

Narrative Therapy in Walk-In Counselling: A Discourse Analysis of Counsellors' Conversational Practices During Intersession Break Consultations

By

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## Abstract

The purpose of this study was to explore how counselling teams draw on narrative therapy during intersession break consultations in walk-in counselling. Walk-in counselling is a form of single-session therapy (SST) that allows an individual, couple, or family to meet with a counsellor on a drop-in basis. Walk-in counselling clinics are becoming increasingly popular in Canada and globally, with a particularly high number operating in Ontario. Sessions in walk-in counselling typically involve a break partway through, during which the counsellor meets with a team of colleagues for a brief consultation; this is referred to as the “intersession break”.

Narrative therapy is a postmodern therapeutic approach commonly used in walk-in counselling.

Data collection occurred at two Ontarian walk-in counselling clinics and involved recording and transcribing a total of six intersession break consultations. Transcripts were examined using discourse analysis as a methodological approach. My analysis process identified four conversational practices counselling teams engaged in that drew on various aspects of narrative therapy theory. These practices are as follows: (a) counsellors engaging in externalization, (b) counsellors orienting to possible alternative narratives, (c) counsellors centring the person visiting the clinic, and (d) counsellors demonstrating tentativeness. This research is most directly relevant to counsellors working in walk-in counselling clinics and agencies offering SST involving intersession breaks. For mental health practitioners interested in postmodern therapeutic approaches, it provides a detailed account of how narrative therapy is being applied within a particular context. Finally, it may be of interest to people accessing walk-in counselling services who are curious about intersession break processes.

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A number of years ago, I opened a text edited by David Paré and was introduced to the world of postmodern, social constructionist, and narrative approaches to therapy. It was a big “aha” moment and the inception of this research project. David, your work in the field of counselling has been a source of inspiration and I am so grateful for your guidance and unwavering support as my thesis supervisor on this journey.

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## Chapter 1: Introduction

*In the institution of psychology, the recent reevaluation of the expert-oriented stance has generated an exhilarating range of ideas for approaching practice with an openness to mutual exploration and discovery. There is a make-it-up-together spirit, a shift from imposing to composing, accompanied by a rejuvenated vocabulary of coconstructed meaning and dialogic mutuality. (Paré & Larner, 2004a, p. 1)*

During my undergraduate degree in psychology, I had become well acquainted with the “expert-oriented stance” referred to by Paré and Larner (2004a). I had encountered it in psychopathology and abnormal psychology courses, which employed authoritative texts such as the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* to categorize and plan treatment for those in distress. It was present in textbooks and research classes that privileged experimental designs and in historical overviews that portrayed psychology as an ever-progressing, empirically-legitimated discipline. The message being that through adequate engagement with the “institution of psychology”, students would acquire the expertise that would qualify them to pursue clinical and/or research careers in the field.

While I had enjoyed my classes and appreciated the scientific method, I emerged from my undergrad questioning the foundations of psychological “expertise.” Discussions with professors and extracurricular reading (e.g. Khoury et al., 2014; Moser & Kleinplatz, 2005) had given me doubts about the validity and ethics of the *DSM*. Reports indicating low reproducibility of findings (Open Science Collaboration, 2015) and providing evidence of publication bias (Franco et al., 2014) called into question what was printed in my collection of textbooks. Perhaps what I struggled with most was the notion of researchers as objective observers of phenomena

and counsellors as “scientist-practitioners” who emphasize nomothetic findings in their interactions with those seeking their services. At the time, I used words like “subjective”, “qualitative”, and “phenomenological” to make sense of my research interests.

In my search for a graduate program and thesis supervisor, I came across the work of David Paré. His writings introduced me to the concept of postmodern therapy, which “downplays formal categorization of such things as developmental stages or mental disorders, and emphasizes processes of mutual meaning-making and collaborative relationship” (Paré & Lerner, 2004b, p. 260). Literature associated with postmodern therapy offered ways of conceptualizing and engaging in therapeutic conversations that resonated with me and sparked my desire to do research in this area. When I met with David to discuss my interests, he spoke enthusiastically about an emerging form of service delivery strongly influenced by postmodern therapeutic approaches: walk-in counselling.

A growing number of mental health agencies in Canada and around the world have begun providing near-immediate access to therapy through walk-in counselling clinics (Hymmen et al., 2013; Slive & Bobele, 2012). These clinics operate at specified hours each week, allowing an individual, couple, or family to meet with a counsellor on a drop-in basis without the usual intake process and waiting period associated with mental health services (Slive & Bobele, 2012). Walk-in counselling is a type of single-session therapy (SST), a term that refers to therapeutic encounters that intentionally occur on a single occasion with the goal of addressing a person’s<sup>1</sup>

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<sup>1</sup> Consistent with much of the literature on postmodern therapeutic approaches, and in particular the narrative therapists whose work is central to my research (e.g. Freedman & Combs, 1996; White & Epston, 1990), I will refer to those seeking services as “people” rather than “clients”. The latter term will, however, show up in quotations and in the study documents included as appendices.

immediate concerns (Slive, 2008). In SST, counsellors seek to establish a collaborative relationship that engages a person's strengths and resources (Campbell, 2012; Hoyt & Talmon, 2014), rather than "looking for root problems or underlying pathology" (Miller & Slive, 2004, p. 98). Gee et al. (2015) assert that, while not a replacement for ongoing counselling or support services, SST "should be seen as a valid component on a continuum of mental health care" (p. 124).

My interest in walk-in counselling was further strengthened by opportunities early on in the development of my research topic to observe walk-in counselling teams in action. Teams are made up of several counsellors and a clinical supervisor who work closely with one another to serve people visiting the clinic during its hours of operation. While counsellors meet with people on their own, or sometimes in pairs, they typically consult with their team before, partway through, and following each session (Bhanot-Malhotra et al., 2010; Tam & Bloom, 2015). In learning about the walk-in counselling process, it was the consultation partway through sessions, often called the "intersession break" (Slive et al., 2008), that most captured my curiosity. Not only had I never heard of this occurring in counselling before, but I also found the idea of being able to confer with colleagues during a time-limited session reassuring. Sitting in with counselling teams allowed me to experience firsthand the role that intersession breaks play in walk-in counselling and to hear from counsellors how useful breaks are in supporting their work.

Although the literature on walk-in counselling identifies intersession breaks as an integral part of the process and describes the clinical use of breaks (e.g. Harper-Jaques et al., 2008; Hoyt et al., 2018; Slive & Bobele, 2014), I was unable to locate empirical research on the topic. Based on what I had heard from counsellors, my experience witnessing walk-in counselling teams, and

my difficulty locating empirical literature on the topic, I decided to focus my thesis research on intersession breaks in walk-in counselling. In particular, I wanted to explore how narrative therapy is used in intersession break consultations.

Narrative therapy (Freedman & Combs, 1996; White & Epston, 1990) is a postmodern therapeutic approach emphasized in contemporary walk-in counselling work (Campbell, 2012; Hoyt et al., 2018), including in the Ontarian context where my research took place (Bhanot-Malhotra et al., 2010; Young, 2018). From the perspective of narrative therapy, people make sense of their lives through stories: they link experiences across time so as to create a “coherent account of themselves and the world around them” (White & Epston, 1990, p. 10). The sociocultural contexts in which people exist privilege certain ways of making sense of experience over others so that not all stories are equally accessible (Freedman & Combs, 1996). Problems arise when the narratives through which people understand themselves and their world become “problem-saturated,” limiting, and dissatisfying (White & Epston, 1990). Counselling provides an opportunity to deconstruct problem-saturated stories and co-create ones that are richer, more nuanced, and that open up new possibilities in people’s lives (Freedman & Combs, 1996; White & Epston, 1990).

The purpose of my thesis research was to consider how counselling teams draw on narrative therapy during intersession break consultations in walk-in counselling clinics. Data collection occurred at two Ontarian walk-in counselling clinics and involved recording a total of six intersession break consultations, which were transcribed and analyzed using a discourse analysis methodology. The Methodology chapter will discuss “discourse” in more detail, but it can generally be understood as a set of related statements, ideas, beliefs, metaphors, images,

practices, and so on that “construct an object in a particular way” (Burr, 2003, p. 202). For my analysis, narrative therapy theory was conceptualized as a discourse composed of a worldview and practices that construct therapeutic processes in particular ways. The specific question guiding my research was: *How do counselling teams draw from narrative therapy discourse in constructing their conversational practices during intersession breaks in walk-in counselling?*

Avdi and Georgaca (2007) suggest that the “careful examination of therapists’ talk” (p. 167) present in discourse analytic studies has a great deal of clinical utility. The results of this study may be useful to counsellors working in walk-in counselling as well as for agencies offering SST involving intersession breaks. For counsellors interested in postmodern therapeutic approaches, the research offers a detailed account of how narrative therapy is being applied in situ within a particular context. By opening counsellors’ practices up to examination and critique, the study also encourages critical reflection, which helps counsellors “make deliberate choices informed by judgment [and] to stay truer to an ethic of care” (Paré, 2013, p. 276). Finally, people accessing walk-in counselling clinics who are curious about intersession break processes may be interested in the research.

The intention of this introductory chapter was to provide an overview of key concepts, introduce the study’s purpose and research question, and suggest possible contributions to the field of counselling while also situating my interest in the topic. Chapter 2 will review relevant literature; Chapter 3 will describe my interpretive framework; Chapter 4 will detail the study’s methodology; Chapter 5 will present the results of the study; and Chapter 6 will provide a discussion of the results and offer concluding remarks.

## **Chapter 2: Literature Review**

This chapter will delve into the clinical and empirical literature relevant to the central topics of this research: walk-in counselling, narrative therapy, and intersession break consultations.

### **Walk-In Counselling**

The Walk-in Counseling Center in Minneapolis, which opened in 1969, is often cited as the first walk-in counselling clinic in North America (Slive & Bobele, 2012), with Calgary's Eastside Family Centre being the first Canadian agency to offer such a service beginning in 1990 (Slive et al., 1995). The stated goal of these clinics, both of which continue to operate today, is to provide accessible, affordable, and quality therapy in the communities they serve (Miller & Slive, 2004; Schoener, 2011). As mental health agencies navigate increasing demands with limited resources and contend with lengthy waitlists, a growing number have implemented walk-in counselling clinics to ensure timely support is available for people (Reid & Brown, 2008; Tam & Bloom, 2015). Currently, there are approximately 80 walk-in counselling clinics in Ontario alone (Young & Jebreen, 2019). In addition to Canada and the United States, walk-in counselling clinics are operating in Australia, England, Ireland, Mexico, Jamaica, Israel, Zimbabwe, China, and elsewhere (Miller, 2014; Platt & Mondellini, 2014; Slive & Bobele, 2011).

As mentioned in the introduction, walk-in counselling is a type of single-session therapy (SST), which can be understood as a service delivery model that seeks to be as helpful as possible within the context of a single therapeutic encounter (Gee et al., 2015; Miller, 2008). SST is closely associated with the brief therapy movement, which refers to a psychotherapeutic tradition emerging in the second half of the twentieth century that seeks “a paradigm shift from

traditional psychotherapy's claim to knowledge, therapist expertise, and interventive practices to a solution orientation that is ... dedicat[ed] to client knowledge, client expertise, client competence, and client agency" (Thomas & Nelson, 2007, p. 22).

SST is not considered an abridged version of long-term therapy (Duval et al., 2012), but rather an approach that adopts "certain assumptions and views [that] create the likelihood of briefer courses of therapy" (O'Hanlon, 1990, p. 83). These assumptions, while articulated in varying ways depending on the work, emphasize collaboration, empowerment of those seeking services, pragmatism, and the inevitability of change (Budman & Gurman, 1983; Duval et al., 2012; Thomas & Nelson, 2007). Brief therapeutic assumptions are evident in Hoyt and Talmon's (2014) guidelines for practicing SST, which include: "expect change"; "view each encounter as a whole, complete in itself"; "develop an alliance by co-creating, with the client, obtainable treatment goals"; and "emphasize abilities and strengths rather than pathology" (p. 4).

Agencies offering SST typically adopt an "open-door" policy: people are welcome to return for SST should they so desire, albeit with the understanding that each visit will be treated as a discrete therapeutic encounter and will likely take place with a different counsellor (Campbell, 1999; Stalker et al., 2012; Tam & Bloom, 2015). SST, therefore, gets its name not from an expectation that people will have only one session, but from approaching each session as a "whole therapy" that has the potential to be helpful to people in meaningful ways (Harper-Jaques & Foucault, 2014; Young & Rycroft, 2012). Reflecting on 25 years of practicing SST, Talmon (2012) states, "I have never tried to convince clients that all they need is one session. ... I see each session as complete in itself. This approach enables me to allow room for the full

potential of that session, and to allow the client and the outcome to dictate what may come next” (p. 13).

### ***Process***

Although there is some variation between clinics, walk-in counselling typically follows a similar sequence, which is described throughout the literature (e.g. Bhanot-Malhotra et al., 2010; Slive et al., 2008; Young et al., 2008). Upon entering the clinic, people are greeted by reception and asked to complete intake forms including a questionnaire related to their presenting concern(s), coping strategies, and session goals. A person’s file is then given to the walk-in counselling team, which is made up of a varying number of mental health practitioners and may include social workers, professional counsellors, psychologists, and student interns (Bhanot-Malhotra et al., 2010; Miller, 2008). For the sake of simplicity, I will refer to these practitioners as counsellors<sup>2</sup>.

When the team receives a person’s file, they decide which counsellor will meet with the person and engage in a brief pre-session discussion to prepare the assigned counsellor. The person and their assigned counsellor then meet for the first portion of their session. Partway through, the counsellor leaves to engage in an intersession break consultation with the counselling team, which lasts approximately 15 minutes but could be shorter or longer depending on the counsellor’s needs and the busyness of the clinic (Bhanot-Malhotra et al., 2010). As intersession breaks are central to this research, they will be discussed in detail later in the literature review. Informed by what was generated during the break, the assigned counsellor

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<sup>2</sup> The term “therapist” is used by many of the sources I will be drawing from; for my purposes, I consider the terms “counsellor” and “therapist” interchangeable. Ditto for “counselling” and “therapy”.

returns to conclude their session. After which, they may engage in a short post-session debrief with the counselling team. In some clinics, counsellors complete a “Summary Report” that provides a summarized account of what occurred in the session, a copy of which is given to the person to take with them (Young et al., 2008).

The duration of walk-in sessions differs between clinics with some offering 50-minute sessions (Slive et al., 2008) and others 90-minute sessions (Young et al., 2008), including the intersession break. However, sessions seek to be responsive to the people’s needs and, especially in cases of high distress or immediate crisis, these session lengths need not be strictly adhered to (Slive & Bobele, 2014). People are typically asked to complete a questionnaire evaluating the services they received and indicating whether the session adequately met their needs (Bhanot-Malhotra et al., 2010; Slive et al., 2008).

### ***Therapeutic Approaches***

While a variety of therapeutic approaches and practices are used in walk-in counselling, reflecting the pragmatism of SST, collaborative approaches that foreground a person’s agenda and orient to strengths and possibilities are highlighted as particularly well suited to this context (Harper-Jaques & Foucault, 2014; Slive & Bobele, 2012; Young et al., 2008). Narrative therapy, solution-focused therapy, and cognitive behavioural therapy are the therapeutic approaches most frequently referenced in the literature on walk-in counselling clinics (Bhanot-Malhotra et al., 2010; Campbell, 2012; Harper-Jaques & Foucault, 2014; Hoyt et al., 2018; Stalker et al., 2012; Young et al., 2008).

### ***Research on Walk-In Counselling***

The empirical literature on walk-in counselling has been expanding in recent years, with the majority of studies being conducted in Canada (Tam & Bloom, 2015). My review of this literature will be organized into findings on satisfaction with services and clinical outcomes.

**Satisfaction With Services.** Miller (2008) reports that of 403 people who completed a post-session satisfaction questionnaire, 82% indicated that they were either “satisfied” or “very satisfied” with their walk-in session at the Eastside Family Centre in Calgary. 16% of people reported being “neutral,” 2% selected “dissatisfied”, and no one reported being “very dissatisfied.” When asked to comment on the strengths of the service, 25% identified the immediate accessibility of the clinic as one of its greatest strengths. Other responses included “having someone who will listen” and discussing therapist attributes such as a caring attitude. In terms of recommended changes, 50 (12%) people offered suggestions, which included offering ongoing counselling with the same therapist and increasing the length of sessions.

Harper-Jaques and Foucault (2014) assessed satisfaction with services at the South Calgary Centre Mental Health Walk-In directly post-session and one month later. 93% of people reported general satisfaction with the service directly following their session, with an average score of 18/20 on access and office procedures, 23.4/25 on manner and skill of the counsellor, and 29.6/35 on perceived outcome. There were no significant differences between these figures and those reported when researchers followed up with people one month following their session. Additionally, 44% of people reported that one session had been sufficient in addressing their concerns.

One important limitation that must be taken into account when considering the findings of Miller (2008) and Harper-Jaques and Foucault (2014) is response rate and potential for participation bias. Only 23% of people asked to participate in Miller (2008) completed a questionnaire and 32% of those invited to participate in Harper-Jaques and Foucault (2014) completed the study. Miller also discusses the possibility that people may downplay negative feedback in satisfaction studies for fear it could impact future services from a caregiver. While clearly communicating confidentiality procedures and reassuring people that their responses will have no impact on the services they receive could lessen the possibility of this occurring, neither study is explicit in addressing this concern.

Stalker et al. (2016) conducted a mixed-methods study comparing walk-in counselling and traditional counselling involving a waitlist within the Ontario context. In the qualitative phase, phone interviews were conducted with 48 people who had accessed services and analyzed thematically; findings were reported in detail in Cait et al. (2017). The authors suggest that qualitative data enable a more nuanced understanding of quantitative findings and state that “participant histories and experiences provide explanations for why and how clients consider a service delivery model useful” (Cait et al., 2017, p. 626). Cait et al. identify three interconnected themes that impacted a person’s experience with walk-in and traditional counselling: accessibility, meaning of service, and readiness for service.

The importance of accessibility for one person who had visited the walk-in is evident in her assertion that “if I couldn’t have gotten in when I needed help I would have been overwhelmed and probably been at the point of self-harm” (Cait et al., 2017, p. 619). A person

who waited 12 weeks for traditional counselling describes how she got through this period and expresses concern for those without similar supports:

It was frustrating and it was uh, quite a long wait period for sure ... I guess the way I got through was that I knew before I called that there was going to be a wait period. I didn't know that the first time I went into it. I guess I had to mentally prepare ahead of time to just try to tough it out until I could get in there. And if I was maybe an individual that didn't have an amazing family and group of friends to support me then it could have been a much harder struggle and I think other people might – could get into a dangerous position in their lives, very vulnerable without support for that amount of time. (Cait et al., 2017, p. 620)

The authors highlight the importance of people being able to access services when they are motivated to do so. One participant stated, “it was nice when you have these things on your mind you kind of want to get it off right away ... so it was nice to have somebody there that day” (Cait et al., 2017, p. 619). A person seeking services for her daughter who was placed on the traditional counselling waitlist described how by the time an appointment was available, her daughter was no longer willing to attend: “she was in the mindset to go [when she made the call] and probably if we had been able to get an appointment that week, yes it probably would have made a difference because she was going to go” (Cait et al., 2017, p. 626).

In Cait et al. (2017), some people reported finding the walk-in model appealing precisely because of its single session structure. This included a woman who had felt stigmatized by her engagement with the mental health system throughout her life and another woman who found it difficult to leave the house, both of whom did not want ongoing counselling. Others reported

being disappointed with their walk-in session and wanting something more, as one person put it, “I just came out from there not being clear of what I needed to do after because um, my understanding was that the walk-in clinic wouldn’t see you on an ongoing basis” (Cait et al., 2017, p. 621). A person receiving traditional counselling described how important it was that she have access to a familiar counsellor in an ongoing way:

I think that’s part of the reason my anxiety was relieved was that I knew that I was going to speak with her. I knew I was going to be very comfortable with her. I knew we could probably carry on from where we left off in a way ... I just have had a fantastic rapport with her. (Cait et al., 2017, pp. 623-624)

Cait et al. (2017) reflect on the “multidimensional and complex story” presented by participant experiences and conclude that “health care systems and mental health agencies need to provide access to both types of counselling in a timely way” (p. 628).

**Clinical Outcomes.** Studies on walk-in counselling have used a variety of measures to assess clinical outcomes. Harper-Jaques and Foucault (2014) employed a Distress Thermometer, Snyder State Hope Scale, and Problem Evaluation Summary, which were administered to participants pre-session, post-session, and one month following their session. The authors report a significant decrease in distress between pre-session and post-session and again between post-session and one month follow-up, with a large effect size in the former and a small effect size in the latter. The Snyder State Hope Scale measures hope on two subscales: pathways (ideas and solutions) and agency (knowing how to implement pathways). Results indicate a significant increase in both subscales over time, with moderate to large effect sizes. Participants also reported significantly lower problem severity and significantly higher coping on the Problem

Evaluation Summary one month following their session, with large effect sizes in both cases. Finally, a hierarchical multiple-regression analysis was conducted to determine which variables best predicted a decrease in problem severity at the one-month follow up. They found these variables to be pathways (ideas and solutions) at post-session and both distress and coping at one month follow up, which together explained 55% of variance in problem severity. The authors conclude, “if clients are able to obtain new perspectives and solutions for their presenting problem in the session, they are likely to experience greater coping, further decrease their distress level, and report a decrease in problem severity 1-month post-intervention” (Harper-Jaques & Foucault, 2014, p. 45).

The investigation by Harper-Jaques and Foucault (2014) is limited by the potential for participation bias, which was discussed in the previous section, as well as by its lack of comparison group. Furthermore, while the authors present a strong argument for the reliability and validity of the Snyder State Hope Scale and Problem Evaluation Summary, they make no such case for the Distress Thermometer, which was developed for use with oncology patients and has not, to their knowledge, been evaluated within the mental health context.

