Scaffolding and Concept Formation in Narrative Therapy: A Qualitative Research Report
ABSTRACT

In his most recent writings Michael White made extensive reference to the work of Russian psychologist Lev Vygotsky, taking up several Vygotskian concepts (e.g., scaffolding) into a revisioning of his narrative conversations maps. We used observational coding to test White’s newly formulated scaffolding conversations map against actual process in therapy with children, and the current paper is a qualitative report of our findings. We found that most speech turns were codable at some level of the map, that children responded to therapists’ scaffolding, and that therapists and children tended to proceed through the steps of the map in single-session therapy. These findings demonstrate that White’s model of therapy is observable and suggest that change occurred at the level of language over the session. This study lays the foundation for future research regarding potential links between White’s process and therapeutic outcomes.

Key words: narrative therapy, children, scaffolding conversations, concept formation
SCAFFOLDING AND CONCEPT FORMATION IN NARRATIVE THERAPY: A QUALITATIVE RESEARCH REPORT

In his most recent writings Michael White (2006, 2007) made extensive reference to the work of Russian psychologist Lev Vygotsky (1978, 1987). Indeed, the increasing use of ideas and terms such as distancing, space, scaffolding, social collaboration, and personal agency in his work suggests a Vygotskian re-visioning of his narrative conversations maps. This newest map developed by White (2007), called the scaffolding conversations map, inspired the following research questions: Do narrative therapy sessions demonstrate the type of conversation described in White’s scaffolding conversations map? If so, do children respond to therapists’ scaffolding by responding to therapists’ questions at the same level of the map? Finally, do therapists and children proceed through the steps of the map over the course of a single session? While we examined similar questions in a previously published study (Ramey, Tarulli, Frijters, & Fisher, 2009), that report focused largely on establishing the utility of a quantitative methodology—sequential analysis—for examining the dynamic, moment-to-moment unfolding of therapeutic social interactions over individual narrative therapy sessions. In the present report, we seek to revisit these questions from the analytic vantage point of a qualitative, practice-based perspective. Accordingly, we draw extensively on specific examples from individual narrative therapy sessions to illustrate our claims.

We begin by outlining a brief history of the theories that have informed White’s (2006, 2007) thinking in narrative therapy, with particular attention to the most recent influence of Vygotsky’s (1978, 1987) work. We then summarize some concepts from Vygotsky’s writings, how these influenced recent developments in narrative practice maps, and how these developments informed our research questions. The research and its results are then described in
detail. We conclude with a discussion of the implications of our findings for both practice and future research.

**Development of the Theory and Practice of Narrative Therapy**

White and Epston’s narrative therapy began evolving in the 1980s with their foundational *Narrative Means to Therapeutic Ends*, published in North America in 1990. In this work they drew on the theories of several philosophers and critical thinkers and applied these theories to their practice, creating a new model of family therapy built around the metaphor of stories. From that time White continued to explore this story metaphor, over the years expanding his thinking and narrative practice through the accommodation of the insights of many additional theorists.

White and Epston (1990) began exploring their story metaphor in therapy using ideas from Bruner (1986) and Geertz (1986). These initial explorations led eventually to the formulation of cornerstone concepts in narrative therapy: externalizing and unique outcomes. Externalizing in narrative therapy involves naming, objectifying, and even personifying the problem to separate people from dominant, problem-saturated stories. These dominant stories often do not reflect people’s preferred ways of being and may obscure alternative interpretations. Alternative interpretations, also known as “unique outcomes” or “initiatives” (White, 2006b), are any stories, ideas or events that would not have been predicted by the dominant problem story. Intertwining with and elaborating on these notions are Bateson’s (1979) ideas of explanation and change, Derrida’s (Derrida & Caputo, 1997) deconstruction, Geertz (1973) and Myerhoff’s (1982, 1986) anthropological contributions, Foucault’s (1980) deliberation of power (see also Danaher, Schirato & Webb, 2000) and, finally, White’s (2007) vision of scaffolding in Vygotsky’s (1978) zone of proximal development.
Michel Foucault’s work appears to have had the most significant influence on White (Duvall & Young, 2009; White, 1989), with White and Epston’s (1990) narrative therapy approach clearly incorporating Foucault’s ideas on the modern power/knowledge nexus, the socio-political context it creates, and its constitutive effects (Besley, 2002; White, 2002). Foucauldian notions of power (Danaher et al., 2000; Foucault, 1980) lead to the practice of deconstruction in narrative therapy, which manifests itself in a persistent questioning of the taken-for-granted (White, 2002, 2007). More specifically, deconstruction is accomplished by questioning the meaning and history of problems and other significant constructs that arise in therapy, and by examining unique outcomes that fall outside the dominant story. Deconstruction also takes place through the unpacking of dissembled or unrecognized practices of power and disciplinary technologies of the self, and by questioning therapeutic discourses themselves.

