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Development of a Therapeutic Protocol Grounded in Narrative Therapy Principles for Children and Adolescents with Anxiety and Depressive Symptoms

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Abstract

Introduction: Unlike modern, structured approaches such as cognitive-behavioral therapy, narrative therapy lacks fixed, standardized protocols. Instead of following predetermined guidelines, the therapeutic process is shaped through collaboration with the client and guided by the approach's principles, goals, and philosophy. However, for conducting efficacy studies, it is necessary to develop structured protocols that remain aligned with theoretical foundations. The present study aimed to design and describe a six-session narrative therapy protocol for children and adolescents exhibiting symptoms of anxiety and depression.

Methods: This study was an intervention development article employing a qualitative developmental approach and was conducted between 2024 and 2025. The design process included a systematic review of the literature, conceptual analysis of the theoretical foundations of narrative therapy, integration of findings into structured therapeutic sessions, and expert review of the protocol content.

Results: The final protocol consists of six individual one-hour sessions designed based on narrative therapy maps. The use of these maps provides structure and coherence for research while preserving the authenticity and flexibility of the approach. Moreover, activities such as drawing during the externalization, between-session assignments, and active involvement of parents and significant others contributed to therapeutic goals.

Conclusion: Grounded in the principles, goals, and philosophy of narrative therapy, the proposed protocol offers a balanced response to both the scientific requirements of research and the approach's core tenets. It may serve as a theoretical and practical model for designing and implementing future research studies in the field of narrative therapy for children and adolescents.

Keywords: Psychotherapy, Narrative Therapy, Therapeutic Protocols, Child, Adolescent.

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Introduction

Narrative therapy, unlike many mainstream psychological approaches, did not emerge from within psychological discourse. Rather, it is a synthesis of the ideas of social theorists such as Michel Foucault, with its philosophical roots grounded in post-structuralism and postmodernism [1]. This approach, introduced in the late 1980s by Michael White and David Epston, draws on a wide range of ideas from philosophy, the social sciences, and psychology. It represents a synthesis of diverse theoretical perspectives across multiple disciplines [2]. During the modernist era, psychological theories dominated by scientism regarded the human being as a collection of drives, needs, or foundational structures. Structuralism maintained that these characteristics could be discovered, measured, and classified, thereby enabling behavior or psychological distress to be treated in a manner analogous to physical illnesses [3]. However, postmodern philosophy challenges this view, as it rejects the notion of a single, absolute truth about the world or about human beings. Instead, realities are understood as products of social and historical structures that are formed and transmitted through interactions among individuals and across generations [4].

Postmodernism offers an alternative way of understanding human beings and the world—one that is grounded in a form of knowledge that views individuals as active agents in shaping their own lives [5].

In narrative therapy, framing problems as inherent to the individual shifts focus toward relying on others—especially professionals—for solutions, which in turn limits the potential for meaningful change [6]. By embracing the view that the self is constructed through language and gives meaning to experiences, the understanding of emotions, concerns, and fears also emerges within an interpersonal context [7]. Thus, these concepts are not located within individuals themselves but are constructed through relationships and social contexts. This approach, also known as "anti-structuralism," focuses on personal intentions, goals, values, hopes, principles, and commitments rather than on traits, needs, defense mechanisms, or unconscious drives [8, 9].

A narrative therapist seeks to connect the individual with aspects of their life, relationships, or ways of living that were previously less accessible or conscious. This process typically opens up new spaces for personal experience. By supporting the client in revisiting, clarifying, and evaluating these experiences, the therapist enables the adoption of fresh perspectives toward new possibilities [4]. This path is not predetermined, nor is it directed by the therapist; rather, it is the client who determines the course of their journey [7]. In contrast, formal guidelines, such as those provided by institutions like the National Institute for Health and Care Excellence, are grounded in modern medical discourse, focusing on diagnosing disorders and prescribing specific, evidence-based treatments for each psychological condition [10]. Within this discourse, research is considered credible when it employs standardized, controlled, and replicable methods. While this approach is useful for resource allocation and evaluating treatment effectiveness, it also elevates a particular type of "valid knowledge" above other forms of understanding [11].

