

## **Transformations: A Blueprint for Narrative Changes in Therapy <sup>1</sup>**

**CARLOS E. SLUZKI**

### **ABSTRACT**

Problematic/symptomatic behaviors are embedded, retained and maintained in collective stories. Therapy is the transformative process by which patients/families and therapists co-generate qualitative changes in those stories. An emphasis on narratives allows to further specify--at the more "micro" level of the exchanges that take place throughout the consultation--how those transformations unfold. To that specification is devote the core of the essay, which closes with a discussion of some clinical, research and, especially, research potentials of this systematization.

A family consults you because of recent, rather intense, obsessive-compulsive behavior in a 56-year-old housewife, who cleans incessantly even as she is crying because she cannot stop. In the course of the first interview with her, her 65-year-old husband, and their 19-year-old daughter, the following information is elicited. Her daughter, her close friend and an ally, is about to leave home to study at a major university 3000 miles away; her husband is a workaholic; the wife doesn't have many contacts outside the nuclear family; there is little intimacy in the couple relationship; the wife was born in Ireland and the husband is of Greek extraction.

Suppose that the night before the interview you were reading a book on the family life cycle. With that model in mind, in the course of the therapeutic conversation you selectively amplify data relevant to this model. The family then generates through your inquiry a picture that fits the "empty nest syndrome." Together, you tentatively explore

---

<sup>1</sup> A preliminary version of this essay was presented at two International Congress: "At the Frontiers of Family Therapy" (Brussels, May 1989) and "Systems and Family Therapy: Ethics, Ideology, New Methods" (Paris, October 1990). The presentation made in Brussels appeared in French in M.Elkaim and E.Trappeniers (Eds.): Etapes d'une Evolution: Approche Systemique et Therapie Familiale. Paris, Privat, 1993. The presentation made in Paris appeared in Italian in Terapia Familiare 36:5-19, 1991 and in German in Familendynamik, 17(1):19-38, 1992. The present article has been translated into Spanish in Sistemas Familiares, 14(2):11-24, 1998.

alternative solutions to the problem and the family, sensing a new understanding of the matter, schedules a follow-up appointment.

But it may have happened that the previous night you were re-reading material on loss and mourning. Using that lens, you discover that the therapeutic conversation highlights information relevant to that model. The family then begins to talk about the death of the wife's mother, which occurred at the time her favorite daughter was born. Because of this timing, her bond with her daughter became unusually intense. Her mother's death was never talked about and her loss was never worked through. At this point in the interview, the patient cries, the daughter sobs, the husband sniffs, and your own eyes water. You all co-generate a ritual of re-mourning for the lady's mother, which, of course, is deemed necessary if the patient is to let the daughter go without resorting to symptoms in an unconscious attempt to retain her. You all feel that you have hit the nail on the head.

However, what if, instead of the above readings, you had been revisiting Minuchin's (1974) classic Families and Family Therapy? You would probably notice, from the beginning of the interview, the family's seating arrangement, the subsystems boundaries, and the alliances. You would react to the skewed structural organization of this family and its strong cross-generational, mother-daughter coalition that has marginalized the father, you would promote a discussion of ways to enhance the decision-making process within the parental dyad in order to empower the father and marginalize the daughter. You may favor a "normative" conversation that might include how isolated the father has felt, how inappropriately concerned this daughter is about her mother's well-being, and everyone will leave the session with a transformed description of the presenting problem, and new hope for their future.

Things would have been vastly different, however, had you been reading, "the night before," material on cultural issues in family therapy (which might have favored the development of a conversation on the contrast between Irish and Greek expectations about marriage); or some literature on relational ethics and entitlement (leading to a discussion about old, unpaid, debts, sacrifices, and family loyalties); or an article on feminism (steering the collective discourse into the existential trap of how everyone in this family undermined any feeble effort this woman made at developing "her own voice").

How come? How is it that families and therapists are able to talk with emotion, intensity, pertinence, and conviction about such a variety of themes? How is it that each of these alternative, hypothetical sessions with this family would have generated an equally plausible story to account for the nature of the problem and/or its roots? And, what is even more surprising, how is it that change may have been generated through so many different conversational avenues?

The answer may lie in one common element: in each case, a plausible, alternative story was built conjointly by therapist and family, using elements of one or more of the stories with which the family came. Each alternative story or narrative was structured around an available cultural myth or theme; each contains a new cast of characters, themes and plot sequences; each has its own new logic, moral, ethical and behavioral assumptions and consequences. Concurrent with the transformation in the narratives, the original story that contained the problem loses its dominance, the problem is redefined, it becomes a nonproblem or even a blessing in disguise. The presenting problem is now amenable to solutions, or it loses focus, it "dis-solves" (to use the felicitous term proposed by Anderson and Goolishian, 1988). The consultation has accomplished its goals.

