

How clients and solution focused therapists co-construct new meanings when having conversations about ‘What’s better?’

“It’s like a rope being thrown to you – that you can use to pull yourself up”

- Client

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for the degree of Masters of Counselling**

by

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Abstract

Solution Focused Brief Therapy (SFBT) is a goal oriented therapeutic approach that assists clients to build solutions rather than analyse problems. Solution focused (SF) therapists often open sessions, subsequent to the first, with the question ‘What is better since we last met?’ with the purpose of enabling clients to gain a heightened sense of their own self efficacy. This research explores how clients and a solution focused therapist co-construct new meanings when having conversations about ‘What’s better?’

The study approaches this question from an interpretative perspective. Five clients agreed to be part of the research while engaging in solution-focused counselling. Each client met with the counsellor on up to five occasions during which time the ‘What’s better?’ question was asked. Following each session clients were asked to provide their perceptions on the session on client feedback forms. Excerpts transcribed from single sessions with different clients were microanalysed to determine how the co-construction process occurs.

The analysis revealed the collaborative and co-constructive character of Solution Focused Therapy conversations. The ‘What’s better?’ prompt led to a shift in meaning for clients. Comments made on the client feedback forms showed that the conversations raised greater awareness of their own achievements, competencies and positive aspects in their lives. Clients also expressed an increase in hope through conversations about ‘What’s better?’

The findings of this study build on research that suggests therapists’ discursive tools such as ‘questions’, ‘formulations’, ‘lexical choice’, and ‘grounding’ provide the means to influence therapeutic conversations. Analysis of dialogues in this study show that purposefully applied ‘compliments’, which do not fit into any previously identified discursive tools, can be useful for co-constructing new meanings. This study also extends previous research by demonstrating that both the choice of discursive tool and the purpose of its application are influential in therapeutic conversations.

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Chapter 1: Introduction

1.1. Context of the study

Solution Focused Brief Therapy (SFBT) was developed during the 1980s in the Brief Family Therapy Centre in Milwaukee by Steve de Shazer and Insoo Kim Berg. SFBT is a short-term, goal oriented therapeutic approach that assists clients to build solutions rather than analyse problems.

In SFBT, therapists allege that no problem is happening all the time. Exceptions are instances where the problem is absent. SFBT therapists use a range of interventions to identify and reinforce clients' skills, resources, resiliencies, strengths and abilities in these problem free times to attain the clients' desired outcome. Repeating clients' successful behaviours is believed to be easier than learning preordained solutions that may or may not work for a particular client. Clients experience themselves as competent when they become aware of their existing problem-solving skills. This increases their hope, feeling of empowerment and confidence to achieve their goals (De Jong & Berg, 2013).

Guided by key principles of social constructionism, SFBT emphasises the importance of language in psychotherapy (De Jong & Berg, 2013; de Shazer, 1994). Social constructionists view knowledge as constructed, deconstructed and obtained in social and cultural interaction (Gergen, 2009). Therapists and clients use language to shape the meanings that emerge during therapeutic conversations in order to accomplish the desired outcome (De Jong & Berg, 2013; de Shazer, 1994). Clients' problems are viewed as constructions, established through language and interaction. The aim of SFBT is to co-create new, helpful, realities or meanings through conversation between therapists and clients (Anderson & Goolishian, 1988).

Interventions are therapy tools used to reach the client's goals. Within SFBT, interventions are language based and mostly composed of questions that are either open ended

or pre-suppositional questions. Open ended questions are used to listen for clients' strengths, skills and resources and to prompt the client to talk in a way that enables the therapist to focus on problem free talk and solution building (Hanton, 2011). Therapist pre-suppositional questions focus on a positive belief or expectation and are used to raise clients' awareness of their own strength, abilities and successes (McKeel, 2012).

A key suppositional question in SFBT that is often used by the solution focused (SF) therapist for opening subsequent sessions (all sessions except the first one) is 'What is better since we last met?' or simply 'What's better?' This question is an intervention whose purpose is to elicit successful behaviours in problem free times (exceptions) between therapy sessions (De Jong & Berg, 2012). The therapist helps the client explore these successful behaviours to determine how the client was able to create them in as much detail as possible. Through a therapeutic dialogue the therapist follows the principle of the acronym EARS and endeavours to Elicit relevant exceptions, to Amplify them, to Reinforce success and strength and then Start again (Hanton, 2011). In this way therapists and clients work collaboratively in their conversations on what emerges in their sessions. This process is termed co-constructing of new meanings (De Jong, Bavelas & Korman, 2013).

1.2. Rationale for research

I first learned about the 'What's better?' questions during my counselling studies. Initially I was very sceptical. I wondered how clients might experience my assumption that they are better. I had the following thoughts: 'How will they react?', 'They might be offended.', 'Is it natural to ask such a question.' Despite my reservations I convinced myself to put it into practice. When I started to systematically use the 'What's better?' question I was very surprised. I noticed that this question often uncovered solutions in the therapeutic process that would remain unnoticed in the absence of it. I felt that asking this question at the beginning of

every subsequent session supported my work in co-constructing new meanings for my clients and helped them move towards their desired outcomes. This prompted me to ask myself questions such as:

- ‘How exactly is co-construction of new meanings happening in conversations initiated by the ‘What’s better?’ question?’
- ‘How do I as a Solution Focused therapist contribute to the co-constructing process?’
- ‘Which communication skills are more and which are less helpful?’
- ‘How can I make the process of co-construction visible?’
- ‘How do clients perceive a dialogue about ‘What’s better?’

In summary I formulated the following research question:

What happens in the therapy room? - How do clients and SF therapists co-construct new meanings when having conversations about ‘What’s better?’

I agree with Pistrang and Barker, (2010) that our understanding of SFBT interventions could be improved if there were more thorough investigations about interventions and the personal meanings of these to both the client and the practitioner (Pistrang & Barker, 2010, p 67). According to Bavelas et al. (2000) it is often taken-for-granted that therapists’ communication is an essential aspect of why and how therapy works (Bavelas, McGee, Phillips & Routledge, 2000). Yet this omits the important role of client meaning and behaviour for change to happen. Consequently, in this research, I decided to undertake an in-depth examination of therapy dialogues (Strong, 2007; Sánchez-Prada & Beyebach, 2014) in the hope of delivering explicit knowledge about the ‘What’s better?’ question and the therapist’s role in the co-constructing process of new meaning for clients.

Recent literature suggests that microanalysis is a useful method for analysing observable communication sequences (De Jong & Berg, 2012). This method is able to provide an understanding and clear evidence of the collaborative and co-constructive character of

therapy conversations initiated by the ‘What’s better?’ question (De Jong & Berg, 2012; De Jong et al., 2013). With this research I aim to make the process of co-construction observable in real therapeutic conversations about ‘What’s better’ between myself and my clients. To enrich these observations I will describe the clients’ individual perceptions and my own perceptions and reflections on this question. Although the overriding goal of this research project is to generate practice based evidence of SFBT interventions, my personal aim is to predominantly reflect on and improve my own Solution Focused practice.

1.3. Organisation of this research

The objective of this research was to examine ‘What happens in the therapy room? - How do clients and SF therapists’ co-construct new meanings when having conversations about ‘What’s better?’ In chapter one I summarise the relevant peer reviewed literature and start with an overview about the outcome research on SFBT. Because my research project is practice based and concerned with a solution focused intervention, I focus on literature that addresses process research in SFBT. My engagement with this literature led to further studies on social constructionism, its approach to co-construction, the impact of language and possible tools that were relevant for understanding co-construction.

In chapter three I present my epistemological background, reason my choice of methodology, method and research design. I explain the layout of my research in relation to aspects such as participants, setting and the data. I reflect on ethical aspects and questions of rigour and trustworthiness that I found important for my research. Finally, within chapter three I introduce the way I analysed the data and how I presented my findings.

Chapter four presents the findings from the research. I outline the process of analysing my data transparently and present main themes that my analyses reveal. Four different conversation examples are presented along with detailed microanalysis and client perceptions

of the session. At the end of chapter four I present further client perceptions of the ‘What’s better?’ question.

In chapter five I discuss my findings in relation to the relevant literature and outline how my research extends previous studies. I identify strengths and limitations, discuss possible future research, reflect on the impact that this research has on my own practice and finish with key conclusions.

Chapter 2: Literature Review

In the following chapter I review the relevant literature to explore current ideas, identify knowledge gaps and develop a theoretical framework for my research. I provide an overview of SF outcome research in general before summarising process research on key SF interventions. Previous research around the Therapist question ‘What’s better?’ is reviewed in some depth as this question is the main focus of my research.

Reviewing the most relevant process research on SF interventions created in me an awareness of the co-constructive character of dialogue and how all therapeutic dialogue can be seen as interventional. As the social constructionist viewpoint of dialogue resonated strongly with my own worldview (see Chapter 3.1. Epistemology and theoretical perspective), I felt compelled to review literature describing the social constructionist approach to co-construction in psychotherapy. I closely examine the importance of language in social interaction and summarise models of language interactions. Relevant lab-based research on dialogical interaction is reviewed as this can lead to a practice-based understanding of co-construction of new meanings. I review key elements of conversation analysis (CA), which was one of the first methods used to make co-construction visibly understandable. Finally, I review microanalysis of dialogue, which is a more recent method that emerged out of CA, and provides a useful approach for visualising the co-construction of therapeutic dialogues.

2.1. Overview of Solution Focused Brief Therapy outcome research

Over the last 30 years, a number of researchers have explored different aspects of SFBT. Macdonald (2014) regularly compiles a SFBT evaluation list and the latest list exceeds 1,600 publications about SFBT. There are 133 relevant outcome studies, five meta-analyses, five systematic reviews and 28 randomised controlled trials (RCT) showing benefits from SFBT

and 14 showing benefits over existing treatments. Of 47 comparison studies, 38 favour SFBT. Further evidence for the effectiveness of SFBT is provided by more than 5,000 case studies that have a reported success rate of 60% (Macdonald, 2014).

The majority of the studies reviewed in meta-analyses, systematic reviews, RCT's and comparison studies are based on analyses of quantitative data. These studies measurably research the effectiveness of SFBT in particular settings, fields of practice or client populations. For example, Gingerich & Peterson (2013) systematically reviewed all available controlled outcome studies (43), 74% of which reported significant positive effects of SFBT. These studies spanned fields of practice as diverse as child academic and behaviour problems, adult mental health, marriage and family, occupational rehabilitation, health and aging and crime and delinquency (Gingerich & Peterson, 2013). Other systematic reviews target particular settings, such as a review of the outcome literature of SFBT in schools that included seven studies (Kim & Franklin, 2009) or an evaluation of the effectiveness of SFBT with children and families, that involved 38 studies (Bond, Woods, Humphrey, Symes & Green, 2013).

Macdonald (2014) includes 50 predominantly quantitative naturalistic outcome studies in his evaluation list. These studies were conducted in the natural settings of participants and researched the effectiveness of SFBT. As with RCT's and comparison studies, these naturalistic studies commonly investigate the application of SFBT to particular problematic behaviours such as domestic violence, substance abuse, bullying, school behaviour and self harm. Similarly, many studies have focussed on certain client populations such as children, families, students with learning abilities, domestic violence offenders, depressed people, obese children, Hispanic American students and golfers (Macdonald, 2014).

The Solution Focused Brief Therapy outcome studies described above strengthen the evidence base of this therapy approach. However, as these studies do not examine therapeutic interventions in-depth they provide little insight into how therapy works.

2.2. Practice based process research on solution focused interventions

Naturalistic process research is conducted inside the therapy room and investigates if and how interventions work and what clients are experiencing during therapy (McKeel, 2012). Process research aims to understand what clients and therapists do together, that is useful (De Shazer & Berg, 1997). However, very few naturalistic studies have been undertaken that target particular aspects of the application of SFBT (Macdonald, 2014).

Early exploratory examples of practice based process outcome research were conducted in the 1980s at the Brief Family Therapy Centre (BFTC) where the SF interviewing skills were developed (De Jong & Berg 2013). A team of experienced therapists, professors and graduate students researched their innovative practice and observed what practitioners were doing that contributed to clients' progress. Remarkable SF interventions evolved from this research, such as the 'pre-session change' question, which explores and amplifies meaningful changes that occur before the therapy starts (De Jong & Berg, 2013).

Practice based change process research studies targeted specific solution focused techniques and procedures with the objective of examining how interventions work and what clients are experiencing (McKeel, 2012). The following sections discuss the findings and limitations of change process research on key SF interventions. Specific attention is drawn to the therapist 'What's better?' question as this intervention is the main focus of my research.

2.2.1. The 'first session task'

The 'first session task', was developed in 1982 by Steve de Shazer and his team at the BFTC (Lipchik, Derks, Lacourt & Nunnally, 2012). The practitioner formulates at the end of the first session an observational or behavioural homework task for the client that incorporates both the client goal and successful strategies (de Shazer, 1985). In the second session the SF therapist

follows up and examines improvements, exceptions to the problem, clients' efforts and achievements. The task aims to stimulate clients to notice exceptions to the problem, improvements or strategies that already work well for them. It is used to induce hope that change for the better will happen and subtly inspires them to take moves towards their preferred future (de Shazer, 1985). In one study, where 56 clients were given a noticing 'first session task', 89% of these clients reported that they noticed something new or different that they want to continue and 57% stated change for the better (de Shazer, 1985). Two other studies researched the 'first session task' with similar outcomes. This research shows that clients, who received the 'first session task' more often reported change for the better and were more likely to expect and notice improvements throughout their therapy (Adams, Piercy & Jurich, 1991; Jordan & Quinn 1997).

2.2.2. 'Scaling Questions'

'Scaling questions' are the most frequently used intervention for SF practitioners (Skidmore, 1993). Scales normally range from one to ten where ten represents the best possible outcome. They tangibly represent clients' goals, severity of problems, experienced progress, the intensity of feelings or emotions, perceived confidence, commitment and more. In order to elicit exceptions to the problem, new possibilities, clients' perceptions, strengths, coping strategies, confidence and hopes, practitioners endeavour to construct useful conversations around the scaling intervention. Scales help to manifest clients' descriptions in a tangible way and allow practitioners, and clients, to monitor progress. Two studies described scaling questions as useful (McKeel, 2012). 'Scaling questions' applied to three depressed deaf persons found that the questions were easily understood and they helped clients to find new possibilities and practical steps in order to achieve their goals (Estrada & Beyebach, 2007). Another qualitative

study reported that clients found that ‘scaling questions’ along with describing their preferred future were the most useful aspects of SFBT for them (Lloyd & Dallos, 2008).

2.2.3. Therapist questions

Therapist questions in SFBT are questions that hold a positive assumption or belief about clients’ abilities, intentions, decision making skills or capabilities (O’Hanlon & Weiner-Davis, 1989). They are used as interventions to help clients to notice their strength, achievements, competencies, successes and potential (MacMartin, 2008). The most well known therapist questions in SFBT are asking for ‘pre-treatment change’, the ‘miracle question’ and the ‘What’s better?’ question. All three therapist questions assume and indicate that (therapeutic) change will happen.

2.2.3.1. *Pre-treatment change*

At the beginning of the first session, SF therapists ask clients what changes they noticed before they started with the therapy (de Shazer, 1985). Asking for ‘pre-treatment change’ is one possible form of exploring clients’ strengths and resources and finding exceptions to the presenting problem. Therapists build on the identified strategies, strengths and skills and clients raise awareness of their own capacities and gain optimism (McKeel, 2012). A number of studies suggest that clients are more likely to report pre-treatment improvement when therapists ask this question (Howard, Kopta, Krause & Orlinsky, 1986; Allgood, Parham, Salts & Smith, 1995; Weiner-Davis, de Shazer & Gingerich, 1987; Lawson, 1994). Client reported ‘pre-treatment change’ varies widely between research with values of 15% (Howard et al., 1986), 30% (Allgood et al., 1995) and 60% reported (Weiner-Davis et al., 1987; Lawson, 1994). One study found that clients who noticed ‘pre-treatment change’ more often successfully finished therapy (Johnson, Nelson, & Allgood, 1998). Another study suggests that noticing no ‘pre-

treatment change' can be an indication that therapy will terminate unexpectedly (Allgood et al., 1995).

