MULTI-STORY LISTENING: USING NARRATIVE PRACTICES AT WALK-IN CLINICS

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ABSTRACT

This paper begins with a short story of the unique service delivery environment in Ontario, which includes an unprecedented number of walk-in therapy clinics, and how this came to be. Some of the pivotal events along this journey are described, which included a policy-ready paper that helped to shape change in services, a multi-agency evaluation project of several walk-in therapy clinics, and a successful appeal resulting in the recognition of single session therapy as psychotherapy. The history of connection between walk-in therapy and narrative therapy is introduced with a focus on what it is about narrative practices that are such a useful fit with these single sessions. A particularly important aspect of narrative therapy that the author calls multi-story listening is explored in detail with a clinical example.

Key words: walk-in therapy, single session therapy, narrative therapy, brief narrative therapy, multi-story listening

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Introduction

What are the stories of how Ontario developed such an enormous number of walk-in therapy clinics? One possible story includes the grass roots movement in mental health that was inspired by people who believed that everyone should have quick access to a useful therapy session. Important milestone events in this story include a policy-ready paper that helped to shape change in service delivery, a multi-agency evaluation project of several walk-in therapy clinics, and a successful appeal resulting in the recognition of single session therapy as psychotherapy. As walk-in clinics developed in Ontario the clinicians that staffed them began to explore the application of narrative practices in this single session therapy environment. Over a nineteen-year timeframe, narrative practices, often referred to as 'brief narrative therapy', have become a prevalent way of working in Ontario's walk-in clinics (Young, 2018; 2011; 2008; Ramey, Young & Tarulli, 2010; Duvall & Beres, 2011). Narrative therapy provides therapists with ways of listening that can be described as 'multi-story listening'. This is particularly useful in walk-in sessions as the questions that spring from this method of listening invite people into explorations of stories that have been in the shadows of problem stories and facilitate powerful realizations for people.

The Phenomenal Growth of Walk-in Therapy

Since 2000 there has been a wave of growth of walk-in therapy clinics in Ontario, Canada. Currently there are at least 80 operating clinics in the province. These clinics provide people with immediate help when they need it, and engage people in therapeutic encounters that are useful, meaningful and oriented to discovery of their knowledge,

skills and values. This is an achievement in responsive socially just service delivery (Young, 2018).

The short story of this journey in service delivery starts with passion and commitment to find new ways to deliver therapeutic conversations to people when they need it, without wait times and without complex access barriers. Increasing accessibility of therapy is a social justice action (Young & Jebreen, 2019 ; Hoyt & Talmon, 2018). Between 2000 and 2001, three organizations in Ontario opened clinics by reorganizing service delivery pathways (Young, Dick, Herring & Lee, 2008). Other organizations followed and by 2008 there were about 15 clinics operating.

As organizations explored which therapeutic approaches might fit well with offering immediate therapy sessions at walk-in clinics, narrative practices appeared to be promising. The invitations to narrative therapy trainers who had experience applying these practices to single sessions grew as organizations sought to provide training in "brief narrative therapy" to clinicians who were staffing walk-in clinics. The connection between narrative practices and walk-in clinics was ignited. Over the years since 2001, I have had the opportunity to support over 60 organizations in developing walk-in clinics that are influenced by brief narrative therapy practices. These practices assist therapists at these clinics to find ways to make the most of every session.

There were some important milestone events in the journey of walk-in therapy in Ontario. In 2012 the policy ready paper, No more, no less, Brief mental health services for children and youth (Duvall, et al., 2012) lead the way to new government policy that required all children's mental health services across the province to include a method of quick access to brief therapy services for families. This set the stage for large-scale

growth of walk-in therapy clinics across Ontario. The interest in developing these clinics spread into adult mental health services rapidly and into most other sectors including on-campus student services at universities and colleges.

In 2014 the Ontario Centre of Excellence for Child and Youth Mental Health sponsored a comprehensive evaluation of multiple walk-in therapy clinics across the province (Young & Bhanot-Malhotra, 2014). This evaluation collected pre and post measures from up to 494 clients who had used walk-in clinics at seven different organizations across the province. Results included understanding that 77% of the clients reported having new realizations/aha moments in the single session and then at 3 months after the session 86% of the clients reported continued use of the ideas from the session. All of the organizations that participated in this evaluation staffed their walk-in clinics with therapists that had been trained in brief narrative therapy.

