Best Hopes – Whatever That Means: Working with Young Adolescents in Solution-focused Brief Therapy

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Abstract

Young adolescents are experiencing high rates of mental health issues worldwide (World Health Organization, 2019). In Aotearoa New Zealand, counselling in a school setting is available to support the young adolescents who may need it. In counselling, it is considered useful for the counsellor to help the client establish the client's goals for therapy, what it is they want from being there (Childers, 1987; Jones-Smith, 2012). To date, there have been few studies that investigate establishing goals when the client is a young adolescent. This qualitative research explores how young adolescents in an Aotearoa New Zealand intermediate school responded to the use of a particular solution-focused brief therapy (SFBT) *goal-setting* technique.

SFBT is a collaborative, future-focused approach that encourages people's agency in counselling so that they can recognise their own authority of their experiences. In SFBT, *goal-setting* is considered to play an important role in helping clients identify what it is they would like different in their life. This process often begins with "What are your *Best Hopes* from being here?". In this research, I investigate how goals are co-constructed with young adolescents in counselling using the *Best Hopes* question. I also explore how asking the *Best Hopes* question might be useful to young adolescent clients, and how I, as a SFBT counsellor, could ask young adolescent clients the *Best Hopes* question in a way that would be helpful to them.

The *goal-setting* conversations in three counselling sessions of four young adolescent students (all aged 11 years) were recorded, transcribed and, together with my professional notes and my own reflexive journal, examined using thematic analysis. Data were coded and four themes were generated: (1) When all goes well - responses to a *Best Hopes* question when expectations of therapy are the same; (2) When expectations differ – responses to a *Best Hopes* question when expectations of therapy are different; (3) Different perspectives can help; and (4) The client is the expert. The key

findings include: that goals are co-constructed with young adolescents within a collaborative *and* a therapeutic relationship; that using SFBT skills, assumptions and techniques when *goal-setting* with young adolescents in counselling can be helpful in creating a shared understanding between the client and the counsellor of the young adolescent client's expectations for therapy; and that SFBT assumptions (such as, taking a *not-knowing* stance and regarding the young adolescent *client as expert* of their life experiences when *goal-setting*) help young adolescents reflect on what they would like different in their life and encourage ongoing engagement in positive and hopeful conversations.

This study extends the limited existing research on asking young adolescent clients about their *Best Hopes*. Overall, this study highlights the usefulness of taking a solution-focused stance when *goal-setting* with young adolescents using the *Best Hopes* question. It also demonstrates the value of practice-based research for counselling practitioners and offers suggestions for counsellors who are using the solution-focused approach with young adolescents.

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Chapter 1: Introduction

Background and context

In Aotearoa New Zealand and across the world, the number of young people reporting mental health and wellbeing issues is increasing and the ripple effect of this is being felt far and wide (Kvalsvig, 2018; Malatest International, 2016; World Health Organization, 2019). For young people, the effects can be personal, social, educational and physical. Families and communities can be impacted as young individuals struggle with issues that, if not addressed adequately, can be ongoing and detrimental throughout life (Jacob, Edbrooke-Childs, Holley, Law, & Wolpert, 2016; World Health Organization, 2019). For some young people, seeking the support of a counsellor may be beneficial in addressing personal issues. However, a lack of appropriate available counselling services is reported globally (Bolton Oetzel & Scherer, 2003; Crocket, Kotzé, & Peter, 2015). In addition, young people are reluctant to attend counselling and for those who do, the attrition rate, is high (Knight, Gibson, & Cartwright, 2018). Some researchers suggest that working with a counsellor is a way of closely examining your own self and exploring issues, and is an opportunity to reflect and understand what is working well in life and what is not (Jones-Smith, 2012). It is a process of seeking hope about living better. Aotearoa New Zealand research has shown that that there is value in counselling children and adolescents, and early intervention can potentially divert young people from the longer-term negative impacts that mental health issues can create (Malatest International, 2016).

I am a counsellor in an Aotearoa New Zealand intermediate school, working with students who are aged between 10 and 13 years. These young adolescents are at a particularly interesting time of their life, somewhere between being a child and an adolescent. Puberty is setting in, their bodies and minds are changing rapidly, and they are beginning to break away from their parents to form their

own sense of identity (Christie & Viner, 2005). The students I work with come to counselling for a variety of reasons. Usually they are sent by a concerned adult, someone who has noticed something negative about their behaviour. For example, the student might appear sad or disengaged, or be acting aggressively towards others. Many of these young students have little understanding of the counselling process and often are unsure how counselling can help. Regardless of their reasons for seeing me, my role as a counsellor is to provide support and guidance in resolving personal issues and to encourage positive change. My research stems from the work I do as a counsellor and from a desire to improve positive engagement with young adolescents in my practice.

As a Master of Counselling student at the University of Canterbury, I have been introduced to solution-focused brief therapy (SFBT). I find the solution-focused approach useful in my work. When young adolescent students come to counselling, I could tell them what *I* think would help them. The benefit of a solution-focused stance, however, comes from the students identifying for themselves what *they* think will be helpful. Important to SFBT is the process of setting goals for counselling in which questions are posed inviting the client to explore what they want to change in their life and how they might make that happen. The most commonly used question to establish a goal for counselling in SFBT is called the *Best Hopes* question, "What are your *Best Hopes* from being here?".

In counselling young adolescent students, I always ask the *Best Hopes* question as a means of starting a conversation that helps to clarify their purpose for being there. In the years that I have worked with young adolescents, I have noticed that although many answer this question with ease, others have more difficulty, often replying with, "I don't know". These responses have made me curious about how they are making sense of the question and what influences their understanding of

it. I am interested in how the *Best Hopes* question helps young adolescents formulate goals in counselling.

Research rationale and aims

There are very few studies that explore the experiences of young adolescents in counselling, and none that examine the *goal-setting* process with young adolescents in a SFBT environment. I am interested in how young adolescents respond to the initial goal setting question, "What are your *Best Hopes* from being here?", and how the questions and language I use in our ongoing conversation together help them to articulate what it is they would like to see changed in their lives. This study, therefore, will provide new insight into how goals are co-constructed with young adolescents in counselling using the *Best Hopes* question. Additionally, this study will examine what the *Best Hopes* question offers the young adolescent client and how counsellors can ask the *Best Hopes* question in a way that is best suited to them.

Thesis organisation

This thesis is composed of six chapters. Chapter One outlines the background and context for this study. It includes the aims of this research and provides an organizational overview. The following explains how the further five chapters are structured, describes the appendices and provides a summary of specific terminology used in this research.

Chapter Two provides a critical overview of current literature on my chosen area of interest, how goals are co-constructed with young adolescents using the *Best Hopes* question. To gain an in-depth understanding of my topic, this chapter investigates and reviews research about the particular subgroup of adolescents I work with, young adolescents. I then examine the literature on counselling young adolescents, exploring the existing research on how counselling young people may differ from

working with other populations. I address the importance of setting goals in counselling, and summarise the SFBT approach. I then consider the current research on *goal-setting* with young adolescents in SFBT. Chapter Two concludes with a rationale for this study and an outline of its research questions.

Chapter Three describes the theoretical framework of this research. I explain how the choice of qualitative methodology was informed by my personal and professional experience and philosophical approach. The appropriateness of choosing qualitative methodology is discussed, and I situate myself as a practice-based researcher.

Chapter Four provides details of the research procedure. This method chapter begins by describing and summarising the study's setting and the participants involved. I then discuss how rigour and trustworthiness were addressed throughout this research project. Ethical issues are then explored with an emphasis on young adolescents in counselling, and the influence that being research participants may have on this process. I explain in detail how the data were collected and then analysed using thematic analysis.

Chapter Five presents the findings of this research. This chapter begins with a personal reflection on the analysis process and then introduces the four themes that were generated from the data. Each theme is explored, and excerpts of counsellor and client conversations are used to demonstrate the key findings. This chapter ends by summarising the findings.

Chapter Six presents my key conclusions. I return to the research questions and consider my findings in relation to relevant existing literature. Implications for counselling practice are considered, limitations of my study and findings outlined, and directions for future research suggested.

The appendices that appear at the end of this thesis include all information and consent forms for the school's principal, deputy principal, parent and participant, and the signed ethics consent obtained from the University of Canterbury Educational Research Human Ethics Committee.

Definition of terms

The terms 'counsellor', 'therapist' and 'practitioner' are frequently interchangeable. In this report I use 'counsellor' when referring to myself and the work that I do, and 'therapist' or 'practitioner' when referring to the literature.

Terms specific to SFBT (such as, for example, *goal-setting* and *client as expert*) are expressed in italics.

The terms 'goal setting' and '*goal-setting'* are both used in this report. As discussed in the literature review (Chapter 2), 'goal setting' refers to the process of setting therapeutic goals regardless of the approach being used, and '*goal-setting*' indicates setting goals as a SFBT technique.

To maintain confidentiality, all participants' names have been changed and the school's name has been omitted from this report.

Chapter 2: Literature review

Introduction

In this chapter I examine the literature using my chosen topic, *goal-setting* in solution-focused brief therapy (SFBT) with young adolescents, as a guide. I begin with an investigation into how adolescence is defined in the literature, and then identify the markers of young adolescence as a subgroup. I review research regarding the complexities of counselling young people. I move broadly examining goal setting in counselling and then look specifically at studies involving goal setting in therapy with young people. I outline research that explains SFBT, social constructionism, *goal-setting* in SFBT and working with young adolescents in SFBT. In the final section of this chapter I state my research question and describe my rationale to support it.

Young adolescence – what exactly is it?

Introduction

While there appears to be no consensus in the literature as to what constitutes adolescence, it is generally thought of as the transitional period in life between childhood and adulthood (bpacnz, 2015; Christie & Viner, 2005; Curtis, 2015; Lane, Brundage, & Kreinin, 2017). There have been many theories about adolescence, outlined in the following paragraph, which have been used to describe the physical, cognitive and emotional changes that occur during this time (Christie & Viner, 2005; Curtis, 2015; Jaworska & MacQueen, 2015; Kilford, Garrett, & Blakemore, 2016). Terms such as 'youth', 'young person', 'adolescent', 'teen' and 'young adult' are used when discussing adolescence in the literature (bpacnz, 2015; Curtis, 2015). Most sources usually define this developmental period chronologically, from the age of about 10 to 25 years, however there are variations to this, as well as to the terminology used. For example, Curtis (2015) suggests the developmental process of adolescence can be broken into three distinct subgroups: early adolescence

(11-13 years); adolescence (14-17 years); and young adulthood (18 – 25 years). The World Health Organization (2019) (WHO) define adolescence broadly, as being between 10 to 19 years of age. Despite these different definitions, all sources agree that adolescence is a part of lifelong human development, is individually variable, and influenced by culture, biology and environment (Curtis, 2015).

Adolescent development is generally understood through a range of psychosocial constructs. Curtis (2015) suggests these can be categorised into three broad perspectives: biosocial, organismic and contextual. Early biosocial theories such as Charles Darwin's, are based on genetic evolution and emphasise the physiological changes that occur during adolescent development (Curtis, 2015). Organismic theories such as Sigmund Freud's, Erik Erikson's and Jean Piaget's, consider biological change as influenced by social and moral forces (Curtis, 2015). Contextual theories such as Urie Bronfenbrenner's, Lev Vygotsky's and Richard Lerner's, recognise biology and environmental influences as interdependent (Curtis, 2015). More recent theories emphasise flexible rather than rigid stages of lifelong human development and focus on scientific aspects of brain development in adolescents. For example, recent research has shown brain plasticity in adolescent development, with neural connections strengthened and pruned according to contextual influences (Curtis, 2015; Jaworska & MacQueen, 2015). Continual changes in neural pathways during adolescent development are connected to the reward and regulatory brain systems, which influence reasoning, affect and impulse control (Jaworska & MacQueen, 2015; Kilford et al., 2016). According to this, adolescents are therefore more likely to make riskier choices and be more emotionally reactive than children or adults.

The very wide range of individual experience and behaviour within the transitional period of adolescence leads me to support Curtis' (2015) notion of subgroups. I also agree with Cook-Cottone,

Kane, and Anderson (2015), who note that transition is individual, nonlinear and influenced by biology, culture and environment, and I am mindful of this as I research the specific age group I work with. Like Curtis (2015), whose early adolescent subgroup definition is influenced by the parameters of the American education system, for the purposes of this study my definition of early adolescence is influenced by the Aotearoa New Zealand education system. Specifically, I focus on students in an intermediate school. The participants in my research are defined as young adolescents, being a subgroup of adolescence, with an age range of between 10 and 13 years. Young adolescents are at the beginning of their transition to adulthood. From an Aotearoa New Zealand perspective, they are in their final two years of primary school, namely years 7 and 8. The Aotearoa New Zealand education system allows for these years to be taught in three main ways: at a primary school that teaches years 1-8; at a secondary school that teaches years 7-13; or in a stand-alone intermediate school that is dedicated to years 7 and 8 only. The school I work at is an intermediate school.

Young adolescent development

The most noticeable developmental changes in young adolescents are the physical changes that occur with the onset of puberty (Christie & Viner, 2005; Curtis, 2015). As mentioned previously, neurological development is occurring, changes in cognition are beginning to happen, with a shift from concrete (literal) thought towards abstract thought. Also emerging is the ability to think reflectively (Curtis, 2015). As the brain and body change, young adolescents must adjust socially and emotionally. Mood swings are common, sexual curiosity is increasing, and conflict with parents arises as young adolescents begin to break away towards an identity of self (Jaworska & MacQueen, 2015; Kilford et al., 2016).

Conclusion

Young adolescent development is not a process of smooth stages. My experience as a counsellor working with young adolescents supports the findings outlined in the literature about working with this age group, namely that within the chronological period of adolescent development, there is a wide variance of physical, cognitive and emotional developmental differences and individual experiences. These highly individualised differences are observed across the whole age span of adolescent development and within the subgroup of young adolescence. All influence how each client perceives and engages with the process of therapy (Christie & Viner, 2005; Cook-Cottone et al., 2015; Curtis, 2015; Ingram & Robson, 2015). In addition, legally, in Aotearoa New Zealand, a young adolescent is regarded as a child and is dependent on their parents for assistance with health issues (Ludbrook & New Zealand Association of Counsellors, 2012). This also needs to be considered, alongside each individual's unique physical, cognitive and emotional development status, when working with this age group.

Counselling young adolescents

Introduction

The subgroup of young adolescents (10-13 years), are at the very beginning of their developmental transition and have very different experiences and levels of physical, cognitive and emotional maturity compared to older adolescents (>19 years) who are nearing adulthood. There appears to be little published research regarding young adolescents and counselling in general and I could find nothing discussing this subject from an Aotearoa New Zealand perspective. For these reasons, my research and the following discussion looks at previous research about counselling adolescents and counselling children when appropriate, with comments made by researchers in other countries deemed relevant to Aotearoa New Zealand.

Mental health issues are increasingly prevalent for children and adolescents globally (bpacnz, 2015; Department of the Prime Minister and Cabinet, 2019; Kvalsvig, 2018; World Health Organization, 2019). For example, WHO and Aotearoa New Zealand statistics report up to 20% of young people, aged between 10 and 20 years, experience psychological distress, with depression being the leading cause of illness in adolescents (bpacnz, 2015; Kvalsvig, 2018; World Health Organization, 2019). Twenge, Cooper, Joiner, Duffy, and Binau (2019) claim a significant recent rise of psychological distress in American adolescents, suggesting this may be linked to social and cultural changes, such as the increased use of digital media and poor sleep habits experienced by this age group. In addition, research indicates half of all mental health issues begin by the age of 14, with most of these going undetected and untreated (Department of the Prime Minister and Cabinet, 2019; Kvalsvig, 2018; Prior, 2012; World Health Organization, 2019). Recent investigations suggest that when issues are not adequately addressed they frequently extend to adulthood and impact on living a healthy and productive life (Jacob et al., 2016; World Health Organization, 2019). Disturbingly, Aotearoa New Zealand is currently ranked highly in the world for suicide in young people aged 15 to 19 years and is one of the lowest ranked countries for supporting the wellbeing of children and young people according to the recent Aotearoa New Zealand Government's Child and Youth Strategy Plan (Department of the Prime Minister and Cabinet, 2019). A large body of evidence points to a global problem of increasing poor mental health for young people, yet there appears to be limited appropriate services, such as counselling, available to address this (Bolton Oetzel & Scherer, 2003; Crocket et al., 2015; Crowe, 2006). As well, Aotearoa New Zealand research suggests that many adolescents are reluctant to engage with therapy and the retention rate of those who do, is low (Knight et al., 2018).

Counselling young people

Offering counselling to adolescents in schools is one way to reach those in need (Knight et al., 2018). In Aotearoa New Zealand, counselling services in schools appear to have fluctuated over time. Counselling has been available to students in Aotearoa New Zealand secondary schools for adolescents aged from about 13 to 18 years since the late 1960s (Barclay, Crocket, Kotzé, & Peter, 2013; Crowe, 2006). At that time the Aotearoa New Zealand Government responded to widespread concerns about delinquent behaviour being observed in young people by promoting and establishing counselling services in secondary schools throughout the country (Webster & Hermansson, 1983). Since then, changes in successive education policies have led to a general reduction of counselling services in Aotearoa New Zealand high schools (Payne & Lang, 2009). In 2012 however, responding to increasing numbers of students in schools seeking help for mental health issues, the Aotearoa New Zealand Government announced the Youth Mental Health Project, which again promoted counselling services in schools for young people aged between 12 and 19 (New Zealand Education Review Office, 2013). Recent research by Hughes, Barr, and Graham (2019) show that students from all levels of Aotearoa New Zealand high schools who access school counselling most often self-refer and use the service for a wide variety of reasons such as social issues, anxiety and depression. However, the same research reports these services are oversubscribed and wait times to see a counsellor are often long. Recently in Aotearoa New Zealand, the need for more attention on improving child and adolescent mental health and wellbeing has again been highlighted, with government reports such as the Child and Youth Wellbeing Strategy (Department of the Prime Minister and Cabinet, 2019) indicating increased support is available, or will be made available, to young people of all age groups. According to Payne and Lang (2009), the number of counsellors employed in schools is unknown. I could find no recent statistical data reporting on how many counsellors work in Aotearoa New Zealand schools. I am aware, however, that most secondary schools employ one or more guidance counsellors. This means that while school counselling is

therefore often available for students from years 9 to 13, it is uncommon in intermediate schools for years 7 and 8, and unusual in a primary school for the years 1 to 6.

Regardless of the client's age or the therapeutic model used by the counsellor, the aims of counselling remain the same: to; help and support individuals face personal challenges, resolve issues, achieve goals and encourage change (Jones-Smith, 2012; New Zealand Association of Counsellors, 2019b). Research on counselling adolescents reports both similarities and differences to counselling adults. Some literature demonstrates that most therapeutic interventions when working with adolescents have been modelled on adult strategies and theories of counselling. The same literature suggests that working therapeutically with adolescents is a complex process, requiring a consideration of individual developmental and cultural factors which, in turn, influence the skills and techniques required by the counsellor (Bolton Oetzel & Scherer, 2003; Cook-Cottone et al., 2015; Erdman & Lampe, 1996; Jaworska & MacQueen, 2015). Murphy (2015) contends that, in general, what the client brings to therapy, such as their attitudes, perceptions, culture, strengths and experiences, is the largest determinant of effective counselling. However, it is important to note that, from a social constructionist view, what I bring to work - such as my attitudes, perceptions and culture - will also influence any outcome with a client. I examine social constructionism further in the SFBT section of this literature review.

As discussed previously, physical, social, cognitive and emotional development is occurring rapidly during young adolescence. This has a constantly changing effect on how an individual makes sense of a situation. As young adolescence is a fluid developmental period, what may work for one client, may not work for another. Cook-Cottone et al. (2015, p. 69) states, "Age, academic success, intelligence, and physical maturity are not reliable indicators of emotional development". Therefore, any counsellor working with young adolescents needs to be flexible in their approach. Regardless of

the model used, therapeutic interventions need to be developmentally appropriate with cultural and environmental factors considered (Bolton Oetzel & Scherer, 2003). For example, Pamela King, a SFBT counsellor who works predominantly with children, recognises that many at a young age struggle to think in the abstract, so she adapts therapy in ways most appropriate for the age and development of the individual, encouraging them to answer non-verbally, in a concrete way, perhaps by drawing their answer to a question (King, 2017). I discuss cultural considerations when working as a counsellor in the ethical section, Method Chapter 4.

Many authors note that counselling adolescents is a complicated interactive process between the counsellor and the client, and the relationship formed between the two will greatly influence their engagement in, and the outcome of, therapy (Bolton Oetzel & Scherer, 2003; Geldard, Geldard, & Yin Foo, 2020; Knight et al., 2018; Manthei, 2007). To facilitate this relationship, commonly referred to as the therapeutic alliance, research again suggests counsellors who work with adolescents need a variety of skills, adapted to the client's age and development. For example, some authors maintain that the complexities of working with adolescents require a counsellor who not only displays empathy but can also understand and validate experiences in a nonjudgmental and respectful way (Barish, 2018; Bolton Oetzel & Scherer, 2003; Cook-Cottone et al., 2015). Other skills suggested by the literature in building a successful therapeutic alliance with an adolescent include being honest and genuine with clients (Ingram & Robson, 2015). Young adolescents have radar systems that are acutely aware of the people around them and will readily disengage if they sense these are not happening. The counsellor's communication skills will also have an influence on the therapeutic alliance and client engagement with therapy (Gibson & Cartwright, 2014; Knight et al., 2018). For example, how a question is posed (its language and tone for example) depends in part on how the counsellor interprets conversations and adapts to the client's age and development (Ingram & Robson, 2015). Bolton Oetzel and Scherer (2003) suggest that the key considerations when

working with adolescents are: emphasising client competence; being positive and hopeful; and, expressing confidence in the therapy process. Adolescents prefer an informal therapeutic relationship according to Aotearoa New Zealand research by Knight et al. (2018) and are more willing to engage with counsellors who are accepting, genuine and understanding, rather than authoritarian or judgmental.