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Narrative therapy challenges this one-sided logic by questioning why only certain types of research should serve as the basis for treatment for everyone [14]. Although this perspective may call into question the legitimacy of narrative therapy within the healthcare system, narrative therapy remains committed to the principles of its foundational philosophy [15]. Conventional research instruments also pose a significant challenge for narrative therapy, as the language and logic underlying these tools often conflict with the principles of the approach. Criticisms of such instruments include their failure to separate the individual from the problem, their inability to construct personalized narratives, and their assumption that there is a single, ideal narrative applicable to everyone [16]. Therefore, the primary challenge in research within this field lies in demonstrating therapeutic changes in a way that aligns with the spirit of narrative therapy while also meeting the standards of evidence-based research [12, 17].

Unlike structured modern approaches such as cognitive-behavioral therapy, narrative therapy lacks fixed, standardized protocols, as its postmodern philosophy views individuals as unique and asserts that each person has their own life story and distinct therapeutic journey [18]. Accordingly, therapists using this approach do not follow predetermined programs; rather, they work collaboratively with the client, guided by the principles and philosophy of narrative therapy and utilizing tools such as maps to shape the therapeutic process [19]. This characteristic has resulted in narrative therapy lacking specific protocols for particular disorders, making the implementation of clinical trials in this area challenging. Nevertheless, developing structured protocols that remain aligned with the philosophy of the approach is essential for conducting effectiveness research [16].

A review of studies conducted with children and adolescents, particularly in the areas of anxiety and depression, indicates that either no protocols have been developed or existing protocols are overly general, vague, and lack practical implementation details. Moreover, they often fail to specify the extent to which they align with the spirit and logic of narrative therapy. This issue has posed challenges to the scientific validity and reproducibility of

research in this field [20, 21, 22]. To address this gap, the present protocol has been designed to integrate the philosophy of narrative therapy with research requirements. Within this protocol, maps are employed as guiding tools for the therapist. In narrative therapy, maps serve as conversational structures that help both therapist and client navigate a meaningful path through therapeutic dialogues. These maps act like a compass, particularly when either the therapist or the client feels uncertain or lost during the therapeutic process. However, the fundamental principle in using maps is to preserve the spirit and flexibility of narrative therapy, customizing them for each individual rather than following a rigid, predetermined sequence [23].

The use of maps in this protocol provides greater structure and coherence for research while simultaneously preserving the authenticity and flexibility of narrative therapy [12]. All the maps used in this protocol have been selected from Michael White's book "Maps of Narrative Practice" [23]. The selection aimed to include maps that not only have high clinical applicability but also align closely with the research objectives. These maps do not need to be applied in a fixed order or as step-by-step procedures; rather, their sequence and the time devoted to each can be adjusted according to the client's needs. In essence, these maps serve as tools to guide the conversation, not instruments to "impose" narrative therapy on the client. As White emphasizes, maps support the conversational process and help clarify the path, rather than dictating a predetermined route [23]. The present protocol was designed and implemented for a clinical trial study (Clinical Trial Registration: IRCT20240318061326N1) to examine the effectiveness of narrative therapy in reducing anxiety and depression among children and adolescents with chronic pain.

Structure and Content of the Narrative Therapy Protocol

This study employed an intervention development design using a qualitative developmental approach. Positioned within applied research, the protocol was developed through a qualitative content synthesis methodology. The primary methodological aim was to articulate the intervention content, clarify session structure, and ensure content validity to support future feasibility, effectiveness, and clinical research.

The development process consisted of four stages: (1) systematic review of key narrative therapy texts and relevant studies; (2) qualitative synthesis of core theoretical and practical components; (3) organization of these components into a structured six-session individual intervention tailored to the developmental characteristics of children and adolescents aged 8 to 18; and (4) expert review to establish content validity and clinical coherence.

The expert review was conducted by one specialist in narrative therapy (second author). Feedback focused on session clarity, developmental appropriateness, and alignment with narrative therapy philosophy. Revisions were incorporated through an iterative reflective process, with discrepancies resolved through discussion and reference to core narrative therapy principles.

