Journal of Systemic Therapies, Vol. 32, No. 4, 2013, pp. 33–51

ASSESSMENT SYSTEM OF NARRATIVE CHANGE

JOANA SEQUEIRA
MADALENA ALARCÃO
Coimbra University

The Assessment System of Narrative Change (ASNC) is a method to evaluate narratives in systemic post-modern therapies. ASNC was conceived to describe narrative changes of the system (families, couples, or/and individuals) and integrates seven main dimensions: (A) singularities, (B) nature of the story, (C) narrative connotation, (D) telling of the story, (E) narrative reflexivity, (F) central themes of the session, and (G) alternative behaviors. This system foresees investigation uses (description of system narratives, identification of relevant changing dimensions), clinical uses (narrative diagnoses and evaluation of changing potential, therapy orientation) and training uses (development of skills in educational systemic post-modern orientated programs for therapists).

Different schools of family and couples therapy understand and promote change differently. First-order therapeutic models assume that change should happen in communication and interaction. Second-order therapies focus on narrative transformations that promote and reflect epistemological and functional changes in interpersonal and intrapersonal aspects. For this reason, second-order therapies are more focused on the way change occurs in client constructions, stories, attributions, and perspectives on problems and solutions (Friedlander & Heatherington, 1998; Gurman, Kniskern, & Pinsof, 1986).

Narratives are "stories in discourse formats with a sequential order that connect events in a significant way, in relation to an audience and that favors visions about the world and about intervenient experiences" (Hinchman & Hinchman, 1997, as cited in Elliott, 2005, p. 3). Speech, time, and the coherence and meaning of the stories are central assumptions about the key narrative functions: intelligibility and significance. They are constructed through language negotiation between subjects in relation to each other. Life narratives can also be condensations and abstractions that contain parts of events and circumstances that people experience. Many events occur every day in our lives, but only some of them are storied and given meaning

Address correspondence to Joana Sequeira, Faculty of Psychology and Education Sciences, Coimbra University, Rua do Colégio Novo, 3000 Coimbra, Portugal. E-mail: joanasequeira@esdrm.ipsantarem.pt.

(Freedman & Combs, 2008), and these choices determine the narratives that we construct and that become part of our remembered experience and part of the way we prefer to give significance to events.

According to social constructionism, reality is produced and transformed through interactions and through linguistic and discursive practices that take place in specific socio-historical contexts. Language is not representative of subjects' inner mental states, as constructivist approaches assume. Reality is created and maintained through language and narratives are a product of the discursive negotiation processes between people in interaction and in specific socio-cultural contexts (Gergen & Kaye, 1992). In the construction of perspectives into narratives, it is important to emphasize that they, too, result from a complex interplay between culture and stories. Problems exist in the constructed perspectives, stories and, narratives that subjects use and difficulties can emerge in the integration of, and negotiation between, personal and cultural narratives (Freedman & Combs, 2008). When people come to therapy they tell stories about their problems; these stories often reflect perspectives of incompetence, loss, and sadness and they underline certain links between live events, in time, according to a theme. In therapy, re-authoring conversations must take place. The therapist invites people to continue to explore and tell stories about their lives and to include neglected, but important, aspects that are exceptions or unique outcomes in relation to their dominant storylines (White, 2007). The focus on these novelties creates a starting point for the re-authoring conversations and leads to narrative change.

Therefore, the proper focus of therapy in this social constructionist perspective is the transformation of narratives through therapeutic conversation. According to Freedman and Combs (2008), there are several different experiences and events in every person's life from which many stories originate. Problems are related to a

> thin story that focused only in few of their many experiences. Therapists listen to central story and help clients understand that this story is one of many possible stories. Whenever references to events that are not predicted by the dominant story are made, clients are invited to talk about them, to discuss their meaning, to get into the event and to create a "vivid story" that originates a "new storyline", besides the one constructed around problems. (Freedman & Combs, 2008, p. 230)

Therapy is a interactional, discursive, and meaningful process wherein participants develop alternative constructions of events or "multiple story lines" that have diversified meanings and create several different possibilities and, therefore, alternative ways of being, seeing, and acting. In this process, problematic stories become only one story in the midst of other stories, consequently losing their power and dominance in the narratives of subjects, families, and couples (Freedman & Combs, 2008, p. 231).

Concerning the specific problematic narrative and the process of questioning or deconstructing it (White, 2007), change may occur through several processes. The perturbation of one or several dimensions of the narrative plot, which compose

the stories of the therapy, can be introduced by the clients and therapists in the time, causality, actions, or specific events of the story, contents, or themes, communicational and narrative formats of stories, and in the narrative positions and roles assumed by the participants (Sluzki, 1992). Reflection about the stories and processes of narrative construction is another way of narrative-breaking (Botella, 2001; Sequeira, 2004). It involves reflection and meta-communication about cognitive, relational, and behavioral processes that contribute to organizing problematic and non-problematic narratives. The narrative dynamics become pliable, bringing up visions that differ from the ones constructed around the problem. The power of dominant stories decreases through the amplification and appearance of singular "versions" and exceptions to the problems that promote new narratives (White, 2007; White & Epston, 1990).

It can be concluded that change in therapy presupposes the creation of new stories around problematic ones in order to change their meanings and to reduce their importance in subjects' narratives and in the interplay between them and the cultural available stories. Change also occurs through the transformation and deconstruction of specific problematic narratives by questioning their construction process, meaning, dominance, power organization, coherence, and applicability.

