present or manifest.

February 15th, 2019

As per my discussion with David, given that the project is about identity construction, the sense of relevance and irrelevance for discourse that appear in the transcripts should be hooked to that in some way.

If assessment of whether a discourse is relevant or irrelevant is done from the perspective of the therapist trying to achieve a preferred client identity, then relevant could refer to discourses that are helpful and contribute to preferred identity, and irrelevant could be discourses that are seen as unhelpful and lead to problem identity.

Drawing on the second part of the question, therapists would be seen as inviting clients to engage in, and take on what (from therapist's point of view) are relevant discourses, and therapists would be involved in inviting clients to let go of, or challenge, the so-called irrelevant discourses, where irrelevant means unhelpful to preferred identity of conversation.

However, we also spoke of distinctions of discourse of noun and discourse as verb as being an important distinction where discourse as noun, would be the influence of an outside discourse on the conversation occurring between client and therapist, whereas discourse as verb may not necessarily mean an outside discourse as full manifest or impinging on the talk. i.e. the session below, we may not see discourse of religion where discourse is a noun, but the topic of religion does occur between client and therapist in session, so in this case it may be discourse as a verb.

We also spoke of distinctions of discourse as drawing on specialized vocabulary that the client or therapist may draw upon, this making discourse (as noun) present. i.e. Listing kitchen appliances is not a "kitchen discourse" but if the client states "The kitchen is the heart of the home" this is a discourse with dominant meanings hovering in the background and influencing this speech.

As per re-reading the transcript I believe that there may be a hovering dominant discourse the client is drawing on believing that people are defined by their problems I.e. daughter's manic depression and son's schizophrenia, where as the therapist is inviting the client to take up a different discourse of identity in terms of her relationship with her kids, making their identities not totally pathological.

February 18th, 2019

I am reviewing my first transcript looking at the first part of my research question about discourses.

February 18th, 2019

Note to David Re: First Session Analysis—What discourses are relevant and irrelevant with respect to client-preferred identity.

Hey David,

Just a quick note-- I think I figured out an important discourse in this first session.

In our conversation on Friday we were categorizing ways of describing discourse, and I remember at one point we were discussing discourse within narrative therapy itself.

I think in this first session there is a discourse of "the client as expert" which the therapist is drawing on. The therapist just seems to be asking questions and privileging the local knowledge and experience of the client.

I believe this discourse of "client as expert" dovetails nicely in terms of being a relevant discourse as per constructing the client's preferred identity.

From this "client as expert" discourse we get co-construction of the client as resilient, empathic, etc. which the therapist then uses to re-position the client in relation to her family's mental health challenges, so the client doesn't get hooked into limiting pathological descriptions of her children, which seem to leave the client stuck and frustrated.

I'll send you the transcript soon with more directed comments so it won't be as much to read, but I just wanted to send this note because its on my mind and feels like I'm making some progress with it.

Thanks again!

Jesse

February 26th, 2019

I've completed a revision of the first session, second analysis as per the suggestions of David that the discourse of "client as expert" may be found in all sessions. I've also added a narrative discourse of "privileging client local knowledge" that also appears to support the client preferred identity of positivity in addition to the other co-constructions of client identity such as being hopeful, empathic and resilient. In addition, it appears that the therapist invokes the client's identity as a mother to further access the client's local knowledge when discussing how she supports her children's mental health challenges.

February 27th, 2019

Today I am beginning to revise my second transcript looking to answer the question of what discourses are relevant and irrelevant in the session in terms of their ability to support client preferred identity. As I am reviewing previous iterations of this transcripts analysis, I am reminded that a discourse of pathological/internal state conception of identity occurs that wouldn't support client preferred identity, and as well, there appears to be a discourse of intentional state conceptions of identity that would support preferred client identity.

March 8th, 2019

Today I have been working on my analysis chapter. After speaking to David, I will now take the five sessions that I have analysed and I am switching the language that I am using from the therapist and client as "influenced by" a discourse, and this will now be changed to "performing a discourse," as this feels more in line with the Foucauldian approach that we are performing discourses.

March 14th, 2019

Yesterday I completed the initial writing of the first session for the analysis chapter. I have gotten it down to 9.5 pages from 55. I am highlighting the performance of different discourses by the client and therapist. In particular the client performs a medical model discourse of pathology and treatment when speaking of her daughter, which the therapist does not take up. The performance of the narrative therapy discourse of "client as expert" by the therapist and client contributes to the construction of the client's preferred identity of being positive, empathic, hopeful and resilient, while making irrelevant this medical model discourse.