The content of sessions was developed based on key sources in the field [8, 20, 23, 24, 25]. The primary aim of the protocol is to facilitate the externalization of the problem, identify and strengthen alternative narratives, and support identity reconstruction grounded in the client's values, hopes, and aspirations. Each session includes defined objectives, between-session activities, and its designated map, which are detailed below. A summary of the session structure and the maps used is presented in **Table 1.**

In the following sections, the content of each session and the maps used are described in detail, along with a brief explanation of each map. The overarching emphasis is that these maps serve as guides rather than prescriptive frameworks; therefore, the sequence and timing of each step may be adjusted according to the client's needs.

One Session

1- The session begins with a conversation about the child's interests and strengths. The therapist also explores the child's talents, achievements, support resources, successes, and positive qualities. The focus is on understanding the child's identity independent of the problem. To support this process, the accompanying caregiver may be asked: "What memories of him/her are meaningful to you and might help me get to know him/her better?"

2- The emphasis is on learning about the child in other environments and aspects of their life, or in situations where the problem does not affect them. 3- Identifying the child's preferred story regarding their identity and their desired way of living. 4- Helping the child articulate what they value, what matters to them, and the kind of life they would like to lead. 5- Identifying the narratives that contribute to the persistence of the problem or those that counteract it. 6- Next, problem-saturated narratives are brought forward and discussed. 7- Finally, the identified problems are prioritized based on their importance, and the child decides which issue they would like to address moving forward.

Table 1. Summary of Session Content.

Session	Map	Protocol Content
First		Get to know the person away from the problem. Exploring knowledge, skills, strengths, and qualities of the person. Begin to surface narratives, perceived problems, and the resources the person and family have to bring to bear later. Prioritize problems. Exploring the many contexts of the person's life experience. Identify preferred alternate reality.
Second	The Statement of Position Map 1	If possible, get to the information-seeking stage. It can be spying, collecting experimental data, etc., to clarify how the problem works. Understanding its operations and tactics can also reveal the problem's intentions and purposes. Assist the person in putting into words the aspects of their life that matter most to them and how they wish to go on in life, and identify the resources or support systems that can help them achieve them. Out-of-session work is data collection or further work externalizing (such as drawing or writing a letter to the problem).
Third	The Statement of Position Map 2	Either begins, if not achieved in two sessions, data collection, or review of data. To gain a clearer understanding of the narratives that contribute to the life of the person or the life of the problem. Out-of-session work will focus on thoroughly exploring the operations and tactics of the problem, to integrate these insights into our strategy thinking for the next session.
Fourth	The Actions to Identify Map	Strategy thinking and planning for action Out-of-session work requires strategy implementation.
Fifth	The Outsider Witness Group Map	thickening and enriching the preferred account of identity. Discuss more broadly with the person the steps or actions they would like to take to align their life more closely with their values and preferred ways of living.
Sixth	Collective Narrative Practice	document and share the story of overcoming the problem to consolidate the new narrative and help others.

Two Session

1- Gathering information about the problem: In this stage, the therapist explores the tactics, tricks, and strategies through which the problem exerts its influence. The child is encouraged to collect additional information at home. The goal is to uncover the intentions and purposes of the problem.

2- Supporting the child in identifying meaningful aspects of their life: The therapist helps the child recognize the areas of life that matter to them and the kind of life they wish to lead. The session also includes identifying resources and support systems that can assist the child in moving toward their preferred way of living.

3- Between-session activities involve continuing the externalization process, including gathering information about the problem's tactics and creating drawings related to it.

Employing the Statement of Position Map 1 [26]:

Statement of Position Map 1, also known as the Externalizing Conversations Map, is designed to explore the problem that brought the person to therapy. White suggests that this map is particularly useful when individuals come to therapy with a problem-saturated story of their lives or with negative assumptions about their identity. Although narrative therapy does not focus solely on the presenting problem, exploring the problem is an essential part of the therapeutic process. Map 1 is grounded in the concept of externalization and supports the separation of the person from the problem. Because it centers on discovering what matters to the client, it is also known as the *Position Map*. Through this process, individuals are helped to determine their stance toward the problem—specifically, which aspects of it they find helpful or unhelpful. White emphasizes that this map positions the therapist as "decentered but influential," a stance that strengthens therapeutic collaboration. The process of this map includes:

1- Identifying and naming the problem:

The first stage of this map involves generating a name or definition for the problem. In this step, the problem is

given an identity—as if it were an external entity—and is named by the person's choice. The purpose of this stage is to separate the problem from the individual's identity. The goal of the first set of questions is to help individuals define the problem (or problems) that brought them to therapy. By deepening the initial descriptions, the process moves from a broad, often textbook-like and distant account of the problem toward a more personal, experience-near, and unique description. During this process, the person may rename the problem in a way that better fits their lived experience. Examples of questions include:

"What name would you give to what you're dealing with?"
"If the problem were a person, what kind of person would it be?"
"If you could see the problem, what would it look like?"
"Does the problem have a voice?"
"Could you draw it or make it out of these materials?"

2- Evaluating the effects of the problem:
This stage evaluates the effects of the problem on various aspects of the individual's life and explores its consequences. The effects of the problem can be very broad. Exploring these influences can be helpful not only in understanding the impact on the person, their relationships, work or school, and mood, but also on their view of themselves and the world around them. The goal is not to produce an exhaustive list of effects, but rather to gain an accurate understanding of the main ones. Examples of questions include:

"In which areas of your life is the problem most present?"
"How do you notice that the problem is showing up?"
"How does this problem affect your life or your schoolwork? What kinds of effects does the problem have on your friendships? Or your relationships with your family?"

3- Exploring the person's position on the effects of the problem:
In this stage, the conversation focuses on the individual's opinions and perspectives regarding these effects, particularly on how desirable they find them—whether they like these effects, dislike them, or feel both ways. This phase involves a deeper examination of the problem's effects to help the person adopt a clear position about the problem. At this point, the therapist may summarize and structure the material discussed. Throughout this exploration, the individual can identify the preferred and non-preferred aspects of the problem. Some parts of the problem may seem useful to the person, while other parts may feel unbearable. Examples of questions include:

"What is life like with this problem? Do you like it?"
"Has the problem made your life better or worse?"
"Is this situation acceptable to you?"
"What is your view on this? What is your position regarding these matters—what position would you like to take?"

4- Identifying values:
The final stage of this map involves identifying the client's values by exploring the reasons behind the person's position on the effects of the problem. This category of questions examines the stances the individual has taken in relation to the problem(s), and seeks to understand the person's reasoning by asking "why." The assumption is that, when responding to the "why" question about their position in Stage Three, the client will begin talking about their values—values that have been overshadowed in their life by the problem. Examples of questions include:

"What things are important to you that the problem is getting in the way of?"
"Why don't you like the problem?"
"What does taking this position in this way tell me/us about what is important to you or about your hopes for your life?"

Through this line of questioning, the hope is to identify and articulate the person's values, hopes, and commitments. It may also open doors to contradictions with negative conclusions or dominant narratives that the person has adopted. Throughout the use of the Statement of Position Map 1, it is quite likely that the therapist has developed multiple lines of inquiry with the individual. Several effects of the problem may be described, each with its own positive and negative evaluations.

Three Session

1- Discussing the child's findings about the tricks and strategies of the problem. 2- Identifying the narratives that support the person's life or that support the problem.

Employing the Statement of Position Map 2 [27]:
The Statement of Position Map 2 maintains the same questioning framework as the first version, but with one key difference: while the previous version shaped externalizing conversations through its focus on the problem, this version—by identifying unique outcomes and points that fall outside problem-saturated narratives—facilitates the re-authoring of the person's life story. Therapeutic questioning based on this map provides a

foundation for implementing the Actions to Identity Map (Session Four). By understanding the client's values and goals, the therapist asks questions oriented toward "practical actions" to encourage the person to revisit their past and recount events that align with those values. The process of this map includes:

1- Naming and characterizing the Unique Outcome:
In this stage, the event, action, or intention that stood in contrast to the problem is named and given identity. The child is invited to talk about this action or intention and to explain what purpose, intention, goal, or hope they had when doing it. Examples of questions include:

"What name would you give this success?"
"When you describe this success, what image, word, or phrase comes to your mind?"