Barwick et al. (2013) examined the psychosocial adjustment of children and youth using a standardized measure called the Brief Child and Family Phone Interview (BCFPI). It includes the following subscales: Internalizing Behaviour, Externalizing Behaviour, Impact on Child Functioning, Impact on Family Functioning, and Total Mental Health Problems. Prior to their session or intake appointment, people who accessed walk-in counselling scored higher (i.e. more severe) than people who engaged in traditional counselling on all subscales; however, these differences were not statistically significant. Two weeks following their session/intake

appointment, those who had accessed a walk-in counselling clinic scored significantly lower on Internalizing Behaviours and Total Mental Health Problems. At the three-month follow-up, these participants scored significantly lower than the comparison group on all subscales. Furthermore, while the scores of people who had visited a walk-in counselling clinic decreased on all subscales from the two-week interview to the three-month interview, people in the traditional counselling group saw an increase in terms of Internalizing Behaviours, Impact on Child Functioning, and Impact on Family Functioning, which the authors refer to as “slippage”.

Stalker et al. (2016) assessed psychological distress using the General Health Questionnaire-12 (GHQ-12), a standardized measure with demonstrated reliability and validity within mental health settings. A score of 0 to 13 on the GHQ-12 is considered within the “normal range” of distress while those from 14 to 36 indicate “clinical severity.” Baseline data collection occurred for people accessing walk-in counselling prior to their session and for the comparison group, who were recruited from an agency offering traditional counselling involving a waitlist, at the time they contacted the agency for services. The GHQ-12 was administered by researchers over the phone four and ten weeks following baseline. Similar to Barwick et al. (2013), people who visited the walk-in clinic demonstrated higher baseline levels of distress than the comparison group, although both groups fell within the range of clinical severity. Using hierarchical linear modelling, the authors infer that participants in the walk-in counselling group moved from clinical to non-clinical range on average five weeks following their walk-in session while those in the comparison group would not make this transition until ten weeks following baseline, at which point both groups had similar scores. In other words, the rates of improvement

for participants who accessed walk-in counselling were significantly greater than the comparison group in the first few weeks following their session.

Barwick et al. (2013) and Stalker et al. (2016) avoid some of the methodological issues present in Harper-Jaques and Foucault (2014) by employing standardized measures and comparison groups. However, both discuss challenges in recruiting participants for their comparison groups and identify differential participation rates between groups as a limitation. In Barwick et al., 74% (n = 112) of participants who accessed walk-in counselling and were invited to participate in the study agreed to, while 38% (n = 60) of those invited to be part of the comparison group agreed to participate. These figures are 42% (n = 307) and 28% (n = 151), respectively, in Stalker et al. Other limitations include attrition and potential for participation bias, which have been previously discussed.

Furthermore, neither Barwick et al. (2013) nor Stalker et al. (2016) include details on the services received by the comparison group, such as how many people were still waiting for an initial session at the various points of data collection or, for those that had begun therapy, how long they had waited and how many sessions they had received. This information would be useful when interpreting the differences in clinical outcomes between participants who accessed walk-in counselling and those in the comparison group as well as being useful when comparing different studies. For example, Barwick et al. reported worsening scores on a number of BCFPI subscales between the two-week and three-month interview for people in the comparison group while Stalker et al. found that by ten weeks post-baseline, both groups demonstrated equivalent improvement on the GHQ-12. Stalker et al. mention that the agency from which they drew their comparison group has a significantly lower wait time, 4-8 weeks on average, than other agencies

of its kind because it limits the number of intake appointments offered. Assuming that participants in the comparison group in Barwick et al. would wait longer than 4-8 weeks to begin therapy, this could help explain why they experienced “slippage” while those in Stalker et al. did not; however, the data needed to support this interpretation are not available.

Keeping in mind their limitations, Barwick et al. (2013) and Stalker et al. (2016) provide evidence for the effectiveness of walk-in counselling. Their findings are consistent with those reported in studies such as Harper-Jaques and Foucault (2014) and in reviews such as Tam and Bloom (2015) and Hymmen et al. (2013). Considered alongside findings on service satisfaction, it appears that there is empirical support for including walk-in counselling within a continuum of mental health services. Such an inclusion gives people more agency in terms of how and when they access services while reducing waiting times for those who prefer ongoing therapy (Cait et al., 2017).

In addition to the empirical findings discussed in this section, Campbell (2012) makes an important point related to walk-in counselling services that have been operating for decades: “There is obviously considerable organisational and experiential evidence that these services work. The longevity and dynamic health of the services described speak for themselves and are very encouraging” (p. 23). This fits with Duval et al.’s (2012) suggestion that when considering the utility of a therapeutic modality, it is important to put “an equal weighting on evidence from rigorous research, therapist expertise, and client and family perspective” (p. 13).

### **Narrative Therapy**

Narrative therapy originated in the collaboration between social workers Michael White and David Epston and their colleagues in the 1980s (Chamberlain, 2012; Tarragona, 2008). As

narrative therapy theory is central to my interpretive framework, relevant theoretical literature will be examined in the subsequent chapter. While its roots are in the field of family therapy, narrative therapy has become a widely adopted approach in a variety of contexts; Chang and Nylund (2013) remark that “in the last two decades, applications of narrative therapy to specific problems, populations, and modalities have proliferated” (p. 75).

Some specific concerns<sup>3</sup> being addressed by narrative therapy identified in the literature include anxiety, depression, anorexia/bulimia, psychosis, violence, substance use, trauma, relationship challenges, grief, learning difficulties, and bedwetting (Chamberlain, 2012; Chang & Nylund, 2013; Tarragona, 2008; Vromans & Schweitzer, 2011). Narrative therapy is being used in work with individuals, couples, families, and groups (Chamberlain, 2012; Chang & Nylund, 2013) and is recognized as well-suited to brief therapeutic contexts, including SST (Cooper, 2013; Young, 2018). Chamberlain highlights narrative therapy’s relevance to social justice and activism, stating that “within the literature of the field, and in the practices of narrative therapists, a wide range of social and political issues are being examined” (p. 119). These issues include racism, sexism, heteronormativity, transphobia, ableism, and poverty (Chamberlain, 2012; Nylund & Temple, 2018).

### ***Research on Narrative Therapy***

As will be detailed in the Interpretive Framework chapter, the philosophical assumptions of narrative therapy are at odds with research paradigms that understand knowledge as the

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<sup>3</sup> It is important to acknowledge that what follows are clinical categorizations that may not align with the way a person themselves would characterize their concern. As will be addressed in the Narrative Therapy Theory section in the next chapter, a key element of the approach involves therapists privileging a person’s understandings rather than reinforcing what is known as “expert knowledge” (White & Epston, 1990).

uncovering of objective reality through adherence to rigorous scientific methods, an epistemological position known as “positivism” (Tarragona, 2008). White and Epston (1990) state:

We become wary of situating our practices in those “truth” discourses of the professional disciplines, those discourses that propose and assert objective reality accounts of the human condition. ... It is the isolation of these knowledges from knowledges at large, as well as their establishment in the hierarchy of scientificity, that endows them with their power. ... We challenge the scientism of the human sciences. (pp. 28-29)

As such, research on narrative therapy tends to favour qualitative methodologies that view knowledge creation as an interpretive process, that attend to sociocultural context, and that yield “thick description” of phenomena (Busch et al., 2011; Gardner & Poole, 2009; Strong & Gale, 2013). Ethnographic studies, case studies, discourse analysis, and conversational analysis are common approaches for investigating narrative therapy (Gardner & Poole, 2009).

O’Connor et al. (1997) adopted an ethnographic approach to explore the experiences of eight families participating in narrative therapy in a university hospital outpatient clinic. The authors discuss families’ experiences around six themes, including aspects of therapy that people found helpful and unhelpful. In terms of helpful aspects, people reported feeling “listened to, acknowledged, and not blamed, and [that they] were respected by the therapist and team” (O’Connor et al., 1997, p. 489). Reflections related to unhelpful aspects of therapy included “slow process” and “some of the feedback was not helpful” (O’Connor et al., 1997, p. 490). O’Connor et al. (1997) suggest that their findings “support the view that narrative therapy provides an excellent context for the ideas and practices that empower personal agency in family

members” (p. 490). The following is an example of a participant reflection related to personal agency:

No one on the team is giving the answers to my problems. I am answering my own questions and the therapist is helping me to do that. I am basically doing my own work and figuring out things for myself through talking to my therapist. (O’Connor et al., 1997 p. 487)

Kogan and Gale (1997) and Muntigl (2004) adopted variations of discourse analysis to examine talk during therapy sessions. Kogan and Gale considered how an established narrative therapist enacted a “decentering agenda” through a variety of conversational practices, including “matching/self-disclosure” and “expansion questions”, within a couples therapy session. Muntigl (2004) examined six therapy sessions involving the same narrative therapist and couple, concluding that by the final session, the couple was “able to deploy meanings that [had] been generated throughout therapy, in order to produce narratives of self agency” (p. 109). Busch (2007) considered “the changes in clients’ discourses and positionings” (p. 9) by analyzing six narrative therapy case studies, finding that in all but one of the studies, “transformations of discourse and subject positions were evident ... indicating a change in the clients’ meaning of their personhood from pathology to growth, from subordination to health expert, to autonomous person” (p. 19).

There have also been efforts to establish the effectiveness of narrative therapy within the positivist paradigm. This is motivated in part by the empirically-supported treatment (EST) and evidence-based practice in psychology (EBPP) movements, which legitimize therapeutic approaches according to the status of their empirical evidence (Busch et al., 2011).

Some researchers (e.g. Epston et al., 2012; Vromans & Schweitzer, 2011) suggest that it is possible to adapt positivistic research designs to study narrative therapy in ways that do not undermine the approach and assert that this type of research is necessary for narrative therapy to “have a voice at the table” (Epston et al., 2012, p. 77). In their review of the empirical literature on narrative therapy, Chenail et al. (2012) assert that while they found no randomized controlled trials, the outcome studies examined (e.g. Mehl-Madrona, 2007; Vromans & Schweitzer, 2011) “support the effectiveness of narrative therapy to treat a variety of presenting problems and disorders across different populations and contexts” (p. 233). Addressing the limited experimental support for narrative therapy, Vromans and Schweitzer (2011) offer the following: “Characterized by a movement away from universal laws and the absolute and toward multiplicity and relativism, narrative approaches are less easily operationalized and, therefore, less easily subjected to empirical evaluation” (p. 4).

### ***Narrative Therapy and Walk-In Counselling***

As previously discussed, narrative therapy is a commonly used therapeutic approach within walk-in counselling sessions (Bhanot-Malhotra et al., 2010; Campbell, 2012; Hoyt et al., 2018; Young, 2018). Social worker Karen Young, who operates an Ontario-based training centre for the implementation of narrative therapy within brief therapeutic settings, refers throughout her writing to the “fit” between narrative therapy and walk-in counselling (Young, 2011, 2018). She offers the following elaboration:

Narrative therapy offers a clear philosophy and practice for creating an impactful, novel, and useful conversation in every session. Brief therapeutic encounters shaped by narrative therapy can shift how people view problems and themselves, expanding and

changing stories, making it possible for people to see ways forward in their lives. People are invited to see themselves as knowledgeable about their own lives, and as having many skills, abilities, beliefs, values, and commitments that will assist them to reduce the influence of problems in their lives. People consistently report experiencing brief narrative practices as meaningful and useful, and often report that “aha” moments in brief narrative sessions ripple forward in their lives, creating lasting change. (Young, 2018, p. 62)

Narrative therapy philosophy and practices will be detailed in the Interpretive Framework section; here, I will focus on empirical literature.

### ***Research on Narrative Therapy and Walk-In Counselling***

In the Research on Walk-In Counselling section, I examined findings related to satisfaction with and clinical outcomes of walk-in counselling services and concluded that current empirical literature supports the usefulness and effectiveness of walk-in counselling (i.e. Barwick et al., 2013; Cait et al., 2017; Harper-Jacques & Foucault, 2014; Miller, 2008; Stalker et al., 2016). The majority of these studies explicitly identify narrative therapy as one of the theoretical approaches used by counsellors, however they also emphasize the theoretical eclecticism of walk-in counselling work. As Cait et al. (2017) state, counsellors “tend to utilize approaches based on postmodern, constructionist, narrative and systemic theories; however, no one approach is seen as superior to another. ... [and] a pragmatic perspective is most important” (p. 614). The findings discussed in the Research on Walk-In Counselling section are, therefore, relevant but not specific to the use of narrative therapy within walk-in counselling.

Young (2018) describes an evaluation project funded by the Ontario Centre of Excellence for Child and Youth Mental Health that examined single-session and walk-in counselling services offered by multiple organizations across Ontario. While a variety of therapeutic approaches were utilized by counsellors, Young (2018) identifies “an over-arching influence from brief narrative practices” (p. 67). 352 people completed surveys directly pre- and post-session with 70 people also completing three-month post-session surveys; participation bias and participant attrition are potential confounding variables. Findings highlighted by Young include (a) approximately 80% of people reported having “aha moments” in session, (b) 86% of people reported using ideas/strategies from the session, and (c) average three-month post-session scores were improved for every outcome measured, including that people perceived problem severity to have decreased and their coping to have increased. Furthermore, the average score on the Sessions Rating Scale, a standardized measure of therapeutic alliance, was 35.16 out of a possible score of 40. Young (2018) states that these results “suggest that a strong therapeutic alliance is possible during brief services” (p. 68) and expresses interest in future research that would explore the connection between therapeutic alliance and clinical outcomes in SST.

Young and Cooper (2008) conducted research they refer to as “The Narrative Therapy Re-Visiting Project”. People who had participated in SST, either through a walk-in clinic or by appointment, with a counsellor adopting a narrative approach returned for a follow-up meeting in which they viewed a video recording of their session. Participants were asked to pause the tape and discuss any moment that stood out to them as significant or meaningful. The process was facilitated by a research assistant and at no time was the original counsellor present. Participants’

reflections were analyzed thematically and grouped into categories including “effects of the posture”, “giving people back their words”, and “externalizing conversations”.

Considering the effects of a counsellor’s posture, Young and Cooper (2008) include the following reflection from a participant elaborating on how he knew that the counsellor was “actually listening”:

Sometimes I think counsellors or psychiatrists are pigeonholed by their own knowledge. So their mind is just not open anymore, it’s like, “Oh yes, I’ve been taught that, I’ve been taught this, and this is the way this goes and that is the way that goes,” and it’s like they forget about everything else. She wasn’t doing that, and I think that was really important. (pp. 74-75)

The category “giving people back their words” explored participants’ experiences of counsellors’ offering summaries of session content that included participants’ language. An 11-year old who had engaged in a walk-in session with her mother remarked that “some of the stuff that everybody said at the very beginning I didn’t quite remember. Then with her reviewing the stuff I said, it just really helped me ‘cause it was in my brain more” (Young & Cooper, 2008, p. 75).

Finally, participants’ reflections related to externalizing<sup>4</sup> conversations included the following:

That was a brilliant request, just brilliant, asking her [participant’s daughter] to put a face on ADHD. ADHD all of a sudden had a face in my mind, and it didn’t look as bad as it had felt to me before. I stopped seeing ADHD as some disease or some obscure hurdle

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<sup>4</sup> The practice of externalizing will be discussed in detail in the Interpretive Framework chapter. It involves speaking about concerns in ways that separate the concern from the identity of the person (White & Epston, 1990).

that had to be jumped . . . now all of a sudden it was helped brought down to size . . . and I have felt differently about the ADHD since. (Young & Cooper, 2008, pp. 76-77).

Young and Cooper describe The Narrative Therapy Re-Visiting Project as “qualitative coresearch” that emphasizes the knowledge of participants.

Utilizing the same recordings of SST as Young and Cooper (2008) – eight single sessions of individual or family counselling by walk-in or appointment – Ramey et al. (2010) engaged in research on therapeutic process. They considered the degree to which sessions demonstrated elements of White’s (2007) “scaffolding conversations map”. The scaffolding conversations map, which draws on the work of developmental psychologist Leo Vygotsky, is a framework for mapping narrative therapy practices in which “the therapist provides scaffolding by asking incremental questions that support movement from the known and familiar to what is possible to know and do” (Ramey et al., 2010, p. 78). The map moves from what are considered “low-level distancing tasks”, in which a person names and characterizes a problem or unique outcome<sup>5</sup>, to “high-level distancing tasks” that involve planning actions aligned with newly developed narratives (Ramey et al., 2010). Ramey et al. found that approximately 87% of utterances corresponded to a level of the scaffolding conversations map, with nearly half of these being at the level of naming and characterizing a problem or unique outcome. They also found that conversations tended to proceed from lower- to higher-level distancing tasks over the course of sessions. Ramsey et al. (2010) conclude that their findings suggest “White’s model of therapy is observable and . . . change occurred at the level of language over the session” (p. 74).

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<sup>5</sup> Unique outcomes are events or experiences that do not fit with a dominant, problem-saturated story (Freedman & Combs, 1996; White, 2007); they will be discussed in the Interpretive Framework chapter.

## **Intersession Breaks**

As previously mentioned, intersession breaks are identified throughout the literature as an important part of walk-in counselling processes (Hoyt et al., 2018); discussing walk-in counselling at the Eastside Family Centre in Calgary, Stewart et al. (2018) refer to intersession breaks as “an essential part of the walk-in single-session approach” (p. 78). Harper-Jaques et al. (2008) state that “the consultation process supports the delivery of a quality service to the client, is a support for the therapist, and provides clients with more than one perspective on their issues” (p. 44). The focus and structure of intersession breaks vary depending on the clinic and counselling team. Breaks may involve reviewing peoples’ strengths and resources, developing interventions, and providing learning opportunities for counsellors in training (Slive & Bobele, 2014; Stewart et al., 2018). While brief descriptions of the purposes and processes of walk-in counselling intersession breaks were common in the literature, I was unable to locate empirical literature on the topic.

The use of reflecting teams (Andersen, 1987) is common in intersession break consultations (Hoyt et al., 2018). Reflecting team processes involve a team of counsellors who observe an unfolding therapy session and then converse with one another regarding what they have witnessed while the person observes. Associated with postmodern therapeutic traditions, the broad purpose of reflecting teams is the elicitation of multiple perspectives (Andersen, 1987; Freedman & Combs, 1996; Sparks et al., 2011). Reflecting team processes have also been adapted to supervisory and consultation contexts in which a counsellor shares an account of their work and team members reflect with one another based on this account (Paré, 2011, 2016). At the walk-in counselling clinics where I collected my data, counselling teams drew on this form of

reflecting team process: reflecting team members (RTMs) responded to the accounts provided by a sharing counsellor (SC). Greater theoretical detail on reflecting teams as well as their use in narrative therapy will be discussed in the Interpretive Framework chapter.

### ***Research on Reflecting Teams***

A number of authors have reviewed the empirical literature on reflecting teams (e.g. Brownlee et al., 2009; Chang, 2010; Kleist, 1999; Willott et al., 2012). Similar to research on narrative therapy, qualitative methodologies based in postmodern and social constructionist philosophies predominate (Willott et al., 2012). Highlighted throughout the literature are findings related to the usefulness of the multiple perspectives generated in reflecting teams, for both those attending therapy and for counsellors in their work (Brownlee et al., 2009; Chang, 2010; Kleist, 1999; Willott et al., 2012). Discussing her experience of the reflecting team in a family therapy session, one participant stated, “with the team we weren’t working with one person, we were getting a mixture of ideas, like those members of that team would look at it from different points of view, and those would be beneficial to us” (Mitchell et al., 2014, p. 247). Reichelt and Skjerve (2013) conducted research on reflecting teams used in group supervision. They found that the majority of supervisees and members of the reflecting team reported finding the approach useful, commenting in particular on “the abundance of ideas and on the freedom to choose ideas you can use, rather than striving for the ‘right’ solution” (Reichelt & Skjerve, 2013, p. 251).

Discussing what people find helpful and unhelpful during reflecting processes, Brownlee et al. (2009) emphasize the importance of keeping the person’s agenda at the fore, of using language that is easily understandable rather than professional terminology, and of orienting to people’s strengths. The authors suggest that reflecting teams are most useful when they offer “a

variety of comparisons, possibilities, and wondering rather than a certain direction or outcome” (Brownlee et al., 2009, p. 144). “Spatial separation” is also identified in the literature as a valuable element of reflecting processes (Chang, 2010; Willott et al., 2012). Spatial separation refers to the intentional differentiation of members of the reflecting team from the person and their counsellor. This separation may be created by the use of a one-way mirror or by the reflecting team sitting at a distance in the same room, but what is important is that the team’s reflections are shared in conversation with one another while the person and their counsellor adopt a listening position. Chang (2010) reports how “clients found spatial separation that prevented them from making an immediate verbal response to the team’s reflections allowed them to process the team’s reflections” (p. 37).

Some challenges people reported in engaging in reflecting team processes included becoming overwhelmed or disinterested when reflections were too numerous or not clearly connected to the therapy session (Brownlee et al., 2009; Chang, 2010; Willott et al., 2012). Sometimes the presence of the reflecting team elicited feelings of anxiety and discomfort (Brownlee et al., 2009), although providing people with detailed explanations of reflecting team processes and emphasizing that they are optional helped make people more comfortable (Chang, 2010). The potential to be overwhelmed within reflecting processes was also articulated by counsellors in ethnographic research conducted by O’Connor et al. (2004) on narrative-informed reflecting teams. The authors describe how “therapists experienced both the consulting/reflecting teams and the process of co-construction as rich and helpful as well as being challenging and overwhelming” (O’Connor et al., 2004, p. 35). Challenges expressed by supervisees in Reichelt and Skjerve’s (2013) study included when reflections were perceived as “too long, tedious, or

unstructured” (p. 251) or with “supervisors behaving as experts or being too dominant” (p. 251). Chang (2010) highlights the importance of theoretical clarity:

Effective use of RTs [reflecting teams] in counselor education and supervision requires that counselor educators and supervisors clarify their theoretical positions, communicate this clearly to trainees, and encourage trainees’ theoretical development. ... For example, given their theory of choice, what should trainees watch for from behind the mirror? For instance, is the goal to locate evidence of a new story and circulate it, as a narrative approach to RTs would suggest? (p. 39)

Based on their reviews of the literature, Brownlee et al. (2009), Chang (2010), Kleist (1999), and Willott et al. (2012) conclude that there is empirical support for the clinical utility of reflecting team processes while also identifying particular areas of challenge and calling for further research. Particular recommendations include more outcome-based investigations, explorations around particular application contexts, and prioritizing research that centres the experiences of people in therapy.