2.2.3.2. The Miracle Question

The 'miracle question' encourages clients to imagine their worlds when the problem that brought them to therapy is not present anymore. The therapist invites the client to imagine a miracle that happened overnight that resulted in a solution to the client's problem. The client is encouraged to visualise their world without the problem. Conversations that follow the miracle question are likely to help clients to specify the future they want, to notice times when the problem is already absent and to raise hope (de Shazer & Dolan, 2007). A range of studies substantiated the beneficial effect of the 'miracle question'. One study that has researched the 'miracle question' found that clients' responses vary widely between concrete, relational and emotional improvements. Research using post session interviews with clients showed that clients perceived the 'miracle questions' as helpful for clarifying their goals and for finding ways to accomplish their goals (Isherwood & Regan, 2005; Shilts, Rambo & Hernandez, 1997).

Observations of experienced SFBT therapists asking the 'miracle question' lead to a better understanding of the way this question could be applied and to more receptive, cooperative and detailed answers (Nau & Shilts, 2000). These findings showed that best outcomes are achieved when therapists genuinely join in with the client, explore the problem before asking the question, show empathy and understanding and do not make suggestions about what happens when the miracle takes place (Nau & Shilts, 2000). Case studies showed the 'miracle question' is most successful when this intervention is applied as a multi questioned conversation which means that the therapist asks, understands the client's answer and then builds on it and formulates the next question (de Shazer & Dolan, 2007).

Some studies outlined several limitations of using the 'miracle question'. They suggest that certain client populations or settings struggle with this question (Bowles, Mackintosh & Torn, 2001; Estrada & Beyebach 2007; Lloyd & Dallos, 2008). Terminally ill clients, for example, tended to focus on miracle medical recoveries rather than achievable improvements that they can accomplish themselves in their situation (Bowles et al., 2001). Mothers of severely intellectually disabled children described the question as confusing, especially the word 'miracle' (Lloyd & Dallos, 2008). Under such circumstances, researchers have advised therapists to reframe the formulation of this question with the objective of prompting clients to imagine their preferred future in more realistic terms. Such formulations could be 'imagine something wonderful has happened...' (Hanton, 2011).

2.2.3.3. Between session change - The 'What's Better?' question

In contrast to research about 'pre-treatment change' or the 'miracle question' very little research has been undertaken about 'between session change' and the 'What's better?' intervention. One quantitative study examined the 'What's better?' question and found how many clients reported treatment related improvements in between sessions (Reuterlov, Lofgren, Nordstrom, Ternstrom & Miller, 2000). The study was conducted in 1993 and 1994 in an Alcohol and Drug Rehabilitation Unit of a Swedish hospital by SF therapists who were trained at the Brief Therapy Centre in Milwaukee, Wisconsin. The participants (129) attended on average 4.5 sessions and were, as the SF process suggests, asked 'What's better since the last visit?' The results showed that 76% of the clients reported treatment related gains from session to session while 24% reported no improvement. A minority of 13% of these 24% clients who stated no improvement in the beginning of sessions, reported change for the better when asked scaling questions at the end of the visit. Herrero de Vega & Beyebach (2004) replicated this study in Spain and focused on the stability of clients' descriptions of improvement during

SFBT. In contrast to Reuterlov et al.'s (2000) findings, Herrero de Vega & Beyebach (2004) put their findings in context with therapists' efforts to 'deconstruct' clients' initial statements of no improvement. They found that for 37.5% of the clients who initially stated no improvement, therapists' efforts in deconstruction of the initial statement have worked as a therapeutic strategy to help clients see some improvement at the end of the interview (Herrero de Vega & Beyebach, 2004).

The Beyebach research team consequently explored the deconstruction process when clients report no improvement in between SFBT sessions (Sanches-Prada & Beyebach, 2014). The study viewed the SF therapeutic process as a process in which client and therapist co-construct new realities in order to move from problems to solutions (de Shazer, 1994). Against this background the study identified under what circumstances deconstruction works and under what circumstances it does not. The findings showed that deconstruction of initial statements of no improvement are complex processes in which therapists respond flexibly to their clients statements. Consequently it was found that there is no exemplary way of deconstruction. The therapists take either early steps into deconstruction, elaboration and consolidation or they firstly connect with the negative report and only start the deconstruction process later. Maintaining solution talk in contrast to problem talk was seen as important (Sánchez-Prada & Beyebach, 2014). This qualitative research examined the de-construction process from a social constructionist perspective and emphasised that therapeutic change occurs through language during the process of therapeutic conversations (Sluzki, 1992).

2.3. Social constructionist approach to co-construction in psychotherapy

2.3.1. The relevance of language interaction

An underpinning belief of social constructionism is that knowledge is sustained by social processes and is a product of interactions between people rather than a product of objective observations of the world (Burr, 2015). Consequently, people develop their sense of reality within their social and cultural contexts through social interactions such as observations or communication (Berg & De Jong, 1996). Personal meanings are expressed and constructed through language. Social constructionists maintain that communication happens *between* and *within* people (Shotter, 1995). Participants of dialogic interaction bring their own current meanings and realities to the conversation (De Jong et al., 2013). Realities are re-constructed through individual interpretations of each participant that arise from conversations. Interpretations are based on peoples' past meaning-making (Berg & De Jong, 1996). Hence, through language interaction, people constantly cooperatively create new and revised meanings and develop common ground in their understanding. This common ground can be altered again through their talking (Clark, 1996). The following section describes the conditions under which language interaction is co-constructive.

2.3.2. The collaborative model of language interaction

Emanuel Schegloff (1968) characterised a dialog or conversation as "... a minimally two-party activity. (...) It requires that there be both a speaker and a hearer. (...) Speakers without hearers can be seen to be 'talking to themselves'. Hearers without speakers 'hear voices'. (...) 'Summons answer sequences' establish and align the roles of speaker and hearer, providing a summoner with the evidence of the availability or unavailability of a hearer, and a prospective hearer with notice of a prospective speaker. The sequence constitutes a coordinated entry into

the activity, allowing each party occasion to demonstrate his coordination with the other, a coordination that may then be sustained by the parties demonstrating continued speakership or hearership” (Schegloff, 1968 p.1093). Psycholinguist H.H. Clark (1996) drew on this idea and developed a social constructionist view on communication, the ‘collaborative model’. The ‘collaborative model’ emphasises that speaker and listener contribute, collaborate, coordinate with each other and shape a mutually agreed-upon piece of information together (Clark, 1996). In contrast, the ‘individual model’ views communication as alternating monologues. Related to psychotherapy, a monologic or individual communication model would be one where therapists direct, influence or treat pathologies in clients. A collaborative dialogic interaction, on the other hand, designates collaboration and reciprocal influence between client and therapist and is inevitably co-constructive (Strong, 2007; Bavelas et al., 2000).

Therapeutic conversations can constitute collaborative language interactions that take clients constructively beyond past ways of understanding (Strong, 2007). Therapeutic change for clients might therefore be a result of co-construction of new meanings through therapeutic dialogue (Franklin, 1998; Gergen, 2009). Hence, the therapeutic dialogue that follows the ‘What’s better?’ question has the potential to be co-constructive and has the capability to create new meanings and induce change in clients.

2.3.3. Laboratory research of co-constructive dialogical interactions

To support these theoretical assumptions previous research has undertaken lab experiments that investigated how dialogical conversations work and supplied a basic empirical foundation that supports the philosophical idea of co-construction through conversations (Clark & Wilkes-Gibbs, 1986; Schober & Clark, 1989). Clark’s Stanford Language Use Group investigated what determines the language that two dialogue participants use to refer to things that are hard to describe (Clark & Wilkes-Gibbs, 1986). Schober & Clark (1989) set up experiments that

exemplify how dialogue differs from monologue. The study stresses that understanding what has been said is determining a dialogue. When there is no understanding, the listener overhears the speaker; the speakers' talk can be seen as monologue. As a result Schober & Clark (1989) established a classification, the group of overhearers, who represent the 'individual model'. The contrasting group of people, who work together, attain shared understandings and have the option of co-constructing, exemplify the 'collaborative model' (Schober & Clark, 1989).

2.3.4. Practice-based understanding of co-construction

Due to the separation of practice from research, there is limited research that helps therapists understand how communication in psychotherapy works (Bavelas, 2012). Furthermore, few studies utilise theoretically compatible research methods to explore social constructionist approaches to psychotherapy, such as SFBT (Strong, 2007). However, Shotter (1993) asserts that the mechanics of co-construction is often visible in observable events arising from and within the dialogue between participants in which they create 'conversational realities'. Such observations can be used to connect the lab with the therapy room and allow researchers to develop an empirically based understanding of how co-construction happens within the context of psychotherapy (Bavelas, 2012).

The following sections expand on research methods that are used to analyse conversations. Firstly, key theoretical insights of the method Conversation Analysis (CA) are outlined. Following this a review of the method 'microanalysis of face-to-face dialogue' is undertaken. This method builds on CA and constitutes the theoretical framework for the methods used in this research.

2.3.4.1. Conversation analysis

Early Conversation Analysis (CA) is based on Wittgenstein's (1953), Garfinkel's (1967) and Goffman's (1967) philosophies about linguistic processes. It was introduced by Harvey Sacks (1992) as a method to analyse collaborative language interaction. Sacks viewed conversations rather technically as 'architectures of inter-subjectivity' and how people 'do' relational activities (Silverman, 1998). CA is concerned with sequence organisation which means speakers have turns of coherent, orderly and meaningful moves or sequences that form a conversation (Hutchby & Wooffitt, 2008). Researchers using CA hope to gain understanding of how speakers in a conversation influence and make sense of each other (Strong, 2007). How a person is understood during a conversation should be evident in how the listening conversation partner responds. In CA this process is known as the 'next turn proof procedure' (Ten Have, 2007). Through analysis of transcribed excerpts from audio or video tapes, researchers using CA have the capacity to study conversations through a microscopic lens (Strong, 2007). In linking responses with outcomes, the analysis is able to reveal the details of a conversation that are relevant to the speakers (Ten Have, 2007). From this perspective it can be alleged that some understandings and actions within a conversation are more meaningful than others (Strong, 2002).

2.3.4.2. Microanalysis of dialogue

From the 1980's, researchers of the Victoria Microanalysis Group applied empirical research of the collaborative model to SFBT (Bavelas, 2012). They extended the fundamental idea of CA and introduced 'microanalysis of face-to-face dialogue', a moment by moment examination of communication sequences. The method was found to provide a feasible approach for making collaboration and co-construction of therapeutic dialogues visible (Bavelas, 2012). Three main discursive tools available for therapists were researched that could

be used to influence therapeutic conversations, ‘questions’, ‘formulations’ and ‘lexical choice’ (Bavelas, 2012). Recent research on microanalysis of therapeutic dialogues adds ‘grounding’ as a fourth aspect for collaborative therapists to influence therapeutic conversations (De Jong et al., 2013).

An analysis of questions and their function in psychotherapy found that traditional ways of categorising questions are rather static and don’t reveal what they do and why they are so useful (McGee, Del Vento & Bavelas, 2005). Categories such as ‘circular’, ‘ranking’, ‘triadic’ and ‘externalising’ don’t reveal the details and mechanisms by which therapeutic questions work and how they can contribute to a transformation of clients’ perceptions of their personal difficulties. Questions in therapeutic dialogue are more than just information seeking (McGee et al., 2005). They are used as therapeutic interventions as they have the potential to introduce alternatives, new possibilities and views of the world to clients. Inevitably therapists employ questions to embody certain statements, assertions or information. As such they confine the recipient to answer within a framework of presuppositions set by the therapist (McGee et al., 2005). Therapists’ questions are a way in which they reveal and apply their theoretical perspective to the therapy process (‘individual model’ or ‘collaborative model’) (Bavelas et al., 2000). They can pathologise or dignify / empower clients (Bavelas et al., 2000). Collaborative therapists use questions as interventions to expand on new ideas without imposing them directly on the client (McGee et al., 2005). Clients then have to work hard to make sense of the question with its presuppositions before they can construct an answer that fits their views and experiences. By providing answers to questions, the clients are involved in co-constructing as they shift their perspective (Bavelas et al., 2000).

Conversational formulations in psychotherapy are responses to clients’ direct speech such as summaries, mirroring reflections, minimal encouragers, paraphrases or perception checks (Bavelas et al., 2000). Traditionally these formulations have the function of connecting

with the client and are seen as neutral (De Jong et al., 2013). Formulations such as reframing, normalising or relabeling were described as deliberate interventions that hold the potential to transform what the client stated (Watzlawick, Weakland & Fisch, 1974). More recently it was found that all formulations are influential choices of therapists. In order to call attention to particularly noteworthy aspects of the clients' statements, therapists decide on which client statements they respond to and in what way. Consequently formulations hold the potential to preserve, delete or transform the original statement and are another possible way of influencing the course of a therapeutic conversation (Bavelas et al., 2000).

Lexical choice is a term for choosing certain words, phrases, forms in a therapeutic conversation deliberately whilst being aware of their potential influence on clients (Bavelas et al., 2000). Such choices can take the form of interpretations, descriptions or information and they can even expand formulations as therapists purposefully add, alter or omit the client's original words (De Jong et al., 2013). Lexical choices are again aligned with therapists' theoretical orientations as they can contain predominantly negative or positive content that significantly affects clients' responses (De Jong et al., 2013). It is difficult to judge what positive and negative content there is within a conversation. One study defines positive content as such that is desirable for the client and the opposite for negative content (Tomori & Bavelas, 2007). Research found that positive content in conversation led to more positive talk. Therapists, such as SF practitioners, who use predominantly positive talk, contribute to the co-construction of a largely positive outcome for the clients whereas negative talk would do the reverse (Smock Jordan, Froerer & Bavelas, 2013).

Grounding is a sequence of actions between therapist and client with the intention of establishing and expressing mutual understanding (Clark, 1996). Without grounding and shared understanding there is no co-construction possible as sequences cannot build on each other (individual model). In contrast to summaries or reflections, grounding actions are quick

overlapping sequences that are happening in the background. Each grounding sequence co-constructs a shared understanding (De Jong et al., 2013). There are three steps within grounding. First, one of the speakers presents information; second, the listener displays an understanding or no understanding and lastly the speaker confirms the display of understanding as correct or provides fuller background (De Jong et al., 2013).

In conclusion microanalysis can be viewed as a feasible method for describing the collaborative and co-constructive character of therapeutic conversations. This method can be directly used to understand co-construction in therapeutic conversations initiated by the ‘What’s better?’ question (De Jong et al., 2013). Yvonne Dolan, co-founder (together with Steve de Shazer and Insoo Kim Berg) of the Solution-focused Brief Therapy Association emphasised the importance of micro-analytic research and stated: ‘More microanalysis research into the co-construction process in solution-focused conversations is needed to develop additional understanding of how clients change through participating in these conversations’ (Dolan, 2015). This research addresses this existing gap in the literature and undertakes in-depth examinations of therapy dialogues about ‘What’s better?’ for the client. It aims to provide explicit knowledge about this intervention and the therapist’s role in the co-constructing process of new meaning for clients.

Chapter 3: Epistemology, Methodology, Method, Research Design

3.1. Epistemology and theoretical perspective

When I devised my research question: **‘What happens in the therapy room? - How do clients and SF therapists’ co-construct new meanings when having conversations about ‘What’s better?’**, I reflected on my own personal background and how I view the world.