2- Connecting:
In this stage, the antecedents and consequences that led to the formation of the "unique outcome" are placed alongside one another and connected. The effects of this event on the person, others, and the future are also explored. Examples of questions include:

"What ideas or actions from other areas of your life might be connected to this?"
"What effect did this event have on others, on yourself, and on your sense of what kind of person you are? What happened afterward? Did this event help you understand something better?"

3- Exploring the Person's Position on the Unique Outcome: In this stage, the person's stance and views about the event are explored—specifically, the degree to which this event aligns with what the person wants for their life. Examples of questions include:

"To what extent does this event align with what matters to you and what you believe in?"
"What is your experience of this event and what happened after it?"
"How do you feel about this?"
"What is your view on this matter?"

4- Identifying Values: Similar to the previous map, the goal is to identify the client's values by exploring the reasons underlying their position regarding the "unique outcome." It is assumed that in responding to the "why" questions about their position in stage three, the client will begin to talk about their values—values that this event is aligned with. Examples of questions include:

"Why do you have this opinion about this situation?"
"How does this event correspond to the things you want in life and work toward?"
"Why do you feel this way about this development?"
"Why do you hold this stance/view regarding this change?"

Four Session
1- Searching for strategies and solutions to address the problem. 2- Planning for implementing and applying the solutions. 3- Applying the solutions at home according to the plan.

Employing the Actions to Identify Map [28]:
In this map, the goal is to identify memories in the person's past that align with their values, goals, hopes, or the "unique outcome." The purpose of this map is to construct a life narrative that is rich and multi-layered. In doing so, the path is paved for building a narrative of life that corresponds to the person's values. After identifying these memories, the following steps are carried out:

1- Inquiry about the intentions and purposes behind the person's actions. For example:

"Why did you choose to do this *action out of all the things you could have done?"*
"What led you to decide to do this?"
"What were you thinking about when you made this decision?"
"What knowledge and/or skills did you use? And where did you learn them?"

2- Inquiry about the person's values and beliefs that formed the basis for their decision and intention to take this action. For example:

"What do you think mattered enough to you that it led you to do this?"
"What convinced you most to take this action?"
"In your view, what does this action—and your reason for doing it—say about your values or what matters to you?"

3- Inquiry about the person's hopes and aspirations in taking this action. For example:

"What did you hope would become possible for you after doing this?"
"Did you have any hope or wish about what this action might make possible in your life?"
"What do these actions/values say about your hopes for your life?"

4- Inquiry about the person's principles in relation to their hopes and aspirations. Principles are similar to values, but they are broader and not tied to a specific context or setting. For example:

"Do you think that if others also held your values and hopes in such situations, the world would become a better place?"
"Are there principles or ethics that you would like to always remember?"
"What does this action say about what you stand for or advocate?"

5- **Inquiry about the person's commitments** in life that are linked to their principles. Commitments are the personal principles that continue to show up repeatedly in a person's actions and are of great importance for them to uphold. For example:

"Are there other instances in your life where you do similar things that reflect these principles?"
"What values do you want to stay connected to or preserve?"
"What difference does staying close to these ideas make (for example, in life, work, or relationships)?"

Five Session

1- A more detailed conversation with the person about the steps or actions they would like to take in the future in order to bring their life more in line with their values and with what they desire.

Involving other people in the session and employing the Outsider Witness Group Map [29]:

The Outsider Witness Group Map can be used to help uncover and strengthen the person's preferred alternative narratives. Outsider witnesses are a group of individuals—selected by the person—from among family members, friends, professionals, neighbors, or even people who have had similar experiences. This group serves as an audience who listens to the person's story or retelling of their experiences. This map aims to consolidate and enrich the person's newly preferred identity, since these newly discovered preferred narratives are vulnerable to fading or being forgotten and therefore need to be strengthened and deepened.