Factors such as personal development, sociological influences, choices of intervention and therapeutic relationship, are further complicated by the personal, social or family issues that the young adolescent requires help with. Researchers note that engaging adolescents in the counselling process is a careful balance of providing needed support with proactive direction (Bolton Oetzel & Scherer, 2003; Prior, 2012). Understanding the needs and expectations of the adolescent client appears to be an important factor in providing this balance. In an Aotearoa New Zealand study, Gibson and Cartwright (2014) found a difference in what adolescents want from counselling, as well as how they understand counselling, when compared to adult clients. Their evidence suggests that for adolescents, the discussions had in counselling help with managing emotions, especially regarding the process of identity change and their ability to cope with their immediate experiences. Similarly, Aotearoa New Zealand research by Crocket et al. (2015) highlight the helpfulness, in counselling adolescents, of talking about issues such as anxiety, stress, relationships and identity. Although not specifically about adolescents, Manthei (2007) reports discrepancies between client and counsellor expectations of therapy, which may hinder effective outcome. Gibson and Cartwright (2014) concur, stating that initial discussions with an adolescent client about what it is they want from the counselling process may help counsellor and client expectations align.

Bolton Oetzel and Scherer (2003) suggest it is important to recognise and understand the needs and expectations of young adolescent clients, as they are most often mandated by an adult to attend

counselling, do not often perceive the need for therapy, and appear to be acutely alert to the issue of stigma in mental health. These challenges are frequently noted in the literature alongside issues of power and control. In the school where I practice, few young adolescents self-refer. Typically, they are sent to me by a concerned adult in their life. In Aotearoa New Zealand high schools, students have more autonomy. Some self-refer, some are mandated (Crocket et al., 2015). Bolton Oetzel and Scherer (2003) maintain that engaging mandated adolescents in therapy can be difficult, as they sometimes fail to see their symptoms as problematic or they may over-estimate symptoms and become very ashamed. Similarly, research highlights that problems of shame and stigma attached to counselling experienced by adolescents can be addressed by therapists ensuring client privacy and confidentiality, as well as normalising mental health issues (Bolton Oetzel & Scherer, 2003; Crocket et al., 2015; Geldard et al., 2020; Ingram & Robson, 2015; Prior, 2012). Bolton Oetzel and Scherer (2003) assert that therapists need to be mindful of the position of their adolescent client and allow them as much choice as possible in therapy in the hope that this may alleviate feelings of powerlessness and increase motivation and engagement. I discuss the issues of power and control when working with young adolescents further in Chapter 4, in a section on ethical considerations.

Conclusion

The evidence in this section indicates that although there is, globally, an increasing demand for counselling adolescents, services for adolescent mental health appear to be under pressure. Although the research regarding young adolescents in counselling is scant, we can look to the literature about counselling adolescents, which suggests it is complex and can be challenging. Counsellors need to consider a wide variety of client, therapist and therapeutic factors and how these might influence the therapeutic alliance, interventions used, and how the client might engage in therapy.

Goal setting in counselling

Introduction

As mentioned previously, for the outcome of counselling to be helpful to the client it is important for counsellors to understand what each client's needs and expectations of counselling might be. Setting goals in counselling, regardless of the theoretical approach, is a way of understanding what it is the client wants from therapy and establishing the direction of the process (Childers, 1987; Geldard et al., 2020; Jones-Smith, 2012; Prior, 2012; Reiter, 2010; Rupani et al., 2014). The same literature also suggests that goal setting is an essential component of therapy, helpful to both the client and the therapist. As well, this literature indicates that goal setting encourages communication and helps structure and focus both the therapeutic process and choice of intervention. Goals can be helpful in evaluating progress in therapy. They act as a gauge against which both the client and the counsellor can measure what has been achieved and what remains to be achieved before therapy is completed (Jacob et al., 2016; Prior, 2012). Some research claims that the process of goal setting is itself therapeutic. Studies show clients felt that being listened to, supported and understood when setting goals for counselling helps to build a positive therapeutic relationship, helps the client clarify issues and develop realistic attainable solutions, and helps drive motivation towards the changes wanted (Childers, 1987; Costa, Brauchle, & Kennedy-Behr, 2017; Jacob et al., 2017; Jacob et al., 2016).

Most therapeutic models use goals in therapy. However, they may differ depending on what the therapist considers important (Jones-Smith, 2012). For example, some therapeutic goals highlight personal insight while others focus on obvious behavioural change. Regardless of the age of the client, goals in therapy tend to first be stated broadly and then become more narrowly defined (Childers, 1987; Cook-Cottone et al., 2015). Childers (1987) suggests that for goals to be useful for clients in therapy they need to be framed positively, be clear and specific, and be within the client's own control. This last factor, the need for the client to retain their own control over goal setting,

again raises the question of how to manage the issues of mandating and power in the young adolescent client-counsellor relationship. Cook-Cottone et al. (2015) maintain that, for those adolescents ready for change, the goal setting process is within their control and can be a helpful part of building the therapeutic alliance, whereas adolescents not ready or willing to change feel less sense of control. In this latter scenario, it is more effective for therapists to focus on the process of bonding. This view is supported by Barbrack and Maher (1984), who found that when adolescent clients were invited to collaborate with their counsellor in goal setting, not only was motivation to achieve their goals increased, but there also emerged a shared sense of understanding about the purpose of therapy which in turn, helped build the therapeutic alliance.

Regardless of theoretical orientation, Jones-Smith (2012) suggests that goal setting in therapy is a three-step process: goal setting introduced by the counsellor and discussed with the client; the client deciding what they want from therapy; the formation of a plan which includes an emphasis on the counsellor guiding and supporting the client to achieve their desired changes. Although this sounds a simple process, Childers (1987) states it can often be a challenge to help clients form realistic therapeutic goals. Finally, some authors noted the paucity of data exploring goal setting and tracking in therapy, and as such suggested that little is known about how goal formulation occurs (Jacob et al., 2017; Jacob et al., 2016).

Goal setting with young people

Goal setting is widely recognised as a common part of therapy. However, there appear to be differences in the process of setting goals for children, adolescents and adults (Geldard et al., 2020; Jacob et al., 2017; Jacob et al., 2016). For children, the literature recommends having the input of parents or teachers when selecting goals, suggesting that collaborative goal setting can be an important factor not only in improving the therapeutic outcome, but also in assisting child

development (Cairns, Kavanagh, Dark, & McPhail, 2019). Although collaborative goal setting is recommended, children from the age of about five years have been shown to be capable of setting their own goals, albeit different goals to any that an adult might choose for them (Costa et al., 2017). Balancing expectations and needs for all parties involved can be challenging for therapists according to Jacob et al. (2017), as the different perspectives of the child, parent and therapist can lead to ethical issues relating to power and control. Added to this, as seen within my own school-based practice, are the expectations of teachers. It can be a fine balance working with young adolescents who, although still under the care and protection of their parent or guardian, are beginning, wanting and needing to be seen as independent from the adults in their life. Jacob et al. (2017) reported that allowing children ownership in goal setting helps improve their sense of agency within the process, aids the therapeutic alliance and enhances the overall outcome of therapy.

Similar to the findings of Costa et al. (2017) and Jacob et al. (2017) which described goal setting with children, one United Kingdom secondary school study with adolescents indicated not only that collaborative goal setting has the potential to enhance overall therapeutic outcome, but also that there can often be a mismatch between the counsellor's and the client's perceptions of client's goals (Rupani et al., 2014). Results from an Aotearoa New Zealand study were similar, with the authors concluding that, as adolescents view the purposes of counselling differently to adults, it is important that counsellors engage with their clients in explicit goal setting discussions (Gibson & Cartwright, 2014). Barbrack and Maher (1984) found that when goals were set collaboratively with both the client and the counsellor involved, compared to when goals were set by the counsellor only, adolescent clients were more likely to remain engaged in therapy and outcomes were more likely to be effective. Results from the study by Cairns et al. (2019) extend this notion, arguing that with young people, *any* form of goal setting appeared to improve engagement with therapy.

Conclusion

Goals appear to be an important part of the therapeutic process across all approaches of therapy and client ages. Goals assist in establishing what the client wants from therapy and are helpful for both the client and the counsellor in guiding and evaluating progress. The literature appears limited regarding goal setting in counselling generally, and few studies specifically regarding the construction of goals in counselling adolescents were found. The studies about adolescents reviewed here appear to support the notion that overall, the process of goal setting is linked to client perceptions and their expectations of, and engagement in, therapy. To date, research acknowledges that much about the complex nature of the goal setting process remains unknown, especially regarding young adolescents in counselling.

Solution-focused brief therapy

Introduction

Solution-focused therapy or solution-focused brief therapy (SFBT) is regarded as a pragmatic, rather than theoretical approach. It was developed inductively during the early 1980's by practitioners Steve de Shazer, Insoo Kim Berg and their colleagues at the Brief Family Therapy Center in Milwaukee, America, when they examined their own practice reflecting on what worked with clients, rather than why it worked (Iveson & McKergow, 2015; Jones-Smith, 2012; Lipchik, Derks, Lacourt, & Nunnally, 2012). SFBT began with the notion that rather than deliberately focusing on problems and issues of the past, it was more helpful for clients to focus on an imagined future, a time when their problems no longer exist. During the 1990s, focusing on solutions rather than problems became deeply imbedded in the SFBT approach, as therapists invited clients from the outset to describe what the differences will be in their life when they no longer need therapy, rather than discussing the problem that had prompted them to seek help (Iveson & McKergow, 2015; Shennan

& Iveson, 2012). It is this focus on a positive, hopeful future that sets SFBT apart from other approaches.

SFBT is grounded in the philosophy of social constructionism. Social interaction and the use of language to create new meanings are considered key (De Jong & Berg, 2013; Jones-Smith, 2012). I examine this in more detail in the next section. SFBT is considered a collaborative therapeutic approach, the conversation between therapists and clients emphasising solutions and the future rather than problems and the past. Iveson and McKergow (2015) assert that the framework of SFBT allows practitioners to know what to pay attention to in any given conversation with a client. Within this framework are the assumptions held and the techniques used by those practicing SFBT.

The assumptions of SFBT form the foundation of how a counsellor works with their client. It is these assumptions that sets SFBT apart from other approaches. For example, in SFBT the client is considered co-equal to the therapist and competent, an *expert* of their own life (Hanton, 2011; Jones-Smith, 2012; Lipchik et al., 2012). When the *client is the expert*, the therapist takes a *not-knowing* approach to therapy (De Jong & Berg, 2013). In *not-knowing*, the therapist is genuinely curious about their client and adopts an interpretive stance which relies on the continual analysis of the client's experiences as they are perceived in context by the client. SFBT therapists use *not-knowing* questions which reflect this therapist position and this therapeutic process. As Iveson and McKergow (2015) assert, using *not-knowing* questions are a way of suspending personal judgment and theoretical knowledge which can get in the way of listening clearly to clients.

Another assumption held by SFBT practitioners is that it is most helpful to encourage clients to *do more of what works* or, *if it is not working, to do something different* (Jones-Smith, 2012). As well, SFBT therapists assume that *change is occurring constantly*, and any small change can have a ripple

effect elsewhere. Jones-Smith (2012) notes that SFBT does not dwell on client pathology which is considered unimportant in helping clients identify how they would prefer to be living. Rather, the emphasis is on the client's existing strengths, skills and beliefs the client has - approaches and behaviour that have helped in the past and will help again in the future.

Throughout the process of SFBT, a number of therapeutic techniques are used. These are based on the core assumptions of SFBT and assist clients in exploring possible goals for therapy and what life might look like as a result of achieving those goals, as well as helping clients identify what they might already be doing or perhaps have done in the past that will contribute toward achieving those goals. (De Jong & Berg, 2013; Hanton, 2011; Jones-Smith, 2012; Shennan, 2014). For example, in SFBT the first technique used is usually *goal-setting*. Asking a *Best Hopes* question when *goal-setting* such as, "What are your *Best Hopes* from coming to see me today?" helps the client examine what they want to be different in their life when the problem that brings them to therapy is no longer there (Shennan, 2014). *Goal-setting* in SFBT is discussed in detail in the following section.

Another technique in SFBT is the *Miracle Question* in which the counsellor asks the client to describe in detail their preferred future, the differences they might notice in an imagined day when their problem is no longer there (Hanton, 2011; Jones-Smith, 2012; Trepper et al., 2012). Hanton (2011) maintains that there are many versions of the *Miracle Question* and the wording of it is rarely the same each time it is asked. The original *Miracle Question* has been attributed to SFBT practitioner Insoo Kim Berg and appears in the book by De Jong and Berg (2013, p. 91) as:

> I want to ask you a strange question. Suppose that while you are sleeping tonight and the entire house is quiet, a miracle happens. The miracle is that the problem which brought you here is solved. However, because you are sleeping, you don't know that the miracle has

happened. So, when you wake up tomorrow morning, what will be different that will tell you that a miracle has happened and the problem which brought you here is solved?

Scaling is a simple, concrete and flexible technique that involves asking the client questions to help them rate the magnitude of their problem (Hanton, 2011). Scales can be marked from 1, being the worst of times, to 10, being the best of times. *Scaling* can also be helpful as a gauge to help guide the client towards the changes they want and to measure their progress in therapy.

Various types of questions are also regarded as techniques and used throughout SFBT. *Exception* questions help clients explore times when their problem is a little less or not happening at all (De Jong & Berg, 2013). For example, the counsellor might ask, "Can you think of a time recently when this just wasn't happening, or perhaps wasn't happening as much?". Exploring exceptions helps to remind clients of their past successes when dealing with the same or a similar problem. Similarly, *coping* questions help clients acknowledge their problem and identify the strengths and resources they already have in dealing with it (Hanton, 2011). An example of a *coping* question is, "How are you managing to cope with all that?". *Presuppositional* questions hold implicit assumptions and, in SFBT are again used to encourage clients to reflect on existing strengths and resources (Froerer, Walker, Kim, Connie, & von Cziffra-Bergs, 2018). An example of a *presuppositional* question is, "How else have you been coping?" which implies not only that the client has been coping, but they have been coping in a number of different ways. *Relationship* questions are used in SFBT to help clients view their situation from a different social perspective, most often expanding the conversation to include someone close like a parent, sibling, friend or co-worker (Shennan, 2014). For example, asking "What might your friend notice that would tell her your problem is no longer there?" is a question that, as Shennan (2014) notes, is concrete and observable and can help add rich details to a client's answer.

Since its inception, SFBT continues to change and develop in a pragmatic way (Shennan, 2014; Shennan & Iveson, 2012) For example, some practitioners have removed the *homework task* and the *feedback break* techniques from their practice. As well, *exception* questions were considered too problem focused and are now asked in a way that invites clients to instead think of *instances of success* to describe times of how they want to be living when their problem is no longer there (Shennan, 2014). One study noted by Iveson and McKergow (2015), found that when practitioners removed the SFBT *homework task* technique from therapy, there appeared to be no impact on the therapeutic outcome for the client.

As with any therapeutic approach, SFBT has its critics. As I discussed earlier, the non-theoretical approach of SFBT can mean little attention is paid to client pathology and the collection of historical client data, which from a client perspective may lead them to believe the therapist is dismissing their problems (Jones-Smith, 2012). SFBT practitioners would argue that clients can express their problems if they find this helpful, however it is believed to be more helpful for a successful outcome, to not dwell on a conversation about problems (De Jong & Berg, 2013; Froerer et al., 2018; Nylund & Corsiglia, 2019; Shennan, 2014). SFBT has also been criticized for claiming to be therapeutically applicable across all ages and difficulties (Jones-Smith, 2012). Shennan (2014) notes that SFBT is a different approach that has the potential to be used *with* anyone, however it is not necessarily *for* everyone. He suggests that key to SFBT is being able to communicate with a client in whatever way you need to, and that the client needs to be willing to communicate with you.

Although SFBT is a relatively new and different approach, studies have shown it to be effective for a wide variety of clients with behavioural and psychological difficulties (Franklin, Zhang, Froerer, & Johnson, 2017; Gingerich & Peterson, 2013). In addition, it has been shown to be an economically

appealing approach, as clients tend to have fewer sessions overall compared to other approaches. This can also help clients feel empowered, able to leave therapy quickly and move on with their lives. Bond, Woods, Humphrey, Symes, and Green (2013) however, report that the evidence for SFBT effectiveness remains weak in the literature and more quality research is needed.

Social constructionism, co-construction and language in SFBT

Burr (2015) argues that social constructionism is a concept that encompasses our understanding of the world as being subjective, historically and culturally specific, and that knowledge is socially co-constructed through the interactions with others. We create our own reality and make sense of it through shared communication, culture and experience. Integral to this is language. "When people talk to each other, the world gets constructed." (Burr, 2015, p. 11).

SFBT is grounded in social constructionist theory and language is regarded as particularly important (Berg & Steiner, 2003; De Jong & Berg, 2013; Froerer et al., 2018; Hanton, 2011; Jones-Smith, 2012). The language used in counselling to co-construct a conversation between the counsellor and the client shapes individual understanding for each. As Berg and Steiner (2003) suggest, SFBT uses precise language as a tool throughout the counselling process. Conversations are collaborative, and language is specifically chosen to encourage clients to explore and create new ideas as to how they want to live a more satisfying life (De Jong & Berg, 2013; Froerer et al., 2018).

Co-constructive collaborative dialogue is the foundation of client change in SFBT (Berg & De Jong, 1996; Froerer et al., 2018; Nai & Rodgers, 2017). Therapist and client work together, the therapist formulating questions and responses using the client's words, highlighting language that is positive and hopeful. As Froerer and Connie (2016) suggest, evidence of client change is observed as the client develops a new perspective of their situation which is reflected in the increasingly optimistic

language being used. The co-constructive process of linguistic technique and collaborative language appears to be an important factor in positive outcomes for clients, with research suggesting that it is the SFBT dialogue itself that is the therapeutic intervention (Froerer & Connie, 2016; Froerer et al., 2018; Iveson & McKergow, 2015). According to the literature, change and positive outcomes for clients in SFBT are due to conversations that use language that focuses positively on client strengths and resources. These conversations create a collaborative, rather than therapeutic, relationship between the client and the therapist (Franklin et al., 2017; Iveson & McKergow, 2015). The same research also suggests that repeating, rather than paraphrasing client's words, listening from a *not-knowing* stance and helping the client to describe a preferred future in detail, all help enhance positive client outcomes. Microanalysis research of language used in SFBT conversations supports this, with for example, studies reporting practitioners of SFBT using more positive language as well as the exact words of a client compared to other therapeutic models (Franklin et al., 2017).

According to Iveson and McKergow (2015), the co-constructive process in a SFBT conversation relies on the therapist being skilled enough to follow the responses of the client closely and make quick decisions about what to pay attention to in the dialogue. One process that describes co-construction in action is termed 'grounding'. Grounding is a sequence of communication interaction that follows three steps: new information is presented; the listener demonstrates that they hear and understand; the speaker acknowledges the listener's understanding and accuracy and the conversation moves on (Froerer et al., 2018). Froerer et al. (2018) also suggest that SFBT co-constructive conversations include both verbal and non-verbal communication, and that specific language is utilised to help the client build a new preferred future. In SFBT, the grounding sequence is incorporated in a framework of 'listen', 'select' and 'build': carefully listening to the client; selecting what to pay attention to; and responding in a way that directs the client toward their desired therapeutic outcome (De Jong & Berg, 2013).

Goal-setting in SFBT

One common goal setting question in therapy is, "How can I help you today?" which frequently prompts the client to talk about their problems. Different to this approach, and central to SFBT, is the process of *goal-setting*. Setting goals in SFBT has developed over time, most notably during the 1990's when practitioners changed their opening question to, "What are your *Best Hopes* from coming here?" (Iveson & McKergow, 2015). This helped to remove the problem from the initial conversation with a client, allowing instead, a focus on solution-building. The intention of SFBT is to help the client describe what it is that they are wanting from therapy, and then to help with their progress towards this. It is within the first part of this process that *goal-setting* occurs in SFBT (De Jong & Berg, 2013). *Goal-setting* in SFBT is about the outcome of therapy, a way to articulate the differences the client would like to see in their life when their problem is no longer there.

Goal-setting in SFBT has been referred to variously as 'goals', 'contracting', '*Best Hopes'* or the 'destination' of the work in therapy (Froerer et al., 2018; Shennan, 2014). While the process of *goal-setting* in SFBT appears to be different from that of other therapies, there are still similarities. For example, for goals to be useful to clients they must be; important to the client, within the client's control, positive, specific, concrete and measurable (De Jong & Berg, 2013). Furthermore, according to De Jong and Berg (2013), in SFBT there is an emphasis on goals being framed positively, as the presence of something wanted rather than the absence of a problem.

Although closely linked, there appears to be a difference in SFBT between *goal-setting*, helping the client to identify their desired outcome for therapy, and that of their preferred future (Froerer et al., 2018; Shennan, 2014). Once a goal for therapy has been established, therapists ask questions to elicit details of what the client thinks will be happening in their preferred future, when their goal has been

reached. The preferred future description is rich in content and is considered the part of the conversation where client change occurs (Froerer et al., 2018).

There are many ways of asking a *goal-setting* question in SFBT, however Shennan (2014) suggests that therapists use questions that help clients focus on solution building, rather than problem solving; the outcome, rather than the therapy process; and the future, rather than the past. Hanton (2011) describes how asking a *goal-setting* question such as "What are your Best Hopes *for* being here?" which suggests a present and immediate focus, is different to the most commonly used, "What are your Best Hopes *from* being here" which suggests a broad and long term future focus. Examples of *goal-setting* questions include, "How will you know that working with me has been useful to you?" and "What might tell you that our time together has been helpful?". Other types of helpful questions include asking the client to imagine their situation from a different perspective by using *relationship* questions, such as "How will your mum/friend know that your time here has been helpful to you?" or "What might your sister/teacher notice that would tell her that coming here has been useful for you?".

Collaboratively negotiated goals are central to SFBT, regarded by much of the literature as the direction of therapy, what needs to be noticed in a client's life for therapy to be useful to them (Froerer et al., 2018; Shennan & Iveson, 2012). A *goal-setting* question like the *Best Hopes* question ("What are your *Best Hopes* from coming to counselling?") is a 'big picture' question, and although not about the work done in therapy, the answer will *guide* the work done in therapy. Froerer et al. (2018) maintain that until goals are set with a client, the therapist cannot move on in a session. They suggest that therapists should remain focused on helping the clients articulate their desired outcome for therapy, and use the grounding sequence, mentioned earlier, to change the *Best Hopes* question to one the client understands best before any other work is done.

Working with young adolescents in SFBT

As indicated previously, many SFBT practitioners argue that SFBT is an approach that works with a diverse range of people, young adolescents included. There appears to be a growing body of research suggesting that SFBT with children and adolescents can be an appropriate approach, however I could find no studies exploring SFBT specifically with young adolescents, and nothing regarding *goal-setting* in SFBT with young adolescents.