Through the years from 2016 to 2019 there were challenges to the recognition of single session therapy as psychotherapy in Ontario. A new professional college was not accepting of some therapist's hours of single session therapy as required hours of psychotherapy practice. There were several appeals taken to the Ontario Health Professions Appeal and Review Board until 2019 when an appeal decision accepted single session therapy as psychotherapy (Young & Jebreen, 2019).

Therapy at Walk-in Clinics

Single session therapy (SST) at walk-in clinics and other service delivery settings is an opportunity for a therapeutic conversation that is meaningful and useful in people's lives.

The philosophy is based on the idea of "when all the time you have is now" (Young, 2011), inviting the therapist to prioritize creating a meaningful therapeutic encounter in the single session. This requires therapists to have faith that one session can facilitate change and to move away from certain traditions or habits that could inform how we shape the conversation (Hoyt, Bobele, Slive, Young, & Talmon, 2018; Bobele & Slive, 2014; Slive & Bobele, 2011; Rosenbaum, 2008; Talmon, 1990). The therapist acts as if the first session is both the first and could be the last, making the most of the session in terms of therapeutic impact. This requires therapists to do more than just information gathering, problem solving, or fixing, more than just pointing out positives, and more than offering advice or psycho-education. The therapist creates an enriched environment for therapeutic change (Young, Hibel, Tartar & Fernandez, 2017) by maintaining a competency focus (Duvall, et al., 2012) and through facilitating high degrees of collaboration and social engagement. This results in an optimal environment for change (Cozolino, 2010).

Narrative Practices at Walk-in

Narrative practices are an excellent fit at walk-in clinics as the posture, curiousity, listening, and questioning supports an optimal environment for a therapeutic journey (Young, 2018; Young, et al., 2017; Duvall & Beres, 2011; Ramey et al., 2010: Young & Cooper, 2008). Within the scope of narrative therapy there are many practices that are useful for single sessions (Young, 2011; White, 2007). What is different when engaging with narrative practices in SST is the importance of establishing a clear purpose or agenda for the conversation and then the therapist being very intentionally focused on which aspects of narrative practice might best fit with the client's desires for the session.

The session must be paced to fit within the allotted time and have a clear beginning, middle and ending (Duvall & Beres, 2011) so the session can potentially stand-alone.

A narrative therapist works to ask unexpected questions that engage the client's interest and imagination. Conversations are outside of the known and familiar (Vygotsky, 1987; 1978; Ramey, et al., 2010; White, 2007) and move into novel and unexpected territories. As a result of this movement, most clients attending sessions at walk-in therapy clinics have reported experiencing new realizations or aha moments (Young & Bhanot-Malhotra, 2014).

Narrative practices engage clients in novel conversations through explorations of stories that are outside of the taken for granted. This can include conversations that deconstruct the problem story, uncovering previously invisible aspects of the operations of the problem through externalizing the problem—separating the person from the problem, which can lead to aha moments about the person's relationship with the problem (Marsten, Epston & Markham, 2016; Young, 2008, White, 2007; Epston, 1998). Narrative practices encourage therapists to not only explore the problem story, but to listen for stories that are outside of the dominant problem story, and to ask questions that thicken or develop the details of these stories. These explorations of stories that have been in the shadows of the problem facilitate powerful aha moments for people.

Multi-story Listening

In therapeutic conversations, including at walk-in therapy clinics, we can use the narrative therapy concept of doubly listening—seeking two stories (White, 2004; 2003), to listen for and enquire into the stories of life that are outside of the problem story. We are listening for two stories, the explicit story, usually regarding something that is

problematic, and the implicit story that is in the shadows of the problem story. The implicit listening we are doing is focused on hearing in people's words, what they value, what they hold as important, what matters to them, and what their hopes and preferences are for their lives, and to hear within these stories reflections of their knowledge, qualities, and initiatives.

Narrative therapy practices as developed by Michael White have, since their beginnings, been oriented to exploring alternative stories (White, 1989) and preferred stories of people's lives and identities (White, 1993; 1995; 2001). Alternative stories can be understood as descriptions or accounts of events in people's lives that are outside of the problem story. Preferred stories are particular alternative stories that represent people's intentions, values and preferences for their lives. "We can use therapeutic questions to provide stepping stones for people to 'learn' previously unknown things about themselves in the, as yet, unexplored, territories of their preferred stories." (Carey, Walther & Russell, 2009, p. 320). White also wrote about these stories as subordinate storylines (2007; 2005) as they are stories that are often over-shadowed by a problematic story. He wrote that through an enquiry into these stories and asking questions that create rich story development that, "what had previously been a subordinate storyline began to overshadow the initially dominant account…" (2007, p. 99).

