A Sequential Analysis of Therapist Scaffolding and Child Concept Formation in Narrative Therapy

Heather Ramey, M.A.

Child & Youth Studies

Submitted in partial fulfillment of the requirements for the degree Master of Arts

Faculty of Social Science, Brock University

St. Catharines, Ontario
© October, 2007
A SEQUENTIAL ANALYSIS OF THERAPIST SCAFFOLDING AND CHILD CONCEPT FORMATION IN NARRATIVE THERAPY

Heather Ramey, 2007
Child & Youth Studies
Brock University

ABSTRACT

Narrative therapy is a postmodern therapy that takes the position that people create self-narratives to make sense of their experiences. To date, narrative therapy has compiled virtually no quantitative and very little qualitative research, leaving gaps in almost all areas of process and outcome. White (2006a), one of the therapy’s founders, has recently utilized Vygotsky’s (1934/1987) theories of the zone of proximal development (ZPD) and concept formation to describe the process of change in narrative therapy with children. In collaboration with the child client, the narrative therapist formalizes therapeutic concepts and submits them to increasing levels of generalization to create a ZPD. This study sought to determine whether the child’s development proceeds through the stages of concept formation over the course of a session, and whether therapists’ utterances scaffold this movement.

A sequential analysis was used due to its unique ability to measure dynamic processes in social interactions. Stages of concept formation and scaffolding were coded over time. A hierarchical log-linear analysis was performed on the sequential data to develop a model of therapist scaffolding and child concept development. This was intended to determine what patterns occur and whether the stated intent of narrative therapy matches its actual process.
In accordance with narrative therapy theory, the log-linear analysis produced a final model with interactions between therapist and child utterances, and between both therapist and child utterances and time. Specifically, the child and youth participants in therapy tended to respond to therapist scaffolding at the corresponding level of concept formation. Both children and youth and therapists also tended to move away from earlier and toward later stages of White's scaffolding conversations map as the therapy session advanced. These findings provide support for White's contention that narrative therapists promote child development by scaffolding child concept formation in therapy.
Acknowledgements

I wish to first and foremost thank my supervisor, Dr. Danny Tarulli, for his theoretical insights, mastery of grammar, and general guidance throughout this entire process. Thanks to my committee members for their feedback: Dr. Hans Skott-Myhre, for making me question the basis of everything I did; and Dr. Jan Frijters, for his keen review and excitement about residuals. As external reviewer, Dr. Susan Lollis offered valuable reminders about the importance of bidirectional process and the value of chaos in therapy. Lianne Fisher was both a co-coder and a good friend, and Dr. John McNamara provided much-appreciated reassurance and understanding.

Thank you to the therapists, Karen Young and Halton Child and Youth Services, and Scot Cooper and Haldimand-Norfolk Resources, Education and Counselling Help (REACH). Karen in particular gave her time and critical thinking over the past three years, and Scot, the worthwhile suggestion to look at scaffolding. Both were extremely generous with their resources and knowledge and regularly offered encouragement, and I hope this thesis does their efforts and thoughts justice. I would like to thank Michael White, whose work contributed to my own and also to my thinking over the past two years in ways that I never anticipated. Especially, I would like to thank the children, youth and families who were so willing to share the videos of their session with this research study and with me.

Finally, I would like to thank my family, who have learned more about narrative therapy and graduate school than they could have ever wished to, and especially John and Tonia, for their patience and support.
Table of Contents

ABSTRACT 2

Table of Contents 5

List of Figures and Tables 7

List of Appendices 8

INTRODUCTION 9

The Theory and Practice of Narrative Therapy 10

Stories and Text 10

Bateson 13

Deconstructing and Re-authoring 16

The Social Construction of Stories 18

Foucault 20

Concept Formation and the Zone of Proximal Development 22

The Turn to Vygotsky in Mapping Narrative Conversations 26

Review of the Literature 29

Outcome Studies 29

Process Studies 36

Reflecting Teams 40

Other Narrative Therapy Writings 44

Future Directions 46

Sequential Analysis 48

A Brief Overview 48

Sequential Analysis in Family Therapy 51
Rationale

Change and Child Development in Narrative Therapy

Research Questions

METHOD

Participants

Procedure

Coding System

Interrater Agreement

RESULTS

Analysis

Results of Log-Linear Analysis

DISCUSSION

Research Questions

Theoretical Implications

Limitations and Future Research

Power and dominant discourses

Conclusion

Appendix A: Scaffolding Conversations Map

Appendix B: Child Consent Form (Under 12)

Appendix C: Child/Youth Consent Form (12 and over)

Appendix D: Parent Consent Form

Appendix E: Ethics Clearance Form

Appendix F: Coding Manual

Appendix G: Parameter Estimates for Second-Order Effects
List of Figures and Tables

Table 1. Coding Scheme

Table 2. Significance Tests for Hierarchical Model of Therapist Scaffolding and Child Concept Formation over Time

Table 3. Frequencies of Coding for Therapist and Child Codes by Time Segment

Table 4. Adjusted Residuals of Therapist by Child Codes

Table 5. Adjusted Residuals of Therapist by Time Segment Codes

Table 6. Adjusted Residuals of Child by Time Segment Codes

Figure 1. Scaffolding conversations map
List of Appendices

Appendix A: Scaffolding conversations map 100
Appendix B: Child Consent Form (Under 12) 101
Appendix C: Child/Youth Consent Form (12 and over) 102
Appendix D: Parent Consent Form 104
Appendix E: Ethics Clearance Form 106
Appendix F: Coding Manual 107
Appendix G: Parameter Estimates for Second-Order Effects 129
INTRODUCTION

The use of narrative has become increasingly popular over the past two decades, as evidenced by the growth in narrative-related practice and literature across psychology, psychotherapy and related disciplines (Hardtke & Angus, 2002; Hevern, 2004; McAdams & Janis, 2002; O’Hanlon, 1994). Although the increasing interest in narrative therapy has shown little sign of ebbing, there is a paucity of research in the area. Studies that do exist more closely resemble therapeutic practice and anecdote than actual research, and have contributed little to an understanding of how narrative therapy works, what its targeted outcomes are, and whether it is effective in reaching them.

In an era overwhelmed by calls for accountability and evidence-based practice (e.g., Hayes, Barlow, & Nelson-Gray, 1999), narrative therapy seems to have resisted the outcry without fully engaging in the dialogue. It is justifiably argued that funders, the general public, and especially those being served deserve an indication of what they can expect when they are devoting their energy, resources, and sometimes most intimate life stories into collaborative work with therapists. At the same time, it seems that narrative practitioners and researchers have quite rightly not attempted some research goals, which risk participation in a scientific culture seeking to elevate therapist knowledge beyond the possibility of full client participation and input. There have been some credible attempts to understand the process of narrative therapy, but until recently there has been a lack of unity in efforts to even articulate theoretical questions about its overarching intentions and framework. This inevitably has repercussions for narrative therapy research, in that before any other questions can be broached further understanding is needed of narrative
therapy process. It is to be expected that the extant lack of empirical knowledge about process also negatively implicates its practice.

Recently, a revised model of narrative therapy emerged (White, 2006a, 2006b, 2007). Comprehending a newly Vygotskian theoretical framework for mapping narrative therapy, White’s recent re-conceptualization made the therapy more accessible to examination, and the intention of this study was to test the revised model from the vantage of developmental theory. To study the model’s unfolding over time, this research used sequential and log-linear analyses to document what occurs in therapy sessions, and to measure empirical process against White’s model of therapy.

In this thesis I will begin with a background of narrative therapy theory and practice, drawing mainly on the writings of Michael White. I will proceed to review the research literature, as it exists. To furnish a basis for the method used in this study, I will outline sequential analysis and provide some examples of its use in other family therapy literature. I will then attempt to consolidate narrative therapy’s theoretical and empirical history in the study’s rationale and will trace my methodology. Finally, I will present the results, and embark upon a discussion of the study’s findings, following which I proffer accompanying limitations and cautions, and potential directions for future narrative therapy research.

The Theory and Practice of Narrative Therapy

*Stories and Text*

White and Epston’s narrative therapy began evolving in the 1980s, and their foundational *Narrative Means to Therapeutic Ends* was published in North America in 1990. In this and other early writings by White, White and Epston drew on the theory of
philosophers and critical thinkers, such as Kenneth Gergen and Michel Foucault, and they applied this theory to their practice, creating a new model of family therapy—a model built around the metaphor of stories and storytelling.

White and Epston (1990) began exploring their story metaphor with the help of psychologists Mary and Kenneth Gergen’s (1984) description of social constructionism. An intrinsic component of postmodernism, social constructionism states that much of what we take to be real is actually a by-product of communal interaction (Gergen, 2001). Observation alone in these interactions is insufficient, and the questions of the objectivist paradigm become liable to suspension; in social constructionism, language is primary in directing and interpreting our observations. In order to make sense of the events and experiences in their lives, people rely on language; more specifically, people create self-narratives, plotting their experiences into stories. These stories determine the meanings people make of their lives (Gergen & Gergen, 1984).

Edward Bruner, an anthropologist and ethnographer, also believed that the story, or ordering narrative, dictates how people make sense of their journeys in life (White & Epston, 1990). Bruner conducted ethnographies of aboriginal peoples in North America. He argued that in the 1930s and 1940s aboriginal culture was seen as breaking down into disorganization in its inevitable transition toward assimilation into the dominant culture. In the 1950s there was a shift to see this disorganization as resistance, and this new meaning supported a movement to reclaim aboriginal land rights. Bruner determined that “narrative structures organize and give meaning to experience, but there are always feelings and lived experience not fully encompassed by the dominant story” (1986, p. 143). Dominant stories lead to a person’s ascription of meaning and the selecting out of
new experiences to be incorporated into the ongoing narrative, indicating the constitutive role these stories play (White, 1989b).

This “text analogy” (Geertz, 1986) served as the basis for narrative therapy. Jerome Bruner’s (1986) narrative mode of thought also followed this literary or text analogy, and he furthered this thinking in stating that texts “initiate ‘performances’ of meaning, rather than actually formulating meaning themselves” (p. 25). As such, narratives are constitutive, being shaped by and shaping our perceptions, memories and lives, and in their actions, people are always re-authoring their lives and making meaning of them. Bruner’s constructivist approach holds that we create our own realities through our interactions with our social world and with symbols.

The text analogy led to two major concepts in narrative therapy: “externalizing” and “unique outcomes” (White & Epston, 1989a). Externalizing in narrative therapy involves naming, objectifying or even personifying the problem, to separate people from dominant, problem-saturated stories. These dominant stories, which often do not reflect people’s preferred ways of being, obscure alternative interpretations. Alternative interpretations, also known as “unique outcomes” (following Goffman) or “initiatives” (White, 2006b), are any stories, ideas or events that would not have been predicted by the dominant problem story. Intertwining with and elaborating on these notions are Bateson’s ideas of explanation and change, Derrida’s deconstruction, Geertz and Myerhoff’s anthropological contributions, Foucault’s deliberation of power, and finally, White’s vision of scaffolding in Vygotsky’s zone of proximal development—each of which I consider below.
Bateson

From early in his writings, White (1989a) made use of the work of anthropologist Gregory Bateson. Bateson (1979) has informed other therapies, such as solution-focused therapy and various schools of family systems therapy (Cottrell & Boston, 2002). White’s earlier ideas appear to be more premised on family systems theory, and although his later work has separated from many of Bateson’s ideas, some of this influence is still apparent.

Bateson’s work on cybernetics challenged linear notions of causality, arguing instead for circular causality and using positive and negative explanations to describe human learning (Monk, 1996). Positive explanations are equivalent to linear cause and effect, where a force drives people in a certain direction—for example, conceiving of a mental health disorder as a motivator for certain behaviours. Instead, White emphasized Bateson’s negative explanations, wherein people follow certain paths because they are restrained from following other alternatives. These restraints take the form of beliefs and expectations, which form families’ maps of the world, and go largely unrecognized by them, leading to the repeated reproduction of paths that are contrary to what families want for themselves. For a new response to take place, what is needed is perception of difference. For White, news of difference is mapped and transformed into stories. These stories have to be different to be noticed, but also have to have meaning in the context of the map’s network. Bateson called this the “difference which makes a difference” (quoted in White, 1989a, p. 88). The therapist’s role is then to help create a welcoming context for news of difference, to support the clients’ discovering news of difference, which allows for double or multiple descriptions of events, and to support the persistence of this interpretive multiplicity.
Double descriptions paved the way for "relative influence" questions (White, 1989a, p. 88). The therapist’s use of relative influence questions establishes two different descriptions. The first set of questions map the problem’s influence on the family, and the second set maps the family’s influence on the problem. Questioning invokes a broad range of domains, including effects on family relationships, friendships and self-concept. In these latter questions, families may be asked about times when they have managed to minimize the effects of the problem, how they have prevented the problem from becoming worse, and what has supported them in their work against the problem. These questions on the family’s influence over the problem begin to draw out alternative stories.

News of difference was also implicated in White’s use of time, which arises in various incarnations of narrative therapy. Because families’ situations change gradually over time, these changes are not easily noticed. To provide a contrast and a setting for the perception of these differences, time is collapsed, and distinctions are drawn between the problem and other aspects of the family’s life at different time periods, including potential trends at points in the future. By highlighting times when the problem has had less control, as well as its current trajectory and future possibilities, one de-stabilizes the static nature of the problem and makes differences more noticeable. The conflict between the requirements the problem will have of the family in the future, and the requirements and consequences of the family’s successfully challenging the problem, produces dilemma-raising. The dilemma leaves the family needing to choose between two potential futures and their consequences, and in this regard is intended to stimulate change.

Relative influence questions and dilemma-raising laid the groundwork for what were later called “statement of position” maps (Morgan, 2000, p. 44; White, 2005b).
These maps suggested a particular line of questioning for therapists to follow: name and characterize the problem or unique outcome; map the effects or influence of the problem or unique outcome across life domains, relationships, values, aspirations, and future possibilities; evaluate the effects or potential effects of the problem or unique outcome; and justify these evaluations. In justifying, the therapist asks the client to explain his or her evaluation of the effects—this in an effort to clarify the therapist’s and the client’s own understandings of where people stand in relation to problems and unique outcomes. The narrative therapist does not attempt to lead clients to any specific solution, but invites opportunities for families to find the solutions that will work for them. While maps for therapy continue to be offered as a useful tool, they are accompanied by the caution that “the map is not the territory” (Korzybski, as cited in White, 1989c, p. 38). That is, the steps on the map are only that, and cannot reflect or capture the emergent, temporally open nature of what happens in the course of therapy.

In addition to his early influence on narrative therapy practice, it is possible that Bateson became the first influence in White and Epston’s critique of scientism in therapy. For Bateson (1979), explanations are part of living systems, and objective reality cannot be understood, because reality cannot be independent from context. Instead, perception is connected to context and subjective meaning-making. A piecemeal, fragmented empirical approach is then inadequate, because the natural world is not only composed of matter, but of systems, and life can be seen in “the pattern which connects” different parts (p. 8). Scientific reductionism, which seeks to find simple, economical explanations, “becomes a vice if it is accompanied by an overly strong insistence that the simplest explanation is the only explanation” (p. 230). In short, any given whole is about more than just its parts,
and information must be understood within its context. For narrative therapy, detaching any aspect of a client’s story and isolating it from its history and context has the potential to become problematic, and is in direct contrast to much of the work done in session.

Deconstructing and Re-authoring

Deconstruction in narrative therapy is linked to both social constructionism and Foucauldian notions of power, and draws on the work of Jacques Derrida (Besley, 2002). White’s (1992, 2000) use of deconstruction departs somewhat from its Derridian use, wherein it could be loosely and cautiously defined as the fluidity, instability and contradiction that occurs in “texts, institutions, traditions, societies, beliefs, and practices” (Derrida & Caputo, 1997, p. 31), and the experience of their uncovering. Deconstruction has been described as a tension between disruption and attentiveness, an analysis of heterogeneities, showing that texts and practices, as forms of otherness, do not have “definable meanings and determinable missions, that they are always more than any mission would impose, that they exceed the boundaries they currently occupy” (Derrida & Caputo, 1997, p. 31).

In narrative therapy, the deconstructive impulse manifests itself in a questioning of the taken-for-granted. More specifically, deconstruction is accomplished by questioning the meaning, historicity of and recruitment by problems and other significant constructs that arise in therapy, and by examining unique outcomes that fall outside the dominant story. Deconstruction also takes place through the unpacking of dissembled or unrecognized practices of power and disciplinary technologies of the self, and by questioning therapeutic discourses themselves, deconstructing clients’ experiences and
the therapist’s role. As such, deconstruction is not intended to detract from or abolish these concepts, but to explicate their complexities.

Rendering the taken-for-granted transparent does not mark an accession to free will and all that it implies; rather, the gaps and discontinuities in the dominant cultural discourse of a person’s life make some room for meaning-making and action to be constituted differently. This thinking marks a return to Jerome Bruner. The therapist invites families to make sense of unique outcomes by locating them within Bruner’s (1986) landscapes of action and consciousness (see also White, 1992). The landscape of action refers to events linked through time according to a plot. The landscape of consciousness—more recently referred to as the landscape of identity (Combs & Freedman, 2004)—refers to interpretation and meaning-making, in reflection of the events taking place in the landscape of action. The landscape of identity therefore comprehends questions about how the landscape of action reflects a person’s desires, values, purposes, dreams, beliefs and commitments.

The therapist encourages the client to situate unique outcomes into enriched narratives (landscape of action), and this re-description is intertwined with questions about what these new narratives reflect about the person and their relationships with themselves, others, and the problem itself (landscape of identity). Together, the therapist and client investigate the development and meaning of alternate stories. The therapist can take the position of curious listener. Moreover, all therapist questioning is tentative, and therapists consistently check in for client evaluations and statements of positions on stories. When unique outcomes are seen as meaningful, they are unpacked and thickened to widen the range of possibilities available in people’s “re-authoring” of their lives.
(Myerhoff, as cited in White, 1989b). They are extended by conversations that look to the future, and what may now be expected given this new knowledge. Stories are further enriched by the involvement of audience, a strategy that highlights the socially constructed nature of stories.

The Social Construction of Stories

Anthropologists Barbara Myerhoff and Clifford Geertz used Ryle's contrasting “thick” and “thin” metaphors (White, 2000, p. 62) to describe the stories people have about their lives. Thin descriptions exclude the involved person’s interpretations, making people objects of observation, generally by those who seek to study them. Thick descriptions, in contrast, engage the person or community’s shared interpretations of meaning (White, 1997). Applying this to anthropological and ethnographic research, Myerhoff (1982) and Geertz (1973) opposed thin descriptions that involved the production of universal or general truths, and emphasized instead the role of the interpreter and the shared values of communities of people. Myerhoff proposed that it was through this engagement of interpretation with a group of people, telling and re-telling preferred stories, and linking them to grander themes, that lives become thickly described. Thickening conversations in therapy link these stories to the values, beliefs, purposes and dreams that people carry with them but that may have previously gone unrecognized, so that new texts are generated. Thickening involves multiplying the strands in the meta-narratives of people’s lives, broadening the range of possible meanings and actions. Involving a community of people, or audience, reinforces the socially constructed nature of stories.
Myerhoff named the tellings and re-tellings in her research: “When cultures are fragmented and in serious disarray, proper audiences may be hard to find. Natural occasions may not be offered and then they must be artificially invented. I have called such performances ‘Definitional Ceremonies’” (Myerhoff, 1982, p. 105). Myerhoff (1986) documented the definitional ceremonies of an isolated Jewish community in Los Angeles, which regularly instituted forums for collectively acknowledging its members’ identity. She called this purposeful attention to experiences, memories, and identity claims “Re-membering.”