According to Berg and Steiner (2003), SFBT and children fit together well. They suggest therapists become familiar with the overall process of SFBT and adapt it to the individual as necessary. This notion is reflected in the work of King (2017) who combines SFBT and creative play methods to encourage school aged children to engage in the process of co-constructing their preferred future. Shennan (2014) suggests that when helping children and adolescents in SFBT formulate goals, they may not be explicit in articulating what they want from therapy, so therapists need to listen closely for even half-hearted replies that indicate a goal has been established. The use of *relationship* questions when working with adolescents is encouraged in the SFBT literature. *Relationship* questions help to focus on the positive and create a way for adolescents to distance themselves from their problem, instead providing a way to view it from afar (De Jong & Berg, 2013).

Many of the challenging aspects of working with young people have been described earlier. From a SFBT stance, the key to working with mandated clients is to work *with* the client from a *not-knowing* position on what is important to them, as this helps encourage engagement and a sense of their own control within the process (Berg & Steiner, 2003; De Jong & Berg, 2001). As well, it is useful to have belief in the client's competence, trusting that they can conceptualise an alternative future and be able to work out which of their strengths and skills they can use to make change happen (Berg &

De Jong, 1996; King, 2017). As Iveson and McKergow (2015) assert, in SFBT, every client even if mandated, has their own good reason for being counselled and therefore will have their own description of what their desired outcome is. Rakauskiene and Dumciene (2013) support this view, noting that rather than echo what their counsellor, teacher, parent or guardian may want, adolescents need to set their own goals in order to promote positive personal change.

As a SFBT counsellor working with young adolescents, my focus is on how I can best help my client find out what they hope to achieve from counselling and to explore what may be different as a result. While some success using SFBT with children and adolescents has been reported in the literature, especially within secondary schools, these same papers stated that the evidence is limited and noted that further research in this area is required (Bond et al., 2013; Jones et al., 2009).

Conclusion

The literature reviewed within this section, shows that SFBT is a collaborative, solution and future focused approach which helps the client seek and develop detailed descriptions of their life without the problem. It assumes that each client is competent in identifying their own set of strengths and skills that will help them with their issues. SFBT counsellors use a *not-knowing* stance to follow their client's dialogue closely without judgment. Therapeutic interventions in SFBT take place within the collaborative dialogue. Change occurs through the use of language and questions that help clients to identify what life would be like without their problem, and that create a new, detailed picture that encapsulates hope for the future. Techniques used in SFBT include the use of language, questions and scaling to reframe client perceptions from a focus on problems to one on solutions. The setting of goals by clients is central to SFBT, as goals create the direction of therapy and help prepare the client for the solution-focused work that will follow. Furthermore, goals are helpful to the client and the counsellor in gauging therapeutic progress. However, there remains a paucity of research

regarding SFBT, young adolescents and *goal-setting* in the literature. It remains unclear how SFBT practitioners help young adolescents set goals in therapy. It also remains unclear how the SFBT *goal-setting* process is helpful to young adolescents.

Research question and rationale

Apart from the work of Crocket et al. (2015), Gibson and Cartwright (2014) and Knight et al. (2018), there appear to be few Aotearoa New Zealand qualitative studies that explore experiences of adolescents in counselling and few that examine SFBT. While the work of Nai and Rodgers (2017) was based in Aotearoa New Zealand, they investigated SFBT from a global perspective. Although as part of my research I found the work of one Aotearoa New Zealand researcher who explored the use of toys in SFBT with children aged between 8 and 11 years (Dell, 2017), I could find none that examine young adolescent perspectives of *goal-setting* in a SFBT environment in a specifically Aotearoa New Zealand setting.

As previously mentioned, working with young adolescents requires me to be mindful of how age, development and being mandated might influence the counselling process. Crucial to working with my young clients is building a relationship of trust, one where we co-construct an understanding of how I might best be of help to the client, how *they* define what it is they want to achieve from our work together. I am interested in what happens in the conversation of *goal-setting* when working with young adolescents using the SFBT goal-setting question, "What are your *Best Hopes* from coming here?". I am interested in the responses I get from asking this question, and in my reactions. I am interested, too, in what kinds of questions and language lead to their understanding and establishing a goal. By examining in depth how the *Best Hopes* question morphs and changes in a *goal-setting* conversation with a young adolescent, my hope is to gain insight, to add to the literature

and to improve my own and others' counselling practice. My overarching aim is to discover how best to co-construct a goal with a young adolescent that makes sense and works for them.

As a result of this literature review, the research question I want to focus on is:

- How are goals co-constructed with young adolescents in counselling using the *Best Hopes* question?

Sub questions to this are:

- What does the *Best Hopes* question offer the client?
- How can SFBT counsellors ask young adolescents a *goal-setting* question that will be best understood?

Chapter 3: Methodology

Introduction

Methodology refers to the theoretical framework that underpins how the researcher conducts the study and interprets the data collected (Creswell & Poth, 2018; Glesne, 2016; Taylor, Bogdan, & DeVault, 2016). Justifying my choice of methodology is, as Crotty (1998) asserts, based on an alignment of epistemological and ontological assumptions and beliefs about how reality and knowledge are built in the world around me, the kind of research question I would be answering and my purpose for asking it. This chapter outlines the process of designing a study that will help guide and shape the process and outcomes of this research.

Philosophical assumptions

My aim at the start of this research was to explore in-depth *goal-setting* conversations with the students I work with. I wanted to understand what kinds of *goal-setting* questions may or may not be helpful during therapy. The research question I formulated was shaped by my worldview, the philosophical assumptions I hold about the world we live in and how we learn what we learn.

According to the philosopher Thomas Kuhn, philosophical assumptions form a conceptual framework which is used to describe and define the researcher's basic set of beliefs. This, in turn, guides the research (Creswell & Poth, 2018; Glesne, 2016). According to Creswell and Poth (2018), four philosophical assumptions underpin the researcher's own worldview and inform their work: ontology, or how reality is understood; epistemology, or how knowledge formation is understood; axiology, or the values that drive the research; and methodology, or how researchers propose to answer the research questions. Facing the challenge of identifying these assumptions for myself, I reflected on the philosophical drivers of my research. I came to appreciate that my personal and

professional identities are interwoven with my own particular understanding of life and the world around me, a belief system that holds that there is no one truth, that life is imperfect and constantly changing, and that perspective is individually created and based on the complex influences of biology, culture, history and interpersonal interactions. Reflecting on this was important, as it has led to a greater awareness about personal biases and assumptions that may influence my research and is the start of a process of being reflective, reflexive and transparent throughout.

Social constructionism

As discussed in the previous literature review section, social constructionism is the theory that comes closest to describing the collaborative, co-constructive nature of SFBT (De Jong & Berg, 2013). Social constructionism claims there is no single reality. Instead, we each construct our own reality through our interactions with others, interactions that are influenced by the social, historical and cultural contexts we experience (Burr, 2015; De Jong & Berg, 2013). When I began training as a SFBT counsellor, and as I learned more about SFBT and its underlying connection to the theory of social constructionism, I was surprised to recognise how it aligned with many of the ideas and beliefs that I already held. Social constructionism gave me a theoretical framework through which to understand them. Throughout my research therefore, I realise that the ontological position I hold is influenced by my views, assumptions, beliefs and experiences. Burr (2015) contends that viewing life through a social constructionist lens requires us to continually critique our understanding and question the assumptions we hold about the world around us. Keeping an open mind, continuing to think reflectively and reflexively will be part of this research process.

While my focus for the research is on the participant and their subjective experience, I also recognise that my being a part of any interaction we have, will alter that in some way. From a social constructionist perspective, as Bager-Charleson (2014) asserts, it is impossible to remain neutral in

our stance with our clients. Rather, we need to acknowledge that multiple understandings of reality are created. When examining the research question, it is important to keep in mind that the young adolescents I work with have their own worldview and therefore perceive and experience the world differently to me.

Viewing my project through a social constructionist lens enables a critical view of how knowledge and learning throughout my research will be constructed. This research is driven and informed by my own philosophical worldview. As well, it is a co-construction of the interaction between myself and the young adolescents I work with, each of whom have their own personal philosophical worldviews. Together we reshape reality.

Positivism or interpretivism

According to Taylor et al. (2016) there are two main research frameworks. The first, positivist, takes an objective stance. It examines the external influences on people. The second, interpretivist, is subjective in approach. It examines how the world is experienced from a personal perspective. Positivist research tends to use quantitative methods to examine data that are measurable, using statistical analysis to find possible causes in answering research questions. By comparison, interpretivist research favors qualitative methods to collect personal, descriptive data with the aim of gaining in-depth understanding of individual experience. My research, which aims to explore and understand the different perspectives of young adolescents when they are asked a *goal-setting* question in counselling, fits within the interpretivist framework and is congruent with my personal and professional worldview, leading me towards qualitative research as the best approach.

Qualitative methodology

Qualitative researchers seek to understand and interpret others' perspectives, focusing on the meanings individuals attach to their everyday experience within their own environment (Bogdan & Biklen, 2007; Davidson, 1999; Taylor et al., 2016). Taylor et al. (2016) define qualitative research as holistic, naturalistic, and inductive. Participants are observed within the context of their usual environment. The data that are captured represents a personal, richly descriptive account of their lived experience. This data, which often includes human concepts and emotions and can be difficult to quantify, is examined closely by the researcher and conclusions are drawn inductively by looking for patterns of understanding. As Creswell and Poth (2018) note, the process of qualitative research requires a flexible approach as although there are guidelines to the methods employed, depending on how the research progresses, the researcher must be openminded to the possibility of change.

A qualitative methodological approach is appropriate for my research. I am interested in understanding how to co-construct goals using the *Best Hopes* question with young adolescent clients. I want to explore how I might phrase this question in a way that will allow them to grasp and conceptualise their reasons for working with me. It is important to listen carefully and follow the changes in our conversation as I help the young adolescent clients co-construct their goals for our time together. I am interested in gathering rich, descriptive data from these conversations which will help me determine how best to ask a goal-related question. Although I have my own inklings as to what I might find, I want to let the data speak for itself.

Qualitative methodology is the best approach for this study. It is congruent with my philosophical stance and with a study which is designed to explore the holistic experiences of young adolescents when *goal-setting* using the *Best Hopes* question in therapy.

Practice-based research

Practice-based research in counselling is a way of directing a focus towards one's own practice, the main aim of which is to inform and help guide counselling practitioners by generating knowledge from data gained in a real-life setting (Bager-Charleson, 2014; Shennan & Iveson, 2012). As mentioned in the literature review chapter, SFBT is grounded in practice-based research and continues to develop as practitioners closely examine what they do and do not do that is most helpful to clients in therapy. My research will add to the body of evidence about how goal setting occurs with young adolescents in SFBT. However, as Bager-Charleson (2014) asserts, conducting research in a clinical setting is not without challenge, as these are real but messy environments. Many personal and social factors, such as the counsellor's skills and the motivation and personality of the client, may influence the findings of practice-based research (McKeel, 2012). In addition, doing research in a school-based practice with young adolescent participants raises many ethical issues, such as possible intrusion of the research work on the therapeutic work and power differentials between counsellors and clients. I discuss this in more detail in the following Method Chapter.

The literature, however, acknowledges practice-based research as a credible means of gaining knowledge within complex real-life situations (Bager-Charleson, 2014). It can be helpful in encouraging continual reflection and evaluation of one's own practice, which is especially useful to critically appraise professional habits. Researchers encourage practicing reflexively throughout any practice-based research project, acknowledging the influence and complex nature of the counsellor as researcher and ongoing practitioner learning (Bager-Charleson, 2014; Creswell & Poth, 2018; Shennan & Iveson, 2012). Situating myself in my practice-based research as the researcher and the counsellor is acknowledged. Writing myself into the research design and process provides some transparency of the influence I have throughout the project. My research will be conducted as part of my usual work counselling young adolescents in an intermediate school in Aotearoa New Zealand.

Practicing reflexively (for example, journaling and writing reflective notes throughout the research project) will allow me to provide some transparency about my role as both researcher and counsellor. From a social constructionist perspective, this will help me take a critical stance, acknowledge my influence in shaping the research as it evolves and show how I interpret and then present my shared experiences about each young adolescent.

The methodological approach for this study is qualitative practice-based research. It fits with my epistemological and ontological assumptions and beliefs, is congruent with how I work as a SFBT counsellor and will allow me to explore in-depth the experiences of the young adolescent participants as I follow my research questions. In the following section I outline my research method, describing how I conducted my research.

Chapter 3: Method

Introduction

Method describes in detail the procedure used to collect and analyse data in a research project (Glesne, 2016). This chapter outlines my research procedure. It describes and summarises the setting of the research, how participants were recruited, how data was collected and analysed, and how I addressed rigour, trustworthiness and ethical issues throughout the research project.

Setting

My research project is an in-depth analysis of how a small group of young adolescents experience *goal-setting* in counselling in an Aotearoa New Zealand Intermediate school. Consistent with the literature which describes qualitative research as having a naturalistic approach, my research was conducted within the student's usual school environment (Creswell & Poth, 2018; Taylor et al., 2016). This is a co-educational year 7 and 8 intermediate school, with over 500 pupils aged between 10 and 13 years old. All counselling sessions were in my usual place of work, my office, a room that is familiar to the students and one that enables us to work privately and confidentially.

Participants

Students were recruited as part of the usual school process of counselling referral to me, which in the first instance is a decision made by the Deputy Principal in conjunction with the student's parent or guardian. I began the recruitment process by discussing the research project with the school Principal and the Deputy Principal. Information sheets and consent forms (Appendices 1 and 2) were provided which explained the school's and the Deputy Principal's involvement and requested signed consent. As part of the conversation with the parent or guardian when they were first contacted by the school with the suggestion of counselling, the Deputy Principal agreed to mention my research intention and

provide an information sheet and consent form (Appendix 3) to the parent or guardian. These explained the study and the potential participant's involvement. The parent or guardian could read this and decide if they felt it was suitable for their child. If the parent or guardian agreed, I met the student briefly before counselling began and gave them a child-friendly information sheet and consent form (Appendix 4) which they could take home and discuss. If the student agreed to participate, the signed parent or guardian and student consent forms were returned to me by the student at their first session with me. As Bager-Charleson (2014) suggests, I ensured continued participation by gaining verbal consent from each student before beginning to record a session. It was made clear to each participant and their parent that counselling would take place regardless of their choice about participating. Ethical issues raised as part of the consent process are discussed within the ethical considerations section of this chapter.

Five students were originally accepted to take part in this study. One student changed their mind about participation before the first session so continued with counselling but was removed from the study. The remaining four participants were all aged 11 years and were in year 7, their first year of intermediate school. To ensure confidentiality, the names of all participants have been changed. Two participants, Bethany and Miley, were girls, and two, Joe and Fred, were boys.

With my own reflections forming part of the data, I too am a participant. I am a middle aged Pākehā Aotearoa New Zealand woman. In this study I positioned myself as both the counsellor to each young adolescent student who participated and as the researcher, observing, gathering data and practicing reflexively throughout.

Rigour and trustworthiness

Creswell and Poth (2018) contend that the value in qualitative research lies in gaining a deep understanding of personal experience. When the research results are published and read, the question of quality arises, how the researcher, the participants and readers can be confident that the results are credible and accurate (Baxter & Jack, 2008; Creswell & Poth, 2018; H. Harrison, Birks, Franklin, & Mills, 2017; Morse, 2015; Nowell, Norris, White, & Moules, 2017). A continual process of evaluating how rigorous the processes I am using are, as well as how trustworthy my findings are, were standards I considered throughout. The section below describes the different standards I used to ensure this research project can be considered useful, genuine and credible when viewed through the lens of myself as a practice-based researcher, the participants involved, and readers from any walk of life.

Practice-based counselling research is a reflective study of one's own practice, the purpose of which is to understand, explain and inform the counselling profession, as well as to gain personal development and competence (Bager-Charleson, 2014; Balkin & Kleist, 2017). According to Bager-Charleson (2014), positioning myself as a researcher within ones' counselling practice is the first step in providing transparency in therapeutic practice-based research. Key to this, is recognising my own biases and assumptions and how they might influence the research (Bager-Charleson, 2014; Creswell & Poth, 2018; Morse, 2015). In the previous chapter I outlined my position as a counsellor researching my own practice, considering the positives and negatives of doing so. I was transparent as a practice-based researcher by being open and honest when writing notes, while collecting data and by consistently journaling reflectively.

Authors J. Harrison, MacGibbon, and Morton (2001) examined issues that arise in the relationship between the researcher and participants when conducting research. I agree with their stance that

although it is difficult to position yourself within your research, acknowledging this positionality is key to understanding any influence you may have. For example, one ethical issue when working with young adolescent participants was that as an adult, and being both the counsellor and a researcher, I was in a position of power. I practiced reflectively and reflexively, acknowledging and remaining mindful of my possible influence during our sessions. I discuss ethical considerations regarding being a practice-based researcher in more detail later in this section.

As Nowell et al. (2017) note, reflexive journaling not only allows the researcher to think critically about how personal biases may influence the data, but also provides a record of decisions made and the rationale of making them. My journal is full of reflections, some meandering and seemingly random, some purposeful and specific. All however have been valuable in reflexively evaluating the research from start to finish, helping me formulate ideas, make decisions, and understand the research from the differing perspectives of the participants, the study's readers and myself (the practice-based researcher). Journaling kept me thinking, kept me on task, and ultimately helped in writing my findings in a way that others can make sense of them.

Described as an 'audit trail', documented evidence lends rigour to research by providing the reader with a way to track details of the entire research process (Creswell & Poth, 2018; Nowell et al., 2017; Yin, 2018). For example, the research purpose and rationale should be evident and explicit. As Baxter and Jack (2008) and H. Harrison et al. (2017) maintain, to ensure rigour personal philosophy and methodology must align with the research purpose and the methods used. In my research, the philosophy, methodology, method and research question collectively align. Each is purposeful, clearly outlined and supported by the literature. Qualitative design was chosen as an appropriate way to explore the research question. Clear research questions ensured the research remained focused (Yin, 2018).

A clear chain of evidence was apparent throughout the project with multiple sources of data systematically collected, managed and analysed (Baxter & Jack, 2008; Creswell & Poth, 2018; H. Harrison et al., 2017; Morse, 2015; Yin, 2018). Collecting multiple sources of data, or triangulating data, is encouraged as the many perspectives explored help to provide credibility and corroborate the findings (Baxter & Jack, 2008; Creswell & Poth, 2018; H. Harrison et al., 2017; Yin, 2018). The data I collected were rich in description and came from recordings, observation, notes and reflections. After each session, I worked quickly to transcribe the conversation as I wanted to have it fresh in mind to capture the nuances expressed.

It was important to me that the data I collected were accurate representations of how the participants experienced being asked the *Best Hopes* question. Creswell and Poth (2018) stress the importance of forming a good relationship with participants so as to form a bridge in collecting honest, accurate data. As a counsellor, building a relationship with the person you are working with forms the backbone of the work you do together. The counsellor-client relationship is similar to the researcher-participant relationship in that both are based on trust, being respectful and nonjudgmental. However, the purpose of my research differed to the therapeutic work undertaken in a session. I was explicit with participants when donning the hat of the researcher, for example, to state openly that the next part of our conversation would be about my research project. This was a conscious ethical decision as although, as J. Harrison et al. (2001) note, research can become inexplicably entwined in the work we do, I wanted to make clear to the participants the distinction between our clinical counselling work and my research. The relationships that I formed with participants enhanced collaboration and allowed honest feedback, which as Baxter and Jack (2008) note, often provides an opportunity to collect more data.

As my research progressed I shared ideas, methodology, data and findings with my research supervisors and with peers who were familiar with the project. Creswell and Poth (2018) encourage this strategy as a way of ensuring that the researcher and the research are kept on task, that the findings make sense and are a true reflection of the data, and that the research is reported in a clear orderly manner. The interactions I had with peers and supervisors not only kept me on task, they kept me motivated and enthused to keep going.

Ethical considerations

Before beginning this research project ethical approval from the Educational Research Human Ethics Committee of the University of Canterbury (ERHEC) (Appendix 5) was sought. In considering ethics I referred to the following to help guide me: the University of Canterbury Human Ethics Policy (University of Canterbury, 2018); the NZAC Code of Ethics (New Zealand Association of Counsellors, 2019a) in conjunction with the principles of the Treaty of Waitangi (*Treaty of Waitangi*, 1840); and Ethical Research Involving Children (Graham, Powell, Taylor, Anderson, & Fitzgerald, 2013). What follows is an account of how ethics informed and guided decisions I made during this research project.

Ethics as a practice-based researcher

In qualitative research there is often a tension between conducting the research and doing it in a way that respects the rights of participants (Bager-Charleson, 2014; Glesne, 2016). Ethical issues include: gaining informed consent; maintaining privacy; maintaining confidentiality; and ensuring the safety of participants. For me, being an ethical practice-based researcher was about using sound ethical judgment and integrity to ensure transparency of process. I felt strongly that it was important that there was always time for questions to be asked and answered and, above all, an understanding by

everyone involved, that participation in the study would in no way interfere with the usual counselling work I do with the students.

As a counsellor in an intermediate school I am acutely aware of the many ethical issues I face when working with young adolescent students. For example and as outlined in the NZAC Code of Ethics (New Zealand Association of Counsellors, 2019a), my work involves being consistently aware and mindful of being respectful and inclusive of cultural difference and human diversity, avoiding doing harm, remaining confidential, and being aware of issues of power imbalance (New Zealand Association of Counsellors, 2019a). When considering the cultural component when interacting, counsellors practise in accordance with the Treaty of Waitangi, a document which established partnership between Māori and Pākehā in Aotearoa New Zealand (Ludbrook & New Zealand Association of Counsellors, 2012; New Zealand Association of Counsellors, 2019a; *Treaty of Waitangi*, 1840). Recognition of, and respect for, differences between myself and those who I work with are core professional values of the counselling profession. One way I strive to remain ethically aware and culturally sensitive, is by acknowledging any difference with the individual I am working with and being transparent about any lack of cultural knowledge. As each information sheet explained (see Appendices 1-4), any bi-cultural issue would be discussed with my cultural supervisor, a person of Māori descent who advises me in cultural matters.