Instead of classifying and objectifying individuals, the narrative therapy practice of externalization re-situates the problem outside of people, challenging cultural discourses that presuppose that individuals can be categorized and their potentials fully contained by those categorizations. Together with deconstruction, externalizing the problem questions this social control and these normalizing truths, unsettling the effects of modern power (White, 1989). The use of externalizing and deconstruction in therapy is intended to liberate people from labels, allow cooperation to influence the effects of the problem, present opportunities for multiple interpretations, discourage conflict about blame, and encourage agency instead of feelings of failure and oppression (White, 1989).

White (2007) later developed maps, such as the statement of position maps, to guide narrative conversations. These maps suggest particular lines of questioning for therapists to follow, assisting in the development of understandings of where people stand in relation to
problems and unique outcomes. The narrative therapist does not attempt to lead clients to any specific understandings or ideas, but rather creates opportunities for people to make discoveries. Although these maps for therapy continue to be offered as a useful tool, they usually have been accompanied by the caution that “a map is not the territory” (Korzybski, 1933, p. 58); that is, the steps on the map are only that, and cannot reflect or capture the emergent, temporally open nature of what happens in the course of therapy.

**Concept Formation and the Zone of Proximal Development**

Vygotsky provided a basis for much of White’s more recent writing (e.g., White, 2006, 2007), leading White in new directions in defining the tasks and maps of narrative therapy and opening space both for re-thinking narrative practice and for incorporating research to analyze the performance of therapist tasks. Vygotsky (1978) emphasized that learning was an achievement not of independent effort but of social collaboration. A critical notion for White (2007) was the “zone of proximal development,” which Vygotsky defined as “the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers” (p. 86). The zone of proximal development bridges the gap between what is known and what is possible to know, and it is in this gap that learning occurs. According to Vygotsky, the zone of proximal development is traversed through social collaboration between a child and some other adult or peer with greater—or perhaps just different—knowledge of a concept at hand. Traversing the zone of proximal development only can be achieved if the developmental gap is broken down into manageable tasks. It is these tasks, which are structured at first but allow for the gradual progression from collaborative to independent performance, that scaffold children’s development of concepts. Verbal interactions
provide the starting point for concept formation. The learning collaborator or partner assists the child to distance from their immediate experience and thereby to “stretch her or his mind” (White, 2007, p. 272), making new connections that lead to the development of higher-level thinking. This makes it possible for concepts about life and identity to develop, which supplies the foundation for deliberate actions to shape the course of life (White, 2007).

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

*The Turn to Vygotsky in Mapping Narrative Conversations*

Using Vygotsky’s theories of development and learning, White (2006, 2007) created a revised version of his statement of position maps. The first version of the statement of position map focused on externalizing the problem, the second on the initiative, and this third, latest version accommodates either the problem or the initiative. Known as the scaffolding conversations map (see Figure 1), it outlines the therapist’s tasks in introducing concepts pertaining to client problems and initiatives and scaffolding the client’s mastery of them. In the current study, this map serves as the basis for coding observations of therapist and client speech turns.
In the scaffolding conversations map the narrative therapist’s role is elucidated as supporting people in distancing themselves from the known and familiar that is being reproduced in their relationships with problems. The therapist provides scaffolding by asking incremental questions that support movement from the known and familiar to what is possible to know and do. The therapist and client work in partnership to traverse the zone of proximal development. The therapist’s scaffolding allows clients to distance themselves from aspects of problems so that they can develop new conceptions of self, identity, problems, and resources. Distance and increased mastery over concepts invite clients to gradually exercise personal agency over the problems they are struggling with, or with the solutions they may have already begun to find, but that may be lacking a strong foundation for continuance. This is in keeping with the notions of mastery and voluntary control/personal agency that Vygotsky (1987) associated with conceptual thought.