White (2000) has utilized reflecting teams as a form of definitional ceremony in narrative therapy. Reflecting teams are generally constituted of additional therapists who observe the interview, or witness the initial “telling” of the stories of people’s lives, and then switch places with the therapist and client to reflect on and wonder about the therapeutic conversation, while the therapist and clients observe. Reflecting team members situate their thoughts in their own experiences, noting what emerged in the conversation and resonated for them, and appreciating the openness the clients and therapist have shown. Places are changed again, as people respond to the reflections they have just heard. Reflecting teams, or outsider witnesses, re-tell the told in therapy, noticing what may have otherwise been unacknowledged, and extending this notice beyond the initial story. This has the potential to transport the person seeking therapy, and the witnesses themselves, and to reflect that witness transport as a new site of extension and thickening of the client’s story.

Narrative therapy has used other ways to incorporate audience. Therapists may ask questions about who from the person’s life may have expected or may be supportive
of alternative stories. The use of written documents, such as letters from therapists, formalizes and reinforces, provides a witness to change, and provides a format that can be re-viewed and re-considered. David Epston’s participation in publicly archiving people’s stories of their struggles with eating disorders is one example of narrative therapy’s use of audience (Lobovits, Epston, & Freeman, 2006; Maisel, Epston, & Borden, 2004).

Foucault

Michel Foucault appears to have had the most significant influence on White and Epston’s (1990) narrative therapy approach. Foucault was a French intellect and scholar, with degrees in psychiatry, philosophy and psychology. White and Epston’s Narrative Means to Therapeutic Ends focused on Foucault’s early and middle years, thereby incorporating his ideas of modern “power/knowledge” and the socio-political context it creates, and “positive” or productive and constitutive effects of power, but with less exploration of his later work on the subject, agency and self-regulation (Besley, 2002).

Foucault (1975) argued that the modern age saw a shift from corporal punishment to bodily training. Classifications of crime and punishment, with the intention of preventing repetition of crimes, also required an accounting for the individuality of the criminal, and a new correlative technique of secretive, institutional power. This power objectifies criminals and crime, and specifically the type of criminal who is seen as “a villain, a monster, a madman, perhaps, a sick and, before long, ‘abnormal’ individual” (Foucault, 1975, p. 101).

Foucault (1975) described the development of “docile bodies” in modern societies. “A body is docile that may be subjected, used, transformed and improved” (p. 136). Exercises of discipline created docile bodies in schools, the military, religion and
factories to increase production and effectiveness, but in doing so created objectified individuals for purposes of subjugation.

Foucault (1975) used Bentham's design of the Panopticon to represent the objectification of persons and the tactics of modern, positive power that infiltrated modern society. The Panopticon was an architectural model designed for use in a prison, but adaptable to other uses such as schools, hospitals or factories. Its design separated the inmates, placing each in a single cell in a circle that permitted them to be seen, but never to see those observing them. They would be unaware of when they were under surveillance, causing them to act as though they were being watched at all times. This produced the consciousness of an ever-present gaze and the individual's self-subjugation, which is more effective than centralized power because of its anonymity, and its ability to increase productivity without overt interference, an ideal condition for capitalist society. Throughout institutions and society in general there are examples of this form of positive power, wherein individuals are subjected to judgment, not simply to repress and contain, but to shape and re-produce themselves according to their ability to perform well enough and fulfill the expectations of normalizing judgments. Disciplines such as psychology, psychiatry, industry, education and medicine refine their abilities to categorize and classify people's behaviour and thinking, creating an asymmetry in power, themselves forming a part of and re-producing the machine that has been created.

Instead of classifying and objectifying individuals, the narrative therapy practice of externalization re-situates the problem outside of people, challenging cultural discourses which presuppose that individuals can be categorized and then practiced upon or that individuals can, through their own self-discipline, readily create themselves anew.
Together with deconstruction, externalizing the problem questions this social control and these normalizing truths, unsettling the effects of modern power (White, 1989a). The use of externalizing and deconstruction in therapy is intended to liberate people from labels, allow cooperation among families to influence the effects of the problem, present opportunities for multiple interpretations, discourage conflict about blame, and encourage agency instead of feelings of failure and oppression (White, 1989b).

Foucault's influence leads to the deconstructing or unpacking of cultural assumptions (Monk & Gehart, 2003; White, 1992), and also to the de-centering of the therapist. The classification of individuals or groups by science is implicated in their objectification by modern power. Instead of assessing and diagnosing, de-centering practices (White, 1997) focus on the client's own knowledge and experience, for example, in asking the client to evaluate the effects of problems and unique outcomes. The therapist still provides direction to the therapeutic conversation, but the client's evaluation and language are at the centre of the therapeutic process.

*Concept Formation and the Zone of Proximal Development*

Vygotsky has provided a basis for much of White's recent writing (e.g., White, 2006a, 2006b). Vygotsky has led White in new directions in defining the tasks of the therapist in narrative therapy, opening space both for re-thinking narrative practice and for incorporating research to analyze the performance of therapist tasks.

A critical notion for White is the "zone of proximal development", which Vygotsky (1978) defined as "the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more
capable peers” (p. 86). According to Vygotsky, the zone of proximal development is traversed through social collaboration between a child and a teacher, or some other adult or peer with greater knowledge of a concept at hand. Verbal interactions provide the starting point for concept formation. Through an awareness of new concepts and by gradually understanding aspects of them according to a hierarchy, the child develops a mastery of them. As I elaborate more fully below, this hierarchy involves making increasing generalizations about objects.

Vygotsky (1934/1987) used a block task to study children’s progressive thinking toward concept formation. The blocks were of different colours, shapes and dimensions, with a nonsense word written on the underside of each. Children were asked to group together objects on which they believed the same word was written. Based on the children’s activities in selecting and grouping the blocks, Vygotsky made inferences about how children form concepts. More specifically, he separated concept development into three stages. The learning of the word is the beginning of concept formation, and the word eventually becomes the carrier of the fully formed concept. At each stage of concept formation different forms of connections are made in the child’s ordering of his or her experiences.

In the first stage, word and symbol definition is incomplete and may be based on as little as a single, idiosyncratic impression of word meaning on the child. The child at this stage forms objects into “heaps” based on these subjective impressions. Through syncretic connections the child initially gathers together these random heaps using trial-and-error means, or bases them on his or her temporal or spatial contact with objects. Items have no unifying objective connection. As children learn word definitions through
their social interactions, their use of words may have the appearance of a fully formed concept, and their ordering of some objects appears correct. This allows communication between people at various stages of concept formation, but disguises an underlying lack of conceptual thinking. In more developed thinking in this stage, an unordered collection of heaps is still produced, but it involves two-stage connections, as previously made groups are separated and re-grouped. Thus, there is additional complexity than in the single connections made in prior phases.

The second stage is thinking in "complexes." Concrete objects are united based on their objective relationships to each other. This is different from the subjective links made in the heaps stage, but the limitation to concrete, empirical, heterogeneous connections between objects prevents them from being true concepts. Objects are still seen for their multiple features, instead of a single coherent feature perceived to unite the whole. This allows the focus to shift from one element or type to another, as during the selection process children used in Vygotsky's block task. There is no hierarchy of features; no central element has been abstracted. In the phases of complex thinking elements fight for precedence, alternately providing the basis for the next connection being made. The pseudoconcept is the last phase in the complexive thinking stage. It has the same appearance as the concept, selecting and uniting objects in the same way.

Vygotsky uses the example of family names, such as Smith, which the child understands to connect separate families. These families are knit together in groups, or complexes. Because children and adults communicate using words that appear to mean the same for both, pseudoconcepts and concepts appear equivalent, but the generalizations made in the former are based on concrete associations instead of logical abstractions.
In the stage of conceptual thinking, the connection among objects is based on abstractions. Parts are linked to the whole and to each other by the same “single image and by the same type of connections” (Vygotsky, 1934/1987, p. 137). This isolated feature, which forms a homogeneous connection, is not only more stable than the features that the child focused on in complexive thinking, but has superseded the mere associative use that is characteristic of earlier stages. The concept no longer relies on its concrete, empirical elements. As a generalization made based on abstract links, the word is still used to direct attention to this feature, but here takes on a different functional use than in complexes.

Concepts develop through the organization of generalizations within a system. The word “flower,” for example, is at first applied to all flowers, and only later does the concept “rose” appear, with an understanding that both are concepts within a system of generalizations. This conceptual thinking, at its highest levels, also produces a consistent conscious awareness of itself, and with that leads to the mastery of concepts and to their voluntary control.

Wertsch (1985) applied the term decontextualization to Vygotsky’s emphasis on the abstraction and generalization inherent in concepts. Decontextualization may be seen as a rationalist exercise, involving the creation of a universal concept that is readily applied to different contexts. As applied to narrative therapy, decontextualization, or concept formation, is a way of rethinking externalizing. The process of externalizing does not produce a concept that is free from context, but rather broadens and shifts it, making it more readily available for use. The concept becomes de-limited, not unlimited, distancing the client from the “known and familiar” (White, 2006a, p. 39).
The Turn to Vygotsky in Mapping Narrative Conversations

Using Vygotsky’s theories of development and learning, White (2006a) has created a revised version of the statement of position maps previously mentioned. Version one of the map focused on the problem, version two on the initiative, and this third version accommodates either the problem or the initiative. Known as the scaffolding conversations map (see Figure 1, Appendix A), it outlines the therapist’s tasks in introducing concepts pertaining to client problems and initiatives and scaffolding the child’s mastery of them. In this study, the map serves as the basis for coding observations of therapist and client actions.

In the scaffolding conversations map the narrative therapist’s role is elucidated as supporting people in distancing themselves from the known and familiar that is being reproduced in their relationships with problems. Vygotsky described the earliest stages of the child’s concept formation as forming an unordered collection or heap of objects, incompletely defined, where internal connections are lacking, and the child’s experience is overwhelmed by subjectivity and by as little as a single perception of objects, syncretic and unstable. People coming to therapy are similarly mired in monolithic but incompletely defined stories about themselves and their lives, in syncretic perceptions about their own inadequacy and incompetence in meeting their own and others’ expectations of them. In narrative therapy, the therapist and client work in partnership to traverse the zone of proximal development, from the known and familiar, into the landscape of what it is possible for clients to know and do. The therapist’s scaffolding allows clients to distance themselves from aspects of problems, so that they can develop new conceptions of self, identity, problems and resources. Distance and increased
mastery over concepts invites children and youth to gradually exercise personal agency over the problems they are struggling with, or with the solutions they may have already begun to find, but that were lacking a strong foundation for continuance. This is in keeping with Vygotskian notions of mastery and voluntary control associated with conceptual thought.

The scaffolding conversation is organized according to a hierarchy, with increasing levels of generalizations that parallel the steps in the statement of position maps. In accordance with this, the revised map begins with naming and characterizing the problem or initiative. For Vygotsky, developing words formed the most primitive level of understanding concepts, and in this version of the map White (2006a) refers to this step as "low-level distancing" (p. 45). This marks the early stages of concept formation, with a transition from the rudimentary heaps of objects and events clients bring into therapy—corresponding to individual, unthematized, unconnected experiences—into their uniting under a common name or category. Medium level distancing tasks, the next step in the map, produce chains of association between the problem and its consequences, previously described as exploring the effects of the problem or initiative. This second step White (2006a, 2006b) clearly correlates with the development of complexes. Chains of association are grounded in the concrete, and no overarching theme has been extrapolated. Medium-high level distancing tasks (previously known as evaluating the effects of the problem or initiative) have the client reflect on these chains of association. High-level distancing tasks (justifying and explaining evaluations, according to earlier versions of White’s conversational maps) ask clients to abstract their learning from specific circumstances, generalizing it to other areas of their lives. White (2006a, 2006b)
states that at this level, where learnings are abstracted from the concrete, there occurs a formation of concepts. With the achievement of this stage externalizations become mediators that can be operated on in their own right (Wertsch, 1985). Very high-level distancing tasks, a level that was not formally included in other versions of the map, have clients making plans to act upon the newly understood concepts and the positions they have taken.

While the specific tasks of the teacher in the zone of proximal development received relatively little attention from Vygotsky, he was quite clear that instruction should be pitched ahead of the child’s actual level of development. In the context of narrative therapy, this means that therapists’ leading activities should occur ahead of clients’ abilities, preceding (and indeed, promoting) their development. Theoretically, then, both children’s and therapists’ tasks can be seen in White’s map. The levels of a therapist’s leading behaviours and a child’s responses on the map will be readily available to observation. For example, if a child switches from one aspect of an externalization to another, as would be expected at the complex stage, the therapist’s task in the zone of proximal development might be observed as re-circulating language so that it consistently directs attention to those elements that the client denotes are relevant.

According to White’s (2006a) utilization of Vygotsky, the overarching tasks of the therapist are manifold: to abstract elements from the totality of clients’ experiences; to foreground their current base of knowledge about concepts and to make this knowledge more available to clients without their being defined by them; to develop these concepts more richly; and ultimately to assist people in revising their relationship with concepts, thereby expanding their options. A successful outcome will lead to the
The text on this page is not legible due to the quality of the image provided. It appears to be a continuous block of text, possibly a page from a book or a report. Without clearer visibility, it is impossible to transcribe or interpret the content accurately.
client's improved self-mastery in functioning. All of this is accomplished through the
tasks the therapist performs as outlined in White's scaffolding conversations map.

This study aims to examine the scaffolding process in the zone of proximal
development defined by the client-therapist interactions. This research is the first known
attempt to empirically study therapist and client movement through the stages of the map.
Toward that end, the following section provides a review of extant research literature in
the area.

Review of the Literature

Despite its popularity, empirical research in narrative therapy is limited (Etchison
& Kleist, 2000; O'Connor, Davis, Meakes, Pickering, & Schuman, 2004). This is likely
due, in part, to its postmodern critique of practices that privilege scientific generalizations
over individual experiences (Epston, 2004; Gaddis, 2004; Gergen, 2001). The few extant
studies in the area explore process and outcome, using quantitative, qualitative and mixed
methods. Additionally, there are a number of studies on the perceived effectiveness of
reflecting teams. There are also case examples and theoretical discussions about research
into narrative therapy. I now turn to a consideration of each of these genres of supporting
evidence.

Outcome Studies

Studies have used a range of approaches to evaluate client experience and
outcome, including interviews, behavioural measures, and analyses of themes both in
therapy discussions and in artistic renderings created in treatment. A study by Hunter,
Ussher, Browne, et al. (2002; Hunter, Ussher, Cariss, et al., 2002) initially appears to
have little to do with narrative therapy. It compared cognitive-behavioral, medical, and
combined treatments. Treatment consisted of 8 sessions of individual therapy, which was "based on the cognitive approach for PMDD and included relaxation therapy" (Hunter, Ussher, Browne, et al., 2002, p. 194) for women diagnosed with Premenstrual Syndrome and Premenstrual Dysphoric Disorder. However, a follow-up article (Ussher, Hunter, & Cariss, 2002), which intended to outline the treatment in detail, described it as a combination of cognitive-behavioural and narrative therapy approaches. Ussher et al. reported that the treatment stemmed from the position that biological, material, intrapsychic and discursive factors contribute to women’s experiences of the disorders, and that therapy included education, the development of activity schedules, recording of cognitions and moods, and cognitive restructuring. The more narratively informed elements involved exploring the history of the problem, deconstructing PMS and the social context, and recognizing the woman’s expertise and ability to re-author her experience. The therapy was found to be as effective as fluoxetine in treating premenstrual symptomatology according to scores on the Calendar of Premenstrual Experiences (COPE) and DSM-IV diagnostic criteria.

Other researchers have used qualitative methods to look at the effectiveness of narrative therapy when combined with other approaches. Knight et al. (2003) evaluated the effectiveness of a 6-week counselling group utilizing motivational interviewing and externalizing conversations with diabetic adolescents aged 13 to 16 years. Motivational interviewing is a directive but non-confrontational counselling intervention focused on change, which attempts to shift the client’s decisional balance while respecting their expertise and right to make choices. The study’s principal investigator facilitated the group intervention, and other than very brief descriptions of externalizing and
motivational interviewing, little was said about the group structure or intervention itself. Youth volunteered for either the treatment \((n = 6)\) or control group \((n = 14)\). Semi-structured questionnaires on client perception of diabetes were administered pre- and post-intervention, and at 6 months follow-up. Content analysis was used to analyze responses. Both groups reported increased feelings of anxiety. The intervention group demonstrated a reduction in concerns about stigma, less negativity in their views about diabetes, more positive perceptions of parents’ worries and involvement in their illness, fewer feelings of depression and low mood, and improved strategies for coping. Some members of the treatment group reported feeling less angry, which was not a finding in the control group. These shifts were maintained at follow-up. The author reported that a large-scale randomized control trial is currently underway.

Cowley, Farley, and Beamis (2002) also combined motivational interviewing with narrative therapy. Their study involved 40 adolescent females presenting at a community health centre for reproductive health services, and determined to be at risk for pregnancy based on a desire to become pregnant or ambivalence toward contraceptive use. The intended outcome was short-term use of oral contraception. The intervention was developed for its relevance to the population of clients, in its consideration of client stage of change and individual reasons for not contracepting, which is in contrast to traditional health education models. Clients were initially assessed and interviewed. Follow-up appointments were offered, or clients could access clinic services as desired, when reassessment and further intervention were provided. The narrative counselling component had therapists maintaining a curious stance, excavating alternate stories, collaborating on problem-definitions, recognizing the clients’ expert knowledge, and focusing on the
preferred future the client envisioned for herself and a future child. More than one-third
of those clients who were initially unwilling to use contraceptives chose to initiate at least
a short-term trial of contraceptive use. However, the study was descriptive in nature. No
comparison group was used, and no generalizations could be made.

Besa (1994) used a multiple-baseline design in a study with families who were
experiencing parent-child conflict. Outcome was measured by clients’ rating the
presenting problem. Besa found no change during the initial phase of therapy, in which
the therapist gathered information, defined and externalized the problem, and discussed
its relative influence on the client. At the end of treatment, Besa found change in five of
the six families studied. He relied on between-session tasks (i.e., behavioural contracts) to
induce unique outcomes, but argued that the emphases on unique outcomes, and not the
contracts themselves, were the reason for change. To support his argument, Besa cited
examples of written agreements used in well-known narrative therapy cases. However,
his reliance on behavioural contracts leaves his study open to the criticism that it is
theoretically flawed, measuring something other than narrative therapy.

Like the Hunter, Ussher, Browne et al. (2002) study, which may arguably be
combining cognitive-behavioural with narrative approaches, the studies combining
motivational interviewing or behavioural contracts with narrative therapy may prove
useful to practitioners looking to replicate those programs in their own work. However,
these studies are of very limited usefulness in indicating the effectiveness of narrative
therapy itself.