From a researcher perspective, many of these ethical issues remain the same. However the difference, as Bager-Charleson (2014) contends, is that as a counsellor my purpose is to facilitate the client's agenda, and as a researcher my purpose is to facilitate my own. Added to this are the power differences when counselling young adolescents. In a school setting children often get little choice if they are asked to see a counsellor and they can find it difficult to regard adult requests as voluntary (Graham et al., 2013). It was very important to me that the students made their decision to participate

willingly, with a full understanding of what it meant to be involved, as well as the ability to withdraw at any stage. Before seeking their consent to participate, I talked openly with each student, outlining the research and how it differed to being counselled.

Mandated participants, informed consent and confidentiality

As previously discussed, there are ethical issues regarding working with mandated young adolescent clients when counselling. Requesting mandated clients to be participants in research adds another layer of ethical consideration. As Graham et al. (2013) suggest, young participants in research are vulnerable to coercion and extra care and consideration are needed. Graham et al. (2013) highlight the importance of obtaining voluntary informed consent from participants as well as from parents or guardians. The process of recruiting participants was outlined previously, within this was how I obtained participant consent. Key to this process was being transparent, open and honest, respecting the participant's privacy and confidentiality, and maintaining a relationship with the participant so they could negotiate their withdrawal at any stage.

A core ethical principle of counselling is to respect confidentiality (New Zealand Association of Counsellors, 2019a). Throughout this research I have maintained the confidentiality of information provided by participants and stored it securely. When writing findings of this research, the identities of participants and the school where this research was undertaken have remained confidential with names being changed and/or omitted (University of Canterbury, 2018).

Avoiding harm

As a counsellor my duty of care is for the person in front of me. As a provisional member of the NZAC, I practice in accordance with the values and principles of the NZAC Code of Ethics (New Zealand Association of Counsellors, 2019a). This code helps inform, guide and maintain

professional standards and ensures I remain mindful of my responsibilities when working as a counsellor. It also offers an ethical guideline for members doing practice-based research. Core to the NZAC Code of Ethics is protecting clients from harm (New Zealand Association of Counsellors, 2019a). As a school-based counsellor doing research, my allegiance is always to the person I am working with, actively ensuring their ongoing emotional, psychological and physical safety. At all stages of providing information and gaining consent, as well as throughout the research, I acknowledged my role as a researcher and counsellor, continually and openly reiterating that counselling would take precedence (New Zealand Association of Counsellors, 2019a; University of Canterbury, 2018). It was made clear that if at any stage a student wanted to withdraw, they could. It was also made clear to parents, guardians and the school's staff members involved, that they could withdraw the student at any stage if they decided to.

Data collection

Audio recordings of participant sessions were made. I chose audio recordings only, as I have previous experience recording young adolescent students in counselling sessions and have found that video recording can be intrusive and influence student behaviour. Three sessions were transcribed for each student forming the bulk of the data I collected. The data collected focused on any part of the conversation when *goal-setting* occurred during the counselling sessions. With each client, the first *goal-setting* question I asked was the same or very similar to, "What are your *Best Hopes* from working with me?". Reflective notes written immediately after each session supplemented the audio recordings and formed part of the data collection alongside my reflective and reflexive journal, which I wrote throughout the research process. The timeframe specified for my research was guided by the restrictions of completing this research component of my master's degree and outlined in all information sheets (Appendices 1-4). A decision was made not to use the participant rating form with an added question, outlined in all the information sheets, as there were concerns about the issue

of copyright as it would not have provided data about co-construction of *Best Hopes*. This form was not introduced during sessions with participants and did not form any part of my data collection.

Data analysis

Data collected in this research investigation was analysed using thematic analysis, a method of systematically detecting and reporting themes or patterns of data which provide meaning and answers to the research question (Braun & Clarke, 2006; Nowell et al., 2017). Thematic analysis is theoretically flexible and is an active reflexive analytic approach. Themes do not emerge from the data. Rather, theme development is an inductive process, the researcher actively creates themes which capture implicit meanings beneath the surface of the data (Nowell et al., 2017). However, according to Nowell et al. (2017), researchers should be cautious when using a flexible analytic approach as reliability can be compromised when themes based on the researcher's interpretation are not adequately supported by the data or a theoretical framework. Thematic analysis has been described as straight forward and user-friendly, suitable for novice researchers like myself and according to Clarke and Braun (2018), has been used extensively by researchers exploring peoples' experiences of counselling.

Thematic analysis was chosen as an appropriate method for my qualitative research project because it fits with research oriented within a social constructionist framework, and because the analysis allowed me to closely and reflexively examine how a *goal-setting* conversation is co-constructed with young adolescents in SFBT.

I followed the six thematic analysis phases outlined by Braun and Clarke (2006) and recommended by Nowell et al. (2017). These start with familiarising yourself with your data, lead on to generating and reviewing codes and themes that develop from the data, and finish with producing a report which

connects the themes from the data to the original research question. Short quotes from participants are encouraged as a way of demonstrating evidence of themes. The final report, as Nowell et al. (2017) suggest, should show a deep understanding of the different themes revealed overall, and be supported by quotes from participants, the researcher's own reflexive journal, and the literature.

I now outline how I analysed the data according to thematic analysis as suggested by Braun and Clarke (2006). In the first phase, '*familiarising yourself with your data'*, I transcribed the three sessions with each participant. I found that the transcription process was helpful as I was forced to slow down and listen intently to the recordings as I typed. I read the transcripts and listened to the audio recordings of each session with clients numerous times. I found this process helped challenge my assumptions about what had happened in each session with clients, as listening closely and reflecting on our conversations enabled me to capture the nuances within them. I made notes continuously and wrote down ideas of possible codes and themes that were focused on sections of the session when *goal-setting* conversations took place. I read my post-session notes and my reflective journal. By the end of this phase I had identified sections of the transcript data that I felt were interesting and relevant to my research question and I printed them out so I could examine them closely.

In the second phase, '*generating initial codes*', I began to notice specific features of the data and coded them using words that to me, captured their essence. As Braun and Clarke (2006) recommend, I remained open and curious during this process, and anything that caught my eye was labelled. I took notes and reflected as I analysed, refining codes and concepts within them as I went. The codes reflect and capture the implicit underlying meanings of each theme and the final codes for each theme are outlined in the following Findings chapter. Initial codes were generated as I examined the data from different perspectives. For example, codes such as *skills, technique, reinforcing, clarifying,*

repeating client words, take time, empathetic, respectful, fun, inviting engagement, were from examining the data from the perspective of counselling in general. From a SFBT perspective, I coded data to include, *assumptions, client as expert, use of language 'from', positive frame, not-knowing, curious, hopeful, change is constant, Best Hopes.* I also coded data examining how the client responded in our conversation. Codes included, *engaged, unengaged, quick, enthusiastic, pleased, unsure, does not know, does not want to answer, real world, many Best Hopes/goals, annoyed.* As well I coded my responses in our conversation such as, *pleased, discomfort, working hard to remain positive, working hard to re-engage.* I followed the advice of Braun and Clarke (2006), who suggest working systematically across all the data, coding and recoding when relevant. During this part of the process I used my reflective journal, writing my thoughts as ideas evolved. For example, early in this process I wrote, *"As I think about the data codes, I am continually thinking about how each code links/fits with the bigger picture – the 'so what?' of this…".*

In the third phase, *'searching for themes',* I used the codes to begin constructing themes. As Terry, Hayfield, Clarke, and Braun (2017) suggest, I experimented with drawing visual maps and diagrams to help me identify potential themes that had distinctive boundaries and few overlapping codes. I wrote codes on sticky notes and attached them to sections of the data, moving them into piles according to possible themes. Themes developed as I examined the data and codes from different angles. The themes I decided upon were tentatively named. The sharing of these with my research supervisors and peers was helpful at this point, as their feedback allowed me to view my themes from a different perspective. Some initial themes such as, 'Asking a *Best Hopes* question helps clients explore possible goals' were discarded and some were combined. I agree with Braun and Clarke (2006) who maintain thematic analysis can be challenging, as when coding and searching for themes, it can be difficult to know just when to stop. After much time and thought, however, well-defined themes that reflected all the participants' data were developed during my analysis.

In phase 4, *'reviewing themes',* the potential themes were refined. Braun and Clarke (2006) note that themes need to capture the meaning of the data clearly. They also suggest that there is a balance between ensuring themes are distinct and clear, and making sure the themes relate in some way. At this point I re-examined the whole data set to ensure that the codes and themes were relevant and accurately represented the patterns I had allocated them.

In phase 5, '*defining and naming themes',* each of the final themes were named. This phase required me to ensure that, as Nowell et al. (2017) suggest, each theme can be clearly described and understood in relation to the data, and to the research overall. I named and renamed each theme as they developed, and I found this helpful in identifying what each theme was about. The final themes developed during this analysis process are described in the following Findings Chapter. Each theme captured what I found interesting and meaningful in my SFBT practice regarding *goal-setting* with young adolescent clients.

The process of analysis was lengthy and not easy. I spent many hours reading, re-reading and coding the data. With each re-reading, the codes formed patterns from which themes began to develop. I returned many times to the literature on thematic analysis to help guide me in this process and discussed codes and themes with my supervisors and peers. As Terry et al. (2017) state, this was active and reflexive, a process that evolved over time. My analysis of the data was just that - *my* analysis, uniquely viewed from my own perspective within the context of my worldviews. The following Findings Chapter is phase 6 of my analysis.

Chapter 4: Findings

Introduction

This chapter presents my findings. I begin with a reflection of the analysis process, followed by an explanation of how the data are presented. I then introduce and present in detail the four themes that were generated from my analysis. Finally, I provide a conclusion.

Reflection on the analysis process

Analysing and reflecting on the data was a process that took a great deal of time and thought. It was both interesting and tedious. Codes and themes were generated through ongoing reflexive analysis and what is presented here is a product of my interpretations. The underlying meanings I interpreted as I examined the data are subjective; my biases and life philosophies have influenced how I read and considered the data, as well as how I have generated themes (Bager-Charleson, 2014; Terry et al., 2017). Throughout the process of analysis, I was keenly aware that this is *my* interpretation, that what I have chosen to focus on, or exclude, has been constructed through a lens of my perceptions and understandings of what *I* consider to be of interest.

As a novice researcher I initially found it difficult to identify patterns in the data and instead found myself looking for themes that answered my research questions with ease. Early analysis was discussed with my supervisors with the advice to re-read with curiosity and to look hard at the details. This process which aligns with the principles of solution-focused counselling, led to a 'slowing down' of the analytic process and, although I was still guided by the research questions, it enabled me to view the data with as few assumptions as possible. I took my time and returned again and again to the data, honing my thoughts in the process. As Braun and Clarke (2006) recommend, I

remained aware of my own biases as I analysed, and I examined the data with open curiosity which helped capture implicit meanings beneath the data surface.

Influenced by my research questions and the literature I had read, my analysis began with an eagerness to examine instances of successful *goal-setting* in conversations with young adolescents. As I analysed and reflected, however, I began to see a different picture. No session is ever perfect, and I began to see real value in examining the conversations when *goal-setting* had not gone particularly well. Although difficult, as it exposed my failings as a human(!) counsellor, examining each part of our conversations in minute detail exposed the complex nature of *goal-setting* in counselling sessions when working with young adolescents. It also provided valuable learning for my professional practice, helping to shape my practice in a positive way.

Data are drawn from the sessions of four clients, all mandated, two girls and two boys of similar age. I was surprised when I discovered that the data that interested me most came from conversations with clients who challenged me most. Of the four participants, Miley and Bethany both enjoyed coming to counselling, were open and willing to explore and discuss their *Best Hopes*, and I felt good therapeutic relationships were formed in our sessions. While all data were examined in depth, I was less drawn to the details of Miley's data because the *goal-setting* conversations we had together appeared to follow the clear pathways indicated by SFBT literature. The three clients whose data appear most frequently in the findings were, for varying reasons, the three most complex cases. I was drawn to the details within these conversations I think, as they were often awkward and did not follow the *goal-setting* path modeled by SFBT literature. Bethany has a complex background and her issues could be demanding. Her data, together with the data of Fred and Joe, who both did not want to attend counselling and whose therapeutic relationships took work to develop, were of greater interest in analysis and, I felt, revealed the most under scrutiny.

The data from the four participants indicated two different paths of a *goal-setting* conversation. The first path was when the conversation went well. In this case, a *Best Hopes* question led to goals being established in a textbook manner. The session was pleasant, and our conversation felt like it flowed. The second path was when a *Best Hopes* question was not answered by the client in a manner suggested by SFBT authors. Rather, I had to work hard, I felt uncomfortable, and the conversations reflected my discomfort and frustration. In the following themes, examples of the data illustrate these two differing perspectives.

The process of analysis was a constant to-ing and fro-ing, expanding and collapsing themes until, as Terry et al. (2017) suggest, I reached a final stage of refinement, where, I hope, the data analysed tells a story in such a way that it illustrates my interpretation and connects to my research questions.

Introduction of themes

In the previous chapter I outlined the process whereby I collected and analysed the research data while considering the research question, 'How are goals co-constructed with young adolescents in counselling using the *Best Hopes* question?'. The following introduces themes from that analysis, gives a very broad outline of each and provides some examples of coding that formed the patterns of each theme.

Theme 1: When all goes well - responses to a Best Hopes question when expectations of therapy are the same

This theme captures the responses of a *Best Hopes* question when the counsellor and the client have a shared understanding of the purpose of therapy. Asking a *Best Hopes* question helps clients explore possible goals for therapy and sessions run smoothly. To illustrate, two examples from Bethany and Miley are provided. Codes that contributed to this theme include: *long term future focus; engaged;*

quick; best version of self; reinforcing; complimenting; broad, language 'from'; positive; understands questions; fun; Best Hopes change; pleased; enthusiastic.

Theme 2: When expectations differ - responses to a Best Hopes question when expectations of therapy are different

This theme encapsulates the responses of a *Best Hopes* question when there is a difference in the counsellor's and the client's understanding of the therapy process. Clients were more likely to be reluctant to engage, issues of mandating, power difference and stigma were exposed, and I had to work hard in my counselling role. Three examples from Fred and Joe provide illustrations. Codes include: *understands?; can't answer; take time; inviting engagement; discomfort; working hard; whose agenda?; perceived stigma; unsure; unengaged; repeating; empathising*.

Theme 3: Different perspectives can help

This theme explores how asking different kinds of *goal-setting* questions, from differing perspectives, helped clients explore possible goals for therapy. Three examples from Bethany and Fred are provided. Codes include: *curious; relationship question; different perspective; hopeful; underlying assumption; there is more; reframing; reflecting; affirming; clarifying; following the conversation.*

Theme 4: The client is the expert

This theme captures how a conversation about goals in counselling is most helpful when it centres on the client, respecting and acknowledging their perceived world and focusing on what makes sense for them. Furthermore, this theme explores the glue that holds it all together, the counsellor and client's therapeutic relationship. Four examples from Bethany and Fred illustrate this theme. Codes include: *client at centre; her/his world; respectful; not knowing; client's words; respectful; listening intentionally; non-judgmental; working with; sighing; encouraging*.

Presentation of the findings

My research is about how goals are co-constructed with young adolescents using the *Best Hopes* question in therapy. When a *Best Hopes* question is asked, I am inviting the client to think about and articulate, what they would like different in their life. Together we discuss all the things the client wants to change about themselves and their life and gradually we condense these down to something they feel they would like to work on in our session(s). All four participants were initially asked the same or a similar *Best Hopes* question to, "What are your *Best Hopes* from working with me?". The following section of this chapter explores the conversations that resulted from asking a *Best Hopes* question. The four themes generated are presented in detail. Examples are used to illustrate each, with my words written in italics prefaced with C for counsellor, and the client's words in standard text prefaced with the first letter of their pseudonym. Data drawn from my post-session and/or reflective notes are distinguished by being written in a different, italicised font. A brief conclusion is given at the end of each theme and the chapter ends with an overall conclusion of my findings.

Theme 1: When all goes well – responses to a *Best Hopes* question when expectations of therapy are the same

This theme explores what happened in a conversation when I asked a *Best Hopes* question and the client responded in a way that indicated we had an immediate shared understanding of the work we would be doing together. How this shaped our conversation is illustrated in the following two examples.

Example 1: Bethany – exploring possible goals

This excerpt is part of a conversation with Bethany early in our second session together. In our first session, Bethany and I had spent time establishing the beginnings of our working relationship. This

second session was the first time I had asked her a *goal-setting* question and I chose to ask her this standard SFBT *Best Hopes* question:

C: Bethany, what are your best hopes from working with me?

B: (responding quickly and enthusiastically) Going to (school name)… a high school that I can be myself and I can push my limits…

C: I love it, hang on (starting to write)...

B: … and make my boundaries bigger and I can learn more things…

As I examine this excerpt, I notice SBFT techniques being illustrated throughout. For example, my question is posed curiously, and I use the SFBT approach of *not-knowing*. As well, using her name and the word "*your*" places Bethany at the centre of our conversation, *presupposing* she has the expertise for answering this question. In the recording of this excerpt, the tone I used indicates that the question itself is framed positively, hinting at the hopefulness of our future work together. These techniques and assumptions are explored further in Themes 3 and 4.

When asking "*Bethany, what are your best hopes from working with me?"*, I intentionally used the word 'from'. The underlying connotations of this word are that the question I have asked has a broad focus on the long-term and is connected to our work together. As previously discussed in Chapter 2, SFBT literature encourages paying close attention to word use and, in this example, the specific use of 'from' helps establish the direction of our work together. There is an assumption in this question that the client has some positive idea of what they would like to discuss in therapy.

Bethany's response indicates that she appears to understand my intention in asking. She immediately replies, describing her *Best Hopes* from working with me as both broad and future-focused: "going to high school"; "can be myself"; "make my boundaries bigger"; and "I can learn more things". These are all descriptions that appear to be versions of her best self. She seems engaged in the

conversation and is answering in a way that most SFBT literature suggests occurs when a client is asked a *Best Hopes* question.

My response picks up on her enthusiasm, reflecting the co-constructive collaborate nature of our interaction. I compliment her with "*I love it*" and start to make a list of her possible goals for therapy (De Jong & Berg, 2013). The written list itself, is a technique that acts to: affirm and reinforce the client's goals for therapy; clarify what the client says; and provide a visual reminder that we can return to either in this or in subsequent sessions (Shennan, 2014). My response is upbeat, indicating my pleasure in her answer. I repeat her words as I write them (De Jong & Berg, 2013), reinforcing as well as clarifying what she is saying. I also note, in my post-session notes that I wrote "*I am sitting close but giving space, leaning slightly towards her…*". My focus is on Bethany, intentionally listening to her words, my body language reflecting my interest in what she is telling me. Our conversation is quick, Bethany almost speaking over me, as I struggle to keep up with what she is saying as I write her future hopes.

Bethany has responded here to an explicit *Best Hopes* question seemingly with ease, replying quickly and enthusiastically. I continue our conversation, echoing Bethany's words to reinforce and clarify them as I write:

> *C: Going to (school name), going to a high school did you say* (writing)… *where you can push your limits?*
>
> B: Yeah…

Bethany's short reply of, "Yeah" clarifies not only that I have understood her answer, but that she has understood my opening question and is engaged in the counselling process.

Example 2: Miley – exploring old goals, making new ones

When clients appear to answer a *Best Hopes* question with ease, their list of goals for counselling may be long. This theme explores the complexities of formulating and clarifying goals with young adolescents, even in sessions when all is going well.

Miley enjoys coming to counselling and is open and willing to discuss how it might be helpful to her. In an earlier session I had asked Miley the same question I had asked Bethany, "*What are your Best Hopes from working with me?"* to explore possible goals for our work together. Her responses indicated that we shared an understanding of the purpose of therapy. They guided the co-construction of a long list entitled 'My *Best Hopes* from working with Jude'. Some of Miley's goals were elicited by asking *relationship* questions (this kind of question is examined more thoroughly in Theme 3). For example I ask what Miley's Mum, Dad, brother, friends, and even her pets might notice about Miley as a result of her coming to counselling. Her description of these aspects included being "positive at home", "doing my chores", "not getting irritated over the smallest things, instead I just walk away and go into my room (with a Milo)", and "smiling and laughing". Miley thought that her pet rabbit would notice her being "extra extra more calm and caring" and being "more patient". Miley had left that session upbeat, having decided that what would be most helpful on that occasion was to spend more time with her pet rabbit.

In this later session I am curious about what might be different for Miley since the list was originally made. The following exemplifies the SFBT assumption that *change occurs constantly* (Hanton, 2011; Shennan, 2014), showing how goals in therapy are not rigid and that there is a continual adjustment. This excerpt occurs about 20 minutes into our session and begins with me reading from Miley's original list:

C: ....So, when I asked you ages ago, what are your Best Hopes from working with me, and you said to me, my Best Hopes from working with Jude are.... (reading from Miley's original *Best Hopes* list)… *I won't feel so depressed all the time, instead I'll feel happy, ... I'll be positive, drawing, reading, writing, snuggling lots* (laughing)...

M: (interrupting and laughing) With my animals, he he…

C: ...(continuing reading from the list) *I'll be saying I'm happy, I'll be enthusiastic, really active, my chin will be above my zip, I'll have lots of energy, I'll be doing yoga, extra calm...*

This appears to demonstrate SFBT goal describing techniques examined in my Literature Review (Chapter 2) such as: assuming that Miley is competent; goals are specific; concrete and what *she* wants; and they are framed positively (De Jong & Berg, 2013; Hanton, 2011).

Re-reading Miley's long list of *Best Hopes* together is an example of the interactional nature of exploring goals for counselling. My tone here is bright and cheery, I sound pleased and enthusiastic to be reading her list. Miley nods and smiles as I read and we both at times giggle, especially when I get to the part about what her pets might notice. The way in which I pose a question or a statement and respond, and the tone and language I use, interacts with and influences Miley, encouraging her ability to answer with ease, increasing the connection we are building, the therapeutic relationship. It is like a conversational ping-pong, with each question I ask, Miley replies quickly, enthusiastically reinforcing me, which in turn drives me to respond to her, using what sounds like on the recording, a tone that is upbeat and positive.

Towards the end of the list I read what Miley would like to do when she leaves school, "…I'm going to architecture school…". As I read this, Miley interjects with an excited tone saying, "I think I might just do interior design…". I respond with:

C: Oh, that sounds a wonderful plan, I love it!... That was a lot of things, hey… Do you think that your Best Hopes from working with me are the same or have they changed slightly?