## OUR SOCIALLY CONSTRUCTED WORLD

Our social world is constituted in and through multiple stories or narratives. This ecology of stories, with different degree of dominance at different moments and in different contexts, establishes the frames within which we become aware of self and others, within which we establish priorities, claim or disclaim duties and privileges, set the norms for appropriate and inappropriate behavior, attribute meanings, and order events in time (Gergen, 1982; Shoetter, 1984). Language is not representational; what we call "reality" resides and is expressed in one's descriptions of events, people, ideas, feelings, and experiences. These descriptions, in turn, evolve through social interactions that are themselves shaped by those descriptions; discourse provides the frames within which social action takes place (Harre, 1984), a statement that echoes Bateson's notion that the Mind is social.

When applied specifically to therapeutic conversations, this constructionist focus on stories--on narratives--allows for a description of therapeutic change that transcends specific dominant themes (for example, the family life cycle, loss and mourning, family of origin), and it is grounded in practice. Within this frame, an encounter can be defined as therapeutic when, in its course, a transformation has taken place in the family's stories that are dominant so as to include new experiences, meanings and (inter)actions that loosen the thematic grip of the story on symptomatic-problematic behaviors.

How does a therapist encourage change in the collective stories? To begin with, stories--narrative structures-- are self-regulated, semantic systems that contains a plot (what), characters (who), and setting (where and when). These narrative components, in turn, are held together regulated by, and in turn regulating, the moral order (meaning or overall theme) of the story, effectively sealing off alternative interpretations (Gergen & Gergen 1986).<sup>2</sup> Individuals, families, larger collectives inhabit multiple stories, and

---

<sup>2</sup> In our daily practice, for reasons sometimes informed by our guiding models and sometimes by simple preference, most family therapists, in their practice, organize the therapeutic dialogue around one or

organize their lives making decisions in accordance with the dominant narratives.

During the interview, the therapist scans the organization and delivery of the collective stories about the family's predicament and, through questions and comments, favors certain kinds of transformation in the nature and/or in the telling of the stories. Because of this recursive, systemic fit, any nontrivial alteration in the content of a story, as well as in the way a story is told, will trigger changes in plot, characters, setting, and theme, will shift the relative dominance of that story over the many other stories that constitute the individual or familial ecology of stories, and will alter the storytellers' experiences of the world. Because these stories organize, maintain, sustain, and substantiate problems (conflicts or symptoms), any change in the dominant stories will affect the way problems are conceived, perceived, described, explained, judged, and enacted. Such change provides access to new solutions (to what is, in fact, a new description of the problem/conflict), or to a nonproblem formulation, or to the fading away of the perceptual-conceptual-behavioral gestalt (system) that constitutes the problem.

In order for a new stories to consolidate themselves in the therapeutic conversation, they must evolve from and yet contain elements of the old, "familiar" stories. The transformed stories are usually a re-combination of the components of the old story to which new elements--characters, plot, logic, moral order--have been introduced either by the therapist, by the patient or by the family, for example, as a result of circular questioning; and they are consolidated by all the participants throughout the therapeutic conversation. The coherence derived from the structural relationship between narrative components, as well as the constraints from both the historical and the material world (cultural constrains, developmental constraints, allowable story lines--that is, dominant myths) limit how stories can be constituted and transformed. A new story that is too different from the old story will not be recognized by the clients as theirs and will simply be rejected as not pertinent. However, if a new story is too similar to the old one, it will not "hold" because the old story tends to reconstitute itself through its many attachments to the material world that is already familiar to the clients

## **BLUEPRINT OF THE THERAPEUTIC ENCOUNTER**

---

more core themes, such as family life cycle, family of origin, autonomy/dependence polarities, ethnicity, gender issues, relational ethics, loss and mourning, and the like. These themes operate as strong attractors in the sense that those elements of the patients' narratives that fit with the therapists' dominant themes are progressively highlighted until they become pertinent and relevant to all parties, and thus become a fertile ground for transformative practices. In fact, thematic preferences organize many of the "schools" or orientations in the field of family therapy, and the emphasis in this essay on the transformation of stories does not reflect the way most family therapists would talk or write about their work .