I will now conduct a similar process of condensing my analysis to max ten pages for all other sessions to construct a first draft of my analysis chapter.

March 19th, 2019

I am now condensing my second transcript analysis and looking at the "how" discourses are made irrelevant and relevant more in session. E.g., In the second session there is an intentional state conception of identity that the therapist performs by not pathologizing the client actions of isolating and rather connecting these actions to an expression of the client's values related to client preferred identity. The "how" of this seems to happen because the client first alludes to the positive aspects of this behavior of isolating, while in the same breath, pathologizing himself for this same behavior in the beginning of the session. The therapist then adopts this positive stance towards the client's words that he is "isolating" and "introverted" thus helping the client re-negotiate the meaning of these words from something that is pathological to something that is positive and represents and expression of the client's values in support of this preferred identity.

March 22nd, 2019

Today I am condensing the third session transcript into ten pages as I have done the first and second session transcripts. I am specifically focusing on the discourses which are performed in relation to the construction of client preferred identity. Upon re-reading the transcripts yesterday, there are two different discourses around value. The first is a discourse of normalizing judgement

around the client not valuing herself and caring what others think of herself. The second is the client valuing herself and also seems in line with a narrative therapy discourse of re-authoring subjugated knowledge that the client enacts with the client to get this to be more full in session.

In addition, it appears the therapist is inviting the client into the socially recognizable identity of counsellor as a way of addressing and further thickening the client's preferred identity of being fully valued. Finally, the therapist is inviting the client to use the language of "passion incarnate", inviting the client to think about how passion incarnate would deal with normalizing judgement as a way of inviting the client to take up this identity in dealing with the issue that has brought them into the session.

March 29th, 2019

Today I am starting to condense the fourth session transcript down to ten pages from 48. I will write major updates as they happen...grief/bereavement discourse is here for sure.

April 5th, 2019

Today I am starting to condense the fifth session transcript down to ten pages from 40. As I am re-reading the transcript and my two rounds of analysis, the biggest two discourses that are appearing in relation to the construction of client preferred identity are 1) a discourse of co-dependency which does not support the client's preferred identity. The client notes that she is co-dependent on others and is trying to be better with being on her own. Thus, it appears that the client's preferred identity is to support herself and what is best for her independent of the influence of others. As such a second discourse appears: 2) a narrative discourse of externalization of the client's "self" and how the client relates to this self. This is also tied into the language that the therapist uses to invite the client into the particular identity as an assessor/evaluator in terms of her relationship with her "self" based on what she needs, rather than one of co-dependency.

April 8th, 2019

As I am continuing to condense the fifth session, I don't believe I'm seeing a discourse of co-dependency in the beginning of this session, but rather, similar to the second session, a discourse of internal state conception of identity when the client states that she is "co-dependent" and "enmeshed" as these qualities construct an identity that the client does not like in that she is not caring for herself and her needs. However, I still believe that there is a discourse of care for the self that is showing up as this is occurring between the client and therapist when they speak of all the things the client is enacting to care for her needs and her relationship with her "self."

Or perhaps it is an expression of both discourses: the discourse of co-dependency, enacted by the client language of co-dependency, and the discourse of internal state identity, enacted by the client noting that "I am" co-dependent.

April 15th, 2019

I have been constructing my analysis chapter over the past few days. I find I am having difficulty describing themes that show up when looking at discourses and language as per client preferred identity co-construction. Therefore, today I will be re-reading all five sessions in their entirety

and thinking about themes that come up in terms of “how” discourses and language show up between client and therapists in the recorded sessions.

3:25PM- As I have re-read over the first three recorded single sessions, I am noticing a few patterns that I will highlight in my analysis chapter:

First Theme: Client’s begin these sessions performing discourses which do not support the construction of preferred identity. Additionally, there are spots where, even while performing the unhelpful discourse, the client mentions a notion of how they want to be i.e. preferred identity. In these cases (session 2 and 3) the therapist then begins performing the alternate discourse in support of the development of the preferred identity. In the first session this happens, yet in a bit of a different order...the client performs the unhelpful discourse...and the therapist launches into the alternate discourse, and from this we get a clearer picture of the preferred identity.

Second Theme: In all the first three sessions there is also then the development of the preferred identity through the therapist’s use of this alternate discourse. At times where this occurs, the client at some points drifts back to the performance of the negative discourse, yet in all cases to help develop preferred identity the therapist sticks to alternate discourse.