The structure of the session in the presence of an outsider witness is as follows: In the first stage, the person recounts the old and new narratives, the stories of overcoming the problem, and whatever else they would like others to hear. In this conversation, the person refers to their values in overcoming the problem and to the progress they have made throughout the sessions. In the second stage, the therapist turns to the outsider witness group and asks for their reflections on the narrative they have heard, across several dimensions, while the client takes the position of an observer. A description of the categories of questions used in this stage is provided below. In the third stage, the client again returns to the position of interviewee and shares their thoughts about what they heard from the outsider witness group. This dialogue concerns the person's experience of hearing others' reflections and the new insights they have gained from them. An important point when using the outsider witness group is that, when the client or participants are in the interviewee position, they should sit with their backs to the outsider witness group and not directly face or look at them. The second stage of the Outsider Witness Group Map includes four categories of questions: 1- Identifying Expression, 2- Identifying Image, 3- Identifying Resonance, 4- Identifying Transport.

1- Identifying Expression:

The aim of this stage is to help the outsider witness articulate what specifically drew their attention during the conversation between the therapist and the young person. It is essential here that the outsider witness focuses on the actual words they heard, rather than using their own interpretations or personal wording. For example, the therapist may ask: *"While you were listening to this conversation, which part of what was said drew your attention the most?"*; *"When the person was speaking, which phrases or expressions particularly stood out to you?"* If the outsider witness begins to shift toward interpretation—for instance, by saying: *"I thought they were very brave"* (which reflects an assumption about the young person)—the therapist can gently guide them back by asking: *"What exactly did you hear that led you to think that?"* This refocusing helps the witness return to the young person's actual words and expressions.

2- Identifying Image:

In this stage, the outsider witness's responses are explored more deeply to understand what the young person's expressions reveal and what the witness values in what they heard. For example, the therapist might ask: *"When you listened to the conversation between the young person and the therapist, what came to mind regarding what matters to them? Did any particular image, scene, or idea appear for you?"*: *"Did hearing these words evoke any specific experience for you? What impressions did you form about the things that are important to them?"*

3- Identifying Reflections:

In this stage, an effort is made to create a connection between the outsider witness's experiences and those of the adolescent. For example: *"After listening to this conversation, was there anything that resonated with or echoed aspects of your own life or work? If so, what was it and in what way?": "Why did these statements catch*

your attention? Are they related to things that matter to you? What aspects of your own life made you feel drawn to these words?"

4- Identifying Transport:

The fourth and final stage of the map addresses the direct influence of the adolescent's narrative on the outsider witness. At this point, the therapist may ask:

"What effect did hearing this narrative have on you? What feelings or thoughts came up for you? What might you carry forward with you from this experience: "What does it mean to you that aspects of your life resonate with those of this person? Did any of this occupy your thoughts? Did hearing these words remind you of something, affirm something, or perhaps challenge something within you?"

A key consideration in working with outsider witnesses is the careful preparation of the individuals involved in the process, as the therapist and the adolescent seek people who can support the adolescent's preferred narratives. These individuals need to understand that their role is to be present as listeners to a particular kind of conversation. With the participants' permission, the therapist may occasionally pause the flow of dialogue. These pauses are intended to guide responses in ways that support the adolescent's preferred narratives. Sessions typically begin with a clearly defined topic. Having a topic—and stating it explicitly—can be a useful means of helping witnesses stay focused, and, when necessary, provides a pathway for pausing and reorienting the conversation.

Six Session

1- Creating an environment and context that support the continuation and strengthening of the person's progress made during the counseling sessions. 2- Helping the individual strengthen their relationships with the important people in their life—those whom they consider significant and choose to include within their close circle. Problems can separate people from one another; therefore, considerable emphasis is placed on reinforcing relationships.

Collaboration of the client in elaborating and expanding the Collective Narrative Practice [30]:

In this phase, the individual, with the therapist's support, writes the story of their victory over the problem in order to consolidate the new narrative and provide guidance to others who may face similar difficulties. Individuals are asked to share their experiences of confronting the problem and the challenges they encountered, to help those with similar struggles. They are also asked to summarize the insights, knowledge, and new achievements they have gained throughout the sessions. In addition, they are encouraged to write about their plans for enriching their preferred life in the future. It is possible to request the adolescent's permission for their presence as an outsider witness if another person with a similar problem seeks help or becomes inspired by their story. In this way, a network is formed among individuals who possess specialized knowledge about confronting the problem and who can support others with similar difficulties when needed. This helps individuals feel less alone in their struggles, and seeing others with similar challenges can increase their hope and motivation in overcoming the problem.