M: Well, some of them have changed and I have more to add on

C: Excellent! Well, I tell you what, which ones have changed do you think?

M: Hmmm… (pause)… ummm…

Miley then takes the list from me and places ticks against some of the items, claiming them to be "done". In the end, Miley decides a new list is warranted, and begins to write her own, stating:

M: Next time… my confidence, my worries, and my stress with two exclamation marks!

With this, we begin a new conversation, expanding on these new hopes Miley has identified, reframing them, as the literature suggests, as goals that are positive, specific, concrete and detailed (Childers, 1987; De Jong & Berg, 2013).

Exploring possible goals with clients is never a simple task. This example illustrates that as goals shift and change over time, my role was to help Miley reassess and clarify what was important for her to be working on next (De Jong & Berg, 2013). When examining this data, what I find most interesting is the implicit undercurrent of our conversation. As with Bethany, Miley was willing and eager to engage, she answered questions quickly in a way that suggested she understood my intention and our conversation was focused on exploring possible goals for the work we would do together.

For the purpose of exploring possible goals with clients I often begin therapy with the question "*What are your Best Hopes from working with me?"*, or something very similar. However, I am never confident that the young adolescents with me will understand what I am asking, so I am always alert to their response. Bethany's and my short interaction illustrated above, suggests she and I have a shared understanding, that we are both talking about what she wants from coming to

counselling. This boosts my confidence and reminds me that this is the beginning of an interactional process. It is, as De Jong and Berg (2013) suggest, a beginning step towards helping the client articulate something they would like different.

In conclusion, I found that when asking a *Best Hopes* question and the client responded in such a way that I could assume a shared understanding of the intention behind the question asked, the session flowed smoothly, and a positive symbiotic relationship was formed. This, in turn, enhanced the conversation. Our expectations of the work we were doing together, addressing life issues and exploring change, appeared to be the same.

Theme 2: When expectations differ – responses to a Best Hopes question when expectations of therapy are different

This theme captures what happened in conversations when I asked a *Best Hopes* question and the client responded in a way that suggested there was a difference in our understanding of the expectations of the work we would be doing together. When there is a misalignment between the counsellor's expectation for therapy and that of the client's, more time is spent working towards a shared understanding. The following three examples illustrate how this kind of response created very different sessions compared with those from Theme 1.

Example 1: Joe – most young adolescents are mandated

All four of the participants in this study had been sent to me by an adult in their life, none had sought me out themselves. Joe had been directed to see me by his mother and he was not particularly pleased about this. I wondered if Joe's reticence was to do with the stigma that surrounds counselling, as he had previously voiced his concern that other students might find out he was coming. The following extract examines part of Joe's first session with me and explores what

happens when I am working with a mandated client who does not want to come to counselling. Part way through our first session, I asked the same SFBT goal setting question I had asked all participants "*What are your Best Hopes from seeing me?*" and Joe replies:

J: Well…(pause)… Mum kind of made me

From the outset, Joe makes clear it is not his idea to come to counselling. His answer indicates his feelings, that he is not totally on board with coming to see me. His statement that someone "made" him attend leads me to think he *definitely* does not want to be here. Joe's response does not answer my question in a way that will direct our conversation towards his goals for therapy. I use his words in my response:

C: It was Mum's idea for you to see me? Not yours?

J: Yes. She kind of duped me into seeing you

C: Oh, she duped you?! (smiling)

J: Yeah… Mum wanted me to come

My questioning here is respectful of Joe, it reflects empathy for his lack of power in this situation. The two questions are inquisitive, however as I analysed this, I realized that I was not being genuine in asking him these. I already knew it was Mum's idea for him to see me, however these questions infer I do not have that knowledge. This example illustrates the power imbalance in our relationship.

That Joe feels he has been "duped" into seeing me makes me feel uncomfortable, as can be seen in our continuing conversation:

C: Oh… OK… well… seeing that you're here… and, thanks for coming Joe… so, seeing you're here and Mum's wanting you to see me, how do you think this might be helpful to you?

J: I don't know

(pause)

C: What are your Best Hopes from coming to see me?

J: Ummm…

(pause)

The discomfort I feel is illustrated by the slowness of my sentence at the beginning of this example. I am tentative in what I say, mindful of the words I choose to use and how they might be construed. I allude to the reality of our situation, "…so, seeing you're here and Mum's wanting you to see me…", and invite Joe to take control, "…how do you think this might be helpful to you?". Joe's reply leaves me feeling unsure. I had asked him a *Best Hopes* question three times and I was uncertain if he had understood the question or if he just needed more time to formulate an answer.

Example 2: Fred – engaged but unsure

This example examines the first session I had with Fred. It is another illustration when there is no clarity of understanding in a conversation between a counsellor and a client.

Fred and I spent some time at the start of the session talking about his home life, family and the things he enjoys spending time doing. Fred, as most of my clients are, had been referred by an adult. As previously noted in Example 1, this adds a power differential to the relationship dynamic. I was mindful that I had some knowledge of the reasons he had been sent to see me and aware that this would bias how I chose to converse with him. I did not explicitly refer to the knowledge I had, preferring to let Fred bring his own perspective into our discussion when he was ready to. As I noted in my post-session reflections, Fred participated willingly in our conversation and was engaged in our dialogue, *"He appeared happy to be there"* and *"was pleasant, smiling throughout".* We had discussed the process of counselling and Fred disclosed that he had seen a counsellor in the past. Although I did not explicitly ask him, I immediately sensed his reluctance in having counselling for any problem he may have. The following example begins twenty minutes into our first session:

C: Fred, I'm going to ask you a question… are you ready for it?

F: Yes (said confidently)

*C: OK (*laughing)*... what are your Best Hopes from seeing me?*

F: (pause)… I dunno…

The beginning question illustrates a demarcation of purpose in a session. It is a way of separating the initial introductory part of a session with therapy itself (Hanton, 2011). Using his name indicates respect for Fred, and the question itself gives him an opportunity to choose whether to engage or not in the process. My tone is playful and upbeat. I speak quickly. As I listen to the recording, I think I sound disingenuous, as if I am trying to entice him, persuade him that this is going to be fun. The data here indicates there is a gap between Fred and my expectations for our time together.

Fred responds as I expect, with a confident "Yes", indicating his understanding of, and engagement in, our conversation. This is the first time I have examined how I demarcate introductions and therapy work in a session and I find myself wondering how I might have proceeded had Fred responded negatively. As I respond to Fred's confident "Yes" my tone changes. I begin by saying "OK" in the playful, upbeat tone I had been using. I then ask the first therapeutic question of our session, *"...what are your Best Hopes from seeing me?"* and my tone changes to one of seriousness, as well I slow my words down. The question I ask is similar to the *Best Hopes* question I had asked Bethany, who I had asked, *"..., what are your Best Hopes from working with me?"* and the intention is the same. As I wrote previously, this *Best Hopes* question carries SFBT assumptions of c*lient as expert* and is posed curiously from a *not-knowing* perspective. It has a broad focus on the long-term and is connected to our work together.

In the continuing dialogue, Fred pauses for four seconds before replying "I dunno". He sounds mildly confused and a little annoyed at my question. I take my time in replying, leaving a gap of about five seconds before I validate his response saying:

C: (pause)… *Tricky question, eh…*

F: (smiling) Yes! (laughing together)

Fred's reply of "Yes" is said with conviction. It *is* a tricky question and we both laugh in agreement. How I continue at this point is based on my perception of his understanding of my *Best Hopes* question. I am hoping that he has something in mind that he wants to work on with me and I am hoping to tease this out. Fred response of "I dunno" after a pause, indicates that either he does not understand the question, or that he understands but has no goals for working with me.

The data show that perhaps there is a mismatch in our perceptions of what is being asked. My hope is that my question will elicit a response from Fred where he will reply with what he would like different in his life. Fred's responses, however, leave me feeling that this is not clear. My post-sessions' reflections note the challenges I was feeling throughout the sessions: "…*He sighed a lot. Like, either I was asking difficult questions for him to answer or he was sighing because the questions didn't really interest him. I felt intrusive, like I was bothering him, wasting his time…. He appeared happy to be there, but I got the sense he did not want to discuss the reasons he was with me…".* I was unnerved, as is frequently the case when a session does not flow in a way that follows a 'best-case scenario' of counselling practice (De Jong & Berg, 2013).

Example 3: Joe – perhaps this will be helpful?

In this example I returns to Joe's first session, in which Joe and I navigated a shared understanding of what he would like different in his life and how this might happen. Each time I got a glimpse of something that sounded like it might be a possible goal for Joe to work on, I would tentatively suggest it and Joe would respond by telling me that he did not have a problem. For example, Joe had suggested that he could be "more positive" by playing "basketball and hang[ing] out with his friends after school". He then stated "I do that stuff mostly anyway". Joe felt he did not have any problems

at this time and when faced with imagining a preferred future, Joe's perception was it is already happening, so in his eyes, he didn't need to come.

This excerpt is taken from near the end of our first session and illustrates my stance as a SFBT practitioner, believing in my client's competence, that they have their good reasons for thinking and responding in particular ways. It demonstrates how this approach helps me to guide our conversation, even when I am unsure whether there will be therapeutic benefits. Joe had mentioned 'stress' as one of the things that was bothering him at the time. I picked up on this and asked:

> *C: Is stress something you think might be helpful to work on here? As something you'd like different?*

This question has the same intention as asking a *Best Hopes* question. The focus is on the future and points to the work we will do together. Here, however, I direct Joe's *Best Hopes* by explicitly asking if 'stress' is something he'd like different. Joe counters this saying:

> J: I used to feel anxious and stressed but not really anymore

I then became curious as to what he had done that had helped:

> *C: Wow Joe. That tells me that things are different now. That you used to feel anxious and stressed but not really anymore… what do you think has helped make things different?*
>
> J: I don't know
>
> *C: Mmmm…. Sometimes it's tricky to know… sometimes things change and we don't really notice… maybe we could talk about stress a bit and how it links to our bodies and our mind, maybe work on some stuff that might help you feel a bit more positive, especially at home and also at school… what do you reckon?*
>
> J: Yeah (sounds unsure).. I guess…
>
> *C: We can start there anyway… since Mum wants you to come and see me… and then we can change stuff as we go. How about that?*

J: OK

Here, Joe reluctantly agrees, and I take this as clarification of a goal for our work together.

This example illustrates how, when working with young adolescents, there are many different underlying forces at play. Issues that can be challenging when working with young adolescents include: being mandated; power and control; stigma of counselling in schools; and reluctance to engage in counselling. Our conversation here, **directed by me**, forced Joe to reflect, to think about what could possibly be different, and/or what he has already done that helps. My core belief remains that talking is helpful, and my hope is that the conversation we had flicked a switch for Joe or, perhaps, sowed a seed toward change.

In conclusion, the data from Joe and Fred illuminate the difficulties raised when a client answers a *Best Hopes* question in a way that suggests our understanding of the conversation does not align. In contrast to Theme 1, the conversation resulted in my feeling uncomfortable and not genuine. I had to work harder to think how best to navigate the awkwardness of our interactions. Even though these conversations did not flow smoothly like those from Theme 1, the questions I asked enabled us to explore possible goals for therapy. The data show that perhaps it is not always necessary to formulate specific goals towards change, perhaps a conversation around how life could be different is enough to begin.

Theme 3: Different perspectives can be helpful

This theme explores different ways of asking a *Best Hopes* question and how these might be helpful in eliciting what a client would like to be different in their lives. The questions illustrated in the following three examples encouraged the clients to see their situation from a different perspective.

Example 1: Fred – exploring possible goals from a different perspective

In our first session together, when I asked Fred about his *Best Hopes* from seeing me, he did not answer the question. Here, I return our conversation to possible goals for therapy by asking:

> *C: …What do you think?... …If I said to you, when you don't need to come and see me anymore, what are you going to notice, that's different or better?*

This example illustrates a different kind of SFBT *Best Hopes* question. The intention and assumptions held in this question are the same as when I asked Fred, *"What are your Best Hopes from seeing me?"*. Both questions are future and long term oriented, aiming to help Fred explore possible goals for therapy. Both ask from a stance of curiosity and *not-knowing*, and assume that Fred has some ideas of his own about how counselling might be helpful to him.

The way this question differs from the first, is from the perspective it offers. *"What are your Best Hopes from seeing me?"* asks the recipient to consider what will be helpful as they look into the future, to explore how therapy might be helpful to them. Asking *"When you don't need to come and see me anymore, what are you going to notice, that's different or better?"* considers therapy from the end point and looks backward. It assumes there is an endpoint to counselling, *"…when you don't need to come and see me anymore…"* and that counselling will help, *"… what are you going to notice, that's different or better"*. It places Fred at the centre, *"…what will* you *notice",* implying something concrete will be different as a result of the counselling process (Shennan, 2014).

My hope is that asking this question will help elicit a reply from Fred that is different from when I first asked him about his *Best Hopes*, a reply that will indicate he and I have a shared understanding of our conversation which will lead to a detailed conversation about what it is he would like different in his life and how this might happen. Fred, however, responds:

> F: I don't know (sounding confused)

Either Fred understands the question and really does not know, or he does not understand the question. In this instance, reframing the *Best Hopes* question to encourage the client to view their situation from a future perspective has not helped.

Another way of asking the *Best Hopes* question in a different way is to ask a *relationship* question. As outlined in my Literature Review (Chapter 2, p. 22), *relationship* questions support clients to construct new meanings towards change by using a reflexive process, viewing themselves from a distance and reflecting on how others might perceive them in this context (Berg & De Jong, 1996; De Jong & Berg, 2013). The following two examples explore the use of *relationship* questions.

Example 2: Bethany – things will be better

Bethany's goals are diverse. She gets excited describing her preferred future and speaks in broad life terms, rather than specific. For example, in our first session together, she commented that it's "hard to be myself". The following examines how asking a different kind of *Best Hopes* question can prompt clients to respond in detail, in the process offering themselves and the counsellor glimpses of hope and resilience.

Toward the end of our second session together, when discussing Bethany's *Best Hopes* of having more friends, we create a list called 'When I'm a good friend'. This is part of that interaction:

> *C: Cool, hey… what do you think your friends will notice about you* (reading off Bethany's 'When I'm a good friend' list) *when they're looking and listening and responding to your questions and supporting you with your feelings?*

I have purposely chosen my words to be future focused, what her friends "will notice… when", which presupposes this is going to happen. This *relationship* question asks Bethany to examine her situation from the perspective of her friends. Her reply is optimistic:

B: That I'm kind of a good person

C: Yeah! (sounding enthusiastic) *So, they'll know that you're a good person…*

B: Talkative… I'm not good at talking but I can give advice at times

C: Nice! Nice! So, what else will they notice about you, that tells them that you're a good person?

Our conversation continues. As Bethany adds to her list, I respond positively, complimenting and reinforcing by echoing back what she is saying. I use "…*what else…*", because, from a SFBT stance, I assume there is more. Bethany adds:

B: That I've changed

It is in this moment that Bethany is clarifying her preferred future, articulating what her friends will notice about her that is different to now, how she will be different, and what is going to make a difference. As described in my Literature Review (Chapter 2, p. 26), exploring the client's preferred future is integrally bound to *goal-setting* in SFBT and helps in establishing the direction of therapy (De Jong & Berg, 2013; Hanton, 2011; Shennan, 2014). The details of Bethany's preferred future include: "listening to her friends"; "saying 'fudge' instead of swearing"; "socializing more"; being "nice"; and being "accepted". All of these express hope and focus on how to live life well. Furthermore, the connotations of this conversation reflect client competence, indicating that Bethany has the skills to work out what it is that will help improve her life.

Example 3: Fred - reflexivity in action

This example returns to my conversation with Fred, this time referring to Fred in the third person and asking a relationship question:

C: What do you think Mum might notice that would tell her, oh, you know what, Fred doesn't need to see Jude anymore?

In this example I use the word ‘notice’, suggesting something concrete and specific, and change the question to include an external perspective, Mum. This is another question with underlying assumptions, that there is an endpoint to therapy and that the process of counselling promotes some kind of change. When asking Fred, my tone is upbeat and curious, I place an emphasis on the word “Mum”. Saying *“Mum* might *notice”* not *“Mum* would *notice”* is tentative and gentle. As Berg and De Jong (1996) note, this question requires Fred to be reflexive in his response. I am hopeful that asking this question may help Fred view therapy differently, that changing the *Best Hopes* question to an external, *relationship* question, will help him in the process of reflecting and articulating his hoped-for outcome from seeing me. Fred, however, replies quickly with:

F: I don’t know

He is starting to sound quite frustrated with me. There is then a long pause in our conversation.

I choose to continue to focus our conversation on possible goals for our work together and ask:

C: …(pause)… *Hmmmm… what about Mrs X? What do you think Mrs X might notice, that would tell her, oh you know what, I don’t think Fred needs to go and see Jude anymore?*

This is another example of asking a client about their goals for therapy using a reflexive relationship question. This time I am inviting Fred to think about what his teacher might notice as a result of him coming to counselling. What follows is an illustration of how my tenacity in asking SFBT questions starts to elicit possible goals. Fred replies:

F: I don’t know… (long pause)…because I don’t really get angry anymore because people don’t annoy me every single second of the day

C: Right (long and drawn out)… *so… you don’t get annoyed every second of the day? Do you get annoyed sometimes?*

F: Yes

C: Ohhhhh….

In answer to my question about what his teacher might see different, Fred begins by saying, “I don’t know”. There is a long pause after this while I choose to give Fred extra time, a technique which has been described as sometimes helpful (De Jong & Berg, 2013; Hanton, 2011; Shennan, 2014). Fred then proceeds to explain why he hasn’t been able to answer my questions about what could be useful to work on in our sessions together. He says this is “…because I don’t really get angry anymore…”, suggesting he does not consider himself to have a problem. I validate this, saying “*Right”* and accentuating the ‘i’ by drawing it out. For me, this clarifies Fred’s stance in our dialogue and explains his good reason for not wanting to partake in the counselling process. I then echo his words, adding, “*Do you get annoyed sometimes?”.* I am curious as to whether Fred feels he has no problem at all, or if perhaps this indicates there may be something here we could work on in our counselling sessions. Fred replies in the affirmative, to which my drawn out “*Ohhhh*” affirms his answer and indicates I understand. Clarifying that he does “get annoyed sometimes” is sufficient for me to consider working on this as a possible goal for therapy and is certainly one worth exploring further (Shennan, 2014).

In conclusion, each of these examples illustrate co-construction occurring in therapy. My questions build on what we have already said and there is a constant backwards and forwards of dialogue as we each work towards a shared understanding of our conversation. In exploring how different *Best Hopes* questions were asked and answered, the data implied that knowing how to remain focused on *Best Hopes* and being able to ask about this in different ways was beneficial to clients. Also illustrated was my intention when a session does not run smoothly and does not proceed as I hope, to trust in the process of SFBT and draw on my knowledge of SFBT assumptions, such as; believe in Fred and his competence in knowing himself, accept he has his good reasons for how he is responding, and remaining curious and respectful.

Theme 4: The client is expert

This final theme examines how the conversations I had with my young adolescent clients were often challenging. Four examples illustrate those challenges and suggest the importance of two things in particular. The first is the building and maintaining of the therapeutic relationship. The second is that from a SFBT stance, knowing that the client is a competent individual who has the strengths and skills needed.

Example 1: Bethany – returning the conversation to goals

Formulating goals in therapy is not a straightforward process of asking one question, hearing the reply, then agreeing on a chosen goal. This example demonstrates how the process is complex, takes time and is driven by the counsellor. Throughout our session together Bethany appears to enjoy our conversation and is happy to talk with me, listening and responding with enthusiasm. This enthusiasm, however, frequently bubbles over and Bethany often takes the conversation to another topic. When asked her *Best Hopes* Bethany had mentioned, "pushing my limits". Our conversation then went off on a tangent about what her life will be like at high school. I purposefully return to goal formulation and say:

C: …I love it…(pointedly going back to the goal list, writing on sheet) pushes my limits…

B: Not in a bad way

C: No, not in a bad way

B: Like, pushes my limits like, dying my hair like how I want it to be, because that makes me, me and getting my nose done coz that's what I want…

C: So… how am I going to help, getting to (high school)?

I remain respectful and curious here, listening intentionally, using vocabulary such as "How…" to formulate open questions which invite further discussion. My repeated use of Bethany's own words, *"push my limits", "not in a bad way",* reinforces her responses, implicitly encouraging her to be

involved in discussing possible goals for therapy. This example reflects my interest in her and her life, my faith in her competence in figuring out what she wants from the counselling process.

This extract also illustrates some of the challenges when working with young adolescent clients which add to the complexity. Bethany stated, "dying my hair" and "getting my nose done" are two examples of goals she would like to achieve. Although these particular goals were important to her and were specific enough to add to her goal list, the 'mother' in me had been alerted and I chose to ignore them. Instead, I redirected our conversation back to formulating a goal for our time together by asking a different kind of *Best Hopes* question, "*So… how am I going to help, getting to (high school)?"*. Choosing not to focus on something that I perhaps do not agree with, and that I find difficult to empathise with, illustrates an instance of respecting and accepting Bethany without judgment. Allowing Bethany to express herself without my critique is a highly regarded professional value of SFBT (De Jong & Berg, 2013). Accepting Bethany without judgment helps enhance a relationship of cooperation and trust between the two of us.

Example 2: Bethany – clarifying a goal

Clarifying the goal for therapy can also be complicated. As Shennan (2014) notes, SFBT conversations are constantly moving, with changes in focus from wide and abstract, to narrow and specific, then back again. Throughout our session, I invite Bethany to add to her *Best Hopes* list by asking the SFBT question "*What else?"*. The underlying assumption of this question is that there is more, it alludes to client competence, in having the ability to answer the question in detail (Hanton, 2011). Bethany's list includes, "get me ready for high school", "me smiling, happy", "I feel OK to hang around with others", "I feel comfortable with people" and "make more friends". To help Bethany clarify her main goal for therapy at this time, we look at her *Best Hopes* list and I ask:

C: What would you put as number one on your list? As most important to you?

B: Make more friends…

C: Nice

B: Make more friends…(repeats herself as I write the number 1 next to 'make more friends on the Best Hopes list)

C: I've put 'make more friends' as number one, is that alright?

B: Yep!