### Chapter 3: Interpretive Framework

An interpretive framework encompasses the philosophical assumptions and theoretical perspectives that inform the research process, a process that includes not only data collection and analysis but all aspects of the inquiry from selecting a topic and research question to writing up the final report (Creswell, 2013). Central to my interpretive framework are postmodernism, social constructionism, and narrative therapy theory, each of which will be explored in this chapter. Gale et al. (2004) emphasize the importance of “logical consistency within the research approach between the researcher(s)’ epistemology, theoretical perspective, methodology, methods, and reporting” (p. 126). The purpose of this chapter and the subsequent Methodology chapter is to detail my research approach as well demonstrate its “logical consistency”.

#### Postmodernism

In *The Postmodern Condition*, Lyotard (1984) describes postmodernism as “incredulity toward meta-narratives” (p. xxiv). Meta-narratives being theories or explanations that are considered “all-encompassing and universally valid” (Grenz as cited in Tarragona, 2008, p. 169), or as Anderson (2007) puts it, “Truths with a capital ‘T’” (p. 8). One way to understand postmodernism is as a critique of the modernist meta-narrative of “progress”, which claims that humanity is on a course of continuous advancement and improvement (Parry, 1993; Tarragona, 2008). Science and technology are central to this narrative: “systematic and objective knowledge. . . . should, it is reasoned, enable society to make increasingly accurate predictions about cause and effect relations, and thus, with appropriate technologies in place, to gain mastery over the future” (Gergen & Kaye, 1992, p. 168). Modernism rests on a positivist epistemology that asserts a knowable, objective reality which is uncovered through the scientific method (Tarragona,

2008). Knowledge is, therefore, considered a “mirror of reality” and language is used to communicate “a correct representation of the world” (Tarragona, 2008, p. 169). Postmodernism challenges these assumptions and represents a “shift from viewing knowledge and language as fixed, universal, and representing and referring to real things and the structures behind them, to viewing knowledge and language as negotiated, particular, and rhetorical-responsive” (Bidwell, 2007, p. 68).

### ***Postmodernism and Therapy***

Within the realm of mental health, postmodern thinking questions many of the foundational assumptions of traditional schools of psychotherapy, particularly the emphasis on “expert knowledge” (Tarragona, 2008). Gergen and Kaye (1992) suggest that within the modernist context, therapy ultimately involves the persons’s narrative being replaced by the counsellor’s meta-narrative: “the client’s account is transformed by the psychoanalyst into a tale of family romance, by the Rogerian into a struggle against conditional regard, and so on” (p. 169). While this new narrative may be helpful in supplanting a problematic storyline and offering a new vantage point, it offers “a relatively closed system of understanding” (Gergen & Kaye, 1992, p. 172) and, as such, is limiting of possibilities. Gergen and Kaye note the tendency for modernist meta-narratives to be pathology-oriented, hegemonic, decontextualized, and to position people as inferior to “all-knowing and wise” counsellors. According to Freedman and Combs (1996), modernism’s emphasis on “objectivity” renders people objects and “invit[es] them into a relationship in which they are passive, powerless recipients of our knowledge and expertise” (p. 21).

From a postmodern perspective, knowledge is socially constructed and the “truth-value” of any psychological theory or empirical finding cannot be ascertained (Hare-Mustin, 1994). This does not mean that “anything goes” (Freedman & Combs, 1996); rather, emphasis is placed on the practical and ethical implications of therapeutic discourse (Bidwell, 2007; Hare-Mustin, 1994). Counsellors are asked to “examine our constructions and stories – how they have come to be and what their effects are on ourselves and others” (Freedman & Combs, 1996, p. 35). While modernist therapy privileges professional knowledge and tends to encourage an “expert-to-object” mindset, therapy in the postmodern context is centred on the knowledge of the person seeking services and involves a “subject-to-subject” collaborative process (Parry, 1993).

The term “postmodern” has been used to describe a range of therapies emerging in the late twentieth century that turned attention to language, knowledge, and meaning construction (Anderson, 2016). These therapies have also been referred to as discursive, dialogical, conversational, social-constructionist, and poststructural, highlighting different aspects of the various approaches (Anderson, 2016; Tarragona, 2008). I have adopted the term “postmodern” in accordance with Tarragona’s (2008) suggestion that it “offers a broad philosophical umbrella that encompasses several different but connected schools of thought” (p. 167). Narrative therapy, solution-focused therapy, and collaborative therapy are three of the most well-known postmodern therapies (Anderson, 2016).

### **Social Constructionist Epistemology**

Postmodernism is associated with a social constructionist epistemology, which views knowledge as the product of human interactions within a specific historical and cultural context (Freedman & Combs, 1996; Burr, 2003). Social constructionism proposes that while the social

realities we inhabit and knowledge systems we rely on appear to us “natural and objective” (Tarragona, 2008, p. 169), they have actually arisen through “members of a culture... interact[ing] with one another from generation to generation and day to day” (Freedman & Combs, 1996, p. 16). Knowledge can be understood as the “edifying conversation of varied voices rather than an accurate representation of what is ‘out there’” (Hare-Mustin, 1994, p. 19).

From this perspective, language does not reflect reality but constitutes it (Tarragona, 2008). According to Gergen (1985), social constructionism involves questioning the claims of objectivity on which empirical classification rests, suggesting that concepts such as gender, emotion, and psychological disorder “acquire their meaning not from real-world referents but from their context of usage” (p. 267). He states that “in each case, the objective criteria for identifying such ‘behaviours,’ ‘events,’ or ‘entities’ are shown to be either highly circumscribed by culture, history, or social context or altogether nonexistent” (Gergen, 1985, p. 276). Employing language is thus a form of social action that constructs certain versions of reality while excluding others (Austin, 1975; Burr, 2003). Therefore, it is important to acknowledge the power relations involved in language use and knowledge construction. Certain societal, cultural, and institutional discourses maintain a privileged status in our social worlds and impact how people understand themselves and treat one another (Avdi & Georgaca, 2007; Burr, 2003).

Research from a social constructionist perspective involves the “production of knowledge that is always informed by theory, systems of method, and social context” (Kogan & Gale, 1997, p. 115). Researchers must acknowledge their “intrinsic involvement” in the process of research and knowledge production (Burr, 2003, p. 152), reflexively situating themselves by giving readers a sense of who they are and why they are interested in the project (Gale et al., 2004). As

Young and Cooper (2008) put it, “there is no possibility of a neutral standpoint from which to interpret” (p. 70).

### *Situating Myself as Researcher*

In the introductory chapter of this thesis, I provided an account of how I came to research the use of narrative therapy in walk-in counselling intersession break consultations. Grounded in the notion that interpretation is not a neutral activity, I would like to elaborate on my perspective and experiences related to the three central topics of this research: (a) narrative therapy, (b) walk-in counselling, and (c) intersession breaks.

My interest in narrative therapy emerged from my engagement with literature related to postmodern therapeutic approaches and the resonance I experienced with the underlying philosophy. This interest grew as I learned more about narrative therapy during my graduate coursework, applied this approach in my practicum placement, and engaged in this research project. I particularly appreciate narrative therapy’s emphasis on deconstructing narratives that are pathologizing/limiting and on centring the knowledge and experience of the person seeking services. My resonance with narrative therapy, and postmodern therapeutic approaches more generally, also comes from disempowerment that I have experienced and witnessed when interacting with mental health practitioners and institutions that I understand as manifesting a strong expert-oriented and pathology-focused stance.

With regards to my perspective on walk-in counselling, when I first encountered its existence, I was simultaneously excited and skeptical. Excited because timely, easily accessible therapy is something I have often wished was available for others and myself. Skepticism arose both because I questioned the utility of a single therapy session and because I wondered whether

the provision of such services was driven primarily by budgetary concerns. Through exploration of relevant literature and participation in parts of the walk-in counselling process, I have come to believe that this service can make a significant difference in the lives of many people and can play a vital role within a larger network of health services. However, I also feel that it will not be sufficient for everyone and that it should not be seen as a replacement for ongoing counselling or support services.

As stated in the Introduction, I was unfamiliar with the practice of intersession break consultations prior to exploring walk-in counselling as a possible research area. Viewing supervision and consultation as essential aspects of ethical counselling practice, the notion of working so closely with a team appealed to me. I wondered how the logistics of intersession breaks would be navigated in the dynamic walk-in counselling context and was particularly curious about the content of consultations. White (1995) discusses some concerns that arose for him when first encountering Andersen's (1987) reflecting team processes:

I was acutely aware of the fact that, in the culture of psychotherapy, most of the interactions between therapists and people who consult them are informed by the discourses of pathology. These discourses inform taken-for-granted ways of speaking about people's lives and relationship practices that have the effect of marginalising and objectifying people who seek help. What sort of requirements on reflecting team practices would be necessary to undermine this potential for marginalisation and objectification? (p. 178)

As a counsellor-in-training, I had experienced ways in which discourses of pathology showed up in consultation contexts and wondered how intersession breaks informed by narrative therapy might, as White says, “undermine this potential”.

### **Narrative Therapy Theory**

As the literature on narrative therapy is rich and abundant, my understanding of this approach has come from a variety of sources. However, the theoretical basis for this research is grounded primarily in three foundational works: White and Epston’s (1990) *Narrative Means to Therapeutic Ends*, Freedman and Combs’ (1996) *Narrative Therapy: The Social Construction of Preferred Realities*, and White’s (2007) *Maps of Narrative Practice*. These texts were identified as central to narrative therapy theory in consultation with my thesis supervisor, who has thirty years of experience engaging in and writing about narrative therapy. The role these texts played in my analysis process will be detailed in the subsequent Methodology chapter. In this section, I will draw on them as well as other literature to discuss narrative therapy theory in terms of its worldview and practices.

### ***Narrative Therapy Worldview***

Freedman and Combs (1996) emphasize the importance of worldview when practicing narrative therapy, explicitly connecting this worldview to postmodernism and social constructionism:

Adopting a postmodern, narrative, social constructionist worldview offers useful ideas about how power, knowledge, and “truth” are negotiated. ... It is more important to approach people and their problems with attitudes supported by these ideas than it is to use any particular “narrative technique.” (p. 22)

This worldview is evident in two key aspects of narrative therapy theory that will be explored in this section: (a) the narrative metaphor, and (b) a decentred and influential therapeutic posture.

**The Narrative Metaphor.** Central to narrative therapy is the notion that we make sense of our identities, our relationships, and our lives through a process of “storying” our experience (Freedman & Combs, 1996; White & Epston, 1990). This notion is not put forward as a truth claim, but rather as a metaphor that enables certain meaning making and ought to be evaluated according to its usefulness and effects. Since it is not possible to story all aspects of our lived experience, “the structuring of a narrative requires recourse to a selective process in which we prune, from our experience, those events that do not fit with the dominant evolving stories that we and others have about ourselves” (White & Epston, 1990, pp. 11-12). Our sociocultural context is highly relevant to this process as certain stories are privileged and more likely to dominate, for example those that construct race, gender, sexual orientation, class, ability, or age in particular ways (White & Morgan, 2006; Freedman & Combs, 1996).

From the perspective of the narrative metaphor, problems arise from the adoption and/or imposition of oppressive, limiting, and dissatisfying narratives and problems are addressed by “opening space for the authoring of alternative stories” (White & Epston, 1990, p. 6). Reflecting on their transition to working in ways informed by the narrative metaphor, Freedman and Combs state: “We discovered that, as people began to inhabit and live out these alternative stories, the results went beyond solving problems. Within the new stories, people could live out new self-images, new possibilities for relationship, and new futures” (p. 16). As White and Epston (1990) put it, the narrative metaphor proposes “that meaning is derived through the structuring of

experience into stories, and that the performance of these stories is constitutive of lives and relationships” (p. 12).

**Counsellor Posture: Decentred and Influential.** An important element of narrative therapy is adopting what Michael White refers to as a “decentred and influential posture” (Tarragona, 2008; White, 2005, 2007; White & Morgan, 2006). Engaging with those seeking services from a decentred posture involves “according priority to the personal stories and to the knowledges and skills of these people. ... [they] have a ‘primary authorship’ status” (White, 2005, p. 9). White and Morgan (2006) describe how “this orientation sees the person or family as the expert in their own lives, and places the knowledges, skills, preferences, and commitments of the [person or] family at the centre of the work” (p. 71). Counsellors are therefore “displaced from the center” (White, 2007, p. 82) when it comes to attributing meaning to the events and experiences of people’s lives. From the perspective of narrative therapy, the role of the counsellor is not to intervene or interpret, but to contribute to contexts in which people are able to thicken narratives that align with their values and open up new possibilities for their lives (White, 2007; White & Morgan, 2006).

Addressing the influential aspect of a decentred and influential posture, White (2005) offers the following:

The therapist is influential not in the sense of imposing an agenda or in the sense of delivering interventions, but in the sense of building a scaffold, through 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. (p. 9)

As counsellors, we are not and can not be neutral: every utterance impacts the conversational territory and unfolding narrative (White, 2000; White & Morgan, 2006). If a counsellor is operating from a centred and influential posture, which may manifest as “imposing an agenda” or “delivering interventions”, it is their knowledge and meaning making that takes precedence. However, when counsellors scaffold and structure therapeutic conversations “in ways that enable the skills and knowledges of [the person] to become more richly known” (White & Morgan, 2006, p. 71), as described in the quotation by White (2005), this is consistent with a decentred and influential posture. Freedman and Combs (1996) suggest that when considering whether a practice is in alignment with this posture, a useful question may be, “does it require the person to enter the therapist’s ‘expert’ knowledge or does it require the therapist to enter the ‘world’ of the client?” (p. 278).

### *Narrative Therapy Practices*

While emphasizing that narrative therapy practices cannot be separated from the worldview underlying the approach, White (1997) also states that narrative therapy is “constituted of a body of skills – there is a ‘know-how’ that can be clearly identified” (p. 218). Tarragona (2008) describes narrative therapy as having “a clear working style that includes different practices or kinds of conversations between clients and therapists” (p. 184). This section will focus on three practices that are particularly relevant to my analysis and results: (a) externalizing problems, (b) orienting to alternative narratives, and (c) reflecting teams.

**Externalizing Problems.** Externalizing involves relating to problems as separate from people (White & Epston, 1990); it is supported by the assumption that “*The person is not the problem. The problem is the problem*” (Combs & Freedman, 2012, p. 1039). This assumption counters internalized understandings of problems, which view the person themselves or aspects of their identity as pathological (Freedman & Combs, 1996; White, 2007). Tarragona (2008) offers the following illustration: “If we say that someone is depressive, it is a description of the person. If we say that a person is living with depression, or struggling with depression, the depression is not defining the person” (p. 184). Externalizing is a key practice within narrative therapy because “when people are not tied to restricting ‘truths’ about their identity and negative ‘certainties’ about their lives, new options for taking action to address the predicaments of their lives become available” (White, 2007, p. 25).

In *Maps of Narrative Practice*, White (2007) identifies various practices that can be used to externalize problems, including: (a) negotiating a particular, experience-near definition of the problem, (b) mapping the effects of the problem, and (c) evaluating the effects of the problem’s activities. A particular, experience-near definition is one that is based in the language and understandings of the person seeking services. White (2007) describes his work with a young boy in which “the ‘professional’ description of the problem as encopresis was displaced by one that was more local to Spencer’s life—Mr. Mischief” (p. 42). The effects of Mr. Mischief on various aspects of Spencer’s life could then be considered, for example how Mr. Mischief’s activities had been impacting Spencer’s relationships and school life. Evaluating the effects of the problem might include questions such as “Are these activities okay with you?” or “What is your position on what is unfolding here?” (White, 2007, p. 44). White (2007) describes how

externalizing practices are decentred because “the therapist is not the author of people’s positions on the problems and predicaments of their lives” (p. 39) and they are influential because “the therapist provides people with an opportunity to define their own position in relation to their problems and to give voice to what underpins that position” (p. 39).

**Orienting to Alternative Narratives.** From the perspective of narrative therapy, problems arise when the stories through which people are making sense of themselves and their lives are oppressive, limiting, and dissatisfying; such stories are sometimes referred to “problem-saturated” (Freedman & Combs, 1996; White & Epston, 1990). Narrative therapy involves the generation and strengthening of “alternative narratives”, a process referred to as “re-authoring”:

The therapist facilitates the development of these alternative storylines by introducing questions that encourage people to recruit their lived experience, to stretch their minds, to exercise their imagination, and to employ their meaning-making resources. People become curious about, and fascinated with, previously neglected aspects of their lives and relationships, and as [re-authoring] conversations proceed, these alternative storylines thicken, become more significantly rooted in history, and provide people with a foundation for new initiatives in addressing the problems, predicaments, and dilemmas of their lives. (White, 2007, pp. 60-61)

Events or experiences that do not fit with a dominant, problem-saturated story are considered “unique outcomes” or “preferred developments” and can provide an entryway to alternative narratives (Freedman & Combs, 1996; White, 2007). An event or experience is only a unique outcome/preferred development if the person sees it as such: “It is important that therapists check frequently to be sure that the direction or meaning of these experiences is preferred to that of

problematic stories ... [we] are not always right about what different people actually prefer” (Freedman & Combs, 1996, p. 119).

White (2007) emphasizes the usefulness of the concepts of “landscape of action” and “landscape of identity<sup>6</sup>” in the development of alternative narratives. It is within the landscape of action that the “plot” of an emerging alternative narrative is thickened by considering “who, what, when, where, and how” (Freedman & Combs, 1996, p. 97). Freedman and Combs (1996) offer examples of questions relevant to the landscape of action that might be posed once a unique outcome/preferred development has been identified, such as “What were the steps you took in doing this?” (p. 132) or “What particular things would I have noticed if I were there?” (p. 132). The landscape of identity contains the “meanings, desires, intentions, beliefs, commitments, motivations, values, and the like that relate to [a person’s] experience in the landscape of action” (Freedman & Combs, 1996, p. 98). White (2007) also includes within the landscape of identity people’s “realizations, learnings, [and] knowledge” (p. 84). Freedman and Combs (1996) identify a range of questions that could be used to explore the landscape of identity, including “What does this new perspective tell you about yourself” (p. 137) or “What did you know about your relationship then that somehow you have lost track of since?” (p. 139).

**Reflecting Teams.** The use of reflecting teams was developed in the field of family therapy and first described in Andersen’s (1987) article “The reflecting team: Dialogue and meta-dialogue in clinical work”. Traditionally, reflecting processes involve a team of counsellors observing an unfolding therapy session and, when called upon by the counsellor in session, the

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<sup>6</sup> The “landscape of identity” is also sometimes called the “landscape of consciousness” or the “landscape of meaning”.

team discusses their ideas about what they have witnessed while the person or family observes; after the teams' reflections are shared, the person or family comment on what they have heard. However, there are many variations on this structure that allow reflecting processes to be used in a range of contexts, including in counsellor supervision and consultation as well as when there is only a single reflecting member available (Andersen, 1995; Freedman & Combs, 1996; Paré, 2011, 2016). The role of reflecting teams in therapeutic work and the content of reflections depend on the particular context, however, the reflecting team approach can be understood as "loosely connected by a commitment to nonpathologizing responses, transparency, curiosity, and the introduction of multiple perspectives" (Sparks et al., 2011, p. 115). Freedman and Combs (1996) state that "in true postmodern fashion, different people and different teams have developed different ways of reflecting" (p. 172).

The use of reflecting teams within narrative therapy practice is described throughout the literature (Freedman & Combs, 1996; White, 1995, 2000, 2007; Zimmerman & Dickerson, 1996). Freedman and Combs (1996) suggest that counsellors on reflecting teams listen to the unfolding therapy session with three main intentions:

- 1) To develop understanding (so that they can join better with the family), 2) To notice differences and events that do not fit dominant narratives (so that they can support the development of new narratives), and 3) To notice beliefs, ideas, or contexts that support problem-saturated descriptions (so that they can invite the deconstruction of those descriptions). (p. 173)

White (1995) states that "those preferred developments that are generative of the curiosity of team members can be considered points of entry or gateways to the alternative stories of people's

lives” (p. 184). However, if an event or experience has not been explicitly identified by the person or family as a unique outcome/preferred development, then it is put forward tentatively with an acknowledgment that the person may or may not see it as such (Freedman & Combs, 1996; White, 1995).

As with the thickening of alternative narratives generally, White (1995) identifies the landscape of action and landscape of identity as useful concepts within reflecting team practices. An example of a reflection oriented to the landscape of action would be “I found that my attention was very much captured by the steps that Simon initiated here to challenge some of the old habits that have been quite dominant. Was this interesting to anyone else here?” (White, 1995, p. 184). In terms of the landscape of identity, a team member might wonder “What do you think these developments reflect about what Simon wants for his life?” (White, 1995, p. 185).

Inspired by the work of anthropologist Barbara Myerhoff, White (1995, 2000, 2007) applies Myerhoff’s concept of the “definitional ceremony” to reflecting team processes. Definitional ceremonies are occasions in which “people's identity claims [are] powerfully acknowledged by the responses of others” (White, 2000, p. 69). These others are considered “outsider witnesses”, since they act as witnesses to a person’s preferred narratives; in the context of reflecting team processes, team members act as outsider witnesses and their reflections are considered “retellings” of the person’s narrative. White (2000) describes how the retellings of outsider witnesses “routinely exceed the boundaries of the original telling in significant ways, in ways that contribute to the rich description of the personal and relational identities of the persons whose lives are at the centre of the ceremony” (p. 64).

White (2007) identifies a range of practices that may find their way into the reflections of reflecting team members, but which are incongruent with narrative therapy and the intentions of definitional ceremonies. These incongruent practices include “theorizing and hypothesizing about people’s lives and relationships, evaluating people’s expressions and reaching diagnoses according to the expert knowledges of the professional disciplines, [and] formulating interventions and treatments for the problems of people’s lives” (White, 2007, p. 215). Equally incongruent, but perhaps less obviously so, are “practices of applause” such as “pointing out positives, praising, [and] giving affirmations” (White, 2007, p. 72). Applause, while seemingly beneficent, reinforces the counsellor’s centrality in judging what is desirable. White (2000) emphasizes that “in contexts in which there are relatively fixed power relations – as in therapeutic contexts – the normalising judgement that is reproduced through the practices of applause is particularly hazardous” (p. 73). As such, he describes adopting an active role when facilitating reflecting team processes, which involves posing questions that centre the expressions and preferences of the people seeking counselling and that encourage team members to situate their reflections in their own experiences (White, 2007).