My personal framework is strongly influenced by the fact that I was exposed to differing interpretations of world events throughout most of my life. My formative years within the German Democratic Republic (GDR) strongly influenced my personal worldview. Growing up in an atheist society reinforced in me the importance of personal agency and of finding meaning in life to attain a sense of self-realisation and fulfilment. As my family were able to receive television broadcasts from both communist East Germany and neighbouring capitalist West Berlin I was exposed to differing interpretations of world events throughout most of my youth. This stimulated in me, from an early age, an urge to critically process contrasting viewpoints and an enhanced awareness that realities must be constructed.

I came to believe that people are inherently neither good nor bad. From birth on they constantly receive stimuli from their environment and respond predominantly to these stimuli. I observed that people’s thoughts, beliefs and behaviour are learned, and change constantly and I learned and observed that they can be adjusted and relearned. I consequently came to the view that an individual’s knowledge is not an objective perception of reality. Every person builds up their own individual experiences through numerous and often different influences including family, cultural backgrounds, significant others, media, observations or education. In line with the fundamental basic worldview of my therapy approach (SFBT), I believe that every person is constantly constructing their own meanings and versions of reality. Their past and present

experiences combined with their culture and language provides a context of meaning for them and influences their cognition, thinking and behaviour.

Consistent with my views and interpretation of personal experiences, my epistemological framework, my conceptual understanding of ‘how we know what we know’ (Davidson & Tolich, 1999), is grounded in social constructionism. This epistemological stance has its roots in postmodernism, an intellectual movement that rejects the philosophical beliefs of modernism (Burr, 2015). As such postmodernism rejects the idea that the world can merely be explained with grand theories and objective laws that hold only one truth. Thus postmodern social constructionism takes a critical stance towards traditional ways of understanding the world and emphasises that what exists is only what we perceive to exist. Social constructionism emphasises a co-existence of multilayered realities and varieties. All understanding is culturally and historically relative, existing concurrently and equally entitled to be true (Burr, 2015). As a consequence different people may construct meaning in different ways, even in relation to the same event. As with Burr, I believe that all knowledge, or meaning, is upheld by social processes and is a product of interactions between people (Burr, 2015). In psychotherapy social constructionists use the term ‘co-constructing of meaning’ to stress that meanings are negotiated and embedded in a collaborative process that occurs during dialogue through use of language (Gergen, 2009).

In alignment with my personal worldview and epistemological framework, I approached my research question from an interpretative paradigm. In order to understand the meaning of social interaction, interpretative researchers not only observe but they also interpret these interactions within their own frameworks. In other words the researchers’ understandings arise from what they think about an experience rather than just going through it. Because what people know is always constructed within cultures, social settings, and relationships with other people, their thinking and understanding is shaped by these cultural factors. When researching

social action, the researcher's viewpoints, values and judgements and the research subject itself are therefore inseparably intertwined as interpretations can only happen subjectively (Hara, 1995). The researcher's viewpoint becomes a source of data and their interpretations a key instrument of the research (Bogdan & Biklen, 1998). Only the researcher's perspective encompasses the context and the deeper understanding of human interaction which is a core strength of interpretative research (Hara, 1995). As value free and objective qualitative research is not possible, it is vital that researchers are transparent about their assumptions (Snape & Spencer, 2003). Therefore it is important to keep in mind that my viewpoints within this project are not objective or value free as they are my personal interpretations of interactions. From this perspective my aim was to provide the reader with clarity and transparency about my assumptions and the reasoning around how they evolved.

3.2. Methodology

After studying different research methodologies I came to the conclusion that qualitative research forms an adequate methodology for answering my research question. I chose this approach as it is consistent with my worldview, epistemological background and the nature of my research question.

A key characteristic and strength of qualitative research is that this methodology is concerned with the context of the complexities of human behaviour (Hara, 1995). Researchers who use this approach see the world from an interpretative paradigm. They systematically analyse and aim to understand socially meaningful action / interaction through detailed observation of people in their natural settings and seek to interpret how people create their own social worlds (Davidson & Tolich, 1999). Qualitative researchers feel that social action / interaction can be best understood when it is observed in the setting in which it occurs. This approach investigates lived realities or constructed meanings of the research participants

(Mutch, 2005). Qualitative research is an exploratory approach and concerned with process, focuses on how definitions are formed rather than simply on the definitions and focuses on the complexities of a particular issue in its context (Bogdan & Biklen, 1998). Data in qualitative research are descriptive and occur in the form of words. Meaning making, which is the way different people make sense of their own lives, is of essential concern to qualitative researchers (Bogdan & Biklen, 1998).

Action- or practice-based research emerged out of the assumption that a theory can be expressed in action. Practice-based researchers argue that theory alone has little power to create change and that there is a need for a more complex interplay between theory and practice (Reason & Bradbury, 2008). For that reason practice-based research is bridging the gap between theory and practice. It mostly involves practitioners as researchers from within (insider researchers) who are studying their own professional contexts.

Within this methodological framework I evaluated qualitative practice based research as the suitable methodology for approaching my research question. My research question challenged the theoretical assumption that the SF question ‘What’s better?’ works for most clients. Against the backdrop of my epistemological stance, worldview and theoretical framework, I wanted to explore ‘how’ exactly does this intervention work and ‘why’ do desired outcomes occur or not. My aim was to concentrate on the process of co-constructing new meanings during conversations about ‘What is better?’ for the client since the previous session. I intended to closely investigate the complexities and details of this client-therapist dialogical interaction. I conducted the study based on my own practice in a real life setting, a therapy room in a counselling agency. I held shared roles that included the role of the therapist, researcher and research participant and was therefore an insider of my research (Cullen, 2005). Words embedded in dialogue formed my main source of data. I aimed to conduct my research with an open mind and allowed ideas or insights to emerge over the course of the research. I

strived to ground my findings in the collected data and to put my interpretations in context. Researching my own everyday experiences with clients might contribute to a better understanding and will ideally lead to improvements for my own and the SF-practice of others

3.3. Method and research design

3.3.1. Participants and research setting

My research took place in a counselling agency in which I worked. Clients who approach this agency are adults and come from a wide spectrum of social contexts and cultural backgrounds. Concerns that brought them to counselling were centred mainly around everyday challenges in life rather than pathological conditions. I did not pre-select specific client groups for this study.

Clients who want counselling normally call the agency and wait until there is a free therapist. When there is a free counselling space for a client, they receive a call from the agency's staff to arrange the first session. During this phone call, clients, who were called to allocate counselling with me, were informed that I was conducting a research project. In this initial conversation the client was informed that an information sheet (see Appendix I) about the research project and a consent form (see Appendix II) for their possible participation (both approved by the University of Canterbury Human Ethics Committee) would be sent out to them. In that way clients had the opportunity to become familiar with the research before they started the counselling.

Prior to the first counselling session all clients in my counselling agency were required to complete an intake form. In this form I included a tick box question around whether or not they would like to participate in my research (see Appendix III). Through including the tick box on the form, I kept the process of approaching clients to participate rather impersonal and ensured that participation in the research would take place voluntarily in an uncoerced manner. Each client was able to reject participation in my research without having to verbally inform

me. When clients indicated (on the form) that they were not interested in participating, I made no further mention of the research during the counselling process.

When a client indicated interest in my research, the client and I had, before the counselling process started, a brief conversation about the research program. The client had the opportunity to ask questions after which time they made their final decision around participation in the research. Clients who were interested in participating were reassured that the research would not interfere with the counselling process. I tried to ensure that client participation in the research caused as little disruption to the regular counselling process as possible. There were only two elements that distinguished participating clients from non-participating clients. Research participants were video recorded and filled in a short feedback form after each session (see Appendix IV).

My research examines the complexities and explicit details of dialogue in great detail. As I expected my qualitative data to be very detailed and descriptive I chose a small sample size of only five client participants for my research. I considered myself a research participant as I was at all times equally an object of interest and part of the research process.

3.3.2. Data

3.3.2.1. *Video recordings of counselling sessions*

Video recordings of the counselling sessions were the main data source used in the research. I recorded up to five counselling sessions with my participants and used this data to accurately transcribe, observe and analyse the client-therapist interactions. In contrast to audio recording, video recording provides observable non-verbal information that includes communication through facial expressions and body language. I transcribed meaningful excerpts of dialogue that were related to the 'What's better?' question which usually occurred at the beginning of the counselling sessions.

3.3.2.2. Client feedback forms

From the second session onwards, clients who participated in the research received, at the end of each session, a feedback form in which I asked them how they experienced the conversation about ‘What is better?’ (see Appendix IV). Research shows that client ratings of the therapeutic alliance are far better predictors of session outcome than therapist ratings (Bachelor & Horvath, 1999). The feedback form captured clients’ own perceptions about the ‘What’s better?’ intervention shortly after they experienced it. I based the feedback form on the Session Rating Scale (SRS) that SF therapists use to explore clients’ perceptions of the therapeutic alliance (Duncan et al., 2003). I asked clients to scale their experiences of the ‘What’s better?’ questions on a scale from “I found discussing what is better not useful” to “I found discussing what is better very useful”. In addition to their rating on the scale, I gave my clients the opportunity to verbally express the reasons for their rating. A second scale in my feedback form asked clients to rate their overall experience of the counselling session. The overall experience scale started with “I wish we could do something different” at the lowest end to “I hope we do the same kind of things next time” at the highest end. I encouraged clients to provide a verbal explanation of the rating. As the lengths of both scales were exactly 10 cm I extracted an exact score between one and ten from both scales. This data source was used to examine between session changes in ratings and ratings were linked to my findings from the session conversations.

3.3.2.3. Overview of collected participant data

Table 1 shows the number of participants, how many sessions were recorded for each participant, how many conversations about ‘What’s better?’ were recorded and how many feedback forms were filled in by the clients. All participants agreed to the recording of the first five therapy sessions. As some clients terminated the counselling before session five the number of recorded sessions varied between two and five. Conversations about ‘What’s

better?’ took place during each session, except the first one. Feedback forms were filled out most times; on occasion the client wanted to leave early and did not have time to fill in the feedback form.

Table 1. Number of sessions recorded, recorded conversations and client feedback forms for each client.

Client	Number of sessions recorded	Number of recorded conversations about ‘What’s better?’	Feedback forms
I	4	3	4
II	2	2	1
III	4	3	3
IV	2	2	2
V	5	4	3
	17	14	13

3.3.2.4. Reflective field notes

During my research I regularly engaged in reflective and reflexive practice. Reflective / reflexive practice to me was an ongoing process of analysing and reanalysing important episodes of my research. Reflective practice refers to the immediate act of reflecting on particular moments of activity, for example reflecting on my counselling, learning about the research, analysing data, formulating findings, receiving supervision and much more (Stedmon & Dallos, 2009). Reflexive practice refers to the act of looking back, or reflection on, action. Hence reflection can be seen as *in* action and reflexivity is *on* action (Stedmon & Dallos, 2009). My personal reflections and reflexivity about my subjective perceptions, the awareness of my own positions, motivations and experiences provided me with an important point of reference throughout my research (Stedmon & Dallos, 2009). My insights during reflective and reflexive practice were documented in the form of reflective field notes.

The reflective and reflexive notes chronicled what I heard, observed, experienced and thought over the course of my research. My reflections *in* and *on* each counselling sessions provided me with particularly useful data that enriched the video recordings of the sessions. I reflected on them from three different angles. Firstly, there were the reflective notes I took during the counselling process (reflectivity in action). These remarks were taken from my perspective as a therapist. Secondly, I made notes straight after the counselling process. These notes were taken from both perspectives, I still reflected from my viewpoint as a therapist and I also changed roles and described my initial thoughts about meanings from my role as a researcher. Thirdly, I took field notes while I watched and analysed the videos. These reflexive notes were thoughts on my past counselling session and were formed mainly from my researcher's viewpoint. During my data analysis I linked the video with these reflective field notes. In that way I was able to see the conducted counselling sessions more as an integrated whole which was helpful for interpreting my data.

3.3.2.5. Research diary

My research diary was an important source of data. The diary was used to collect ideas, reflections, observations, insights, literature links, opinions and interpretations. During my time as a researcher there were many occasions when I suddenly had a valuable thought, observed things, took notes about useful conversations with peers and supervisors, came across useful literature, or took research relevant notes during my university lessons. The diary helped me to record the meaning of my thoughts, observations or reflections at the time as I kept the context in which my diary notes were written in mind (Alaszewski, 2006). I revisited the diary countless times. It helped me to be a thorough and organised researcher.

3.3.3. Ethical considerations

I believe that research that is entrenched in ethical practice invokes the researcher's moral responsibility and requires their engagement in a reflexive process (Crocket, Agee & Cornforth, 2011). For this reason I allowed myself adequate time to reflect on ethical questions. Sometimes during the course of the research there were conflicts between the objectives of the research and my own ethical obligations as a researcher which created ethical dilemmas.

From an early stage of my research I started to think about ethical aspects. Before I committed myself to my research subject, I examined the question 'Will my research benefit clients directly or indirectly, or is it just beneficial to me, the researcher?' (New Zealand Association of Counsellors Code of Ethics (2015; 11.1b)). This question really highlights the tension between the research itself and the principles of beneficence and minimising risk for the participants. By conducting research as a student researcher I benefit in terms of personal growth and development. Ethical research, on the other hand, needs to ensure that the research is directly or indirectly valuable to the client(s). Over the course of my research I visited and revisited my data many times and engaged in intensive reflective practice. Insights that I gained may have improved my practice and in that way could have benefitted my participants. Although the participants did not directly benefit from my research findings, these findings may be of benefit to future clients. Contribution of the research to the literature could be of benefit to other SF practitioners.

During the process of obtaining consent for my research I considered the ethical principles of respect and autonomy of the potential participants. I strived to gain voluntary consent from participants, free from coercion after they received comprehensive, understandable information about the research (Tolich & Davidson, 1999). During this process I was very aware that the ethical principle of voluntary and coercion free consent for participation is potentially compromised if I create an atmosphere in which the client feels

obliged or pressurised to participate. I mitigated this dilemma by establishing a non-intrusive and impersonal process for gaining consent. I posted the information about the research to the client (but only if the client wanted to receive such information). The general willingness of the client to participate in my research was then ascertained through a tick box on the counselling provider's standard intake form. In that way the client had the opportunity to say 'no' to the research without dealing directly with me. Following this process I restricted further discussions around consent to only those clients who showed a general interest to participate in the research programme.

As a researcher in a counselling agency I held shared roles that included the role of the therapist, researcher and research participant. I was an insider of my research (Cullen, 2005). I reflected on my potentially split attention between my client, my clients' role as participant, my own role as participant, myself as therapist and myself as researcher. I thought that this balancing act might distract me from my counselling practice and/or participants might experience the research as an intrusion of the counselling process. I reflected on the risk for participants and thought that they may feel used, distracted or preoccupied with the research. I considered that, as a result, they may hold back information that they would otherwise have disclosed. My dilemma affected the ethical principle of minimising the risk for participants and the principle of doing no harm. To address this issue, I ensured that the participants' needs are placed first at all times, which means the counselling process had at all times priority over the research. During my research I developed ways of conducting the counselling first and foremost and engaged in reflective and reflexive activities as a researcher only after each counselling session. Throughout the counselling I encouraged the participants to disclose feelings of intrusion or distress as they occur. I was prepared to respond to observations of interference or distraction to the counselling process (for the client and/or myself). Even though it might have been prejudicial for the research, my approach was to be sensitive to the

participants' right to leave the research programme without suffering penalties. Prior to the counselling I agreed with the participants that in the event of a withdrawal from the research the counselling will be continued normally.