The scaffolding conversation is organized according to a hierarchy, with increasing levels of generalizations that parallel the steps in the statement of position maps. In accordance with this hierarchy, the revised map begins with naming and characterizing the problem or initiative. For Vygotsky, developing words formed the most primitive level of understanding concepts, and in this version of the map White (2006) refers to this step as “low-level distancing” (p. 45). This marks the early stages of concept formation, as unthematized, unorganized, and unconnected experiences are united under a common name or category. Medium-level distancing is the next step in the map, and these tasks produce chains of association between the problem or initiative and its consequences, a step previously described as exploring the effects of the problem or initiative. White clearly correlates his second step with Vygotsky’s notions of the development of complexes and chains of association, which establish objective (but not yet abstract)
relationships between objects or events. Medium-high-level distancing tasks (previously known as evaluating the effects of the problem or initiative) have the client reflect on these chains of association. In high-level distancing tasks (justifying and explaining evaluations, according to earlier versions of White’s conversational maps) clients are invited to generalize their learning from specific circumstances into other areas of their lives. White states that it is at this level, where learnings are both generalized from the concrete and abstracted from the totality of experience, that the formation of concepts occurs. Very high-level distancing tasks, which were not formally included in previous maps, invite clients to make plans of action based on the newly understood concepts and the positions they have taken.

While the specific tasks of the partner/collaborator in the zone of proximal development received relatively little attention from Vygotsky (1978), he was quite clear that instruction should be pitched ahead of the child’s actual level of development. In the context of narrative therapy, this means that therapists’ leading activities should occur ahead of clients’ abilities, preceding (and indeed, promoting) their development. Theoretically, then, both children’s and therapists’ tasks can be seen in White’s map. The levels of a therapist’s leading questions and a child’s responses on the map should be readily available to observation. For example, if a child switches from one aspect of an externalization to another, as would be expected at the complex stage, the therapist’s task in the zone of proximal development might be observed as re-circulating language (Duvall et al., 2003) so that it consistently directs attention to those elements that the client denotes as relevant.

According to White’s (2006) utilization of Vygotsky (1978, 1987), the overarching tasks of the therapist are to abstract elements from the totality of clients’ experiences; to foreground clients’ current base of knowledge about concepts and to make this knowledge more available to
clients without their being fully defined by the concepts; to develop these concepts more richly; and ultimately to assist people in revising their relationship with concepts, thereby expanding their options. A successful outcome will lead to the client’s improved self-mastery in functioning. All of this is accomplished through the tasks the therapist and subsequently the clients perform, as outlined in White’s scaffolding conversations map.

The current study aimed to examine the scaffolding process in the zone of proximal development, as defined by the client-therapist interactions. This research was the first known attempt to study empirically therapist and client movement through the stages of the map. Toward that end, the following section provides a review of the extant research literature on the externalizing process that White (2007) delineated in the statement of position and scaffolding conversations maps.

Externalizing in Narrative Therapy

Few studies exist on the externalizing process in narrative therapy. None that we found looked at White’s maps explicitly, and none included in its definitions or analysis the full richness of the externalizing process as White more clearly described it in his maps and in the later years of his work (e.g., White, 2007).

Some steps on the map, such as naming the problem and recognizing unique outcomes, have arisen in examinations of client and therapist’s descriptive experiences of narrative therapy (O’Connor, Meakes, Pickering, & Schuman, 1997; O’Connor, Davis, Meakes, Pickering, & Schuman, 2004), but overall the findings from these studies suggest that these aspects of externalizing, which are situated earliest on the map, played a smaller role than other aspects of narrative therapy, such as reflecting teams and respectful therapist posture. In contrast, studies that have analyzed language in counselling session (Kogan & Gale, 1997; Muntigl, 2004)
suggest that therapists’ emphasis on naming the problem and its effects have aided client development of resources in meaning-making and in shifting client language around problems and unique outcomes.