The purpose of this article is to present the Assessment System of Narrative Change (ASNC) that enables the identification of narrative dimensions, narrative processes, and detailed changes that occur in clients' narratives and stories in systemic therapies. ASNC was developed to access specific characteristics of the narrative work that happens in systemic constructionist therapies. With ASNC we hope to give clinicians and researchers a tool to evaluate the narratives during therapy, to diagnose the critical narrative blockages that are related to problems in order to identify and introduce changes in those dimensions. Applications of the ASNC in clinical research about narrative change in systemic therapies, comparing failures to good outcomes, and a qualitative micro analysis of narratives from completed therapeutic processes, considered failures, underline both the research and clinical utility of ASNC (Sequeira, 2012; Sequeira & Alarcão, 2013). Furthermore, subsequent articles from the authors will provide detailed knowledge about these ASNC applications with clinical examples of the coding process of therapy sessions.

The use of the narrative metaphor to explain the process of reality construction and the interaction/negotiation that takes place between subjects in therapy introduces, among other aspects, the assumption that our visions about life are always changing and that therapy is the context were changes must be promoted. In this sense the study of narrative change in therapy is not compatible with conventional approaches, such as psychometric instruments, because they usually don't capture or describe the dynamic process of change that takes place in therapy across time. Several authors (Helmeke & Sprenkle, 2000; Pinsof & Wynne, 2000; Sydow, Beher, Schweitzer, & Retzlaff, 2010; Sprenkle, 2003) point out the importance of increasing the client-focused research, to explain how clients change and how therapy facilitates these processes. That is why, in time, since the narrative concept was adopted, several

different narrative assessment systems have been developed. However, most were originally designed to evaluate narratives in context of individual psychotherapy and were focused on dimensions of the narrative, depending on the epistemological position assumed regarding the concept of narrative, the language, psychological processes, and psychotherapy. Avid and Georgaca (2007) identified two main trends in these studies that utilize the notion of narrative in therapy. The first trend, which reflects the majority of studies, assumes a constructivist approach to narrative drawn from cognitive and constructivist or process-experiential approaches. The second trend, corresponding to a smaller group, assumes a social constructionist approach and draws from the work of post-structuralist theoreticians such as White and Epston (1990) and Parry and Doan (1994, as cited in Avid & Georgaca, 2007). Several narrative assessment systems have been developed drawing from each of these trends, and these systems are focused on thematic analysis and evaluate the meaning and format of narratives during therapy.

From a systemic therapeutic background, Friedlander and Heatherington (1998) developed the Cognitive Construction Coding System, which evaluates clients' descriptions of their problems in four dimensions (intrapersonal-interpersonal, internal-external, responsible-not responsible, and linear-circular).

Theme Analysis is another method of evaluating narratives in therapy (Meier, Boivin, & Meier, 2008). This method combines both qualitative and quantitative approaches and allows the identification of core and subordinate themes in sessions as well as describing their development across sessions using a measure of change.

Grafanaki (1997) developed the Structured Narrative Analysis for Psychotherapy Segments (SNAPS), which helps clinicians analyze narrative themes through the information produced by two questionnaires: Brief Structured Recall and Helpful Aspects of Therapy (Grafanaki & McLeod, 2010). This method allows for the analysis of actual interaction in therapeutic contexts and therefore is more in line with constructionist approaches to therapy.

The Innovative Moments Coding System (IMCS) (Gonçalves, Matos, & Santos, 2008) is a method of analyzing events that occur in therapy in which the client describes or narrates himself differently, considering the perspective of the problematic self-narrative. This system was strongly inspired by White and Epston's (1990) concept of unique outcomes and assumes a constructionist perspective about narratives and therapy. There are five different types of Innovative Moments (IMs; action, reflection, protest, re-conceptualization, and performing change) that can emerge in different forms (thoughts, plans, feelings, or actions). Through the study of IMs, it is possible to trace client change and development of a new narrative of the self. The IMCS was initially applied to individual narrative therapies with women having experiences of multidimensional partner abuse (Matos, Santos, Gonçalves, & Martins, 2009; Santos, Gonçalves, Matos, & Salvatore, 2009) and then to Emotion-Focused Therapy with depressive subjects (Mendes et al., 2010).

Several other narrative evaluation systems have been developed that are more in line with constructivist concepts. The Narrative Process Coding System (NPCS)

is a method for analyzing psychotherapy sequences according to three different narrative processes that may occur in therapy: external, internal, and reflexive narrative sequences. This method was first applied (and specially conceived) to analyze process-experiential therapy (Angus, Levitt, & Hardtke, 1999) and, afterwards, was used in marital and family therapy to analyze the development of the therapeutic system, although some differences and problems have been found in this second application, pointing out the need for further studies (Laitila, Aaltonen, Wahlström, & Angus, 2001).

Hardtke and Angus (2004) have also developed the Narrative Assessment Interview, a method to evaluate therapeutic change through a brief semi-structured interview that can be applied before and after therapy. In this interview, clients' narratives are evoked, and changes in personal narratives that occurred during therapy are explored.

The Assimilation of Problematic Experiences Scale (APES) is a method designed to analyze the process of clients' assimilation of problematic experiences in their lives. Although it may not be considered a specific narrative assessment tool, APES uses both cognitive and affective features and focuses on clients' discourses collected from therapy sessions to characterize each level of a client's assimilation problems. Clients may initiate treatment while at any point of the APES continuum, and movement along the continuum can be interpreted as therapeutic progress (Stiles & Angus, 2001).

The Grid of Problematic States (GPS) is an assessment system that describes recurrent patterns of problematic experiences and behaviors as narrated by clients. The GPS is applied to transcripts from psychotherapy sessions and focuses on narrative episodes within the patient's discourse. GPS has been applied to cognitive psychotherapy to assess the development of stable construct clusters of thought themes, emotions, and somatic sensations. Meaningful changes in observed states indicate therapeutic change (Semerari et al., 2003).