## Chapter 4: Methodology

The purpose of this study was to address the following question: *How do counselling teams draw from narrative therapy discourse in constructing their conversational practices during intersession breaks in walk-in counselling?* I adopted discourse analysis as my methodological approach, which is a qualitative methodology that has been identified as well-suited to examining various counselling processes (Avdi & Georgaca, 2007). Discourse analysis is congruent with social constructionism, the epistemological position of this research, in that it emphasizes the constitutive nature of language and the importance of context in meaning construction (Avdi & Georgaca, 2007; Philips & Hardy, 2002). This chapter will begin by discussing the methodology of discourse analysis before describing the methods employed in the study; it will conclude with considerations related to the trustworthiness of the research process and results.

### Discourse Analysis

Burr (2003) defines discourse analysis as “the analysis of a piece of text in order to reveal either the discourses operating within it or the linguistic and rhetorical devices that are used in its construction” (p. 202), wherein “text” refers to any piece of written or spoken language. Evident in this definition are two strands of discourse analysis, which can be said to focus on macro and micro concerns, respectively. Discourse analyses that highlight macro concerns conceptualize discourse as “a system of statements, practices, and institutional structures that share common values” (Hare-Mustin, 1994, p. 19). They may investigate the ways in which dominant discourses, such as those related to gender, race, disability, or mental health, constitute social reality and constrain people’s identities and interactions (Hare-Mustin, 1994; Phillips & Hardy,

2002). Foucauldian discourse analysis, which is based on the work of French philosopher Michel Foucault (e.g. Foucault, 1961, 1963), and critical discourse analysis (Fairclough, 2013) are approaches that employ a macro focus to critically examine dominant discourses and power relations (Phillips & Hardy, 2002).

Alternatively, a second strand of discourse analysis adopts a micro focus by examining discourse as “the actual spoken interchanges between people” (Burr, 2003, p. 202). This “non-critical” (Fairclough, 2013) approach to discourse analysis considers how individuals use language in their everyday lives to perform actions and construct certain accounts of the world (Potter, 2003). A micro approach to discourse analysis is evident in the field of discursive psychology (Edwards & Potter, 1992), which engages in detailed linguistic analyses of individuals’ interactions in a variety of naturalistic situations. Analyses might be conducted, for example, on couple’s arguments, family mealtimes, or therapy sessions (Burr, 2003; Potter, 2003).

Macro and micro approaches to discourse analysis are not, however, mutually exclusive (Burr, 2003). Rather, discourse analyses can be understood as existing on a continuum with many addressing both macro and micro concerns, to varying degrees (Phillips & Hardy, 2002). Speaking of discourse analyses within the field of psychotherapy specifically, Avdi and Georgaca (2007) state that “in addition to emphasis on the immediate interactional context ... most forms of discourse analysis also examine the role of socially available discourses in shaping the therapeutic encounter, linking, thus, the micro-processes of interaction with wider societal macro-processes” (p. 171). My analysis drew on a macro approach in conceptualizing narrative therapy as a discourse, composed of a worldview and practices articulated in relevant literature,

that was available to counselling teams; I engaged in micro analyses of how this discourse manifested in the interactions of counsellors during walk-in counselling intersession breaks. This process is described in detail in the Data Analysis section of this chapter.

## **Methods**

Following a brief overview of my research design, this section will delve into the specifics of recruitment, data collection, clinic and participant information, transcription, and data analysis.

Three walk-in counselling clinics were invited to take part in this research, two of which accepted (referred to as Clinic A and Clinic B to protect confidentiality). Clinics were selected based on a combination of purposeful and convenience sampling, which will be elaborated on in the Recruitment section. I arranged for one day of data collection at each clinic, during which I was present in the room where the counselling team met in order to audio and video record intersession breaks as well as take field notes related to clinic processes. Three intersession break consultations were recorded at each clinic, for a total of six recordings. The decision to examine six intersession breaks was made in discussion with my thesis supervisor as we considered how much discursive material would enable a meaningful analysis without becoming overwhelming for myself as the sole researcher. The intersession breaks recorded for the study ranged from 14 to 17 minutes and totalled 92 minutes; each recording was transcribed in its entirety and considered using a discourse analytic approach. Participants in this research were the counselling teams at Clinic A and Clinic B, ten counsellors in total, as well as the six people who consented to have the intersession break regarding their session included in the study.

## ***Recruitment***

Having received approval from the University of Ottawa's Research Ethics Board, I began recruitment by sending an email (Appendix A) to the directors/clinical supervisors of three walk-in counselling clinics. Sampling was purposeful in that I was seeking clinics whose walk-in counselling processes were informed by narrative therapy; counselling teams at the clinics contacted in recruitment received ongoing training in narrative therapy, including trainings by social worker Karen Young, whose work in brief narrative therapy was discussed in the Literature Review chapter. However, there are approximately 80 walk-in counselling clinics in Ontario and, as has been previously discussed, narrative therapy is one of the predominate therapeutic approaches drawn on in walk-in counselling work (Bhanot-Malhotra et al., 2010; Young & Jebreen, 2019). Therefore, convenience of location was also a factor in selecting clinics for recruitment.

Clinic A and Clinic B agreed to take part and distributed recruitment letters to the counsellors on their walk-in counselling teams (Appendix B), which instructed counsellors to contact myself or my thesis supervisor should they be interested in participating. Counsellors on the walk-in counselling teams at both clinics agreed to participate and I scheduled one day of data collection at each clinic. On the day of data collection, I met with counsellors half an hour before the clinic opened to discuss the study in person, answer questions, and address any concerns. Counsellors reviewed and signed a consent form at this time (Appendix C), of which they were given a copy.

Upon entering Clinic A or Clinic B, a person is greeted by the receptionist and given intake documents to complete. On the day of data collection at each clinic, included in these

documents was a written notice informing people of the research taking place and stating that they may be invited to participate by their counsellor (Appendix D). At the beginning of sessions, counsellors provided a description of the study to the person based on a script (Appendix E), which included the statement, “Please let me know if you have any questions and if I cannot answer them, I will inquire with the researcher, as she is onsite.” If a person was interested in participating, they reviewed and signed a consent form (Appendix F). They were given a copy of this consent form, which included the contact information of myself and my thesis supervisor should any questions arise after leaving the clinic. In order to allow a person to reconsider participating based on what had been shared in session, counsellors checked in directly before leaving for their intersession break, which was noted by checking a box at the bottom of the person’s consent form indicating that “Counsellor confirmed client’s consent before leaving to consult with the team”.

### ***Data Collection***

As previously stated, one day of data collection occurred at each Clinic A and Clinic B. Walk-in counselling teams operated out of an office, which I will refer to as the team meeting room, where they received people’s intake forms and engaged in pre-session discussions, intersession break consultations, and post-session debriefs. The question of whether or not to be present during data collection was a consideration in my research design, as it may have been possible to have counsellors tape intersession breaks without my being in the room. The decision to be present was made for the following reasons: (a) walk-in counselling work is typically busy and my being responsible for collecting recordings meant that this was not an additional task for counsellors to take on, (b) it allowed me to respond immediately to any questions or concerns

that arose, and (c) it enabled me to take field notes related to the team's processes and pre- and post-session discussions.

In addition to recordings of intersession breaks and field notes, two other forms of data were collected: (a) demographic questionnaires completed by counsellors during our half hour meeting before the clinic opened (Appendix G) and (b) questionnaires related to the specific intersession breaks recorded, which were completed by sharing counsellors (SCs) at their convenience and collected at the end of the day or emailed to me afterwards (Appendix H). Field notes and questionnaire responses, while not examined using discourse analysis, provided useful contextual information and contributed to various considerations within the Discussion chapter.

### ***Clinic and Participant Information***

Clinic A and Clinic B are two of several connected walk-in counselling clinics offered at community agencies throughout a particular region in Ontario, Canada. The clinics followed a similar operating procedure<sup>7</sup>:

1. A person enters the clinic and completes an intake form.
2. The counselling team receives the form and engages in a brief discussion to collaboratively decide which counsellor will meet with the person.
3. The assigned counsellor meets with the person.
4. Partway through the session, the assigned counsellor leaves their session and returns to the team meeting room to participate in an intersession break consultation with their colleagues.

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<sup>7</sup> Procedures included a variety of other processes and documentation; this list is a simplified summary of procedures relevant to my research purposes.

5. The assigned counsellor engages in the remainder of their session with the person.
6. The assigned counsellor returns to the team meeting room and may or may not have an opportunity to debrief the session with other members of the team.

On the day of data collection, Clinic A had a counselling team of five counsellors and Clinic B had a team of four counsellors and a counselling intern. The number of counsellors present in the team meeting room at any given time fluctuated as they came and went from sessions or lunch breaks. Two counsellors at Clinic A and one at Clinic B acted as walk-in counselling “leads” or “supervisors” and did not engage in sessions; these counsellors remained in the team meeting room to attend to logistics and to ensure that there was always someone available for consultation.

Counsellors on the walk-in counselling teams had completed a masters degree in either social work or counselling and their time working in the field ranged from under a year to over 30; the counselling intern<sup>8</sup> was in the process of completing a masters of social work. Professional development trainings in narrative therapy were offered multiple times per year to staff of both clinics and all counsellors indicated that they had training in narrative therapy. Demographic questionnaires asked counsellors two questions related to their theoretical orientation: (a) “What counselling theories or approaches do you most draw on in your walk-in counselling work?” and (b) “What counselling theories or approaches most resonate with you as a counsellor (not specific to your work at the walk-in counselling clinic)”. Table 1 provides a summary of counsellors’ responses.

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<sup>8</sup> From this point forward, my use of the term “counsellor” includes the intern at Clinic B.

**Table 1***Summary of Counsellors' Theoretical Orientations*

Counselling theory/approach	Walk-in counselling work	Most resonant generally
Narrative therapy	10	9
Cognitive behavioural therapy	4	6
Solution-focused therapy	3	4
Systemic/family systems	2	1
Mindfulness	2	2
Client-centred/humanistic	2	2
Strengths-based therapy	1	2
Collaborative therapy	1	3
Psychodynamic therapy	1	1
Attachment theory	1	3
Neuro-linguistic programming	1	0
Acceptance and commitment therapy	1	1

*Note.* This table indicates the number of counsellors, of 10 total, who included a particular counselling theory/approach in their response to questions (a) and (b) identified above.

Counsellors wrote in their answers and were able to include as many theories/approaches as they wished. All theories/approaches identified in response to question (a) have been included; there were a number of other theories/approaches included by a single counsellor in response to question (b) that have not been included for the sake of simplicity.

Intersession break consultations at both clinics were informed by reflecting processes, which were discussed in detail in the Interpretive Framework chapter. One divergence from traditional reflecting processes was that counsellors acting as reflecting team members (RTMs)

did not observe therapy sessions; instead, reflecting conversations occurred in response to the account of the session provided by the sharing counsellor (SC). Breaks at Clinic A followed a more traditional structure in that after sharing their account and answering any questions, the SC typically sat back and adopted a listening posture while RTMs engaged in reflective conversations amongst themselves; the SC re-joined the conversation towards the end of the break to share their thoughts or ask any remaining questions. At Clinic B, there was less delineation between different stages of reflecting processes and the SC tended to be more participatory in reflective conversations. An important consideration, however, is that at least two RTMs were present during all of the breaks at Clinic A, whereas there was often only one RTM during breaks at Clinic B, which would have impacted the ability to engage in a more traditional reflecting team structure. Each of the six intersession breaks analyzed involved a different SC.

I will also provide some general information regarding the people visiting the walk-in counselling clinics who had the intersession break regarding their session recorded; much of this information was collected as field notes during the counselling teams' pre-session discussions of people's intake questionnaires. While couples and families also access Clinic A and Clinic B, the breaks recorded for this study happened to all be individual counselling sessions. Of the six participants, two identified as male and four as female and their ages ranged from early 20s to late 30s. Presenting concerns included depression, anxiety, relationship difficulties, and challenges related to specific traumatic experiences. In their intake questionnaires, people were asked to rate both the severity of the problem/concern that brought them to the clinic as well as their current coping on a scale of 1-10. Ratings of problem/concern severity ranged from 7 to 10 with an average of approximately 8; ratings of coping ranged from 1 to 7 with an average of

approximately 4. People's responses to "What would you like to achieve at this meeting today?" on the intake questionnaire involved looking for support, ideas, solutions, resources, coping mechanisms, less distress, and a better understanding of counselling. Talking to friends and family, taking medications, and engaging in counselling were all identified as strategies people were using to address their problem/concern.

### ***Transcription***

The amount of detail included in transcription for discourse analysis is dependent on what is needed to address a study's research questions (Harper et al., 2008). Potter and Wetherell (1987) suggest that for many studies, "fine details" related to prosody are not necessary and can obscure a transcript's legibility. As such, I took what is referred to as a "broad" approach to transcription that captures participants' words verbatim but does not include elements of communication such as emphasis, length of pauses, speech rate, or body movements (Gee, 2014). Using primarily the audio recordings collected, I transcribed each of the six intersession break consultations in their entirety; video recordings were used as needed to clarify a word or confirm which counsellor was speaking. In order to protect participant confidentiality, pseudonyms were used in the initial transcription and identifying information was altered. Any changes made to transcripts to protect confidentiality were noted to ensure that analyses were not made based on altered information.

**Exemplars.** Exemplars are segments from the transcripts used to illustrate my analyses, as will be evident in my Results chapter. Rather than linking utterances to consistent pseudonyms, which was not necessary for my analytical purposes, I chose to distinguish speakers by their role in the particular intersession break. Therefore, speakers are identified in

exemplars as the sharing counsellor (SC) or as a reflecting team member (RTM if only one member speaks in the exemplar or RTM1, RTM2, etc. if more than one member speaks). Names and any potentially identifying information was altered or omitted. Unless relevant to a particular analysis, I removed minimal responses<sup>9</sup> to increase clarity and ease of reading. The following is an example of an exemplar before and after removing minimal responses:

*Before removing minimal encouragers*

SC: And also that she continues going to work, you know, she's not– she says, “It's very easy for me to stay home and sleep all day.”

RTM: Mhm

SC: But she's not doing that, she's going to work.

*After removing minimal encouragers*

SC: And also that she continues going to work, you know, she's not– she says, “It's very easy for me to stay home and sleep all day.” But she's not doing that, she's going to work.

Table 2 on the following page outlines notion used in the transcription process and in exemplars.

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<sup>9</sup> Hackney and Cormier (2013) define minimal responses as “brief statements, including the familiar *OK*, *mmm*, and similar minimal expressions” (p.22) that are used to communicate attentiveness or interest.

**Table 2***Transcription Notion*

Symbol	Meaning
.	Fall in intonation suggesting finality
,	Brief pause in speech
?	Rise in intonation suggesting appeal
–	Truncated/interrupted utterance
“ ”	Speaker adopting another’s perspective
[ ]	Overlapping speech
[ <sub>n</sub> ]	Overlapping speech (more than one overlap in close proximity)
( )	Nonlinguistic vocalizations (e.g. laughter)
{ }	Researcher additions (for clarity)
{...}	Portion of transcript omitted (not relevant to current analysis)
<u>Single underline</u>	Researcher drawing attention to part of exemplar
<u>Double underline</u>	Used in conjunction with single underlining to draw attention to parts of exemplar for different analytic reasons

*Note.* Transcription notion was informed by Chafe (1993), Du Bois et al. (1993), and Fullen (2019).

***Data Analysis***

My analysis was guided by four stages of discourse analysis outlined in Potter (2003): (a) generating hypotheses, (b) coding: the building of a collection, (c) doing the analysis, and (d) validating the analysis<sup>10</sup>. While described separately, Potter acknowledges the overlapping nature

<sup>10</sup> The concept of “validation” evokes a quantitative paradigm that is inconsistent with the epistemological position of this research and, therefore, the notion of “trustworthiness” will be used instead, which is explored in a separate section later in this chapter.

of these stages and I cycled between them in a non-linear fashion. The concept of the hermeneutic circle, drawn from hermeneutic phenomenological methodology, is also useful in characterizing the unfolding of my analysis. The hermeneutic circle recognizes research as an interpretive process that involves “movement between parts (data) and whole (evolving understanding of the phenomenon), each giving meaning to the other such that understanding is circular and iterative” (Ajjawi & Higgs, 2007, pp. 622-623). At each stage of my analysis, detailed below, I was engaged in the hermeneutic circle as I moved between transcripts, literature on narrative therapy, my reflective journal<sup>11</sup>, and conversations with my thesis supervisor.

**Generating Hypotheses.** This stage began in transcription and involved using the commenting tool of my word processing program to make “analytical notes” (Potter, 2003). I highlighted segments of the transcripts that appeared relevant to my research question, that is, instances where counsellors seemed to be drawing on narrative therapy discourse in their conversational practices. Using the commenting tool, I also noted thoughts and questions that arose in relation to segments of transcript; an example of such a note might be something like, “Seems to be lots of reflections related to the landscape of action in this break – same for other breaks?” I might then transfer this question to my reflective journal to return to. My analytic notes at this stage were quite informal in that I was not engaging with the transcripts in a systematic or comprehensive way, but simply noting what stood out to me in my early engagement with the data.

**Coding: The Building of a Collection.** Potter (2003) describes coding as the process of “sifting relevant materials from a larger corpus” (p. 83), which involves identifying and building

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<sup>11</sup> My use of a reflective journal will be described in the Trustworthiness section of this chapter.

a collection of “phenomena of interest”. Demonstrating the ongoing nature of this process, Potter (2003) states that “at this stage in the research the coding is inclusive, but coding can continue cyclically throughout the research process as ideas are refined and the understanding of the phenomena changes” (pp. 83-84). My phenomena of interest were any counsellor utterances or interactions that appeared to be drawing on narrative therapy discourse. At this stage, I engaged in multiple systematic readings of each transcript, noting any instance of my phenomena of interest using my word processor’s commenting tool.

In order to help orient myself to my phenomena of interest, I created a document with descriptions of various narrative therapy concepts drawn primarily from three foundational works in the field: White and Epston’s (1990) *Narrative Means to Therapeutic Ends*, Freedman and Combs’ (1996) *Narrative Therapy: The Social Construction of Preferred Realities*, and White’s (2007) *Maps of Narrative Practice*. In developing this document, which I titled “Narrative Discourse Overview”, I began with elements of narrative therapy discourse that had stood out to me in the previous stage as well as concepts I believed would be particularly relevant to the context of intersession break consultations. However, I was also mindful of Potter’s (2003) call for inclusivity and added any concept I came across that was plausibly relevant to my analysis. The document evolved as I engaged in multiple readings of the transcripts, immersed myself in narrative therapy literature, had conversations with my thesis supervisor, and worked through questions in my reflective journal.

Although I continued to engage in elements of coding throughout my analysis, my transition to the next stage occurred when I had compiled what Potter (2003) refers to as an “archive” of instances of my phenomena of interest. For my particular analysis, this meant a

document of segments of interest from the transcripts accompanied by analytic notes considering various ways narrative therapy discourse was relevant to counsellors' utterances within the segments. By this point in analysis, my Narrative Discourse Overview document was nearly 50 pages long; while the document itself has not been included in my write-up, the Narrative Therapy Theory section of my Interpretive Framework chapter is essentially a distillation of this document. Although my research question is concerned with practices drawing from narrative therapy discourse, included in my archive were also segments of interest that demonstrated significant incongruence with narrative therapy; Potter (2003) suggests that "problem or doubtful instances" be included in coding as they may become "analytically productive" (p. 84). In terms of my analysis, I found drawing on incongruent instances useful at various points in my Results chapter to help describe certain narrative therapy concepts or practices by providing contrasting examples.

**Doing the Analysis.** The naming of this stage is perhaps misleading as previous stages also involved analysis; however, the focus at this point is more squarely on "develop[ing] conjectures about activities through a close reading of the materials and then check[ing] the adequacy of these hypotheses through working with a corpus of coded materials" (Potter, 2003, p. 84). Potter (2003) emphasizes that discourse analysis does not adhere to a standardized process: "The procedure used is related to the type of materials used and the sorts of questions being asked" (p. 84). As suggested by Phillips and Hardy (2002) and Potter, I spent time reading research studies employing discourse analysis and related methodologies, particularly those examining actual talk within psychotherapeutic processes (e.g. Kahn, 2013; Kogan & Gale,

1997; Sutherland, 2008). Although our particular data and purposes were different, these studies helped spark ideas for how I might approach and present my own analyses.

Having built a collection of segments of interest with accompanying analytic notes, I began to, as Potter (2003) describes, “develop conjectures”. My primary anchor in this process was my research question: *How do counselling teams draw from narrative therapy discourse in constructing their conversational practices during intersession breaks in walk-in counselling?* Another question also emerged as an important guide: *How might this analysis be most useful to practitioners in the field?* As my research question itself was intentionally quite broad, this second question became invaluable when discerning between various analytical paths that I might follow. For example, different iterations of my analysis involved: considering the unfolding of each intersession break consultation separately; organizing analyses according to the content being discussed (i.e. presenting concerns, goals for the session, identification of unique outcomes, etc.); and engaging in in-depth analyses of large segments of transcript. While elements of these approaches are evident in the write-up of my results, ultimately, my analysis process culminated in the identification of four overarching conversational practices counselling teams engaged in that draw from narrative therapy discourse. These practices, which are detailed in the subsequent Results chapter, are: (a) counsellors engaging in externalization, (b) counsellors orienting to possible alternative narratives, (c) counsellors centring the person visiting the clinic, and (d) counsellors demonstrating tentativeness.

The four conversational practices identified reflect the aspects of narrative therapy discourse that emerged as most salient during my analysis and each contain two or three sub-

practices<sup>12</sup>. Potter (2003) describes how “often phenomena that were initially seen as disparate merge together while phenomena that seemed singular become broken into different varieties” (p. 84). Guided by my research purposes and through iterative engagement with segments of interest, analytic notes, narrative therapy literature, reflective journaling, and conversations with my thesis supervisor, I arrived at the particular connections and distinctions between conversational practices presented in the Results chapter.