Each encounter is essentially idiosyncratic because the fabric of the process and content of the conversation is woven by contributions from all the participants. However, when one attempts to analyze the moves or sequence of episodes that characterize the natural history of a session using the narratives vantage point, most consultations seem to follow a blueprint with the following elements, generally in sequence and most definitely intertwining:<sup>3</sup>

1. Framing the encounter: Early exchanges frame the process, proposing and evolving issues of power (who has what rights to define the nature of the problem and the nature and goals of the consultation; who can impose what on whom) and responsibility (who can generate initiatives; who is in charge of proposing and sanctioning solutions; in which arena is the problem located; who will monitor the process; who gets the credit or blame for the problem and for changes). These exchanges are sometimes explicit, but generally they are implicit, conveyed by social pleasantries, seating arrangements, opening exchanges, questions by the therapist as well as by the patient/family, and other socially sanctioned ways of addressing the frame that contextualizes the therapeutic conversation, in a process that establishes areas of collective agreement.

2. Eliciting and enacting the dominant stories: The interviewer elicits information about the nature and context of the problem or conflict, its main associated themes, its characters, its logic, its ethical and behavioral corollary.

3. Favoring alternative stories: the interviewer (a) elicits new information or alternative views of the same events from all the participants through (linear or circular) questions, comments, and so on, and notes exceptions that deviate from or challenge the mainstream stories, and/or (b) tests the tenacity of the mainstream stories by proposing unorthodox views or making unorthodox comments about them, usually through a stance of positive connotation.

4. Enhancing (instancing) the new stories: Once the therapist notices that an alternative to the mainstream stories has become (even slightly) viable--that is, that the conversation may evolve toward a new consensus around alternative moral and behavioral corollaries--, she or he will selectively enhance those alternative views, eliciting and validating them through additional questions and comments. The goal of this part of the process is to bolster the new stories (or the alternative dominance of stories) with a tighter logic and a more favorable distribution of roles, labels, and moral stances, to reach a preliminary consensus about the new stories, about the nature of

---

<sup>3</sup> This blueprint follows steps proposed by Cobb (1991) when discussing the components of a mediation consultation. Cobb argues that, although mediation and therapy have distinctive differences, both require the management of communication processes in which narratives emerge and are transformed.

the problem and its resolution (dissolution?) that will replace the old one. Broadly speaking, therapists will tend to favor alternative or dominant stories that create pattern, prospection, options, agency and moral codes.<sup>4</sup>

5. Anchoring the new stories: The therapist may chose to further anchor the new stories through the recommendation of post-session rituals or tasks that are specifically designed to reconstitute and reconfirm the new descriptions.

This reconstructive blueprint or sequence allows one to track the shadow of a design that underlies almost every session conducted by a systemic therapist. What it does not specify is how are new stories favored by the therapist, how the transformation of narratives begins to take place in practice, at the material level of the discourse, throughout the actual therapeutic conversation. To deal with these questions, a new level of analysis must be introduced, focused on micro-practices, which allow one to specify and operationalize the processes corresponding to the third step of the blueprint, that is, "favoring new stories." The rest of this essay will address this issue.

## **TRANSFORMATIVE MICRO-PRACTICES**

Stories about problems, symptoms, or conflicts -the thousand and one stories about and answers to the question "What brought you to the consultation?" or "What can I do for you?"- are organized around characters and their many attributes, relationships, and vicissitudes; plots and events, and the degree of agency of the participants; settings and their weight on events; the ethical corollaries of the story and the value judgments derived from them; and the behavioral corollaries or unavoidable consequences for the participants. In addition, stories can be told in a fashion in which the storyteller--and, complementarily, others-- is portrayed as protagonist, bystander, witness or interpreter of events, and with varying degrees of competency and reliability.

Specific variables along each of those dimensions will be discussed in detail in the next pages, as they are the locus of transformative micro-practices throughout therapy. Strictly for didactic purposes, each will be discussed separately. However, it should be underscored that most of these dimensions are inextricably connected, and that a shift in any one of them affects each of the others. In fact, the very definitions of (and, of course, the pragmatic boundaries between) many of the categories in this listing are far from mutually exclusive--nor can they be.

---

<sup>4</sup> Marcelo Pakman suggests that the relevance of a new story- -a new reality construction--developed in the course of therapy can be evaluated on the basis of three parameters: (a) pragmatic, that is, new observable actions by the subject in the problem areas; (b) ethic, that is, respect for the autonomy of all the meaningful members of the system; and (c) aesthetic, that is, movement from dis-ease to well-being for all members of the system in the problematic domain and in associated domains (Pakman 1991).