Even fewer studies have examined outcomes in narrative therapy as they relate to externalizing, and these findings also have been mixed. A single-case study by Besa (1994) relied on naming the problem and its effects as the initial, baseline period of therapy, and no change was observed until the implementation of behavioral contracts in subsequent sessions. A study by Weber, Davis, and McPhie (2006) was hampered by an insufficient number of participants for statistical analyses, although in qualitative reports participants identified that naming and characterizing the problem contributed to a sense of increased personal agency. Most informative, however, is a recent study by Matos, Santos, Gonçalves, and Martins (2009), which found that unique outcomes and metacognitive reflections were associated with problem-reduction.

The study by Matos et al. (2009) is the most rigorous of the outcome studies and also provides the most positive evaluation of the outcomes of externalizing. Its evaluation of narrative therapy process, however, relied on the authors’ own coding system, rather than on White’s formulation. In contrast, the present study extends previous research on aspects or individual steps of the externalizing process by examining White’s (2006, 2007) more recent, broader definition of externalizing, as clarified in the scaffolding conversations map.

Research Questions

In this study we sought to examine whether narrative sessions demonstrated the type of conversation described in White’s (2006, 2007) scaffolding conversations map. If this concordance could be observed, we sought further to explore whether children responded to
therapists’ scaffolding by responding to therapists at the same level of the map, and whether therapists and children proceeded through the steps of the map over the course of a single session. In this latter regard, we are not suggesting that therapists will necessarily move through the complete scaffolding conversations map in single session, nor that it is preferable to do so, but only that it is possible to do so and hence worth exploring.

**PARTICIPANTS AND CODING**

In this study, we used previously recorded videos of eight single sessions of narrative therapy. Children and youth were 6 to 15 years of age, and usually were participating in services at one of two children’s mental health agency’s walk-in clinics (Young, Dick, Herring, & Lee, 2008). Children and parents specifically consented to the use of the data for the current study. The therapists had not previously met with any of the children and youth, who had a variety of reasons for coming to therapy, such as worry, fear, and ADHD. Three therapists were involved in the study, each a well-established narrative therapist who also had a history of providing training in narrative therapy. One of the therapists (KY) is also an author of this article. Any concerns that therapists’ usual practices may have been altered by a prior knowledge of the research were mitigated by the fact that the study had not been conceived at the time of the recorded sessions.

**Coding**

Each of the video recordings was transcribed verbatim; then, using the transcript, each therapist and child speech turn was coded according to its corresponding step on White’s (2006, 2007) scaffolding conversations map. The coding system comprised five categories or levels, each of which applied equally to both therapist and client contributions to the process, with an additional code of *Other* for utterances that did not fall into any of the existing categories. These
codes, along with examples of their use, are described more fully below. As the more detailed procedures for coding and establishing inter-rater reliability are described in depth in a previous publication (Ramey et al., 2009), they will not be repeated here. It bears noting, however, that the therapists who conducted the sessions were not involved in coding the sessions and that a manual (available from the corresponding author upon request) was prepared to describe therapist and client coding in detail and to guide raters.

To demonstrate the coding system, we will describe each of the levels as they were coded, and provide an example from a transcript by Michael White (2007). In the example we will use, White was meeting with Peter, a 14-year-old with a history of angry outbursts and criminal charges. Peter’s referring therapist noticed that Peter had lately been involved in a situation that he found very frustrating, but Peter chose to leave the room rather than lashing out. In each of the quotes from the sample, White made a statement or asked a question about Peter’s initiative, and Peter responded at the same level of coding. This observed pattern was not assumed to be the case in the sessions under study—indeed, whether such a pattern could be detected was one of our research questions; we draw on these examples to only to illustrate and simplify the explanation of the various levels of the coding system.

*Name.* In the first level, therapists’ and children’s speech turns included naming or characterizing problems or unique outcomes/initiatives. This often involved the therapist re-circulating significant child language. Names and characterizations were offered by children spontaneously or invited through therapist questions or suggestions. As part of characterizing the externalization, speech turns coded *Name* also included conversation about the history of problems or initiatives, or the tactics and strategies used by the problem. In the conversation between White (2007) and Peter, White responded to a statement from Peter by saying, “So
that’s a name for what you did? It was about ‘walking away from trouble.’” Peter confirmed White’s statement and elaborated on it, saying “Yeah. I figured, ‘Who needs it?’” (p. 223). In our coding system, these both would be coded as Name.