The two questions I ask at the start of this excerpt suggest that although we are co-constructing goals together, ultimately it is Bethany who is expert, it is her voice that counts. The words '*your list*' and '*most important to you'* indicate that the work we do together belongs to her. The written list is helpful to return with Bethany quickly pointing out the goal that she felt was most important and writing '1' beside it to clarify her choice. My comment "*Nice*" was complimentary, a positive reinforcement of her choice. Bethany's "Yep!" at the end indicates she is pleased with herself and with this process, that 'making more friends' is the goal she feels is most important to pursue at this time. I assume that Bethany's enthusiastic "Yep!" is enough to be considered something we can focus on in our work together (Shennan, 2014).

We then begin to explore Bethany's preferred future, how she might know her goal is happening.

C: What kind of difference will that make?

B: Not being lonely at lunch

My question is open and inquisitive, asking how her goal might be useful to her in reality, "*What kind of difference…"*, and is focused on the future, "…*will that make?*". It is a reflective question that assumes it *will* make a difference somehow (Shennan, 2014). As well, it changes the focus of our conversation from the work we will be doing in therapy, to an emphasis on the real world outside (Hanton, 2011). To answer, Bethany has to reflect on what it is that will happen as a result of

"Make[ing] more friends" and describes her preferred future as "Not being lonely at lunch". Her answer is real-world, specific and directly related to her goal. It is however, worded in the negative.

From an SFBT stance, *goal-setting* is directional. The focus is on what it is the client wants to be happening as a result of therapy, rather than what they do not (Froerer et al., 2018; Hanton, 2011). When I asked Bethany how she perceives what will be happening as a part of her goal, her reply is focused on an absence of her problem ("Not being lonely at lunch"), rather than a description of what will be happening when she has made friends. SFBT requires the counsellor to help the client reframe an answer like this (Hanton, 2011). For Bethany I am interested in what her life will look like when she has made friends, so I was hoping she would reply with something like, "I'll be sitting with my friends at lunch". To help Bethany reframe her thinking, I use her words to formulate my next question, beginning with a compliment, "*Nice"*, and adding 'instead' at the end:

C: Nice… so, when you're not lonely at lunch, how are you going to be feeling, instead?

B: Better!

C: Better? Cool. Do you think you'll be smiling and happy when you're not lonely at lunch?

B: Yep!

When I listened to this excerpt, I realised that I altered the focus of Bethany's goal from an action to an emotion; from being lonely, to feeling. It may have been more useful to attach my 'instead' question to the same action in which case I would have asked, "*…so, when you are not being lonely, what are you doing instead?*". Nevertheless, in the excerpt above Bethany's answer as to how she will be feeling when not lonely is a broadly focused enthusiastic, "Better!". I am quick to respond, reinforcing and affirming her reply. In my hope to elicit more specific details of Bethany's preferred future, I return to the written *Best Hopes* list and use specific words she had chosen and ask if she will be, "*…smiling and happy…*". Bethany confirms with a confident, "Yep!", verifying our continued shared understanding of our conversation.

This example illustrates active co-construction of Bethany's goals. The language I used, Bethany's responses and the attention I paid to her as she spoke, were all part of some kind of circular motion of connection within the conversation. We were both engaged and the conversation seemed to flow with ease. The data showed many instances of Bethany being competent and the expert of her own life and experience. Co-constructing possible goals is a process that occurs together (Berg & De Jong, 1996), the relationship we have being the glue.

Example 3: Fred –it's about the client

The data here demonstrates working *with* a client, respecting and supporting their views, placing them at the centre, acknowledging their expertise. I work hard to maintain a focus on Fred as well as on the process of exploring his hopes for counselling. This excerpt begins at a point when I am not certain of Fred's understanding of our conversation, which is noticeable in my use of lots of words, interspersed with pauses:

> *C:* (laughing with Fred)… *What do* you *think?* (pause)... *Coz you know what?*... (pause)…*Students come and see me for* heaps *of different reasons*….(pause)… *But, this is about you, isn't it?*....(pause)… *and for* your *good reasons for seeing me*…(pause)... *And I don't know, do you think I can read your mind?*

I speak slowly at the start; I am thinking hard as to how to proceed. I have an acute sense of awareness that whatever I say next and how I say it, is important to Fred's and my conversation, our shared understanding of what it is we are talking about. My question *"…What do you think?"*, is a grab at time. My curiosity here reflects my thinking that perhaps we did not explore the counselling process well enough together, perhaps Fred does not understand that the *Best Hopes* question is about imagining life without issues and exploring change. The exaggerated inflection I use when

saying "*heaps*" implies a normalising of counselling and when saying "*your*" implies Fred is the expert of himself, only he knows how counselling might be helpful to him.

There are many pauses in my monologue and Fred is not adding a response. I am struggling with what to say next so I go to one of my standard fallbacks when I realize the line of questioning is not quite going to plan in a session, and ask, "…*do you think I can read your mind?".* This is said quickly, and my tone becomes upbeat and playful again as I attempt to keep Fred engaged. Fred replies quickly here, indicating his understanding of the question:

F: No

C: No. Thank goodness. Can you read my mind?

F: No (smiling)

C: No (laughing)

F: I'm not psychic! (laughing)

This very brief banter lifts the mood, Fred had been respectfully listening and his joke about not being psychic assures me he is still engaged. I laugh and agree with him, saying:

C: No, you're not (laughing*)…*

I continue, returning to what I hope will help Fred explore some possible goals for therapy. My tone is thoughtful, a little more serious. The verbosity of this passage alongside the many pauses, again illustrates how hard I am working:

…(pause)… *and I always say…*(pause)… *I always say…* (pause)…*everyone wants something to be different or better in their lives…* (pause)…*Sometimes it's a bit tricky working out what that thing might be…*(pause)…

I attempt to explain the counselling process slightly, "…everyone wants something to be different or better in their lives…" and I empathize with Fred in this situation, "…sometimes it's a bit tricky working out what that thing might be…". This is all said rather slowly, the pauses allow me to think

about what to say next and give Fred time to hear what I am saying as well as to respond if he chooses. Fred listens but does not say anything.

This example illustrates how I remained attuned and alert to Fred, placing him at the centre of my focus. The data here also illustrate the complexity of language use when attempting to construct a shared understanding (Berg & De Jong, 1996). As the counsellor, the words I use and the way I use them will affect Fred's interpretation of my intent. I have my own understanding and for me it is clear, however Fred's perception is his alone, influenced by context and experience (Berg & De Jong, 1996). I remain respectful of him being his own expert.

Example 4: Fred – "I don't know"

In this example I explore what happens when clients respond in ways that are unsettling. It was common for Fred, throughout our conversations together, to respond to a question with, for example:

F: I don't know (sounding confused)…(pause)… (sigh)…

Taken from our first session, this reply is Fred's second "I don't know" in succession. It is said almost immediately, suggesting he understands what I had asked him and is engaged with me and our conversation. However, Fred's tone here is quizzical and he sounds uncertain. There is a long pause after he says this, followed by Fred audibly sighing. Sighing can indicate feelings of sadness, boredom or tiredness according to Teigen (2008). They can also be a non-verbal marker of communication, signaling that the individual is finding the situation or the person they are talking with stupid or hopeless. When Fred sighs, I hear it and it unnerves me. There is a pause in our dialogue as I consider my next question.

My perceptions of how Fred is choosing to respond is coloured by my interpretation of how and why he is saying this. At first, because he sounded confused, I think he doesn't understand the question.

Then when he sighed, I wondered, as I had written in my reflective notes, *"Is he bored?"*. He was starting to sound irritated. When analysing this excerpt I think that I was working hard to think about what is happening between us, to remain calm, positive and curious with the hope of retaining Fred's attention. I want him to want to work with me, but I am sensing he does not.

Although I am used to hearing "I don't know" from my young adolescent clients, it can be challenging for any counsellor (De Jong & Berg, 2013; Shennan, 2014). Shennan (2014) considers clients answering with "I don't know" to be not uncommon, as the questions a SFBT counsellor asks can be unusual and difficult. Clients can answer in this way if they perhaps, really don't know, don't understand the question, or understand the question but are unwilling to answer (De Jong & Berg, 2013).

This short excerpt is an example of how sometimes clients respond to questions in a way that can challenge us. As I analysed Fred's data, it was noticeable that working *with* Fred, as De Jong and Berg (2013) note, was key in ensuring his continuing engagement in our conversations. Each time Fred responded this way I returned to my core beliefs as a counsellor, continually working to build and maintain a cooperative relationship with him, and persistently assuming his competence.

In conclusion, working with young adolescents can be challenging for many reasons. I found the analysis of data in this theme allowed me to explore and understand my responses and responsibilities as a counsellor when working with this cohort. The examples demonstrated the complex processes involved in formulating goals for therapy and how these are driven primarily by the counsellor. I found it important to place the client at the centre of the conversation, accept them without judgment, and acknowledge their expertise of their lives, experience and competence. I

worked to ensure our continual connection; this relationship being the foundation of all conversations we had.

The findings conclusion

The analysis of the data generated four distinct but connecting themes. Of the four young adolescents who participated in this study, two responded to *Best Hopes* questions with ease and two did not. All the themes examined the complexities of goal setting in SFBT and working with young adolescents in detail.

The examples in Theme 1 demonstrate an alignment of shared understanding between me and the clients, one where we implicitly agree on the process of therapy. As Shennan (2014) suggests, there is a distinction in a conversation between a client's *Best Hopes* or what it is they would like to see different in their life, and a client's expectations of the therapy process itself. As a SFBT practitioner, my expectations of the counselling process include; that talking helps, that within our talking we will address issues and explore change. Being on a similar tangent appeared to not only enhance the therapeutic process of exploring and establishing how life for the client will be different, but also bolstered the relationship between us, and helped the session flow with a sense of pleasure and ease.

Theme 2 examined what happened in conversations when I asked a *Best Hopes* question and the result was not as I had hoped or expected. The client responded in a way that made me unsure as to their understanding of the question and/or of their engagement in the process of working with me. These sessions were challenging, and the data show I had to work harder. I needed to ask: different questions to establish the goals for our work together; use different techniques in attempts of engagement; remain positive with my responses; and feel positive about the work I was doing. Examples demonstrated a misalignment in a shared understanding of the conversation between me

and the client. I suggest here that perhaps a focus on the goal is not completely necessary. Rather, it is the questions asked and the subsequent conversation which enables a process of reflection towards positive change.

Theme 3 examines the SFBT process in closer detail, presenting different kinds of *Best Hopes* questions alongside responses analysed. The data in this theme indicate the subtleties of language use in SFBT. They show that goals are co-constructed collaboratively, and that key to this is the ability to follow the client's conversation closely. This theme highlights the language used in SFBT and suggests that to be helpful to their clients, counsellors need to understand the process of SFBT and foster the skills and techniques used within it. Examples demonstrated the importance of understanding the process, the intention of what you are asking, and using this to be able to ask questions in different ways.

Finally, the examples in Theme 4 explored some counselling fundamentals; the therapeutic relationship and the SFBT assumption of the client being the expert of their own lives. This theme indicates that working with young adolescents in therapy is complex and counsellors use core counselling and SFBT skills to enhance engagement. All the themes demonstrated that guiding a goal setting conversation using a *Best Hopes* question with young adolescents is a complex process. A knowledge and understanding of SFBT questions and techniques is required, as well as a plentiful supply of subtle abilities that help foster a connection with the client and maintain a focus on exploring possible goals for therapy.

Chapter 5: Discussion

Introduction

The purpose of this qualitative research project was to examine how goals are co-constructed with young adolescents in SFBT counselling sessions in an Aotearoa New Zealand intermediate school using the *Best Hopes* question. Also considered in this study, was how asking the *Best Hopes* question might be helpful to young adolescents in counselling, and how I, as a SFBT counsellor, might ask young adolescent clients the *Best Hopes* question in a way that would be helpful for them. *Goal-setting* conversations with four young adolescents were recorded and the data were examined using thematic analysis. Four main themes were generated from the data. These themes were explored and outlined in the previous chapter. The findings are of interest, reflecting much of the known research regarding co-constructing goals in SFBT and providing some new insights for counsellors working with young adolescents. In the following sections I return to the aims of this research and explore the findings alongside relevant literature. I consider the implications for practice and discuss the limitations of this study.

How goals are co-constructed with young adolescents in counselling using the *Best Hopes* question

In SFBT goals are co-constructed with young adolescents within a collaborative relationship, enhanced by a therapeutic relationship

Although a small number of the young adolescent students I work with request therapeutic services at school, the vast majority are mandated to counselling by a concerned adult in their life. All four of the participants in this study were mandated and as previously mentioned, it became quickly evident that two of the participants engaged willingly in counselling, and two engaged, but were perhaps a little less willing. A main finding from this study, in line with the literature and apparent throughout

all the themes, suggests that, in SFBT *goal-setting* conversations with young adolescents, goals are able to be co-constructed within a collaborative relationship and that the therapeutic alliance helps to enhance this (Barbrack & Maher, 1984; Childers, 1987; Cook-Cottone et al., 2015; Costa et al., 2017; Jacob et al., 2017; Jacob et al., 2016).

A great deal of the literature has previously noted that for any therapeutic approach, the quality of the therapeutic relationship between the client and the counsellor, influences the client's outcome of therapy (Bolton Oetzel & Scherer, 2003; Geldard et al., 2020; Knight et al., 2018). The therapeutic relationship, or the personal dynamic that occurs between the client and the counsellor, is also an important factor in SFBT and should not be dismissed (Hanton, 2011). However, some research suggests that it is the collaborative relationship between the client and the counsellor, rather than the therapeutic relationship, which positively influences client therapeutic outcome in SFBT (Berg & De Jong, 1996; Froerer et al., 2018). In SFBT the collaborative relationship is made possible because of the social constructionist perspective that underlies the approach. This perspective encourages an interactive working dynamic within conversations (De Jong & Berg, 2013). Rather than separating the two types of relationships, the findings from this study suggest that they are interdependent; building a positive therapeutic relationship with a young adolescent client in SFBT appears to help engage them in therapy, and this therapeutic relationship enhances a collaborative relationship.

For example, data in Theme 1 demonstrated a 'positive symbiotic relationship' (Findings, pp. 55-61), which was formed as the clients and I engaged with each other and worked together to co-construct goals. Many instances noted throughout the findings suggest that positive therapeutic relationships guided by my own values as a counsellor, were built with all the participants and that these helped to engage the young adolescent clients in conversations about goals. For example, the way I spoke with clients, such as being respectful, non-judgmental, and curious with my questions, placed the client at

the centre of our conversation and helped to build our therapeutic relationship. From a SFBT stance when working with Fred (Findings, pp. 70-72), the data illustrated that I remained focused on him, respecting his expertise with a *not-knowing* stance. My curiosity in attempting to elicit what it is *he* thinks will be helpful from therapy is evident and it appears to be helpful in guiding the conversation toward goal-setting. When Bethany (Findings, pp. 73-74) began talking about wanting to have her nose pierced, I responded without judgment, gently refocusing the conversation back to goal-setting. These conversations all demonstrate a collaborative relationship that is enhanced by a therapeutic relationship. The skills and assumptions that may be helpful for counsellors working from a SFBT approach in building and fostering collaborative and therapeutic relationships with young adolescents are discussed later in this chapter. The findings of my study are consistent with, and extend, that of other research such as Froerer and Connie (2016, p. 25), who report that the therapeutic alliance and the co-constructive collaborative process in SFBT are synonymous, and note that a collaborative process begins as soon as the counsellor and client meet, with the counsellor fostering this by "taking a 'curious', 'warm', and 'accepting stance'…". Similarly, Nai and Rodgers (2017) suggest that in SFBT, the collaborative relationship links to the change process, or how new meanings are co-constructed with clients, and this is enhanced by the therapeutic relationship.

The co-construction of Best Hopes conversations is guided by the counsellor

For a collaborative conversation to be helpful to a client, it has been suggested that therapists need to be skilled in the SFBT process and its techniques (Iveson & McKergow, 2015). My study's findings indicate that when asking young adolescents SFBT *goal-setting* questions in counselling, it is important for counsellors to understand the process, within which the techniques sit. Thus, by understanding the intention of the *Best Hopes goal-setting* question, I was able to pose it in different ways when clients did not respond as expected in a *goal-setting* manner. The data from Theme 3, example 1 (Findings, pp. 67-69), demonstrated the value of asking a future focused *goal-setting*

question by incorporating a different perspective, in this instance by asking Fred to consider what might be better once therapy has finished. In Example 2 of the same theme (Findings, pp. 69-70), I use a *relationship question* and ask Bethany what others might notice that will be different once the problem is not there. In Example 3 (Findings, pp. 70-72), I ask Fred *relationship questions* in the hope that changing the *goal-setting* question to one with an external perspective, might be helpful in prompting Fred's *Best Hopes* for therapy. Each of these examples demonstrate conversations that remained focused on what it was the client wanted from therapy. In each I asked about *Best Hopes* in different ways without changing the intention the question. While the outcome of these different ways of asking the *goal-setting* question was not always a clearly articulated client goal, the findings support SFBT literature and widen it to include the young adolescent cohort, suggesting that there are many different questions which can be helpful to clients when *goal-setting*. In this case, and as highlighted by SFBT research, being able to ask a *Best Hopes* question in a variety of ways helped keep the focus of the *goal-setting* conversation on what it is that the young adolescent client would like different in their life when their problem is solved (De Jong & Berg, 2013; Froerer et al., 2018; Hanton, 2011; Shennan, 2014).

Language is used to co-construct goals with young adolescents

SFBT literature suggests that positive client outcome is about a personal shift or change as new perspectives are developed and language moves to become more optimistic (Froerer & Connie, 2016). *Goal-setting* conversations are considered integral to this solution-building approach (De Jong & Berg, 2013; Froerer & Connie, 2016) and as discussed in the literature review (Chapter 2, pp. 24-25), language is particularly important. Connected to social constructionism, language shapes how we think about and perceive situations, and in SFBT the intentional use of language by counsellors helps clients construct new realities. The findings from this study suggest that this also occurs when working with young adolescent clients. For instance, this study indicates that the words

we use can be a powerful tool that can guide positive conversations and help build and foster collaborative therapeutic relationships. Furthermore, using the SFBT grounding technique of *listen, select, build*, can enhance the co-constructive collaborative process of *goal-setting*. The following paragraphs demonstrate these two findings.

This study is consistent with the work of Froerer et al. (2018) that suggests it is helpful for therapists to be purposeful in their use of language as specific language can shape and guide *goal-setting* conversations. The extra element, however, is that, in my study the guiding conversations are with young adolescents. Words hold assumptions, and when used, can be powerful. As Froerer et al. (2018, p. 25) maintain, "…*language is the tool for thought, and thus the language we use in SFBT is the vehicle for helping the client change the way they think*…". One example is when I asked Bethany (Findings, p. 69), "*…what do you think your friends will notice about you…when…*". This question held two assumptions, firstly that her friends will notice something, and secondly, that something will happen. Further in the same example I asked Bethany, "*What else?*" a question which assumed there was more to her answer than had just been given. This assumption appeared to reinforce and affirm her response, supporting the notion that the *client is the expert* and at the same time helped build and foster our collaborative therapeutic relationship.

Research by Bolton Oetzel and Scherer (2003) and Reiter (2010) encourages therapists to use language that is positive and hopeful because it not only enhances the therapeutic relationship and encourages client engagement, but it also helps clients think about and develop an expectation of change. The findings from this study add to the literature by suggesting that positive and hopeful language benefits young adolescents in counselling. This kind of language, and the tone associated with it, encourages engagement of young adolescents in *goal-setting* conversations and assists them to reflect on, and articulate, not only what changes they would like to make in their lives, but also

what is going well. For example, when asking "What are your *Best Hopes* from working with me?", the words '*Best*' and '*Hopes*' are both uplifting and help change the direction of conversation from problem-solving to solution-building. In Theme 1 (Findings, pp. 55-61), Bethany and Miley responded to the *Best Hopes* question with lists of possible goals, to which I enthusiastically replied with, for example, "*I love it…*" and "*Oh, that sounds a wonderful plan*…". My positive responses reflected and encouraged their optimism and hope, and, helped continue their articulation of something they would like different in their lives. Even when, as the data indicated, conversations became stilted and the young adolescents could not answer the *Best Hopes* question, the language and tone I used helped to keep them engaged. For example, when Fred (Findings, pp. 63-64) replied to the Best Hopes question with "I don't know", I used an upbeat tone to say, "…*Tricky question, eh*…". The positive, playful tone I used encourages Fred to laugh which brings a sense of fun and helps to hold his attention. Other examples of SFBT *goal-setting* conversations that promote optimism and hope are, asking "…*how do you think this might be helpful to you?"*(Findings, p. 62) and "…*what are you going to notice, that's different or better?*" (Findings, p. 68). Additionally, conversations can be directed toward solution-building at times when the young adolescent client frames their answer as a problem they don't want, by using language that guides them to reflect in a positive manner. An example of this is the use of the word 'instead', such as "*...so, when you're not lonely at lunch, how are you going to be feeling instead?*" (Findings, p. 76).

This study also extends the SFBT research that suggests that using the framework of intentionally listening, selecting and building on the client's words helps shape the collaborative process when *goal-setting* (De Jong & Berg, 2013). Research by Iveson and McKergow (2015) and Froerer et al. (2018) highlight the importance of therapists having these skills. My study demonstrates that following a young adolescent client closely in the collaborative co-construction of goals, helps to acknowledge and validate their perspective, all the while maintaining a focus on their preferred

future. For example (Findings, pp. 56-57), writing a list of Bethany's goals as she articulated them, helped to affirm and clarify what she said, and as in another conversation with Bethany (Findings, pp. 69-70), I specifically chose the optimistic words she used to describe herself and I repeated them back to her in my response, "*…so, they'll know you're a* ***good person****…*". As suggested in the findings (p. 70), this helped in the work of building a shared understanding in counselling with Bethany and with the other young adolescent clients.

What asking the Best Hopes question offers young adolescents in counselling

Asking a Best Hopes question helps young adolescent clients articulate possible goals for counselling

Setting goals in counselling, as mentioned in the literature review (Chapter 2, pp. 15-16), is useful to both the client and the therapist as they help establish what it is the client wants from counselling and facilitate motivation and engagement in therapy. As SFBT research suggests, asking the *Best Hopes* question begins a process of co-constructing a shared understanding of what it is that the client wants, and the ensuing conversation helps make this clear for both the client and the counsellor (Berg & De Jong, 1996; Froerer et al., 2018; Shennan & Iveson, 2012). The findings of my study demonstrate that asking a *Best Hopes* question is consistent with existing research and demonstrate that asking *goal-setting* questions is beneficial to a client **of any age**. For example (Findings, pp. 55-57), Bethany responded to the *Best Hopes* question in a way that suggested she understood my intention for asking, and her enthusiasm indicated she was eager to explore new ideas of what life might be like in her ideal future. Bethany replied to the *Best Hopes* question by beginning to outline what it was she wanted different in her life.