/ Table 1 about here /

## **Transformations in the NATURE of stories**

### Transformations in Time

Static/Fluctuating (shifts between a description that does not present temporal fluctuations and one that does): When someone describes a symptom, conflict, problem, or other event as a stable phenomenon, the therapist may ask, for example, "When do you notice that your mother is more frail--in the morning or in the afternoon?" or "Did the bickering become more or less marked when you took your new job?"<sup>5</sup> Or the therapist may simply highlight fluctuations that were mentioned by one member, using the "search for exceptions" that will lead to solution-oriented conversations, as proposed by DeShazer (1985, 1988). The addition of fluctuations makes it easier to call attention to exceptions ("What happens when the problem is not present?"), competence ("How did you manage to reduce the intensity of the problem then?"), and alternative patterns and scenarios ("What do other people do when the symptom is more [or less] intense?").

However, there are occasions when the therapist may want to pin down a constant condition that is "smoke-screened" by fluctuations. This can be done by highlighting a common denominator of the descriptions. The therapist might say, for example, "Have you found a common theme in all those episodes of bickering?"

In turn, the inclusion of a time dimension in a time-less story, the introduction of comparisons between then and now or between now and the future, allows the consultees to recover a sense of evolution, a progression of events that expands their repertoire of descriptions and interpretations of the problem as well as their collective participation in its maintenance.

Nouns/Verbs (shifts between static definition of events, symptoms, traits, or people and descriptions of actions): If people or situations are described as possessing immutable attributes, the therapist might ask, "What does your mother do that makes you say that she is frail?" or "Under what circumstances is she behaving in a frail manner?" The transformation of states into actions allows for the generation of contexts ("Under what circumstances...?"), fluctuations ("When is it less intense?"), shifts in focus ("How do you react to those behaviors in turn?"), and so forth. For an eloquent discussion of the importance of transforming diagnostic labels into behaviors, see Selvini Palazzoli et al. (1978).

---

<sup>5</sup> Some of the examples used to illustrate micro-practices consist of statements, but the majority are questions --most of them circular. This is not surprising since circular questioning is one of the most powerful interventive tools at the service of a transformative conversation. For an eloquent discussion of circular questions, see Penn (1985 and 1987) and Tomm (1985, 1987, 1988).

There are, however, stories that abound in descriptions of actions but lack any overall corollary, as when the speaker describes people as repeating one kind of action but does not propose a general categorization. In those circumstances, a transformation toward nominalization (naming) may be preferable. The therapist may query, for instance, "Considering all that, how would you label your parents (or yourself)?" A nominalization may encourage patients to assume responsibility or to take remedial actions stalled by the previous descriptive form.

A-historic/Historic (shifts between a story devoid of historical roots and context and one with a starting point, scenario, and evolution): When the story conveys events devoid of context, the therapist can pose "becoming" questions, asking, for example, "In what circumstances, or when, did it start?" The introduction of history allows for the generation of explanatory hypotheses, shifts in punctuation, positive connotations, detection of fluctuations, exceptions, and patterns.

There are stories, however, that, because of their historic structure, lodge all responsibility in past circumstances and assign little to the protagonists. In those cases, questions that encourage a movement from a historic to an a-historic perspective ("Why do you consult me now?") may illuminate new, viable alternatives to the symptomatic stalemate.

### Transformations in Space

Non-contextual/Contextual (shifts between a narrative that is devoid of a scenario and one that has spacial context): The introduction of the idea of space allows one to invite speculations about the way context affects and is affected by the event, historically and in the present. If someone describes a symptom, feeling, or behavior out of context, the therapist might ask, "In what circumstances is this problem more (or less) noticeable?" However, stories that are entrenched in contextual variables--centered in descriptions of scenarios and circumstances--may benefit from the introduction of noncontextual perspectives through comments such as, "But I understand that now you are not drinking. How do you account for your present bickering?", thus dislodging the locus of responsibility from its context.

The introduction of alternative scenarios complement the transformations in the "time" axis discussed above. In fact, time and space are the two coordinates that generate the transformative shift that follows.

### Transformations in causality

Cause/Effects (shifts between a story centered in the assumed causes or origins of the problem/symptom and one that includes its ongoing effects on self or others): This

category ties in with one of the liminal concepts of the interactional approach, the notion of "punctuation of the sequence of events," so named first by Bateson and Jackson (1964) and then incorporated as a basic axiom of human communication by Watzlawick et al. (1967). This notion refers to the intrinsically arbitrary (and consensual) nature of a sequential description in interpersonal processes, with a pretense of a beginning that has been agreed upon--but sometimes vehemently objected to-- by the participants. Many therapeutic transformations of stories result from a shift in punctuation that change attribution of blame or guilt.

If someone dwells upon a past event, which is defined as the cause of the current difficulty, the therapist may explore whether the difficulty existed in any form or fashion before the occurrence of that event, or explore in what way others were affected by that event (thus defining the response as idiosyncratic and not generic). Correspondingly, when a story emphasizes the effects of a problem, it may be useful to explore the patient's theories about its causes. This can transform a story into one that contains contexts of justification or responsibility, which in turn may be then destabilized by an exploration in the opposite direction.