Keeling and Neilson (2005) sought to study the application of narrative therapy
with Asian Indian women. However, talk therapy, the usual modality for narrative
therapy, was not used. Rather, both the intervention and data gathering were accomplished in the form of three weeks of guided journaling on questions seeking to externalize problems and draw out unique outcomes, and art work and diagrams completed pre- and post-therapy to externalize the problem and illustrate participants' changing relationship with it. Semi-structured interviews were conducted with the eight participants at the conclusion of therapy. Analysis followed a heuristic model. This study outlined themes in participants' written and drawn responses to questions about individual problems. Themes that emerged during the interviews about their experiences with the project included its emphasis on strengths and resources, and a reduction in the salience of problem.

In the outcome study that is perhaps most clearly aligned with narrative therapy, qualitatively measuring outcome and incorporating client perception, O'Connor, Meakes, Pickering and Schuman (1997) explored families' involvement in narrative therapy using an ethnographic research design. Eight families presented with various problems, and were later interviewed about their experiences. Five types of therapeutic conversation emerged from the interviews: externalizing conversations, unique occurrence and alternate stories, the building of an audience to the new story, involvement of a reflecting/consulting team, and personal agency. Externalizing the problem was the least-mentioned of the five aspects. Clients also rated problem reduction on a scale of 1 to 10. Results indicated that all families reported a reduction in the presenting problem, with longer involvement in therapy producing a greater reduction in the presenting problem.

Some studies have attempted to bridge the gap between the evidence-based treatment movement and agency requirements, and narrative therapy ideology, through a
mix of qualitative and quantitative methods. Kelley and Clifford (1997) employed grounded theory and quasi-experimental designs to study the effectiveness of group narrative therapy with adult clients suffering from fibromyalgia. Therapy included relative influence questions, externalizing and re-authoring through the use of unique outcomes. Clients were randomly assigned to either the treatment ($n = 11$) or control group ($n = 8$). Audio recordings of group sessions, participant journals and therapist and principal investigator notes were analyzed for themes and changes over time regarding the effects of the problem and coping mechanisms. The analysis found that middle sessions focused on group members prioritizing, planning and sharing their own techniques, and later sessions focused on acceptance, self-knowledge, empowerment and self-advocacy. Discussion on loss and not being understood decreased over the duration of the group. The quasi-experimental component was used to examine the usefulness of the intervention, and measures were administered to assess health functioning, self-esteem, pain experience, and coping. While the group numbers make findings only exploratory, the control group had significantly better health functioning but also significantly more emotionality about the pain, while the treatment group showed non-significant changes in opposite directions. Kelley and Clifford interpreted these findings, somewhat paradoxically, as offering tentative support for the usefulness of narrative therapy in coping with increasing impairment.

Kelley, Blankenburg, and McRoberts (2002) studied the effectiveness of narrative therapy when provided in a group format. Participants were eight female youth ages 13-17 who had been referred as part of a court diversion program. Criminal charges included theft and assault. The group met for three hours per day, five days a week, for eight
weeks, and included daily discussions that involved externalizing, mapping the problem domain and effects, uncovering unique outcomes, and sharing new stories with an audience. Creative activities of their choosing allowed for reflection and provided a further means for sharing outside of the group, and for educating researchers and therapists about their experiences. Group sessions were audiotaped, and recordings and art was analyzed for themes, which included anger, pride and identity, control and coping, loss, chaos and violence, confusion and choice, support from others, connection to family, trust, creating a privileged world within a peer group, and hope. This analysis, in conjunction with pre- and post-interviews, highlighted changes in coping, with increasing emphasis on change, compromise, and examples of ways of coping, more discussion about family, and expressions of hope. Most group members detailed positive outcomes in their lives outside of group as a result of their experiences in the program. Despite the small number of participants, measures of self-esteem, locus of control and coping were administered. No significant change was found in self-esteem or locus of control, but significant improvement was found in coping.

Although all of the aforementioned studies name narrative therapy or its intrinsic aspects, in most it is still unclear what comprises the intervention under study. Narrative therapy is usually described vaguely if at all, and in at least one case—namely, the Keeling and Neilson (2005) study—it is not even narrative therapy that is being offered, but a written substitute. Narrative therapy has been consistently connected to a body of approaches, but the ambiguous treatment it has received from most of the authors places limitations on the usefulness of their findings, even had there been no question of methodological rigor. Prior to embarking on any further studies of outcome, then, it is
necessary to turn to studies examining the process of narrative therapy.

*Process Studies*

Process studies have explored therapists’ experiences of narrative therapy, and have conducted textual and linguistic analyses of themes and discursive change in therapy sessions. O’Connor, Davis, Meakes, Pickering and Schuman (2004) used a similar design to the O’Connor, Meakes et al. (1997) study, but with therapists instead of clients as participants. Therapists were asked about their experiences practicing narrative therapy, with some questions specific to reflecting teams. Semi-structured interviews were used with an 8-member team of varying disciplines and lengths of experience with narrative therapy. Four of the researchers were also part of the newly formed therapy team that was being interviewed. Five themes emerged. The strongest theme was that therapists found narrative therapy to be successful in reducing presenting problems, and believed this was because of its respect for clients and its use of personal agency.

Therapists were concerned about the training required, the difficulty they were having using it with the problem of family violence, staff requirements for reflecting teams, and the time reflecting teams require. Reflecting teams were seen to both be rich in the learning opportunities they offer therapists and the multiple interpretations and possibilities they present, but this multiplicity was sometimes felt to be overwhelming for clients and therapists. Finally, therapists reported enjoying the process and challenge of co-constructing unique outcomes.

Other process studies looked at discourse in therapy sessions. Coulehan, Friedlander and Heatherington (1998) used the Cognitive Constructions Coding System to study transformational process in eight families involved in Sluzki’s narrative therapy.
They considered that a transformation of the client’s construction of the problem from an intrapersonal to an interpersonal, or relational, view would indicate a successful session. This parallels the process of externalizing the problem in White and Epston’s (1990) narrative approach. However, although Coulehan et al. outlined differences between those sessions considered successful and those considered unsuccessful, they stated that clinic data did not indicate that the “successful” families had better outcomes. This could be interpreted as support for Besa (1994) and O’Connor, Meakes et al.’s (1997) findings that externalizing the problem in narrative therapy had less to do with positive outcomes than other aspects of narrative therapy. Coulehan et al. suggested that successful transformations only predict successful outcome when they enhance the therapeutic relationship and result in collaborative goals for treatment. However, this study’s apparent afterthought of a second criterion for success highlights what is perhaps the most significant barrier to outcome research in narrative therapy: the absence of a clear definition of outcome.

In an exploratory study of therapist talk in the process of narrative therapy, Kogan and Gale (1997) conducted a textual analysis of a couples therapy session, using a videotaped interview involving Michael White that had been released for commercial sale. Kogan and Gale examined how the therapist managed talk in narrative therapy by conducting a qualitative analysis of the text for themes and patterns, which specifically included consideration of text that reflected client and therapist agendas. Parts of the interview were transcribed, with notations for non-verbal behaviours. Kogan and Gale saw centering or de-centering of therapists and clients as a prominent theme, and provide interpretations of this shifting process to accompany the transcripts. They found that the
therapist affected the text while being minimally centered. This de-centeredness was managed through therapist practices. Kogan and Gale named and described these practices as: matching and self-disclosure, which emphasizes shared positions and experiences; "reciprocal editing," which tentatively submits adjustments and seeks clarification in meaning, and which could perhaps be described as negotiating meaning and language; managing turns in who takes the role of speaker; using "expansion questions" to expand an emergent concept, such as respect, to other areas of the client's life; prioritizing indigenous client resources or achievements; and using "reversals" or practices that reverse dominant narratives and explore different perspectives. Kogan and Gale posited that narrative therapists have agendas and intentions in therapy, differing from other therapies not in attempts to be non-interventive, but in practices of de-centering themselves as therapists.

Muntigl (2004) sought to expand Anderson and Goolishian's (1988) theories on language and meaning-making through a linguistic analysis of client and therapist speech turns and interactions, and their meanings. Based on his own previously unpublished research, Muntigl proposed a three-stage model of therapy, which involves a shift from narrative, to expository, and back to narrative modes of speech. In narrative phases, clients use a story format to narrate events. In exposition, knowledge is classified, causal relations are identified and the subject recedes in a tendency toward generalizations. Muntigl's conceptual model of changing modes, or genres, of speech also draws on Vygotsky's zone of proximal development, as the therapist scaffolds client meaning-making to produce a shift in the client's construal of problems.
Muntigl's (2004) analysis of six sessions of narrative therapy with one couple supported his hypothesis. He found that the first phase was marked by extreme characterizations of events, problems and people, by personal recounting, and by negative evaluations. The second phase, in which the therapist scaffolded new formulations iteratively and in collaboration with the clients, contained nominalizations and elucidation of the causal relationship between the problem and its effects, as the clients developed a new semiotic repertoire. In this analysis, cause was not tied to traditional concepts of uni-directional causality, but rather incorporated influences, effects, invitations, and opening up of space to imply the problem or individual's agency. In the third phase, he found a return to the narrative mode in effacing the problem and re-authoring. However, this differed from the first narrative phase, as clients deployed the resources gained from therapist scaffolding in the second phase. Narratives were accompanied by positive evaluations and increased client resources in attributions of agency, nominalizing and causality, in accordance with their preferences for and re-authoring of their lives. Further, Muntigl's analysis demonstrated that the scaffolding the therapist used in interviews framed the direction of the session and required taking a directive role, but that the therapist followed clients' re-authoring of their own experiences, for example, by retaining client wording of problems. This mutuality of influence is what would be expected from theoretical writings on narrative therapy, such as those of White. It also follows Kogan and Gale's (1997) findings on how the therapist manages talk and centres the client in the therapy.

To summarize the research on narrative therapy process, O'Connor et al. (2004) provided a subjective analysis of therapists' experiences, pointing to the intent of the
therapists in emphasizing personal agency and collaborative learning. Coulehan et al.’s (1998) findings support the notion that externalizing takes place in sessions and is observable. Kogan and Gale’s (1997) findings build on O’Connor’s et al. and Coulehan et al.’s findings to some extent in describing the therapist’s management of externalizations and the directive role that the therapist embraced while maintaining the narrative therapy emphasis on the expertise of the client. Muntigl goes even further, again indicating the therapist’s direction in sessions, and for the first time linking therapeutic process to Vygotsky’s description of scaffolding in the zone of proximal development. In addition, the therapist’s use of nominalization and causation in scaffolding overlap with low level and medium level distancing in the scaffolding conversation map. Without consultation to concept formation, Muntigl’s analysis leads to the expectation that scaffolding and concept formation are occurring at a broader level in narrative sessions. Muntigl’s research predates White’s ventures into Vygotskian theory and scaffolding—including the emphasis given to maps in White’s recent body of work (e.g., 2005b, 2006a, 2006b, 2007)—but while managing to answer some questions about scaffolding and concept formation, leaves others still to be addressed.

Reflecting Teams

Andersen’s (1987, 1999) notion of reflecting teams inspired a spate of research studies in the early 90s. Despite the frequent references to them in narrative therapy literature, a variety of therapy models have employed reflecting teams. Studies that have been done on reflecting teams are described here in virtue of their potential to inform narrative therapy, but they have not been included elsewhere in this literature review because the studies’ authors do not clearly align themselves with narrative therapy.
Smith, Winston and Yoshioka (1992) employed a participant-observation methodology with a 3-member reflecting team in a university-based family therapy clinic, interviewing team members about the therapeutic process of the team, its usefulness and limitations. Reflecting teams were a relatively new phenomenon, as suggested by the team’s average experience of 7 months. The data were similar to those of O’Connor, Meakes et al. (1997), suggesting that reflecting teams have value when they increase practitioner and client options, but do not produce such a plethora of responses as to become overwhelming. Reflecting teams were also considered to enhance learning. However, they may be contraindicated during early alliance-building. Moreover, the team expressed concern about the practical requirements on therapist time, especially in other counselling settings.

Sells, Smith, Coe, Yoshioka and Robbins (1994) conducted an ethnographic domain analysis of reflecting team experiences with seven couples and five therapists at a marriage and family therapy clinic. They mentioned externalizing and narrative therapy, but did not explicitly describe the theoretical approach being used. Clients and therapists were interviewed repeatedly using an iterative process of question development and confirmation of emergent domains and categories. Analysis also included field notes, interview transcripts and observations. The first domain was the benefits of a reflecting team. All couples and therapists reported that the additional opinions, perspectives and commentaries were helpful. Therapists found it helpful to the families and to themselves. Most couples found it important that the therapists come out from behind the mirror, but therapists made no mention of this. All but one couple noted the importance of having both genders on the reflecting team to have both points of view represented. It is implied,
but not clearly stated, that all couples were male/female. This finding may have been different had individual clients been present, or had families been constituted differently. Therapists did not proffer any comments on gender. The third domain was specific times when the reflecting team was effective. Couples felt this could include times when there was tension between the couple, or when the couple felt too close to the problem or had multiple problems in need of solutions. Some therapists felt the team could be most useful at specific times, such as with a specific issue or crisis, or when a couple was stuck; some felt it would be just as effective at any time; and others felt that it was helpful for the therapists themselves. Couples felt the team was less effective at the beginning of therapy before a comfortable rapport was established, and while therapists felt it was not particularly useful when there was no major issue that needed resolving, couples found these sessions quite helpful. Couples, but not therapists, commented on the helpfulness of the team being separated from the clients, and noted that this made them more comfortable, took the pressure off of them, and supported their ability to hear what was being said.

Smith, Sells and Clevenger (1994) followed-up on the Sells et al. (1994) study, quantitatively testing the latter’s concluding hypotheses that therapists’ and couples’ descriptions about reflecting teams were significantly different, and that couples’ reports about hearing a problem differently were associated with the spatial distance between themselves and the reflecting team. Smith et al. used an ethnographic content analysis. This method begins with open-ended interviews and observation to elicit descriptive data, which is then coded and analyzed through frequency counts and a chi-square statistic, finally producing both narrative and numeric results. Quantification was used for greater
precision and specificity in comparisons. Data from Sells et al. were coded according to the categories defined in that study, but changes to categories were allowed as new meanings and understandings emerged. Results of the chi-square tests indicated significant differences between client and therapist perceptions of reflecting teams. Clients focused more on the benefits of the reflecting team, while therapists were more concerned with occasions when it would or would not be an appropriate intervention, and with its utilization by lead therapists. A significant positive correlation was found between perceived spatial boundaries between couples and the reflecting team (i.e., where couples remained outside of the team’s sharing of reflections), and a self-reported ability to see the problem differently, thereby supporting the apparent connection clients identified in Sells et al.

Höger, Temme, Reiter and Steiner (1994) conducted two parallel studies on families where the therapy was solely comprised of reflecting teams. In Göttingen, Germany, the sample consisted of 33 families presenting at a university-based child and adolescent psychiatric clinic; and in Vienna, of 26 families presenting at a marriage and family therapy clinic whose patients were children, adolescents, adults or couples. Number of sessions ranged from 1 to 24. Data were gathered through in-session ratings of process variables and client and therapist questionnaires, including follow-up interviews or questionnaires with parents, with some differences in procedures between the two samples. For the Göttingen sample, correlation analysis was also computed for process variables, diagnostic criteria, and outcome. Positive changes in the presenting problem were reported by about two-thirds of families. On a global satisfaction question, 82% of the German and 76% of the Austrian families responded that they were very
satisfied. Clients with psychosomatic disorders were less satisfied than clients with emotional complaints, and the reflecting team seemed to be less effective with clients suffering from a psychotic disorder. In the Göttingen sample, families with a parental mental diagnosis, deviance, or poor intrafamilial communication reported lower satisfaction, but the severity of the presenting problem did not make a significant difference to satisfaction or outcome. Neither the number of sessions nor the number of therapists in the reflecting team was found to be of importance, although greater variety in ideas was correlated with more favourable results, especially in the area of client satisfaction. This is an interesting finding when compared to the Smith et al. (1992) and O’Connor, Meakes et al. (1997) studies, which documented therapists’ beliefs that too many ideas were overwhelming for clients. Most clients in the Höger et al. study chose to have only one session, which may challenge concerns about the feasibility of reflecting teams due to their demands on therapist time. Given the reliance on client self-report, small sample sizes, and methodological limitations, Höger et al. suggest that their study be seen mainly as a means of hypothesis-generating for future studies.

Other Narrative Therapy Writings

In addition to empirical research, narrative therapists and researchers have engaged in theoretical discussion and offered theoretical guidelines (e.g., Morgan, 2000; White & Epston, 1990), conversational maps, and descriptions of case examples (e.g., Combs & Freedman, 2005; Focht & Beardslee, 1996; Fristad, Gavazzi, & Soldano, 1999; Kahle & Robbins, 1998; Redstone, 2004). It is also necessary to acknowledge the practice of “co-research,” an approach to inquiry that was defined by Epston (2004) and that has since been identified by numbers of other narrative practitioners as the preferred
method of inquiry in narrative therapy. Co-research, broadly defined, consists of collaborative inquiry between therapists and clients. It may be ethnographic, or form part of the therapeutic process, incorporating practices that would not traditionally be considered research, but forms of intervention: For example, co-research may involve the client creating (perhaps with the therapist) written documents or visual depictions about their experiences with the problem and in therapy, which may then be archived for use by future therapists, clients and family members, and the public (Denborough, 2004; e.g., Lobovits, Epston, & Freeman, 2005; Maisel, Epston, & Borden, 2004). Another commonly cited example involves clients viewing recordings of past sessions and reflecting on their experiences (Denborough).

The definition of co-research allows it to reinforce White and Epston’s (1990) philosophical stance about research but, as previously mentioned, it is not always what would be traditionally considered research. Co-research also overlaps with a variety of disciplines, methods and practices in providing therapy. To be sure, co-research has valuable contributions to make, but to date its use leaves significant gaps in the empirical literature, including a failure to establish reasonable grounds for confidence in narrative therapy’s effectiveness, to offer systematic descriptions of what happens in therapy, or to provide any descriptions of process outside of accounts by therapists and clients of what may be atypical experiences. For example, it seems that many clients and therapists would be unlikely to participate in co-research, especially those who have less than ideal experiences or who are not highly invested in the therapy. It could also be argued that much of what is being done is simply therapy and use of the term research is inappropriate.
Future Directions

It is clear that a great deal is missing from the existing research, and the limitations of each study are only amplified by the lack of replication in the research corpus. Further research in almost all areas of process and outcome is needed for greater accountability, to better understand what it is narrative therapy and therapists do, and in some cases to better understand what it is they are trying to do. This gap has led to criticism that narrative therapy emphasizes technique over outcome (Amundson, 2001), that there are ethical implications of failing to provide research on effectiveness (Larner, 2004), and that narrative therapy is failing to incorporate valuable insights from mainstream mental health research (Carr, 1998). These arguments are especially salient given narrative’s increasing application in therapy (Hardtke & Angus, 2002; Hevern, 2004; McAdams & Janis, 2002). Consequently, these critics have argued for the necessity of empirical research through the use of methodologies that support postmodern ideals while providing critical information to practitioners and future researchers.