Ethical reflections on my insider role as a researcher inevitably led to reflections on power relationships between myself and my participants. I focussed on a number of power issues that had the potential to conflict with the ethical principles of minimising risks for participants, do no harm and also adherence to the Treaty of Waitangi¹. While I claimed to be just learning, it was my responsibility to be aware of how and what I said would affect my participants. I was aware that in our society, even as a student, a therapist is often perceived as an expert by the client. The fact the research participants in my research were vulnerable people, led to an enhanced awareness and sensitivity of this issue in me. I found that when the researcher is an insider and the research topic involves an element of self study, a 'collaborative action research' approach could be contemplated (Locke, Alcorn & O'Neill, 2013). This approach challenges the 'objectification' of the participants. Action research has a strong practical focus and is characterised by a non hierarchical collaborative relationship between researcher and participants. I found that this approach is well aligned with the cooperative character of SF counselling and my own views of the therapeutic relationship. As a consequence I established a cooperative, warm, friendly and non-judgemental approach and showed respect for the participants, their autonomy and dignity. I believe that these underlying principles defused power imbalances to the greatest possible extent.

Through considering the impacts of publishing my research findings on participants I identified two main concerns. Firstly, due to the sensitivity of the information that participants

¹ The Treaty of Waitangi is New Zealand's founding document signed on February 6th 1840 between representatives of the Queen of England and Māori rangatira (chiefs). The treaty states the principles on which the nation state and government in New Zealand was founded. Today, the Treaty guides the relationship between Māori and Pakeha (non-Māori) and ensures the rights of both ethnicities are protected.

disclose during counselling conversations, protecting clients' anonymity was my paramount concern. I chose not to disclose the counselling provider I worked for, did not mention or, disguised, participants' names, age and other identifying information. I disclosed only as much contextual information about my participants as was required to comprehend the research undertaken. Secondly, as context is such an important part of my research, reflections, interpretations, and participant observations were an important part of my data. I considered the effects that publication of my research might have on my clients and concluded that reading my reflections around them could provoke negative reactions in my participants (Furlong, 2006). Consequently, while formulating my findings, I have phrased them in a way that was accurate but at the same time mindful of the possible effects of my reflections or insights on my participants.

I became aware that researchers, especially in qualitative methodology frameworks, carry the power to choose whose voices are heard or not. I was conscious that I was the one who determined which conversations were worth including and which were not (Etherington, 2000). I strived to be honest in choosing dialogue excerpts that truly represent my own practice and did not look for examples that fitted my preconceptions of the topic. In order to mitigate potential interpretative subjectivity I utilised triangulation and obtained second opinions about my interpretations and findings from supervisors and co-researchers (Please see also paragraph 3.3.4. Rigour and trustworthiness).

I considered additional ethical considerations during the course of my research. These included questions such as how my research was aligned with the organisational structure and values of the counselling agency that I worked for and how researchers act ethically in certain cultural settings, other than their own (Mutch, 2005). I regularly discussed ethical dilemmas with my supervisors and peer-researchers.

In conclusion, I experienced that as an ethical researcher I had to continuously reflect on ethical practice and counter ethical dilemmas with awareness, openness, sensitivity and creativity. I found that developing solutions for ethical issues was a complex process. Despite difficulties, it was important to me to fully consider, on an ongoing basis, all ethical issues surrounding research on clients. I constantly reminded myself that ethical research is good research (McLeod, 2010).

The research reported in this research project underwent a comprehensive ethical appraisal through the Human Ethics Committee of the UC (see Appendix V). I declared my ethical standards for this research which are characterised by care and respect for human dignity, individual and cultural differences and the diversity of human experience (New Zealand Association of Counsellors – Te Roopu Kaiwhiriwhiri o Aotearoa, 2012).

3.3.4. Rigour and trustworthiness

The goal of qualitative research is to gain understanding, develop sensitising concepts and describe realities amongst human beings (Bogdan & Biklen, 1998). As with qualitative research in general my research design was individually customised, inductive, flexible and evolved over the duration of my research. My findings are presented in the first person as they were a result of my own thoughts and interpretations. My research is deeply influenced by my own subjectivity. I questioned whether my research project can, under these circumstances, deliver trustworthy results. I was determined to prevent my study ending up as a collection of stories that display little scientific grounding (Williams & Morrow, 2009).

The underlying ontological assumptions in qualitative research hold that reality is only knowable through our mind and multiple realities exist at the same time (Snape & Spencer, 2003). I believe that the search for an ultimate truth in qualitative research is therefore pointless. I strived to deliver trustworthy research in which my research question accurately represented

the concept that I aimed to examine (Davidson & Tolich, 1999). For that reason I tried to leave no areas of uncertainty for the reader (Guba & Lincoln, 1989).

Qualitative research is an evolving and flexible approach which means the full picture of the research takes shape as you examine the parts (Bogdan & Biklen, 1998). I believe, despite its inductive character that allows room for unforeseeable events, qualitative research needs to follow a systematic, purposeful set of research procedures (Yin, 2010). Consequently, while I allowed my research to evolve, I strived to be methodical. I sought to bring a sense of consistency, order and completeness into my research (Yin, 2010). I considered microanalysis to be methodical as this procedure follows particular steps that are clearly described and applied to all four researched dialogue excerpts (Sánchez-Prada & Beyebach, 2014). Conducting methodic research is one means of establishing trustworthiness and credibility within qualitative research (Yin, 2010).

As with Yin, I believe that complete transparency within my research strengthened the trustworthiness of my findings (Yin, 2010). For that reason I thoroughly described procedures, my personal background, my views, positions and all data sources. My data were saved onto the University of Canterbury server and are accessible for inspection. While displaying excerpts of the participants' original language and connecting them with my findings (Yin, 2010) I tried to make the micro dynamics of dialogue 'instructably observable' (Strong, 2007). Hence my conclusions are grounded in and linked to the data and will therefore withstand scrutiny by others (Yin, 2010).

I was careful to ensure that rigour was not compromised through my own passionate involvement in the research. I became aware that it is difficult to analyse and interpret data without including my own preordained assumptions, subjectivities, stances, personal biases and experiences, personality, cultural values and predispositions. By disclosing the interplay between my own positioning and the research events that happened (Eisenhart, 2006) in the

form of reflective comments, I aimed to deliver a richer deeper perspective of my research subject. With revealing reflective information I tried to provide another layer of depth to capture the social contexts more fully for the reader. Beyond that I described my worldview, epistemological stance and where I was coming from (Hara, 1995). Rather than having issues with bias in my research, I strived to disclose what kind of bias existed (Elliott & Williams, 2001). The strength, vitality and rigorousness of my qualitative study was improved as a result of taking these measures.

Triangulation is used to strengthen the trustworthiness of a qualitative study further (Davidson & Tolich, 1999). Triangulation refers to the use of different data sources, utilising multiple analysing methods, techniques and interpreters. Ideally, when different sources and methods lead to the same consistent interpretation, the research can be seen as trustworthy (Davidson & Tolich, 1999). I triangulated my data sources by not solely relying on the main data sources which were the video recorded client-therapist conversations. A feedback form, filled out by the participants after each counselling session, captured clients' own perceptions about the 'What's better?' intervention. The verbally expressed perceptions of this intervention from the participants formed an additional reliable source of data that had the potential to strengthen my own findings and interpretations.

Beyond that I used triangulation through obtaining alternative viewpoints from different people (supervisors) to analyse and interpret certain dialogue sequences. In order to re-evaluate my own interpretations I presented excerpts of video recordings and transcriptions to my supervisors and peer researchers. Learning about and incorporating their thoughts, perceptions and alternative interpretations helped me to overcome the intrinsic biases that often result from research by a single observer.

I believe that my attention to these elements increased the trustworthiness and strengthened the validity of the study.

3.3.5. Data analysis

For my data analysis I used the analytical tool of microanalysis. I started the process of data analysis after all data were collected. Prior to the analysis a number of steps were undertaken to prepare the data. These steps included an intensive engagement with all data, hyper linking data from different sources, organising and re-organising data, transcribing dialogue excerpts, breaking data into manageable units, coding them, synthesising them and searching for patterns.

I examined dialogues that were initiated by the SF interventional question ‘What’s better since we saw each other last time?’ or simply ‘What’s better?’ I examined video recorded dialogues and their transcriptions with the aim of understanding how my participants and I influenced each other. Within these dialogues I identified meaningful co-constructive sequences and microanalysed how these interactions function and how they are co-constructive (Strong, 2007; Sánchez-Prada & Beyebach, 2014). The interpretation of my data involved framing my ideas, making them understandable and illustrating why and in what way they are important.

3.3.6. Presentation of the findings

Within the results I describe the process of analysing my data and provide some reflections on this process. Following this I outline the main themes that I identified. The analysis uses four transcribed client-therapist conversations in conjunction with the corresponding microanalysis and interpretation of these dialogues. The transcriptions were compiled using Kogans (1998) transcription notations (see Appendix VI). Each turn between speakers was numbered. In my interpretation of the dialogue I referred back to these numbers. The conversation examples are presented from a researcher’s perspective. Within these examples I referred to myself as ‘the therapist?’

At the end of each of the four dialogues, I included the clients' verbatim perceptions of the presented conversations about 'What's better?' They were taken from the feedback forms (see Appendix IV) that the participants filled in after the session the conversation example was extracted from.

The finding chapter ends with a presentation of all client comments describing how they perceived talking about 'What's better?' In contrast to the presented clients' perceptions, which are linked to the four conversation examples, this chapter presents all collected client perceptions. I viewed the written client perceptions as particularly valuable data as they describe genuine insights about how clients' perceived the conversations about 'What's better?' It was my intention to convey these perceptions comprehensively and to find common characteristics.

Chapter 4: Findings

4.1. Process of analysing my data

For initial analyses I set aside long undisturbed times for reading and listening to my data. I chose long undisturbed times because I did not want my concentration to break so that I can get a sense of the totality of my data. During this time-consuming process I viewed and reviewed my recorded counselling sessions focussing on the conversations about ‘What’s better?’ I engaged with the corresponding transcriptions, my reflective field notes and the client feedback forms.

I started to develop an initial set of coding categories and looked for regularities, patterns or topics. I wrote down words and groups of words that represent these patterns. These words formed an initial set of coding categories.

I assigned these initial categories to my data and tested if they are generally applicable or not and if they are sufficient or if further categories are needed. I noticed that particular categories such as personal attributes that included the ‘ethnicity of participants’ or the ‘age of participants’ were less meaningful and excluded them. Through this process new categories gradually emerged and were added. After several iterations of this process I developed a final set of categories for interpreting my data.

Using this final set of categories I coded my data. I undertook the coding by using numbers to represent the different categories and assigned them to my data. I noticed that some categories overlap. Using the numbers I grouped each category together. The process of categorising the data produced a list that included collated information from all data sources. I began to study this list and tried to search for regularities, patterns and topics. I wrote down phrases that could represent topics or patterns that could become the means for sorting my data. I eventually grouped certain categories together into schemes that are superordinated

descriptions of categories. For example, I formulated the scheme ‘Initial answer to ‘What’s better?’ for four categories which are ‘Client doesn’t know’, ‘Client reports there is no change to the better’, ‘Response unrelated to question’ and ‘Client reported change to the better’. All five elaborated schemes and their categories are presented in Appendix VII.

I noted some categories that occurred throughout my data such as ‘Therapist asking open question’ or ‘Client states something’. A closer inspection of my data also revealed links between certain categories. For example I found that the category ‘Therapist asking pre-suppositional question’ could be related to ‘Client surprised’ and ‘Client thinking’ or perhaps to ‘Client has new insight’. I identified a number of categories that I found helpful for describing how co-construction might happen when talking about ‘What’s better?’ for the client.

4.2. Main themes of my data

I found that clients are usually willing to engage in a conversation about ‘What’s better?’ Even though their initial answer can vary (see Appendix VII Scheme: Initial answer to ‘What’s better?’), the therapist’s persistent questions prompt them to think about ‘What’s better?’ for them. I found that clients’ perceptions of the changes to the better can be caused by:

- An external event (such as, better weather, the unexpected visit of a friend or other fortuitous events)
- An internal event (the client herself induced the change to the better by, for example, changing her behaviour or attitude, using some new strategy, finding a new coping mechanism)

I developed three schemes that can be used to describe how the process of co-constructing of new meanings (primarily for the client) happens. I called these schemes ‘Client behaviours that

indicate a shift in meaning', 'Observable Client behaviours' and 'Therapist's purposeful actions and possible motivations' (see Appendix VII).

The categories under the scheme 'Client behaviours that indicate a shift in meaning' are able to describe when exactly a shift in meaning for the participant happened and in what way it could be observed. A shift in meaning or the co-construction of a new meaning took place when one participant of dialogic interaction brought her own initial meanings and realities to the conversation; then, through this conversation and the participants individual interpretations which arose during the conversation, these realities were re-constructed. I observed a number of client behaviours that indicated that current client meanings were re-constructed over the course of the therapeutic conversation (see Appendix VII). Such observations were for example: the client adopted a new fact, built on a new idea, had a new insight or saw something differently than before.

The categories under the theme 'Therapist's purposeful actions and possible motivations' are able to describe how the therapist used actions with a certain motivation in order to influence the client. I observed that different actions are often combined with different motivations. For example, the therapist may paraphrase some of the client's words with the motivation of building rapport and also to highlight an important statement of the client or to remain longer within a newly elaborated perspective. Different actions can be cross-connected with different motivations.

Categories under the theme 'Observable Client behaviours' are able to describe the clients' actions during a meaningful dialogic conversation.

In my following microanalysis I used the categorisation resulting from these schemes to explicitly describe what happened during the outlined conversation. I also outlined my interpretations of these micro level events. In that way I outlined step by step on a micro level how co-construction of new meanings happened.

To highlight for the reader within the microanalysis the visibility of factors that induce co-construction (categories) the therapist actions are given in **bold** while the client actions are underlined.

4.3. First conversation example: 'It's good to see the positive bits'

This example takes place at the beginning of the third session with one client. The counselling conversation started with some small talk before the therapist asked the question 'What's better?' The client thought for a moment and stated that a friend came back into their lives (hers and her partners). The therapist investigated briefly the facts around this statement and did not expand on this topic.

The therapist asked 'What else?' (is better) and the client answered 'Well, it was pretty crap at times but it turned out better.' She then engaged in a description about her partner's difficulties at work and how the couple managed to see positives in an initially negative event.

The transcription notations used within the passage are described in Appendix VI. The abbreviations C. and T. are shorthand, respectively, for 'Client' and 'Therapist'.

1. C.: ((final part of a lengthy passage))... and he's got extra hours, working longer, that's only one extra hour but that's five hours a week, which is an extra 100 Dollars (hmm) that's also a bonus {laughter} (wow), that, like, 500 Dollars rent a week, like, it's ridiculous (hmm). So, you know, something positive around the negative (wonderful) And I normally just see the negative.
2. T.: You normally just see the negative?
3. C.: Yeah, so it's good to see the positive bits.
4. T.: How did you manage to see the positive?
5. C.: I don't know why it worked; it just did {laughter}
6. T.: you noticed it, you said, okay...
7. C.: I'm doing it quite often; you know, not in the moment, I don't notice it, but later on I go, oh? I actually did turn something bad into something good (hmm).