Third Theme: Once the preferred identity is more fully developed by the end of the session through the use of the alternate positive discourse, the therapist then reinforces the construction of this preferred identity by inviting the client to take up language/identity that they used previously at the beginning of the session (i.e. “mother”, “introvert”, “counsellor”) in the context of this new discourse, and in this sense further develops the preferred identity. In two session (3rd and 4th) this is done through externalization of identity quality (i.e. “passion incarnate” and “relationship with self”).

Fourth theme: There also is in the 4th and 5th sessions a combination of discourses to support client preferred identity discourse. 4th- discourse of staying in room as agentic + re-memembering surrounding language of “comfort zone”...and 5th: discourse of care of self + re-memembering + externalization.

June 14th, 2019

Today I am opening up the envelopes of therapist and client questionnaires after completing my first analysis chapter and discussing it with my advisor. In my second draft of the analysis chapter, I will incorporate therapist and client comments into this chapter to have some degree of co-construction into the research process.

June 26th, 2019

Today I am nearing completion of my second draft of my analysis chapter, however, I am needing to rework one of the discourses in the session themes I present. In the fourth recorded single session with the 22-year-old client who had lost her mom, I have presented the problem discourse as the client staying in her room as a problem to be solved, versus the client staying in her room as an act of agency. I feel like these discourse categories don’t quite describe what I’m trying to say. Therefore, I am reading Brinkmann’s 2016 book, *Diagnostic Cultures: A Cultural Approach to the Pathologization of Modern Life*.

I feel this book will help me more accurately describe the influence of different discourses I see when the client originally speaks about staying in her room as a problem, versus staying in her room as part of her comfort zone. There is something that the therapist is doing in this session to give the client's actions of staying in her room more context, such as: 1) staying in her room because her housemates are fighting, and 2) staying in her room because of the associations to her deceased mother. These contextual factors lessen the client's own self pathology that occurs in the beginning of the session when speaking about staying in her room solely due to depression and anxiety.

June 29th, 2019

Upon reviewing the fourth session transcript I now am thinking that the discourse performed by the therapist is the narrative discourse of the client as expert, as this same therapist performed this discourse in an earlier recorded session. The questions about the meaning of client actions lead me to believe it makes sense to categorize this same discourse as being performed by the therapist in this other recorded session.

July 5th, 2019

After reading Brinkmann's book I now believe that the discourse that "Suzie" performs at the beginning of her single session when stating her actions of staying in her room due to her suffering from anxiety and depression is the performance of a problem discourse of self-pathologized suffering. I have gone more in-depth about this problem discourse in both my analysis chapter and in the glossary of discourses.

July 8th, 2019

Last night I sent of my second draft of my analysis chapter to my advisor. Now, since I have opened therapist and client questionnaires I am beginning to think about how to incorporate participant voices into the results chapter.

July 19th, 2019

After revising my conceptual framework chapter over the past week and a half, last night I began thinking about incorporating participant voices from questionnaires into my results chapter. I am debating whether to put therapist and client voices from questionnaires at the end sections of their sessions, as this may shed more contextual light of what they were thinking right after the sessions. Alternatively, I was thinking about putting these participant comments up front to give primacy to participant voices over my own voice in my research analysis. As I go over the data and my chapter today I think this will become clearer.

Upon reviewing participant responses and questionnaires and the results chapter itself, I think it best to present client and therapists voices through these questionnaires as similar themes come up in their questionnaires to that which I wrote about in my own analysis. E.g., In the session between therapist Karen and client Amélie, Karen notes the importance of focusing on Amélie's resilience and hope at one point in their questionnaire. I think it makes sense to put such comments in at the point where I have already put that in my analysis to give further context.

There are also times in the questionnaires where a participant will reference something that I didn't talk about in my analysis. i.e., In the session with client Suzie she notes an important time for her in the session is when she and therapist Karen speak about what they notice about each other. This was not put into my analysis, but I still think putting in these words from the questionnaires is valuable in shedding light on the sessions and co-construction of identity.

July 20th, 2019

Today I have begun incorporating the voices of research participants into my results chapter. I am doing this but imputing their responses to questions in parts of my analysis chapter where either the therapist or client and I use the same word to describe what is happening in the session. For example, at one point I highlight a disagreement between therapist Karen and client Suzie. Additionally, there are times when clients and therapists refer to things occurring in session that I did not include in my analysis. In my discussion chapter I will have to account for this as well.