### **Trustworthiness**

From a positivist epistemological perspective, the goal of a research project is to arrive at an understanding of the phenomena being investigated that accurately reflects objective reality (Tarragona, 2008). Methodological criteria such as validity, reliability, and generalizability are evaluated in order to “ensure the truth value of research efforts” (Angen, 2000, p. 381). These criteria are not appropriate for research situated in social constructionist and related epistemologies that believe knowledge, rather than reflecting reality, is constructed within particular social, historical, and cultural contexts (Burr, 2003; Gergen, 1985; Morrow, 2002). As such, various sets of criteria have been developed for assessing the quality, commonly referred to as the “trustworthiness”, of research studies that reject positivism (Creswell, 2013; Lincoln et al., 2011; Morrow, 2005). Angen (2000), however, questions the use of criteria-based approaches, suggesting that the emphasis on “specific methodological criteria continues the positivist assumption of an external foundational reality, untainted by our subjective involvement, to which research results can be compared and judged for their truth-value” (p. 383). Rather than engaging with the topic of trustworthiness according to a set of criteria, I will instead draw on Daly’s

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<sup>12</sup> A summary of practices and sub-practices is presented in Table 3 in the Results chapter.

(2007) notions of “credibility of procedures” and “credibility of outcome” to discuss research practices that I believe contributed to the trustworthiness of my study.

### ***Credibility of Procedures***

Credibility of procedures “has to do with the way the method was articulated in the study, the way it reflects the decisions that were made along the way, and the transparency of the strategies and techniques used in the research” (Daly, 2007, p. 252). Within a social constructionist epistemology, the credibility of a researcher’s procedures involves “being reflexive about how we bring meaning and focus to the research. ... [and] concerned with the ways knowledge is interactively constructed” (Daly, 2007, p. 255). In terms of practices that contributed to the credibility of my procedures, I will briefly discuss the following: (a) researcher-as-instrument, (b) reflective journaling, and (c) articulating my meaning-making strategies.

**Researcher-As-Instrument.** Daly (2007) suggests reflecting on and articulating “how personal experiences or theoretical interests led to specific lines of inquiry” (p. 255), which relates to Morrow’s (2005) recommendation that all qualitative studies include a “researcher-as-instrument statement”. Recognizing the central role that a researcher plays in every stage of the research process, Daly and Morrow are highlighting the importance of sharing personal and professional information relevant to the study with readers. In this thesis, such details were a key element of my Introduction chapter as well as being addressed in the Situating Myself as Researcher section of my interpretive framework.

**Reflective Journaling.** Daly (2007) identifies keeping a reflective journal as an “important means for tracking procedures and communicating these to our audiences” (p. 253)

and it is recognized throughout the methodological literature as a useful tool (e.g. Creswell, 2013; Morrow, 2005). My reflective journal served three main purposes: (a) tracking my procedures; (b) working through questions related to my analysis; and (c) keeping an ongoing record of what Morrow (2005) refers to as “experiences, reactions, and emerging awareness of any assumptions ... that come to the fore” (p. 254). In my write up, it contributed greatly to the specificity with which I was able to describe my methods of data analysis.

**Articulating My Meaning-Making Strategies.** According to Daly (2007), credibility of procedures within a social constructionist epistemology also involve describing “how various meaning-making strategies, including the researcher’s own, were incorporated into the analytic process” (p. 255). My Interpretive Framework chapter and this Methodology chapter are particularly relevant to my meaning-making strategies as they describe the philosophical, theoretical, personal, and methodological perspectives informing my research process. My meaning-making strategies were explicitly addressed in the Data Analysis section as I described my use of Potter’s (2003) stages of discourse analysis, the hermeneutic circle, and the “Narrative Discourse Overview” document. The practice of articulating my meaning-making strategies relates to the two previous practices discussed: my reflective journal helped me document and recall meaning-making strategies and situating myself as researcher throughout the write-up contributes to the transparency of my meaning-making processes.

### ***Credibility of Outcome***

Credibility of outcome involves “presenting the results of our research in a way that is careful, honest, and transparent” (Daly, 2007, p. 255). In considering this element of

trustworthiness, I will address the following: (a) epistemological integrity, (b) reader's evaluation, and (c) pragmatic utility.

**Epistemological Integrity.** When it comes to communicating the outcomes of a research process, epistemological integrity requires that “the form and style of our written reports is rooted in and shaped by our ... epistemological starting points” (Daly, 2007, p. 258). Daly (2007) emphasizes that for research situated in postmodernism and social constructionism, “it is important to bring our subjective self into the research account” (p. 261). At its most basic, this involves writing in the first rather than the third person (Daly, 2007); the practices described in the Credibility of Procedures section also illustrate ways I brought myself into the research account.

Daly (2007) discusses how epistemological integrity is also related to a researcher's methodology and states that “making a choice about how to present our subjectivity in research accounts becomes a matter of determining the degree of emphasis on my story, their story, or our story” (p. 261). As a discourse analytic study, my Results chapter might be considered a story of counsellors' discourse. My explicit presence in this chapter is fairly minimal, which is why I begin the chapter by emphasizing my epistemological position: that my results are not intended to be understood as truth claims but rather the products of my particular interpretive process.

**Readers' Evaluation.** This involves providing enough detail regarding analyses that readers can, to a certain degree, engage in their own evaluations of my interpretations (Potter, 2003). Particularly important in discourse analytic studies is the use of exemplars drawn from the transcripts to illustrate analyses as well as the inclusion of relevant contextual information (Potter, 2003), which are practices evident in my Results chapter. Daly (2007) discusses this as

“phenomenological validity”, which refers to the degree to which a researcher’s account resonates with a reader and “gives them a ‘vicarious’ experience of the phenomenon being studied” (p. 256).

**Pragmatic Utility.** Pragmatic utility essentially involves the question: “Has the research been useful and effective?” (Daly, 2007, p. 258). Related is Lincoln et al.’s (2011) concept of “catalytic authenticity”, which refers to the potential for a study to inspire and inform the actions of relevant parties. Pragmatic utility was an important consideration in my research process: as described in my Data Analysis section, I was guided both by my research question and by the question “How might this analysis be most useful to practitioners in the field?” Possible implications and applications of my research will be considered in the Discussion chapter. A summary of my results will be provided to the walk-in counselling staff at the clinics where I collected my data. It is my intention to publish this summary so that it is readily accessible.

In this Trustworthiness section, I have described my engagement with various practices that I believe relate to the credibility of my procedures and outcome. Considering the topic of validity, Angen (2000) reflects:

The etymological root of valid is the Latin word *valere*, which means to be well, strong, powerful, or effective and to have worth or value. Thus, validity does not need to be about attaining positivist objective truth, it lies more in a subjective, human estimation of what it means to have done something well, having made an effort that is worthy of trust and written up convincingly. (p. 392)

Each person who interacts with this thesis (you!) will have their own sense of the degree to which its contents are useful and worthy of trust.

## Chapter 5: Results

As previously discussed, my epistemological position in this research is that of social constructionism, which understands knowledge as constructed within a particular context rather than viewing it as an accurate representation of the world arrived at through objective measures (Burr, 2003; Gergen, 1985). The results presented in this chapter are, therefore, meant to be understood as the culmination of my interpretive process, a process that was detailed in the Methodology chapter. When using language such as “I noticed/identified/found” to communicate results, I am pointing to the outcomes of this interpretive process and do not intend to suggest that I have uncovered something inherent in the data itself.

In terms of the therapeutic approaches informing walk-in counselling work generally, both the clinical literature (e.g. Campbell, 2012; Harper-Jaques & Foucault, 2014; Slive et al., 2008) and the demographic questionnaires of counsellors in this study point to theoretical eclecticism with an emphasis on postmodern approaches. This is consistent with what I encountered in my analysis: discourse associated with a variety of therapeutic approaches showed up in counselling teams’ conversational practices during intersession breaks, with narrative therapy figuring prominently. Acknowledging the eclecticism, dynamism, and pragmatism that is characteristic of walk-in counselling work, my analysis process lead me to four conversational practices demonstrating various aspects of narrative therapy discourse: (a) counsellors engaging in externalization, (b) counsellors orienting to possible alternative narratives, (c) counsellors centring the person visiting the clinic, and (d) counsellors demonstrating tentativeness. For each of these practices, I have honed in on two or three particular ways that it manifested, which are considered “sub-practices”.

The conversational practices identified are examined below by drawing on exemplars<sup>13</sup> from the transcripts and relevant narrative therapy discourse; for more comprehensive descriptions of narrative therapy concepts, see the Interpretive Framework chapter. I will also at times include in my analysis examples of practices incongruent with narrative therapy in order to provide contrast. Table 3 summarizes my results and may provide a useful overview for readers to return to as they progress through this chapter.

**Table 3**

*Summary of Results*

Conversational practice	Sub-practices
Counsellors engaging in externalization	Using language that objectifies concerns Considering the effects of concerns on people's lives
Counsellors orienting to possible alternative narratives	Drawing on the landscape of action Drawing on the landscape of identity
Counsellors centring the person visiting the clinic	Counsellors endeavouring to adhere to what the person has shared Reflecting team members wondering about the person's knowledge
Counsellors demonstrating tentativeness	Speaking in the first person Using speculative language Reflecting team members demonstrating tentativeness towards sharing counsellors

<sup>13</sup> See Table 2 in the Methodology chapter for transcription notation used in exemplars.

## **Counsellors Engaging in Externalization**

As discussed in the Interpretive Framework chapter, externalization involves relating to concerns as separate from people: “*The person is not the problem. The problem is the problem*” (Combs & Freedman, 2012, p. 1039). White (2007) describes how when people believe that problems are an aspect of who they are or of who someone else is, for example that they *are* an angry person or that their child *is* out of control, “this belief only sinks them further into the problems they are attempting to resolve” (p. 9). In externalization, the problem is situated outside of the person and then the relationship between the person and problem can be considered. Reframing the examples from above, a person might consider how anger is impacting their life or a family might personify “the chaos” and work together to create a list of the tricks that it gets up to. White (2007) states that “in the context of externalizing conversations, the problem ceases to represent the ‘truth’ about people’s identities, and options for successful problem resolution suddenly become visible and accessible” (p. 9). I found that counsellors participated in externalization during intersession breaks by (a) using language that objectifies concerns<sup>14</sup> and (b) considering the effects of concerns on people’s lives.

### ***Using Language That Objectifies Concerns***

White (2007) states that “externalizing conversations employ practices of objectification of the problem against cultural practices of objectification of people” (p. 25). Counsellors separated problems from the identities of people visiting the clinic when they spoke about concerns in objectified ways. One way counsellors did this was by referring to “the” concern; for

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<sup>14</sup> The literature uses both the terms “problem” and “concern” to refer to whatever situation has motivated the person to seek services; I prefer the latter and will use the terms interchangeably.

example, counsellors at various points throughout the transcripts spoke about “the depression”, “the anxiety”, “the meltdowns”, etc. They also referred to concerns as “it”, as in the following exemplar:

*Exemplar 1*

SC: Um, so she says she’s had depression for many years. Um, and it’s been around, let’s see my notes, around all of high school.

*Exemplar 1* demonstrates the SC sharing details about the person’s experience using language that objectifies depression. As a comparison, internalizing language that ties a concern to the person’s identity would refer to the person “being depressed” and might include a statement like “she’s been depressed all of high school”.

The difference between externalizing and internalizing language is evident when comparing the ways in which two different SCs spoke about people diagnosed with autism<sup>15</sup>.

One used externalizing language:

*Exemplar 2*

SC: Um, she, she said that, um, when she was in elementary school, she was diagnosed with autism.

*Exemplar 3*

SC: {...} she had also kind of come to terms with the autism diagnosis by going on forums and chat groups.

The other spoke about the child of the person visiting the clinic using internalizing language:

*Exemplar 4*

SC: Uh, he has a young autistic daughter who he has total custody for.

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<sup>15</sup> According to Autism Canada (2016), “there has been a great deal of debate over ‘person-first’ and ‘condition-first’ terms”, the former corresponding to externalizing language and the latter internalizing language. Some people identify with condition-first language and refer to themselves as “autistic” (Autism Canada, 2016). My analysis is particular to the context of counsellors’ language use when it is unclear what the person’s preferences are.

In *Exemplar 4*, a person is being defined by their diagnosis, whereas this is not the case in *Exemplars 2* and *3*. These breaks occurred at the same clinic and I noticed that a RTM who participated in both breaks took up the language used by the SC. Meaning that in the break where the SC used externalizing language, the RTM subsequently spoke about “people with a diagnosis of autism”, while in the break where the SC used internalizing language, the same RTM went on to refer to the person’s “autistic daughter”. This brings up some interesting considerations for counsellors in both SC and RTM roles around how language gets taken up within reflecting team processes, which will be touched on in the Discussion chapter.

SCs at times also provided what White (2007) refers to as “rich characterization[s] of problems” that “uses the parlance of the people seeking therapy and that is based on their understanding of life” (p. 40). In the following exemplar, the SC uses externalizing language to characterize the “extreme waves of emotion” that the person experiences and has identified as a concern:

*Exemplar 5*

SC: Umm, and so we talked a little bit about those, um, extreme waves of emotion that she has. She says, “It feels like it’s an object in my brain. It occupies a space.” And she also described it as “It creates an aura.” So, she’s— either it’s a strong euphoria on some days or, um, it’s a really deep sadness as well.

According to White (2007), this type of externalized elaboration is useful because “it is in [the] rich characterization of problems that people’s unique knowledges and skills become relevant and central to taking action to address their concerns” (p. 41).

***Considering the Effects of Concerns on People’s Lives***

In *Maps of Narrative Practice*, White (2007) identifies several “categories of inquiry” associated with externalization, one of which he titles “Mapping the Effects of the Problem”.

Considering the ways that a concern is impacting various aspects of a person's life involves using language that objectifies concerns and reinforces the notion that problems are separate from people (Freedman & Combs, 1996; White, 2007). In their accounts to the team, SCs often included a description of the effects of concerns on a person's life. Describing the effects of depression, one SC stated that "it holds her back from how she would normally be. So hanging out with her friends, playing sports". Another SC spoke about the "extreme waves of emotions" experienced by the person and how "it really zaps her of her energy and it makes it really hard for her to speak to others". One SC explicitly identified having a conversation with the person about the impact of concerns:

*Exemplar 6*

SC: We talked about impact, um, of distress and pain on his life, right, and he, he talked about it in terms of it interferes with his life and causes frustration and anger and all these emotions {...} Um, he doesn't know what to do with these really strong feelings and emotions and it gets, and he finds that it gets in the way of him moving forward, sort of staying focused on what's important, right, at times and staying calm. So that's, uh, that's how we talked about the, the impact on that- of that.

The SC in *Exemplar 6* externalizes the emotions that the person is experiencing, which then allows for an exploration of how the "distress and pain" and "strong feelings and emotions" are impacting his life.

The conversational practices discussed above can be contrasted with times in the transcripts when SCs used internalizing language, such as when one referred to a person as "very emotional" or another stated the following:

*Exemplar 7*

SC: And he's just kind of- inside he's all torn up. But he's having trouble expressing it 'cause he's never really been an overly expressive kind of guy.

These descriptions of people may contribute to “restricting ‘truths’ about their identity” (White, 2007, p. 25). White (2007) states that “inquiry into the effects or influence of the problem places the externalizing conversation on firm footing, and at this point the transition from the more commonplace internalizing conversations is highly evident” (pp. 43-44).

When RTMs considered the effects of concerns, it was most often in the form of questions within reflecting processes, as in the following exemplars:

*Exemplar 8*

RTM1: {...} I think I’m still curious how that fee– how that problem is impacting the relationship in his mind.

RTM2: How depression is getting in the way of the relationship?

RTM1: Yeah, yeah.

*Exemplar 9*

RTM: Um, so, I wonder like this whole emotional sensitivity {...} I wonder how much of that is helpful and how much of it is not so helpful.

*Exemplar 8* and *Exemplar 9* align with what Freedman and Combs (1996) consider “deconstructive questions”, which refer to types of questions oriented to the deconstruction of problem-saturated narratives. They assert that externalization and deconstruction go hand in hand: “We believe that people can most easily examine the effects of problem-saturated stories on their lives when they do it in the context of an externalizing conversation” (Freedman & Combs, 1996, p. 58).

This section has examined ways in which counsellors within walk-in counselling intersession breaks engaged in externalization by using language that objectifies concerns and by considering the effects of concerns on people’s lives. Before turning to practices that orient to alternative narratives, a final exemplar illustrates the characterization of a concern involving both of these practices:

*Exemplar 10*

SC: Um, so she says she's had depression for many years. Um, and it's been around, let's see my notes, around all of high school. {...} Um, so she's saying— then I asked her about, she wrote anxiety on the form so is it— are these linked or are they separate? Um, so she described it as like “The anxiety is there first, um, like if I don't have interest in things or if I'm overwhelmed by something then the depression hits.” And so I asked her like “Where does it hit?” {...} and she goes, “Oh, it, I think it comes through my head, right, and— because it's got all these negative thoughts and it brings me down and then I start feeling sad and a loss of interest in— and a loss of energy.”

*Exemplar 10* offers a rich description of the person's experience with anxiety and depression that situates these concerns outside of the person's identity: anxiety and depression are objectified and some of their impacts are described.

**Counsellors Orienting to Possible Alternative Narratives**

In *Narrative Means to Therapeutic Ends*, White and Epston (1990) suggest that “when persons seek therapy, an acceptable outcome would be the identification or generation of alternative stories that enable them to perform new meanings, bringing with them desired possibilities – new meanings that persons will experience as more helpful, satisfying, and open-ended” (p. 15). Such stories are considered alternatives to “problem-saturated,” limiting, and dissatisfying narratives that can come to dominate a person's experience (White & Epston, 1990). Within the context of intersession break consultations, I refer to “possible” alternative narratives because only the person themselves can determine what represents an alternative narrative in their life. As White (2007) states, “retellings are not about ... imposing alternative stories about people's lives” (p. 187).

As mentioned in the Interpretive Framework chapter, White (2000, 2005, 2007) uses the term “retellings” to refer to an element of therapeutic encounters involving outsider witnesses. These encounters involve an initial “telling” by the person seeking services, a “retelling of the

telling” by outsider witnesses, a “retelling of the retelling” by the person, and so on. Retellings strengthen and support emerging alternative narratives. Within the context of intersession break consultations, I am considering the initial telling to have occurred within session and use the term “retellings” to refer to accounts of the telling offered by the SC and RTMs during the break. The retelling of the retellings would, therefore, refer to what the SC shares with the person when they return to session. I believe that my usage, while differing from White’s, is a useful adaptation of the concept to the context of walk-in counselling intersession breaks.

As I engaged with the transcripts, I noticed counsellors orienting to possible alternative narratives through questions and retellings within the “landscape of action” and the “landscape of identity” (Freedman & Combs, 1996; White, 2007); I will examine each of these landscapes in turn.

### ***Drawing on the Landscape of Action***

It is within the landscape of action that the “plot” of an emerging alternative narrative is thickened by considering “who, what, when, where, and how” (Freedman & Combs, 1996, p. 97). Counsellors offered retellings within the landscape of action oriented to possible alternative narratives:

#### *Exemplar 11*

SC: And we also talked about how he’s able to leave this pain, you know, behind the door when he goes and sees his daughter {...} and just focus on what’s, um, on being there for his daughter.

*Exemplar 12*

RTM: Umm, well I guess I was thinking about, um, how many areas of her life she seems to be feeling pretty good about. Um, and that that doesn't happen without, uh, quite a bit of work and reflection on her, her part. Um, in particular, the word compassion has stood out for me from the beginning. And it sounds like she's able to, um, at least in what she's presenting to {the SC}, she's able to, uh, express some compassion towards herself.

These exemplars relate to Freedman and Combs' (1996) assertion that within the landscape of action, counsellors are interested in “enhancing those aspects of the emerging story that support ‘personal agency’” (p. 97); they also refer to this as “constructing an ‘agentive self’” (p. 97).

In addition to retellings within the landscape of action, RTMs included in their reflections questions associated with the landscape of action:

*Exemplar 13*

RTM: And what's, what's the history of that {steadiness}, but also, is there a history of excitement {...}

*Exemplar 14*

RTM: {...} so how– what were the, what were the steps that he took in order to be able to do that.

Freedman & Combs (1996) provide a detailed description of various types of questions within the landscape of action<sup>16</sup>. *Exemplar 13* would be considered a “historical antecedent” question as it seeks to explore the history of an element of a possible alternative narrative; *Exemplar 14* aligns with what they call “process” questions, which “invite people to slow an event down and notice what went into it” (Freedman & Combs, 1996, p. 132).

There were also times when counsellors engaged in conversational practices that could be understood as contributing to a problem-saturated narrative rather than an alternative one. In the

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<sup>16</sup> While Freedman & Combs (1996) use the term “story development questions”, they explicitly state that this is equivalent to White's use of “landscape of action”.

following exemplar, the SC is considering a book chapter suggested by the RTM that outlines strategies for responding to challenging emails:

*Exemplar 15*

SC: I'm reading 'cause it says, "brief," she has not been brief.

RTM: Yes.

SC: [(Laugh)]

RTM: [She maybe could] work on that one.

This exchange evaluates the person's behaviour according to expert knowledge and suggests that it is problematic. Another example involves a SC connecting events in a way that supports a problem-saturated story, one in which the actions of others are being foregrounded and evaluated:

*Exemplar 16*

SC: So, um, one of the things we went back to was what happened to that first relationship, the mother of the child. And the mother of the child, basically, just wanted to party and cheated on him shortly after the child was born. So I said, "Does this sound a little bit familiar to you?" You know, because now this– the present girlfriend wants to basically go out a little bit more and do a few more exciting things. So there was that aspect that– is he reliving that, is that part of his, um, worry about this relationship?

Rather than contributing to the construction of an agentic self within the landscape of action that Freedman and Combs (1996) advocate, the conversational practices of the counsellors in *Exemplar 15* and *Exemplar 16* are more aligned with problem-saturated narratives that evaluate people's actions according the expert knowledges and minimize personal agency.