Previous research has indicated that counselling can be helpful to adolescents with specific issues, as well as helping them in the longer term as they work their way through the developmental process of

forming their self-identity (Crocket et al., 2015; Gibson & Cartwright, 2014). The findings from this study lend support to the literature suggesting that SFBT *goal-setting* conversations can help young adolescents articulate a broad range of issues, especially when clients are willing to take part and are engaged in the therapeutic process. As I asked Miley and Bethany about their *Best Hopes*, they replied with answers that reflected their own lives and experiences, some were broadly focused and others quite specific. Miley said for example, she'll "…feel happy…I'll be positive, drawing, reading, writing…" (Findings, pp. 58-60). Bethany said, "Going to…a high school that I can be myself and I can push my limits and make my boundaries bigger and I can learn more things…" (Findings, p. 56). The co-constructive collaborative approach in our conversations appeared to promote their ability to articulate what it was *they* wanted from therapy. The data demonstrated that *goal-setting* conversations with young adolescents promoted a sense of agency in discussing specific issues and enabled a much wider discussion of making sense of life during their transition to adulthood.

The conversation itself can be helpful

When examining the data from this study it was interesting to find that when goals were not formulated it appeared that the conversations themselves were helpful to young adolescent clients. For example (Findings, pp. 65-67), as Joe and I discussed his possible *Best Hopes*, he had mentioned stress as something he considered to be a past issue. I felt that this was perhaps a start of a discussion that might be helpful for Joe and suggested that "*We can start there anyway*…". While this may indicate a counsellor led, solution-forced rather than a solution-focused approach and, as Nylund and Corsiglia (2019) suggest, risks alienating the client from the therapeutic process, this was not the case. Rather, the findings appear to support the literature that suggests therapists need to provide a delicate balance of support and proactive direction when working with young people (Bolton Oetzel & Scherer, 2003; Geldard et al., 2020; Nai & Rodgers, 2017; Prior, 2012). Although Joe had not

articulated his goals for therapy, when I took control and decided what we would talk about, he remained engaged in our conversation.

Additionally, this study indicates that even when there is a mismatch in the alignment of understanding between a young adolescent client and a counsellor, positive and collaborative conversations can continue, and co-constructions of new meanings might occur. For example, Fred (Findings, pp. 63-65) was engaged in our conversation but unsure in his responses. I remained focused on him and gave him time to formulate and articulate his answers and I trusted that the questions I was asking were helping Fred to reflect on what he might want different in his life. These findings support SFBT literature that suggests client change occurs within the co-constructive collaborative dialogue between the client and the counsellor (Berg & De Jong, 1996; Froerer et al., 2018; Nai & Rodgers, 2017). Perhaps, as the findings from this study suggest, the conversation itself is enough for young adolescents who, for whatever reason, are unwilling to engage in the therapeutic process.

How counsellors can facilitate a *goal-setting* conversation with young adolescents

Conversations about Best Hopes happen most easily when young adolescents are willing to participate and are engaged

As the literature notes, there appears to be an increasing number of young people experiencing mental health issues globally and limited services are available to address this (Bolton Oetzel & Scherer, 2003; Crocket et al., 2015; World Health Organization, 2019). The challenging nature of providing mental health support to young people can sometimes create a barrier. Research suggests that engaging and retaining young people in therapy seems to be key, but can be difficult (Bolton Oetzel & Scherer, 2003; Knight et al., 2018). The findings of this study demonstrate that when young adolescents are willing and engaged, the *goal-setting* process is more likely to occur.

According to Nai and Rodgers (2017), clients who benefit most from brief intervention are those who from the outset, are willing to engage in the therapeutic process. Similarly, Shennan (2014), suggests that when a client *wants* to take part in a dialogue, they are more readily engaged and *goal-setting* is more likely to occur. It appears that the findings in Theme 1 (Findings, pp. 55-61) support this research as they show that the two clients who were willing to engage in therapy appeared to respond to the *Best Hopes* question with many goals for therapy, and our conversations seemed easy as we worked together. Although these two clients appeared to benefit from therapy, some caution should be taken when interpreting the data. I would suggest that the findings demonstrate that when willing and engaged, my role as a counsellor is made easier, which is helpful to both the client and the counsellor in the overall therapeutic process.

Share an alignment of understanding

Previous research has suggested the importance of the client and the counsellor sharing an understanding of what it is the client needs and expects from counselling (Bolton Oetzel & Scherer, 2003; Gibson & Cartwright, 2014; Manthei, 2007; Shennan, 2014). The results from this study are consistent with this literature and extends them by suggesting that *goal-setting* conversations with young adolescents help clarify a shared understanding of purpose. The findings demonstrated that with two of the participants, Bethany and Miley, asking a *Best Hopes* question helped them articulate their needs and expectations with lists of goals related to things they would like different in their lives (Findings, pp. 55-61). The conversations I had with these two clients were collaborative and collegial, and the way they responded to questions implied that our understandings aligned and that this helped support their ability to discuss changes to the issues they had. As noted in the findings (p. 61), the relationship we formed was symbiotic. When there was a shared understanding of the expectations of counselling, and when the young adolescent client was willing and engaged, the

process of *goal-setting* was enhanced, conversations flowed smoothly and engagement in therapy was further enhanced.

There can be a mismatch in the alignment of understanding

Gibson and Cartwright (2014) maintain that young people's general understanding of the purpose of counselling sometimes differs from professional understanding. For example, young people tend to view counselling as an outlet for their emotions rather than a change process. This suggests there can be a misalignment in the understanding of the purpose of therapy between the client and, especially a SFBT, therapist (Gibson & Cartwright, 2014; Manthei, 2007; Prior, 2012; Rupani et al., 2014). As Shennan (2014) suggests, some clients can interpret a *Best Hopes* question as being about the process of therapy, rather than about the outcome. The findings from this study appear to confirm the research, that clients, in this case young adolescents, and counsellors, can differ in their expectations of the outcome of therapy. When there is a misalignment, the counsellor may, as De Jong and Berg (2013) note, feel challenged. The findings from Theme 2 (Findings, pp. 61-67), demonstrated many instances when I was left with doubt as to what the client wanted from therapy. Furthermore, when I asked a young adolescent client a *Best Hopes* question and they responded in a way that indicated that our understanding of the conversation did not align, it left me feeling unsure and I had to work harder in considering my responses.

Implications for practice

As mentioned previously, even when there appears to be a misalignment of understanding of the purpose of counselling between the young adolescent client and the counsellor, it is important to continue to engage in a *goal-setting* conversation and work towards a clear understanding of purpose (Froerer et al., 2018). The following paragraphs outline the ways in which counsellors can work with young adolescents to engage them in a *goal-setting* conversation.

Encourage engagement by offering control within the conversation

When working with young adolescent clients in counselling, allowing them a sense of choice and control helps to engage and enhance *goal-setting* conversations (Barbrack & Maher, 1984; Berg & Steiner, 2003; Bolton Oetzel & Scherer, 2003; Childers, 1987; Cook-Cottone et al., 2015; De Jong & Berg, 2013; Rakauskiene & Dumciene, 2013). In my study I have demonstrated that the collaborative conversations are enhanced when the client was encouraged to be in control of the SFBT *goal-setting* conversation. For example, "What are **your** *Best Hopes* from coming to counselling?" and from a conversation with Bethany (Findings, p. 74), "What would you put as number one on your list? As most important to you?".

Ensure that goal-setting is explicit and clear with young adolescents

To engage young people and to enhance the alignment of understanding between the client and the counsellor, research suggests that when *goal-setting*, counsellors be explicit and clear (Gibson & Cartwright, 2014; Prior, 2012). The findings from this study support this view. Examples throughout theme 1 (Findings, pp. 55-61) illustrate a continual focus on the client's *Best Hopes*, client's goals are repeated by me for clarification, and written lists are used to provide explicit, concrete confirmation. Additionally, when uncertain about what it was that the young adolescent client was wanting from our *goal-setting* conversation (Findings, pp. 61-62, 67-71), I was forced to ask the *Best Hopes* question differently, in the hope of making it clear.

Counselling skills that are helpful when goal-setting with young adolescents

Consistent with the literature (Barish, 2018; Bolton Oetzel & Scherer, 2003; Cook-Cottone et al., 2015), the data in this study demonstrated that treating the young adolescent client with respect and accepting them without judgment appeared to foster the therapeutic relationships and enhance

engagement in *goal-setting*. For example (Findings, p. 73), Bethany mentioning getting her "*nose done*" challenged my own personal judgment values. Miley stated that spending time with her pet rabbit was her current priority (Findings, p. 58). I was respectful and receptive of their choices, an approach which implicitly affirmed their competence and capability. The findings are also consistent with the views of Bolton Oetzel and Scherer (2003), who maintain that the adoption of a neutral stance by therapists who work with young people can help them feel supported and heard without judgment. As well, I believe my use of Fred's name (Findings, p. 63) as a preface to my question, indicated respect, emphasised that he was my focus and enhanced engagement in our conversation.

Specific SFBT assumptions that are helpful when goal-setting with young adolescents

The counselling skills mentioned in the previous section are central to SFBT. This study also indicates, however, that taking a SFBT stance when *goal-setting* helped foster the therapeutic and collaborative relationship, and enhanced engagement with the young adolescent clients. Consistent with existing literature (De Jong & Berg, 2013; Hanton, 2011; Trepper et al., 2012), the findings from this study appear to indicate that assuming young adolescent *clients are experts* of their own lives and maintaining a curious and *not-knowing* stance are particularly helpful to forming positive therapeutic and collaborative relationships. I suggest these aspects of SFBT practice may be of particular importance for counsellors working with young adolescents, given that there is a need to consider individual developmental factors and issues such as being mandated that can bring added layers of challenge in this age group (Bolton Oetzel & Scherer, 2003; Cook-Cottone et al., 2015; Murphy, 2015). In my research, when working with Miley (Findings, pp. 58-60), goals from a previous session were re-examined and new goals were formed. Miley's goals were her own, they meant something to her within the context of her own life. I took a *not-knowing* stance as the counsellor, remained curious and put all personal assumptions and biases aside as our conversation

continued. I demonstrated that I believed that Miley had the skills and resources to not only know what differences she would like to see in her life, but also how she might achieve them.

What if the client has been mandated?

There is an assumption that most clients come to counselling with some idea as to the changes they want to make in their life. Yet this is not the case with all clients, and this is especially evident with young adolescents who are mandated. In this study all four participants were mandated to counselling. Two were willing to engage in therapy and two appeared less willing. When mandated, other people's views and ideas can sometimes overshadow what it is the client wants from therapy (Costa et al., 2017; Jacob et al., 2017). As the literature suggests, however, from a SFBT stance every client has their own perception of the issue and will therefore have their own desired outcome (De Jong & Berg, 2013; Iveson & McKergow, 2015). Taking a SFBT stance with a young adolescent who is mandated appears to enhance engagement in a *goal-setting* conversation and, as previously mentioned, this may be enough to promote change.

Additionally, the findings from this study demonstrate that a continual refocusing of the conversation back to what it is that the young adolescent client wants from therapy by asking different *goal-setting* questions, helped in several ways. It engaged us both in the collaborative conversation, it helped me as the counsellor to get closer to understanding the expectations of the client, and also, as I wrote previously, it helped to give the client some sense of control in the conversation. For example, Joe had indicated he had been "duped" into coming to counselling by his mother (Findings, pp. 61-62). In my response I acknowledged this and then shifted the dialogue back to Joe and his opinion by asking "…*how do you think this might be helpful to you?*". These findings are in line with, Froerer et al. (2018), who suggest that *goal-setting* is a very important part of the SFBT process and that therapists need to remain focused on the client's therapeutic goals until they are

articulated. They also align with research by Bolton Oetzel and Scherer (2003) who suggest that therapists allow clients as much choice and control as possible in order to promote motivation and engagement in therapy. Further, the findings of this study appear to be consistent with Berg and Steiner (2003) and De Jong and Berg (2001) who suggest that taking a SFBT *not-knowing* stance can be helpful in inviting the client to take control by asking questions that help them describe their mandated situation.

When a young adolescent has difficulty answering a question

The findings of this study lend support to existing literature that indicates that perhaps there are occasions when a client has real difficulty in answering a question (De Jong & Berg, 2013; King, 2017; Shennan & Iveson, 2012). When a client responds to a *Best Hopes* question with "I don't know", it can be challenging as a counsellor to know how to respond (Findings, pp. 79-80). The SFBT literature suggests giving time for the client to reflect before formulating an answer, and believing that the client will be able to answer, given enough time (De Jong & Berg, 2013; Shennan, 2014). De Jong and Berg (2013) maintain that clients have their own good reason for answering in the way they do and encourage therapists to listen closely to clients from a *not-knowing* stance when clients respond in a way that suggests maybe they really don't know, don't understand the question or are unwilling to answer. As well, the literature suggests acknowledging that the question being asked is difficult and that the therapist could invite the client to guess by asking, for example, "*…suppose you did know?*" (De Jong & Berg, 2013; King, 2017; Shennan, 2014). The data demonstrated that when Fred said, "I don't know", I responded by giving him time and affirmed the difficulty of the question with, "*…Tricky question, eh…"* (Findings, p. 64). According to the literature, this should encourage him to respond but in Fred's case, while I found that he remained engaged, he still did not know. Some researchers recommend taking a proactive approach with young people as they may require some direction when they perhaps really don't know how to

answer (Bolton Oetzel & Scherer, 2003; Geldard et al., 2020; Nai & Rodgers, 2017). As discussed above (Discussion, pp. 65-67), when I used this technique with Joe it did provide some impetus for a *goal-setting* conversation. However, as noted there, it seems more a solution-forced than solution-focused approach.

Limitations and suggestions for further research

This research study provided a small glimpse of *goal-setting* with young adolescents in an Aotearoa New Zealand intermediate school counselling service. The most obvious limitation of this study was the number of participants involved. A more thorough investigation would include a wider number of participants, with the age range extended across the entire young adolescent subgroup of adolescence. Furthermore, participants from different cultures and a wider geographical spread would strengthen the findings. Appropriate to qualitative research, the findings of this research cannot be generalised to a wider population.

An additional limitation concerned the participants' vulnerability to power differentials and what influence these may have had on the findings. This is an ethical issue, common when researchers work with young people. In this research project I strove to mitigate power differences by continually making the purpose and process of the research clear to the young adolescent participants and ensuring that they were participating voluntarily.

As a practice-based researcher I acknowledge the unknown influence of any bias I may have had on the findings. Throughout this research I practiced reflectively and reflexively, using journaling as a way of mitigating possible biases. Journaling was helpful to me professionally, as a counsellor and a researcher, as it helped me clarify what I was doing and why. A researcher with more experience as a

solution-focused practitioner may have developed different conclusions. Again, this is appropriate with practice-based qualitative research.

Using video rather than audio recording may have generated richer data. However, I found that most of the young adolescents were sensitive to being recorded. I noticed their hesitancy when I checked at the beginning of each session if they still wanted to participate in the study before turning on the recorder. This confirmed my decision to use the less intrusive audio device.

This study recognises that more research is required on *goal-setting* with young adolescents in SFBT. Many questions were raised and not answered during this research. For example, how does brain development and cognition influence *goal-setting* with young adolescents? When considering the developmental aspect of young adolescents, where they are not quite a child and yet not quite an adolescent, it would be interesting to examine the use of creative methods that may be helpful to them when *goal-setting*. Additionally, not addressed in this research were the participants' own perspectives on the *goal-setting* process overall. It would be useful to hear what young adolescents think and feel is helpful to them about the *goal-setting* process in counselling.

Conclusion

With mental health issues burgeoning for young people worldwide and a great demand for counselling services, this research highlights the usefulness of *goal-setting* conversations with young adolescents to provide the support they need. This study has been an in-depth exploration of how goals are co-constructed with a small number of young adolescents in my Aotearoa New Zealand SFBT practice. The findings provide a unique snapshot of how goals are co-constructed with young Aotearoa New Zealand adolescents using the *Best Hopes* question. They support much of the existing literature regarding *goal-setting* in SFBT counselling and contribute to our understanding of

goal-setting with young adolescents. Although this is an Aotearoa New Zealand practice-based research project, the findings will be of interest to counsellors globally.

Counselling young adolescents can be challenging, as their age and development bring added layers of complexity. This research has indicated that young adolescents are beginning to navigate their way in the adult world and with this they bring to counselling a range of individual problems and concerns. Additionally, being mandated to counselling can be difficult for young adolescents. It is clear from this study however, that *goal-setting* conversations may offer young adolescents an opportunity to discuss their issues and get the support they are needing. Furthermore, the SFBT technique of *goal-setting* helps young adolescents reflect on and articulate their hoped-for future, one where the problem that brought them to counselling is diminished or even no longer there. Goals are co-constructed with young adolescents in SFBT using the *goal-setting* technique which is collaborative and enhanced by a positive therapeutic relationship. Asking the *Best Hopes* question is the beginning of the *goal-setting* process.

It is generally assumed that clients come to counselling knowing what it is they want different in their life. However, this research reveals that there are times with young adolescents, especially when they are mandated, that this is not so. This study found that when young adolescents were unwilling, or perhaps could not articulate an answer to a *goal-setting* question, the conversation itself appeared helpful. The variety of questions and the manner in which they are asked, are key in supporting a young adolescent engage in the process.

This study supports existing literature suggesting that many young clients have a difference in understanding of the purpose of counselling when compared to counsellors. When working from a SFBT stance, the *goal-setting* process helps young adolescents and counsellors work toward a shared

understanding of purpose. The findings from this research suggest that sharing an alignment of understanding, when both the client and the counsellor are working toward the same thing, improves young adolescent engagement in therapy and promotes positive client outcome.

This research demonstrates the value of learning and implementing the SFBT *goal-setting* technique with young adolescents in counselling. To facilitate the *goal-setting* process with young adolescents it is recommended that counsellors are purposeful in using SFBT skills, assumptions and techniques. This study found that the key SFBT approaches to encouraging engagement in the *goal-setting* process were taking a *not-knowing* and curious stance with clients, and assuming them to be the *expert* of their experiences, issues and solutions. In addition, it is recommended that counsellors understand the SFBT process of *goal-setting* and how to pose a *Best Hopes* question in a variety of ways so the intention remains the same. Furthermore, this study suggests that collaboration with young adolescents requires paying close attention to the language used when *goal-setting*. The findings highlight the importance of counsellors using the listen, select, build sequence, language that is positive and hopeful, and presuppositional questions that assume client competence. This research has found that when using these SFBT skills, assumptions and techniques when *goal-setting* with young adolescent clients, they are more likely to remain engaged in the conversation, goals are more likely to be thought about and articulated, and counsellors and clients are more likely to share an understanding of the young adolescent's individual needs and expectations for counselling.

Other skills that counsellors can use to guide *goal-setting* conversations with young adolescents that this study found to be beneficial include: working *with* the young adolescent in a respectful, nonjudgmental manner; maintaining a focus on the young adolescent client as the centre of the conversation; giving plenty of time to formulate and articulate an answer; and, being clear and explicit when goal-setting.

This study supports existing research and extends it, suggesting that taking a SFBT stance and using collaborative *goal-setting* conversations can be helpful for young Aotearoa New Zealand adolescents in counselling. *Goal-setting* can assist a young adolescent client's motivation and engagement in therapy. It is also valuable to both the counsellor and the young adolescent client in establishing the direction of therapy. *Goal-setting* conversations give young adolescents the opportunity to reflect on and articulate their specific concerns. The *Best Hopes* question begins the collaborative co-construction of goals with young adolescents, helping them to articulate what it is they want different in their life, and helping to shape a shared understanding of this with their counsellor.

Working with young adolescents in counselling requires a counsellor to focus on what it is that *they* want from being there, regardless of who sent them. Asking a *Best Hopes* question supports an exploration of this purpose. This study demonstrates that when a young adolescent is unwilling or finds it difficult to participate, asking a *Best Hopes* question helps to engage them and continue the conversation. The co-constructive and collaborative nature of *goal-setting* encourages young adolescents to reflect and as they do this, new possible ideas of how to live differently may emerge. Maintaining a SFBT *goal-setting* conversation that is hopeful and future focused with a young adolescent might make all the difference for them. Who knows what light bulb may be switched, or seed may be sown?

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Appendices

Appendix 1: Information and consent forms for school Principal

Department of Education, Health and Human Development
Researcher/Counsellor:
Jude Griffiths
Email: jude.griffiths@pg.canterbury.ac.nz
Phone: [redacted]
Date:
ERHEC Ref: 2019/32/ERHEC

Supervisor of Research:
Dr Judi Miller
Email: judi.miller@canterbury.ac.nz
Phone: [redacted]

Best Hopes – Whatever That Means:
Working with Young Adolescents in Solution-focused Therapy

Information Sheet for [redacted], Principal
[redacted]

Kia ora [redacted]

As you're aware, I am currently working towards a Master of Counselling at the University of Canterbury and as part of this I am required to complete a research project examining my practice. The students who see me for counselling come for a variety of reasons, most often sent by an adult who has noticed something negative about their behaviour. However, until the student discovers what it is *they* would like from counselling I can do little to help. So, one of my first tasks is to help them set some goals, help them identify what they would like to get out of the counselling process. I practice using the model of Solution-focused Therapy and I am particularly interested in researching

how students respond to the goal setting question we use, “What are your best hopes from being here?”.

I hope to recruit up to 5 students to participate as research volunteers when they are first identified as someone who needs the support of counselling. As part of our usual process of assigning me students, the Deputy Principal has agreed to provide information about the research project to the parent/guardian when she first contacts them to suggest the student see me for counselling. Consent will be sought from the parent/guardian and the student. Information sheets and consent forms will be provided by the Deputy Principal to those interested in participating. If the student agrees, I will meet with them for 10 minutes before counselling begins to discuss the research, their participation in it and provide a consent form to take home, sign with their parent/guardian and return to me in our first session together.