### Transformations in interaction

Intra-Personal/Inter-Personal (shifts between descriptions of a person's attributes and descriptions of patterns of interaction): If the speaker refers to properties of another individual ("She is stubborn"), the therapist could include the speaker as actor, asking, for instance, "How do you react to her stubbornness?", which is a point of departure for (re)constructing an interpersonal sequence in which intra-personal attributes are dissolved. Conversely, if a story focuses on interpersonal patterns while omitting the personal qualities of individuals, asking about such qualities may be useful for organizing alternative descriptions. The therapist may ask, for instance, "Throughout those confrontations with your mother, who was the grown-up and who the child?"; "Who was supposed to take care of whom?"

The relocation of the subject of the narrative--between self- and other-based stories-- may affect the position of the storyteller as agent, that is, as responsible actor.

The following two categories are variations on the theme of shifts between intrinsic attributes and interpersonal patterns, and also illustrate a shift between noun and verb. I am including them in this listing because of their frequent usage.

Intentions/Effects (shifts between attribution of intent to a person or group during a given event, and discussion of the effect of that person's behavior or of the event's dynamics): When the story is tied to attributions of negative (sometimes positive) intent or motivation of others (or even of self), the therapist may ask, "And what was the effect of that behavior on you (or others)?" or "If someone had been witnessing that exchange

as an outsider, how do you think he would describe it?"

Again, this transformation may be turned around, namely, by shifting from effects to intentions if speculation about intent may introduce potentially viable alternatives to the current story. Needless to say, the therapist may choose to favor shifts in the nature of the attribute rather than a shift from attribution to effect.

Symptoms/Conflicts (shifts between a story based on "expressions of mental disorder" and one based on the reciprocal behaviors): When someone talks about fears, for example, the therapist might inquire, "And what is the effect of your fear-related behaviors on others (if the speaker is a symptom-carrier), or of those behaviors on you (if the speaker reports symptoms/problems of others?)" and later, "And how do you react to his(her) reactions?" This transformation opens a variety of enriching alternatives since it allows for the generation of patterns, contexts, exceptions, the development of agency, and so forth.

A transformation in the opposite direction would be useful if a symptomatic label may allow one to add an explanatory or contextualizing dimension. A comment such as, "And how could you expect to have a good time when you are depressed!" may have the effect of neutralizing the syllogistic trap of the self-torturing injunction "Have fun!"

Roles/Rules (shifts between descriptions that consign people to socially sanctioned niches and stories that include interactive rules, of which roles may be a collective consequence): If a story characterizes individuals in terms of role attributes (a severe father, an oppressive boss, a dominant husband, a submissive wife, an intrusive mother, a protective sister, a scapegoated sibling), the therapist could ask, for example, "Toward whom does this person behave like that?"; "Was your mother intrusive also with your sisters?"; "Who agrees with that definition?"; "Does your brother also consider your father's behavior as severe?" Or the therapist could state, "Well, if you are the bad guy in your family, who ends up being the good guy (torturer, incompetent, victim)?" In fact, an isolated description of a role robs the story of the interpersonal pattern of which that role is a part. This transformation adds context, re-shuffles responsibilities, enriches the scenario.

There are, however, roles defined by our culture that may be useful to highlight as unacknowledged variables within a story in order to loosen the implications. Thus, a therapist could interject the question, "All this is well and good; but who assumed the role of mother, and who played the daughter?"

### Transformation in the Values of the Story

This refers to axiological shifts, that is, shifts in the moral order evoked by the story. This transformation is a frequent indirect result of other shifts in the narrative, which

lead to changes in the attribution of values to events or people and in the location of attributes such as good and evil, generous and stingy, healthy and sick, beautiful and ugly, wise and ignorant, competent and incompetent. However, it may also be the direct result of commentaries by the therapist from a stance of positive connotation, which lead to--or imply--dramatic shifts in assumptions. For instance, if a patient describes in a self-deprecatory fashion his or her short-tempered behavior toward his or her children as a reason for the consultation, the therapist may choose to comment: "It takes a lot of responsibility and courage to decide to consult about behaviors that are seen in such a bad light!", or "Throughout your life you didn't have examples of how to be patient and tender, so you are not cruel, you are ignorant!"--"ignorance" is a softer attribute that is not immutably "engraved in the character," and can be changed through learning. The following subcategories expand and exemplify this point.