**Consequences.** In the second level, chains of association were made between problems and initiatives and consequences in children’s lives. Speech turns focused on the effects or potential effects of the problem or initiative on aspects of children’s lives, such as their relationships, behaviour, or feelings about themselves.¹ In the sample from White’s (2007) transcript, White asked about the effects walking away had on Peter’s life: “What did this make possible for you?... What happened after this that wouldn’t have happened if you’d lost it?” Peter responded at the same level: “I kept my privileges… Weekend leave. My metalwork class. I didn’t have to go to counseling” (p. 224).

**Evaluate.** In the third level of coding, therapists and children drew realizations and learnings about these consequences. This included therapists inviting or children spontaneously presenting an evaluation, or statement of position, on the problem or initiative or its effects. These statements indicated where children stand in regard to the problem or initiative. Occasionally, this level also included other realizations about the problem or initiative or its effects as new learnings emerged about previously established chains of association—for example, what children felt the problem needed or what should be done to it. At this level White (2007) summarized the changes Peter had made, and asked “What is it like for you to see this happening in your life?” and Peter responded, “It’s good to see I suppose… It’s positive” (p. 227).

**Intentions.** At the fourth level of coding, therapists and children reflected on realizations from the previous level (**Evaluate**), and children’s statements about what they want with regard
to the problem or initiative were connected to what children value and intend for their lives. Speech turns were about the broader purposes, beliefs, intentions, hopes, wishes, commitments, or dreams children or youth have for their lives or identities. At this level, White (2007) asked Peter to explain why walking away from trouble and other changes were positive: “Do you know why this development makes you feel good… Why is getting somewhere important to you?”, and Peter replied “Because I’ll be able to do something with my life…I’ll be able to say what I want and do something about it” (pp. 227-228).

Plans. In the final level, therapists and children expanded their conclusions into plans. Speech turns involved next steps, possibilities, or outcomes, given children’s conclusions and what they want for their future. Making plans included using what had been learned about problems, expanding on initiatives, and recruiting support systems. There are no speech turns at this level in the section of transcript from White (2007), but it is possible to imagine that speech turns at this level might include plans to do something that worked in the past, such as Peter reminding himself that he has done this before and that he wants a say in the direction of his life.

Other. Any speech turn that did not correspond with one of the steps on the map was coded as Other.

In the example with Peter it is an initiative, namely “walking away from trouble,” that is the focus of the scaffolding and concept formation conversation. However, as White (2006, 2007) incorporated both problems and initiatives in his revised version of the map, both were included in the sessions coded in the current study.

This first level of coding for the therapist and child speech turns was used for the initial frequency counts. Once the first level of coding was complete, speech turns were paired, so that each therapist speech turn and the following child speech turn contained two units of coding, but
each pair contributed one data point to the analysis. Speech turn pairs also were coded according to whether they occurred in the beginning, middle, or end of the session, to see if the patterns of talk were different at different points in the session.

**Analysis**

In addition to simple descriptive data on whether and how often therapists’ and children’s statements corresponded with the levels of the map, the original quantitative study relied on sequential analysis (Bakeman & Gottman, 1997). As its name indicates, sequential analysis allows for the examination of sequential behaviors, to discover what patterns of serial behaviors occur in social interactions. The use of sequential analysis allowed us to determine whether children were significantly more likely to respond at the same level of the map as the therapist, rather than pursuing conversation at another level of the map or another line of discussion altogether. It also allowed us to examine whether the conversation advanced along the steps of the map over the course of the session.

**RESULTS**

**Overall Frequencies**

In total, more than 2300 individual speech turns were coded. Overall, therapist and child speech turns were most frequently coded as Name (46% and 47%, respectively), followed at some distance by speech turns at other levels. The coding frequencies were as follows: Consequences (therapist 14%, child 13%), Evaluate (6%, 6%), Intentions (12%, 12%), Plans (10%, 9%), and Other (13%, 13%).