***Drawing on the Landscape of Identity***

The landscape of identity contains the "meanings, desires, intentions, beliefs, commitments, motivations, values, and the like that relate to [a person's] experience in the landscape of action" (Freedman & Combs, 1996, p. 98). White (2007) also includes within the

landscape of identity people's "realizations, learnings, [and] knowledge" (p. 84). Counsellors offered retellings within the landscape of identity oriented to possible alternative narratives:

*Exemplar 17*

SC: Um, and we also talked, of course, we talked about what, you know, his commitment to being a dad, right, and what that's like for him and what kind of dad he, uh, wants to be to his, um, to his daughter, and, and he talked about it, uh, he's always wanted children.

*Exemplar 18*

RTM: I guess I'm, I'm thinking, you know, that he's, he's interested in keeping the relationship going, uh, with her.

Both of the above exemplars demonstrate what White refers to as "intentional state understandings" of identity: they orient to a construction of identity founded on people's intentions and preferences. This can be contrasted with "internal state understandings", which construct identity as the "manifestation of specific elements or essences of a self. ... [such as] dispositions, personality traits, [and] personal properties (like strengths and resources)" (White, 2007, p. 101). While recognizing that both intentional and internal understandings can be useful in therapeutic conversations, White states that there is typically more emphasis placed on intentional state understandings within narrative therapy since "this notion casts people as active mediators and negotiators of life's meanings and predicaments" (White, 2007, p. 103), thus foregrounding personal agency. The following is an example of a retelling that draws on both intentional (single underlined) and internal state understandings (double underlined):

*Exemplar 19*

SC: Um, in terms of strengths, we talked about how, uh, I asked her about that piece where she mentioned {in the pre-session questionnaire} she's really compassionate and she said, "Yeah, it's, it's super important to me to help others and to do something." She's like, "I am a doer."

As with the landscape of action, RTMs also drew on the landscape of identity in the questions they posed during their reflecting. These questions oriented to various aspects of the landscape of identity, including people's hopes, values, goals, needs, skills and learnings:

*Exemplar 20*

RTM: It's like, you know, what is it that he's hopeful will continue in the relationship.

*Exemplar 21*

RTM1: Yeah, I'm also curious about the stipulation that he receive counselling before they enter into couples counselling.

RTM2: Aha

RTM1: And, uh, what value he sees in that, or what goals he has for himself in that.

*Exemplar 22*

RTM: And then the other thing would be like the— that mantra really stands out to me. Um, “But I'm okay with this now.” So I'm wondering, you know, what might she need in her life, what kind of skills might she want to build upon to be okay with where she is right now and I'm kind of curious about that. Or what has she learned that's helped her be okay with it at, at this point.

Returning to the notions of intentional and internal state understandings, questions related to a person's hopes, values, goals, and learnings would be associated with intentional understandings while those related to needs and skills are more aligned with internal understandings (White, 2007).

At times, counsellors engaged in retellings within the landscape of identity more aligned with problem-saturated narratives than alternative ones. For example, rather than demonstrating curiosity about the purposes, values, etc. that brought the person to the clinic, one SC asserted that “the whole reason that he's here is that she {the person's girlfriend} pushed him to be here as a first step. And so he's just saying, ‘Okay, I'll just do what you want,’ kind of deal”. Another SC stated that the person is “not very specific in, you know, what it is that she wants”. In both of

these instances, SCs are engaging in conversational practices that minimize the agency of the person visiting the clinic. This is also the case in the following exemplar<sup>17</sup>:

*Exemplar 23*

SC: And he's just kind of— inside he's all torn up. But he's having trouble expressing it 'cause he's never really been an overly expressive kind of guy.

The SC states an identity conclusion that is restrictive and limiting, thereby orienting to a problem-saturated narrative.

While I have examined the landscapes of action and identity separately, Freedman and Combs (1996) discuss how it is “the interplay between these dual landscapes” (p. 98) that allows for the rich development of alternative narratives. In *Exemplar 17*, the SC discussed the person's “commitment to being a dad”; a few sentences later they describe actions connected to this commitment:

*Exemplar 24*

SC: How he's been, he's been very resourceful, he has taken some parenting courses and has registered for some more, I think some more here. And then there's all these, I guess, um, like, few hour seminars that are being offered I guess through another centre.

In the following exemplar, the SC offers a possible identity conclusion (single underlined) based on landscape of action retellings (double underlined):

*Exemplar 25*

SC: Well, I, I get the impression that she, um, you know, values her friendships 'cause she talked about, um, you know, she, she enjoys being social and, um, she has this friend that she reached out to, the friend mentioned before.

These exemplars demonstrate counsellors incorporating both the landscape of action and the landscape of identity as they orient to possible alternative stories.

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<sup>17</sup> This exemplar was also used as an example of internalizing language in the previous section Counsellors Engaging in Externalization. Exemplars may be used in multiple analyses.

### Counsellors Centring the Person Visiting the Clinic

Throughout his work, one of the ways White (e.g. 2000; 2007) characterizes the position of the counsellor in narrative therapy is as “decentred”. A decentred posture “sees the person or family as the expert in their own lives, and places the knowledges, skills, preferences, and commitments of the family at the centre of the work” (White & Morgan, 2006, p. 71). This can be contrasted with a centred position that “privileges the knowledge and experience of the therapist” (White & Morgan, 2006, p. 60). When considering who is being centred by a practice, Freedman and Combs (1996) find it useful to ask the following: “Does [the practice] require the person to enter the therapist’s ‘expert’ knowledge or does it require the therapist to enter the ‘world’ of the client?” (p. 278). During my analysis, I identified two primary ways that counselling teams centred those visiting the clinic: counsellors endeavouring to adhere to what the person has shared and RTMs wondering about the person’s knowledge. Before examining these conversational practices, I would like to consider some examples of times when counsellors centred their own “expert” knowledge as a means of fleshing out this distinction between a centred and decentred position.

The following exemplar illustrates an SC centring their own interpretations and evaluations during their account to the team:

#### *Exemplar 26*

SC: Um, so he’s very easygoing, very sedate, sort of calm, doesn’t talk much, uh, calls himself introverted. Um, quiet, um, he likes to play computer games. He does those kind of things. He’s, um, he’s kind of a homebody. He doesn’t participate in any, you know, uh sports, he stays at home, watches TV. {...} He works at a restaurant. Uh, so he’s got a good job. He doesn’t have any aspirations to go any further, to take any more school or anything like that.

The portions of the exemplar that are single underlined represent interpretations of the person's behaviour, which are presented as facts rather than as the SC's perspective<sup>18</sup>. While notions of what it means to be "easygoing," "calm," "a homebody," etc. evoke certain cultural discourses, the utterances that are double underlined are more explicitly evaluative, for example the SC considering playing computer games as being part of a category of things ("he does those kind of things"). Furthermore, the SC including in their account to the team things that the person does not do or does not want (i.e. play sports or have aspirations to "go further" in his career) connects to what White (2007) refers to as "normalizing judgment"<sup>19</sup>. The SC seems to be measuring the person's actions and desires against certain societal norms related to young men playing sports and having certain career or educational aspirations.

The utterance "he's got a good job" from *Exemplar 26* can be understood in terms of narrative therapy discourse around "practices of applause" (White, 2000). While seemingly positive, this statement centres the SC's assessment instead of privileging the person's perspective on his employment. White (2000) states that "often therapists participating in reflecting teams engage with practices of applause in their efforts to break from and challenge the routine pathologising of personal and relational identities. ... however, these practices of applause do reproduce normalising judgement" (pp. 72-73). Other examples of applause included when an SC stated "so you can see like she's a good mother" or when counsellors stated that something was "really great", "really nice", or "kind of amazing". These practices reflect a

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<sup>18</sup> This relates to tentativeness, which will be examined subsequently in this chapter.

<sup>19</sup> The concept of normalizing judgment comes from the work of philosopher Michael Foucault and describes "a mechanism of social control that incites people to measure their own and each other's actions and thoughts against norms about life and development that are constructed within the professional disciplines" (White, 2007, p. 25).

centred position on the part of counsellors and can be contrasted with the practices discussed below.

### ***Counsellors Endeavouring to Adhere to What the Person Has Shared***

White (2005) describes how centring those seeking services involves “according priority to the personal stories and to the knowledges and skills of these people. ... [they] have a ‘primary authorship’ status, and the knowledges and skills that have been generated in the history of their lives are the principal considerations” (p. 9). In the context of intersession break consultations, one way that counsellors respected the “primary authorship status” of those visiting the clinic was to endeavour to adhere to what the person shared in their session or on their intake questionnaire. For SCs, this occurred in the accounts they provided to the rest of the team; for RTMs, this showed up in their reflections.

In their accounts to the team, SCs frequently paraphrased<sup>20</sup> what the person shared in session. These paraphrases often began with some variation of “she/he said”, as in the following exemplars<sup>21</sup>:

#### *Exemplar 27*

SC: And, um, she said what was helpful about the woman’s centre is that she felt empowered when she was there because it worked from that model of empowerment and then, but, she said the hard thing about it was {...}

#### *Exemplar 28*

SC: Uh, and he’s uh, um, he’s in a relationship, well, he’s ending a relationship. He– the way he talks about it is he’s still hopeful there might be something there.

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<sup>20</sup> Paré (2013) offers the following definition of paraphrasing: “altering the [person]’s wording while trying to stay as close as possible to the perceived meaning” (p. 132).

<sup>21</sup> Double underlining is used for the portion of the utterance that situates the paraphrase in what the person shared and single underlining is used for the content of the paraphrase.

Many of the SCs' paraphrases also involved speaking in the first person as though from the person's perspective. For example:

*Exemplar 29*

SC: But she— I asked, uh, how it was going and she said “It’s good” and I said “Okay, what’s good about it?” She says “I’m not as nervous and I’m more willing to talk about it” {...}

*Exemplar 30*

SC: Um, she says “I can sense how I’m feeling in a situation and how that’s gonna help me make a decision but also I can sense it off, off other people, I can feel their emotion really strongly.”

*Exemplar 31*

SC: He’s like, “No I don’t think so ‘cause when I’m there, you know, my daughter is all that matters.”

There were also times SCs appeared to be paraphrasing but did not explicitly identify the information as coming from the person:

*Exemplar 32*

SC: But he’s, um, you know, he’s going to— he’s looking forward to, basically, exploring what the options are at this point, um, as far as, as far as employment is concerned.

*Exemplar 33*

SC: Uh, he was on medication at some point in time but he decided not to take them because they just made him feel, um, like he wasn’t experiencing life.

These statements have more of an omniscient quality and might be considered less decentred when compared with previous exemplars, although the content is still oriented to the person’s experience.

In addition to paraphrasing, SCs sometimes indicated that they were using the exact language of the person, as in the following exemplars:

*Exemplar 34*

SC: Uh, so Sophie’s come in today wanting to learn about coping mechanisms to reduce, uh, the number of what she calls “meltdowns”.

*Exemplar 35*

SC: {...} her common phrase was, um, “But I’m okay with this now. But I’m okay with this now.”

*Exemplar 36*

SC: She’s like, “The woman’s centre to me, it was like, okay this is logical, it makes sense and then I would go back to this illogical—” she called it, “I’d go back to this illogical environment, where you were like, keep quiet and not talk about things.”

This relates to White’s (2007) discussion of using “experience-near and particular terms”, which he believes is important because “no development in life will be perceived or received in identical ways by different people” (p. 234).

The exemplars above demonstrate SCs endeavouring to adhere to what the person shared regarding a variety of content, including the person’s presenting concern, their hopes for the session, what they have found helpful or unhelpful, and many other aspects of their experience. I use the term “endeavour” because it is not possible to know how closely SCs’ captured the person’s intended meanings without checking this out with the person, which is not part of this research. Moreover, from a postmodern perspective, language is not a vehicle through which we transmit information; rather, “we construct and reconstruct our lived realities through talking and listening” (Paré, 2013, p. 37). As such, meaning is dynamic and words spoken in one moment or context mean something different in another moment or context. My purpose is, therefore, not to assess whether counsellors “accurately” conveyed what the person shared in session, but to consider how endeavouring to adhere to what was shared is a practice that helps keep the person, as White and Morgan (2006) say, “at the center of the work” (p. 71).

While I have focused thus far on SCs' accounts to the rest of the team, RTMs also endeavoured to adhere to what the person shared. One way this showed up was through questions that explicitly asked SCs to centre the person, for example:

*Exemplar 37*

SC: Um, and I've kind of talked to her about what taking back her life would be like, what that would look like. Um,

RTM: Does she have ideas about that?

*Exemplar 38*

SC: So we did talk about, like, those two sort of, sort of voices [for her.]

RTM: [Did she name] them?

*Exemplar 39*

RTM: Um, so, in terms of what– I mean, is there anything she wanted from you on the break?

Sometimes this involved recalling and refocusing on what the person shared:

*Exemplar 40*

SC: Umm, yeah, I'm just curious to hear what other stories you guys are hearing from the dialogue and, if there's anything that we could move forward with after the break that would be beneficial for her.

RTM: So did I understand correctly that her hope is to talk about how to reduce the meltdowns?

SC: She says she'd like learning some coping mechanism to reduce the meltdowns, or reduce the really really tough days.

Attentiveness to the person's expressions was similarly evident in an exchange that involved

RTMs distinguishing between the SC's language and the person's:

*Exemplar 41*

SC: Um, I'm wondering if you guys can talk maybe a little bit about, like, strengthening the voice of advocacy. Like what that might look like for someone.

RTM1: You mean [the, the other voice, the deserve voice?]

SC: [To strengthen that– yeah, to like] strengthen that, that voice.

{...}

RTM1: How often is it– did she name it like “advocacy voice”?

RTM2: That's {the SC's} word.

RTM1: Okay

RTM2: She, she said, “I deserve,” was a– was her word I think. The voice that says, “I deserve.”

The RTMs privilege the person's language in this exchange and continue to do so a few sentences later when RTM2 refers to “that deserving voice”.

***Reflecting Team Members Wondering About the Person's Knowledge***

In addition to endeavouring to adhere to what they shared in session, RTMs also centred the person visiting the clinic by wondering about their knowledge. I am using the term “knowledge” broadly here to refer to what the person could know about various aspects of their experience. RTMs wondered about the person's knowledge around their hopes, values, and goals:

*Exemplar 42*

RTM: It's like, you know, what is it that he's hopeful will continue in the relationship.

*Exemplar 43*

RTM1: Yeah, I'm also curious about the stipulation that he receive counselling before they enter into couples counselling.

RTM2: Aha

RTM1: And, uh, what value he sees in that, or what goals he has for himself in that.

They wondered about the person's knowledge about what is and is not helpful:

*Exemplar 44*

RTM: Um, so, I wonder like this whole emotional sensitivity, which I, I've heard about from other people with a diagnosis of autism, um, like there's– I wonder how much of that is helpful and how much of it is not so helpful.

*Exemplar 45*

RTM: So, knowing that she is, um, she calls that something, that ability to avoid, that ability to not accept the invitation, is that helpful for her to– like, is it helpful to thicken that {...}

RTMs wondered about the person's knowledge around their actions, including the meaning of various actions and how the person achieved them:

*Exemplar 46*

RTM: She went to the hospital, she's coming here, what does she want to take from those things?

*Exemplar 47*

RTM: {...} the fact that he'd had this visit to his daughter in which he, he clearly was able to, uh, take that wound if you will and, uh, you can– I guess you can't leave a wound outside the door but it was adequately dressed {...} while he was with his daughter, so how– what were the, what were the steps that he took in order to be able to do that.

*Exemplar 48*

SC: And also that she continues going to work, you know, she's not– she says, “It's very easy for me to stay home and sleep all day.” But she's not doing that, she's going to work.

RTM: So to ask {a counsellor on the team's} question, “What allows you to do that?”

Evident in these questions are also elements of narrative therapy discourse discussed under previous conversational practices, for example externalization (i.e. “how much of that [emotional sensitivity] is helpful and how much of it is not so helpful”), drawing on the landscape of identity (i.e. “what is it that he's hopeful will continue in the relationship”), and drawing on the landscape of action (i.e. “what were the steps that he took in order to be able to do that”).

### **Counsellors Demonstrating Tentativeness**

Presenting ideas in a tentative manner is a way of “introducing possibilities, but not prescribing them” (Freedman & Combs, 1996, p. 89), which aligns with narrative therapy's

postmodern critique of universal truth claims. Grounded in Foucault's analysis of knowledge/power, which is detailed in the Interpretive Framework chapter, White and Epston (1990) state that they reject "situating our practices in those 'truth' discourses of the professional disciplines, those discourses that propose and assert objective reality accounts" (p. 23). Since narrative therapy sees the imposition of such "truth discourses" as central to the problems people experience, doing so would be counter to the therapeutic approach. As Freedman and Combs (1996) put it, "inflicting our beliefs on the people we work with would replicate the effect of the dominant culture's privileged knowledges and practices on those in subjugated positions" (pp. 57-58).

In differentiating the practices of narrative therapy from those associated with modernist therapeutic approaches, White and Epston (1990) draw on Jerome Bruner's notion of "subjunctivizing reality." Bruner (1986) describes how subjunctivizing reality, which he argues is central to compelling storytelling, involves existing in the realm of "human possibilities rather than [of] settled certainties" (p. 26). The term "subjunctive" refers to "a mood of verbs expressing what is imagined or wished or possible" ("Subjunctive," 2015) and can be contrasted with the indicative mood, which is used to convey statements of fact. References to the "subjunctive mood" throughout the literature on narrative therapy draw on this concept in an expansive way to refer to a variety of language, not just verb conjugation, that supports possibility and multiplicity. With regards to reflecting processes in particular, White (1995) suggests that "team members are careful to avoid the indicative, and instead frame their responses to each other in the subjunctive mood of 'as if', 'maybe', 'possibly', and so on" (p. 182). Freedman and Combs (1996) indicate that they "ask questions or offer ideas tentatively,

talking about what we are wondering (*I was wondering if...*) or using the subjunctive mood (*could, might, perhaps*)” (p. 178).

During my analysis, two manifestations of tentativeness stood out within counselling teams’ conversational practices: counsellors using speculative language and counsellors speaking in the first person. The way in which these practices contribute to tentativeness becomes evident when comparing two excerpts from the transcripts:

*Exemplar 49*

SC: And he’s just kind of– inside he’s all torn up. But he’s having trouble expressing it ‘cause he’s never really been an overly expressive kind of guy.

*Exemplar 50*

SC: And she says that it’s hard for her to get that kinda quiet space that she needs to kinda process stuff. And, and, um, I’m wondering if all of this, not only just noise in general, but all this emotional noise that she’s getting from all of these interactions everyday might be making it really tough for her too.

Both exemplars involve SCs interpreting the experience of the person visiting the clinic.

However, the addition of speculative language (“wondering if” and “might”) as well as the counsellor explicitly recognizing the interpretation as their perspective (“I’m wondering”) in *Exemplar 50* evoke tentativeness, whereas *Exemplar 49* is presented with certainty. This section will first address the practices of using speculative language and speaking in the first person separately before considering how they combine to create what might be understood as a continuum of tentativeness. It will conclude with an analysis specific to reflecting processes by examining the ways in which RTMs demonstrate tentativeness towards SCs.

Before turning to the results of my analysis, it is important to note that my focus in this section is on the tentativeness of counselling teams’ conversational practices and not on the content of what counsellors are being tentative about; as such, the content of counsellors’

utterances ranges in its alignment with narrative therapy discourse. For example, White (2007) suggests various utterances that are inconsistent with narrative-informed reflecting team processes, including “theorizing and hypothesizing about people’s lives and relationships” (p. 215). *Exemplar 50*, while tentative, involves theorizing and hypothesizing. This is an illustration of the nuanced ways narrative therapy discourse manifests in counselling teams’ conversational practices. It is also important to acknowledge that while paralinguistic features of communication such as tone and facial expression are relevant when considering the tentativeness of an utterance, the focus of my analysis is on tentativeness as manifest in spoken language.

### ***Using Speculative Language***

As previously mentioned, White (1995) and Freedman and Combs (1996) identify particular language narrative therapy associates with the subjunctive mood, such as “might”, “maybe”, “possibly”, “perhaps”, and “could”. Recognizing that the term “subjunctive” has a specific dictionary definition referring to a mood of verb conjugation, I have chosen to characterize this language as “speculative” rather than “subjunctive” as I believe this better captures what I am discussing. In doing so, I am drawing on White’s (1995) suggestion that when counsellors share ideas during reflecting team processes, “care is taken to acknowledge the fact that this response remains in the realm of speculation until confirmed or refuted by the people concerned” (p. 183) and on Andersen’s (1987) statement that “as a general rule, everything that is said should be speculative” (p. 5).

Consistent with the language identified in White (1995) and Freedman and Combs (1996), the words “might” and “maybe” appeared frequently in the transcripts, for example: “she

might similarly be surprising herself”, “that might be a good question to ask”, “maybe it’s a really important step”, and “maybe she draws from those things, maybe she doesn’t”.

Counsellors also demonstrated tentativeness through the use of “seems to be”, “sounds like”, and “could be”, as in:

*Exemplar 51*

SC: {...} there seems to be just like a, a readiness.

*Exemplar 52*

SC: {...} she plays sports so that’s, it sounds like that’s an outlet for her–

*Exemplar 53*

RTM: And it sounds like she’s able to {...} express some compassion towards herself.

*Exemplar 54*

RTM: Who helps strengthen it {“the deserve voice”}, is there anyone she, that she has in her network or that she knows of or that– it could be God {...} it could be her dog, right.

In *Exemplar 52*, the SC pauses to add “it sounds like” to what may otherwise have been the statement “she plays sports, so that’s an outlet for her”. This is a useful illustration of how the counsellor’s addition of speculative language transforms an utterance from one implying certainty about the person’s experience to one demonstrating tentativeness.

***Speaking in the First Person***

This practice relates to what Bruner (1996) calls “subjectification”, which he defines as “the depiction of reality not through an omniscient eye that views a timeless reality, but through the filter of consciousness of the protagonists in the story” (p. 79) and which is discussed in White and Epston (1990) as a means of subjunctivizing reality. Applied to reflecting team processes, it means that “team members speak as individuals, not as representatives of

‘knowledge’ or ‘authority’ (Freedman & Combs, 1996, p. 179). The following exemplar highlights the difference between these two positions:

*Exemplar 55*

RTM: She’s getting her goals met which is vent and validation.