8. T.: So how do you do this, when you switch it around {therapist shows with thumb and pointer finger a turning movement}, what happens in your thinking?
9. C.: Oh yeah {surprised} I don't even realise that I am... at that moment I go, grrr {client makes gnarly sound}
10. T.: But you told me now...
11. C.: yeah {therapist nodding} and you look back and go, oh, well actually... it's like last night, I'm building a website for my cake business (aha) {therapist nodding} and I printed out like 300 flyers on the laptop and I was like maybe should just I spell check it. And I spelled a word wrong. Idiot! And I was like, no, calm down, I just put my music on, put my headphones on and I twink the word out AND WRITE IT BACK IN there {client smiles}, it's only one word, it won't make too much of a difference, and it's not as professional as it would have looked, BUT, (Yeah), you know, I'm not wasting 300 copies, so I got out the twinker pen and N. writes the word in, we kind of had a line going on, I'm twinkling, N.s writing someone else is folding them {therapist nodding, smiling} and we had like a little sweep shop going {laughter} in our kitchen last night, * till like, one o'clock, so that was pretty cool*
12. T.: Ok, so, also an example when you actually said, oh, something bad happened, but... {therapist shaking head to indicate that this is not happening anymore}
13. C.: =I can fix it!
14. T.: Wow {therapist nodding}
15. C.: I would have normally screamed and thrown them away, start again...
16. T.: Probably that's the new normal now?
17. C.: {client nodding, smiling} yes, exactly, I like it. It saved me an extra hour printing them again {laughter}
18. T.: So that's the new normal that you say, look, it's actually not that bad, we can do it and you probably had a bit of a chat and a bit of a nice time, I don't know? {therapist nodding}
19. C.: Yeah, it was good. (ah, lovely) >yeah and there were times when this was totally different<
20. T.: What do you think what caused this new normal, that we just discovered? How come that that is the new normal now?
21. C.: Ahm, I don't know, I think it's coming here, you know, it's creating new ways to work (hm) {therapist nodding}, you know, that's really helpful
22. T.: hm (.) Can you tell me {therapist makes a 'poking deeper' gesture}

23. C.: {laughter}
24. T.: ... so what is it that is helpful.
25. C.: I don't know {client thinking}, probably understanding myself (hmm) {therapist nodding}, you know, how I tick, that's always helpful
26. T.: so do you think you also want to see things in a different way?
27. C.: {client nodding} oh, definitely, you know, nobody wants to live a crappy, horrible, miserable life (yeah) {therapist nodding}, > maybe some people do< {laughter} I don't! So
28. T.: So that's what you already changed? {therapist nodding}
29. C.: yeah, I want to be happy and healthy and {not understandable}
30. T.: and then you decided (.), ok (.) that's the way to go?
31. C. yeah {client nodding}
32. T.: well done! I find it amazing. I mean, you can be miserable or you can be quite positive and see the positives in things, and you just managed to do that {therapist nodding}, ({client nodding}), like that {therapist clicked her fingers}, How do you feel about it?
33. C.: yeah good, it's making life a lot easier {therapist nodding}.

Analysis and interpretation of this therapeutic conversation

The client finished her description about her partner's new work situation in that she was explaining how she managed to see positives within a negative event, with 'I normally just see the negative' (1). This statement signifies that she has changed that behaviour and stopped seeing just the negative. The therapist **built on this statement** and **paraphrased** it by **preserving five of the client's exact words** 'So, you normally just see the negative?' The paraphrase is formulated as a grounding sequence to clarify the fact that she did just see the negatives in the past (2). The client confirmed and stated that she finds it good to see the positives (3). Her answer indicates that this is the change to the better that she perceived and that she is talking about.

The therapist **built on the client's statement**. She formulated a **pre-suppositional question** 'How did you manage to see the positive?' that embedded the presumption that the client did actively take some action in order to see more positives (4). This question is composed in alignment with the SF approach of the therapist and based on the assumption that people hold, within their experiences, a wealth of skills. It also leads to the client experiencing herself as competent. The question prompted the client to purposefully think about what it was that she did do in order to induce this change. Her answer indicates that she engaged in thinking about it, but she was still unable to figure out what it was (5). The therapist decided to encourage more thinking by **mirroring** that the client has noticed that change herself - '...you noticed it, you said, okay...' (6). Even that formulation includes the **presupposition** that the client must know what caused her change to the better. With formulating her answer the client worked hard to make sense of the change in her behaviour. She thought and reflected on past events and stated that she often notices not until later that she turned something bad into something good (7). The therapist investigated deeper and **asked** one more **pre-suppositional question**. With asking 'So how do you do this, when you switch it around?' (8), she **reframed** her question by **introducing a new wording**. By using the phrase '...you switch it around?' the therapist offered a new perspective to the client. She intensified this new wording with a **hand gesture** of switching something around using her thumb and pointer finger to make a turn movement. This was an attempt to help the client to imagine how she might have achieved that change. The question also reinforced the presupposition that the client actively did do something to cause this change.

The client's answer indicates that she was not aware of her own skill (9). Her statement implies that she is NOW aware which indicates the client's construction of a new meaning. To highlight the fact that this change in the client's behaviour did really occur, the therapist **mirrored** to the client that she herself talked about these changes (10). The client agreed that

she herself induced the change to the better (Says 'yeah', nods) and delivered another example when she managed to stay positive when something challenging happened (11).

After listening to the client's story, the therapist briefly **summarised** the client's further example of the improvement to the better and said 'Ok, so, also an example when you actually said, oh, something bad happened, but...' (12). Before the therapist could finish her summary, the client interrupted and stated 'I can fix it.' (13). This statement indicates that the client perceives being aware of positives in a challenging situation equates with 'Fixing things'. The therapist acknowledged and reinforced the client's achievement with a **complimenting** 'Wow!' (14). The client referred back to the past and made a statement about how things would be before the change happened (15). She used the words 'would have' and 'normally' to express her typical behaviour in the past which shows again that she adopted the fact that she changed that behaviour at present. The client's examples and statements led the therapist to **pick up on** the word 'normal'. According to the client's comment the therapist heard that there is an old 'normal', so the therapist's assumption was, there must be a new 'normal'. Consequently the therapist transformed the client's negative content (old behaviour) into positive content by **asking the pre-suppositional question** whether the described examples represent her new 'normal' now (16). The client stayed in the positive frame, agreed and visibly enjoyed this realisation and said 'I like it' (17). The therapist **noticed** that her transformation to the new 'normal' was well perceived by the client and decided to **paraphrase** her own statement to remain engaged longer in the discussion about the 'new normal' (18). The therapist **invited the client to listen to her imagination** about how the evening might have gone for the client and her partner within the 'new normal'. This seemed to further intensify and establish this newly constructed view for the client. The client did not fully engage with the therapist's invitation and responded once again with looking back to her old behaviours. She stated that there were times when this (the 'new normal') has been totally different (19).

The therapist reframed the client's negative content (old behaviour) into a positive reference and asked another **pre-suppositional question** with the objective to elicit what exactly prompted the client's change (20). The therapist used the terms 'new normal' again to maintain this wording for representing the new meaning. The client responded and worked hard to construct an answer to this question. She indicated that she found coming to counselling and working on creating new ways to be helpful (21).

The therapist smiled and persisted with eliciting at a deeper level how the change was achieved. She asked the client the **open question** 'So what is it that is helpful' (22; 24). The client was initially unsure but worked with the therapist to construct an answer to this question (25). The therapist used a **pre-suppositional question** to open up a new possibility for the client and assumed that the client possibly wanted to see things differently (26). In that way the therapist still took the stance of not knowing while consciously raising awareness of the fact that the client has choices. The client, in response, did not challenge this new content, in contrast she agreed and built on this idea (27). The therapist established the new insight by **summarising** 'So that's what you already changed' (28). The therapist was nodding. The client agreed and extended this summary even further and stated that she wants to be '...happy and healthy...' (29). The therapist formed another closed **summarising question** that also contained a **presupposition**. She asked '...and then you decided, ok, that's the way to go?' (30). By using the word 'decided' the therapist suggested once more that the client has a choice how to react to events in her life. The client agreed with this summary (31). At the end of this conversation sequence the therapist **complimented** the client for her achievements (32). In this way the therapist highlighted the client's competency and acknowledged her effort. She checked the client's perception about this achievement and **asked the open question** 'How do you feel about it?' The client's answer '...good, it's making life a lot easier' (33) indicates that she might have experienced herself as competent and successful. She might have become aware

of a new skill, being able to see positives in challenging situations and transforming negative events into positives.

Client's perception of the 'What's better?' question (see Appendix VIII)

The client rated the usefulness of the 'What's better?' question on a scale from one to ten where one means "I found discussing what is better not useful" and ten stands for "I found discussing what is better very useful" as a eight point five. She reasoned her rating with the following words "It (the 'What's better?' question) helps me see that there is not just bad in my life and there are so many little happy times through my week". In her overall perception of the counselling she stated, that she hopes to do the same kind of things next time, namely "Reminding myself how great my life is".

4.4. Second conversation example: 'I am trusting myself'

This conversation example takes place at the beginning of the second session with one client. The conversation started straight away with the 'What's better?' question. The transcription notations used within the passage are described in Appendix VI. The abbreviations C. and T. are shorthand, respectively, for 'Client' and 'Therapist'.

1. T.: Since we last saw each other last week, what is better?
2. C.: Ahm, well I think I've been positive within myself {client smiles}, I think I've mentioned to you that I've finished all my assignments (hmm) {therapist nodding}, I'm not sure... with my study? So I did have one returned, but I didn't panic too much about it; I just got the questions and answers that needed to be (done) and resubmitted it. I DO have some fairly big news on the ex-boyfriend front (yeah); he did make contact with me.
3. T.: How was that?

4. C.: It was good. He has apologised for everything and wants to meet and have a big talk about everything and (.) initially I was a bit of, sort of, I just let it go {therapist nodding} and, ahm, not doing anything about it {therapist nodding} and, because we had basically no communication for = I think when I saw you was the Saturday (yes) {therapist nodding} = we hadn't seen each other for a couple of weeks, and there were no communication nearly for a week (yeah) and then there has been a lot happening with him...

The client delivers factual information of her latest experience with her ex-boyfriend. This discourse follows up a previous conversation between the client and therapist about the client's struggles with her ex-boyfriend. The therapist listened attentively. The client finished her sequence with sequence number five, please see below how the conversation developed after that:

5. C.: ... I sense from him, there has been a shift, he is more feeling, more empathetic (hmm), and is genuinely wanting to, ahm, talk about it and address anything there {therapist nodding} and then obviously have a talk about it. I mean, regardless, I've got my future plan (hmm) {therapist nodding} I'm doing my thing, ahm, but you know, if we could be friends that would be really nice. Ahm, and yeah, I'll just see how it all sits.
6. T.: Ah ok (.) ok. You also said in the beginning, you've been positive within yourself, so when you're positive within yourself, what are you doing {therapist smiles}?
7. C.: Ahm {client smiling} Well, I think, I don't know if I said to you, but, I have, like, what I call like, I'm giving myself a pat on the back. I actually say, you know, just that sort of self-, is it called self gratification. Just say, well done that I've actually got through my study {therapist nodding}, my family can actually see that, ahm, and I be really proud of my efforts as well {therapist nodding}. Ahm, just knowing what's happening for the future, like it's actually been really stressful with work, and (hmm) {therapist nodding}, you know, with finishing that ((the studies)) and then thinking about getting away to Nelson*. There has been a change of plans there, I'm going over Christmas, but then I'm gonna come back and hope get started up there till the

end of January {therapist nodding}, so, whilst I won't have any work after the 19th of December, I'm not worried about this. There is an actual calmness; I just feel that everything is rolling nicely. So I just, it's almost like I'm at peace with things.

8. T.: ah, ok.

9. C.: I'm not stressed. I am aware that there has been times when I have been feeling like {client sighs} it's all happening, but I'm ((now)) just going with it. I can get the car sold, so there is some planning going on, some forethought, is that the word {client smiles}

10. T.: Ah yeah {therapist smiles}

11. C.: So thinking about, ok, I've got my things to pack, car to sell, I can finish my work. So there is a process, I'm just sort of working on a process.

12. T.: Ok, and that's how you do it. ((to be positive within yourself))

13. C.: Yeah

14. T.: So, foreseeing things, planning {therapist nodding}

15. C.: Yes

16. T.: That keeps you calm, organized {therapist nodding}

17. C.: Yes, yes, and working towards a date. And now... because initially it was all going to happen and going to head away on the 22nd, and then be gone (hmm). But that was getting all a bit much without my licence coming though {therapist nodding} and everything, and so I had a talk to the people I'm gonna be working with in Nelson and said: I just come up the end of January {therapist nodding}, when things are settled and we're ready to go (hmm), and it makes sense. It gives me that time with Sophie** ((her child)) (yeah) and if I do a bit of temporary work or I can get some hotel cleaning work, I've done that before {therapist nodding}, so (.) I just feel – I don't know what it is – I've just got this feeling that I trust it's all gonna work out ok

18. T.: Yeah, ok.

19. C.: So that's good.

20. T.: Maybe you learned that you can trust yourself?

21. C.: I think that's the big thing (yeah). Ahm (.), I always had on me, I always trust myself {therapist nodding}, then I went to a whole self-doubt, you know (hmm), that depression, when now, I'm back to thinking, yeah, it is, you know, it will all happen.

22. T.: yeah, yeah

23. C.: I am trusting myself, you're right.

24. T.: yeah, yeah {therapist thinking}, so what I also heard was, ok, you rang them and you actually talked {client nodding} ... and you asked is there any flexibility.
25. C.: Yes, yeah
26. T.: ... you wanted to know... {client nodding}
27. C.: So I needed to have some sort of gate, some sort of idea as well, because, you know (hmm), to go up for Christmas and then come back and it's like 700 dollars (hmm), and that is money that I could use for my business {therapist nodding} and whatever (yeah, yeah), so it was a matter of working that all out (yeah, yeah). It has worked out better because the way that we doing things as well (wow), ahm, we going up as a family for Christmas {therapist nodding}, to have it with friends and relatives up there. And then they've now said we can pick up their car from their house to drive that up {therapist nodding} so that's saved busses and costs (hmm), so there have been a lot of little things (hmm). (.) Do you know the old saying, people don't fail... people don't plan to fail – they fail to plan? {therapist nodding} {both smile} , and I think it's just the matter of having a plan (yeah!) {both smile} and working towards it.
28. T.: So, that's the thing, what I always believe, people have, they learn (yes), they make their experiences (yes) and then they learn from them. So, three things that I heard, that made you, feeling calm and quite organized and actually quite happy
29. C.: Yes
30. T.: and not stressed, {therapist shows number one with her hand} fore-thinking and planning
31. C.: Hmm
32. T.: {therapist shows number two with her hand} talking with people and, yeah, actually make things happen (yes) {client smiles} as action rather than reaction
33. C.: Yes
34. T.: and trusting yourself {client nodding eagerly} {therapist nodding}
35. C.: Yeah, you're dead right. And that's actually a big shift for me again. That is REALLY a big shift. And not reacting to things (yeah) has been really a big thing.

*Name of city changed

** Name of child changed

Analysis and interpretation of this therapeutic conversation

The client initially responded to the ‘What’s better?’ question by stating that she has been positive within herself (2). In her answer she then refers to mostly external events that happened over the course of the time between her first and second session with the therapist (having assignment returned, her ex-boyfriend contacting her). The therapist **listened** to the client’s description and **minimally encouraged** her client’s report. The open ended question ‘How was that?’ (3) was used as a minimal encourager. In that way the therapist acknowledged what is happening in the client’s life with the intention of building up good rapport. As the client’s ex-boyfriend contacting the client is a change to the better that was not initiated by her client, the therapist decided not to explore these events further.

After the client finishes her report, the therapist **took up** the client’s initial statement that she has been positive within herself (2) and **asked** the client the **open ended question** ‘When you are positive within yourself, what are you doing?’ (6). The therapist chose to **build on** this statement to explore at a deeper level if this change to the better was induced by the client herself rather than by external events that just happened to the client. With formulating her answer the client worked hard to make sense of the reason why she felt positive within herself. She explained that she finds encouraging and praising herself helpful and describes that knowing her future is contributing to the positive feeling (7). The therapist **minimally encourages** (8) the client’s remarks and remained **listening** to the client reflecting on how she felt positive within herself. The client became aware and stated that planning and fore-seeing things are contributing to feeling positive within herself (9). At this point the client also **stated** that this has been different in the past. The therapist **minimally encourages** her client again (10) and **allows more time** for the client to follow up her thoughts. The client finished her reflection with the statement ‘I’m just sort of working on a process’ (11).