Discussion

The six-session narrative therapy protocol presented in this article is intended as a clinical strategy for addressing anxiety and depression. It was developed based on Michael White's therapeutic maps and takes into account the developmental characteristics of children and adolescents. This approach facilitates distancing from problem-saturated narratives by focusing on the individual's values, hopes, and aspirations and re-authoring them into a rich and preferred narrative [6]. The protocol emphasizes identity reconstruction, fostering the child's sense of agency in confronting problems, and expanding their social support network, offering an approach distinct from symptom-focused therapies. The maps used in this protocol provide a structured yet flexible framework to facilitate this process. The "Statement of Position Map 1" allows the individual to narrate their lived experience of the problem in an externalized and separate manner [26], while the "Statement of Position Map 2" focuses on identifying exceptional moments and meaningful departures from problem-saturated narratives [27]. The "Actions to Identity Map" links the child's actions in confronting the problem to an identity grounded in their intentions and purposes, values and beliefs, hopes and dreams, principles and commitments [28]. Finally, the "Outsider Witness Group Map" and the "Collective Narrative Practice" activity serve to consolidate and reinforce the new narrative within the child's social context [29, 30].

A key strength of this protocol is its attention to the child's experiences across different life domains and its focus on enhancing their support network, which is specifically targeted in sessions five and six. Moreover, the use of maps and clear specifications of each session's content adds structure and clarity to the therapeutic process. This contrasts with many narrative therapy protocols employed in efficacy studies, which are often

vague and general, lacking clear procedural guidance, potentially undermining research validity and reliability [16]. The integration of metaphorical language, between-session activities, active participation of parents and significant others, and the use of creative tools such as drawing and writing aligns this intervention with the cognitive and emotional capacities of children and adolescents. However, implementing such a protocol requires thorough training of therapists in narrative therapy principles and conversational skills, as well as familiarity with the underlying philosophy of the approach [17]. Establishing a supportive social environment for the child to accept and reinforce the new narrative is also essential. Given that narrative therapy has roots in family therapy and maintains a strong connection with it, particular attention is given to the child's family and social context [4]. Therefore, active involvement of parents, caregivers, and other significant individuals, especially in sessions involving the "Outsider Witness Group" is central to the process.

There are, however, considerations when applying this protocol. Since the philosophical foundation of narrative therapy emphasizes the uniqueness of each individual's experience [25], strictly following a predefined sequence of questions or session order may not suit every child. Some maps may require more time, or certain maps may not be applicable to a particular child. Unlike structured approaches such as cognitive-behavioral therapy, narrative therapy does not have rigid frameworks; its structure is flexible and fluid. Therefore, rigid adherence to a specific narrative therapy protocol is neither feasible nor desirable [16]. The sample questions provided in this protocol are intended as guidelines and should be individualized according to the developmental level of each child, with language and tone adapted to their needs. This is particularly important for the "Actions to Identity Map", as concepts such as values, hopes, beliefs, principles, and commitments need to be translated into language that children can understand. For example, in the "Commitments" section, a child might be asked: "Are there other situations where you also support 'caring for others, for instance at school, in clubs, or at home?" Parents may also be consulted to support the dialogue: "Do you have any memories of your child showing care for others in particular situations?" Depending on the therapeutic context, certain question categories may be omitted, or the session focus may be placed on deepening a specific category.

Given the high prevalence and comorbidity of anxiety and depression, as well as the promising application of narrative therapy in these conditions [21], the present protocol was specifically developed to support a study examining the effectiveness of narrative therapy for anxiety and depressive symptoms. Nevertheless, within narrative therapy, primary emphasis is placed on the person's relationship with the problem rather than on the diagnostic nature of the problem itself. Consequently, the specific form of psychological distress is of secondary importance [8].