Narrative therapy is generally considered a form of family therapy, despite some controversy (Combs & Freedman, 1998; Cottrell & Boston, 2002; Minuchin, 1998, 1999; Tomm, 1998). Research on other models of family therapy is of longer standing than research in narrative therapy, and reflects greater variation of opinion about the aims and necessity of research. Researchers range from those who prefer to abandon quantitative methods to those who continue towards the goal of establishing family therapy as an evidence-based practice (Cottrell & Boston, 2002; Pinsof & Wynne, 2000). The larger body of family therapy has struggled with unease and resisted traditional research paradigms in a way that recalls a similar resistance in narrative therapy circles.
Practitioners and researchers have voiced concerns about quantifying a therapy that is complex, client-directed and based in language and relationships, about the clinical relevance of research, and particularly efficacy research, and about the monological ideology of traditional research and its discounting of client voice (Addison, Sandberg, Corby, Robila, & Platt, 2002; Larner, 2004; Pinsof & Wynne; Sprenkle & Piercy, 2005). They have argued that research must be accomplished in a way that addresses current concerns, acknowledges multiplicity in interpretations and meaning-making, has value, locates the researcher and applies reflexivity, and is "catalytic, liberating, transformative" (Sprenkle & Piercy, 2005, p. 7). Accordingly, they suggest an inclusive approach when considering methodology, which could involve anything from aesthetic work, such as poetry or performative autoethnography, to advanced statistics, such as multilevel growth modeling, depending on the context and aims of the research.

Regardless of any desire for insight into narrative therapy’s effectiveness, given the state of narrative theory and research at this point in time, it seems premature and antithetical to delve into outcome research. A therapy that avoids the obvious goal-directedness often expected by management and funding sources (Bubenzer, West, & Boughner, 1995), narrative therapy would first require clarification and concretization of its overall purpose and the therapist’s role. It may be contested whether outcome research is an end to be wished for, but, as suggested by Besley (2002) and to a lesser extent by Karl Tomm (1993), it is time to turn the gaze back on narrative therapy. In short, research on the therapist’s role and purposes is needed to complement the active accumulation of co-research.
One method that may be able to provide some illumination on this issue is sequential analysis, a strategy with the unique capacity to capture therapist utterances and client responses in the therapeutic process while respecting narrative therapy's epistemic stance. Sequential analysis is essentially a quantification of qualitative methods such as discourse and conversational analysis. It can answer questions similar to those using these qualitative methods, but using a different lens and often offering greater precision and information. Models of therapy can be assessed without making the assumptions of normality, or estimates of population parameters found in most statistical analyses. This is in accordance with narrative's therapy's critique of scientific reliance on dominant discourses, and the potential harm of professional judgments and labeling (White, 1992; White & Epston, 1990).

Sequential Analysis

A Brief Overview

Sequential analysis (Bakeman & Gottman, 1997) is used to describe dynamic processes in social interactions, and it has some history of use in family therapy research. Researchers have advocated for its increased use, arguing that its non-parametric design and use of in vivo observations allow for the examination of small process units and the capturing of micro-models of specific clinical events (Barbera & Waldron, 1994; Moran, Diamond, & Diamond, 2005). The advantage of sequential analysis is its ability to study interactions as they unfold over time, in contrast to static measures, such as questionnaires, which are less suited to examining the dynamic nature of the therapeutic process.
Based on previous research or theory, an interaction to be studied is first chosen. Sequences may contain two or more steps, or events, and a coding system is developed for possible events in each sequence. Coding may be derived from previous research, or from systematic observation, but some form of hypothesis helps to direct the observation and can limit the possibilities for coding systems and the amount of data generated, preventing these from becoming overwhelming but without eliminating the data's ability to surprise. The simplest codes may indicate only whether an event occurred; more complex codes can be developed to code events according to type, known as cross-classification. In either case, codes are created for the interaction and research question at hand. These coding systems become the measurement tools for the sequential analysis.

In therapy, therapist and client utterances can provide ideal matter for this type of coding and analysis. Raters record utterances according to the code assigned, noting, for example, client responses to specific interventive questions, the likelihood that a therapist will respond with specific statements or questions given a type of client statement, or rating entire combinations of utterances in terms of when they are made in time relative to each other and what combinations are most common in the sessions under study.

Data are then arranged in the form of a contingency table, which gathers clear, simple and informative data about the processes involved. Analysis can be done in a variety of ways, depending on the research question. It can generate descriptive data, such as frequencies, rates, and simple probabilities, which, while not actually sequential may still be useful. Conditional probabilities (e.g., the likelihood of target client statement at some point in a session given a specific therapist statement) and transitional probabilities (e.g., the likelihood of client statement B following therapist statement A)
are somewhat more informative. The different times at which these statements can occur are called lags, with onset behaviours at lag 0, immediate responses at lag 1, the following action or speech turn at lag 2, and so on. For example, lag sequential designs have been used to look at responsive patterns in mother-infant attachment behaviours and communication (e.g., Deckner, Adamson, & Bakeman, 2003).

Inferential analysis has the potential not only to describe data, but also to match data to models, as the coding system itself becomes a sort of hypothesis. There are various ways to examine resultant data, such as lag sequential analysis, in which patterns in selected lags are parsed out for analysis. This could, for example, determine the transitional probability of an event at lags 1, 2, 3, and so on, given an event at lag 0. The criterion event can be shifted once or repeatedly, and the difference between the observed and expected transitional probabilities can be calculated, followed by a test to calculate the significance of this difference. By combining different significant lagged behaviours a sequential pattern is finally suggested.

The advantage to lag sequential analysis is its ability to detect certain, specific patterns within sequences. The drawback is that data are fragmented, and repeated testing increases the likelihood of Type I error.

While lag sequential analysis may be preferable for some research questions, Bakeman & Gottman (1997) generally recommend log-linear analysis for cross-classified events. Log-linear analysis was created to analyze multidimensional contingency tables. As a multivariate extension of traditional chi-square analysis, it is used to explain patterns in the observed frequencies in cells, but is able to comprehend the entire table of data, limiting the possibility of Type I error that can exist with lag sequential analysis. While
[Text content not visible due to image obstructing view]
chi-square tests examine significance using only two categorical variables, hierarchical log-linear analysis allows for the analysis of multiple categorical variables. Log-linear analysis also allows the use of standard statistical packages, such as SPSS.

In both lag sequential and log-linear analyses, tests of significance compare the observed transitional probability with the expected transitional probability, which is calculated according to a model. For example, an equiprobable, or zero-order model, assumes that all sequences are equally likely to occur, and a first-order model assumes that each code is as likely to occur as it did occur in the data, but that the order itself was random.

Hierarchical log-linear analysis allows all potential models to be evaluated. The search begins with the saturated model, in which the observed data always fit the expected data. For example, in a hierarchical log-linear analysis involving three variables, and therefore requiring a three-dimensional table, all seven terms (012, 01, 12, 02, 0, 1, and 2) are nested hierarchically within the saturated model. The likelihood-ratio chi square ($G^2$) for each term is calculated to test the statistical significance of each sequence, and non-significant terms are deleted in turn until the simplest model is found that still fits the data relatively closely. Depending on the final model, the analysis indicates which variables cell frequencies are a function of, and what, if any, interactions can be seen between variables. For example, the final model may indicate that a specific type of therapist utterance increases the odds of a consequent client action.

*Sequential Analysis in Family Therapy*

Sequential analysis has not been used in narrative therapy research. However, it has the potential to provide a quantitative parallel to the text and conversational analyses
that have been used in this research, thereby supplementing other accounts of therapeutic conversations. Although family and narrative therapy are resistant to structured, step-by-step approaches, patterns do occur in any therapy, and sequential analysis is important in attempting to understand what patterns can occur in examples of therapeutic discussion.

Sequential analysis has often been used in family therapy to examine patterns of marital interaction, especially in regard to negativity and conflict between couples (Gottman & Notarius, 2000, 2002). There has been less use of sequential analysis to study therapist behaviours. De Kemp and Van Acker (1997) used it to determine whether there was a correlation between client outcome and therapist and client interaction in a family therapy program based on systems theory and social learning theory. Patterns of client-therapist-client utterances that they labeled cooperative/collaborative were determined to occur more often than would be expected by chance, using lag-sequential analysis. This pattern of interaction then formed the independent variable, with problem reduction as the dependent variable. De Kemp and Van Acker found a significant correlation between the two when the pattern was found at a certain phase in treatment.

Barbera and Waldron (1994) studied the relationship between therapist utterances and family cooperation and resistance in systemic family therapy. They coded seven therapist actions and clients' subsequent resistant or cooperative behaviours. Twelve adolescent and parent family units participated in the study. Results were plotted in contingency matrices, and z-scores were computed. Therapist supportiveness was associated with significant client cooperativeness in 9 of the 12 cases. Therapist confronting was not significantly related to either resistant or cooperative family behaviour, and reframing was related to significant increases in resistance. Their findings
were not in accordance with previous research, and Barbera and Waldron suggest this may be a result of sequential analysis' ability to garner more specific information about therapy processes.

Moran, Diamond, and Diamond (2005) used sequential analysis to look at the effects of relational reframe interventions on clients' constructions of problems, and vice-versa, in attachment-based family therapy (ABFT). ABFT is intended to improve adolescent-parent interactions in families where adolescents are struggling with depression. Sessions were rated for clients' use of intrapersonal and interpersonal problem constructions, therapist reframes, and an observer-rated measure of therapeutic alliance. By examining the lagged effects of therapists' use of relational reframes, the investigators determined that interpersonal constructions followed reframes at a rate 2 to 15 times greater than chance in up to five lags (i.e., client speech turns), providing some support for the notion that reframes lead parents to shift from intrapersonal to interpersonal problem constructions. Supporting this finding, sequential analysis and a bootstrapping technique were used to demonstrate that reframes resulted in shifts from intrapersonal to interpersonal constructions, and complementarily, that a lack of reframes was associated with non-shift sequences of one intrapersonal construction followed by another.

The aim of this study was to apply sequential analysis to narrative therapy process, and in particular to those components that reflect White's Vygotskian thinking—a connection that I will articulate more fully below.
Rationale

*Change and Child Development in Narrative Therapy*

In his discussion of method in psychology, Vygotsky (1978) highlighted the need to look at the developmental “process in flight” (p. 68). He argued that studying the development of psychological processes microgenetically or over relatively short periods of time in a particular task setting, offers rich information about critical reactions as they are forming. The connection to microgenesis, not heretofore made by White, undergirds narrative therapy’s location as part of the brief therapy movement, and illuminates the intention and method of the current study. A sequential analysis provides an apt platform for studying microgenetic change over the course of a therapeutic session. The use of sequential analysis is also consistent with Vygotsky’s argument that the scaffolding of concepts cannot be restricted to didactic teaching and learning. Wertsch and Stone (1999) make the point that “one must speak here of the *formation* rather than the transferal of something from an external plane of activity” (p. 372). Concepts do not merely reflect the adult’s world as the child can absorb it, and method must embrace bidirectionality in human interactions.

In keeping with the tenor of Vygotsky’s developmental theory, Muntigl’s (2004) linguistic analysis concentrated on the movement from external to internal, or equally from socially supported (interpersonal) to individualized (intrapersonal) modes of narrative expression. The therapist scaffolded client movement from a narrative mode, to a transitional expository mode, and finally into a revised narrative mode. Muntigl found that therapist scaffolding in the expository phase led to the formation of higher generalizations culminating in the changes in the final narrative mode. In this mode the
interpersonal scaffolding was appropriated into the client’s intrapersonal plane of thought. This was demonstrated by the shifting mode of speech, as the classifications and relationships emphasized by the therapist were appropriated in the client’s later speech. Muntigl’s research explored some aspects of the narrative therapy approach, such as relative influence questioning and externalization, but left space for further explication of what happens in narrative scaffolding. In particular, despite references to Vygotsky, he did not utilize White’s re-visions of the narrative therapy map along Vygotskian lines.

As intimated earlier, White’s (2006a, 2006b) recent writings contain a paradigm shift in considering the purpose of narrative therapy. His utilization of Vygotsky has articulated concept formation, with a view to personal agency, as the crux of children’s development in narrative therapy. Development for children in therapy, then, is their changing ability to perform the tasks of concept formation. White (2005a) states that:

The extent to which children have formed these concepts is dependent upon the stage and state of the child’s development, and even for older children these concepts are rarely fully formed...such conceptual development is critical to the establishment of children’s ability to intervene in shaping their own lives and to influence their relationship with others. (p. 13)

Correspondingly, the therapist’s task is defined as no less than aiding the child in the development of abstract thought (White, 2006a).

Wood, Bruner and Ross (1976) initiated the use of the term scaffolding—a term now popularly associated with Vygotskian theory. They described scaffolding as part of the tutoring process. The tutor initially controls some elements of problem-solving, allowing the child to complete the elements that she is able to. In this way the child can
achieve goals that she would be unable to without support, or can at least accomplish them at a much more rapid pace. This corresponds to scaffolding as White (2006a) has described it through the use of his map. Again, it is important to note that the child is not simply reproducing the therapist’s behaviour. Wood, Bruner and Ross state that recognition and comprehension “must precede production” (p. 90). In order to be successful, scaffolding must also be relevant to the child, engaging, accessible, and have an encouraging atmosphere. It must be sufficiently but not overly interventive, helping the child to recognize the discrepancy between what is immediately seen and what is possible.

The central role given to the circulation of client language in externalizing and concept development (Duvall et al., 2003; Muntigl, 2004; White, 2006a) may provide interesting implications for the scaffolding task. Re-formulating a client’s use of a word would seem to ensure that the potential concept is relevant and accessible to the child. There would be little need to recruit them into the task. When pre-concepts are drawn from the child’s language, there is the expectation that the child would answer therapist scaffolding, responding to questions about externalizations, affirming their use, appropriating the concept’s new incarnation into their own utterances, and even expanding on their application. The shared work of therapeutic conversations found by Kogan and Gale (1997), with elements such as co-authoring and reciprocal editing, would similarly support the likelihood that scaffolding would be successful.

Research Questions

If scaffolding occurs in narrative sessions, it would be expected that therapist utterances would lead client utterances at the same level. It would also be expected that
these levels would advance during the course of a session. It is unknown how frequently the therapist would move from level to level, or at what levels they would most frequently scaffold. However, these patterns in therapist utterances are available for comparison to changes in the level of concept development in the child. If White’s (2005a, 2006a, 2006b) representation of development is a fair interpretation of what happens in therapy, then some movement across levels should be expected. In other words, this pattern should be observable in the microgenetic processes of therapy sessions. The questions to be asked by this study therefore include:

1. Does the child’s development, defined as proceeding through Vygotsky’s stages of concept formation, occur across a session?

2. Does the therapist scaffold concept formation according to White’s scaffolding map, and in light of subsequent client responses?
METHOD

Participants

Three therapists were involved in the study. One has a Master’s degree in Social Work and the second a degree in psychology. The third therapist was also educated in the area of social work; he was not anticipated as a participant, but had been brought in by one of the two initial therapists to consult with a family and the recording of that session was made available for this study. The consulting therapist was the primary therapist in that session. He has an extensive history of consulting, publishing, and providing training in narrative therapy. Length of both clinical experience and experience in narrative therapy for all therapists was a minimum of 9 years. The two original therapists regularly provide training in narrative therapy at the local level, and have provided training nationally and internationally. In accordance with narrative therapy values, collaboration with therapists was ongoing throughout the development and implementation of this study.

The eight child and youth participants, ages 6 to 15 years, were clients who received brief services at one of two children’s mental health centres. In most cases these were clients from the agencies’ respective walk-in clinics, and had not been seen by the therapist previously. The data were therefore secondary data, gathered and retained by these agencies. Children and youth presented with various kinds of problems. This was reflective of narrative therapy practice, which is not specific to any problem or age.

Procedure

The video recordings used in the analysis were part of a compilation of recordings obtained and used by the therapists participating in the study. The recordings were
primarily collected for training and research purposes. Therapists obtained informed consents/assents from all child participants and from their parents (see Appendices B, C and D) to allow the data to be used in this study. Child and parent participants were told that the research was intended to learn more about what happens when therapists meet with children, and to see if the way narrative therapy is described matches what actually happens when people meet with therapists.

Session recordings were transcribed verbatim. Previously written transcriptions were checked against session recordings to ensure completeness, and therapist and child speech turns were numbered in preparation for coding.

Coding System

The original intention was to code therapist utterances according to their movement through White’s (2006a) five scaffolding tasks, and to code client utterances according to the five correlative stages of client concept formation:

a) name and characterize the problem or initiative (Name)
b) make chains of association to consequences in clients’ lives (Consequences)
c) draw realizations and learning about these consequences (Evaluate)
d) reflect on these realizations and derive conclusions from them about what clients value and intend for their life (Intentions)
e) expand these into some steps or plans to be taken in line with these conclusions (Plans).

This created a coding system of five levels, with an additional code of Other for utterances that did not fall into any of the existing categories (see Table 1 for samples from transcripts).
In the first level, referred to as *Name*, therapists’ and children’s utterances included naming or describing aspects of problems or initiatives. At this level significant child language was often re-circulated. The therapist suggested or requested labels and phrases to describe a problem or initiative, the child offered language spontaneously or in response to a therapist question, or language was negotiated between the child and therapist. As part of characterizing the externalization, utterances coded *Name* also included such conversation as the history of the problem or initiatives, or its tactics and strategies.

In the second level, referred to as *Consequences*, utterances focused on the effects or potential effects of the externalization on aspects of the child’s life, such as her relationships, behaviour, or feelings about herself.

The third level of coding, referred to as *Evaluate*, included the therapist soliciting or the child presenting an evaluation, or statement of position, on the externalization or its effects. Statements concerned what the person wants or does not want in regard to the problem or initiative. Occasionally, this level also included other realizations about the problem or initiative or its effects as understandings and learnings about chains of association, such as what the child felt the problem needs or what should be done to it.

At the fourth level of coding, referred to as *Intentions*, the therapist sought or the child made statements about the broader purposes, beliefs, intentions, hopes, wishes, commitments, or dreams the child or youth has for her life or identity. At this level reflections included justifying evaluations from the previous level (*Evaluate*), as the child’s statements about what they want in regards to the problem or initiative were connected to what the child gives value to in her life, and what she wants for her life and
identity.

In the final level, referred to as Plans, utterances involved next steps, possibilities or outcomes, given the conclusions the child arrived at and what they want for their future. Making plans often included using what was learned about problems during the session, expanding initiatives, and recruiting support systems.

Speech turns were paired, with therapist utterances at lag 0, and each subsequent child utterance at lag 1, so that each therapist utterance and the following child utterance contained two units of coding, but resulted in one data point on the frequency table.

To capture change over time, the number of speech turns in a session was divided into three equal time segments, and each was also coded according to whether it occurred in the beginning, middle, or end of the session. For example, if a session contained 120 pairs of therapist–child speech turns, speech turns 1–40 were coded as segment 1, speech turns 41–80 were coded as segment 2, and turns 81–120 were coded as segment 3.

During a pre-coding exercise, it became apparent that progress through the map with an externalized problem could be followed by progress through the map with an externalized initiative.¹ This was in accordance with the fact that the revised third version of the scaffolding conversations map combined the first, problem-based version of the map, and the second, initiative-based version.

