Second Edition

Of Mice and Metaphors

Therapeutic Storytelling with Children

JERROLD R. BRANDELL

1

Stories and Reciprocal Storytelling in Dynamic Child Psychotherapy

❖　❖　❖

The significant differences in psychotherapy with children, adolescents, and adults have multiple ramifications for the ways in which we approach the treatment process. As a general rule, few adolescents and even fewer children express interest in discussing their wishes or intrapsychic conflicts, nor are most very receptive to this idea. Not unrelatedly, the overwhelming majority of children and adolescents do not usually seek out psychotherapy independently for themselves but, rather, are brought, sometimes quite unwillingly, into treatment by their parents. Moreover, children and adolescents reside in an environment that has become a historical milieu for the adult patient: Children and adolescents are in the process of negotiating in real time those conflicts and crises that for the adult patient are only variously accessible memories. Children and adolescents are, in effect, still heavily engaged with both parents and siblings in multiple discourses that for most adults may have come to exist only at the level of the imaginary.

Aside from these distinctions and many others that we might focus on, there is a fundamental difference in the repertoire of treatment techniques suitable for clinical work with these three clinical populations.

1

Because children, unlike their adolescent and adult counterparts, have often not achieved full mastery of either spoken language or secondary process thinking, the use of the full adult range of verbalized communications is rarely possible for them (Lieberman, 1983). Thus doll play, puppetry, therapeutic games, modeling, mud and clay, painting and drawing, and other "play" techniques are used either alone or in conjunction with elicited narratives, which, in turn, involve either direct verbal exchange or communication made *per metaphor*.

❖ CHILDREN'S STORIES: AN OVERVIEW OF THE LITERATURE

In one form or another, stories and storytelling have constituted an important activity in psychodynamically oriented child therapy since the earliest clinical encounters with child patients in the first two decades of the twentieth century, although a review of the early child psychotherapy literature reveals relatively few instances in which storytelling is used systematically and independently of other psychotherapeutic techniques. Despite the relatively infrequent reports of techniques that made prominent use of stories and storytelling before the mid-1960s, the value of stories in both treatment and evaluation was recognized quite early. Indeed, it was over a century ago that pioneering child psychoanalyst H. von Hug-Hellmuth (Hug-Hellmuth, 1913, 1921; Gardner, 1993) first suggested that children's projective stories and other fantasy play might provide the child analyst with dynamically meaningful information about a child's characteristic conflicts and adaptations. J. Conn (1939, 1941, 1948) and J. Solomon (1938, 1940, 1951) were among the first clinicians to experiment with children's stories both as projective media and as a technique in child psychotherapy; both are credited with early contributions to this literature (Gardner, 1993).

Louise Despert and her associate, H. W. Potter, reported in 1936 on a study undertaken to evaluate the story as a means of investigating psychiatric problems in children. Their subjects were 22 institutionalized children ranging in age from 4 to 13 years. Although their research was not methodologically rigorous, Despert and Potter offered several conclusions based upon the impressionistic evidence they amassed:

- The story is a form of verbalized fantasy through which the child may reveal his or her inner drives and conflicts.

- A recurring theme generally indicates the principal concern or conflict, which in turn may be corroborated with other clinical evidence (e.g., dream material).

- Anxiety, guilt, wish-fulfillment, and aggressiveness are the primary trends expressed.

- The use of stories appears to be most valuable when the child determines the subject matter of his or her own story.

- The story can be used as both a therapeutic and an evaluation device.

Often, stories have been elicited by a child therapist in conjunction with particular therapeutic media or activities, such as puppetry (Bender & Woltmann, 1936; Hawkey, 1951; Woltmann, 1940, 1951), finger painting (Arlow & Kadis, 1946), drawing and watercolor painting (Rambert, 1949; Tanaka, 2012), costume play (Marcus, 1966), clay modeling (Woltmann, 1950), letter writing (Knoetze, 2013), and sand-play (Burt, 2014; Heiko, 2010). Doll play (Millar, 1974) has also proved to be a rich source of stories and fantasies.

Some writers, among them L. Gondor (1957), have taken the position that the selection of a mode for communicating fantasies should depend on the child's own preference, necessitating the therapist's motivation and ingenuity in assisting the child to discover the best means of expression for such fantasies. Gondor illustrated this process with a clinical example involving a withdrawn 10-year-old patient who had difficulty with direct verbal communication but was able to express herself through the medium of a story, which was dictated to the therapist in weekly installments.