The coding frequencies tell us a number of things about what occurred in the sessions. First, in light of the fact that relatively few speech turns were coded as Other, and in answer to our first research question, most therapist and child speech turns were codable at some level of
the scaffolding conversations map. In the sessions under study, therapists and children speech turns matched some level of the map approximately 87% of the time. Also interesting was the distribution of the codes. Almost half of the speech turns were dedicated to naming and characterizing the problem or initiative, perhaps the most widely recognizable aspect of narrative therapy. The remainder of therapists’ and children’s speech turns were coded at the levels of Consequences, Intentions, Plans, and Other an approximately equal number of times, with somewhat fewer speech turns dedicated to the Evaluate level. The Other category was not broken down more precisely, so the conclusions that can be drawn from it are limited. However, speech turns at this level sometimes contained discussion about strengths and interests, and about other people in the children’s lives, such as parents and coaches. These might simply be considered ways to facilitate joining, but such questions also might have acted as precursors to the final level, Plans, as the information gathered sometimes contributed to the development of plans to recruit support people or build on strengths in the future.

Further analysis was necessary to provide answers to our second and third research questions. To analyze the coded data, the paired therapist-child speech turns first were compiled in a frequency table (see Table 1 for a condensed version). We have also made extensive use of the qualitative data contained in the transcripts to explore these questions and further illustrate our findings.

*Therapist Scaffolding*

In answer to our second research question, we found that children responded to the scaffolding provided by the therapists, as indicated by their tendency to respond at the same level of the scaffolding conversations map. This tendency is illustrated by the following excerpts from the transcript data:
Example Name:

Therapist: “Can you think of times when ADHD’s tried to get the steering wheel but you’ve managed to take it yourself?”

Child: “Helping out with the gardening.”

Example Consequences:

Therapist: “Whereabouts does [the ADHD] get you in trouble?”

Child: “Fighting with [my brother].”

Example Evaluate:

Therapist: “How do you feel about that now?”

Child: “I feel good that I didn’t do it.”

Example Intentions:

Therapist: “Why would you worry about that?”

Child: “Because I want to be strong and get bigger.”

Example Plans:

Therapist: “How can your mom and dad help for back up?”

Child: “Maybe talk to me in private sometimes, to see how it’s going.”

Movement Through the Map

Our third research question was whether therapists and children proceeded through the steps of the map over the course of single sessions of therapy. Again, as expected, we found that both therapists and children tended to move away from the earlier stages in the map and toward later stages of the map over the course of a single session. The following therapist quotes are all taken from the same session, and illustrate this movement.

Example, early in session:
Is it okay to call it perfectionism? *(Name)*

What else does perfectionism demand from you? ... Does it demand of you to act certain ways with people or be certain ways with people? *(Consequences)*

Example, mid-session:

So, if you were going to evaluate this on sort of like it/don’t like it, appreciate it/don’t appreciate it, or even good/bad, where would that be? *(Evaluate)*

Does that have to do with that idea of I’m fine how I am… And I guess I’m talking about it because I think that the more you can understand that to be a big part of yourself and who you are, the more you have some words to describe that, kind of like the more available it can be to you. *(Intentions)*

Example, later in session:

I wonder if there might be some way that you can actually begin to protest this? To protest the way that perfectionism creates frustration for you. *(Plans)*

Our results show that children’s movement across the stages of the map was similar to therapists’ movement.

Example, early in session:

It's a little bit of feeling worried, a little bit of stomach acid, and burning. *(Name)*

[The worry] kind of tells me to feel the pain sometimes, because it doesn’t want me to do something sometimes. *(Consequences)*

Example, mid-session:

I just really don’t want to think about the worry. *(Evaluate)*

Example, later in session:
[Because the worry] kind of makes me not believe in myself. It makes me think that I can’t do it. It’s like almost the exact opposite of, that I can believe in myself. (*Intentions*)

[I could ask my parents] about what I should do if I feel sick. What they did about their worries when they were a kid. Like, they might have got their parents to help them or something, and my dad, he’d probably tell me and it could just work! (*Plans*)

**DISCUSSION**

The results demonstrate that therapists and children and youth’s conversations were reliant on the scaffolding conversations map, primarily at the level of naming and characterizing the problem, but also at the four other levels of externalizing. In answer to our first research question, whether narrative therapy sessions demonstrate the type of conversation described in White’s scaffolding conversations map, we found that the majority of speech turns were coded at one of these levels of the map. Also of interest, almost half of the speech turns were coded at the first level of the map, naming and characterizing the problem. Although this study was a process analysis and did not consider outcomes, the high proportion of therapist questions and statements at the first level of the scaffolding conversations map suggests that naming and characterizing the problem is an important part of narrative therapy.