SC: Mhm. Yeah, I hope so.

The RTM is speaking in the third person, as though through the “omniscient eye” referred to by Bruner or as a representative of knowledge/authority mentioned by Freedman and Combs, whereas the SC demonstrates tentativeness by situating her response in her own individual experience.

However, it is not only the SC’s use of the first person in *Exemplar 55* that makes their statement tentative but also their use of the verb “hope”. If, for example, the SC had said “Yeah, I know she is”, they would have been speaking in the first person without being tentative. Therefore, speaking in the first person contributes to tentativeness depending on what other language it is accompanied by. While this most often involved counsellors pairing first person and speculative language, which will be addressed below, there were utterances that took on a tentative quality by being situated in the counsellor’s experience without the inclusion of language that is necessarily speculative:

*Exemplar 56*

SC: Uh, I see her having such a strong kind of love story with her husband {...}

*Exemplar 57*

RTM: Um, in particular, the word compassion has stood out for me from the beginning.

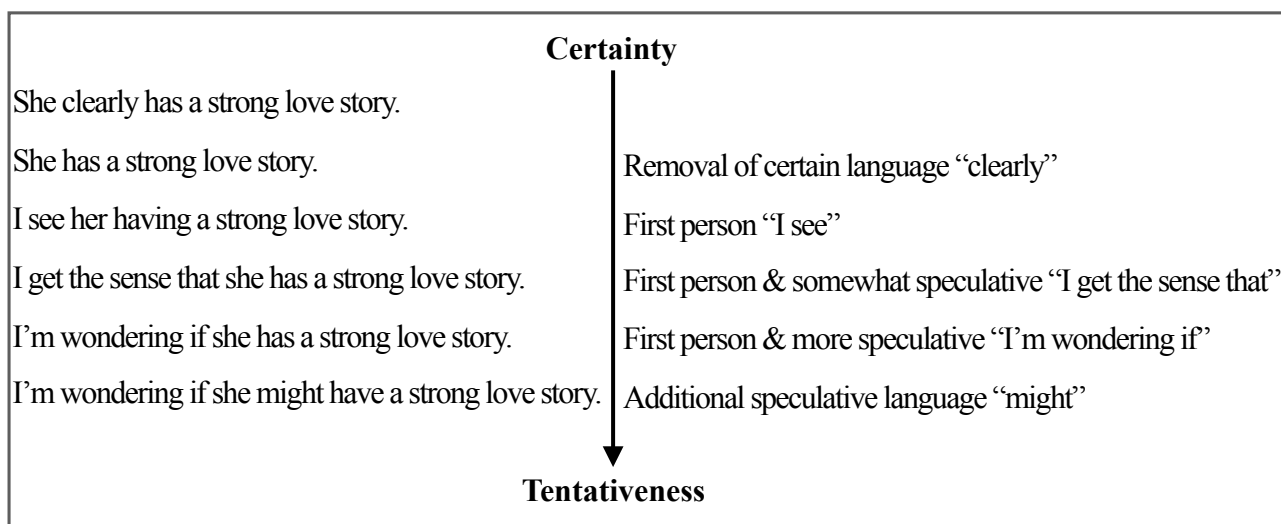
*Exemplar 58*

SC: Um, but that makes a lot of sense to me.

Drawing on the utterance in *Exemplar 56*, Figure 1 illustrates how the tentativeness of counsellor’ conversational practices can perhaps best be understood as existing on a continuum rather than as dichotomously tentative or not tentative.

### Figure 1

#### *Continuum of Tentativeness*



*Note.* A visual representation of a possible continuum ranging from certainty to tentativeness; variations of the utterance “I see her having a strong love story” are presented on the left and changes in language that contribute to tentativeness are identified on the right.

The most common example in the transcripts of counsellors speaking in the first person using a verb that suggests speculation was the utterance “I think”. For example: “I think she’s finding it difficult,” “I think she sees the potential for change,” or “I think this is useful”. Other formulations included:

*Exemplar 589*

SC: Well, I, I get the impression that she, um, you know, values her friendships ‘cause she talked about, um, you know, she, she enjoys being social and, um, she has this friend that she reached out to {...}

*Exemplar 60*

SC: And, so, it seems to me like she has a sense that talking, talking through it would be really helpful for her {...}

*Exemplar 61*

RTM: And so in that moment you offered her something that was pretty important, would be my guess.

*Exemplar 62*

RTM: {...} I was kind of wondering does she know about, um, basic mindfulness stuff or the polyvagal. I wonder if she would find that kind of thing interesting.

The following exemplars demonstrate slightly more nuanced combinations of first person and speculative language:

*Exemplar 63*

SC: And I think that will– that might be a good question to ask {...}

*Exemplar 64*

RTM: And he seemed to really join with– the way she {the SC} described it made me think that he joined with it {a metaphor} on a deep level.

In *Exemplar 63*, the SC shifts mid-utterance from the indicative mood (“will”) to speculative language (“might”), which renders the utterance more tentative than it otherwise would have been. Similarly in *Exemplar 64*, the RTM’s adjustment to include first person language increases the tentativeness of the statement. The notion of a continuum of tentativeness is useful when considering the various combinations of first person and speculative language that manifested in counsellors’ conversational practices during intersession breaks.

*Reflecting Team Members Demonstrating Tentativeness Towards Sharing Counsellors*

Having considered how counsellors' use of speculative and first person language contributes to the tentativeness of utterances, I would now like to hone in on the particular context of reflecting processes within intersession breaks. As previously mentioned, breaks at both clinics incorporated reflecting processes informed by the work of Andersen (1987) and White (1995, 2000, 2007). Whereas reflections within traditional reflecting processes are offered by team members in response to the conversation they have witnessed between a counsellor and the person(s) seeking services, reflections in the context of the intersession break consultations in this study refer to RTMs' responses to what has been shared by the SC. In the process of my analysis, I came to differentiate between reflections framed as suggestions versus those offered as wonderings/curiosities, the latter being more aligned the "tone of curiosity" and "spirit of multiplicity" (Paré, 2016, p. 280) sought in reflecting processes. In the following exemplar, the RTM's reflections are presented in the form of suggestions:

*Exemplar 65*

SC: {...} there seems to be just like a, a readiness.

RTM: I would tell her that.

SC: Yeah

RTM: Yeah. You could see if that word fits for her.

SC: Yeah

While the RTM includes speculative language ("would" and "could see if") and speaking in the first person ("I would"), these reflections are less tentative vis-à-vis the SC than times when reflections are offered as wonderings/curiosities, as in the following exchange:

*Exemplar 66*

RTM1: I guess I'm, I'm thinking, you know, that he's, he's interested in keeping the relationship going, uh, with her. And I'm wondering more about where that angle might go. It's like, you know, what is it that he's hopeful will continue in the relationship.

{...}

RTM2: Yeah, I'm also curious about the stipulation that he receive counselling before they enter into couples counselling.

RTM1: Aha

RTM2: And, uh, what value he sees in that, [or what] [2 goals] he has for himself in that.

RTM1: [Aha]

RTM3: [2 Mmm]

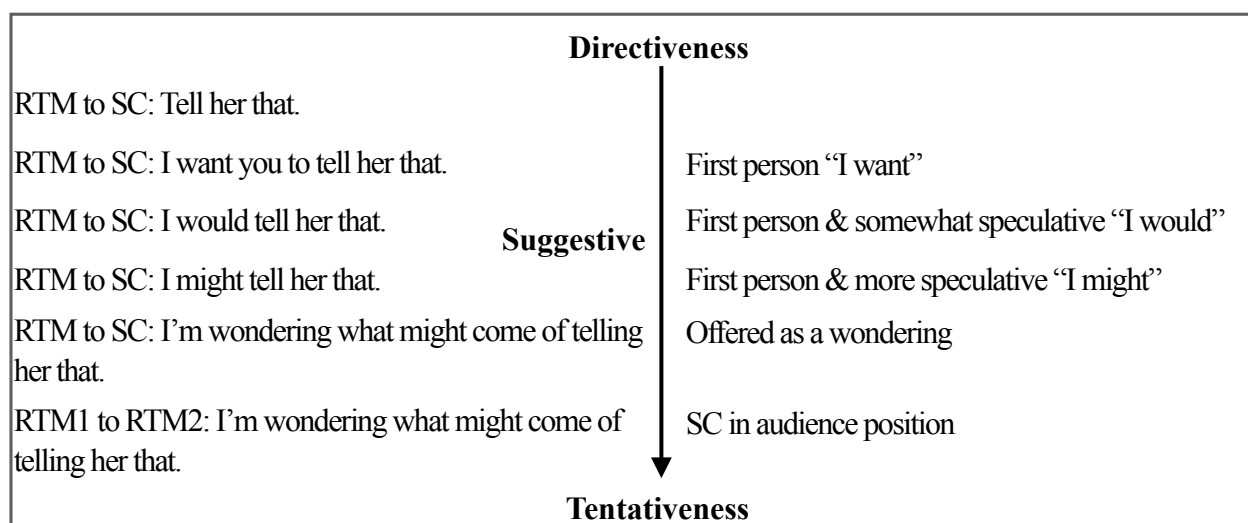
RTM1: Yeah

In addition to framing reflections as wonderings/curiosities, another notable difference between *Exemplar 65* and *Exemplar 66* is that the latter takes the structure of a more traditional reflecting team wherein RTMs speak with one another rather than speaking with the SC. This allows the SC to adopt what White (2000, 2007) refers to as the “audience position” in which they are “free to ingest, evaluate, reflect, take notes, all without the expectation of responding or even making eye contact” (Paré, 2016, p. 279). The lack of an audience position is evident in *Exemplar 65* as the SC responds with “Yeah” to the RTM’s reflections and it is suggested in *Exemplar 66* as RTMs engage with one another and not the SC. Sharing wonderings/curiosities rather than making suggestions and engaging in a reflecting format that allows the SC to adopt an audience position are practices that demonstrate tentativeness towards the SC because they support the SC’s ability to “tak[e] in reflections without social pressure to signal agreement, collecting and discarding input in accordance with their discernment of its utility” (Paré, 2016, p. 277).

As with the tentativeness of counsellors' utterances generally, tentativeness towards SCs can perhaps best be understood in terms of a continuum. Figure 2 draws on the utterance "I would tell her that" from *Exemplar 65* to illustrate a possible manifestation of such a continuum.

**Figure 2**

*Continuum of Tentativeness Towards Sharing Counsellor*



*Note.* A visual representation of a possible continuum ranging from directiveness to tentativeness; variations of the utterance "I would tell her that" are presented on the left and changes in language that contribute to tentativeness are identified on the right.

Highly directive reflections, represented in Figure 2 by the statements "Tell her that" and "I want you to tell her that", were not present in the transcripts but have been included in my hypothetical continuum to provide contrast. In addition to those identified in *Exemplar 65*, examples of reflections within the suggestive realm included:

*Exemplar 67*

RTM: You could make a list.

SC: Mhm

RTM: You could be really practical. Um, I think that would maybe be a helpful thing.

*Exemplar 68*

RTM: You could thicken that a little if [you] chose and say, “It sounds like you’re

ST1: [Mhm]

RTM: surprising yourself.”

ST2: Mhm

*Exemplar 69*

RTM: So, you might ask her what she’s fighting for. Like, what is that voice an initiative towards? Right? Like, and that might be values. The more she can bring it to life, the more she will know how to be in it.

SC: Mhm

While these exemplars demonstrate various degrees of tentativeness towards the SC depending on the language used, for example the inclusion of “if you chose” in *Exemplar 68* or “might” in *Exemplar 69* increase tentativeness, they all involve suggestions directed at SCs. The reflection “I think that would maybe be a helpful thing” in *Exemplar 67* illustrates the complexity that can arise when assessing tentativeness. The statement itself is quite tentative, it is spoken in the first person (“I think”) and involves a variety of speculative language (“think”, “would”, and “maybe”), however when spoken directly to the SC alongside clear suggestions (“You could make a list” and “You could be really practical”), I would argue it serves to strengthen the suggestive nature of the reflections. That being said, it could also be argued that by explicitly recognizing the suggestions as the RTM’s personal ideas, the statement “I think that would maybe be a helpful thing” softens the suggestions and actually increases tentativeness vis-à-vis the SC.

Acknowledging the potential complexities within reflections that I have characterized as suggestive, as previously mentioned, I found there to be a useful distinction between such reflections and those framed as wonderings/curiosities and shared in exchanges between RTMs. In addition to those offered in *Exemplar 66*, other reflections of this kind included:

*Exemplar 70*

RTM: So I'm wondering, you know, what might she need in her life, what kind of skills might she want to build upon to be able to accept where she is right now and I'm kind of curious about that.

*Exemplar 71*

RTM: Um, I'm curious about where he is right now in the healing process and what that wound might look like and, as well as what it might need.

*Exemplar 72*

RTM: {...} this whole emotional sensitivity, which I, I've heard about from other people with a diagnosis of autism, um, like there's— I wonder how much of that is helpful and how much of it is not so helpful. Like, are there ways that she's able to, uh, contain the amount that she receives from other people, um, or not allow it in if it's too much.

Regardless of the tentativeness with which they are presented, RTMs' reflections during intersession breaks have the potential to support the SC's work in a number of ways, a topic that will be considered in detail in the Discussion chapter. For example, both "So, you might ask her what she's fighting for" from *Exemplar 69* and "So I'm wondering, you know, what might she need in her life, what kind of skills might she want to build upon to be able to accept where she is right now" from *Exemplar 70* identify specific questions that the SC could take back to session with them. As I have argued throughout this section, however, the latter is more aligned with narrative therapy practice as it embodies greater tentativeness towards the SC and their discernment process about what is useful.

Finally, I would like to address the reality that there were not always enough counsellors present for a traditional multi-person reflecting team to occur, which would seemingly preclude the SC from adopting the audience position. Although it did not occur during the intersession breaks examined in this study, there is the possibility of engaging in what Freedman and Combs (1996) refer to as a “single-member reflecting team”. In a single-member reflecting team, a counsellor reflects aloud while, in this case, the SC is able to assume the socially-disengaged listening position.

This chapter thoroughly examined four conversational practices identified as central in my analysis as well as related sub-practices. The four primary practices were: (a) counsellors engaging in externalization, (b) counsellors orienting to possible alternative narratives, (c) counsellors centring the person visiting the clinic, and (d) counsellors demonstrating tentativeness. I will now turn to a discussion of my results and offer concluding remarks.

## Chapter 6: Discussion

*In sessions where I feel like I am drowning in content, intersession breaks are vital in recentering my focus and giving me new ideas for the second half of the session. (Research Participant)*

*The break gives you a chance to come up for air, gain support, and perspectives {...} Having the option of breaking means you can try and do your best work with each client, and carry problems together instead of alone. (Research Participant)*

*I find the intersession break a great opportunity to slow down a therapy session, step back and reflect which all enable a much richer experience for the clients. (Research Participant)*

The above quotations were taken from SCs' responses in the Questionnaire Regarding Intersession Break, which they completed as part of data collection. What stands out for me is the notion of intersession breaks as a respite and as a source of support for their work with people in session. While it is beyond the scope of this research to explore the myriad ways intersession breaks might contribute to walk-in counselling work, I would like to briefly consider what the conversational practices identified in my analysis might offer. I will then reflect on some specific aspects of my results; discuss research relevance; comment on the study's delimitations; and present possible directions for future research. Drawing on White's (2007) notion of "katharsis", this chapter will conclude with a reflection on how engaging in this research has impacted me personally and professionally.

### **Contributions of Conversational Practices to Walk-In Counselling Work**

White and Epston (1990) describe how, from the perspective of narrative therapy, “meaning is derived through the structuring of experience into stories, and ... the performance of these stories is constitutive of lives and relationships” (p. 12). This performance is not a solitary endeavour but occurs interpersonally and within a sociocultural context: identity is “a public and social achievement, not a private and individual achievement” (White, 2005, p. 215). In intersession breaks informed by narrative therapy, one might ask, “What stories about a person – their identity, relationships, and life – are being co-constructed by the counselling team?” I believe practices of (a) engaging in externalization, (b) orienting to possible alternative narratives, (c) centring the person visiting the clinic, and (d) demonstrating tentativeness contribute to stories that honour the dignity and knowledge of people accessing services. These practices take on particular importance in settings where counsellors are speaking about people without the people present, as there may be an increased tendency to foreground expert knowledge or engage with discourses of pathology.

The stories constructed during intersession break consultations have the potential to impact a counsellor’s work in many ways. Firstly, I would like to recognize that one of the central ideas within narrative therapy is that when people are not tied to problem-saturated stories, possibilities open up that were previously unimaginable and could not have been predicted. I believe that the conversational practices identified support “possibilities ... to journey to places that we could never have predicted journeying to” (White, 2000, p. 98) within intersession breaks themselves and, by extension, in a counsellor’s work when they return to session. Secondly, I believe my Results chapter points to two concrete things that SCs could take

back to session with them following an intersession break: (a) outsider witnessing-type retellings and (b) specific areas of inquiry.

### ***Outsider Witnessing-Type Retellings***

In the Interpretive Framework chapter, I discuss White's (1995, 2000, 2007) application of the concept of "definitional ceremony" to reflecting team processes, in which RTMs are understood as "outsider witnesses" to people's preferred narratives and engage in "retellings" that strengthen these narratives. Definitional ceremonies necessitate the presence of the person accessing services and are, therefore, not possible within intersession break consultations. However, present throughout counselling teams' conversational practices in intersession breaks were retellings congruent with outsider witnessing, that is, retellings within the landscapes of action and identity oriented to possible alternative narratives. For example:

#### *Exemplar 12*

RTM: Umm, well I guess I was thinking about, um, how many areas of her life she seems to be feeling pretty good about. Um, and that that doesn't happen without, uh, quite a bit of work and reflection on her, her part. Um, in particular, the word compassion has stood out for me from the beginning. And it sounds like she's able to, um, at least in what she's presenting to {the SC}, she's able to, uh, express some compassion towards herself.

This is an example of an outsider witnessing-type retelling that the SC could relay to the person in session to see if it resonates for them and whether it might be part of an emerging alternative narrative.

A number of SCs' responses in their questionnaires regarding intersession breaks suggest that engaging in outsider witnessing-type retellings were useful. One SC wrote: "We spoke about the client's energy to keep motivated despite the influence of the depression which lead me to use the word 'readiness'. There seemed to be a readiness for the client to talk about these things."

SCs also mentioned that the break was useful “to highlight the client’s subordinate story line” and in “highlighting areas of strength for the client”. Considering which moments from their break most stood out, one SC stated that “The biggest moment was talking about how the client described herself as not good at talking about problems, but we reflected on break that as she speaks we as clinicians hear that she is open, ready, willing and is clear when she talks.”

### *Specific Areas of Inquiry*

Combs and Freedman (2012) state that “narrative therapy is a therapy of questions” (p. 1043). Situated in a social constructionist understanding of knowledge, the purpose of questions in narrative therapy is not to gather information but to “*co-author* experience” (Freedman & Combs, 1996, p. 116). Evident throughout the exemplars in the Results chapter are narrative therapy-informed areas of inquiry and questions that the therapist might explore with the person upon returning to session. For example, *Exemplar 8* identifies an area of inquiry oriented to exploring the effects of a problem:

#### *Exemplar 8*

RTM1: {...} I think I’m still curious how that fee– how that problem is impacting the relationship in his mind.

RTM2: How depression is getting in the way of the relationship?

RTM1: Yeah, yeah.

*Exemplar 21* involves questions related to the landscape of identity:

#### *Exemplar 21*

RTM1: Yeah, I’m also curious about the stipulation that he receive counselling before they enter into couples counselling.

RTM2: Aha

RTM1: And, uh, what value he sees in that, or what goals he has for himself in that.

In their questionnaire regarding intersession breaks, one SC stated, “I believe {a RTM} asked the question ‘what would the client call her efforts of not accepting her ex’s invitations to fight’ and this enabled a conversation about all the ways the client was able to ‘keep it cool’”. Going to the transcript of this intersession break, the SC appears to be referring to the following exchange:

SC: And she had a lot of opportunities and invitations to lose her cool with him. And because the children were there, she didn’t.

RTM: She didn’t. Okay. Did she see it? She sees [that?]

SC: [Uh,] does she see him?

RTM: Uh, does she see—

SC: That?

E: [her] efforts in [2 that regard. Okay.]

G: [Yeah.] [2 Oh yes. Yes.]

E: What does she call that?

G: I don’t know but I can ask her.

The SC describes a possible unique outcome within the landscape of action (single underlined); the RTM calls attention to the possible unique outcome and wonders what the person would name it (double underlined). Based on the SCs’ response in the questionnaire, it sounds like taking this question back to session led to a useful exploration within the landscape of action that supported a preferred narrative related to how the person is able to “keep it cool”.

### **Reflecting on Results**

In *The Reflective Practitioner: How Professionals Think in Action*, Schön (1992) states that “professional knowledge is mismatched to the changing character of the situations of practice – the complexity, uncertainty, instability, uniqueness, and value conflicts” (p. 14). He describes how, when faced with complexity and uncertainty, professionals can seek “high, hard ground” that involves recourse to established knowledge and “may preserve his [*sic*] sense of

expertise at his clients' expense" (Schön, 1992, p. 45). In contrast to the certainty of the high, hard ground is the "swampy lowland", where professionals recognize the messiness of situations and engage with challenges by "trial and error, intuition, and muddling through" (Schön, 1992, p. 42). According to Schön, the swampy lowland is the realm of the reflective practitioner, and it is here that the "professional facade" drops and client and practitioner learn alongside one another. Schön applies his analysis to a variety of settings, including counselling contexts and research endeavours.