In fact, most techniques utilized in child psychotherapy have been designed to elicit fantasies, and not necessarily stories. Contemporary exponents of the Kleinian school of play therapy might conceivably object to a technique requiring the child to produce an autogenic or stimulus-independent story, on the grounds that it imposes an unnecessary structure on the flow of material from the unconscious or that it restricts expression to the level of verbal communication. Phenomenologically speaking, however, such a story may be thought of as possessing an intermediate level of organization "somewhere between the more fluid primary process—like ideational activity of free association, and the more orderly, secondary process thinking of logical, conscious syntactical communication" (Kritzberg, 1975, p. 92). In other words, the autogenic story, though perhaps restricted to the domain of expressive language, does appear to provide reasonably direct access to a child's fantasy life, as do other techniques of play. One may even view the mandate to verbalize these fantasies in story form as a potential means of *enhancing* dynamic communication rather than diluting, masking, or distorting it. In one classic investigation of children's verbalized

fantasies, eliciting an autogenic communication is described as comparable to eliciting a "dream on demand" (Pitcher & Prelinger, 1963).

Storytelling and story materials are sometimes associated with highly specialized procedures used in the psychotherapeutic treatment of children. One such procedure is *psychodrama*, in which children are called upon to utilize sociodramatic play in order to achieve insight into their behavior and to enable them to learn other, more appropriate roles for meeting the challenge of different interpersonal situations (Dreikurs, 1975; Starr, 1977). Another is the *structured therapeutic game method of child analytic psychotherapy* (Kritzberg, 1971, 1975), a method that combines stimulus-based (as opposed to autogenic) storytelling with two therapeutic games: The first (TISKIT, or Therapeutic Imaginative Storytelling Kit), designed for pre-literate children, contains iconic objects; the second (TASKIT, or Tell-A-Story-Kit), designed for school-age children, contains word-cards. The *mutual storytelling technique*, originally conceived as a reciprocal storytelling procedure (Gardner, 1977), was the earliest effort to formalize the use of children's autogenic stories. Children's stories have also been combined with a variety of card and board games (Gardner, 1993). The *creative characters technique* (Brooks, 1981, 1993) is an interesting amalgam of N. Kritzberg's *structured therapeutic game method* and R. Gardner's *mutual storytelling technique;* more collaborative than reciprocal, it puts considerable focus on the strengthening of cognitive skills and various ego functions (e.g., anxiety-binding, promotion of mastery and competence). Yet another, more recent effort has involved the creative interweaving of therapeutic storytelling with the principles of EMDR or Eye Movement Desensitization Therapy (Turner, 2005, pp. 327–344).

The therapist's collaborative participation in the co-construction of children's stories has been used to clinical advantage by others. One example is J. Liebowitz's (1972) study of a severely disturbed 7-year-old whose use of storytelling was less a means of communication than a way of holding onto his relationship with the therapist. This child's stories had no plot or meaning—only characters with no apparent relationship to each other. Puppets and graphics materials were freely used to assist in the continuing therapeutic work with the child, and the therapist participated quite directly in altering or adding material to his autogenic stories. M. Robertson and F. Barford (1970) found therapist-constructed stories to be useful in therapeutic work with a chronically ill child hospitalized with respiratory failure. The stories were composed on a daily basis and incorporated not only the child's view of his life within the hospital but also the therapeutic team's perspective. The authors believed that the stories read to this child

ultimately equipped him to involve himself "both psychologically and physiologically in the world beyond the hospital," culminating in his separation from the respirator and his eventual discharge (1970, p. 106). Another collaborative model involved the use of drawings and what the author has termed "embedded therapeutic messages" (Handler, 2012, pp. 243–267) in the treatment of a "Billy," a very bright, though controlling and resistant 6-year-old child, who was prone to troubling displays of aggression and primitive behavior. Additional modifications and applications of the basic reciprocal storytelling technique have been described by other authors as well (e.g., Claman, 1980; Davis, 1986; Gabel, 1984; Kestenbaum, 1985; Kottman & Stiles, 1990; Lawson, 1987; and Spees, 2002).

❖ WHAT IS RECIPROCAL STORYTELLING?

The use of allegories, fables, parables, myths, and legends in the intergenerational transmission of important values and moral precepts has been traced to virtually every culture since the beginning of recorded history, underscoring the effectiveness of storytelling as a mode of communication with the young. Developmental psychology also tells us that children experience themselves from an early age "through the symbols they use to apprehend, encode, change, and describe experience," and that self-composed stories may serve as the "most essential symbolic process" for reflecting on and describing such experiences (Engel, 1999, p. 185).