As we can see from the descriptions above, several narrative assessment systems have been developed, but none of them evaluates the several components of the narratives. For example, none of these systems describe both changes in the narrative dimensions and the narrative processes that occur in therapy between clients and therapists. None of them were originally conceived from a constructionist systemic perspective or designed to analyze the specific nature and dimensions of narratives produced in systemic therapies. By contrast, the ASNC is a narrative assessment system that relies on a constructionist perspective, and its constitutive dimensions represent empirical findings about changing dimensions. It includes the core theoretical concepts of change in systemic therapy.

The guidelines for future research about narrative change in systemic therapies note the need for studies that describe the process of change and that identify the crucial dimensions of narrative transformation and the connections between these dimensions, the predictive value of these elements and the way change happens in a therapeutic setting. Several authors stress the need to establish bridges between

clinical approaches and research in order to be mutually inspired (Beutler, Williams, & Wakefield, 1993; Blow et al., 2009; Christensen, Russel, Miller, & Peterson, 1998; Pinsof & Wynne, 2000; Sprenkle, 2002; Sprenkle & Blow, 2004). Research on therapeutic processes also underlines the importance to understand *how, when,* and *what* changes occur in therapy (Helmeke & Sprenkle, 2000), for the purpose of clarifying the relations between process and results and pointing out the small advances or improvements that occur in sessions.

The emergence of qualitative approaches reflects the need to promote a deeper and more specific understanding of the transformation process and the singularity that characterizes it, allowing the development of descriptions that organize themselves in "local micro-theories of change." The identification of common aspects of change, and of the most effective therapeutic interventions to promote it, demands a methodological, qualitative leap about therapeutic processes as well as about change and its development in several systems (individuals, families, and couples) and in different therapy interventions. To reach these aims, enlarged (different modalities, contexts, and problems) and standardized evaluation methods of change and effective therapeutic interventions must be used in a longitudinal perspective.

Given this goal, we developed the Assessment System of Narrative Change (ASNC), a method of evaluating narratives' organization and change that can be applied in systemic therapies. The ASNC integrates several important theoretical contributions about aspects and factors involved in change in the therapeutic process. Below, we briefly describe each dimension, present the codification rules and give examples that easily elucidate comprehension of each dimension and sub-dimension. We also briefly present the applications for this system of assessing narrative change.

ASSESSMENT SYSTEM OF NARRATIVE CHANGE

Description

The ASNC is an evaluation and classification system for narratives expressed in therapy. The ASNC results from a qualitative study that identified the dimensions of change in systemic family therapies with families dealing with substance abuse from one of their elements drawn from a narrative approach. Our case studies come from four Portuguese middle class, white, heterosexual, catholic families that voluntarily requested family therapy in an outpatient treatment drug addiction center. These families participated in the original study in which the ASNC was developed (Sequeira, 2004). We analyzed twenty-two sessions according to a specific qualitative methodology design that combines ethnographic research, grounded theory, and clinical qualitative research. From this qualitative analysis, seven main dimensions emerged as related to narrative change in therapy. The ASNC aims to identify the characteristics of clients' narratives, to trace their changes over the course of therapy, and to note crucial dimensions that enable or block change in each therapy and in each family.

The ASNC allows the analysis of the therapeutic session to proceed from "narrative episodes." These episodes contain elements expressed in discourses that connect events in a sequential and significant order with an identified beginning and end (Elliot, 2005; Friedlander, & Heatherington, 1998). Narrative episodes correspond to sequences of discourse where clients and therapists try to understand and make sense of something or negotiate perspectives about an event that is in the focus of the conversation. These episodes can, therefore, be the problems that brought clients to therapy or any other issues that emerge in the sessions. In the first part of the analysis, narrative episodes are identified; next, judgments about the dimensions expressed in these episodes are made.

Clients came to therapy with specific ways of thinking and comprehending their live events, in particular problems. They often have thin stories, that portrait what happens, how they are relating to each other, and how they see things at the moment. According to narrative approach those stories must be explored in order to be deconstructed, questioned, and modified (White, 2007). The ASNC allows a qualitative and quantitative analysis of the central dimensions in a client's narrative, its transformation in therapy, and enables the descriptive and comprehensive analysis of therapeutic processes. This assessment system gives information about characteristics of clients' stories, more preferred narrative processes, and narrative dimensions that are more important in the clients' storytelling. It allows therapists to identify stories that must be questioned due to their blocking effects in clients' lives and that can be transformed in the context of therapy through the co-construction between participants (clients and therapists). Therapists can, therefore, make use of the ASNC to identify the critical points of stories, to easily create a relational, discursive, and cognitive space for the deconstruction of the narratives related to problems as well as for the construction of new narratives.

The ASNC includes seven dimensions, some divided into sub-dimensions and almost of all of which are inextricably connected. Dimensions that belong to the narrative plot include the nature of the story (B), its narrative connotation (C), the telling of the story (D), and themes of the narrative (F); these are structural and constitutive dimensions of the stories and narratives. Singularities (A) and narrative reflexivity (E) are dimensions that correspond to narrative processes that are promoted in therapy to introduce changes in the stories that maintain problems and to create new narratives, respectively (Sequeira, 2012).