Good Intent/Bad Intent (shifts between an attribution of intentionality that is positive and one that is considered negative): The symptomatic daughter is described by the mother as "wanting to drive everybody crazy with her confrontations", which implies an attribution of ill intent. The therapist may ask, "From whom did she learn to be so firm in her convictions?" Through this question, the therapist proposes a relabeling of the problematic behavior within a stance of positive connotation--from "confrontation" to "firm"--that allows for a historic-oriented exploration, which may anchor the removal of the attribution of ill intent.

Sane/Insane (shift between attributions of craziness--which implies saneness in others--and attribution of saneness, if possible, to all participants): The patient states, "When I drink I become crazy"; the therapist may comment, "What you told me you said when you were drunk may not have been nice but it made sense to me," which may cancel the alibi of being insane, and change the whole story.

Legitimate/Illegitimate (shifts between reasonable and unreasonable, or between logical and illogical): A woman, in the course of her consultation describes, with indignation, that her mother told her that they wouldn't get along if they were to live together at this time. The therapist's comment, "A rather lucid lady, your mother!" (in a context of trust) shatters the implicit assumption of agreement about the mother's "unreasonableness," which allows a re-examination of the description and the corollaries of that event.

### **Transformations in the telling of the story**

Passive/Active (shifts between a story in which the storyteller is the object and others [or even the symptoms] are actors, and one in which the speaker is an agent and thus is accountable): If someone describes a situation in which he or she is a victim, the therapist, knowing that that description evades the issue of actor-as-agent, might ask, "And what did you do about it?" or "And what have you done about it successfully in the

past?"

A transformation from passive (victim) to active (agent) constitutes a powerful way of expanding the story. Such may be the case, for instance, when patients describe themselves as victims of symptoms, or of relationships in which passivity has not been imposed by physical force, economic oppression, or ideological coercion. However, this passive stance may be difficult, if not undesirable, to change in stories in which the passive actor is a child, a chronically battered woman, a frail elder, or is suffering from chronic pain, since the alternative description may blame the victim. Even further, in such cases, support of a description of passivity or victimization through a contextual appraisal of the lack of alternatives at the time may need to be favored first in order to empower the subject.

In the course of discussing this dimension, Rausch (1990, personal communication) proposed the following, interesting, matrix.

**/Figure 2 about here/**

Stories in which the problem is defined as external and the solution is also contingent upon an external source, evoke, trigger, are evoked by, are triggered by blame or helplessness. Stories in which the problem is defined as internal, but the source of the solution is depicted as external to the storyteller, may lead to damnation or salvation. Stories that are located in a scenario internal to the individual, and the solution also lies within the individual, favor hopelessness and guilt. Finally, stories in which the problem is defined as external to the storyteller, but the storyteller is proposed as the agent of change, lead to action.

By specifying the location of agency and of the problem in a story, this matrix allows one to pinpoint the thematic effect favored by the story. It also allows one to infer the direction of change favored by most therapists--descriptions in which the storytellers can do something about events that are external to them.

A powerful variation on the theme of this transformation is the strategy of externalization, as proposed by White (1986) and White and Epston (1990); see also Tomm (1989). In this approach, the symptom is transformed into independent characters (rather than transformed into conflicts), that is, explicitly described as something against which the patient is waging a territorial battle.

Interpretations/Descriptions (shifts between assumptions about hidden meanings of events and accounts about those events): If the storyteller focuses on suppositions, attributions, or assumptions surrounding an event, the therapist could ask, "Would you describe for me what actually happened, as if I were witnessing it?" However, if

descriptions continually leave out some common trait, or some intent by the actors in those descriptions, the therapist may encourage the narrator to take a more interpretative stance by introducing questions such as, "And what do you believe motivated them (or you) to behave in this way?"

This transformative orientation was also noted previously in the discussion of shifts from dynamic to static, from verb to noun, and from historic to a-historic.

Incompetence/Competence (shifts between a description that defines the speaker [or any group of which the speaker is a part, his/her family, for instance] as inept, and one in which any competence is highlighted): If the storyteller describes himself or herself as incompetent, ignorant, or confused, the therapist could highlight the wisdom that this acknowledgement entails, or the clarity of mind that is needed to judge confusion, or to describe it so clearly; or the therapist may highlight exceptions that show the speaker as effective or wise. The effects of these comments on the speaker can be quite dramatic. On the other hand, the interviewer may choose to evoke a degree of uncertainty in a speaker who strives to convey a flawless image of self through asking, "What is the advantage that you see in portraying yourself as always right?" or "What is the habitual effect on others of that stance?"

The conversational search for exceptions as well as externalizations--both discussed above--may lead progressively to a shift in omnipresent self-attributions of incompetence, sickness, or stupidity, until-then immutable assumptions on the part of the speaker. Attributes such as incompetence or competence may be attributed to characters other than the storyteller, which may have the effect of implying the opposite trait in the storyteller. Hence, any shift in attributions to others will affect the storyteller. It should also be noted that a therapist can encourage a shift toward competence in the explicit or implicit position of the storyteller by maintaining throughout the interview a respectful "one-down" stance.