I bring in Schön's (1992) work because walk-in counselling is replete with complexity, uncertainty, instability, uniqueness, and value conflicts. On any given day, it is unknown how many people will visit the clinic and what support they will be seeking. Counselling teams are navigating time pressures, logistical concerns, a multiplicity of counsellor theoretical orientations, and a varying number of counsellors present for intersession break consultations. They may also be involved in training counselling interns and, as evidenced by the present study, contributing to research. Throughout this research process, I consistently bumped up against my desire for high, hard ground when trying to make sense of this dynamic practice context. My hope is that the results presented in the manuscript reflect my wading into the messiness of the swamp and will therefore be useful to actual practice contexts. I would also like to say that I believe narrative therapy is well-suited to navigate the swampy lowland of therapeutic practice in that it values multiplicity, possibility, and the co-construction of knowledge, which help guard against the impulse to retreat into expertise.

## **Research Relevance**

This research may be of interest to anyone curious about narrative therapy practice, walk-in counselling processes, and consultation contexts informed by postmodern therapeutic approaches. However, it is most directly relevant to counsellors working in walk-in clinics and to agencies offering SST involving narrative-informed intersession breaks. With the intention of supporting the use of narrative therapy practices in walk-in counselling intersession breaks, I would like to offer various questions informed by my analysis that counsellors might ask themselves. In doing so, I am drawing on Freedman and Combs' (1996) suggestion that questions, rather than guidelines, are more congruent with a postmodern worldview. I will organize questions by the counsellors' role in the intersession break as either a SC or a RTM.

### ***Sharing Counsellors in Intersession Breaks***

Questions to consider when providing an account of the session thus far to the counselling team:

- Am I endeavouring to adhere to what this person shared in session?
- Am I using this person's specific language when possible?
- Am I speaking about this person's concern(s) as separate from their identity?
- Am I speaking about the effects of the concern(s) on this person's life?
- Am I sharing events or actions that are part of a preferred narrative for this person?
- Am I describing intentions, beliefs, commitments, motivations, values, realizations, or learnings that are part of a preferred narrative for this person?
- Am I using speculative language and speaking in the first person when sharing my own ideas?

### ***Reflecting Team Members in Intersession Breaks***

Questions to consider as you listen to the SCs' account of the session thus far:

- Am I listening for the effects of this person's concern(s) on their life?
- Am I listening for events or actions that could support a possible alternative narrative?
- Am I listening for intentions, beliefs, commitments, motivations, values, realizations, or learnings that could support a possible alternative narrative?

Questions to consider as you offer reflections in response to the SCs' account:

- Am I keeping what this person shared with the SC during session at the centre of my reflections?
- Am I using this person's specific language when possible?
- Am I speaking about this person's concern(s) as separate from their identity?
- Am I reflecting on events or actions that stood out to me and could support a possible alternative narrative?
- Am I reflecting on intentions, beliefs, commitments, motivations, values, realizations, or learnings that stood out to me and could support a possible alternative narrative?
- Am I using speculative language and speaking in the first person when sharing my ideas?
- Am I framing reflections as wonderings/curiosities and not suggestions?
- If I am the only RTM, would it be helpful to engage in a single-member reflecting team so that the SC can adopt a socially-disengaged listening posture?

## **Delimitations**

O’Leary (2014) refers to delimitations as “a study’s boundaries or how your study was deliberately narrowed by conscious exclusions and inclusions” (p. 76). Of the many methodological decisions made throughout my research process, I will address three that stand out as particularly relevant. Firstly, aside from specific instances where it was directly relevant to an analysis, I decided not to distinguish between clinics, counsellors, or people visiting the clinics in my Results chapter. My analysis highlights instead the roles of sharing counsellor and reflecting team members. The reasoning for this is twofold: (a) the lack of consistent pseudonyms further protects the confidentiality of participants and (b) I felt my research question could be addressed more clearly by providing an overview of contextual information in my Methods section and then honing in on specific contextual information only as necessary. Secondly, I did not distinguish between counsellors acting as the “lead” or “supervisor” at clinics from other members of the reflecting team. The power differentials in these roles are worth acknowledging, however, I felt including this consideration was beyond the scope of my analysis. Finally, my transcription did not include non-verbal or paralinguistic elements of language such as body language, length of pauses, and emphasis. Although these are certainly important elements of communication, I did not feel they were necessary for my research purposes.

## **Future Research Possibilities**

While empirical literature related to two of the three central topics of this research, namely narrative therapy and walk-in counselling, is abundant and growing, I was unable to locate research on intersession breaks in walk-in counselling. The present study has provided one

vantage point from which to consider the topic, however, there is a need for a variety of investigations given the popularity of walk-in counselling and the role of intersession break consultations within this service modality.

Questionnaires regarding intersession breaks collected in this study suggest that breaks play a significant role in counsellors' walk-in work. Future research exploring the experiences of both counsellors and people accessing services would be valuable, perhaps drawing on ethnographic or phenomenological methodologies. Other potential areas for inquiry that stand out include considering how intersession breaks might be impacted by:

- whether a counsellor is engaged in an individual, couple, or family session;
- the number of counsellors on a counselling team;
- the use of various intersession break structures, including those where people accessing services are present for the break; and
- power dynamics present in counselling teams, which might take into account factors such as counsellors' amount of experience, role within the team, race, gender, etc.

### **Katharsis**

In *Maps of Narrative Practice*, White (2007) describes an experience as kathartic “if one is moved by it – moved not just in terms of having an emotional experience, but in terms of being transported to another place in which one might ... reconnect with revered values and purposes for one's life” (p. 195). The opportunity to not only witness counselling teams' conversations during intersession breaks, but to engage with transcripts of these conversations in such an in-depth manner has been incredibly impactful. Narrative therapy theory, with which I have been enamoured since first encountering the approach, came to life in counsellors'

conversational practices in ways that were nuanced, innovative, and idiosyncratic. Engaging in this research has illuminated possibilities for translating my values and purposes into specific practices within professional settings. I feel committed to centring the lived experiences and knowledges of people accessing services; de-centring expert knowledge; and supporting the co-construction of narratives that are non-pathologizing, that align with people's preferences, and that open up new possibilities.

I am currently working in a team-oriented counselling context that, while different from walk-in counselling, involves significant collaboration and consultation. When seeking support or responding to what a colleague has shared, I find myself drawing on the practices identified in this research of externalization, orienting to alternative narratives, centring the person accessing services, and demonstrating tentativeness. In particular, I often ask myself questions along the lines of those articulated in the Discussion chapter, such as "Am I speaking about this person's concern as separate from their identity?" or "Am I using speculative language and speaking in the first person when sharing my ideas?". As this research experience comes to completion, I am reflecting on the formative role it has played in my personal and professional life and am curious how it will continue to inform my values, purposes, and practices moving forward.

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## Appendices

### Appendix A: Recruitment Email to Walk-In Counselling Clinics

Dear [*Director of clinic*],

I would like to invite [*Name of clinic*] to participate in a research study conducted by myself, Tess Rhodes, under the supervision of Professor David Paré and funded by the Social Sciences and Humanities Research Council. The research is being conducted as part of my master's thesis in Counselling Psychology at the University of Ottawa's Faculty of Education and has received ethics approval from the university's Office of Research Ethics and Integrity.

The purpose of the study is to examine counsellors' talk during the intersession break consultations that occur partway through sessions in walk-in counselling. It will focus on intersession breaks in clinics that are informed by narrative therapy approaches to walk-in counselling. Although an important part of the walk-in counselling process, intersession breaks have been given little attention in the clinical and research literature. By contributing to a greater understanding of how intersession breaks are used by counsellors in walk-in counselling, the study has the potential to inform counsellors and mental health agencies implementing walk-in services. In turn, it may benefit clients visiting walk-in counselling clinics.

Participation in this study would involve my videotaping two to three intersession break consultations between participating counsellors on the walk-in counselling team over the course of one workday at [*Name of clinic*]. I would be present in the room where the counselling team meets in order to operate the video camera and to take notes. On this day, I would meet with participating counsellors half an hour prior to the opening of the clinic to go over how the study would be conducted and to answer any questions counsellors may have. Counsellors would complete a consent form and a demographic questionnaire. They would also be given instructions for obtaining informed consent from their clients. Consent to videotape consultations regarding their sessions would be obtained from clients. However, if a counsellor got the sense that asking a certain client to participate might negatively impact the client in any way, the counsellor would be under no obligation to mention the study. The wellbeing of clients would be of primary importance. Finally, counsellors who receive consultation in an intersession break that is recorded for the study would be asked to complete a brief questionnaire.

In terms of risks, participation in this study may be a minor inconvenience to counsellors; however, every effort would be made to minimize interference with their work. All information gathered would remain strictly confidential and would only be used for the purposes of the research study and any related publications. Video and audio recordings would be used for

analysis purposes only and would not be seen or heard by anyone other than Professor Paré and myself. All data collected would be kept in a secure manner in a locked filing cabinet and in password-protected computer files. In the written thesis, any identifying information, such as names and places, within the data would be removed or altered as needed to protect counsellors' anonymity and that of the clinic.

**If [*Name of clinic*] is interested in participating in this study, please inform Tess Rhodes [*email, phone number*] or Professor David Paré [*email*] by [*date*].** We would also welcome any questions or concerns you may have. Attached is a recruitment letter that I would ask you to distribute via email to counsellors working in [*Name of clinic*] should the clinic choose to participate.

Thank you for your time and consideration.

[*Signature*]

## Appendix B: Recruitment Email to Walk-In Counselling Counsellors

Dear Counsellor,

My name is Tess Rhodes and I am a master's student in Counselling Psychology at the University of Ottawa's Faculty of Education. My thesis research, which is supervised by Professor David Paré and funded by the Social Sciences and Humanities Research Council, will look at intersession breaks in walk-in counselling. The Walk-In Counselling Clinic at [*Name of clinic*] has expressed an interest in participating in this research. I would like to provide you with information about the study and invite you to participate. Please take note of the instructions at the end of this letter for informing me if you are interested in participating.

**Purpose of Study:** The purpose of the study is to examine counsellors' talk during the intersession break consultations that occur partway through sessions in walk-in counselling. It will focus on breaks in clinics that are informed by narrative therapy approaches to walk-in counselling.

**Participation:** Participation would involve my videotaping two to three intersession break consultations between counsellors on the walk-in team over the course of one workday at [*Name of clinic*]. I would be present in the room where the counselling team meets in order to operate the video camera and take field notes. On this day, participating counsellors would meet with me half an hour before the clinic opens to go over how the study will be conducted and for me to answer any questions you or your colleagues may have. You would be asked to sign a consent form and complete a brief demographic questionnaire. If you are one of the counsellors who receives consultation in an intersession break that is recorded for the study, then you would also be asked to complete a questionnaire related to that specific intersession break. The questionnaire would take approximately 15 minutes and would be completed at your convenience sometime during your workday.

**Seeking Client Consent:** Consent to videotape consultations regarding their sessions would be obtained from clients. I would ask you to provide clients with a brief explanation of the study based on a script and to have clients sign a consent form at the beginning of your sessions alongside the clinic's standard procedures of discussing confidentiality and consent. As part of this process, clients would be reassured that their participation is completely voluntary and you would double check with clients directly before the intersession break to ensure that they are still comfortable having the consultation about their session recorded. Furthermore, if you were to 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 or not to mention the study to this client. The wellbeing of clients would be of primary importance.

**Benefits:** Although an important part of the walk-in counselling process, intersession breaks have been given little attention in the clinical and research literature. By contributing to a greater understanding of how intersession breaks are used by counsellors, the study has the potential to benefit counsellors and agencies offering walk-in counselling as well as the clients they serve. Furthermore, I will provide counselling teams with a summary of findings relevant to the intersession breaks recorded at their clinic, which may be useful for reflecting on practices.

**Risks:** In terms of risks, participating may be a minor inconvenience during your workday and having your consultations videotaped could elicit some discomfort; however, every effort would be made to minimize interference with your work and to reduce any discomfort.

**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 write-up so as to protect the anonymity of counsellors, clients, and the clinic. Clients' anonymity would also be protected by referring to them by the initial of their first name during the recording of intersession breaks. The recordings would only be used to transcribe the conversations that take place and would only be viewed by the researcher and her supervisor. The recordings would be kept in password-protected files on the researcher's computer and would be deleted once her thesis is submitted. All other data gathered would be conserved for five years in a locked filing cabinet, after which it time it would be shredded.

**Voluntary Participation:** Your participation in the study is entirely voluntary and can be withdrawn at any point throughout the study up until the researcher's thesis is submitted to the University of Ottawa. If you do not wish to participate, it will still be possible for your colleagues at [*Name of clinic*] to take part in the study if they are interested in doing so. There will be no negative consequences to your work at [*Name of clinic*] should you choose not to participate.

**If you are interested in participating in this study, please inform Tess Rhodes [*email, phone*] or Professor David Paré [*email*] by [*date*].** We would also welcome any questions or concerns you may have.

Thank you for your time and consideration.

[*Signature*]

## Appendix C: Counsellor Consent Form

*Constructing Consultation: A Discourse Analysis of Counsellor  
Conversational Practices in Walk-In Counselling Intersession Breaks*

### Researchers and Contact Information:

Tess Rhodes  
MA Candidate  
University of Ottawa  
[Contact information]

David Paré, Ph.D  
Thesis Supervisor  
University of Ottawa  
[Contact information]

**Invitation:** I am invited to participate in a research study conducted by Tess Rhodes under the supervision of Professor David Paré and funded by the Social Sciences and Humanities Research Council.

**Purpose of the Study:** I understand that the purpose of this study is to examine counsellors' talk during intersession breaks in narrative therapy-informed walk-in counselling clinics.

**Participation:** My participation will involve the researcher audio and video recording two to three intersession break consultations between my colleagues and myself over the course of one workday at [Name of clinic]. On this day, I will be asked to meet with participating counsellors half an hour before the clinic opens so that the researcher can explain the study and answer any questions. I will also be asked to complete a demographic questionnaire, which will take approximately 10 minutes. Throughout the day, I understand that the researcher will be present in the room where the walk-in counselling team meets and will take field notes based on her observations of our consultations. In my sessions with clients on this day, I will provide them with an explanation of the study and have them sign a consent form. I will re-confirm their consent to participate directly before leaving to consult with the counselling team. However, I understand that I am under no obligation to present the study to clients whom I sense might be negatively affected in any way by being asked to participate. Finally, I may be asked to complete a questionnaire regarding specific intersession breaks, which will take approximately 15 minutes and is to be completed at my convenience and submitted to the researcher by the end of the day.

**Risks:** My participation in this study may be a minor inconvenience in my workday as it will entail meeting a half an hour before the clinic opens, completing two questionnaires and obtaining informed consent from clients for their participation. I may also experience some discomfort at having my consultations with colleagues videotaped. I have received assurance from the researcher that every effort will be made to minimize

interference in my workday and to reduce any discomfort I may experience.

**Benefits:** By contributing to a greater understanding of how intersession breaks are used by counsellors, the study has the potential to benefit counsellors and agencies offering walk-in counselling as well as the clients they serve. Furthermore, I will be provided with a summary of study findings relevant to the intersession breaks recorded at [*Name of clinic*], which may be useful for reflecting on the counselling teams' practices.

**Confidentiality:** I have received assurance from the researcher that all information gathered will 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 will be removed or altered in the write-up so as to protect the anonymity of counsellors, clients, and the clinic. The recordings of breaks will only be used to transcribe the conversations and will only be viewed by the researcher and her supervisor. The recordings will be kept in password-protected files on the researcher's computer and will be deleted once her thesis is submitted. All other data gathered will be conserved for five years in a locked filing cabinet, after which it will be shredded.

**Voluntary Participation:** I understand that my participation in this study is entirely voluntary and can be withdrawn at any point up until the researcher's thesis is submitted. If I do not wish to participate, I understand that it will still be possible for my colleagues at [*Name of clinic*] to take part in the study if they are interested in doing so. There will be no negative consequences to my work at [*Name of clinic*] should I choose not to participate.

**Acceptance:** I, \_\_\_\_\_ [*Name of participant*], agree to participate in the research discussed above. This study is being conducted by Tess Rhodes for her master's thesis 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 researcher or her supervisor at the contact information provided above.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research at the University of Ottawa:

[*Contact information*]

There are two copies of the consent form, one of which is mine to keep.

Participant's Signature: \_\_\_\_\_

Date:

Researcher's Signature: \_\_\_\_\_

Date:

**Appendix D: Notice of Research at [Name of clinic]**

Dear Client,

About halfway through your session, your counsellor will leave to consult with a group of counsellors in another room. This midsession “break” is a normal part of walk-in counselling and its purpose is to allow your counsellor to gather helpful input for your work together. There is a research study being conducted today by a graduate student from the University of Ottawa that is looking at the conversations between counsellors during midsession breaks. Your counsellor may ask whether you would like to participate in this research.

If you agree to participate, then the conversation between your counsellor and his or her colleagues during the midsession break may be audio and video recorded. The researcher may also take notes during the break as part of data collection. The focus of the research is on what happens in the break and not on clients or their sessions. You would **not** be speaking with the researcher and at **no time** would you be recorded.

We understand that you have come to the clinic seeking support for your concerns and whether you choose to participate in the research study will have no impact on your session. It is completely understandable if you do not want your counsellor’s conversation with colleagues recorded.

If you are invited to participate in this research, you will be provided with further information on the study including its risks, benefits, and how your information will be kept confidential. This will allow you to make an informed decision about whether or not to participate.

Thank you for your time.

[Signature]

## Appendix E: Counsellor Script for Informing Clients of Study

The following script will assist you in explaining the study so that clients can make an informed decision about whether to participate. Please modify as you see fit, while ensuring that all the information is adequately explained. If a client wishes to participate, please have them read and sign a consent form and give them a copy. Then, before you leave for the intersession break, please confirm their desire to participate and indicate that you have done so by checking the box at the bottom of their consent form.

*There is a research study being conducted at [Name of the clinic] today by a graduate student from the University of Ottawa. She is researching the “breaks” that I mentioned take place partway through walk-in counselling sessions. You are invited to participate in this research, which would involve my conversation with the counselling team during the break being audio and video recorded. The focus of the research is on the counselling team’s conversations and not on clients or their sessions. You would not be speaking to the researcher and you would at no time be recorded.*

*Your participation in the study entails no foreseeable risks. However, if you begin to experience any discomfort, you can let me know and withdraw without any problem. Participating in this study will increase understanding of the use of midsession breaks in walk-in counselling, which could benefit counsellors and agencies offering walk-in counselling as well as the clients they serve.*

*If you choose to participate, I would refer to you only by the initial of your first name during the break so that your name would not be included in the recordings. More information on how your confidentiality would be protected is detailed in the consent form.*

*I understand that you have come to the clinic seeking support for your concerns and whether you choose to participate in this study will have no impact on our session together. It is completely understandable if you do not want my conversation with the counselling team recorded. If you agree to participate, I will ask that you read and sign a consent form. I will also confirm your desire to participate right before I leave to talk with the counselling team.*

*Please let me know if you have any questions and if I cannot answer them, I will inquire with the researcher, as she is onsite.*

## Appendix F: Client Consent Form

### *Constructing Consultation: A Discourse Analysis of Counsellor Conversational Practices in Walk-In Counselling Intersession Breaks*

#### **Researchers and Contact Information:**

Tess Rhodes  
MA Candidate  
University of Ottawa  
[Contact information]

David Paré, Ph.D  
Thesis Supervisor  
University of Ottawa  
[Contact information]

**Invitation:** I am invited to have today's session contribute to a study being conducted by the researchers above and funded by the Social Sciences and Humanities Research Council. My counsellor has explained that he or she will take a midsession "break" to consult with counsellors in another room in order to gather helpful input for our work together. This is standard practice in walk-in counselling. The purpose of this study is to look at what happens in the midsession break. The focus is on counsellors' conversations and not on me or my session.

**Participation:** Participating in this study means that my counsellor's conversation with colleagues during the midsession break may be audio and video recorded. The researcher may also take notes during the break as part of data collection. I understand that I will not be speaking with the researcher and that at no time will I be recorded.

**Risks:** My participation in this study entails no foreseeable risks. However, if I experience any discomfort, I realize that I can withdraw from the study at any time without any negative consequences.

**Benefits:** My participation in this study will increase understanding of the use of midsession breaks in walk-in counselling. This could benefit counsellors and agencies offering walk-in counselling as well as the clients they serve.

**Confidentiality:** In order to protect my confidentiality, my counsellor will refer to me by the initial of my first name during the midsession break and any information that could be used to identify me will be altered in the write-up of the study. Recordings of the break will only be used to transcribe the conversation and will only be viewed by the researcher and her supervisor. The recordings will be kept in password-protected files on the researcher's computer and will be deleted once her thesis is submitted. Transcripts will be conserved for five years in a locked filing cabinet,

after which they will be shredded. Data collected will only be used for the purposes of the research study and any related publications.

**Voluntary Participation:** I understand that it is my choice whether I want to participate in this study and that my session will in no way be affected if I choose not to. If I participate but change my mind later, I can contact the researcher up until the time that her thesis has been submitted to ask her to destroy any data related to my session. Finally, my counsellor will confirm my desire to participate before he or she leaves for the midsession break.

**Acceptance:** I, \_\_\_\_\_ [*Name of participant*], agree to participate in the research discussed above. This study is being conducted by Tess Rhodes for her master's thesis 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 researcher or her supervisor at the contact information provided above.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research at the University of Ottawa:

[*Contact information*]

There are two copies of the consent form, one of which is mine to keep.

Participant's Signature: \_\_\_\_\_

Date:

Researcher's Signature: \_\_\_\_\_

Date:

Counsellor confirmed client's consent before leaving to consult with the team:

**Appendix G: Counsellor Demographic Questionnaire**

1. Name: \_\_\_\_\_
2. Age: \_\_\_\_\_ 3. Gender identity: \_\_\_\_\_
4. Highest degree completed and name of institution: \_\_\_\_\_  
\_\_\_\_\_
5. How long have you been working in the field of counselling? \_\_\_\_\_  
\_\_\_\_\_
6. Please list any professional designations (e.g. CCC, RP, RSW, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. What counselling theories or approaches most resonate with you as a counsellor (not specific to your walk-in work): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. How long have you worked at [*Name of clinic*]?  
\_\_\_\_\_
9. What counselling theories or approaches do you most draw on in your walk-in counselling work? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Have you received any training in narrative therapy? If so, please list specific training completed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. Please share any other demographic information you believe may be relevant:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