The different dimensions of the narrative are recursively related. This means that, for example, the dimension of singularities (A) may reflect aspects of the dimensions of the story's nature (B), its narrative connotation (C), the way the story is told (D), and the client's narrative reflexivity (E). Changes in one dimension will be reflected in the others. In the same way, shifts in a story will affect the role of this story in the narrative network of the individual and the family. Definitions and pragmatic borders between narrative dimensions are far from being mutually exclusive, nor can they be (Sluzki, 1992). In this section, we briefly present the theoretical assumptions that underlie the dimensions of the ASNC. For didactic

purposes, each dimension will be separately presented. Key words related to the dimensions and examples of each coding possibility are presented in Table 1 and they were selected from discourse excerpts from sessions with two families. Family A sought therapy due to relational problems: the father's verbal violence and high conflict between parents were seen as the major problems. Family B sought therapy due to the challenging behaviors of their oldest son.

Dimension A: Singularities. Originally described by Elkaïm (1985), singularities are "particular heterogeneous elements in relation with our usual codes (…) that present themselves as fluctuations and whose amplification is able to change systems functioning" (Elkaïm, 1990). They were broadly examined (Sequeira, 2004) in the ASNC development study, which resulted in an enlarged and revised notion of the concept, incorporating the operational and distinctive characteristics from other similar concepts such as exceptions (White & Epston, 1990), unique outcomes (UO), or innovation moments (IM) (Gonçalves et al., 2008). The singularity is a creative and effective strategy promoted autonomously by the system in response to a problematic situation. Singularities are strategies that aren't usually implemented, but that are in line with the system's identity and that promote novelty in individuals', families', and couples' responses. Singularities must be amplified and discussed in the therapeutic context so that clients better understand and include them as new functional resources and to introduce perturbation in other narrative dimensions, particularly of the narrative plot.

Singularities may also correspond to alternative discourses about a relation, an event, a situation, or an experience—these are *discursive singularities* (A1). However, they can be new behaviors, interactions, or practical strategies, *behavioral singularities* (A2), or new visions and distinct comprehensions about important questions, *cognitive singularities* (A3). These three kinds of singularities may occur simultaneously when new speech is related to a new behavior and a new comprehension of problems. However, new speech can emerge concerning problems that may not reflect different comprehensions or behaviors. In the same way, people can develop new and effective behaviors to address problems without changing their previous problematic constructions and discourses about them. Discourses are, in this sense, easier to change compared to constructions or visions of problems or to behaviors. Changes in one aspect can introduce changes in others, depending on their impact on the functional patterns of the system. Cognitive singularities are, therefore, the most complex, and they tend to be associated with discursive singularities.

Dimension B: Nature of the Story. According to Sluzki (1992) the nature of the story is organized around characters and their attributes as well as relations and events that transpire in the discourses and narratives about people and events. The "transformations in the nature of the story" introduce oscillations in specific aspects of problematic stories and narratives, developing new stories and relations.

TABLE 1. ASNC Dimensions, Description, and Examples

ASNC Dimensions	Examples
A. Singularities—new, creative, and effective strategies, promoted by the system in response to a problematic situation: **A1. Discursive**: alternative discourses about a relation, an event, a situation, or an experience **A2. Behavioral**: alternative behaviors, interactions, or practical strategies implemented by one or several elements **A3. Cognitive**: new visions and distinct comprehensions about important problematic questions.	**Family A** Therapist: "What do you think it is different in your family, since last session?" Mother: "I think that we have changed the way we say things to each other, starting always by the positive side (…). Then, we became more open to talk." **(A1, discursive singularity)** Father: "When we had problems, we were able to talk." **(A2, behavioral singularity)** Family B Therapist: "What exactly is different about your previous perspective of your son?" Father: "I stopped thinking only in my perspective, and I put myself in his shoes, for the first time. I can understand what he feels (…) I finally understood the way he thinks and acts, and that changes the way I see is behavior." **(A3, cognitive singularity)**
B. Nature of the story	
B1. Time–time of the narrated stories: *Static*, stories focused in a specific time *Floating*, stories that reveal action and several times Stories may be focused in *past*, the *present,* or the *future.*	**Family A** Therapists: "What are the differences that you see in your relation between now and when the problem began?" Mother: "There were never differences!" (**B1, static time**) Father: "We have better and worse periods!" **(B1, floating time)** Therapist: "How do you see the future?" Father: "I believe that, even today despite of our many problems, we will solve them in the future." **(B1, present-future)** Mother: "I think that it all has to do with our past, and we won't be able to get out of the problems that came from there." **(B1, past)** **Family B** Therapist: "How did the problems evolve?" Mother: "Before entering to that school, it was different. The problems began by that time." **(B1, past)**
B2. Space–contextual definition of the stories: *Contextual*, stories have reference to space, or scenario where they occur	**Family A** Therapist: In which occasions/contexts do the problems occur more?"the events in a context, Mother: "The problems happen when we are at

(*continued*)

TABLE 1. (*continued*)