The study will in no way interfere with the usual process of counselling students at school, the only difference being their first 3 sessions will be audio recorded and transcribed by me, and the usual session rating form I use in counselling sessions with students will have the addition of one question. These will form part of the data for the research alongside my own notes and observations. Each participant will be offered the opportunity to check their transcript. I have attached copies of information sheets and consent forms for the students and their parent/guardian as well as the amended session rating form.

Participation in this study is voluntary and the students can withdraw at any time without penalty. The parent/guardian and/or the school can also withdraw the student from this study at any time without penalty. You can withdraw the school from the research project at any time without penalty should you choose to do so. If the student withdraws, I will destroy all their recordings, transcripts and notes and remove all information relating to them from the research project. However, once analysis of the raw data (recordings, transcripts and notes) starts on 1 September 2019, it will become increasingly difficult to remove the influence of their data on the results. Counselling will continue regardless of if the student participates or withdraws from the study.

Possible risks for participants taking part in this research are associated with their psychological wellbeing. As a provisional member of the New Zealand Association of Counsellors I practice in accordance to their Code of Ethics guidelines. During all counselling sessions with each participant I will listen and watch for possible risks that may occur, such as harm to their emotional or physical

wellbeing. If I, the school or the parent/guardian feel concerned that the student's safety is at risk, they will be withdrawn immediately and given appropriate wellbeing support. Counselling the student, ensuring their wellbeing, will always come first.

The results of the project will be published and made available through the University of Canterbury Library, but you may be assured of complete confidentiality of all information I collect. I will change names and identifying features of all participants and the school. The data I collect will be securely stored on my password protected computer and backed up on password protected files on the University of Canterbury server or in a locked filing drawer in my home. I may at times need to consult my supervisors to discuss my work. This includes my clinical supervisor who I consult about my counselling work with clients, my cultural supervisor who I consult about my counselling work with clients who are Māori and/or my research supervisor who I consult about my research project. During any of these discussions all information about the participants remains confidential. All data will be destroyed after 5 years, as required by the University of Canterbury. Please indicate on the consent form if you would like to receive a copy of the summary of the research results.

If you have any queries or concerns about the study at any time please contact me (details above) or my research supervisor, Judi Miller (details above). This project has been reviewed and approved by the University of Canterbury Educational Research Human Ethics Committee. If you have any complaints you can contact The Chair, Educational Research Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

If you agree for students to participate in this study could you please complete and give Jude the attached consent form.

Ngā mihi
Jude Griffiths

Department of Education, Health and Human Development
Researcher/Counsellor:
Jude Griffiths
Email: jude.griffiths@pg.canterbury.ac.nz
Phone: [redacted]
Date:
ERHEC Ref: 2019/32/ERHEC

Best Hopes – Whatever That Means:
Working with Young Adolescents in Solution-focused Therapy

Consent form for [redacted], Principal
[redacted]

☐ I have been given a full explanation of this project and have had the opportunity to ask questions.

☐ I understand what is required of the students if they agree to take part in the research.

☐ I understand that participation is voluntary and students may withdraw at any time without penalty. Withdrawal of a student can be made by the school and/or the student's parent/guardian at any time without penalty. I understand I can withdraw the school from the research project at any time without penalty. I understand that counselling will continue regardless of whether the student participates or withdraws from the study. I understand that withdrawal of participation will also include the withdrawal of any information they have provided should this remain practically achievable.

☐ I understand that any audio recordings or information the students provided will be kept confidential to the researcher, her clinical, cultural and/or research supervisors and that any published or reported results will not identify the participants or the school. I understand that a research thesis is a public document and will be available through the UC Library.

☐ I understand that all data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and will be destroyed after five years.

☐ I understand that as part of the usual school counselling process, student safety is paramount and if students are deemed to be at risk they will be removed from the study immediately and receive appropriate care.

☐ I understand that I can contact the researcher, Jude Griffiths (details above) or her supervisor, Dr Judi Miller (Email: judi.miller@canterbury.ac.nz, phone: [redacted]) for further information. If I have any complaints, I can contact the Chair of the University of Canterbury Educational Research Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz)

☐ I would like a summary of the results of the project.

☐ By signing below, I agree to allow students to participate in this research project.

Name:_____

Signed:_____

Date:_____

If you would like a summary of the results, please enter your email address:

_____

Please return this consent form to Jude.

Ngā mihi
Jude Griffiths

Appendix 2: Information and consent forms for Deputy Principal

Department of Education, Health and Human Development
Researcher/Counsellor:
Jude Griffiths
Email: jude.griffiths@pg.canterbury.ac.nz
Phone: [redacted]

Date:
ERHEC Ref: 2019/32/ERHEC

Supervisor of Research:
Dr Judi Miller
Email: judi.miller@canterbury.ac.nz
Phone: [redacted]

Best Hopes – Whatever That Means:
Working with Young Adolescents in Solution-focused Therapy

Information Sheet for [redacted], Deputy Principal
[redacted]

Kia ora [redacted]

As you're aware, I am currently working towards a Master of Counselling at the University of Canterbury and as part of this I am required to complete a research project examining my practice. The students who see me for counselling come for a variety of reasons, most often sent by an adult who has noticed something negative about their behaviour. However, until the student discovers what it is *they* would like from counselling I can do little to help. So, one of my first tasks is to help the student set some goals, help them identify what they would like to get out of the counselling process. I practice using the model of Solution-focused Therapy and I am particularly interested in researching how students respond to the goal setting question we use, "What are your best hopes from being here?".

I hope to recruit up to 5 students to participate as research volunteers when they are first identified as someone who needs the support of counselling. As we have previously discussed, recruitment will be a part of our usual process of your assigning me students when you first contact the parent/guardian to suggest the student see me for counselling. Consent will be sought from the parent/guardian and the student. As part of your conversation with the student's parent/guardian you have agreed to mention my research intention and ask if they might be interested in receiving some information about it. If so, an information sheet and consent form for the parent/guardian and an information sheet for the student will be provided. If the student agrees, I will meet with them for 10 minutes before counselling begins to discuss the research, their participation in it and provide a consent form to take home, sign with their parent/guardian and return to me in our first session together.

The study will in no way interfere with the usual process of counselling students at school, the only difference being their first 3 sessions will be audio recorded and the usual session rating form I use in counselling sessions with students will have the addition of one question. The recordings will be transcribed by me and will form part of the data for the research alongside my own notes and observations. Each participant will be offered the opportunity to check their transcript. I have attached copies of information sheets and consent forms for the students and their parent/guardian as well as the amended session rating form.

Participation in this study is voluntary and the students can withdraw at any time without penalty. The parent/guardian and/or the school can also withdraw the student from this study at any time without penalty. If the student withdraws, all recordings, transcripts and notes about them will be destroyed and I will remove all information relating to them from the research project. However, once analysis of the raw data (recordings, transcripts and notes) starts on 1 September 2019, it will become increasingly difficult to remove the influence of their data on the results. Counselling will continue regardless of if the student participates or withdraws from the study.

Possible risks for participants taking part in this research are associated with their psychological wellbeing. As a provisional member of the New Zealand Association of Counsellors I practice in accordance to their Code of Ethics guidelines. During all counselling sessions with each participant I will listen and watch for possible risks that may occur, such as harm to their emotional or physical wellbeing. If I, the school or the parent/guardian feel concerned that the student's safety is at risk, they will be withdrawn immediately and given appropriate wellbeing support. Counselling the student, ensuring their wellbeing, will always come first.

The results of the project will be published and made available through the University of Canterbury Library, but you may be assured of complete confidentiality of all information I collect. I will change names and identifying features of all participants and the school. The data I collect will be securely stored on my password protected computer and backed up on password protected files on the University of Canterbury server or in a locked filing drawer in my home. I may at times need to consult my supervisors to discuss my work. This includes my clinical supervisor who I consult about my counselling work with clients, my cultural supervisor who I consult about my counselling work with clients who are Māori and/or my research supervisor who I consult about my research project. During any of these discussions all information about the participants remains confidential. All data will be destroyed after 5 years, as required by the University of Canterbury. Please indicate on the consent form if you would like to receive a copy of the summary of the research results.

If you have any queries or concerns about the study at any time please contact me (details above) or my research supervisor, Dr Judi Miller (details above). This project has been reviewed and approved by the University of Canterbury Educational Research Human Ethics Committee. If you have any complaints you can contact The Chair, Educational Research Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

If you agree for students to participate in this study and you are happy with your role in providing information to parents/guardians, could you please complete and give Jude the attached consent form.

Ngā mihi
Jude Griffiths

Department of Education, Health and Human Development
Researcher/Counsellor:
Jude Griffiths
Email: jude.griffiths@pg.canterbury.ac.nz
Phone: [redacted]
Date:
ERHEC Ref: 2019/32/ERHEC

Best Hopes – Whatever That Means:
Working with Young Adolescents in Solution-focused Therapy

Consent form for [redacted], Deputy Principal
[redacted]

☐ I have been given a full explanation of this project and have had the opportunity to ask questions.

☐ I understand my role in inviting voluntary participation and what is required of the students if they agree to take part in the research.

☐ I understand that participation is voluntary and students may withdraw at any time without penalty. Withdrawal of a student can be made by the school and/or the student's parent/guardian at any time without penalty. I understand that counselling will continue regardless of whether the student participates or withdraws from the study. I understand that withdrawal of participation will also include the withdrawal of any information they have provided should this remain practically achievable.

☐ I understand that any audio recordings or information the students provided will be kept confidential to the researcher, her clinical, cultural and/or research supervisors and that any published or reported results will not identify the participants or the school. I understand that a research thesis is a public document and will be available through the UC Library.

☐ I understand that all data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and will be destroyed after five years.

☐ I understand that as part of the usual school counselling process, student safety is paramount and if students are deemed to be at risk they will be removed from the study immediately and receive appropriate care.

☐ I understand that I can contact the researcher, Jude Griffiths (details above) or her supervisor, Dr Judi Miller (Email: judi.miller@canterbury.ac.nz, phone: [redacted]) for further information. If I have any complaints, I can contact the Chair of the University of Canterbury Educational Research Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz)

☐ I would like a summary of the results of the project.

☐ By signing below, I agree to allow students to participate in this research project.

Name:_____

Signed:_____

Date:_____

If you would like a summary of the results, please enter your email address:

_____

Please return this consent form to Jude.

Ngā mihi
Jude Griffiths

Appendix 3: Information and consent forms for parent/guardian

Department of Education, Health and Human Development
Researcher/Counsellor:
Jude Griffiths
Email: jude.griffiths@pg.canterbury.ac.nz
Phone: [redacted]
Date:
ERHEC Ref: 2019/32/ERHEC

Supervisor of Research:
Dr Judi Miller
Email: judi.miller@canterbury.ac.nz
Phone: [redacted]

Best Hopes – Whatever That Means:
Working with Young Adolescents in Solution-focused Therapy

Information Sheet for Parent/Guardian

Kia ora

I'm Jude Griffiths and I work as the school counsellor at [redacted], a role I enjoy and feel privileged to have. I am currently working towards a Master of Counselling at the University of Canterbury and as part of this I am required to complete a research project examining my practice.

When students come to see me they are often sent by an adult, however until they discover what it is *they* would like from counselling I can do little to help. So, one of my first tasks is to help them set some goals for what they would like to achieve from counselling. I am trained in Solution-focused Therapy and I am particularly interested in researching how students respond to the goal setting questions we use.

When consenting to be a part of my research it is important for you and your child to understand that:

- The study will in no way interfere with the counselling process. Counselling your child and ensuring their wellbeing will always be first. Counselling sessions will take place regardless of your or your child's choices around participating in this research.
- If your child agrees to participate in this research, we will meet for 10 minutes in school time before counselling sessions begin to discuss the research in detail and answer any questions they may have. If they choose to participate, I will give them a consent form which they can take home to discuss and sign with you and return to me in our first session together.
- Participation is voluntary. Your child can withdraw at any time without penalty. You or the school can withdraw your child at any time without penalty.
- When I work with your child the only difference to usual counselling is that the first 3 sessions will be audio recorded and transcribed by me and I will ask one question about goal setting at the end of the session. Your child will be offered the opportunity to read through and check the transcripts before I begin analysing them. If your child withdraws, I will destroy their recordings, transcripts and notes and remove all information relating to them from the research project. However, once analysis of the raw data (recordings, transcripts and notes) starts on 1 September 2019, it will become increasingly difficult to remove the influence of their data on the results. Counselling will continue regardless of whether your child participates or withdraws from the study.
- Possible risks for your child taking part in this research are associated with their psychological wellbeing. As a provisional member of the New Zealand Association of Counsellors I practice in accordance to their Code of Ethics guidelines. During all counselling sessions with your child I will listen and watch for possible risks that may occur, such as harm to their emotional or physical wellbeing. If I, the school or you feel concerned that your child's safety is at risk, they will be withdrawn from the study immediately and given appropriate wellbeing support. Counselling your child, ensuring their wellbeing, will always come first.
- All information about your child will remain confidential. The results of the project will be published and made available through the University of Canterbury Library, but the names of all students and the school will be changed. No personal or identifiable information will be made public at any stage.
- I may at times need to consult my supervisors to discuss my work. This includes my clinical supervisor who I consult about my counselling work with clients, my cultural supervisor who I

consult about my counselling work with clients who are Māori, and/or my research supervisor who I consult about my research project. During any of these discussions all information about your child remains confidential.

- The data I collect will be securely stored on my password protected computer and backed up on password protected files on the University of Canterbury server or in a locked filing drawer in my home. All data will be destroyed after 5 years, as required by the University of Canterbury.
- Please indicate on the consent form if you would like to receive a copy of the summary of the results of the project.

If you have any queries or concerns about the study at any time please contact me (details above) or my research supervisor, Dr Judi Miller (details above).

This project has been reviewed and approved by the University of Canterbury Educational Research Human Ethics Committee. If you have any complaints you can contact The Chair, Educational Research Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

If you agree for your child to participate in this study could you please complete and give the attached consent form to your child to return to me at our 10 minute pre-counselling meeting.

Ngā mihi
Jude Griffiths

Department of Education, Health and Human Development
Researcher/Counsellor:
Jude Griffiths
Email: jude.griffiths@pg.canterbury.ac.nz
Phone: [redacted]
Date:
ERHEC Ref: 2019/32/ERHEC

Best Hopes – Whatever That Means:
Working with Young Adolescents in Solution-focused Therapy

Consent form for Parent/Guardian of _____

☐ I have been given a full explanation of this project and have had the opportunity to ask questions.

☐ I understand what is required of my child if they agree to take part in the research.

☐ I understand that participation is voluntary. My child may withdraw at any time without penalty. Withdrawal of participation will also include the withdrawal of any information they provide should this remain practically achievable.

☐ I understand that I can withdraw my child from the research at any time and this will not affect their counselling in any way. Counselling will continue regardless of any choices I or my child makes regarding participation or withdrawal from the research.

☐ I understand that any audio recordings or information my child provides will be kept confidential to the researcher, her clinical, cultural and/or research supervisors and that any published or reported results will not identify the participants or the school. I understand that a research thesis is a public document and will be available through the UC Library.

☐ I understand that all data collected for the study will be kept in locked and secure facilities

and/or in password protected electronic form and will be destroyed after five years.

☐ I understand that as part of the usual school counselling process, student safety is paramount. If my child is deemed to be at risk, they will be removed from the study immediately and receive appropriate care.

☐ I understand that I can contact the researcher, Jude Griffiths (details above) or her research supervisor, Dr Judi Miller (Email: judi.miller@canterbury.ac.nz, phone: [redacted]) for further information. If I have any complaints, I can contact the Chair of the University of Canterbury Educational Research Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz)

☐ I understand a summary of the results of the project is available by entering my email address below.

☐ By signing below, I agree to allow my student to participate in this research project.

Name:_____

Signed:_____

Date:_____

If you would like a summary of the results, please enter your email address:

_____

Please give this consent form to your child to return to me at our 10 minute pre-counselling meeting.

Ngā mihi
Jude Griffiths

Appendix 4: Information and consent forms for students

Department of Education, Health and Human Development
Researcher/Counsellor:
Jude Griffiths
Email: jude.griffiths@pg.canterbury.ac.nz
Phone: [redacted]
Date:
ERHEC Ref: 2019/32/ERHEC

Supervisor of Research:
Dr Judi Miller
Email: judi.miller@canterbury.ac.nz
Phone: [redacted]

Best Hopes – Whatever That Means:
Working with Young Adolescents in Solution-focused Therapy

Information Sheet for Students

Kia ora

I'm Jude Griffiths and I work as the school counsellor at [redacted]. I also study at the University of Canterbury doing a Master of Counselling. As part of this I have to complete a research project looking at my practice. My research is about how students respond to the goal setting questions I use.

If you take part in this research, there's a few things you need to understand about it:

- It won't get in the way of the work we do together. Counselling you and ensuring your wellbeing will always be first. Whatever choices you make about taking part or not taking part in the research, you'll still get counselling.
- If you are interested, we will meet for 10 minutes before the counselling sessions begin and we can talk about the research and answer any questions you may have. If you choose to take part, I'll give you a consent form to take home which you can discuss and sign with your

parent/guardian and return to me in our first session together.

- Taking part is voluntary. You can withdraw at any time, for any reason, if you want. Your parent/guardian can also withdraw you if they want.
- The counselling work we do together will be normal. The only difference will be that our first 3 sessions will be audio recorded and transcribed (written out) by me. I will also ask you to fill in a form at the end of the session. After I've transcribed the recordings, you can read what I've written to check for mistakes. Your parent/guardian will not listen to the recordings or read the transcripts or the form you fill in. If you withdraw from the study I will destroy all your recordings, transcripts and notes and I will remove everything about you from the research project, but after 1 September 2019 this becomes difficult because that's when I start to analyse (read over and look for patterns of words) your transcripts and the form. Whatever you decide about taking part or withdrawing from the study, counselling will continue.
- A big part of my job is to make sure you stay safe. If I, the school or your parent/guardian feel that it is unhelpful to you to be in the study for any reason, we will withdraw you and make sure you get whatever extra support you might need.
- Taking part in the research is confidential. This means that when I write about how we set goals together nobody will know your name or the school's name. When I finish writing the research it will be published on the University of Canterbury's library website, but the names of all students and the school will be changed. No personal information will be made public at any stage. No-one will know you've been involved in the research except you, your parent/guardian, [redacted] and me.
- I may at times need to talk with my clinical, cultural and/or research supervisors (they are experts) to help me with my work. If we talk, all the information about you stays confidential, I will never tell them your real name.
- All the audio recordings, transcripts and notes I make when I am with you will be securely stored on my password protected computer and backed up on password protected files on the University of Canterbury server or in a locked filing drawer in my home. After 5 years it'll all be destroyed, as required by the University of Canterbury.
- If you would like a copy of the summary of the research results, please write your or your parent/guardian's email on the consent form in the space provided.

If you have any questions about the study at any time you can ask me. Or you can ask your parent/guardian to ask me (details above). Or you or your parent/guardian can ask my research

supervisor, Judi Miller (details above). I encourage you to discuss being part of my research with your parent/guardian and ask questions if you are unsure.

This project has been reviewed and approved by the University of Canterbury Educational Research Human Ethics Committee, and if you have a complaints you or your parent/guardian can contact: The Chair, Educational Research Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

If you agree to participate in this study could you please complete and return the attached consent form to me in our first session together.

Ngā mihi
Jude Griffiths

Department of Education, Health and Human Development
Researcher/Counsellor:
Jude Griffiths
Email: jude.griffiths@pg.canterbury.ac.nz
Phone: [redacted]
Date:
ERHEC Ref: 2019/32/ERHEC

Best Hopes – Whatever That Means:
Working with Young Adolescents in Solution-focused Therapy

Consent form for Student: _____

☐ Jude has explained the research. I understand my part in it and I have had the opportunity to ask questions.

☐ I understand that taking part is voluntary. If I decide I no longer want to take part, that's OK. I'll get counselling whatever I decide.

☐ I understand that if I withdraw from the study Jude will destroy all my recordings, transcripts and notes and remove everything about me from the research project, but after 1 September 2019 this becomes difficult for her to do.

☐ I understand that our first 3 sessions together will be audio recorded. Jude will make sure that all the recordings, transcripts and notes are kept confidential. When talking with her supervisors and publishing the research results on University of Canterbury library website, Jude will make sure that the school and I won't be identified.

☐ I understand that the audio recordings, transcripts and notes Jude collect for the research will be kept locked and secure and after five years it will all be destroyed.

☐ I understand that if Jude, my parent/guardian or the school are concerned about my safety, they will withdraw me from the study and get me whatever extra support I need.

☐ If I have a question I or my parent/guardian can ask Jude, or I or my parent/guardian can ask Jude's supervisor, Dr Judi Miller (Email: judi.miller@canterbury.ac.nz, phone: [redacted]) for further information. If I have any complaints, I can ask my parent/guardian to contact the Chair of the University of Canterbury Educational Research Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz)

☐ I can get a summary of the results of the research by writing my or my parent/guardian's email address below.

☐ By signing below, I agree to participate in this research project.

Name:_____

Signed:_____

Date:_____

If you would like a summary of the results, please enter your or your parent/guardian's email:

_____

Please bring this consent form with you to your first counselling session with Jude.

Ngā mihi

Jude Griffiths

Appendix 5: Ethics consent

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

HUMAN ETHICS COMMITTEE

Secretary, Rebecca Robinson Telephone: +64 03 369 4588, Extn 94588 Email: human-ethics@canterbury.ac.nz

Ref: 2019/32/ERHEC 21 June 2019

Judith Griffiths
College of Education, Health and Human Development UNIVERSITY OF CANTERBURY

Dear Judith

Thank you for providing the revised documents in support of your application to the Educational Research Human Ethics Committee. I am very pleased to inform you that your research proposal "Best Hopes - Whatever That Means: Working With Young Adolescents in Solution-Focused Therapy" has been granted ethical approval.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 18th June 2019, **and the following:**

Please include in your Information Sheets that data will also be backed up on password-protected files on the UC server (this is to enhance data security provisions).

Should circumstances relevant to this current application change you are required to reapply for ethical approval.

If you have any questions regarding this approval, please let me know.

We wish you well for your research.

Yours sincerely

pp

R. Robinson

Dr Patrick Shepherd

Chair
Educational Research Human Ethics Committee

Please note that ethical approval relates only to the ethical elements of the relationship between the researcher, research participants and other stakeholders. The granting of approval by the Educational Research Human Ethics Committee should not be interpreted as comment on the methodology, legality, value or any other matters relating to this research.

FES