The therapist initiated her response with an **indirect compliment** and stated ‘Ok, that’s how you do it’ (12) which prompted the client to notice her own competencies and acknowledge her achievements. The therapist then **paraphrased** the client’s words ‘foreseeing’ and ‘planning’ (14) to reinforce the client’s new meaning that she elaborated in her answer. The client listened carefully and agreed (13, 15).

The therapist then **summarised** the effects of her client planning and foreseeing by **paraphrasing a word that the client has used herself** (calm, client used it in sequence 7) and introducing a new term (organised). She stated ‘That keeps you calm, organised...’ (16). The client agreed and built on this summary by stating that she finds working towards a date helpful (17). She extended on this idea and delivered examples that substantiated their finding (17). The therapist **acknowledged** the client’s contributions with **minimal encouragers** (18) whereupon the client ended her chain of thoughts with the statement ‘So that’s good’ (19) which indicates that she experienced the newly gained insights (shift in meaning) as positive.

To provide the client a new perspective on her insights the therapists **introduced new content** in form of a **pre-suppositional question**. She asked ‘Maybe you learned that you can trust yourself?’ (20). The client built and extended on this idea, agreed and referred back to the past when that was not the case (21). The client’s answer ‘I think that’s the big thing.’ indicates that she strongly agrees and that she experienced herself as competent. The fact that she noticed that this was not always the case in the past, might have highlighted the fact that it is the case right now for her. The therapist acknowledged with **minimal encouragers** (22) and the client confirms the new perspective once again and states ‘I’m trusting myself, you’re right’ (23).

The therapist then **picked up on** one comment of the client (that she **noticed** earlier in the sequence when client extended on examples and statements in 17) that showed that the client’s particular action led to the perceived improvement. The therapist **reflected back** ‘I also heard was, ok, you rang them and you actually talked, and you asked is there any flexibility’

(24). In that way the therapist **indirectly compliments** the client and extends her elaboration of the client's own competencies and skills. The client agreed (25) with this statement, then noticed and acknowledged this aspect of her own impact on improving her situation. She then explained and reasoned her action and stayed that way reflecting on her own problem solving skills (27). The client finished her sequence with a saying that emphasises the importance of planning (27).

To sustain the new insights for the client, the therapist initiated a **summary** sequence of the co-construction between client and therapist (28). On the one hand the therapist aimed to make it easy for the client to relate to her summary and **uses her client's own vocabulary** (that she used in sequence 21). She started her summary with 'So, that's the thing...' (28). She also **implemented some the client's own words** of feeling 'calm' (client's use in 7, therapist's adoption in 28) and 'not stressed' (client's use in 9, therapist's adoption in 30), that the client used to describe her perception of what it means to her to feel. On the other hand the therapist **introduces her own words** (as an alternative to the client's words 'being positive within myself') to **introduce her perception** of the effect that the client's problem solving skills might have had on her client's life. She used the words '... three things that I heard, that made you feeling quite organised and actually quite happy...' (28). The client listened intently and agreed with the new wording (29). The therapist then **summarised** what she has heard that contributed to her client 'being positive within myself' and **uses a hand gesture** for numbers to amplify the new insights. In her **summary** she enumerates that the client firstly fore-thought and planned (30), that she secondly talked with people (32) and that the client thirdly trusted herself (34). When the therapist designated the second insight, she **added the new wording** 'make things happen' and 'action rather than reaction'. The client agreed with the whole summary and stated 'Yeah, you're dead right'. She also adopted the wording 'not reacting to things'. At the end the client stated that using these three strategies were a 'big shift'. She said:

‘And that’s actually a big shift for me again. That is REALLY a big shift.’ Her response to the therapist’s summary indicates that her awareness of her own problem solving skills, strategies and her own competencies has increased.

Client’s perception of the ‘What’s better?’ question (see Appendix IX)

The client rated the usefulness of the ‘What’s better?’ question on a scale from one to ten where one means “I found discussing what is better not useful” and ten stands for “I found discussing what is better very useful” as a nine point five. She reasoned her rating with the following words “(the ‘What’s better?’ question) allows me to reflect on the week that was + the week ahead”, she adds in brackets “self reflecting + planning”. She also noted down “to look at positives through any emotional downs or sadness” and added in brackets again “pragmatic approach”. During the next session one of her comments for finding the ‘What’s better?’ question useful was “(the ‘What’s better?’ question) allows me to reflect on my achievement which I do not necessarily take the time to do + when I reflect back with my counsellor I go, wow, I’ve done well.”

4.5. Third conversation example: ‘It’s like a rope being thrown to you – that you can pull yourself up’

One client described her problems during the first session as being not focused enough, having too many ideas and not following them through (she stated, she never finishes things) and dreaming too much. During this conversation the client and the therapist identified three exceptions to the problem of not following through or finishing things. Firstly the client always follows through with being a mum, secondly she never gave up being a partner for her boyfriend and thirdly she took on and finished an IT course. Therapist and client worked out that the client completed her IT course through telling herself that she really wants to achieve

something. The following therapeutic dialogue takes place at the beginning of the second session with this client. The transcription notations used within the passage are described in Appendix VI. The abbreviations C. and T. are shorthand, respectively, for ‘Client’ and ‘Therapist’.

1. T.: It’s a while ago since we saw each other ((while sitting down))
2. C.: Yeah, aright, yeah
3. T.: And I would like to start with getting to know what is better since we saw each other
4. C.: Yeah, sure. ((looks up)) {client thinking} ahm, What is better? (.) Ahm, I have been – I started a job. And that’s been actually really cool to have like a bit, to feel I have somewhere to go, like a bit of a purpose
5. T.: hmm {therapist nodding}
6. C.: Even though it’s certainly not my dream job. I don’t necessarily know if I’m best, the best person for this particular job. I’m doing like an internship (hmm) {therapist nodding} for an IT company
7. T.: Ah yeah, you mentioned it last time (yeah, yeah), that you applied for it (yes) or you considered it, or... {client nodding}
8. C.: So, I’m doing it, yeah
9. T.: Wonderful, wonderful {therapist nodding}
10. C.: And ahh, so yeah, it’s been plenty of, you know, benefits from doing it, ahm (.), yeah, that I’m not just sort of, you know, I was finding what was happening, I was going from (.) like leaving Derrick* say at preschool {therapist nodding}, then racing home, and sort of getting caught up all the time in cleaning the house or whichever, whereas this is, you know, it’s like I drop off Derrick and then go to this job and work and its, you know, kind of learning things and I’m enjoying the conversations that I’m having with people, so, yeah, so that’s been, that’s been much better. Ahm, what else’s been better? {client thinking}
11. Ahm, I have been like cleaning, just sort of more decluttering our home (hmm), and changing things a bit there, ahm, {client thinking}
12. T.: how is that better for you

13. C.: I'm quite into, like, Feng Shui, and so {therapist nodding}, yeah, I really like the idea of, ahm, just making your home flow (hmm) {therapist nodding}, ahm, better, and how that affects the people living in the home as well, so ...
14. T.: yeah, ok, decluttering the home, so it is clear
15. C.: yes
16. T.: How does it affect you?
17. C.: Yeah, it's really, it feels great, like I just, on the weekend, cleared out the entrance way of all the shoes and everything and got rid of the shoe rack and then cleaned out the cupboard which is now become the shoe cupboard (hmm). So when you go into our entrance way it's really clear (yeah). It's not just bags, you know, like, going into sort of like, a wardrobe ((not understandable)) and it just feels so much better (yeah)
18. T.: Can you describe in what way you feel better? What does it do with you?
19. C.: It makes me feel clearer in my mind (hmm) {therapist amazed} less distraction ahm (.) {client thinking} yeah {client nodding}
20. T.: and that's what you want, that's what you strive for?
21. C.: That's what I'm striving for {client nodding}, yeah, I'm striving for, ahm, I'm striving for, yeah, clarity, and purpose, focus, ahm, completing tasks (hmm) and following through like with the things that I say I'm going to do, following through with them (hmm, hmm), yeah,
22. T.: yeah, that's what I remember what we talked about when we met for the first time last time (hmm) and we actually figured that you (.) already do that
23. C.: Yes {client smiling} {client nodding}
24. T.: Probably not as much as you would like to do it {client nodding} (yes, yes) but you ((initially)) came and said oh, I never do it
25. C.: yes, yes, yeah
26. T.: Which is not quite right (yeah)
27. C.: That's right. So those are the things that are better
28. C.: I feel like I'm, I feel like today, I feel a little bit sad about myself, just from something that I realise I keep doing, I just, I'm just disappointed in myself (hmm)
29. T.: What is that, do you want to talk about it?
30. C.: Yeah, I keep, I keep smoking cigarettes....

* Name of child changed

Analysis and interpretation of this therapeutic conversation

The therapist placed her ‘What’s better?’ **question** right at the beginning of the session and **invites** the client to state things that are better in her life (3). The client engaged, thought and reflects on her past weeks. Then she came up with an example that represents things that she perceives as better for her, namely that she got a job (4). Without being asked she reflects on how that is better for her and stated that she feels a sense of purpose (4). The therapist is **acknowledging** this change to the better and **minimally encourages** her (5). The client gives some more information around the job (6) which leads the therapist to **link this information** with their previous session (7). This might have the effect that the client feels listened to. The client in return acknowledges that the therapist made that link (8). To acknowledge and reinforce this achievement, the therapist **compliments** the client directly (9). That leads the client to reflect more on this change and she points out more benefits (‘learning things’, ‘enjoying conversations with people’) for her, in contrast to the past, the time before the change to the better (10). The client finished this chain of thoughts and reflects more on things that are better for her, through asking herself ‘Ahm, what else’s been better?’ (10).

She then reflects on another aspect in her life that she is experiencing as better (11). To elicit her client’s perceptions of the change for the better at a deeper level, the therapist invited her to reflect on what particular aspect of this change is important to her. She **asked** the **open question** ‘How is this better for you?’ (12). The client worked hard to make sense of her perception of her experience of feeling a change to the better and started to state her thoughts around this (13). She still remained quite vague in her answer. To explore what ‘decluttering the home’ means to the client, the therapist **paraphrased** these three words and **added** the converse argument ‘So, it’s clear’ as **new content** for the dialogue (14). The therapist hoped that this approach would encourage further reflections for the client. Because the therapist framed the new content as a closed question, the client did not engage in further thinking, she

rather answered with a short ‘yes’ (15). The therapist reframed this and **asked the open ended question** ‘How does this affect you?’ (16). In her answer the client explains what exactly she has done in order to declutter and finishes with the statement ‘it just feels so much better’ (17). In order to explore the useful aspects of decluttering for the client, the therapist persists and **asked further open ended questions** ‘Can you describe in what way you feel better? What does it do with you?’ (18). Her second question includes the presupposition that decluttering does have an effect on her client. This question leads the client to think exactly about that and she stated that she feels ‘clearer in her mind’, ‘less distracted’ (19). This can be seen as a new insight from the client. With her next statement, ‘and that’s what you want, that’s what you strive for?’ the therapist **checked her perception** of the client’s answer (20). Through doing this the newly gained insight was highlighted and acknowledged. The client confirms by paraphrasing the therapist’s exact words and she expands this thought even further (21). The therapist **acknowledged, agreed and linked** the client’s comments to their conversation they had during the previous session (22). She emphasised that last time they already had found exceptions to the problem. The client remembered and confirmed the therapist’s statements (23). With her comments 24 and 26 the therapist **challenged the client’s initial perception** that she never finishes anything she started. The client agreed and summarised ‘That’s right. So those are the things that are better’ (27) before she engages in problem talk about an issue that bothered her (28). Because the client indirectly verbalised that she feels the need to talk about something else, the therapist **acknowledged that need** and invited the client to talk about her concerns (29). The client then explained her difficulties (30).

Client’s perception of the ‘What’s better?’ question (see Appendix X)

Instead of rating herself on the scale of the ‘What’s better?’ question, this client circled the explanatory comment at the end of the scale which has the wording ‘I found discussing what

is better very useful'. She reasoned her evaluation with the following words "I am able to stay focused on my life vision - not stay bogged down in what's not going right – it's like a rope being thrown to you – that you can pull yourself up. Remembering what's good in life".

4.6. Fourth conversation example: 'It's like been forced'

The following conversation takes place at the beginning of the fifth session with one client. The client is battling with sadness, feelings of inadequacy, despondency and experiences a constant lack of motivation. During the previous four sessions, the client tended to engage in problem talk which the therapist acknowledged and validated, and yet the therapist sought opportunities to elicit, become aware or build solutions.

At the beginning of the fifth session, described below, the client and the therapist engaged in small talk and talked about the cold weather. The client then made a statement that was not understandable (it was too quiet), the therapist replied as transcribed below. The transcription notations used within the passage are described in Appendix VI. The abbreviations C. and T. are shorthand, respectively, for 'Client' and 'Therapist'.

1. T.: ok, before we come to that, I ask you, of course, what's better?
2. C.: Ahm, yeah, I struggle with that, still, with the 'What's better?' question, I feel it's almost like, I have to... been forced to find something that is good
3. T.: no, no, no, I don't want to force, I want to check with you
4. C.: No, I know, I just ... (.)
5. T.: Do you want to
6. C.: I feel like it's the same (hmm), I had a pretty rough couple of weeks, ahm, I did get to talk to my nephew, he's doing well despite having a heart attack at the age of 21...

The client and the therapist engaged in a conversation about the client's nephew, for some time, before the therapist made another attempt to explore an exception at a deeper level.

7. T.: so he has a bit a career in front of him now, some outlook.
8. C.: hmm, hmm
9. T.: Good, good (.) oh, that's good. And you went to the gym, of course {client mentioned this as a sideline}, the gym is still crap {laughs} but you were good?
10. C.: {client nodding} I did go last week, I did go three times.
11. T.: Wow {client nodding} wow! {therapist surprised} So is that what you would say is better {client has sad face expression} or would you say that's still not good
12. C.: yeah, no, I mean its good {client shrugs shoulders indifferently}, its (.) {client thinking} But I wouldn't say that is better, because, that's like, that's supposed to be how it is, I'm supposed to go those three times a week
13. T.: But that is better than it was before, isn't it?
14. T.: I think it's amazing, three times {client smiles slightly}
15. C.: {client thinking}
16. T.: How come that you did do it?
17. C.: I wasn't too miserable to get dressed {client laughs} and my son, he's been quite well with the morning routine (hmm) getting up and getting dressed. No fuss
18. T.: it seems to be quite stable at the moment, isn't it?
19. C.: At the moment, yeah {client nodding}
20. C.: We had a visit with his psychiatrist or psychologist, we have to start medication, and it's very scary for me...

The client then engages in further problem talk.

Analysis and interpretation of this therapeutic conversation

The therapist places the 'What's better?' question (1). The client struggles with the question, seems to feel uncomfortable to be asked that question and expressed her dislike (2). The therapist intends to clarify her motivation for asking this question and **introduced** new content to the client (3). The client understood (4), the therapist started to **ask a closed question** (5) as the client continued to engage in problem talk about the client's nephew. The therapist **acknowledged** the client's need to talk about her nephew, allowed time for it and listened

carefully. She finishes the sequence with a **summarising** statement about her client's nephew (7). The client agreed to the summary with a 'hmm hmm'. Because the client did not give more details about her nephew, the therapist viewed the conversation sequence as finished.