In answer to our second question, the results indicated that when therapists offered a statement or question, children and youth were likely to reply at the same level of externalization. In other words, we found that children tended to respond to therapists’ scaffolding by responding to therapists’ questions or statements at the same level of the map.

In answer to our third research question, the results also indicated that both therapists and children and youth demonstrated movement through the general steps of externalizing during single-sessions of therapy. According to White’s interpretation of Vygotsky (1978, 1987),
therapists tended toward increasing levels of scaffolding and children tended toward increasing levels of concept formation as the session progressed.

It may be taken as self-evident that children follow the lead of therapists in therapeutic conversations. The scaffolding metaphor certainly suggests this much: through the linguistic scaffold constituted by externalizing talk the therapist assists the client in moving toward ways of thinking and speaking that afford the latter greater choice for action and increased opportunities for self-reflective engagement with multiple voices and narratives (Paré & Lysack, 2004), all toward the end of enhancing possibilities for self-definition. However, it is in no way a natural consequence that children mechanically follow the reasoning or language of adult therapists, nor, more generally, that they play a passive role in therapeutic conversations. As Paré and Lysack (2004) have argued, although the therapist may introduce the externalizing talk into the therapeutic conversation,

clients can and do bring material to therapeutic conversations that subsequently provide structure for co-shaping meanings. Like the non-metaphorical sense of the word—a temporary structure for aiding in construction—the “scaffold” that [the therapist] introduces is subsequently reshaped and modified by both he and [the client] through their responses to each other. (p. 13)

It is also important also to note in this regard that Vygotsky (1934/1987) himself strongly disputed the belief that imitation is independent of understanding. Vygotsky stated that children can only imitate what lies within their potential: “if I do not know higher mathematics, a demonstration of the resolution of a differential equation will not move my own thought in that direction by a single step. To imitate, there must be some possibility of moving from what I can do to what I cannot” (p. 209). In considering the stages of White’s map, blind imitation must have been especially unlikely at higher levels of externalizing, as children had to comprehend
lower levels of externalizing sufficiently to respond and formulate new understandings based on prior therapist scaffolding. The intricacy of this task is apparent in the following example from the transcripts:

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

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

In the example, the therapist briefly summarized at the first level of the map, naming and characterizing the problem, and scaffolded with a question at the fourth level, regarding intentions the child has for his life. The child responded with his wish for a life without the pain or worry, at the same time drawing together evaluations and realizations from earlier in the conversation (including the realizations that the worry lies, that the hurting is an effect of the worry, and the “feeling better” is an effect of his initiatives into carrying on despite the worry). Such complex responses were not unique, and do not demonstrate speech or behaviour that is automatic, mechanical, or passively repetitive of authoritative therapeutic discourse; rather, they disclose children’s active efforts to appropriate the linguistic resources of the therapeutic encounter (cf. Muntigl, 2004).

Limitations and Future Directions

As already noted, the study reported here did not attempt to establish effectiveness or efficacy outside of sessions. Further, as it involved a limited number of therapists, clients, and
sessions, the results are not necessarily generalizable or reflective of narrative therapy as such. The study also was limited to the statement of positions maps (externalizing, unique outcomes) and their incarnation in the scaffolding conversations map. It was not possible to incorporate other maps used in narrative therapy, such as the re-membering or re-authoring maps (White, 2007), within the limited scope of this study. Future directions for research might include the longer-term use of narrative therapy, replication with other therapists, children, and youth, the use of other narrative therapy maps and, with caution, outcome research.

**Implications**

The current study has implications both for research and practice. With regard to research, the findings demonstrate that Michael White’s (2006, 2007) model of therapy is observable in sessions. This opens the door for further research on process in narrative therapy, possibly as described above. Also, although the non-experimental research design does not allow us to attribute changes in children’s language specifically to the therapist scaffolding, the findings do suggest that change occurred at the level of language over the course of the session. As such, this study lays the foundation for research questions regarding potential links between White’s process and therapeutic outcomes around children’s thinking and actions outside of sessions.