This realization had several implications for the study. First, it was possible that simply using the original codes would portray movement into externalizing the initiative as the equivalent of a return to earlier levels of the scaffolding conversations map, when externalizing the initiative actually appeared to be building a new form of concept

¹ This was the idea of Karen Young, one of the therapists collaborating on the study.
Table 1

Coding Scheme

<table>
<thead>
<tr>
<th>Coding level</th>
<th>Sample from transcript</th>
</tr>
</thead>
</table>
| Name         | Therapist: “Okay. So I was wondering about the worry and what kind of things get the worry going?”  
               “Can you think of times when ADHD’s tried to get the steering wheel but you’ve managed to take it yourself?”  
               Child: “White. Because white is for fear.”  
               “Sometimes I just think to myself that I got through it when I was feeling sick before, and I’m not that bad.” |
| Consequences | Therapist: “What kind of things does discouragement get you worried that they’re going to say?”  
               “Do you think your saying no to it reduced the chance of him doing it?”  
               Child: “It doesn’t want me to do it. It’s like it makes me say all these excuses or something but it’s just the worry making me say it because, like, the worry is in my head, like, it’s kicking me around.”  
               “I asked him if he did it. He said no and that made me really happy.” |
| Evaluate     | Therapist: “But the black rings under your eyes, that doesn’t worry you?”  
               “How do you feel about that now?”  
               Child: “Because I could get injured bad.”  
               “I don’t like it when people are demanding so much.” |
| Intentions   | Therapist: “Is that a quality that you like in people generally, that you would strive for; is that something that you want in life—to be giving?”  
               “Okay, was this a good development? It wasn’t a good development? How come? Why was this not a good thing going on?”  
               Child: “Because I want to be strong and get bigger.”  
               “I want to be my own person. I don’t want to be like everyone else.” |
| Plans        | Therapist: “This trying it plan, is that an okay name for this plan?”  
               “So if they knew about the kind of reassurance that you need at those times, would that be helpful?”  
               Child: “When I’m in a fight with them and I feel scared and I can just think about, like, before, and how we worked it out…”  
               “Kind of like a tag team.” |
| Other        | Therapist: “Grade six, and you’re doing these kind of projects, figuring things out, solving these problems. Is that like a skill of yours, an ability?”  
               Child: “Good. I like coming here to say these things. Your questions really made me think.” |
development often based on the foundation of the first. This realization prompted the decision to create two sets of codes, one signifying the coding of the problem, and a second signifying the coding of the initiative. The exploratory nature of this study made it prudent to code as proposed, and collapse cells once more was known about the patterns that were occurring in the therapy sessions and how the data were distributed. In collaboration with the participating therapists, a coding manual was prepared to describe therapist and client coding in detail and to guide raters (see Appendix E). It was revised to reflect the decision to use double coding as described above.

Once the data were gathered, this decision was reviewed. In frequency analyses, sufficient data points must be gathered for results to be stable. This depends on the total number of events, and their distribution among possible codes. The double coding increased the number of cells in this model from 108 (6 x 6 x 3) to 363 (11 x 11 x 3). Regardless of the distribution of codes, the general rule of thumb is that the minimum number of data points be at least 4 to 5 times the number of cells to prevent unacceptably low levels of power (Bakeman & Gottman, 1997). Once data collection was underway, it became apparent that it would not be possible to use the double coding, given the increase in the number of cells and the scope of the current study. After a survey of the data, it also appeared that sessions largely adhered with externalizing either the problem or the initiative, rather than moving from one version of the map to the other. Accordingly, the decision was made to collapse the data into the original single coding scheme for the final analysis.
**Interrater Agreement**

A second graduate student coded data to provide a basis for interrater agreement. The second coder had extensive experience with coding practices in developmental psychology research and some mental health experience, but no prior experience with therapy and little knowledge of narrative therapy.

Cohen's (1968) weighted kappa was used to determine interrater agreement. This accounted for the probability of the amount of agreement likely to happen by chance and the varying significance assigned to different types of disagreement. Values just off the diagonal were weighted more highly than values farther off the diagonal. Interpretation of weighted kappa is the same as that of unweighted kappa: values greater than .75 signify excellent agreement, values between .40 and .75 signify fair to good agreement, and values below .40 signify poor agreement when chance has been taken into account (Fleiss, Levin, & Paik, 2003).

As closely as possible, the procedures used for assessing reliability followed the recommendations of Lombard, Snyder-Duch and Campanella Bracken (2002). The second rater was not aware of the study's research questions. She first read through the training manual and some supporting articles, including some work by White. Raters were required to achieve 75% agreement before data collection (Bakeman, Deckner, & Quera, 2005). A variety of transcript samples were used to calibrate observers, including published samples from White, and unpublished training samples from one of the therapists participating in the study. Reliability was informally checked during training, and the coding manual was refined until informal checks of independently coded
transcripts suggested a sufficient level of agreement. In total, approximately 40 training hours were undertaken.

Coding then proceeded to an independently coded pilot test, using 30 units of coding from the full sample, but not of the randomly selected sessions to be used for interrater agreement. Percentage agreement on this pilot test was 84%, and weighted kappa was .77. Finally, coding checks proceeded to a random selection of the full sample. Weighted kappa was checked again at the completion of every 30 units. A weighted kappa of .71 was achieved on a sample of 514 simple units, or 22% of the full sample.
RESULTS

Analysis

Hierarchical log-linear analysis was used to examine the associations among the following variables: 1) level of therapist scaffolding, 2) level of client concept formation, and 3) segment of time in session. For purposes of interpretation, an overview of log-linear modeling will be provided, followed by a more detailed description of the particular analytic strategy used in this study.

As described earlier in the section on sequential analysis, hierarchical log-linear analysis begins with the saturated model, containing all possible associations. The likelihood ratio $\chi^2 (G^2)$ is calculated for all effects and, using backward elimination, the highest order interactions are deleted to produce a model that retains significant main and/or interaction effects. As many one-, two- and three-way associations are eliminated from the log-linear model as possible, as long as an adequate fit is maintained between expected and observed cell frequencies. As a test of model fit, a good model must have a nonsignificant $G^2$. The optimal model must also not be significantly worse than the next most complicated model. The intention is to find the simplest model to reliably fit the data. In other words, the intention in this study was to arrive at a model that only included those variables that were most important in explaining the patterns of utterances that were found in the therapy sessions studied, and any important influences the variables had on each other.

The final step in log-linear analysis is to interpret and evaluate the selected model. There are various possibilities for interpretation. Residuals for each cell may be computed based on the selected model. These are used to assess the fit of the model for
each cell. Residuals are standardized to produce a $z$ value for ease of interpretation. Adjusted (standardized) residuals have a distribution that is nearly normal. Although claims of statistical significance are not used in analysis of residuals because log-linear models rarely meet the conditions required, critical values are still useful in judging the meaningfulness of adjusted residuals (Rojewski & Bakeman, 1997). For a normal distribution under ideal conditions, a standardized residual absolute value of 1.96 and 2.58 would be considered significant at $p < .05$ and $p < .01$ respectively.

Parameter estimates (lambdas) are coefficients for effect sizes, paralleling treatment effects in analysis of variance. Larger standardized parameter estimates indicate that an effect was relatively more important in explaining the frequencies in the table than those effects with smaller standardized parameter estimates. Again, standard normal deviates are interpreted as $z$-scores and compared to critical $z$ to assess the contribution of each effect. Because of the number of tests in log-linear models it has been suggested that a more conservative criterion be used, and given the number of effects in this model that caution seems appropriate. Tabachnick and Fidell (2007) suggest a reasonable criterion $z$ of 4.

Results of Log-Linear Analysis

A three-way frequency analysis was performed to develop a hierarchical log-linear model of therapist scaffolding and child concept development over time in narrative therapy, to determine whether therapists’ use of the scaffolding conversations map was related to patterns of child responses in therapy, and to assess whether these patterns changed over the course of single sessions. Utterances in therapy sessions were analyzed according to White’s (2007) five levels of therapist scaffolding and child
concept development (Name through Plans, as described in the Coding System subsection). A sixth code was included for utterances that were categorized as Other. The overall number of utterances in each session was trichotomized, with codes for the first, second and third segments in a session.

A total of 1187 speech utterances were included in the analysis. As a sequential analysis, the frequencies represent the number of two-event sequences, or therapist-child utterance pairs. The resultant 6 (therapist level) x 6 (child level) x 3 (time segment) table contained 108 cells, the number of cases thereby easily meeting the minimum requirements of five times the number of cases as cells (Bakeman & Gottman, 1997). Power is reduced if expected cell frequencies in two-way contingency tables fall below five. One of the cells had an expected frequency of 4.2; all others were above five, adequately meeting this assumption (Bakeman & Gottman; Tabachnick & Fidell, 2007). After model selection, none of the cells contained outliers.

Stepwise selection by simple deletion of effects using SPSS HILOGLINEAR eliminated the three-way interaction. The research questions suggested that therapist utterances scaffold child concept development, and that both child and therapist utterances proceed over time, or move toward higher levels over the course of the therapy session. The best-fitting model would then include all three two-way interactions, that is, the therapist level by child level interaction, and the child level by time and therapist level by time interactions. As expected, the final model included all two-way associations. The model had a likelihood ratio \( \chi^2 (50) = 60.07 \) with 95% confidence limits from 0 to 38.84, \( p = .16 \), indicating a good fit between the observed and expected frequencies generated by
the selected model. A summary of the model with results of tests of significance on partial likelihood ratio $\chi^2$ and confidence limits is shown in Table 2.

All three two-way interactions were significant at the $p < .05$ level, indicating the need to include them in the final model. Because this is a hierarchical model and all three one-way effects form part of significant two-way associations, they also need to be included regardless of their significance.

A summary of the data on which the analysis was based appears in Table 3. Overall, as this table indicates, a large proportion of therapist and client utterances were coded as Name (45.7% and 46.6%, respectively), with fewer coded as Consequences (13.9%, 13.3%), Evaluate (6.0%, 5.9%), Intentions (11.5%, 12.0%), Plans (9.5%, 8.9%), and Other (13.4%, 13.3%). This means that overall, therapists’ and clients’ utterances were equally frequent at each level. The largest number of utterances was at the first level, naming and characterizing the problem or initiative, followed at some distance by utterances at other levels. Codes for Other occurred approximately the same number of times as codes for the second level, exploring the consequences of the problem or initiative on the child’s life, and the fourth level, drawing reflections for what the child intends for her life. Utterances pertaining to future plans occurred less than 10% of the time, and the level coded least frequently was the third level, evaluating and drawing realizations about the problem or initiative and its effects. The division of time segments was almost equal, as constrained by the research design.

Adjusted residuals were examined to identify the cells that accounted for the fit of the final model. For client by therapist codes (see Table 4), all values on the diagonal, indicating times when child responses matched therapist utterances, were large and
Table 2

Significance Tests for Hierarchical Model of Therapist Scaffolding and Child Concept Formation over Time, $N=1187$

<table>
<thead>
<tr>
<th>Effect</th>
<th>df</th>
<th>Partial association chi square</th>
<th>95% Confidence interval for chi square</th>
</tr>
</thead>
<tbody>
<tr>
<td>First-order effects:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child level</td>
<td>5</td>
<td>622.89**</td>
<td>525.03</td>
</tr>
<tr>
<td>Therapist level</td>
<td>5</td>
<td>590.36**</td>
<td>495.09</td>
</tr>
<tr>
<td>Time segment</td>
<td>2</td>
<td>.01</td>
<td>.00</td>
</tr>
<tr>
<td>Second-order effects:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child by therapist</td>
<td>25</td>
<td>2187.32**</td>
<td>1984.39</td>
</tr>
<tr>
<td>Therapist by time</td>
<td>10</td>
<td>51.82**</td>
<td>19.80</td>
</tr>
<tr>
<td>Time by child</td>
<td>10</td>
<td>22.66*</td>
<td>1.10</td>
</tr>
</tbody>
</table>

*p < .05. **p < .01

positive. All values off the diagonal were negative. This suggests that children were much more likely to follow therapist utterances at the level of therapist scaffolding than to respond at a different level. The adjusted residuals for therapist by time segment codes (see Table 5) evinced an interesting pattern of movement throughout sessions. In earlier segments higher coded utterances (Intentions and Plans) occurred less often than
Table 3

*Frequencies of Coding for Therapist and Child Codes by Time Segment*

<table>
<thead>
<tr>
<th>Time</th>
<th>Therapist level</th>
<th>Name</th>
<th>Consequences</th>
<th>Evaluate</th>
<th>Intentions</th>
<th>Plans</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Name</td>
<td>172</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Consequences</td>
<td>6</td>
<td>56</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Evaluate</td>
<td>2</td>
<td>1</td>
<td>15</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Intentions</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>20</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Plans</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>80</td>
</tr>
</tbody>
</table>

| 2    | Name            | 190  | 8             | 1        | 3          | 3     | 3     |
|      | Consequences    | 7    | 50            | 0        | 2          | 2     | 3     |
|      | Evaluate        | 1    | 1             | 14       | 0          | 0     | 0     |
|      | Intentions      | 3    | 0             | 4        | 52         | 0     | 2     |
|      | Plans           | 0    | 1             | 0        | 0          | 18    | 0     |
|      | Other           | 6    | 0             | 0        | 4          | 1     | 16    |

| 3    | Name            | 140  | 3             | 0        | 0          | 1     | 1     |
|      | Consequences    | 5    | 28            | 2        | 1          | 0     | 0     |
|      | Evaluate        | 2    | 0             | 25       | 6          | 0     | 3     |
|      | Intentions      | 3    | 0             | 2        | 45         | 1     | 1     |
|      | Plans           | 3    | 2             | 2        | 0          | 72    | 9     |
|      | Other           | 2    | 0             | 0        | 6          | 2     | 30    |
Table 4

*Adjusted Residuals of Therapist by Child Codes*

<table>
<thead>
<tr>
<th>Therapist level</th>
<th>Name</th>
<th>Consequences</th>
<th>Evaluate</th>
<th>Intentions</th>
<th>Plans</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>29.1</td>
<td>-9.3</td>
<td>-7.4</td>
<td>-10.7</td>
<td>-9.1</td>
<td>-10.5</td>
</tr>
<tr>
<td>Consequences</td>
<td>-9.9</td>
<td>27.7</td>
<td>-2.4</td>
<td>-4.3</td>
<td>-3.7</td>
<td>-4.2</td>
</tr>
<tr>
<td>Evaluate</td>
<td>-6.9</td>
<td>-2.7</td>
<td>25.9</td>
<td>-.6</td>
<td>-2.7</td>
<td>-2.3</td>
</tr>
<tr>
<td>Intentions</td>
<td>-10.2</td>
<td>-4.9</td>
<td>-.4</td>
<td>28.2</td>
<td>-3.6</td>
<td>-3.8</td>
</tr>
<tr>
<td>Plans</td>
<td>-9.6</td>
<td>-3.5</td>
<td>-2.0</td>
<td>-4.1</td>
<td>29.4</td>
<td>-1.8</td>
</tr>
<tr>
<td>Other</td>
<td>-9.9</td>
<td>-5.1</td>
<td>-2.7</td>
<td>-2.4</td>
<td>-3.0</td>
<td>26.3</td>
</tr>
</tbody>
</table>

Table 5

*Adjusted Residuals of Therapist by Time Segment Codes*

<table>
<thead>
<tr>
<th>Therapist level</th>
<th>Segment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Name</td>
<td>1.1</td>
</tr>
<tr>
<td>Consequences</td>
<td>1.8</td>
</tr>
<tr>
<td>Evaluate</td>
<td>-1.2</td>
</tr>
<tr>
<td>Intentions</td>
<td>-4.2</td>
</tr>
<tr>
<td>Plans</td>
<td>-6.6</td>
</tr>
<tr>
<td>Other</td>
<td>7.1</td>
</tr>
</tbody>
</table>
expected, and in time segment 3 lower coded utterances (levels *Name* and *Consequences*) occurred less often than expected, while higher coded utterances (levels *Evalue* and *Plans*) occurred more often than expected. Adjusted residuals for child level by time segment coding, which appear in Table 6, had a pattern similar to that of therapist by time residuals, indicating that child utterances also evidenced a pattern of moving away from lower codes and toward higher codes as the session progressed. These patterns suggest that, as expected—given the developmental implications of the scaffolding model—therapists and children moved away from the earlier stages in the map and toward later stages of the map (i.e., higher stages of concept formation) as they moved through the therapy session.

A summary of log-linear parameter estimates in raw and standardized form is provided in Table 7 (see Appendix F). Calculation of parameter estimates was accomplished using GenLog in SPSS. GenLog uses dummy coding, by default constraining the highest level of an effect to 0 and using these values as comparators. In this analysis, and for the interaction effects, which are the parameters of interest, the codes constrained to 0 were those for *Other*, and time segment 3. These values do not appear in the table of parameter estimates. If significant and positive, the larger the parameter estimate for an effect, the more cases are predicted to be in a cell beyond those predicted by the constant and other effects. If significant and negative, fewer cases are predicted to be in a cell. A review of the effect parameters reinforced what was found in the examination of adjusted residuals. In this analysis, for the therapist by child interaction, the largest standardized parameters occurred when the child followed the therapist at the same level. This occurred for all five levels of scaffolding, and these
Table 6

*Adjusted Residuals of Child by Time Segment Codes*

<table>
<thead>
<tr>
<th>Child level</th>
<th>Segment 1</th>
<th>Segment 2</th>
<th>Segment 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>.9</td>
<td>2.8</td>
<td>-3.7</td>
</tr>
<tr>
<td>Consequences</td>
<td>2.3</td>
<td>1.3</td>
<td>-3.6</td>
</tr>
<tr>
<td>Evaluate</td>
<td>-.9</td>
<td>-1.1</td>
<td>2.0</td>
</tr>
<tr>
<td>Intentions</td>
<td>-4.6</td>
<td>2.6</td>
<td>2.0</td>
</tr>
<tr>
<td>Plans</td>
<td>-6.3</td>
<td>-2.4</td>
<td>8.7</td>
</tr>
<tr>
<td>Other</td>
<td>6.8</td>
<td>-5.2</td>
<td>-1.6</td>
</tr>
</tbody>
</table>

values were positive, indicating more logged frequencies in those cells than a model that predicted no effect. This supports the fundamental narrative therapy claim that therapists scaffold child responses.

The effects were less clear for the time by therapist level and time by child level interactions; however, the effect size for therapist coding at the final scaffolding level, *Plans*, in time segment 1 was significant and negative, indicating that according to this model, the therapist is predicted to be coded *Plans* at the beginning of the session significantly less often than at the end of the session. None of the time segment by child parameters had a z-score larger than 4.
DISCUSSION

Research Questions

In the first known study to compare narrative therapy’s empirical process with its theoretical intention, the findings supported the assertions posited by narrative therapy theorist and co-founder Michael White (2006a, 2006b, 2007). When sequential therapist-child utterances in narrative therapy were analyzed, therapists were found to scaffold child concept formation according to White’s scaffolding conversations map. Further, child and therapist utterances demonstrated progression in the scaffolding conversations map within single therapy sessions, supporting White’s position that therapists scaffold child development, defined in this case as progress through Vygotsky’s stages of concept formation.