The therapist then **picked up on a comment** that the client mentioned earlier about going to the gym. Going to the gym more often was one of her client's goals. The client confirmed that she went to the gym and added that she went three times within the last week. From earlier conversations the therapist knew that this was definitely an improvement on the previous weeks. She built on this knowledge and **placed a complimenting 'Wow'** and then another 'Wow' (11). The therapist is puzzled by the client's sad face expression and intends to explore how the client perceived herself going to the gym three times asking closed questions. The therapist **gave** the client two pre-constructed **suggestions** about her perceptions (is going to the gym three times an improvement for the better, or is this still perceived as not good) (11). The client reacted to the therapist's question and stated that she thinks it is good, but she disagrees that this is better because, according to the client, it just is like it should be (12). The therapist **challenges her client's perception** and **offered a new more positive perspective** to the client by **asking the closed question** 'But that is better than it was before, isn't it?' (13). She then **compliments** her client (14) which establishes the newly introduced positive content. The example shows how different people can experience the same event (in this case the 'What's better?') differently. The client's answer indicated something is perceived to be better for her when something is better than it should be (and how it should be is defined by the client). For the therapist something is better when it is better than before.

The conversation leaves the client thinking (15). The therapist **asked the open question** 'How come that you did do it?' (16) to encourage the client to think about her own impact on making this happen. The client answered and referred to certain circumstances that are better at home (17). To expand on the client's impact on these improvements for the better at a deeper

level, the therapist intended to engage in a further conversation around this exception. She **checked her perception** of the situation with the client, that she thinks the situation with her son is lately rather stable (18). This statement also **links back to previous conversations** that this client and the therapist had, when that was not the case and rather a problem for the client. The client confirmed that the therapist was right with her perception (19). A deeper exploration of the exception did not happen within the conversation around ‘What’s better?’ as the client initiated a problem focused conversation about her challenges with her sons mental condition (20).

Client’s perception of the ‘What’s better?’ question (see Appendix XI)

At the end of this session the client rated the usefulness of the ‘What’s better?’ question on a scale from one to ten where one means “I found discussing what is better not useful” and ten stands for “I found discussing what is better very useful” as an eight point five. She reasoned her rating with the following words “I’m starting to evaluate helpful vs. non helpful thoughts throughout the week, trying to let go of what’s not helpful”.

4.7. Overall client perceptions of the ‘What’s better?’ question

This section focuses on the clients’ original words that represent their perceptions of the ‘What’s better?’ question. The client perceptions given in the four analysed conversation examples, above, were directly related to the examples. In contrast, the following perceptions provide further insights through providing a comprehensive full summary of the clients’ perceptions, extracted from all counselling sessions. Clients expressed their experiences of the ‘What’s better?’ question in a feedback form at the end of each recorded counselling session (See Appendix IV). In general, this data shows that clients experienced a substantial shift in their perceptions.

One client started to reflect more on her own situation and raised more awareness of the things she already achieved. She stated:

“I’m learning I’m thinking and doing things that we talk about without realizing it.”

“I’m thinking of ways to change my relationship with my daughter.”

“Making me think + fix my stuff.”

“Bringing to light what I achieved that I might not notice.”

Her comments indicated that the ‘What’s better?’ question brought about an increased awareness of her own competencies and induced a solution focused self-reflection and way of thinking.

Another client experienced the ‘What’s better?’ question similarly. She wrote the following:

“Allows me to reflect on the week that was + the week ahead (self reflecting + planning).”

“To look at positives through any emotional downs or sadness (pragmatic approach).”

“Allows me to reflect on my achievements which I do not necessarily take the time to do. when I reflect back with my counsellor, I go, wow, I have done well.”

“This has helped me today as we have focused on my future goal and reviewed that the past year has got me to this point.”

Her feedback distinctly suggests that she also experienced a shift to more awareness of her own achievements and competencies. She stated that through the ‘What’s better?’ question she took her time to reflect on her achievements. Because the client’s perceptions represent her own thoughts and way of thinking, her comments indicate that a shift from problem thinking to solution thinking took place.

The next client’s comments show that she experienced greater hope and, again, a raised awareness of positives in her life. She outlined a new skill that she identified and consciously applied through talking about ‘What’s better?’ Her comments were:

“It’s good to hear I’m not alone in my negative thinking. I want to believe it can be changed. I’m excited to see how it works for me. “

“It makes me aware during the week of what is going on that’s good in my life.”

“I’m starting to evaluate helpful vs. non helpful thought throughout the week, trying to let go of what’s not helpful.”

Another client also experienced a change of perspectives. In her comment she stated that she became more aware of the positive times in her life. She clearly changed from experiencing her life as predominantly negative to becoming aware of positive times.

“It helps me see that there is not just bad in my life and there are so many little happy times through my week. Reminding myself how great my life is.”

The next client also found that she began to notice positives, her own achievements or the improvements in her life. Her comments make it clear that she gained an awareness that she can create her own future and she shows agency to make this happen. She experienced the counselling as a useful means for her to help herself (“rope being thrown to you”).

“I am able to stay focused on my life vision – not stay bogged down what’s not going right – it’s like a rope thrown to you – that you pull yourself up. Remembering what’s good in life.”

“Again, it makes me reflect on my week and think, oh yes, things have improved; my life is in fact getting better. I can overcome things and create the life I dream of.”

Chapter 5: Discussion

This research aimed to improve the understanding of the SFBT intervention ‘What’s better?’ Consistent with SF theorists assumptions, the findings suggest that conversations about ‘What’s better?’ can be viewed as a process in which client and therapist co-construct new meanings for clients in order to move from problems to solutions (de Shazer, 1994). The research confirmed the often taken-for-granted assumption that therapists’ communication is an essential aspect of why and how therapy works. It builds on recent literature and suggests that certain discursive tools used by therapists provide the means to influence therapeutic conversations. The research also emphasises the importance of the therapists’ motivation to use a certain discursive tool for co-construction to happen. Through microanalysis of client therapist dialogues the research provides better understanding and clear evidence of the collaborative and co-constructive character of therapeutic conversations initiated by the ‘What’s better?’ question. Analysed dialogue examples are able to make the process of co-construction comprehensible.

When clients undergo counselling or psychotherapy they start by possessing their own perceptions of their situation, their definition of reality and the way they see their situation (Berg & De Jong, 1996). In line with SF literature (De Jong & Berg 2013; Herrero de Vega & Beyebach, 2004; Reuterlov et al., 2000; Sanches-Prada & Beyebach, 2014) this research found several possible initial answers to the ‘What’s better?’ question. Examples in this research mostly displayed that, once the ‘What’s better?’ question was asked, the clients took the chance to reflect on their situation and came up with experiences that they perceived to be better for them. Occasionally clients initially did not know what’s better for them. In conversation example four, the client started the dialogue about what’s better with the statement that she perceives her situation as the same. This example, consistent with previous research, shows how an initial statement of no improvement can be de-constructed (Sanches-Prada &

Beyebach, 2014) and how client and therapist are then able to co-construct new realities in order to move from problems to solutions (de Shazer, 1994).

In SF conversations the role of the therapist is to listen carefully to clients' perceptions and experiences, explore the meaning of their words and build their next statement or question from the client's latest conversation turn (Berg & De Jong, 1996). Consistent with this, the presented research shows how the therapist can induce change for the client by letting client led dialogue evolve and guide the client by making purposeful decisions about which understandings are more significant than others (Strong 2007). The research identified two main classifications of the cause of the change to the better for the client. Firstly, the change was caused by an external event that happened without any behavioural effort or expenditure from the client. Secondly, it could be caused by an internal event that took place because of the clients' own actions towards change. As external events are subject to chance rather than their own input, the therapist in this research, did not expand further on these events as they were seen to be less significant than internal events. For example, in the first presented counselling conversation, the client's initial statement referred to an external event, namely that an old friend came back into the client's family. To acknowledge her client's experiences, the therapist briefly investigated the facts around this statement but did not expand on this topic. After this conversation sequence the therapist asked 'What else?' (is better) whereupon the client explained further improvements, this time initiated by her own actions. An external event was also reported during the second counselling conversation. The client referred to events that happened to her by chance at the beginning of the conversation. Both examples display how the therapist's decision-making about the meaning of content influences the course of the conversation and with it the co-construction process.

This study's therapeutic conversation examples strongly resonate with social constructionist perspectives about reality. The dialogues illustrate how people develop their

sense of reality within their social and cultural contexts (Berg & De Jong, 1996) and how they bring their own current meanings and realities to the conversation (De Jong et al., 2013). The fact that multi-layered realities and varieties can co-exist (Burr, 2015) came to light rather distinctively in conversation example four when the client expressed a perception about the ‘What’s better?’ question that markedly differed from the therapist’s perception. In contrast to the therapist’s perception the client did not perceive something that she had improved since her last session as being better. She stated ‘but I wouldn’t say that is better, because, that’s like, that’s supposed to be how it is... ’ (conversation example four, turn 12). This example clearly illustrates how different people may construct meaning in different ways, even in relation to the same event (Burr, 2015) and that during dialogue these meanings can be re-negotiated through use of language (Gergen, 2009).

The four conversation examples presented in this research show how understandings, meanings, insights, reflections or thoughts were collaboratively worked out turn by turn between client and therapist (Clark, 1996). The retrospective microanalysis provided a means of understanding what happened in the therapy room and how clients and SF therapists practically co-construct new meanings when having conversations about ‘What’s better?’ for the client. Consistent with other studies this research reveals that the therapist’s intentions and conversational choices are their interventional means to co-construct new meanings. They are constructed moment by moment within the back and forth of the therapeutic conversation (Vehviläinen, 2003; Strong 2007). During the documented conversations subsequent client behaviours often indicated that a shift in meaning took place for them.

The recent literature suggests that certain discursive tools used by therapists provide the means to influence therapeutic conversations (Bavelas, 2012; De Jong et al., 2013). While the presented research outlines an array of therapists’ tools and intentions (see Appendix VII) that, in combination with each other, are able to facilitate co-construction of new meanings,

previous research described four main discursive tools available for collaborative therapists to influence therapeutic conversations. These tools are ‘questions’, ‘formulations’, ‘lexical choice’ (Bavelas, 2012) and ‘grounding’ (De Jong et al., 2013). Consistent with these studies this research found that most of the tools, outlined in Appendix VII, fit one of these four categories. For example the therapist’s purposeful actions ‘listening’, ‘minimal encouraging’, ‘reflecting back’, ‘paraphrasing’ that are outlined in Appendix VII might fall into De Jong et al.’s (2013) discursive tool ‘formulations’. The actions ‘ask pre-suppositional question’, ‘open question’ would match the discursive tool ‘questions’ while the therapist’s actions ‘introducing new content’, ‘picking up on something’, ‘suggesting’ might fit in the ‘lexical choice’ tool.

This study builds on this research and proposes that not just the choice of the discursive tool but also the purpose of its application can be seen as influential of therapeutic conversations. Findings also suggest that a certain therapist action when used with a certain purpose can change the category of discursive tool. For example, a ‘question’ combined with its purpose can be used as ‘minimal encourager’ and could be seen as a ‘formulation’ rather than a ‘question’. Conversation example two illustrates this point. At turn three (3) the therapist listened to her client’s narration of her ex-boyfriend contacting her. She minimally encouraged her client’s report by using the question ‘How was that?’ (for you) (3). The therapist did not use this question as an intervention to expand on a new idea, introduce an alternative or new possibility. This question was instead formulated with the intention of acknowledging the things that matter to the client. A further example shows how a pre-suppositional question can be used to introduce a new idea representing the discursive tool ‘lexical choice’. The therapist chose the words of the question in turn 20 intentionally (conversation example three) whilst being aware of their potential influence on her client (Bavelas et al., 2000). She offered the client a new perspective on her insights and introduced new content in the form of the pre-suppositional question ‘Maybe you learned that you can trust yourself?’ (20). The client built

and extended on this idea, agreed and referred back to the past when that was not the case (21). The client's answer 'I think that's the big thing.' indicates that she strongly agreed and that she now trusted herself and experienced herself as competent. These examples represent the rationale for the suggestion that both, the choice of the discursive tool combined with the purpose of its application, can be seen as influential of therapeutic conversations and suitable as a means to describe how co-construction works.

This research extends previous work by identifying purposeful therapists' actions that were potentially co-constructing and did not fit any of the four discursive tools identified previously (De Jong et al., 2013). Co-constructive dialogue examples in this study showed that purposefully applied 'compliments' hold the potential to be co-constructive. For example, at the end of a conversation sequence in conversation example one, the therapist complimented the client for her achievements. The therapist stated 'Well done! I find it amazing. I mean, you can be miserable or you can be quite positive and see the positives in things, and you just managed to do that (just) like that {therapist clicked her fingers}' (32). With these complimenting words the therapist highlighted the client's competency and acknowledged her effort. She checked the client's perception about her achievement and asked the open question 'How do you feel about it?' (32). The client's answer '...good, it's making life a lot easier' (33) shows that she absorbed the therapist's compliment and experienced herself as competent and successful. She might have become aware of a new skill, being able to see positives in challenging situations and transforming negative events into positives. Other examples for using compliments as co-constructive tools are displayed in conversation examples one, turn 14; example two, turn 12 and 24; example three, turn 9 and conversation example four, turn 11 and 14.

Consistent with previous research this study found that microanalysis of face-to-face dialogue is a feasible approach for making collaboration and co-construction of therapeutic

dialogues visible (Bavelas, 2012). The research displays how the speakers in each conversation example influence and make sense of each other (Strong, 2007). Within the conversation examples it is clear through the responses of the listening person that the speaking person was understood (Ten Have, 2007). Aside from that the study identified certain client behaviours that indicated a shift in meaning for them. Such behaviours included, for example, the client stated a new insight, a new realisation, noticed something useful, adopted a new fact, saw something differently than before, built on an idea. It was found that these observable, comprehensible behaviours consolidate the co-constructive character of a conversation.

As found previously (Egan, 1998; Strong, 2007) this research shows real-life therapeutic conversations to be more complex than those presented in therapy textbooks. Purely theoretical arguments for co-construction do not uncover these micro details of collaboration in dialogue (Bavelas, 2012). The research shows that in practice clients' discourses are often unpredictable and multifaceted. Clients are not always as receptive as textbooks imply and their reactions to therapists' influences vary widely. Similarly, therapists are not always highly accomplished and sufficiently well trained to place pinpointed dialogical turns. The displayed conversations demonstrate that a therapeutic conversation is a complex process where the therapist has to undertake multiple tasks within moments (listening, being perceptive, reflecting, weigh up next discursive steps, think them through, decision making, formulating) and the client has to listen, reflect, make sense and expand on their dialogue. Further research could be undertaken to examine the therapist's decision-making processes during co-constructive therapeutic conversations. It would be interesting to explore how they evaluate certain understandings as more significant than others. Such research could also study how they decide moment by moment which discursive tools to use in order to induce the desired change for the client.

There are strengths and limitations to the presented research. While the therapy sessions in this research were conducted in only one setting, the study presents dialogues from five different clients, with different demographic and clinical features. Through linking the dialogue analysis with the excerpts of the real life therapeutic conversations the presented qualitative study is well founded, grounded in the data, transparent and therefore trustworthy. The verbatim client perceptions of the outlined conversations provide an additional data source that strengthened the analysed conversations. Although qualitative research examines the mechanisms by which change can occur, a potential limitation of this research is the low sample size which may constrain generalisation. Further research should be undertaken by different therapists with a wide range of experience across a broader range of settings to examine the extent to which the findings are generalisable.