Owing to its flexible, non-prescriptive, and meaning-centered orientation, narrative therapy allows this protocol to be adapted to other psychological concerns with minimal modification. Such adaptability is often less evident in highly structured approaches, such as cognitive-behavioral therapy, which typically rely on disorder-specific and differentiated treatment protocols [19]. By foregrounding individualized narratives, present-focused exploration, and the reconstruction of identity independent of problem-saturated stories, narrative therapy offers greater adaptability across diverse psychological concerns [1]. In research settings, treatment fidelity could be monitored through therapist session summaries, reflective clinical notes, and checklists emphasizing adherence to core narrative processes, aims, and philosophical principles.

Despite the effort to design a coherent, structured protocol grounded in narrative therapy principles, several limitations exist. First, the protocol was specifically designed for children and adolescents, and its use in other populations would require adaptation. Second, due to the flexible and non-linear nature of narrative therapy, session order and duration may not be uniform across all participants. While this characteristic aligns with the dynamic spirit of narrative therapy, it can present challenges for conducting quantitative research with controlled, fixed designs. It is recommended that this protocol be implemented in randomized controlled trials with larger sample sizes and long-term follow-ups to more accurately evaluate its effectiveness in the target population. Future studies may evaluate the effectiveness of this protocol using a combination of quantitative symptom measures (e.g., anxiety and depression scales) and qualitative indicators such as preferred story development, analysis of identity reconstruction, and meaning-making processes assessed through interviews or narrative analysis. Using this protocol can expand existing knowledge on narrative therapy in children and adolescents and enable empirical comparisons with other therapeutic approaches. In applied settings, it can also serve as an educational framework for training and guiding therapists, psychologists, and child and adolescent counselors.

In summary, this narrative therapy protocol addresses the need for structured interventions for clinical

trials while remaining faithful to the core principles of narrative therapy. The primary objective is to provide a therapeutic framework that simultaneously meets research considerations and aligns with the essence and goals of this postmodern approach, supporting identity re-authoring and the reinforcement of preferred narratives. This protocol can serve as a model for developing narrative therapy interventions in various areas of child and adolescent psychology and pave the way for future research on their effectiveness and adaptability.

Highlights

What Is Already Known?

Anxiety and depressive symptoms are common mental-health concerns among children and adolescents and can significantly impair their emotional, social, and academic functioning. Narrative therapy, which is grounded in postmodern and poststructuralist perspectives, emphasizes the uniqueness of each individual, the meanings attributed to personal stories, and the externalization of problems rather than defining individuals by their difficulties. However, unlike structured approaches such as cognitive-behavioral therapy, narrative therapy generally does not rely on standardized, fixed treatment protocols. Consequently, the lack of clearly described and theoretically consistent protocols may hinder the design, replication, and evaluation of effectiveness studies involving children and adolescents with anxiety and depressive symptoms.

What Does This Study Add?

This study contributes a structured yet adaptable narrative therapy protocol for children and adolescents experiencing anxiety or depressive symptoms associated with chronic pain. By detailing therapeutic maps, session content, sample questions, and activities, the protocol enhances the transparency, clarity, and replicability of narrative therapy research while maintaining its collaborative and individualized principles. It integrates parents, caregivers, and other significant individuals into the therapeutic support system and employs developmentally appropriate techniques, including externalization, identification of unique outcomes, identity development, outsider-witness practices, creative activities, metaphor, and between-session tasks. The protocol is intended as flexible clinical guidance that can be tailored to each young person's developmental stage, lived experience, therapeutic needs, and sociocultural context, thereby providing a foundation for future research and clinical practice in chronic pain and related psychological difficulties.

Authors' Contributions

This article is derived from the first author's master's thesis, supervised by the second author.

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Conflicts of Interest Disclosures

The authors declare that there is no conflict of interest regarding this study.

Ethics approval

This article is derived from the first author's master's thesis in Clinical Psychology at the School of Medicine, Zanjan University of Medical Sciences. The study was conducted in accordance with ethical research principles and received ethical approval from the Research Ethics Committee of Zanjan University of Medical Sciences (Ethics Code: IR.ZUMS.REC.1402.286). Before the commencement of the study, written informed consent was obtained from the parents or legal guardians of the participating children, and verbal assent was obtained from the children themselves. Participants were assured that their information would remain confidential and that they could withdraw from the study at any stage without any consequences.

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Consent For Publication

All authors expressed explicit consent for the publication of this manuscript.

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