ASNC Dimensions	Examples
Noncontextual, stories lack a reference to context, space, or scenario.	home." **(B2, contextual)** **Family B** Therapist: "Can you tell me in which circumstances your fears appear more?" Son: "No. This happens everywhere! I can't say specific circumstances" **(B2, noncontextual)**
B3. Causality—explanatory attribution to the events: *Linear*, evidence of a direct and simplistic perspective about causes of events *Circular*, association of multiple causes, factors, or variables that interact and sustain the relations or the problem cycles	**Family B** Therapist: How do you explain the behavior of your son? Mother: "He is like his father. Maybe it's genetic! " **(B3, linear causality)** **Family A** Father: "I don't want to know whose blame it is, I not concerned about the reasons, what concerns me is the effect that our relationship has on our children." **(B3, circular causality)**
B4. Interaction—description of the events, reflecting the participation of the actors and the narrative focus translated in discourses: *Intrapersonal* and *interpersonal*, references to the attributes of the subjects or references to the occured interactions *Intentions* and *effects*, references to the motives and intentions of the subject or to the effects of something, in a given reported event *Roles/labels* or *rules*, references focused in usual roles of subjects or in the interactions between subjects	**Family B** Therapist: "Maybe his attitude means that he is suffering. How do you see it?" Mother: "These attitudes are on purpose to offend us!" **(B4, intentions)** That's how he is, and now he is even more and more selfish!" **(B4, intrapersonal narrative)**. Son: "They are all very concerned about what the others think, and they are not concerned about my problem and my limitations." **(B4, interpersonal narrative)**. "This whole situation makes me sick, I feel that it's restricting my life!" **(B4, effects)** **Family A** Mother: "The problem is his violence." **(B4, symptoms)**. "But he thinks he was always the victim of our home and he will continue to be." **(B4, roles)** Therapist: And what do you do that might contribute to the increase of the problems? Mother: "I think our misunderstandings also make him lose his mind . . ." **(B4, conflicts)** "But any conversation always ends up in shouting, whoever is involved." **(B4, rules)**
C. Narrative connotation (values of the story)—moral value contained in the stories told: *Good* and/or *bad intent,* reflect the subjects' intention in the reported events	**Family A** Father: "The way she talks to me has the clear intention of hurting me." (**C, bad intention)** "It's unfair that he makes us suffer like this." **(C, illegitimate)**

TABLE 1. (*continued*)

ASNC Dimensions	Examples
Sanity/normality and/or *anormal/illness,* reflect the subjects' adequacy or normality in the reported events *Legitimacy* or *illegitimacy* of the actors and of the described events	Mother: "Our difficulties are similar to what others experience…" **(C, normal)** **Family B** Father "Sometimes, he does things that don't work, but he does it with the best of intentions!" **(C, good intent)** Mother: "We can understand that he wants to do things in his way, I would do the same. **(C, legitimate)** Son: "I was never normal! I have always had these problems!" **(C, illness)**
D. Telling of the story—in stories actors reflect different participation and interventions: *Passive* or *active,* agency of the subjects involved in the stories *Competent* or *incompetent,* evaluation of the performance of the subjects involved in the stories	**Family A** Mother: Right now we are resigned with the difficulties." **(D, passive)** "We were parents without ability to comprehend what was going on, and now it's too late . . ." **(D, incompetence)** Father: "We were and still are able to move the world to save our family." **(D, active)** **Family B** Son: "In that day, all of us strived (…): each one, in its turn, didn't shouted but spoke with respect, calm and we even laugh." **(D, competence)**
E. Narrative reflexivity—reflection and meta-perspective about factors and processes of stories and narratives construction: **E1.** Reflection about elaboration of problematic and nonproblematic narratives **E2.** Reflection about the discursive factors **E3.** Reflection about the relational and interactive factors **E4**. Reflection about the behavioral factors	**Family A** Mother "By thinking and acting this way I contribute to the maintenance of theproblem." **(E1, individual construction of problem narrative)** Father: "If we are always saying how unhappy we are, we can only be it." **(E2, discursive construction of the problem narrative)** **Family B** Therapist: "What could you do differently?" Mother: "If we focus ourselves in other aspects of life maybe we didn't have this sensation." **(E1, familiar construction of problem narrative)** Son: "As long as we don't respect each other, and if we continue shouting and attacking, like we have been doing so far, we won't be able to be anything different from what we are." **(E3, interaction that underlies the construction of the problem narrative)**

(*continued*)

TABLE 1. (*continued*)

ASNC Dimensions	Examples
	Father: "If we do things without telling him anything, he will gets angry and stops talking to us." (**E4, behaviors that maintain the problem narrative)**
F. Themes of the session—themes of the stories that emerge in the therapy session: *Symptom*s, usually the question that justified therapy *Other problematic themes,* other problems besides symptom *Nonproblematic themes,* other matters that are not seem as problems	**Family A** Violence of the father **(symptoms)** Problems in father's job, money difficulties, conflicts with other family members **(other problematic themes)** **Family B** Routines of the family, hobbies, activities on weekends, vacations and family rituals, things they appreciate in each other **(nonproblematic themes)**
G. Alternative behaviors—attempts at doing or being different that don't have positive effects	**Family B** Mother: "In that day, instead of reprimanding him, I didn't say anything and I sulked. In the meantime, I proposed that, for not arguing, we just didn't mention the subject that was disturbing us, but it didn't work out well."

According to Freedman and Combs (2008), stories involve events plotted in time in particular contexts. This dimension is subdivided into 4 distinct axes: time, space, causality, and interactions.

B1. Time Axis. Hinchman and Hinchman (1997, as cited in Elliott, 2005) identified two *key features* in the time of narrative. The first feature refers to the chronological dimension of time that all stories must contain (past, present, and future perspective). However, the historical structure of the narrative can be static, fixed in a specific time, or floating, revealing oscillations between circumstances and times.

B2. Space Axis. In general, all events have a scenario that gives them intelligibility and meaning (Labov & Waletzky, 1997). Some problematic narratives do not contain references to specific contexts or scenarios, resulting in a distorted perspective on their dominance in subjects' and families' lives.