While not examined in this study, the quality of the therapeutic relationship is likely to strongly influence the co-construction process of new meanings in SFBT. Although the presented research focuses on the impact of therapists' skills and techniques on co-construction, previous research has found that only 15% of therapeutic change in the client is attributable to this factor (Lambert & Barley, 2001). Other factors that can induce therapeutic change, but cannot be influenced by the therapist, include clients' own capacities for change, their hopes, optimism and expectancies (15% influence) and clients' environmental factors outside the therapy (40% influence). The quality of the therapeutic relationship (30% influence) is a very important factor affecting therapeutic change that can be directly affected by the therapist. Consequently, further research should be undertaken to examine the impact of this factor on co-construction.

As well as addressing the research questions this project was invaluable for improving my own practice as a SF therapist. I found this research project extremely useful because the degree of the engagement with this topic exceeded my normal reflective and reflexive practice

that I undertake after therapy sessions. I was occupied with studying the co-constructive character of the ‘What’s better?’ for an extended period of time and at a very deep level. This engagement not only encompassed a thorough study of the relevant literature, it also required a methodical and detailed observation and analysis of my own practice. Reflective and reflexive thinking was necessary at all times to gain insights, derive and challenge interpretations, findings and conclusions. Furthermore fruitful conversations with my clinical- and research supervisors as well as peer researchers enriched, inspired, influenced my insights and induced new thoughts. All these actions consequently influenced the way I practice solution focused therapy today.

As a result of engaging in this research, I now regularly use the ‘What’s better?’ question confidently in my practice as I now understand the process in which client and therapist co-construct new meanings for clients. I am aware that initial statements of no improvement can occur, they can be de-constructed (Sanches-Prada & Beyebach, 2014) and my clients and I may then co-construct new ways of understanding in order to move from problems to solutions. I have also learned that persisting with solution talk often results in solution building for a client.

Through observation and analysis of my own practice I learned that focusing on certain understandings can be more fruitful than expanding on others. The intensive engagement with therapeutic dialogues taught me how to look for opportunities for solution building conversations. My current practice is characterised by a sharpened awareness for finding these opportunities and a more conscious and confident decision making process about which topics should be expanded.

My research strengthened my conviction that the role of the SF therapist is to listen carefully to clients’ perceptions and experiences and that it is important to explore the meaning of their words. I found that building up my next statement or question from the client’s latest

conversation turn works best in working towards solutions. I also learned to observe the client's reactions more attentively. In particular, I check for possible misunderstandings, try to reconstruct common ground if necessary and check perceptions with clients more regularly.

I noticed that over the course of my engagement with this project the spectrum of discursive tools that I use widened considerably. For example I use compliments more often and continue to observe its co-constructive character. I use my discursive tools more deliberately, in conversations about 'What's better?' and also for other solution focused conversations. These tools are used to induce new meanings for the clients in order to move towards their preferred futures. I also use these discursive tools to help clients perceive themselves as competent, to increase clients' sense of hope, and to highlight their strengths, resiliencies and useful strategies.

My practice today is informed by the learning during my university studies and to a large extent by this practice-based research project. My internal decision making about next steps during a therapeutic conversation is well founded and happens consciously. I learned which discursive tools I can utilise for certain intents and how their applications are influential, co-constructive and meaningful for therapeutic conversations.

SFBT therapists, and other practitioners using various theoretical models, use certain discursive tools in alignment with their theoretical perspective. The presented research might offer them some useful learning about the functionalities of co-constructive conversations. This research might inspire them to reflect on the variety of discursive tools they use in combination with their motivations for using them.

In conclusion, this research initially began with reflections about the SF 'What's better?' question and challenged its assumption that therapists' communication is an essential aspect of why and how therapy works (Bavelas et al., 2000). The study helped me to close the gap between theory and practice and revealed the co-constructive character of the 'What's

better?' question. It displayed how co-construction of new meanings actually happened, how this process was made visible, how a SF therapist may have contributed to the co-constructing process and which communication skills are helpful within this process. Consistent with Bavelas et al. (2000) it was found that therapists' communication is an essential aspect of why and how therapy works. The turn by turn microanalysis of dialogue was found to be a feasible method for illustrating the collaborative and co-constructive character of therapy conversations and to understand clients' perspectives better (De Jong et al., 2013). Original clients' words given in form of written feedback highlighted how they experienced the 'What's better?' question. These comments showed that clients and therapist co-constructed a greater sense of competence for the clients. Conversations about 'What's better?' amplified clients self efficacy, raised greater awareness of their own achievements, competencies and positive aspects in their lives. Clients also expressed an increase in hope through conversations about 'What's better?'

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Appendix I

Information Sheet for clients of the (name of the counselling agency)

University of Canterbury School of Health Sciences
Email: Katrin.Richter@pg.canterbury.ac.nz

Research project: Clients' and practitioner's experiences and perceptions of the 'What's better?' question in Solution Focused Brief Therapy

Dear _____

I am Katrin Richter, a student counsellor undertaking my Masters of Counselling at the University of Canterbury. I am on placement in the (name of the counselling agency) and I am using the Solution Focused Brief Therapy model in my counselling work.

What is this study about?

Solution Focused counsellors often start sessions with the question 'What is better since we last met?' or simply 'What's better?' The counsellor then helps the client describe these changes and explores how the client was able to create them.

My main research focus will be to look at how the client and their counsellor work together to build new understandings, possibilities and solutions after the 'What's better?' question has been asked.

What could be your involvement in this project?

Please note that your participation in the study is voluntary. There will be no difference to the counselling if you do or do not take part in the study. If you decide to take part I will ask for your consent to video record the first five counselling sessions. At the end of each counselling hour I will ask you to complete a feedback form around the 'What's better?' question. This will take up to three minutes to complete.

You have the right to withdraw from the research programme at any time. The counselling process will then continue without disruption.

How will I ensure confidentiality and protection of your privacy?

Please be assured of the confidentiality of the personal information about you gathered during the course of my research. My research findings will not disclose that I carried out my research programme in the (name of the counselling agency). I will take actions to ensure your anonymity by using pseudonyms and removing any identifying information about you. All data that is related to you will be securely stored on the University of Canterbury server and on my personal computer. All files will be password protected. I will store the data related to my research for five years, and after that time data will be deleted without further notice.

Who will have access to the research findings?

A research portfolio (Master's thesis) is a public document that will be available through the University of Canterbury Library. Extracts of my research portfolio may be published in a peer-reviewed journal. As described above, I will disguise your identity within these documents to protect you from being identified by others. Research participants are welcome to receive a summary of the findings from this study. If you wish to receive a summary, please write your contact details on the consent form and I will email/send it to you at the end of the research.

Under whose supervision will the project be carried out?

The project is being carried out as a requirement for the 'Masters of Counselling' course under the supervision of Associate Professor Judi Miller and Shanee Barraclough. You can contact my supervisors at Judi.Miller@canterbury.ac.nz and Shanee.Barraclough@canterbury.ac.nz. Both supervisors will be pleased to discuss any questions that you may have about your participation in the project.

Does this research project meet ethical standards?

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee. Participants can address complaints to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

How can you become a participant?

As part of our first counselling session, you will need to fill out the (name of the counselling agency) intake form. This form will include a tick box where you can indicate whether or not you want to be part of the study. If you have any questions about the study before the first counselling appointment, please contact me or my supervisors. If you agree to participate in the study I will ask you to sign the enclosed consent form at your first counselling session.

Thank you.

Kind regards

Katrin Richter

Appendix II

Consent Form for clients of the (name of the counselling agency)

University of Canterbury School of Health Sciences

Email: Katrin.Richter@pg.canterbury.ac.nz

Clients and practitioners experiences and perceptions of the 'What's better?' question in Solution Focused Brief Therapy

- ✓ I have been given a full explanation of this project and have had the opportunity to ask questions.
- ✓ I understand what is required of me if I agree to take part in the research.
- ✓ I understand that participation is voluntary and that I can withdraw at any time. If I withdraw from the study all information that relates to me will be deleted from the study.
- ✓ I understand that if the research is at any point interfering with the counselling process, I can withdraw from the research and continue with the counselling.
- ✓ I understand that any information or opinions I provide will be kept confidential by the researcher and the researcher's supervisors and that any published or reported results will not identify the participants.
- ✓ I understand that a research portfolio is a public document and will be available through the University of Canterbury Library. Extracts of the research portfolio may be published in a peer-reviewed journal.
- ✓ I understand that all data collected for the study will be kept in locked and secure facilities in an electronic form that is password protected. The data will be destroyed without any further notice after five years.
- ✓ I understand that I am able to receive a summary on the findings at the end of the study by ticking the box below.
- ✓ I understand that I can contact the researcher, Katrin Richter (email: Katrin.Richter@pg.canterbury.ac.nz) or the supervisors: (Judi.Miller@canterbury.ac.nz and Shanee.Barraclough@canterbury.ac.nz) for further information.
- ✓ I understand that if I have any complaints I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).
- ✓ By signing below, I agree to participate in this research project.

Name

Date

Signature

Please tick if you would like to receive a summary of the findings from this research

- YES
- NO

If yes, please fill in your e-mail address or postal address

Please bring this consent form with you on the day we start the counselling.

Katrin Richter

Appendix III: Counselling agency intake form

**TO BE FILLED OUT BY COUNSELLING CLIENTS –
PREFERABLY BEFORE START OF THE FIRST SESSION**

Please give this form to your counsellor after completion – not to the Support Worker at the front desk.

Name : _____

Address : _____

Date of Birth : _____

Ethnicity : _____

Phone : _____

Mobile : _____

Email : _____

Please describe your current family circumstances e.g. Living alone, with partner, children under 17 (names, ages), day-to-day care/contact (access) situation if applicable:

How did you hear about the (the counselling agencies') free counselling service?

Are you interested in Katrin's research programme, as outlined in the letter you previously received?

YES NO (Please circle your choice)

Appendix IV: Client feedback form

Feedback

Name: _____	Date: _____
-------------	-------------

What is better?

I found discussing what
is better
not useful



I found discussing what
is better very
useful



For the following reasons:

Overall

I wish we could do
something different



I hope we do
the same kind
of things next
time



Namely:

Appendix V: Ethics approval University of Canterbury Human Ethics Committee



HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2014/118

25 September 2014

Katrin Richter
School of Health Sciences
UNIVERSITY OF CANTERBURY

Dear Katrin

The Human Ethics Committee advises that your research proposal "Clients and practitioners' experiences and perceptions of the 'what's better?' question in solution focused brief therapy" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 24 September 2014.

Best wishes for your project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'L. MacDonald'.

Lindsey MacDonald
Chair
University of Canterbury Human Ethics Committee

Appendix VI

Transcription notation

Symbol	Indicates
(.)	A pause which is noticeable but too short to measure
(.5)	A pause timed in tenths of a second
=	There is no discernible pause between the end of a speaker's utterance and the start of the next utterance
:	One or more colons indicate an extension of the preceding vowel sound
<u>Underline</u>	Underlining indicates words that were uttered with added emphasis
CAPITAL	Words in capitals are uttered louder than surrounding talk
(.hhh)	Exhalation of breath; number of h's indicate length
(hhh)	Inhalation of breath; number of h's indicates length
()	Indicates a back-channel comment or sound from previous speaker that does not interrupt the present turn
[Overlap of talk
(())	Double parenthesis indicates clarificatory information, e.g. ((laughter))
?	Indicates rising inflection.
!	Indicates animated tone
.	Indicates a stopping fall in tone
**	Talk between * * is quieter than surrounding talk
> <	Talk between > < is spoken more quickly than surrounding talk
{ }	Non-verbal, choreographic elements

Source: (Kogan, 1998)

Appendix VII

Main Themes, Schemes and Categories

1. Main Themes: Reported change for the better for clients is caused by

Categories

External event

Internal event (client herself did induce the change)

2. Scheme: Initial answer to ‘What’s better?’

Categories

Client doesn’t know

Client reports there is no change to the better

Client reports it is the same

Client reported change to the better

3. Scheme: Client behaviours that indicate a shift in meaning

Categories

Client has new insight (becomes aware, has aha-moment, has realisation, notices something useful)

Client adopts a new fact or meaning

Client sees something differently than before

Client thinking, reflecting on, works hard, elaborates, makes sense of something

Client builds on idea, expands on an idea

4. Scheme: Therapist’s purposeful actions and possible motivations

Categories

Therapist listening, noticing, becoming aware

For building rapport

Therapist reflecting back

For transforming negative content into positive

Therapist minimal encouraging (nodding, smiling)

For transforming negative content into positive

Therapist engaging in small talk

For offering new perspective / possibility

Therapist using humour

For eliciting client’s perceptions

Therapist acknowledging client’s reality

For investigating on deeper level

Therapist acknowledging client’s insights, ideas

For highlighting client’s competency

Therapist acknowledging client’s needs

For prompting client to notice her competencies

Therapist asking presuppositional question

For prompting client to think

Therapist asking open question

For highlighting statement

Therapist asking closed question	For making it easier for client
Therapist linking content with previous session	For reframing content
Therapist suggesting	For raising client's awareness
Therapist inviting client to listen to her perception	For encouraging the client
Therapist introducing new content (wording)	For eliciting answers on a deeper level
Therapist building on client's statement	For allowing time for thinking, reflections
Therapist picking up on something	For checking client's perception
Therapist paraphrasing (preserving client's words)	For offering new perspective / possibility
Therapist summarising	For following client's pathways
Therapist complimenting	For clarifying content (grounding)
Therapist mirroring	For staying longer in a new perspective / possibility
Therapist using gestures	For reinforcing, amplifying statements, meanings
Therapist challenging client's perception	For establishing new insight
Therapist using client's words	For acknowledging, reinforcing achievements, effort
	For prompting client to notice her competencies
	For encouraging further thinking
	For helping the client to imagine

4. Scheme: Observable client behaviours

Categories

Client states something (describing, explaining, referring to, expressing, remarking, reasoning, adding)

Client answering (responding, reacting)

Client engaging

Client understanding

Client listening

Client noticing

Client acknowledging

Client summarising

Client agreeing

Client disagreeing

Client confirms

Client clarifying content

Client surprised

Client delivers example

Client not understanding

Client expressing humour

Client expresses emotion

Client expresses dislike

Client engages in problem talk

Client doesn't know, is not sure

Appendix VIII: Client feedback form matching conversation example one

Feedback

Name: S Date: 26/2/15

What is better?

I found discussing what is better not useful



I found discussing what is better very useful



For the following reasons:

it helps me see that there is not just bad in my life and there are so many little happy times through my week

Overall

I wish we could do something different



I hope we do the same kind of things next time



Namely:

Reminding myself how great my life is.

Appendix IX: Client feedback form matching conversation example two

Feedback

Name (only Initials): LM. Date: 27/1/14

What is better?

I found discussing what is better not useful



I found discussing what is better very useful



For the following reasons:

- Allows me to reflect on the week that was + the week ahead (self-reflective + Planing)
- To look at positives thru any emotional distress or sadness. (Pragmatic approach)

Overall

I wish we could do something different



I hope we do the same kind of things next time



Namely:

Appendix X: Client feedback form matching conversation example three

Feedback

Name: [REDACTED] Date: 20.04.15

What is better?

I found discussing what is better not useful



I found discussing what is better very useful



For the following reasons:

I am able to stay focused on my life vision - not stay bogged down in what's not going right - its like a rope being thrown to you - that you can pull yourself up. Remembering what's

Overall

I wish we could do something different



I hope we do the same kind of things next time



good in life

Namely:

Talking about the island - creating a vision of the person I want to be.

Appendix XI: Client feedback form matching conversation example four

Feedback

Name: L Date: 28/5/15

What is better?

I found discussing what is better not useful



I found discussing what is better very useful



For the following reasons:

I'm starting to evaluate helpful vs non helpful thoughts throughout the week, trying to let go of whats not helpful

Overall

I wish we could do something different



I hope we do the same kind of things next time



Namely: I'm stuck for knowing what to do next,