It may be taken as self-evident that children follow the lead of therapists in therapeutic conversations. However, it is in no way a natural consequence that children actively follow the reasoning or language of adults. Both Vygotsky (1934/1987), in his exploration of instruction and development, and Wood, Bruner and Ross (1976), in their introductory article on the theory of scaffolding, strongly disputed the belief that imitation is independent of understanding. The distinction between blind following and active imitation and appropriation is especially important for narrative therapy because of the basic tenet that therapy be client-centered. Vygotsky stated that children can only imitate what lies within their potential: “if I do not know higher mathematics, a demonstration of the resolution of a differential equation will not move my own thought in that direction by a single step. To imitate, there must be some possibility of moving from what I can do to what I cannot” (p. 209). Vygotsky argued that children might be
able to do more with support, but only to a certain limit, with the ceiling of abilities differing for different children at any given time. Collaboration and imitation are features of movement within the zone of proximal development, and they are pre-requisites for independent action.

In Wood et al.'s (1976) study, in which children and a tutor were observed at a problem-solving activity, the researchers came to the conclusion that “comprehension of the solution must precede production” (p. 90), based on two factors. First, they found that younger children recognized appropriate steps in a problem-solving activity as frequently as older children, but were not yet able to perform them at the same level. Second, younger children ignored adult interventions more frequently than older children. It was not assured that children who were offered scaffolding supports would accept them; the child must have sufficient competency and understanding to take advantage of the scaffolding that was in place. Wood et al. further stated that they found not a single instance of blind imitation in their study, and concluded by emphasizing that imitation depended on a child first understanding how the act fits with the task at hand.

In considering the stages of White's map, blind imitation must have been especially unlikely at higher levels of concept development, where tasks were more complex. In order to engage in higher levels of the scaffolding conversation, children had to sufficiently comprehend pre-concepts and concepts to respond and formulate new understandings based on prior therapist scaffolding. At those levels of the map where children were invited to make chains of association with the broader intentions they had for their lives, or to base a plan of action upon all of the preceding concept development, this was a more intricate task, as is apparent in examples from the transcripts:
Example 1

Therapist: “So, worry kind of equals, is the same thing as, thinking about the bad feeling. So your wish for yourself is...”

Child: “Is, I really don’t want the pain anymore. I don’t want to think about the worrying anymore because it really hurts and it makes me think that I can’t do it when I actually can, and like, so many people tell me that I actually probably could and the worry tells me that they are wrong but like the people who tell me this are actually right, it just takes me a little while to figure out they are right, because I feel better over time...”

Example 2

Therapist: (talking with a youth and her worker about her experience of losing significant people) “...She rides them (the losses) out, and it has to do with hopefulness, you think, and allowing—what—that, you said, she could have held you at arms length, she could have not connected with you in any way, not allowed any relationship to develop...?”

Worker: “Ya, and she could have done that in many ways—she could have said to herself: how long are you going to be here, right, the last person I only had for a year, are you going to only be here for a year, but I didn’t get that from her.”

Youth: “That was Jean who left, and then there was Suzanne for a year...but I think something that would help me would be to think about all the good times that I have with my friends and think about all those instead of thinking about me going to be losing them or something. And do things that I know will make myself feel better....“

Such complex responses were not unique, and do not demonstrate behaviour that is automatic or mechanical. They do, however, represent the therapist’s scaffolding and its appropriation into the structure of the child’s thinking and speech. In the first example, the therapist briefly summarized at the first level of the map, naming and characterizing the problem, and scaffolded with a question at the fourth level, regarding intentions the child has for his life. The child responded with his wish for a life without the pain or worry, at the same time
drawing together realizations from earlier in the conversation (including the realizations that the worry lies, that the hurting is an effect of the worry, and the “feeling better” is an effect of his initiatives into carrying on despite the worry).

In the second example, the therapist, with the support of a social worker, explored the youth’s abilities to be hopeful in new relationships despite her past losses (“she rides them out, and it has to do with hopefulness”). The youth responded by reworking the strategies she had used to build relationships with new workers and caregivers into strategies she can use when she perceives a threat to her relationships with friends, as an alternative to self-doubt and self-harm (“that was Jean who left, and then there was Suzanne for a year…but I think something that would help me would be to think about all the good times”).

Just as child responses could not be expected to simply follow a therapist’s verbal scaffolds, according to the same reasoning the movement across levels of the map could not be expected to occur naturally. Indeed, only a few sessions reflected even roughly linear advances across all of the levels. Because of the variation in sessions, and the lack of coherent linear movement, it is unlikely that a qualitative study would have found an overall change over time. Aggregate data were needed for such change to be noticeable. The sometimes small movements in child concept formation, and the shifts forward and backward in the map, might have hidden the overall forward progression apparent in the results of this study. The statistical analysis discerned patterns that might have been harder to discover with a qualitative analysis of the same data. The aggregate results brought new insights and information even in their simple descriptive form.
At its most basic level, the simple frequencies from the analysis provided new insights into the occurrence of and distribution of externalizing behaviours in narrative therapy. Externalizing was clearly happening in sessions, with most utterances coded at one of the five levels of scaffolding and concept formation. One interesting finding was the substantial amount of time that therapists and children spent naming and characterizing the problem or initiative. While this finding reflects the importance given to this pivotal feature of narrative therapy (White, 1989b) and its location as the entry point for externalizing, it also merits consideration in light of other studies that have explored it. The previously mentioned findings of Coulehan et al. (1998), Besa (1994), and O'Connor, Meakes et al. (1997) point to the expectation that externalizing the problem in narrative therapy is less impactful than other aspects of narrative therapy. Their interpretation and applicability to the current study may be called into question because, in addition to some methodological questions, the definitions of externalizing in those cases do not exactly parallel the first level of coding in the current study. However, Coulehan et al. suggested that extrapersonal definitions of the problem were only linked to successful outcome when they were connected to collaborative treatment goals. This suggestion does cohere with the current findings when taken together with therapist in-session comments about the usefulness of externalizing, and with the significance of the final code (Plans) at the end of sessions.

Therapists frequently and explicitly stated that their intent in loitering at the first level was that ideas for action often flow naturally from this process. For example:

“So if we could get to know discouragement, how it works, the kind of lies it tries tell you, then we could figure out how best to shrink discouragement down, free your life from it...”
"Could I get to know what each of these worries is like? Could I get to know them better than just their names for a few minutes? Because it might be important for me to really get to know what the fears are so we can help and figure out what to do about them."

Children seemed to be similarly aware of this intention, as illustrated in the following two excerpts:

Therapist: "Do you think it was a good thing to do or not a good thing to do, to put a picture to it (the ADHD)?"
Child: "A good thing to do... because then everybody and whoever needs to know will know what it looks like and get a better picture."

Therapist: "Why do you think it's a good idea to describe the fears and know what they look like and what they say and things?"
Child: "It's good, because you can know what they look like and then you can know how to help me defeat them."

The earlier stages of externalizing, then, may be more useful than previously thought by researchers.

Another result of the simple frequency table was that questions and responses at the level Evaluate, where usually the therapist would scaffold or the child would make a statement of position on problem or initiative, were coded least frequently of all of the levels. It is possible that this finding was a result of the coding procedure, which dictated that only verbal behaviours be coded. Therapist utterances seeking the child’s statement of position appeared to take the form of closed questions, allowing for non-verbal indicators of agreement or disagreement. To elaborate on child responses, therapists often moved on to questions about why the child had responded the way that he or she had, leading to a code of Intentions for the utterance, and no record at all of the child’s response. It was expected that the decision not to code non-verbal behaviours would exclude some child or therapist responses. Including those behaviours in the coding scheme would have hampered the coders’ ability to capture the verbal behaviours, in that
it certainly would have limited how many sessions could be included given the scope of this study, and shifted the focus from verbal language—the core unit of study for theoretical and practical reasons.

The significance of the final level, which expands conclusions from previous levels into plans for action, was not apparent in the frequency table, but was highlighted by the post hoc examination of residuals and parameters. This finding emphasizes some of the theoretical implications of White’s (2006a, 2007) ideas. These issues are addressed in more detail below.

**Theoretical Implications**

In the scaffolding conversations map, White (2006a, 2007) marked the fourth level—that is, scaffolding intentions for the child’s life based on their articulation of the problem or initiative, its consequences on the child’s life, and the child’s evaluative position—as the achievement of concept formation. In the map it is the pinnacle of abstraction. In this regard, White’s theory reflects what Wertsch (1985) referred to as the principle of decontextualization of mediational means, which Vygotsky used to help explain the relationship between thinking and speech. According to this principle, language serves as a mediator between thought and word. In higher levels of reasoning, people are able to use language that is decontextualized, to come to new understandings and conclusions from a linguistically created reality. The ability to remove language from its context was connected to higher mental functioning, and improved task performance. The principle of decontextualization of mediational means is evident in the incremental abstractions of the scaffolding conversations map. Through progressive externalizing,
children move from highly contextualized, concrete understandings to the
decontextualized abstract concept.

However, in the scaffolding conversations map, White (2007) not only re-interpreted the statement of position maps, but also added a fifth level. In a move that on the surface appears theoretically contrary, White turned to the final level, the importance of which is accentuated by the results of this study, to re-contextualize the fully formed concept. The gradually abstracted learnings and realizations that began with naming the problem or initiative and was transfigured into the child’s hopes for her life, became a basis for drawing on concrete, child- and context-specific tasks to be carried out by the child and family. The level is clearly essential in therapy practice as an indicator that learning is transferred into real-life applications. The continued contribution of in-session learning through the implementations of plans outside of therapy is something to be hoped for if the child is to have greater agency over her life. However, it is an ideational reversal. The addition of the final level creates theoretical implications pertaining to Vygotsky’s work, and particularly to Vygotsky’s ideas about the development of inner speech, that have not been fully elucidated by White.

Wertsch (1985, 1996, 2000) described the two opposing directions in Vygotsky’s (1934/1987) research on thinking and speech, or what Wertsch has referred to as the unresolved tension between decontextualization and contextualization. At some points, the telos of development for Vygotsky clearly appeared to be the Enlightenment attainment of rational thinking, achieved through decontextualized concept formation. In studying the generalizations in word meanings that are overt in the older child and adult’s external speech, Vygotsky focused on decontextualization in language. From its first use,
The text of the page is not visible in the image provided.
speech serves a communicative function, and generalizations make it possible for meaning to be shared and experiences to be transmitted in social interactions, functions intertwined with the new capacities they bring for thinking and problem-solving. At other points in his writing, Vygotsky seemed to place the achievement of the highly contextualized language of inner speech almost in opposition to the decontextualized conceptual thinking of external speech. Inner speech derives from external speech, and allows people to dialogue with themselves as they would dialogue with others, producing reflections that help people plan and regulate actions.

In distinguishing between external speech and inner speech, Vygotsky (1934/1987) separated meaning—the abstract, decontextualized signification of a word, from sense—the contextualized, personal signification of a word. Inner speech is highly contextualized because it is characterized by a “predominance of the word’s sense over its meaning” (Vygotsky, 1934/1987, p. 275), the sense being the sum total of all the events and associations aroused in our consciousness by the word. Unlike a word’s generalized meaning, a word’s sense is highly context specific—that is, it acquires its sense from the context in which it appears. Although in some ways standing in opposition to meaning, the sense of a word also subsumes a word’s meaning, as one, more stable contribution to a person’s sense of a word. A complex, mutual relationship develops between the word’s meaning and sense, but both are necessary for a child’s development.

Decontextualization seems to fit with White’s scaffolding from the known and familiar, toward the possible to know. The immediate relationship people have with events and experiences in their lives can be experienced as futile, and even traumatic (White, 2005), and there is a need for the relationship to become mediated so that people
can return to a position of safety and hope. As already stated, the broadening and abstraction of the concept make it more readily available for use and increasingly subject to the child’s voluntary control. The turn to re-contextualization in the scaffolding conversations map and its connection to inner speech is not discussed by White. Vygotsky’s descriptions of the functions of inner speech do, however, explain the necessity of such re-contextualization in thought. Vygotsky’s explanation of the roles of meaning and sense brings us forward in reconciling the seemingly paradoxical contextualization and decontextualization both in Vygotsky’s writings and White’s shift in the scaffolding conversations map. It also brings us forward in reconciling seemingly rationalist ideas with narrative therapy’s espousal of the local and particular.

White has explained that “the distancing from the known and familiar is not synonymous with a splitting off from one’s life. Rather, it is a distancing that provides a foundation for people to play a more significant part in influencing the course of their own development” (2007, p. 275). The distancing from the known and familiar is not a turn to an absolute, abstract and rational stance; it is instead a relative distancing, a relative abstraction. Rather than being immersed in ineffectual or detrimental stories about life, the distancing from a single, overwhelming yet fragmented story in this way brings with it a multiplicity of stories, an expansion of avenues, and the emergence of new possibilities for making connections. In this way the idea of abstraction is rehabilitated. Decontextualization does not eliminate contextualization. Rather, it includes expanded understandings that exist within a coherent system, as new meanings are adopted within the child’s overall sense of their situation.
Limitations and Future Research

There are several limitations that apply to the current study. They concern the specificity of its focus, the use and analysis of observational coding, and especially, its neglect of Foucauldian thinking, one of the philosophical cornerstones of narrative therapy.

The data used in this study were derived from video recordings of single sessions of brief therapy. This focus was intentional, and its specificity was intended to be one of the study’s strengths, but it also might limit the applicability of the current findings for children and therapists meeting over several sessions. The study was also limited to the statement of positions maps (externalizing, unique outcomes) and their incarnation in the scaffolding conversations map. It was not possible to also incorporate other maps used in narrative therapy, such as the re-membering or re-authoring maps (White, 2007), within the limited scope of this study. The longer term use of narrative therapy and the use of other maps are areas that might benefit from future research. Sequential analyses can be equally and fruitfully applied to other narrative therapy maps, and to consecutive therapy sessions.

Decisions regarding how to implement the coding scheme also had important influences on the study’s results. Such influences are to be expected in any research involving coding, but the limitations and implications of the coding presented themselves in interesting ways in this study. One potential limitation, intimated earlier, was the coding scheme’s focus on verbal language only. The limitations of the coding scheme were similarly demonstrated in the attention to explicit content only, implicit content being missed entirely. For example, there were occasions when therapists asked questions
about teachers, parents, or other supporters, or about skills and abilities children possessed. In addition to contributing to alliance-building, these questions often appeared to preface conversations about skills or supports children could make use of in creating a plan of action, the final level of scaffolding. The rules of the coding manual, however, dictated that these be given the code Other, which failed to capture the likely importance of such utterances as an early form of therapist scaffolding at the level of planning. In a future study, therapists’ coding of their own behaviours might provide an interesting comparator; such an inclusion was unfortunately beyond the scope of this study.

Further to the observational coding, the decision to pair therapist and child interactions with the therapist utterance first left the reciprocal child to therapist influence, and therefore any bi-directional process, unexamined. This is an issue that I hope to address in future research.

There were also significant limitations in this research relating to Foucault and his examination of power and dominant discourses. Despite the unique importance Foucault’s theories have on the history and practice of narrative therapy, and on its conceptualization of the problem in particular, this study neglected to directly address the way Foucauldian ideas and practices manifest themselves over the course of therapy.

Power and Dominant Discourses

People who seek therapy usually do so because they are experiencing problems in their lives. White (2007) has referred to Foucault in discussing the cultural climate that can not only lead to internalized understandings that confound people’s attempts to resolve their problems, but that also tend to shape what people consider problems in the first place.
Foucault (1991b) wrote of dominant discourses being given a privileged position in society, while others are marginalized, creating a body of discourses that are considered culturally appropriate for a given experience. Stories that are accorded truth or normative status inevitably influence how people interpret and speak about their experiences, and what are considered problems.

Foucault not only dealt with the influence dominant discourses have on our interpretations, but also on the government surrounding these discourses, and what they invoke from the population. In discussing the discourse of sexuality, for instance, Foucault (1978) stated that “it was essential that the state know what was happening with its citizens’ sex, and the use they made of it, but also that each individual be capable of controlling the use he made of it” (p. 26). Discourses such as that of sexuality, medicine, mental health, and so on had and were intended to have a profound influence on citizens, on their behaviour, their use as resources, their knowledge, their self-knowledge, and their self-discipline. Despite the power of these discourses, it was imperative that individuals were understood to have and accepted their own responsibility and control over their behaviour. It was in this way, through individual’s self-government, that the discourses produced and held their power. Only a secretive, normative power, combined with the ever-present gaze represented by the panopticon, could both carry such power and leave the work of it to individuals and societies.

This functioning of power at the individual level is important in considering therapy. Individuals’ stories reside within grand discourses regarding what is expected of them, what they should know about life and themselves and for what they are responsible. It is a hallmark of narrative therapy that people are understood to come to
therapy when the dominant stories they have about their lives do not match their preferred reality, and that therapy can offer support in acknowledging and questioning these discourses. This occurs through both the unpacking and deconstruction of truth discourses and problem-saturated stories, and through re-authoring and the archaeology of new stories.

Discourses constrain our understandings, and impose notions of individual responsibility, but Foucault also emphasized the discontinuities, the pluralities and transformations of discourses. Personal agency allows people to choose to inhabit the discontinuities in discourses, understanding and questioning the constraints of the systems within which we act, rather than unquestioningly owning responsibility for expectations not of our own choosing. White and Epston (1990) have argued that externalizing is a liberatory counter-practice to objectifying, normalizing cultural practices that create docile bodies. It is only one aspect of narrative therapy that challenges received therapeutic discourses, discourses which aim to situate problems within the individual, where the machine of power gives it an “analytic, visible, and permanent reality” (Foucault, 1978, p. 44).

That externalizing is a venue for uncovering dominant discourses was evident to some extent in the verbal content of the transcripts used in this study, as children, youth and therapists spoke about problems with expectations, the demands and protest of perfectionism, and problems frequently linked to guilt and worries. The meanings and stories that constitute people's lives depend upon language to mediate self-understandings. The role of power and dominant discourses were therefore treated implicitly through the treatment of language in externalizing conversations. However,
this study did not address the epistemological and ontological standpoint on the problem in narrative therapy as, for example, Lobovits, Epston and Freeman (2006) have in co-research with women on eating disorders. It therefore treated as secondary what is possibly the fundamental framework of all practice and theory in narrative therapy—namely the critique of hegemonic discourses.

It was simply not within the realm of this study to focus on social constraints, political influences, and dominant discourses in people’s lives as a primary goal. Narrative therapy, and its research, must be oriented towards the techniques of power exercised in relationships, towards others and in self-subjugation (White & Epston, 1990). Other forms of research in narrative therapy, specifically co-research, are better able to explicitly uncover the social and cultural histories of people’s lives (White, 2006a). This research has conformed to Foucauldian ideas in its attempt to establish a self-reflective platform for offering therapy, and to evaluate narrative therapy’s own ideas about what it is trying to accomplish.