July 22nd, 2019

As I am incorporating client and therapist responses from questionnaires into my results chapter, I am finding it helpful by noting that whenever I highlight these responses I am noting that "After the session when clients and therapists were asked" and then highlight the specific question that they are answering. I find this is a way of being clear and distinguishing excerpts from the sessions between clients and therapist which highlights my analysis of their voices in these sessions, and their own voices upon reflection of the session. Again, as I go through this process I aim to be clear about when I am seeking to highlight the therapist's or client's voice through their questionnaire response.

July 22nd, 2019

As I continue to work in comments from therapists and clients from the questionnaires into my analysis chapter I am highlighting these sections "Participant Voices." I think doing so clearly delineates for the reader the space between my own analysis of the session and the subsequent reflections from the sessions by clients and therapists.

August 1st, 2019

I am continuing to revise my results chapter. In response to my supervisor's note that I should change the language in the chapter instead of "alternate discourses" that therapist perform in response to therapist practices that support identity co-construction I responded with the following email noting that I think this makes sense and is a good idea and I also need to give a nod, from the Foucauldian perspective of the discourses that are present when preferred identity co-construction occurs. Not just the problem discourses initially performed by clients.

I am thinking that rather than "alternative discourses" that speak to different aspects of narrative therapy, as it is presented in the chapter now, it may make more sense that there is an overall narrative therapy discourse that therapists are engaged in that then allows for certain practices that support client preferred identity construction. The email to my supervisor is as follows:

Note to David: August 1st, 2019- Re- Prep for Meeting on Thursday August 8th, 2019

Hey David,

In prep for our meeting I wanted to make some focused notes as I know you have to leave shortly after we are done.

So here are some notes after I reviewed your comments:

1. I agree with all your points about changing the language to reflect therapist practice rather than “alternate discourses” and I will start working on this. I do think it makes sense to write it up this way and it will help answer my main research question “How do therapists trained in narrative therapy facilitate the co-construction of client preferred identities within the context of discourses that appear in the context of single session therapy.”

2. I also think I do need to acknowledge the influence of discourses not only in the beginning of the session (the problem discourses that client’s perform) but also something about the discourses/or discourse at play when therapists and clients are in the process of co-constructing client preferred identity. The way I’ve written it now, maybe it seems too macro in focus, but I do think I need to give a nod to something happening regarding the bigger influence of outside discourses influencing this process of identity co-construction.

I think this will also help answer the question put in my proposal and in the results chapter that I used to analyze transcripts which is: “what discourses are relevant (and irrelevant) [as per co-constructing client preferred identity]? How are they made relevant (and irrelevant), and in what ways?” (Gee, 2011a, p.110).

So if I frame it as therapists are influenced by a narrative therapy discourse which they invite clients into, this allows certain therapeutic practices to occur which support preferred identity co-construction.

I feel if I don’t include something like this the committee might wonder how is this a Foucauldian discourse analysis when I only talk about the problem discourses at play at the beginning of sessions. I could picture Richard for instance saying, “Aren’t discourses always influencing our language.”

Perhaps an overarching narrative therapy discourse isn’t a discourse in the way we normally think of it as it does not show up in wider culture as the initial problem discourses do, but narrative therapy could be considered a therapeutic culture in its own right, so I think I could make a case for this.

Perhaps its an overarching narrative therapy discourse that I could write about in the glossary of discourses as well rather than the separate individual ones I’ve labeled as “alternate discourses.” And then if I write about one overarching narrative discourse in the chapter then I could comment that these narrative practices that therapists are engaged in with clients are happening in the context of an overarching narrative therapy discourse that allows therapists to subvert client problem discourses in support of client preferred identity co-construction.

3. I am attaching two additional documents. Which help visualize some of this.

The first document is a diagram I've made for my theoretical framework/conceptual framework chapter. We've talked about it before. It depicts the co-construction of preferred identity occurring between therapist utterance by utterance (social constructionist perspective) happening in the context of multiple discourses which impinge on this process (the poststructural/Foucauldian perspective).

So based on this conceptual framework, I think I can make the case that this is what is being seen in these sessions. Problem discourses are present and not supportive of preferred identity co-construction, and an overarching narrative therapy discourse is present which supports therapists engaging in specific therapeutic practices which help facilitate the co-construction of preferred identity.

The second document is a picture I found online that may support me in writing about an overall narrative discourse and the practices associated with that.

Thanks again for your time. I will keep reviewing the chapter notes before next weeks meeting.