The practice of exploring these alternative, preferred, or subordinate stories is not limited to a search for exceptions to the problem such as enquiring about times when "the problem" is not present or not occurring. It is also not a re-framing of people's experience, or simply a looking for the positive side of experiences, nor is it a re-placing of one story with another account. It is rather a re-visioning of people's experience and

histories that brings forward a multi-storied account (White, 2000). It is not story replacement but is story expansion. The therapist is "being consistent with the assumption that life is multistoried" (White, 2007, p. 213).

When we are attending to stories, we listen to the events as they unfold across time in the "landscape of action" and to the meaning-making part of the story in the "landscape of consciousness" (White, 2007, p. 78). The landscape of consciousness is composed of conclusions or descriptions about the identity of the person. White eventually began to refer to this as the "landscape of identity" (White, 2007, p. 81) and proposed that a principle task of therapy is the "redevelopment of personal narratives and the reconstruction of identity" (White, 2007, p. 80). Landscape of identity questions support this task and give rise to both "internal state understandings" and "intentional state understandings" (White, 2007, p 100-104).

Landscape of identity questions that give rise to internal state understandings and intentional state understandings are very powerfully transporting of people's personal narratives. Internal state understandings generally feature conclusions about qualities 'within' a person such as bravery, determination, patience and so on. In walk-in therapy sessions we could ask questions that elicit internal state understandings such as:

- What would you say it took for you to come here today?
- What is it about you that made it possible for you to speak about this today?
- What do you know about yourself that might explain your ability to take an action like this?

We then thicken these descriptions by tracing the quality across time, across contexts of the person's life, across relationships in their lives and so on. We might ask, "When you

say that you're determined, can you tell me a bit about how you might have developed this determination? Did you have determination training? Oh you did. What was it? The quality is not just seen as 'naturally' present, but is accounted for as a response to experience and events of life. The quality becomes part of a larger story.

Many parents who attend walk-in clinics with their sons or daughters might describe a problem story like this; "we are arguing almost all the time, yelling, disagreeing about most things, and not talking much." Listening to this problem statement or 'complaint' for multi-stories changes the questions that the therapist could ask next. If we listen for what is not yet spoken of in terms of intentional state understandings, we would ask questions to explore values, hopes, commitments and so on. We might ask:

- When you say this, it has me guessing that there is something that you really value and perhaps even long for that is very different from what is happening? What is that?
- When you tell me this, it has me wondering how you'd describe what it is that you're longing for?
- What would you say coming here today to speak about the arguing and its negative effects on your relationship with your daughter says about what you're placing value on?
- Would you say that speaking about this today is more like going along with what The Arguing would have for your relationship with your son, or more like a refusal to let The Arguing have its way with your relationship? What does this refusal say about who you are and what matters to you?

In walk-in therapy sessions the responses from parents to these intentional state questions that seek multi-stories shift the conversation away from being dominated by the 'complaint' story and instead toward a story of longing, values and preferences. This opens space for stories of how the person preserved what is valued, how they have taken even small initiatives toward what they prefer, and perhaps how this longing may be shared by both the parent and the child or youth. As White wrote, "Of all the responses that are invoked by landscape of identity questions, it is the intentional understandings and understandings that are centred on considerations of value that are most significant with regard to rich story development" (2007, p. 100).

The Absent but Implicit

Explorations of multistoried accounts of life were further expanded upon by White in describing listening for and exploring the 'absent but implicit' (White, 2007; 2000). White proposed that there is a duality to all descriptions or that all single description can be understood as "the visible side of a double description" (p. 36). What is on the other side of the description is what is being discerned and that which allowed for the discernment. "We can describe the absent but implicit as the idea that we make meanings of any experience by contrasting it with some other experience or set of experiences" (Freedman, 2012, p. 2).

Listening for the absent but implicit expands therapist's abilities to attend to what matters to people, what they value, and then link these to experience and knowledge that has shone a light on what is valued. The knowledge that has informed these values is understood as the person's skill in discerning the contrast between what is and what they are longing for instead. The therapist listens closely to people's expressions and asks

questions that explore the unstated; "that is, whatever it is that this discernment speaks to" (White, 2000, p. 41). These multi-story explorations bring forward alternative identity descriptions that contrast with negative identity conclusions that have been constructed within a problem story.