It must be noted, however, that the current study was not an attempt to manualize process in narrative therapy in order to lay the groundwork for effectiveness or efficacy research. Rather, it was—in part—an attempt to respond to Foucauldian ideals in establishing a self-reflective platform for offering therapy by evaluating White’s (2006) ideas about what narrative therapy is intended to accomplish. Such systematic self-reflection is necessary for therapists to be accountable to the people who consult with them. We believe that research is a form of self-
examination, as it involves re-visiting therapy work that has been done, and thus can provide one, although not the only, tool for self-reflection. Nonetheless, and despite the usefulness of research as a form of systematic self-reflection, research alone should not drive therapy. Research findings must be balanced by other contributions to practitioner knowledge, and research in narrative therapy must be conducted with attention to the philosophical foundations provided by Foucault (White & Epston, 1990).

With regard to implications for practice, the findings demonstrate that the narrative therapy approach of scaffolding and the use of maps can be learned by therapists other than Michael White; the model that White (2006, 2007) has presented is reproducible. As well, in supporting White’s claim that scaffolding and concept formation occur in session, the study clarifies what is happening in narrative conversations.

**Conclusions**

Overall, our findings indicated that White’s (2006, 2007) scaffolding conversations map and model of therapy was observable in single-sessions of therapy with children and youth. Patterns of therapists and children and youth’s interactions demonstrated White’s interpretation of scaffolding and the development of concept formation. The occurrence of change in a therapy session, with its potential to influence subsequent action, is the first step toward change in a child or youth’s life.
Michael White has used the terms “consequences,” “effects,” and “chains of association” to describe this level of scaffolding. We will use the term “consequences” for the remainder of this paper, as it is clearer than “chains of association,” and avoids the connotations of the term “effects,” particularly in the context of its use in experimental research designs (e.g., main effects, program effects).
REFERENCES


Table 1

*Frequencies (and Percentages) of Therapist by Child Codes (N = 1187)*

<table>
<thead>
<tr>
<th>Therapist level</th>
<th>Name</th>
<th>Consequences</th>
<th>Evaluate</th>
<th>Intentions</th>
<th>Plans</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>502 (42.3%)</td>
<td>18 (1.5%)</td>
<td>5 (0.4%)</td>
<td>8 (0.7%)</td>
<td>4 (0.3%)</td>
<td>16 (1.4%)</td>
</tr>
<tr>
<td>Consequences</td>
<td>18 (1.5%)</td>
<td>134 (11.3%)</td>
<td>2 (0.2%)</td>
<td>0 (0.0%)</td>
<td>3 (0.3%)</td>
<td>1 (0.1%)</td>
</tr>
<tr>
<td>Evaluate</td>
<td>2 (0.2%)</td>
<td>3 (0.3%)</td>
<td>54 (4.6%)</td>
<td>7 (0.6%)</td>
<td>2 (0.2%)</td>
<td>2 (0.2%)</td>
</tr>
<tr>
<td>Intentions</td>
<td>5 (0.4%)</td>
<td>3 (0.3%)</td>
<td>7 (0.6%)</td>
<td>117 (9.9%)</td>
<td>0 (0.0%)</td>
<td>10 (0.8%)</td>
</tr>
<tr>
<td>Plans</td>
<td>4 (0.3%)</td>
<td>2 (0.2%)</td>
<td>0 (0.0%)</td>
<td>1 (0.1%)</td>
<td>95 (8.0%)</td>
<td>4 (0.3%)</td>
</tr>
<tr>
<td>Other</td>
<td>11 (0.9%)</td>
<td>5 (0.4%)</td>
<td>3 (0.3%)</td>
<td>4 (0.3%)</td>
<td>9 (0.8%)</td>
<td>126 (10.6%)</td>
</tr>
<tr>
<td>Distancing level/Code</td>
<td>Possible to know</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very high level (<em>Plans</em>)</td>
<td>“Do you know why this development makes you feel good?”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High level (<em>Intentions</em>)</td>
<td>“What’s it like for you to see this happening...?”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium-high level (<em>Evaluate</em>)</td>
<td>“What happened after this…?”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium level (<em>Consequences</em>)</td>
<td>“It was about ‘walking away from trouble’. ”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low level (<em>Name</em>)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 1. Sample scaffolding conversations and coding map. Samples in quotes are all therapist statements taken from White (2007, pp. 223-227).