   Reciprocal storytelling was specifically designed as a means of both eliciting children's self-composed or autogenic stories and providing a therapeutic response to them in the context of psychoanalytic child psychotherapy. Compared to the dreams and free associations of adult patients, such stories and fantasy productions may indeed be less subject to the processes of censorship and distortion, and to other influences that obscure or disguise dynamic meaning. Autogenic stories, which, of course, are projective in nature, provide children with an opportunity to give expression to disturbing wishes, fears, and defensive adaptations in a "safe," though largely unconscious, metaphorical form. Because such stories are composed without specific thematic direction or guidance from the therapist or the use of storytelling "props," they are far more likely to represent faithfully the children's concerns, conflicts, and resolutions than are stories linked either to specific play materials or to themes suggested by the therapist.

The technique of reciprocal storytelling calls for the child's creation of an imaginary story with make-believe characters. The story must be original and there must be a beginning, some development, and an ending; sometimes, but not necessarily, a lesson or moral can be appended. The therapist then discerns the dynamic meaning of the story and responds within the story metaphor with a therapeutic version of his or her own. The responding story provides healthier, relatively conflict-free alternatives to the child's original conflict-laden solutions (Gardner, 1993).

One distinct advantage to the technique of reciprocal storytelling is the manner in which it shapes the patient-therapist discourse. Without creating a rigid structure that is inimical to both the clinical process and the basic objectives of sound psychodynamic treatment, the stories enhance the therapist's ability to apprehend and decode important primary process communications; at the same time, they offer a natural vehicle for therapeutic responses. The reciprocal storytelling process thus establishes an intersubjective discourse that can be maintained throughout treatment and serve as an undeniably powerful therapeutic tool for the child clinician.

❖ WHEN IS RECIPROCAL STORYTELLING USEFUL AND WITH WHICH PATIENTS?

Storytelling procedures can be used selectively with children as young as 3 and as old as 15 years, although the most effective age range seems to be school age to early adolescence (roughly 5 to 12 years). Reciprocal storytelling, in particular, appears to be therapeutically effective across a wide spectrum of childhood problems and emotional disorders: phobias, anxiety disorders, depression, obsessive-compulsive problems; chronic depletion states, self-object disorders, and difficulty in the regulation of self-esteem; and sequelae of emotional neglect and physical and/or sexual abuse. It is especially helpful in work with children of divorce and those suffering from other environmental crises (e.g., loss of a parent or sibling, life-threatening illness of a close family member). In addition, children who have experienced trauma—that is, in cases where a massive paralysis of ego functions has occurred—may be receptive to the use of such story communications *per metaphor*. Therapists may also find reciprocal storytelling a useful adjunct in their clinical work with children suffering from chronic or life-threatening illnesses, or with those who have developmental disabilities. Even schizoid children, or those with nascent borderline personality disorders, may be good candidates for reciprocal storytelling.

Storytelling also seems to work well with resistant children. It may, in fact, provide the therapist with a vehicle for circumnavigating or surmounting initial resistance and establishing a basic working alliance despite the children's disinclination to reveal much of themselves in more direct verbal discourse or even through other play activities. Owing to the fact that stories are "make-believe," children seem reassured that they are not actually revealing anything of great import about themselves. So far as they are concerned, any disturbing wishes, conflicts, secrets, and the like are safely obscured from view. Precisely—and paradoxically—because the story is ostensibly about *someone else*, it permits the *most* important unconscious conflicts and disturbing fantasies, as well as other closely guarded or otherwise hidden parts of the self, to emerge in a disguised though decodable form.

On the other hand, storytelling isn't for everyone, nor is it invariably effective even for the same patient at different points in the treatment process. Certain children with developmental disabilities may be incapable of the minimal cognitive organization required for even the most elementary story. Others whose expressive language is compromised by developmental or organic factors may prefer play activities that do not highlight spoken language. Still others may enjoy the reciprocal storytelling process early in the treatment relationship but later express a preference for alternative play activities. This is especially true over long courses of treatment that begin in preadolescence. In such instances, the child's increasing developmental sophistication makes storytelling, as well as other play activities, seem infantilizing. Indeed, like any other technique in the child psychotherapist's repertoire, storytelling should be deployed with sensitivity and in accord with a particular child's preferences.

It is not essential for a child to be highly verbal in order for such techniques to be used successfully. Even a short, three-line story from a very young or self-conscious child may prove quite revealing, in much the same way that adult patients' dream "fragments" often seem to be. Furthermore, when children express little confidence in their ability to compose a make-believe story, the therapist may suggest the use of a pictorial adjunct to the storytelling procedure to help them "get started." D. W. Winnicott's (1971) *squiggle* technique is ideally suited for such occasions, inasmuch as it provides a natural lead-in to story making without suggesting specific themes or story-content to the child.

The squiggle technique calls for the clinician and child to take turns drawing "squiggly" lines and completing each other's squiggle drawings. The squiggle is made with one's eyes closed, although the other subject always completes the drawing with his or her eyes open.