I propose that this alternative theory or method of listening is highly useful in walk-in therapy as it opens up alternative understandings of experiences and how people see themselves in relation to these in a single session. It is an intentional listening. The therapist is not listening for symptoms or reasons to explain the problem, nor are they listening for strengths or resources. These ways of listening are based on searching for truth shaped by a metaphor such as 'peeling the onion' and an understanding of establishing people's worth according to their contribution to society through being a resource (White, 2002). Instead the therapist is not just listening to but is intentionally listening for certain expressions (Hibel & Polanco, 2010). We are listening for "what is said only faintly" (Hibel & Polanco, 2010, p. 51).

A conversation guided by the absent but implicit

In the following conversation I am meeting with a woman that I will call Elissa, who is 28 years of age. She has come to a clinic where I was teaching for a day and providing 'demonstration' sessions for a team of clinicians regarding narrative therapy with single sessions.

K: What hopes or wishes do you have for this conversation that you'd like me to know about? *(Therapist is "setting the agenda", finding the theme for or purpose for the conversation.)*

E: Ok. Well, what I hope from this conversation is that- I'm ready to put some things away, and move forward…

K: Move forward from what?

E: From some family stuff, I had some traumatic things in my family, some emotional abuse really…mental abuse. But I know that my father is not going to change. He says so many things that are so hurtful. It just gets me so upset. I get taken back into how it was when I was growing up. My dad is so extreme with his emotions, and even now when my dad yells I am still shocked, after all these years. You'd think after years and years of this that I'd just become numb or just accept it, but I obviously haven't been able to do that, I still cry. I think that's what I need to do- I need to get over this. Why I am so shocked still?

A close listening to the words "I am still shocked" invites attention to the absent but implicit in those words. What does her expression of "shock" suggest about what she has discerned or contrasted? What does the "shock' point to in terms of preferences for her life? What does the "shock" illuminate about what Elissa places value on?

There is also another background story that can be heard within Elissa's words, "I obviously haven't been able to do that, I still cry. I think that's what I need to do-I need to get over this." These words seem to represent an evaluation of failure—failure to get over it. This requirement to 'get over things' is influenced by a cultural discourse to do with moving on, letting go of, and stories that being strong and 'together' would include doing this. I would not want to inadvertently join in an agenda to work on 'getting over this' and thereby join with the failure evaluation. I wondered if questions that intend to draw out the absent but implicit in the words "shock" might be useful in

dissolving the failure story. I thought it possible that questions that explored this might bring forward stories of Elissa's preferences and hopes, and the knowledge, qualities, skills and values that assisted her in recognizing or discerning what she has. I thought that this might facilitate the most potentially powerful outcome for the single session.

K: What do you think that the "shock" might reflect about things like values, your position on how people should treat each other, or other things…what do you think the shock is a reflection of? *(seeking what is absent but implicit)*

E: What is it a reflection of? (pauses, thinking) I don't know. (pauses again) Maybe it's… it's that I wish, I want my dad to be the kind of dad that will just talk, and listen to what is happening in my life, … just have conversations, and not just about how he thinks I should be and how I should do this, this, and this…. I think the shock is a reflection of maybe this image and that he is not this person. *(Elissa has begun to describe what she is contrasting with her current experience).*

K: So what I understand is that you've hung onto these wishes of what you'd like in your relationship with your dad, and generally between dad's and daughters. That you've got some images of how those relationships could look that you have hung onto all these years?

E: Yes. That's all I wanted.

K: Where do you think this image of a loving father/daughter relationship came from for you? Do you think you saw it somewhere, maybe witnessed this in someone else's relationship?

Here there is an exploration of Elissa's history of experiences that she was drawing on to inform this image. This included a re-membering conversation (White,

2007) where connections were made with significant persons in Elissa's past that contributed to her understandings of what is important in life.

E: I never thought about it until now, but knowing them really helped. Cause how they were was so opposite of what I had at home—the criticism and all the anger, then and now. It still shocks me how bad it is. I guess the shock was there then too. (She pauses and appears to reflect deeply) It's always been there, the shock. So much that I even knew when I was a teenager that I needed to move out soon, to get free, if I didn't I wouldn't survive, so I secretly looked for an apartment and moved out. I had to find it myself, get a job, and leave, at such a young age. But I had to—to get away from all of it.