Best,

Jesse

August 2nd, 2019

Today I am starting to draft my third draft of the results chapter and will be cutting out the alternative narrative discourses section and others that aren't the problem discourses and re-writing around these quote examples instead about how the section of the session can be characterized as a particular narrative practice in the support of client preferences or preferred identity co-construction, all of which is occurring in the backdrop of an overall alternate narrative therapy discourse. I will write up exactly what this narrative therapy discourse is afterwards in the glossary of discourses document, and additionally I will likely include in greater depth the theory behind therapist practices that are utilized in the glossary of discourses document.

August 5th, 2019

Today I am, as per David's suggestions, unpacking the term "thickening" that I have used in my most recent draft of the findings from my analysis. Much of the passage that I point to speaks to the narrative practice of "thickening." Once defining this for the reader, I will look into how the narrative practice of "thickening" occurs in the transcript excerpts. Sometime thickening occurs in the "here and now" by therapists focusing on a word the client says and getting a description of that word from the client as per co-constructed meaning making. Other times it appears that thickening happens as a result of clients telling historical stories of a time they were able to act in a way that aligned with a preference.

August 9th, 2019

I am now working on continuing my third draft of my analysis chapter and focusing on the narrative practices which support the co-construction of client preferred identity which I am seeing in sessions. To more precisely name the practices used by therapists I am reading *Narrative Therapy: An Introduction for Counsellors* by Martin Payne (2006). In this book Payne goes into several practices of narrative therapy that I will reference, including: the person tells her story, naming the problem, using externalized language, social and political issues, relative influencing questioning, deconstruction of unique outcomes, the person is invited to take a position on the problem, re-membering (which I already reference in my findings), telling and re-telling towards enrichment of the self story (Payne, 2006), and thickening preferences which is also already referenced in my findings. These narrative practices will highlight how therapists help facilitate client preferred identity co-construction in the context of problem discourses that clients bring into the session. In addition, I will describe therapist work as practice rather than my previous use of the term “alternate discourses” that therapists were drawing on. I believe instead it makes more sense to describe an overall “narrative therapy discourse” that therapist draw on which allows for these practices to be enacted. I will also further describe this “narrative therapy discourse” in the glossary of discourses section.

August 10th, 2019

Last night while reading Martin Payne’s (2006) book I found a good passage that I believe speaks to narrative therapy discourse that I will include in my glossary of discourses.

August 13th, 2019

Today I am re-working the language that I use to describe what therapists are doing in session to help co-construct client preferences/preferred identities. Rather than my previously used language of different narrative “discourse”, as noted above I am referencing a single narrative therapy discourse that allows for specific therapist practices to occur. I am now languaging those practices as follows: Therapist practices that are performed the context of a narrative therapy discourse including therapist’s soliciting an experience near descriptions of client problem stories from the client, therapists inviting the client to take a position on the problem, therapists mapping the effects of problems stories, resulting in a re-authoring of problem, therapists thickening in the “here and now” language that further supports client preferences/preferred identity, including: thickening by focusing on client language, and thickening by therapist offering up their own language to clients to support client preferences, and thickening by focusing on historical stories, therapists engaging in the practice of re-membering, therapist engaging in the practice of externalization, and therapists thickening client-specific identities.

August 31st, 2019

As I near completion of my third draft of my results chapter I will be re-reading the initial transcripts for the first and fifth recorded single sessions. The problem discourses I have noted that clients lead these sessions with are a medical model discourse of “pathology and treatment” and a problem discourse of self pathologized suffering. As per my supervisor’s comments concerning the medical model discourse, this may actually be helpful as the client discusses

issues with her daughter's mental health. In reading the session over again I feel it will help me clarify what I'm trying to say with the problem discourse and how it prevents conversation around the client expressing a wish to be "positive." As per the fifth session that I have categorized as a problem discourse of self-pathologized suffering, I will be re-reading it and asking myself "what is the (unhelpful) claim being made by this discourse?" as pointed out by my supervisor.

September 27th, 2019

As I have been re-reading the fourth session transcript between client "Suzie" and therapist "Karen", I believe the initial discourse may be the problem discourse of pathology and treatment that I mentioned was present in another session. I believe my previous categorization of a problem discourse of self-pathologized suffering still fits, but more accurately is contained within the medical model discourse. Thus, I will be re-writing this to reflect this idea. Additionally, I believe there is another problem discourse that shows up: a discourse of progress which is then re-authored by therapist "Karen." Again, I will reflect these ideas in the chapter re-write.