## **A RECAPITULATION**

Each category in the proposed list of micro-practices defines a dimension of a narrative, and transformations that can be effected by shifting a description toward either end of a parameter. In fact, my descriptions omit any recommendation to push specific narratives toward one end of any specific dimension. While the therapist may keep in mind the broad guidelines for a "better dominant story" discussed several pages ago, in the practice of psychotherapy, in critical moments within sessions, transformative moves in any given direction within any given dimension are frequently interspersed with moves in the opposite direction. This destabilization of one dominant description may have the effect of generating in the participants a "hunger for clarity" that may favor the production of consensus around new narratives. In the course of

most therapeutic consultation, however, therapists may choose to enhance particular features of stories when they estimate that the potential shape of the new narrative will broaden the patient's or family's range and quality of options for resolving problems. In fact, the specific direction of the transformation of narratives is contingent upon the evolving fit between the family's dominant and alternative stories, style, and moment, and the therapist's own preferred models, idiosyncracies, and style.<sup>6</sup>

Needless to say, many transformative moves favored by therapists, while reorganizing the narrative, are far from being "revolutionary," since the alternative stories have already been legitimized by the clients as also dominant. For instance, while a client is delivering an a-historic description of his or her current, excessive drinking problem, the interviewer asks about the family history of excessive drinking (favoring a historical slant), and the client comments, "As you may already imagine, my father was an alcoholic, and, in fact, he taught me to drink." A shift thus takes place from an a-historic to a historic description of the problem, but without containing any novelty (at least at that time) from the perspective of the patient. On other occasions, however, that same shift may open alternatives that, from the viewpoint of the patient/family, are totally novel -for instance, that drinking is "like being with my father, whose death I always denied."

It is important to acknowledge that the transformative process is affected not only by the speech acts of the therapist but also by additional experiences in the session--such as enactments--or outside of it--such as tasks and rituals--that reconfirm the new story while contradicting and making untenable the old one. It is also important to underline once again that it is not that "the therapist transforms"; rather, the therapist generates an opportunity for change, but the transformation is the result of the entire therapeutic process.

## CONCLUSIONS

The model on transformations presented in this essay has powerful implications as a clinical, training and research tool, as these micro-practices lie at the heart of the transformative process of therapy. An emphasis on these processes can, in my view, enrich the narrative that constitutes the practice of systemic therapy, and its recursively related set of practices: theory building, clinical practice, training and research.

In terms of its clinical implications, this description provides a new level of detail of a map of a territory that is central to the therapeutic endeavor. Therefore, it may allow the

---

<sup>6</sup> A lucid description of the singularity of the intersections between complex systems--the patient's/family's reality and that of the therapist--can be found in Elkaim (1985).

clinician to expand his or her ability to explore most dimensions of stories, rather than "specializing" in a few. One could apply this map, for instance, to the practice of circular questioning because it allows one to discuss not only the specific form of the questions (Tomm, 1987, 1988) but also the specific locus and direction of change in the patients' or families' narrative.

As for training implications, if one forgoes the temptation to use these items as discrete units or "bricks" rather than as a repertoire of decision-making tools, this vocabulary and this repertoire of transformative dimensions may be useful for expanding the teaching of therapeutic skills. As with any other conceptual tool, trainees may chose to enhance their skills to favor transformations in each of these parameters, but they should be advised to promptly "forget them" after learning them, for two reasons: firstly, a systemic practice requires the ability of the therapist to relate to conceptual tools on an instrumental, and not on a subservient basis; and secondly, it is important to avoid confusing the tree of a singular story with the forrest of the ecology of stories in which people inhabit. In fact, what many expert therapists call "intuition" may consist precisely in having learned and then forgotten the right things!

In terms of research implications, an operationalization of the parameters proposed in this essay would open the doors to a most interesting and potentially powerful arena for research on the process of change in therapy.

Variables that may be taken into consideration as operationally defining a transformative event include (1) the relative dominance and characteristics of a given story; (2) a given intervention by the therapist--question, comment--along a specific dimension that challenges the structure or dominance of the story, or attributes of the storyteller; (3) a corresponding shift in the story (the lack of shift along that dimension or pole should be considered as an unsuccessful attempt, a non-transformation, even if picked up later by the therapist--unless picked up later by the client); in addition, (4) the persistence of the shift over time may add weight to a given transformative move.