Ideally any research, like any therapy, should try to comprehend the conditions that make possible its own existence, how it is situated and functions amongst other discourses, and its relation to the broader political, economic and social context (Foucault, 1991). It is an ethical imperative of narrative therapy that practitioners strive for awareness of the systemic discourses of people’s lives. Narrative researchers similarly need to strive for an awareness of these discourses, as they influence and constitute the practices, intentions and expectations of the research and researcher.
Conclusion

Despite its limitations, this study provided empirical support for the overall purpose of and the therapist’s role in narrative therapy, that of scaffolding child development through concept formation. It is hoped that future research can improve upon the therapy’s ability to account for itself while invoking Foucauldian thinking, to capture the full scope of narrative therapy.
References


Appendix A: Scaffolding Conversations Map

<table>
<thead>
<tr>
<th>Possible to know</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Very high level distancing task: plans for action</strong></td>
</tr>
<tr>
<td>e.g., deciding to consult with another family member, negotiate with parents</td>
</tr>
<tr>
<td><strong>High level distancing task: abstraction of learnings and realizations</strong></td>
</tr>
<tr>
<td>e.g., the person’s intentions for their life, “safety”, “freedom”</td>
</tr>
<tr>
<td><strong>Medium-high level distancing task: reflections on chain of associations, learnings and realizations</strong></td>
</tr>
<tr>
<td><strong>Medium level distancing task: problem taken into chain of association</strong></td>
</tr>
<tr>
<td>e.g., exploring the effects/consequences on family relationships, “worry…”, “more independence…”</td>
</tr>
<tr>
<td><strong>Low level distancing task: characterizing the problem or initiative</strong></td>
</tr>
<tr>
<td>e.g., naming “fighting”, “responsibility”</td>
</tr>
<tr>
<td><strong>Known and familiar</strong></td>
</tr>
</tbody>
</table>

Figure 1. Scaffolding conversations map.
Appendix B: Child Consent Form (Under 12)

Project Title: A Sequential Analysis of Therapist Scaffolding and Child Concept Formation in Narrative Therapy
Agency participants: Haldimand-Norfolk Resources, Education and Counselling Help (REACH) and Halton Child & Youth Services (HCYS). This study has received clearance from Brock University’s Research Ethics Board (File # 06-251).

Informed Assent (under 12)

You are invited to be part of a new study. The study is to learn more about what happens when therapists meet with children. This study will use the video of your meeting with your counsellor. A researcher will watch the videos to learn about what you both say.

Your counsellor will keep the video. For some children, the researcher will write down what you and your counsellor said on the video. The researcher won’t write down your name, or anything else that would let other people know who you are. Other researchers who are helping with the study might see these notes. Just like your counsellor, the researchers will keep your information confidential. That means that without your permission they won’t tell other people who you are or what you say in the video.

I agree to have my video used in this study. I know that I can ask any questions that I have. I understand that I have the choice to take part in this study or not, and that I can still talk to my counsellor no matter what I decide.

Name: __________________________________________

Signature: ____________________________ Date: ________________

I give my permission for the researcher to quote what I say in reports and articles from this study. I understand that the researcher will not use my name in these quotes (please circle). Yes  No

Thank you for your help!

Researcher: Heather Ramey–heather.ramey@brocku.ca
Appendix C: Child/Youth Consent Form (12 and over)

Informed Consent (youth over 12)
Project Title: A Sequential Analysis of Therapist Scaffolding and Child Concept Formation in Narrative Therapy

Principal Investigator: Heather Ramey, student
Department of Child & Youth Studies
Brock University
heather.ramey@brocku.ca

Faculty Supervisor: Donato Tarulli, Ph.D.
Supervising professor
Department of Child & Youth Studies
Brock University
(905) 688-5550 Ext. 4513
dtarulli@brocku.ca

Agency participants: Haldimand-Norfolk Resources, Education and Counselling Help (REACH) and Halton Child & Youth Services (HCYS). These agencies and some therapists have given permission to have videos of therapy sessions used in the study when clients give their permission.

INVITATION

You are invited to have the video recording of your meeting with the therapist used in a research study. This study is intended to get more information about narrative therapy with children and youth, to see if the way we describe therapy matches what actually happens when people meet with therapists. Narrative therapy usually involves people working together to explore the stories they have about their lives, to understand the effects and ways of re-authoring these stories. If you choose to participate, the video recording of your therapy session will be viewed and used in the study.

CONFIDENTIALITY
All video recordings will be kept by REACH or HCYS. For this study, the principal investigator will review the videos. Only this researcher will see them. Because the study involves videos, the researcher who views your video will be able to identify you. This means that the data cannot be anonymous. However, all data will be kept confidential. A transcript might be also made of your session. If that happens, a research assistant and the supervisor will also see the transcripts. They will not see the videos. To protect confidentiality, your name and other information that can identify you will be taken out of the transcripts, and the researcher, research assistant and supervisor will all sign the agency’s confidentiality form.

VOLUNTARY PARTICIPATION

By participating in this study you will be helping researchers and therapists better understand what narrative therapists do in therapy and how change happens for children and youth. In this way, your participation might also improve other people’s experiences.
Narrative Therapy

in therapy. Since video recordings of counselling sessions are already used by the agency for training, teaching and other research, participating in this study is not expected to cause greater risks.

Participation in this study is voluntary. You can withdraw your consent for this project until May 15, 2007. Your decision will not change the services you receive from REACH or HCYS.

PUBLICATION OF RESULTS

Results of this study will be published in a thesis, and may also be published in professional journals and presented at conferences. You will not be directly identified in any publication resulting from this research. With your permission, anonymous quotes may be used. When the study is finished, around September of this year, a report on its results will be available from your therapist.

CONTACT INFORMATION AND ETHICS CLEARANCE

If you have any questions about this study or would like more information, please contact the principal investigator or the supervising professor. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University (File # 06-251). If you have any comments or concerns about your rights as a research participant, please contact the Research Ethics Office at (905) 688-5550, ext. 3035, reb@brocku.ca.

Thank you for your help with this project. You will be given a copy of this form, so that you can save it for your records.

I agree to participate in the study described above. I have been able to ask questions, and understand that I can get more information about the study and my participation in the future. I understand that I have until May 15, 2007 to withdraw this consent.

Name: ___________________________________________

Signature: _______________________________________

Date: ___________________________

☐ I give permission for anonymous quotes to be used in reports from this study.
Appendix D: Parent Consent Form

Informed Consent (Parent)
Project Title: A Sequential Analysis of Therapist Scaffolding and Child Concept Formation in Narrative Therapy

Principal Investigator: Heather Ramey, student
Department of Child & Youth Studies
Brock University
heather.ramey@brocku.ca

Faculty Supervisor: Donato Tarulli, Ph.D.
Supervising Professor
Department of Child & Youth Studies
Brock University
(905) 688-5550 Ext. 4513
dtarulli@brocku.ca

Agency participants: Haldimand-Norfolk Resources, Education and Counselling Help (REACH) and Halton Child & Youth Services (HCYS). These agencies and some therapists have given permission to have videos of therapy sessions used in the study when clients give their permission.

INVITATION

Your child is invited have the video recording of their meeting with the therapist used in a research study. This study is intended to get more information about narrative therapy with children and youth, to see if the way we describe therapy matches what actually happens when people meet with therapists. Narrative therapy usually involves people working together to explore the stories they have about their lives, to understand the effects and ways of re-authoring these stories. If you and your child consent, the video recording of your child’s therapy session will be viewed and used in the study.

CONFIDENTIALITY
All video recordings will be kept by REACH or HCYS. For this study, the principal investigator will review the videos. Only this researcher will see the videos. Because the study involves videos, the researcher who views the tape will be able to identify your child. This means that the data cannot be anonymous. However, all data will be kept confidential.
A transcript might also be made of the session. If that happens, a research assistant and the supervisor will also see the transcripts. They will not see the videos. To protect confidentiality, names and other information that can identify participants will be taken out of the transcripts, and the researcher, research assistant, and supervisor will all sign the agency’s confidentiality form.

VOLUNTARY PARTICIPATION

Participation in this study will help researchers and therapists better understand what narrative therapists do in therapy and how change happens for children and youth. In this
way, participation might also improve other people’s experiences in therapy. Since video recordings of counselling sessions are already used by the agency for purposes such as training, teaching and other research, participation in this study is not expected to cause greater risks.

Participation in this study is voluntary. You can withdraw your consent for this project until May 15, 2007. Your decision will not change the services you or your child receive from REACH or HCYS.

PUBLICATION OF RESULTS

Results of this study will be published in a thesis, and may also be published in professional journals and presented at conferences. Participants will not be directly identified in any publication resulting from this research. With your permission, anonymous quotes may be used. When the study is finished, around September of this year, a report on its results will be available from your child’s therapist.

CONTACT INFORMATION AND ETHICS CLEARANCE

If you have any questions about this study or would like more information, please contact the principal investigator or the supervising professor. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University (File # 06-251). If you have any comments or concerns about your child’s rights as a research participant, please contact the Research Ethics Office at (905) 688-5550, ext. 3035, reb@brocku.ca.

Thank you for your help with this project. You will be given a copy of this form, so that you can save it for your records.

I agree to have my child participate in the study described above. I am aware that this research is intended to study children, youth and therapists, but in the event that I appear in the video, I agree to have the video included in the study. I have been able to ask questions, and understand that I can get more information about the study and my child’s participation in the future. I understand that I have until May 15, 2007 to withdraw this consent.

Name of child/youth: __________________________ Name of parent: __________________________

Parent signature: __________________________ Date: __________________________

☐ I give permission for anonymous quotes to be used in reports from this study.
Appendix F: Coding Manual

Coding Manual: A Sequential Analysis of Therapist Scaffolding and Child Concept Formation in Narrative Therapy

This observational coding system is designed to measure child client and therapist behaviours during narrative therapy sessions. Specifically, it uses the stages of Michael White’s (2006a, 2006b, 2007) scaffolding conversations map.

Narrative therapy uses externalizations, or language to situate problems, solutions, useful initiatives people have taken, and other aspects of people’s lives outside of themselves. At times problems and initiatives are even personified. Externalizing language may be derived directly from client statements and re-circulated, or it may be negotiated between the client and the therapist. As separate entities, externalizations can be held up as reflecting surfaces so that a client may view and reflect upon them from a new position. Ideas that have been very close to people become separated or distanced from them; what was known and familiar can be perceived and acted upon differently. Instead of people’s lives being defined by their problems, they are able to negotiate new understandings and become agents of change.

The scaffolding conversations map scaffolds the progression from the known and familiar to what is possible to know. White’s map is based on Vygotsky’s (1934/1987) theories of the zone of proximal development (ZPD) and concept formation. A ZPD is created as inceptual externalizations, or pre-concepts, are submitted to increasing levels of generalization. The therapist scaffolds the formation of abstract concepts in collaboration with the child client. It is movement through the levels of therapist
scaffolding and child concept formation that are described for coding in this manual. The same set of content codes describe both children’s and therapists’ utterances.

Content Codes

Therapist and child utterances are coded according to their movement through the scaffolding conversations map. White has delineated multiple maps, but those that are most prominent in his recent writings are the statement of position map one, also known as the externalizing map, which scaffolds the problem; the statement of position map two, also known as the unique outcomes map, which scaffolds the initiative; and the scaffolding conversations map, which he presents as scaffolding either the problem or the initiative (e.g., White, 2006a, 2006b, 2007). It was decided to separate the problem and initiative in this coding system. This was expected to be particularly relevant when dialogue is being coded to capture change over time, as people often start with the problem and move on to the initiative, and returning to the first level of scaffolding for an initiative is very different from revisiting the beginning of the problem. The ten levels of coding denote the ten therapist scaffolding tasks and the correlative steps of child concept formation:

a. name and characterize the problem

b. make chains of association to consequences in clients’ lives

c. draw realizations and learning about these consequences

d. reflect on these realizations and derive conclusions from them about what clients value and intend for their life

e. expand these into some steps to be taken in line with these conclusions

aa. name and characterize the initiative/unique outcome
bb. make chains of association to consequences in clients' lives
cc. draw realizations and learning about these consequences
dd. reflect on these realizations and derive conclusions from them about what
clients value and intend for their life
ee. expand these into some steps to be taken in line with these conclusions.
o. utterances that do not fit under any other code.

Coding System

This coding system was created to explore the actual practice of scaffolding and
client development in narrative therapy, in light of current theoretical understandings. In
the instructions for coding client and therapist utterances, a description of verbalizations
at each level is offered, including examples. In addition to the use of this manual,
transcripts such as those from White (2006a) may be used in sample coding exercises for
rater training, or as an extended demonstration of the coding procedure.

To measure change, utterances are coded in sequence, and also according to
whether they occur in the beginning, middle, or end of the session. For time segments,
the total number of utterances is divided into three equal segments and assigned a code of
1, 2 or 3.

Data

Data consists of video recordings of sessions and transcriptions. Either may be
used for coding.

Only verbalizations are assigned codes, and each speech turn is assigned a single
code. They are coded in the sequence in which they occur, but not for duration. When
utterances do not otherwise fit within the coding scheme they are assigned a code for
other. This creates a system of codes that is mutually exclusive and exhaustive for more concise analyses, and to ease the comparison of code sets in assessing interrater reliability.

Often, family members or others will be part of the session. Coding does not pertain to their utterances, and the speech turns of family member, witnesses, and conversational participants are not coded.
Therapist and Child Utterance Codes

a/aa. *Name and characterize the problem or initiative*

As problems and initiatives are located, scaffolding at this level is intended to draw out words for pre-concepts as beginning externalizations. Therapist utterances may include recapping what the child has said, often using significant words of the child. Names may be verbatim, as the child’s language is re-circulated, they may include therapist suggestions or negotiations of labels and phrases to describe a child’s idea, or the therapist may explicitly ask for language to describe an idea. The child’s utterances may include the use of names or descriptions of aspects of problems or initiatives. The initiative may be a thought, behaviour, or feeling the child is experiencing that stands apart from the problem, and may at times also be considered an exception to the problem, or a unique outcome. It is therefore something that has happened or is currently happening for the child.

Examples:

“The thoughts that come when the fighting starts, what would you call them?” (a)

“I would guess that my mom wanted to come because of the problems with my sleeping.” (a)

“Talking when you are angry, finding ways to cooperate?” (aa)

“Okay. It means that you don’t shut down. Is that right?” (aa)

“This means that you’ve got more to say about your own future. What would you call that sort of development?” (aa)

“Can you tell me about a time when you knew you were in that same kind of situation, but you chose to do something different, something you’re pleased
with?” (aa)

“But sometimes it doesn’t bother me at all.” (aa)

Therapist: “You’ve talked about following through, taking time out when you need it”. (aa)

Child: “Yeah.” (aa)

Therapist: “What do you do when you’re taking time out?” (aa)

Child: “I go outside, sometimes I do work outside.” (aa)

This level also includes characterizing or describing the externalization, and includes discussion about the history of the externalization, such as when and how it began, and how it came to be significant.

Examples:

“Can you draw the fears for me?” (a)

“Tell me about how the worries try to trick you.” (a)

“When did the worries begin?” (a)

“How did the worry get so big?” (a)

“The worrying about your marks at school, is that part of the problem, or is that something else?” (a)

“It kind of starts out as a feeling in my stomach.” (a)

“It really got bad when I was in grade three.” (a)

“How did you do that? How did you manage to follow through?” (aa)

“What made it possible for the calming thoughts to happen?” (aa)

“Did you know before that you would act with that sort of compassion?” (aa)

“I just told myself that I didn’t want to listen to the ADHD.” (aa)
Therapist: "You took a stand and chose not to do it. Was that difficult for you?"

(aa)

Child: "No, not at all." (aa)

Therapist: "Why is that? Why wasn't it hard?" (aa)

Note: Narrative therapy is an approach that avoids totalizing. A story about the history of the problem, for example, may include very positive aspects or develop through a positive experience.

Example:

"I think the worry partly just came from me wanting to do well at school." (a)

In the same way, when first discussing what brought the child to a session, it should not be assumed that a problem is the motivation for the meeting unless it described in a way that this is reasonably clear.

Examples:

"I did something at the group home." (o)

"I was in a fight at the group home." (a)

In talking about the problem and initiative, when the therapist or child focuses on the effect of the problem itself on the initiative or the inverse (i.e., how the problem can impact the initiative, or the effects of the initiative on the problem) the utterance is coded aa.

Examples:

"Worry makes me forget things I know can stop it." (aa)

"Talking to my dad helps to make the fears go away." (aa)
Other aspects of the child’s life, such as skills, knowledges, gifts or talents, are coded as a stage of scaffolding or concept formation only when they relate to the externalization or it is made explicit that they are being explored because they could potentially relate to the externalization. Otherwise, they are coded o.

Examples:

Therapist: “Can you tell me about yourself?” (o)

Child: “I’m in grade three and I’m good at drawing. (o)

Therapist: “Can you tell me about any talents, skills, or gifts you might have? I’m asking because sometimes it helps to know abilities or tools you have, that might be something to use against the problem.” (aa)

Child: “I’m good at drawing.” (aa)

Note: At all levels, any therapist utterance to draw out further conversation or elaboration of a topic is scaffolded at the same level (usually the most recent stage of verbalization). This includes repeating something the child has said or direct questions or requests for elaboration. At all levels, a child response to therapist questions or statements is coded the same as the therapist utterance, when the child confirms, contradicts or elaborates on the therapist utterance within the same level. A response that indicates that the child does not comprehend the therapist utterance or is not engaging in an aspect of a conversation would not be assigned the same code. However, child codes at a level do not need to be preceded by therapist codes at the same level. A child may offer a response one or several levels below or above the therapist’s utterance that precedes it.

b/bb. Make chains of association to consequences in clients’ lives

This level includes verbalizations about the effects or potential effects of the
externalization on aspects of the child’s life, such as her relationships, behaviour, or feelings about herself. Connections may be drawn between previous externalizations or already mentioned aspects of the child’s life to differentiate externalizations and their (potential) effects.

Examples:

“Okay, more worries about your homework have meant more trouble sleeping?”
(b)

“What does the problem demand of you?” (b)

“Does the ADHD give you any trouble?” (b)

“It gets me thinking that my friends won’t want to talk to me anymore.” (b)

“So taking time out has meant not getting into fights.” (bb)

“Before you decided to tell the truth, what did you think your mom might do if you acted on your commitment to honesty, and told her what had really happened? (bb)

Therapist: “So taking time to think, making that choice means now you can…?” (bb)

Child: “Not lose privileges, take time to relax.” (bb)

Therapist: “You can keep your privileges and take time, what else?” (bb)

Child: “Make more choices for myself”. (bb)

Therapist: “So taking time means keeping privileges, making more choices for yourself. Anything else?” (bb)
If the problem and possible effects are undifferentiated, which is often the case when presented by the child and at the beginning of the session, the utterance is coded as a. If therapist or child differentiates the problems and effects in an utterance it is coded b.

Examples:

“I'm really weak. I can tell because I can't do all my chores.” (a)

“You're really weak, so you can't do all your chores” (b)

“What other sorts of clues are there that you can take care of yourself that way?” (aa)

“Can you give me another example of a time when “taking care of yourself” made things different for you?” (bb)

Again, to be coded b/bb, utterances must involve an aspect of the child’s life, not simply be about characterizing the problem or initiative. Causal words such as of, with, and means are clues that the utterance is likely, although not always, at level b/bb. For example, the problem may lie, interfere, sneak, or trick (a), or it may tell lies that makes the child question herself, interfere with plans, sneak into sleep, cause trouble, or trick her into misbehaving (b).