November 1st, 2019

As I have been re-writing my theoretical/conceptual framework chapter over the past week, today I had an idea in terms of my Foucauldian methodology that would attend not only to the macro analysis of the discourses present in session, but also the more micro analysis that I do of the sessions.

Below is an email that I sent today to my advisor about it and his reply:

Hey David,

I've been thinking more about your last note in the past couple of days as I'm re-working my theoretical conceptual framework chapter and I think I may have a solution about having a hybrid Foucauldian Discourse Analysis attending to both the broader macro discourse, but also showing the micro back and forth, all under the umbrella of Foucault.

As I'm re-reading my poststructural theoretical framework I'm writing a lot more this time about resistance to dominant discourse thorough the subjugation of a person's local knowledge. I think these ideas help with my previous writings that dominant discourse constrains language use and meaning making. But besides the power of dominant discourse, a major focus of the poststructural perspective to be tackled could be Foucault's ideas on resistance.

It's not listed as such in the analysis chapter, but this could be a way of laying the groundwork in the conceptual framework and methodology chapters, and a way to comment on my analysis in a more meta way in the discussion chapter...kind of book-ending the analysis I suppose.

The more micro focus on client preferences and preferred identity, while social constructionist in its back in forth co-constructed meaning making, could also be seen as big part of the Foucauldian perspective- even though it is micro.

The client and therapist focusing on the utterances of client preferences, while micro, is also a needed part of the analysis to show how the development of client local knowledge, or resurrection of usurped knowledge against the dominant problem discourse.

But with a focus on only the macro showing use the dominant discourses, whether they are problematic in terms of what the clients start with, or a broader narrative discourse that therapists bring to the session would completely miss this point.

Therefore, to actually do the Foucauldian perspective justice, I need to comment on it both from a macro and micro perspective, because the micro perspective has a direct relation on the macro problem discourses.

Everything I've read on Foucauldian discourse analysis focuses on the macro discourses that effects the process, but nothing really on how resistance and the development of local knowledges gets done. But I'm sure I could make a case as the literature calls for a blending of micro and macro, and there is no set way to do Foucauldian DA.

Anyways, just some thoughts that I think I've hooked onto an important angle here.

Thanks again for all your support.

Jesse

Hey Jesse, this sounds really clear and well thought out to me. I can imagine you savouring your aha moment! I agree with all you've said and as you've pointed out before there is a lot of call for the blending—now you're the guy doing it!

Thanks for this, very exciting the way it's coming together.

David

November 21st, 2019

I am currently nearing completion of my Participant Voices chapter and am finding the page length is going longer than expected. It currently sits at 26 pages long, while my hope is to get it down to 20 pages. I find as I am reviewing it I am not only comparing and contrasting participant answers between pairs of therapists and clients, in addition to comparing participant answers with my own results chapter, I find at times I am expressing my own thoughts and opinions about congruencies and discrepancies between my own and participant perceptions. In order to trim this chapter, I find it may be helpful for me to cut out these later thoughts of mine and input them into the future discussion chapter. I believe I will be being that process tomorrow.

November 23rd, 2019

I am closer to nearing completion of my first draft of my "Participant Voices" chapter, and I have added a section of a session transcript from the recorded session from therapist "Karen" and

client “Suzie” as “Suzie” references the tail end of the discussion several times in her answers to her questionnaire. She notes how she and “Karen” spoke of their impressions of each other, and as well this discussion that related to who “Suzie” is and how she sees herself “doesn’t change” on her bad days, and can help her engage with her roommates in her communal kitchen on days when she may not want to. I have included these sections of the transcript in the chapter as I did not include this in my own results chapter. In doing so I am engaged in the poststructural research practice of “power sharing” in terms of what is deemed as important in the construction of this text.

February 9th, 2020

As I am editing my fifth draft of my results chapter I am now switching the section of transcript from when therapist “Karen” and client “Suzie” speak of her “comfort zone” from a narrative practice of thickening, to one of gaining an experience near description because I feel it fits better as per what Karen is doing that is in line with the definition of experience near description.

February 15th, 2020

As per David’s comments on the last draft of my results chapter I talk about re-authoring along side other narrative practices such as thickening as if these are separate things. However, his point is that re-authoring is an overarching narrative concept and thickening can be considered a type of re-authoring conversation in narrative therapy. As such, I have taken out my previous language of re-authoring practices in this fifth draft of my results chapter and I have brought this concept into my glossary of discourses. I.e., It is through a narrative therapy discourse of re-authoring that therapists engage in the various practices of narrative therapy that I mention in the results chapter.