K: What might you call this action and decision you took?

K: Well …. like a stand (pauses thoughtfully) a stand for healing and a better life.

K: What do you think it took for you to do this? What kind of quality in you was reflected in this stand for healing and a better life?

E: Well, I think, I guess, maybe it was like a fierce determination, determination for a different life than that one was. *(This description is an internal state understanding within the landscape of identity—a quality)*

K: Might that have been a type of refusal or a protest?

E: Yes. Then and now, I've had enough of it!

K: What exactly have you had enough of?

E: Those ways that he treats me, and my mother. And in a way, this has made me clear about how I want to be treated in relationships.

K: What are these ways that you want to be treated in relationships that are now more visible to you?

E: Well, I want to be in relationships that are, let me see…I guess I'd say based on respect of each other, really liking the other person for who they are, you know, valuing them. And being kind, and giving to each other. That's what I want.

K: Do you see this ability to recognize what is not ok, and to have this vision of how you do want relationships to be—the contrast, of how 'this' is different from 'how it should be', as something useful, even though the shock is a part of these recognitions?

E: (pauses, thoughtful) Ya. Now I am thinking, yes! It is a good thing that I developed this awareness I think…yes. It's been something I've been able to keep with me.

K: Can you tell me something about why you would say this—that the awareness is a good thing?

E: I think because knowing, or like, picturing how things could be different is what helped me to decide to leave back then, and now keeps me in relationships with friends who are, you know, how I want things—like respectful and kind. And, it keeps me clear about how I want to be treating people.

K: And you said a minute ago too, that you've 'been able to keep' the awareness with you?

E: Right. Yes.

K: When you state it like that—'been able to', it sounds like you might be seeing this as an achievement of some kind?

E: Now, when I think about it, I'd say yes. That even though my home life was so different from the picture of what I wanted, that I managed to keep a hold of the picture, and that I took steps in my life to, like, um, create, I guess, that picture for myself.

K: So, from that vantage point, now, how might you see 'shock' differently than before?

E: I guess before I was seeing the shock as something I shouldn't still be having. But now, I think that now I'm seeing the 'shock' as still there because of my strong picture of how it could be, and my wish for that, and even though, like I'm not saying I like the 'shock' (laughing a bit) but now it's like I see it differently. *(Her response seems to indicate that her sense of failure is beginning to dissolve.)*

K: How might seeing the 'shock' in this way, make some difference to how you might be seeing yourself, or the situation, next time you're faced with the abusive practices at home? *(As the session moves toward an ending I am exploring Elissa's imagined future possibilities for the effects of this new view.)*

E: Well, I think that, let's see…. I believe that next time this happens, even though I probably will still feel upset and shocked, that I will be seeing myself differently, and that these feelings are, like they show my ability to hang on to the vision. And this is really a good thing—I mean to have the picture in my mind of how else it could be. And I guess that I'll still be shocked but I won't be so hard on myself and thinking I'm sort of 'not ok' for feeling that. I will help me to get through it to think that.

As this single session of therapy comes to an end Elissa describes a newly emerged alternative story which contrasts with the original problem story that characterized her as failing to 'get over' the shock. She is instead connected to a story that honours the shock as a reflection of her values, acknowledges the history of these preferences, and recognizes her ability to keep hold of what is important to her. Through training our 'ears' to hear what is not yet spoken too in people's words and what represents important but so far hidden identity stories, we can co-create meaningful and impactful journeys at walk-in such as this one with Elissa.

Conclusion

Walk-in therapy clinics have created an opportunity for people to experience contact with the mental health system in a way that respects people's unique identities—the knowledge, skills, qualities and values that they have with them. The therapist listens in a way that reflects the belief that life is multi-storied. We listen for the alternative or preferred stories, for stories in the landscape of identity that have been subordinated by the problem story, for what is absent but implicit in peoples' words, and co-develop with the person rich understandings of their internal and intentional states—knowledge, qualities, values and so on. Multi-story listening—listening for and inquiring about multiple stories, especially those stories that have been overshadowed by problem stories, facilitates an unexpected journey in a walk-in session. Elissa's journey was one that she, nor I, could have predicted. The way of listening and the questions are intentional but the destination is always unexpected.

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