B3. Causality Axis. Causality is frequently presented as one of the central components of structure and of narrative changes (Friedlander & Heatherington, 1998; Moran & Diamond, 2006; Sequeira, 2004; Sequeira, & Alarcão, 2009), although it is not universally recognized as a constitutive element of narrative (Rimmon-Kenan,

1983, as cited in Elliott, 2005). Causality refers to the way people explain events and how they establish the causal relations about them. Usually when people come to therapy they have specific explanations and attributions about problems that are related to causes that promote certain effects. However, the explanations that people brought to therapy hadn't lead then to any resolution or modification but, instead, often resulted in the maintenance or increase of problems. These explanations or causal relations must be questioned about their utility to the involved subjects and new perspectives must emerge in therapy conversation so that other solutions are possible. Causality can be a restraining or a promoting element of narrative flexibility, and Sluzki (1992) describes how changes in a narrative proceed from causes to another narrative centered in effects or vice versa. This can transform the initial story into a more complex and inclusive one or can generate other stories. This circular perspective on problems and interactions seems to increase the engagement process between families and therapists because therapists are deeply influenced by the assumption of circular epistemology (Sequeira, 2004). Linear causality is not bad, or a problem by itself, but it can limit or restrain the acquisition of a larger, ecological perspective about events, especially concerning problems. Linear perspectives may reduce narratives to a single version and constrain the development of multiple perspectives and, therefore, of new stories.

B4. Interaction Axis. This refers to the description of events, subjects and type, and degree of their participation in the referred events (Labov, & Waletzky, 1997). According to Sluzki (1992) interactions may be based in the following: (a) *intrapersonal* or *interpersonal* descriptions, depending if they report the attributes of the subjects or the interactions; (b) *intentions*, or *effects* of the event; and (c) personal *roles and labels* or *rules* of the system.

Dimension C: *Narrative Connotations (Values of the Story).* This aspect refers to the meanings and moral values that are evoked in the telling of the stories. There may be different attributions for the behavior of one or more elements, namely, the intention and legitimacy of the subjects (*good/bad* intention; *legitimate/illegitimate* behavior) and the degree of health/illness of the person(s) concerned.

Dimension D: *Telling of the Story.* This dimension refers to the position assumed by the actors: who reports the story (main or secondary actor), the shape of the report (descriptions or interpretations of the events), the assumed roles (active or passive), and the evaluation of the actors' performances (competent or incompetent).

Dimension E: Narrative Reflexivity. The promotion of therapeutic change emphasizes the importance of reflection on and the questioning of narrative processes, factors, and cycles of interaction that maintain clients' problems (Anderson & Gehart, 2007; Botella, 2001; Sequeira, 2012; Sequeira & Alarcão, 2009). This dimension refers to the meta-perspectives that subjects take in their narrative pro-

cesses (functional and dysfunctional) about the several aspects related to problems and their maintenance.

Dimension F: Themes of the Session. Narratives always include central themes toward which other themes gravitate or that hide others, in particular situations that are experienced as problematic. Social discourse and audiences with whom we are related also contribute to the development of individual and familiar stories. Some social discursive constructions, for example, being more powerful, older, or perceived as a larger threat, can limit and constrain the development of alternative meanings and stories about specific events that are seen as problems. Clients who come to therapy bring stories that are organized around particular themes that are more salient in their individual discourses than they are in the client-therapist discourse. Several therapeutic approaches (Anderson & Gehart, 2007; White, 2007; White, & Epston, 1990) and studies of therapeutic change (Sequeira, 2004, 2012; Sequeira, & Alarcão, 2009) support the conclusion that change is the result of thematic diversification and of the reduction of symptoms' salience.

Dimension G: Alternative Behaviors. This category refers to new behaviors, distinct from the usual repertoire of the system, that are developed inside or outside of the therapeutic context. They differ from the singularities in that they are not totally successful movements as concerns the needs that cause the behaviors. However, they deserve recognition for the flexibility and attempts at adjustment and transformation that they demonstrate.

Application Conditions

The ASNC must be implemented based on the observation and analysis of therapeutic process sessions. First, the sequences that constitute "narrative episodes" are identified. The narrative episode is a segment of discourse that may contain statements or testimonials organized around a question or a theme. They result from the therapist's questions or from the client's discourses and contain perspectives about the theme, the actors, the results, the lessons, and the "moral of the story." Even if they are not structured in an explicit and coherent way, they have a beginning, a middle, and an end (real or presupposed). Depending on the objectives and themes of the session, narrative episodes may be more or less numerous.

After the identification of the narrative episodes, judgments and evaluations can be made about the dimensions expressed or contained in the discourses about family elements, according to the ASNC's dimensions. It may be the case that some dimensions and sub-dimensions are missing; in these cases, the dimension is coded with 0.

The ASNC can be applied after each session or when the therapeutic process is closed, depending on the defined objectives. Its use presupposes a previous process of training and familiarity with the dimensions and sub-dimensions in its comprehensive, descriptive, and operative aspects.

Codification

In each narrative episode, the dimensions of the ASNC are coded. Each dimension and sub-dimension is assigned a value of 1 if it is present and 0 if it is absent. After coding, the therapist can classify the referred dimensions or sub-dimensions among the options available and, when appropriate, the number of occurrences is counted (e.g., 10 singularities and 8 narrative reflexivity moments). For the same narrative episode, all dimensions of the ASNC may be present, or only some of them may be present.

ASNC APPLICATIONS: FROM CLINICAL TO RESEARCH

The ASNC can be applied in clinical, training, and research contexts as a possible map of therapeutic dialog and of the transformations to be promoted. According to Sluzki (1992), the focus on the "micro-processes of change" can enrich our ability to produce and improve theories, clinical practices, and research processes in systemic therapies with narrative focus.