July 6th, 2020

Today as I just finished the sixth draft of my literature review I am now working on editing my glossary of discourses and the sixth draft of my results chapter to be more specific about the alternative discourses that therapists draw upon to support their brief narrative therapy practice. Rather than just grouping all therapist work under the umbrella of a “Narrative Therapy Discourse of Re-authoring” as I have been doing, I will be more specific about the alternate discourses that therapists bring into sessions to support client-preferred identity co-construction and to counter the client performed discourses related to problem identity and to bring a more macro-Foucauldian perspective to therapist work. In this spirit the following guidance from my supervisor David will support me. The following was a note David wrote to me following a conversation about this process we had on May 22nd, 2020:

We've been looking at the issue of how to portray the discourses and a couple of ideas came up. One is about the focus of the discourses on identity. Another one is about the possibility of symmetry so that for each of the problem discourses which should be making claims about identity, there should be counterclaims or alternative claims about identity.

The idea of claims is another thing we talked about. It's one thing to talk about how a discourse plays out in society by practices that can be listed. And it's a similar thing to talk about how an alternative narrative discourse plays out in therapy as practices (and therapeutic

postures) which can be described. But I think in your glossary it would be useful to start with the fundamental claim about identity associated with that discourse before you start talking about the practices. And the practices as I mentioned on the problem side would be about practices within society. The practices on the alternative side would be therapeutic practices associated with narrative therapy.

Once you articulate the alternative discourse to one of the problem discourses, which would be claims about identity which run counter to the claims of the problem discourse, then you can direct our attention to what the therapist is doing in the session and talk about how what they are doing is congruent with the alternative discourse that they are informed by. So this is slightly different than what you started our conversation with, which was to describe the way the therapist positions themselves and to characterize that as a discourse. The problem with making that out to be the alternative discourse is that it doesn't contain a claim about identity. Instead it's a description of a therapeutic orientation. Nevertheless, it's not that aspects of this don't have a place in the thesis, more a case of how it gets mentioned. For instance. let's say you are talking about the intentional state discourse. After making claims about identity according to this discourse, such as the claim that people act based on values, purposes and intentions rather than because their actions are the expression of personalities and traits, then you can start looking at how the therapist interacts with people as they are informed by this view. So that decentered piece that was part of your description of the therapist positioning is certainly part of describing the therapist practice which is informed by this alternative discourse. Why? Well, if you ascribe to a problem discourse about internal State identity, you may try to re-shape a personality or assess a trait etc. But if you ascribe to an alternative discourse about intentional state identity, you will orient to the client in a manner congruent with that discourse. You would naturally be curious about values, intentions, purposes because that is how the alternative discourse make sense of people's actions and identities.

So, and I'm probably repeating myself here, whereas the description of the problem discourses includes laying out what kind of claims about identity the discourse makes followed by how that discourse gets performed or is played out in society, the description of the alternative discourses starts with laying out what kind of claims about identity those discourses make, but is then followed by how the alternative discourse plays out in therapy, how it is performed in the room in the interaction with the client. And that's what your transcripts demonstrate to the reader.

Good to talk to you today and wonderful to see the thesis unfolding the way it is. D

July 7th, 2020

Today I am beginning to revise my glossary of discourses and results chapters by looking at the counter discourses about client identity utilized by therapists to provide symmetry to the following client problem discourses:

A Discourse of Internal State Conception of Identity

A Discourse of Normalizing Judgement

*A Discourse of Co-Dependency**A Medical Model Discourse of Pathology*July 8th, 2020

This morning I have started re-writing my glossary of discourses looking at the alternative discourses and their claims about identity. As I am processing this I am thinking about the following:

The alternative discourse to the internal state discourse of identity is likely the intentional state discourse of identity as White differentiates these clearly in his writings (White, 2007). I will likely draw on White (2007) as I develop this alternate discourse in my glossary and research chapter.

The alternative discourse to the problem discourse of normalizing judgement may be a discourse that celebrates creativity, diversity and individuality rather than conformity. Additionally, the alternative discourse to the problem discourse of co-dependency, may be an alternative discourse of choosing intentional relationships with others and self. These comments are from my notes from a May 22nd, 2020 conversation with my supervisor David where we started to brainstorm what potential alternative discourses may be. As I figure these out I will begin with what is the alternative discourse's claim about identity and then after developing this, drawing on how this alternative identity claim is made manifest by the therapist in session by the therapist's brief narrative practice, and how this plays out between client and therapist in my results chapter.