Examples:

“The worry tells me I won’t be able to do the test.” (b)

“The worry says I won’t see my mom again.” (b)

“The calming thoughts make the worry go away.” (aa)

“The calming thoughts make the throwing up feeling the worry causes go away.” (bb)

“The fear puts the thoughts in my head that I shouldn’t go to sleep.” (b)
Along the same lines, if the problem refers back to itself, it is coded at level a.

Examples:

"The worry makes me think more about the worry." (a)

"The worry makes me think I won’t be able to do it." (b)

Note: Previously established, and even new externalizations will be used frequently in later levels, as they are built upon. When used at other levels they are not coded as a, unless the therapist returns to stage a to re-negotiate the name or language of a new externalization, or to characterize it. If an utterance contains different and clearly competing elements, it is assigned the code of the higher level. Exception: In cases where two different elements appear in an utterance, and in which the intention of the utterance is clear and when it is directed at the child, assign the code that is most consistent with that intention.

Example:

"So you’ve told me a lot about the lies and the problems they are causing you. Is it okay if I ask you a few more questions? (o)

c/cc. Draw realizations and learning about these consequences

Utterances at this level include the therapist soliciting or the child presenting an evaluation, or statement of position, on the externalization or its effects. Therapist utterances soliciting client evaluations may seek statements on whether the child views a problem or initiative and its effects as good or not good, positive or negative, or whether they are something the child likes or does not like, wants or does not want, or they may use other, similar terms. Utterances at this level are statements of position because they concern what the person does or does not want in regard to the problem or initiative.
Examples:

"Are you okay with the ADHD making it hard to concentrate?" (c)

"Do you think it's fair that the fears sneak up on you when you're not expecting it and take away your sleep?" (c)

"Are you OK (or not OK) with the problems you've told me the expectations have caused for you?" (c)

"Getting into fights is just stupid. It just doesn't make any sense." (c)

"Some worry is okay, because it's all right to worry if it's something I should worry about." (c)

"It's not right that this is happening. Women shouldn't be expected to look perfect all the time. Something should be done about this." (c)

"I don't like it. It's frustrating." (usually c)

"Is that good for your development or is that bad for your development?" (c/cc)

"What is this like for you?" (c/cc)

"Those steps that you've been taking, to be there for your friends when they need you, do you think they're important? (cc)

"You also talked about being responsible, making your own choices. Do you see these developments as positive?" (cc)

"It's positive for me, but it sometimes it makes things uncomfortable." (c/cc)

"It makes me feel good." (usually cc)

Therapist: "Is that something you want to be happening?" (cc)

Child: "Yes, yes I think so." (cc)

Therapist: "You want to be more responsible." (cc)
Child: “To be able to make the choice. Yeah.” (cc)

Evaluations or statements of position must be explicit to be coded as c.

Examples:

“It sounds like those are nasty thoughts the worry puts in your head. What other thoughts does the worry cause?” (b)

“Are those things the worry is doing to you kind of nasty? (c)

They are statements about the child’s current position, and therefore would normally be in the present tense.

Examples:

“So afterwards you feel sorry that the worry has got you acting that way.” (b)

“So you regret how the worry gets you being grouchy with others.” (c)

Occasionally, level c may also include other realizations about the problem or initiative, as understandings and learnings about chains of association. The therapist may solicit or the child may offer realizations about the problem, initiative, or its effects, such as what the externalization needs or what should be done to it.

Examples:

“Those fears need to stop bothering me when I’m trying to sleep.” (c)

“The problem needs to be put in its place.” (c)

“The closeness with my mom that day, that’s something that should happen all the time.” (cc)

d/dd. Reflect on these realizations and derive conclusions from them about what clients value and intend for their life

At this level the therapist seeks or the child makes statements about the purposes, beliefs,
intentions, hopes, wishes, commitments or dreams the child or youth has for her life or identity.

Examples:

“I just want to live my life without the fear.” (d)

“Helping others, caring for the people around you, those sorts of things seem to be really important to you in your life.” (d/dd)

“What do you think your mom might say, if I asked her what kind of wishes she might have for your life?” (d/dd)

“That commitment to honesty, where did it come from?” (d/dd)

At this level reflections on realizations from level c may be connected to what the child gives value to in her life, and what she wants for her life and identity. Reflections might take the form of justifying evaluations from level c. These types of utterances try to account for why or how the child took the position they did on problems, initiatives, or their effects, to get at the implications of the child’s realizations. Unlike utterances at level c, which focus on the externalization and/or its effects, such as what the problem wants, or what the child wants in regard to the problem or initiative, at level d utterances expand into what the child wants for his or her life and identity.

Examples:

“You’re frustrated that society’s expectations of how women should look has had you doing things that aren’t good for your body. How would you prefer to be treating it?” (d)

“You feel like the change is a good thing for you. What’s your understanding about why it’s positive?” (dd)
Therapist: “You said that some of the things the sadness has had you doing are wrong. Why do you think they’re wrong?” (d)

Child: “Because that’s not something I had the right to do. It’s wrong to do that to other people.” (d)

Child: “The closeness with my mom that day, that’s something that should happen all the time.” (cc)”

Therapist: “Is that what you want?” (dd)

Child: “Yeah. I want to feel like I’m part of the family.” (dd)

Therapist: “Now you can take time out, you can go to the deck or rake leaves.” (aa)

Child: “Mmhmm.” (aa)

Therapist: “You said it’s good that you’re able to do that now. What’s your understanding of why it’s a positive development in your life?” (dd)

Child: “It means I can make my own choices about what happens when I’m angry. I can stay or I can go outside.” (dd)

Utterances at this level might resemble the externalizations negotiated at level a, but again, are about what people want for their lives and identities. They will therefore be broader, and may be connected with more than a single concrete experience. In scaffolding more generalized themes, the therapist may seek to connect multiple externalizations from lower levels with new abstract concepts.

Examples:

“Taking direction, making your own choices, are about freedom. That’s really important to you. How does that make things different for your life?” (dd)
“So talking to your grandma, telling her what happens with your dad, telling your mom about the worries, all of that is about keeping your family safe. That’s really important to you.” (dd)

Therapist: “Is that something that you want?” (c/cc)

Child: “Yeah.” (c/cc)

Therapist: “How come? How would talking to each other and to other people, not worrying so much, make things different for your family?”

(d/dd)

Child: “We can be safe. We can be happy. We can do fun things.” (d/dd)

If the therapist asks a question at level d/dd, the child may respond by repeating or noting the effects of the problem or initiative (level b). However, if an element of the child’s response to the question indicates or re-iterates their statement of position, such as “because…” or “yes…” the utterance is coded at level c.

Examples:

“No, I don’t like the worries because they made me think I couldn’t write the test.” (c)

“No, I don’t like the worries because I don’t want to be afraid.” (d)

Therapist: “So you’d like to get rid of the problem. Why would you like to get rid of it?” (d)

Child: “Because, like I told you before, it gets me into trouble at school.” (c)

Therapist: “But, the wanting to have the problem gone from your life, what do you think that might say about you as a person?” (d)

Child: “I think it shows that I’m a person who’s responsible. And it means
that I can finish school and get a good job someday.” (d)

Especially with young children, these might be simpler utterances about what the child wants for their life, without a clearly stated overarching theme.

Examples:

“You don’t like the fears. They stop you from doing the things you want. You want to be able to sleep over at your friends’ house, to sleep without the light on, to be able to do the things your friends do.” (d)

Therapist: “You said you don’t like the anger because it gets in the way.” (d)

Child: “Mhhmmm.” (d)

Therapist: “What do you want to be doing instead?” (d)

Child: “Getting along with everybody. Not getting into trouble at school.”

(d)

At times, externalizations about the child’s intentions for their life and identity, normally considered to be level $d$, will be explicitly named, their effects contemplated and evaluated, as would be the expected course of scaffolding for any problem or initiative. When this occurs, intentions that are about something the child has done or is currently doing are double coded. Otherwise, they are coded as $d$.

Examples:

“You’ve talked about how things in your relationship with your parents, your sisters, have sometimes been different lately, and how you’re happy with some of the consequences of that. What do you think that says about what you want in those relationships, like, what would you call that? Caring, closeness…?” (dd)

“You’ve said that you’re not happy with the worry and the problems it’s caused
you, and that you’d rather live a life without worry. What effects might that have on your life?” (d)

In double coding, initiatives may be given names that appear to overlap with intentions, such as honesty, hope or compassion. Initiatives are thoughts, feelings or actions that could not have been predicted by the problem, or that stand apart from it, often recognizable as sparkling moments in conversations. When they are named or characterized by value-laden words, for example, wrong decisions, hopeful acts, or nasty thoughts, they are coded as *aa*.

Examples:

“You’ve talked about all these changes you’ve made, with school, and decision-making, and the steps you’ve taken with your friends. What would you call all of these changes? Is there a name you can think of for them? You talked about good decision-making, responsibility…does that fit?” (aa)

“So that was a time that you were faced with that same dilemma, of choosing between right and wrong, but that time you chose to do something different from what you have in the past. You said that you chose to do what you knew was right.” (aa)

“How has your recent commitment to honesty made things different between you and your dad?” (bb)

Double coded intentions (dd) are recognizable as reflections based on *aa*, *bb*, or *cc*. To be coded level *dd*, value-laden names or characteristics must be broadened from specifically describing that initiative, to describing the child’s intentions. Often, this will involve a move from the past to present tense.
Examples:

“That step that you took recently, that you called being open with your mom, can you tell me more about why you described it as “being open”? (aa)

Therapist: “That step that you took recently, to be more open with your mom about what’s going on, what would that tell me about what you give value to?” (dd)

Child: “I think that my relationship with my mom is important to me, that we get along and I can talk to her about things.” (dd)

Therapist: “And where did that valuing the connection, the wanting to be open and connected with your mother, where did that come from?” (dd)

e/ee. Expand these into some steps to be taken in line with these conclusions

These involve plans, steps, possibilities or outcomes, given the conclusions the child has come to and what they want for their future. Making plans often includes using what has been learned about problems, expanding initiatives, and recruiting support systems.

Examples:

“Do you think there’s something your dad might be able to do to help keep the sadness from sneaking up on you?” (e)

“I think that getting to know the fears will give us a better idea about what to do about them.” (e)

“Now that I know that you’re a person who values your freedom, who wants to be able to make choices for himself, what do you think I might guess would be the next step you take?” (e/ee)

“Maybe I can remind myself that I want to finish my homework, that I’ll be able
to do fun things afterwards.” (e/ee)

“I could get my mom to remind me that I can do it, that I already know how.” (ee)

“I need to just tell myself that it’s okay, and that we’ve been through this before and it worked out all right.” (ee)

Therapist: “Now that I know that it’s important for you that your family is safe, and that you can talk to each other, what do you think I might guess you would do next?” (e)

“I’ll talk to my mom about the worries.” (e)

“Anything else?” (e)

“I’m going to talk to my grandma about what is happening, and call her when I need to. When I see my grandma tonight, I will tell her that that’s what I’m going to do.” (e)

“I’m writing down all those things: talking to your mom, calling your grandmother. This plan you’re making, what name would you give to it?”

(e)

Note: Utterances are coded ee when steps involve something that has been done or attempted previously or that the child is currently doing, or when they expand on previous or current initiatives. If the individual is referring to something he or she has never done before, such as a new idea for next steps to address the problem, it is coded e.

o. Other

Any utterance that does not otherwise fit is assigned the code for other.

Common examples include the first question in a session, and forms of a meta-conversation when they are not specifically referring to any level of scaffolding, such as a
general check-in, or a question following a therapist conversation with a witness.

Examples:

"What brought you here today?"

"How is this conversation going for you?"

"Listening to all the things your mother just said, what stood out for you?"

Even if the remainder of the utterance can be coded otherwise, if the intention is appropriately coded other, that is the code the utterance should be given.

Example:

"You’ve told me a lot about the perfectionism, how it’s pushed you around, and that you don’t think that’s right. Do you mind if I ask your mom some questions now?" (o)

Exception: If an utterance, such as an instance of meta-conversation, unambiguously refers to an idea that is coded at a single level, the new utterance should be coded at that same level.

Examples:

Therapist: “What your worker just said, that she thinks that the sadness is the problem, is it okay if we talk about that a little?” (a)

Child: “Yes.” (a)

Therapist: “You’re okay with that?” (a)

Child: “I don’t mind. It might be helpful.” (a)

“What your worker just said, that she thinks the sadness is the problem—sorry, do we need to take a break right now? Let’s take a break, then.” (o)

Where there is pre-knowledge on the part of the participants, such as an externalization
that is known to participants from a previous session, conversation, or from prior casenotes and the coder is aware of this, it should be coded as it is understood by the participants.

Example:

“The rule that you agreed on when you met with the therapist last time, how has that been going?” (code as appropriate, for example, *aa* or *ee*)
Appendix G: Parameter Estimates for Second-Order Effects

Table 7

Parameter Estimates for Second-Order Effects of Hierarchical Model of Therapist Scaffolding and Child Concept Formation over Time; N = 1187; Constant = 3.40

<table>
<thead>
<tr>
<th>Effect</th>
<th>Log-Linear Parameter Estimate (Lambda)</th>
<th>Lambda/SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist Name by child Name</td>
<td>5.78</td>
<td>14.26</td>
</tr>
<tr>
<td>Therapist Name by child Consequences</td>
<td>5.26</td>
<td>4.89</td>
</tr>
<tr>
<td>Therapist Name by child Evaluate</td>
<td>2.31</td>
<td>2.19</td>
</tr>
<tr>
<td>Therapist Name by child Intentions</td>
<td>1.54</td>
<td>2.41</td>
</tr>
<tr>
<td>Therapist Name by child Plans</td>
<td>2.11</td>
<td>2.68</td>
</tr>
<tr>
<td>Therapist Consequences by child Name</td>
<td>3.23</td>
<td>5.63</td>
</tr>
<tr>
<td>Therapist Consequences by child Consequences</td>
<td>8.07</td>
<td>7.30</td>
</tr>
<tr>
<td>Therapist Consequences by child Evaluate</td>
<td>3.50</td>
<td>3.41</td>
</tr>
<tr>
<td>Therapist Consequences by child Intentions</td>
<td>1.79</td>
<td>2.21</td>
</tr>
<tr>
<td>Therapist Consequences by child Plans</td>
<td>2.20</td>
<td>2.21</td>
</tr>
<tr>
<td>Therapist Evaluate by child Name</td>
<td>2.47</td>
<td>3.15</td>
</tr>
<tr>
<td>Therapist Evaluate by child Consequences</td>
<td>4.51</td>
<td>3.30</td>
</tr>
<tr>
<td>Therapist Evaluate by child Evaluate</td>
<td>7.01</td>
<td>7.46</td>
</tr>
<tr>
<td>Therapist Evaluate by child Intentions</td>
<td>3.09</td>
<td>3.98</td>
</tr>
<tr>
<td>Therapist Evaluate by child Plans</td>
<td>-13.46</td>
<td>-0.01</td>
</tr>
<tr>
<td>Therapist Intentions by child Name</td>
<td>2.63</td>
<td>3.91</td>
</tr>
</tbody>
</table>
Table 7 Continued

<table>
<thead>
<tr>
<th>Effect</th>
<th>Log-Linear Parameter Estimate (Lambda)</th>
<th>Lambda/SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist <em>Intentions</em> by child <em>Consequences</em></td>
<td>-12.35</td>
<td>-.01</td>
</tr>
<tr>
<td>Therapist <em>Intentions</em> by child <em>Evaluate</em></td>
<td>4.56</td>
<td>4.77</td>
</tr>
<tr>
<td>Therapist <em>Intentions</em> by child <em>Intentions</em></td>
<td>5.64</td>
<td>9.22</td>
</tr>
<tr>
<td>Therapist <em>Intentions</em> by child <em>Plans</em></td>
<td>1.69</td>
<td>1.36</td>
</tr>
<tr>
<td>Therapist <em>Plans</em> by child <em>Name</em></td>
<td>1.09</td>
<td>1.59</td>
</tr>
<tr>
<td>Therapist <em>Plans</em> by child <em>Consequences</em></td>
<td>3.94</td>
<td>3.19</td>
</tr>
<tr>
<td>Therapist <em>Plans</em> by child <em>Evaluate</em></td>
<td>2.64</td>
<td>2.41</td>
</tr>
<tr>
<td>Therapist <em>Plans</em> by child <em>Intentions</em></td>
<td>-15.71</td>
<td>-.01</td>
</tr>
<tr>
<td>Therapist <em>Plans</em> by child <em>Plans</em></td>
<td>5.65</td>
<td>8.17</td>
</tr>
<tr>
<td>Segment 1 by therapist <em>Name</em></td>
<td>-.30</td>
<td>-.81</td>
</tr>
<tr>
<td>Segment 1 by therapist <em>Consequences</em></td>
<td>-.52</td>
<td>-1.09</td>
</tr>
<tr>
<td>Segment 1 by therapist <em>Evaluate</em></td>
<td>-.136</td>
<td>-2.47</td>
</tr>
<tr>
<td>Segment 1 by therapist <em>Intentions</em></td>
<td>-.63</td>
<td>-1.30</td>
</tr>
<tr>
<td>Segment 1 by therapist <em>Plans</em></td>
<td>-2.90</td>
<td>-4.48</td>
</tr>
<tr>
<td>Segment 2 by therapist <em>Name</em></td>
<td>.58</td>
<td>1.39</td>
</tr>
<tr>
<td>Segment 2 by therapist <em>Consequences</em></td>
<td>.44</td>
<td>.92</td>
</tr>
<tr>
<td>Segment 2 by therapist <em>Evaluate</em></td>
<td>-.88</td>
<td>-1.50</td>
</tr>
<tr>
<td>Segment 2 by therapist <em>Intentions</em></td>
<td>.44</td>
<td>.92</td>
</tr>
<tr>
<td>Segment 2 by therapist <em>Plans</em></td>
<td>-2.06</td>
<td>-3.31</td>
</tr>
</tbody>
</table>
Table 7 Continued

<table>
<thead>
<tr>
<th>Effect</th>
<th>Log-Linear Parameter Estimate (Lambda)</th>
<th>Lambda/SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Segment 1 by child <em>Name</em></td>
<td>-.43</td>
<td>-1.14</td>
</tr>
<tr>
<td>Segment 1 by child <em>Consequences</em></td>
<td>.27</td>
<td>.56</td>
</tr>
<tr>
<td>Segment 1 by child <em>Evaluate</em></td>
<td>-.17</td>
<td>-.30</td>
</tr>
<tr>
<td>Segment 1 by child <em>Intentions</em></td>
<td>-1.30</td>
<td>-2.71</td>
</tr>
<tr>
<td>Segment 1 by child <em>Plans</em></td>
<td>-.98</td>
<td>-1.45</td>
</tr>
<tr>
<td>Segment 2 by child <em>Name</em></td>
<td>.28</td>
<td>.66</td>
</tr>
<tr>
<td>Segment 2 by child <em>Consequences</em></td>
<td>.75</td>
<td>1.44</td>
</tr>
<tr>
<td>Segment 2 by child <em>Evaluate</em></td>
<td>.69</td>
<td>1.16</td>
</tr>
<tr>
<td>Segment 2 by child <em>Intentions</em></td>
<td>.21</td>
<td>.43</td>
</tr>
<tr>
<td>Segment 2 by child <em>Plans</em></td>
<td>1.14</td>
<td>1.84</td>
</tr>
</tbody>
</table>