In clinical contexts, the application of the ASNC allows a clear characterization of family narrative style. The application of ASNC to consecutive sessions of therapy allows the identification of the main blockages in the stories that compose the narratives related to problems. Once diagnosed, therapists and clients work on those stories and dimensions in order to introduce the necessary changes. One of the main objectives of ASNC applications is the identification of narrative change conditions and of change indicators in earlier phases of an intervention. This information can be useful in decision-making processes about conditions for therapeutic interventions and about the possibilities for change within the system (e.g., in legal processes related to neglectful families and child protection interventions).

In the training process, ASNC provides guidelines for the description and comprehension of the narratives of families, couples, and subjects. This is an important resource for the evaluation of the narrative functioning of the system and of the transformations of narratives (stories) in therapy. Its systematic and diversified application in several clinical contexts will enable therapists to note the common aspects of the narrative organization at different stages of therapeutic process. In the execution of the therapist's role, ASNC allows for a better description of intervention focus or style, facilitates the therapy orientation, and evaluates the corresponding impacts.

In research, ASNC allows the study of the dimensions that narrative therapies address. As a tool to evaluate the micro analytic processes of change in narrative focused therapies, ASNC helps to make evidence and reinforce the utility and efficacy of systemic therapies. The development of research instruments and methodologies informed by systemic/narrative approaches are actually very important as response to the actual climate of scientific and politic forces that require efficacy proofing of therapeutic approaches that, in a certain way, systemic therapies researchers have avoided to address.

CONCLUSIONS

The ASNC is an observational classification system applied to the narrative that emphasizes different dimensions of change. As a system that classifies and analyses narratives, the ASNC involves a certain degree of inference, and it has limitations concerning the subjectivity of the discourse and the classification work.

Because the ASNC can be applied in several contexts—the clinic, in research about change in therapeutic process, and in systemic therapist training—the development of larger and more diversified studies of ASNC applications is justified to establish the validity and reliability of the system. The accuracy of the information produced by the ASNC must be evaluated in diversified therapeutic contexts and must involve several coders, allowing that generalizations can be performed as is suggested by the application of the ASNC in previous case studies. Preliminary ASNC application studies (Sequeira, 2004; Sequeira & Alarcão, 2009) concluded that the initial narratives in therapy are frequently dominated by themes such as "symptoms" and "family problems," while "other nonproblematic themes" are more frequent in cases where change occurs and in middle and final stages of therapy. The problematic narratives, particularly when reported as specific symptoms or psychopathologies (e.g., drug addiction, psychosis, or schizophrenia), are mainly static in time, noncontextual in space, and linear in causality. The causality transformations—from linear to circular—appear to be crucial for strengthening and promoting change.

Subsequent studies will clarify the specific applications, utility, and applicability of the ASNC, specifically to the study of narrative changes in systemic therapies in clinical contexts (Sequeira, 2012; Sequeira & Alarcão, 2012, 2013).

REFERENCES

Anderson, H., & Gehart, D. (2007). *Collaborative therapy. Relationships and conversations that make a difference.* New York: Routledge.

Angus, L., Levitt, H., & Hardtke, K. (1999). The narrative process coding system: Research applications and implications for therapy. *Journal of Clinical Psychology*, *55*(10), 1255–1270.

Avid, E., & Georgaca, E. (2007). Discourse analysis and psychotherapy: A critical review. *European Journal of Psychotherapy and Counseling, 9*(2), 157–176.

Beutler, L. E., Williams, R. E., & Wakefield, P. J. (1993). Obstacles to disseminating applied psychological science. *Applied and Preventative Psychology*, *2*, 53–58.

Blow, A. J., Morrison, N. C., Tamaren, K., Wright, K., Schaafsma, M., & Nadaud, A. (2009). Change process in couple therapy: An intensive case analysis of one couple using a common factors lens. *Journal of Marital and Family Therapy*, *35*(3) 350–368.

Botella, L. (2001). Diálogo, relações e mudança: Uma aproximação discursiva à psicoterapia construtivista. In M. Gonçalves & O. Gonçalves (Eds.), *Psicoterapia discurso*

e narrativa: A construção conversacional da mudança [Psychotherapy, discourse and narrative: The conversational construction of change] (pp. 91–123). Coimbra, Portugal: Quarteto.

Christensen, L. L., Russel, C. S., Miller, R. B., & Peterson, C. M. (1998). The process of change in couples therapy: A qualitative investigation. *Journal of Marital and Family Therapy*, *24*, 177–188.

Elliott, J. (2005). *Using narrative in social research: Qualitative and quantitative approaches.* London: Sage.

Elkaïm, M. (1985). From general laws to singularities. *Family Process*, *24*(2), 151–164.

Elkaïm, M. (1990). *Se você me ama, não me ame. Abordagem sistémica em psicoterapia conjugal.* [If you love me, don't love me. A systemic approach to couple therapy]. São Paulo: Papirus Editora.

Freedman, J., & Combs, G., (2008). Narrative couple therapy. In A. Gurman (Ed.), *Clinical handbook of couple therapy* (pp. 229–258). New York: Guilford Press.

Friedlander, M., & Heatherington, L. (1998). Assessing clients' constructions of their problems in family therapy discourse. *Journal of Marital and Family Therapy*, *24*(3), 289–303.

Gergen, K., & Kaye, J. (1992). Beyond narrative in the negotiation of therapeutic meaning. In S. McNamee & J. Gergen (Ed.), *Therapy as social construction* (pp. 166–185). Thousand Oaks, CA: Sage Publications.

Gonçalves, M., Matos, M., & Santos, A. (2008). *Inovative moments coding system: Version 7.* Braga, Portugal: Universidade do Minho.

Grafanaki, S. (1997) *Client and counsellor experiences of therapy interaction during moments of congruence and incongruence: Analysis of significant events in counselling and psychotherapy*. Staffs, UK: Keele University.