I also believe that the alternative discourse to the medical model discourse of pathology seen in therapist "Karen's" session with client's "Amélie" and "Suzie" is an alternative discourse of the "client as expert." This is spoke about in Gergen's (1999) work to counter his other writing on medical model discourse. However, I will still have to work out how this alternative discourse of client as expert explicitly means for an identity claim and thus how this identity claim then guides therapist "Karen's" sessions.

Also, I will likely change the layout of my glossary of discourses writing about the problem discourses and following this with the alternative discourses for each session rather than grouping all problem discourses together followed by grouping all alternate discourses. By writing about these problem and alternative discourses by session in the glossary I feel the information will be easier for readers to follow.

I am also reading my results chapter over again so that when I suspect I have a better grasp on the alternative identity claims being made I can base this on the therapist language and how they respond to client problem discourses and see how therapist and client language supports these alternative discourses of identity.

July 13th, 2020

Today as I continue to re-work my glossary of discourses document along with my results chapter I started to re-write the problem discourse of normalizing judgement with more references to Foucault in the glossary document. Additionally, as I was then starting to write about the therapist initiated alternative discourse of creativity, individuality and uniqueness used

to counter the discourse of normalizing judgement, I noticed that while the bulk of the session has the therapist using this alternative discourse, at the very beginning when the therapist asks the client to take a stance against the normative judgement, this appears to be operating out of a different discourse. After some searching I found through Corey (2013) a description of the deconstruction of normalizing judgement which I think fits in terms of the alternative discourse the therapist draws on briefly before going into the other alternative discourse of creativity, individuality and uniqueness. This will be explained in greater detail in my results chapter and in the glossary of discourse.

July 31st, 2020

As I am re-working my glossary of discourses and results chapter I am taking out the discourses of progress, enmeshment, and bereavement that clients perform later on in certain sessions because after reflecting on this with my supervisor, these later performed client discourses, while interesting, do not affect the client identity and client-preferred identity in their respective sessions and thus will be omitted.

October 9th, 2021

After receiving feedback from two of the three profs on my thesis committee (Richard and Nick) on the first draft of the thesis, it seems that they are requesting some of my later chapters and related documents in the thesis be integrated into my results chapter. While Nick noted he enjoyed the glossary of discourses, Richard appears to allude that it should be integrated sooner into my result chapter rather than being at the end of the thesis. Additionally, both Richard and Nick seem to take issue with my Participant Voices chapter with Nick encouraging a blending of these responses from my participants into my result chapter, so it is portrayed along with the sessions themselves. While I noted previously in this reflexivity journal, I had chosen to create this glossary of discourse and create the participant voices chapter to present post-session questionnaire data so my result chapter wouldn't balloon to an enormous amount, it appears that Richard and Nick are advocating for greater integration and editing of these into my result chapter.

Additionally, Richard noted he felt the first half of my discussion chapter feels more like result commentary and suggested that this too be integrated into my result chapter. I will be meeting with David to discuss these requests and how to operationalize them in my writing and editing prior to hopefully meeting with my committee members to discuss their feedback in greater detail.

November 18th, 2021

Today I had a meeting with my thesis supervisor David, and my internal committee members Cristelle, Nick, and Richard. During the hour and a half meeting we discussed each committee member's comments on the first draft of the dissertation, and we brainstormed as a group the bigger changes that the committee wanted in relation to my re-organizing how my later chapters (Results, Participant Voices, and Discussion) will be presented in their final form.

We agreed that I will integrate section 7.1 from my discussion which Richard felt was more of a results section, as a framework or skeletal outline, for how my results will be ultimately

presented. We also agreed that rather than presenting my participant voices chapter as is (participant post-session questionnaires and my own commentary comparing and contrasting my session analysis with these post-session questionnaires), instead I will integrate the post-session questionnaires at the end of my results chapter. Additionally, I will cut my own commentary about post-session questionnaires, and I may relocate this to the discussion chapter if I find this is warranted. I may also bring the glossary of discourses to the fore of the results chapter as this is part of the findings as well and it may be beneficial to put this up front rather than to hide it in the back of the thesis.

Finally, as per the suggested changes from this committee meeting I will re-allocate all of the narrative practice literature that I cite in the results chapter into the literature review where it is better suited. We brainstormed as a committee that this will then set up my results chapter and discussion chapter better, in that I can give readers a sense earlier in the thesis of what structure narrative sessions commonly take, and what practices are commonly employed. I can then comment in my discussion chapter about the significance of my findings compared to how narrative therapy is commonly portrayed in the literature.