In turn, this tool (1) may allow for a new, micro-analytic description of the therapeutic process, and also an analysis of the "natural history" of individual, couples, or family; (2) it may provide us with new, and hopefully heuristically useful, ways of studying what actually takes place in the process of transformation of narratives, including, but not limited to, the process of consensus development, shifts, and the different ways in which families, couples and individuals participate in the process of therapy; (3) it may also provide new operational ways of categorizing therapists' styles or orientations, and the way they respond to or participate in the process of therapy; (4) it may offer insights into the fit between family styles and therapist styles and the role of the therapist in the process of change; and, finally, (5), it may allow the development of a next generation of new, more powerful conceptual tools that will accelerate the demise of the one we propose here.

Hoffman (1981) has noted: "Up to now the family therapy movement has done better in the area of how-to-change-it than of what-to-change"(p.176). The level of analysis proposed in this essay defines a region that overlaps in part with both the "how" and the "what," and it provides new insights about a theory of practice that may enrich them both.

-----00000-----

### **REFERENCES**

Anderson, H. @ Goolishian, H.A.(1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. Family Process 27(3): 371-393.

Bateson, G, @ Jackson, D.D. (1964). Some varieties of pathogenic organization. In D.McK. Rioch @ E.A.Weinstein (eds.), Disorders of communication, Vol.XLII (pp.270-283). Research Publications. Association for Research in Nervous and Mental Disease.

Cobb, S. (1991). Mediation process as the management of stories, submitted for publication.

DeShazer, S. (1985). Keys to solution in brief therapy. New York: W.W.Norton.

\_\_\_\_\_ (1988): Clues: Investigating solutions in brief therapy. New York: W.W.Norton.

Elkaim, M. (1985). From general laws to singularities. Family Process 24:151-164.

Gergen, K. (1982). Toward transformation in social knowledge. New York: Springer-Verlag.

\_\_\_\_\_, @ Gergen,M. (1986). Narrative and the self as relationship. In L. Borkowitz (ed.), Advances in experimental social psychology. New York: Academic Press.

Harre, R. (1984). Personal being. Cambridge: Harvard University Press.

Hoffman, L. (1981). Foundations of family therapy: A conceptual framework for systemic change. New York: Basic Books.

Minuchin, S. (1974). Families @ family therapy. Cambridge: Harvard University Press.

Pakman, M. (1991). La cibernetica de segundo orden. In H.von Foerster (M.Pakman, ed.): Las semillas de la cibernetica. Barcelona: Gedisa.

Penn, P. (1982). Circular questioning. Family Process 21:267-280.

\_\_\_\_\_ (1985). Feed-forward: Future questions, future maps. Family Process 24:299-310.

Shoetter, J. (1984). Social accountability and selfhood. New York: Basil Blackwell.

Tomm, K. (1985). Circular interviewing: A multifaceted clinical tool. In D.Campbell & R. Draper (eds.), Applications of systemic therapy: The Milan approach. London, Grune & Stratton.

\_\_\_\_\_ (1987). Interventive interviewing: Part II. Reflexive questioning as a means to enable self-healing. Family Process 26:167-183.

\_\_\_\_\_ (1988). Interventive interviewing: III. Intending to ask lineal, circular, strategic or reflexive questions? Family Process 27:1-15

\_\_\_\_\_ (1989). Externalizing the problem and internalizing personal agency. Journal of Strategic and Systemic Therapies 8(1):54-59

Watzlawick, P., Beavin, J.H., @ Jackson, D.D.(1967). Pragmatics of human communication: A study of interactional patterns, pathologies, and paradoxes. New York: W.W.Norton

White, M. (1986). Negative explanation, restraint and double description: A template for family therapy. Family Process 25:169-184.

\_\_\_\_\_, @ Epston, D. (1990). Narrative means to therapeutic ends. New York: W.W.Norton.

TABLE 1  
Summary of Dimensions and Transformative Shifts in Narratives

---

**TRANSFORMATIONS**

<b>Dimensions</b>	<b>Shifts</b>
In Time	Static/Fluctuating Nouns/Verbs A-Historic/Historic
In Space	Non/Contextual/Contextual
In Causality	Cause/Effects
In Interactions	Intra-/Interpersonal Intentions/Effects Symptoms/Conflicts Roles/Rules
In Values	Good Intent/Bad Intent Sane/Insane Legitimate/Illegitimate

In the Telling

Passive/Active  
Interpretations/Descriptions  
Incompetence/Competence

---

FIGURE 2  
Combined effects of location of problem and location of agency

P R O B L E M

		EXTERNAL	INTERNAL
A G E N C Y	EXTERNAL	blame or helplessness	salvation or damnation
	INTERNAL	action	guilt or hopelessness

--- |-----|-----|