Grafanaki, S., & McLeod, J. (2010). Narrative processes in the construction of helpful and hindering events in experiential psychotherapy. *Psychotherapy Research, 9*(3), 289–303.

Gurman, A. S., Kniskern, D. P., & Pinsof, W. M. (1986). Research on marital and family therapies. In S. L. Garfield & A. F. Bergin (Eds.), *Handbook of psychoterapy and behavior change* (3rd ed., pp. 567–624). New York: Wiley.

Hardtke, K., & Angus, L. (2004). The narrative assessment interview: Assessing self-change in psychotherapy. In L. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory and research* (pp. 247–262). Thousand Oaks, CA: Sage Publications.

Helmeke, K. B., & Sprenkle, D. H. (2000). Clients' perceptions of pivotal moments in couples therapy: A qualitative study of change in therapy. *Journal of Marital and Family Therapy*, *26*(4) 469–483.

Hinchman, L., & Hinchman, K. (1997). *Memory, identity, community: The idea of narrative in the human sciences.* Albany, NY: State University of New York Press.

Labov, W., & Waletzky, J. (1997). Narrative analysis: Oral versions of personal experience. *Journal of Narrative and Life History*, *7*(1–4), 3–38.

Laitila, A., Aaltonen, J., Wahlström, J., & Angus, L. (2001). Narrative process coding system in marital and family therapy: An intensive case analysis of the formation of a therapeutic system. *Contemporary Family Therapy, 23*(3), 309–322.

Matos, M., Santos, A., Gonçalves, M. M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19,* 68–80.

Meier, A., Boivin, M., & Meier, M. (2008). Theme-analysis: Procedures and application for psychotherapy research. *Qualitative Research in Psychology, 5*(4), 289–310.

Mendes, I., Ribeiro, A., Angus, L., Greenberg, L., Sousa, I., & Gonçalves, M. (2010). Narrative change in emotion-focused therapy: How is change constructed through the lens of the innovative moments coding system? *Psychotherapy Research*, *20*(6), 692–701.

Moran, S. G., & Diamond, G. M. (2006). The modified cognitive constructions coding system: Reliability and validity assessments. *Journal of Marital and Family Therapy*, *32*(4), 451–464.

Parry, A., & Doan, R. (1994). *Story re-visions: Narrative therapy in the postmodern world*. New York: Guilford Press.

Pinsof, W. M., & Wynne, L. C. (2000). Toward progress research: Closing the gap between family therapy practice and research. *Journal of Marital and Family Therapy*, *26*, 1–8.

Rimmon-Kenan, S. (1983). *Narrative fiction: Contemporary poetics*. New York: Methuen.

Santos, A., Gonçalves, M., Matos, M., & Salvatore, S. (2009). Innovative moments and change pathways: A good outcome case of narrative therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 82(4)*, 449–466.

Semerari, A., Carcione, A., Falcone, M., Nicolò, G., Procacci, M., Alleva, G., et al. (2003). Assessing problematic states in patients' narratives: The grid of problematic states. *Psychoterapy Research, 13*(3), 337–353.

Sequeira, J. (2004). *Caleidoscópio terapêutico. Mudança e co-construção em terapia familiar*. [Therapeutic kaleidoscope. Change and co-construction in family therapy]. Unpublished master's thesis dissertation, University of Coimbra, Coimbra, Portugal.

Sequeira, J. (2012). Narrativa, mudança e processo terapêutico. Contributos para a clínica e para a investigação sistémicas. [Narrative, change and therapeutic process. Contributions for systemic therapy and research]. Unpublished doctoral dissertation, University of Coimbra, Coimbra, Portugal.

Sequeira, J., & Alarcão, M. (2009). A mudança nas terapias sistémicas. Transformação narrativa nas terapias familiares e de casal. [Change in systemic therapies. Narrative change in families and couples therapy]. *International Journal of Developmental and Educational Psychology. INFAD, Revista de Psicologia*, *XXI*, *1*(4), 13–24.

Sequeira, J., & Alarcão, M. (2012). *Assessment System of Narrative Change. Reliability and validity studies.* Manuscript submitted for publication.

Sequeira, J., & Alarcão, M. (2013). Porquê não mudam as famílias? [Why Don't Families Change? Narratives of Family Therapy Failures]. *Temas em Psicologia*, *21*(1), 203–219.

Sluzki, C. (1992). Transformations: A blueprint for narrative changes in therapy. *Family Process, 31*, 217–230.

Sprenkle, D. H. (Ed). (2002). *Effectiveness research in marriage and family therapy*. Alexandria, VA: American Association for Marriage and Family Therapy.

Sprenkle, D. H. (2003). Effectiveness research in marriage and family therapy: Introduction. *Journal of Marital and Family Therapy*, 29*(1),* 85–96.

Sprenkle, D. B., & Blow, A. J. (2004). Common factors and our sacred models. *Journal of Marital and Family Therapy*, *30*, 113–129.

Stiles, W. B., & Angus, L. (2001). Qualitative research on clients' assimilation of problematic experiences in psychotherapy. In J. Frommer & D. L. Rennie (Eds.), *Qualita-*

tive psychotherapy research: Methods and methodology (pp. 111–126). Lengerich, Germany: Pabst Science Publishers.

Sydow, K., Beher, S., Schweitzer, J., & Retzlaff, R. (2010). The efficacy of systemic therapy with adult patients: A meta-content analysis of 38 randomized controlled trials. *Family Process*, *49*(4), 457–485.

White, M. (2007). *Maps of narrative practice.* New York: Norton.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.