Winnicott characteristically used the squiggle content as a springboard for analytic investigation; he did not always work within the metaphor of the drawing in the discussions that followed, nor did he ask the child to use the picture to compose an original story, although some of his subjects did this spontaneously.

When a story is the goal, however, it should always be based on the child's completed drawing rather than on the therapist's. The same ground rules apply: The story must be original, the characters must be imaginary, and there must be a beginning, some development of the story, and an ending. I don't require a moral or lesson since I don't believe this to be absolutely essential, but I will sometimes suggest that one be included. Years of personal observation confirm that even children who at first claim to be poor storytellers or unable to "think of one" to tell will suddenly launch into a story without any further prompting. In these instances, the process of creating a drawing from the squiggle somehow liberates preconscious fantasies and their accompanying affects in such children. In fact, some children prefer to base their stories on such drawings, even though they may already have demonstrated an ability to compose their stories independently of this technique. The therapist is well advised to honor the child's wish to combine these two media and, indeed, may be rewarded for doing so with particularly fertile results.

❖ ELICITING THE CHILD'S STORY

Because storytelling is for most children a mode of narrative interchange that is both experience-near and entertaining, they are typically more than pleased to provide an autogenic story at the clinician's request. Inasmuch as original stories are a more accurate measure of the child's issues, conflicts, and adaptations, the clinician may wish to emphasize that telling *made-up* stories is more fun than simply repeating something one has seen on a children's show or a video. (Although there is undoubtedly always some contamination of the content from exposure to movies, videos, and television, it is generally not pronounced.) Most children at 6 or 7 years of age are able to provide reasonably well-integrated stories without a specific injunction to include a beginning, middle, and end. The use of a tape recorder frequently serves to enhance the children's storytelling, allowing them the narcissistic satisfaction of hearing their own voice played back. And at least one author has suggested that the storytelling process can be "framed" as a television show, in which the therapist serves as the interviewer/

moderator and the child is introduced as a "special guest" (Gardner, 1977). Such an approach may be quite appealing to some children and, in any event, establishes a somewhat more natural linkage with audio or videotape. Certain children, however, are resistant to the idea of audio recording or videotaping their stories and may experience such technology as intrusive or anxiety-generating. The recording of stories and perhaps even the therapist's note taking may be contraindicated with these children or with others who exhibit paranoid ideation or fears.

Occasionally, a child will ask the therapist to construct a story collaboratively. Although the likelihood of the therapist's influence over story theme and content is undoubtedly increased in such instances, there are ways to minimize this effect; one might, for example, consent to help with the introduction though not with the rest of the story. Certain children, especially those who lack self-confidence, or who are extremely anxious or perhaps decompensation-prone, may require this parameter until they are sufficiently self-assured to create a story without the therapist's active collaboration.

❖ THE LESSON OR MORAL

For many, a well-told children's story is one that ends with a moral or lesson—certainly a time-honored and integral feature of numerous cautionary tales, fables, fairy tales, and other kinds of stories. The lesson or moral is particularly helpful, too, because it identifies for the listener what the story is intended to teach. Among younger listeners less able to accomplish this task without some assistance, a carefully articulated lesson or moral may make the story both more memorable and more meaningful.

Although it is true that asking the child to draw a lesson or moral at the conclusion of an autogenic story (Gardner, 1977, 1993) may sometimes enable the therapist to select the most salient theme or clarify the meaning of ambiguous story content, that lesson or moral will not always be especially well matched to story theme or content. In fact, it may be chosen not for reasons having any obvious connection to its dynamic meaning but, rather, because the child knows a particular proverb and tosses it in as a way of pleasing the therapist. (Instead of specifically requesting a moral from a younger child, the therapist may find it more helpful to ask "what the story teaches.") Even those therapists who do not believe that doing without a moral from the child results in a significant loss of data may wish to include a moral or lesson at the

conclusion of their responding story. In such cases, the moral or lesson creates an additional opportunity for the therapist to demonstrate alternative strategies or new ways of thinking about problems that enhance the child's adaptive evolution of his or her narrative account.[1]

❖ POSTSTORY DISCUSSION

It is often beneficial to explore the child's understanding of the stories at the conclusion of storytelling. This practice permits the therapist to test the child's awareness of particular story elements that may differ between the two story versions. It can also serve as a natural segue to other play activities. And at times, poststory inquiry can provide a point of departure for discussing the child's conflicted feelings, fantasies, or thematically relevant recent experiences. Note, however, that although therapists do not generally find it problematic to use the stories as a springboard for discussion, perhaps even to suggest a certain similarity between some feature of the story and a recent experience of the child, direct interpretation is best avoided.

❖ THE THERAPIST'S ROLE IN THE STORYTELLING PROCESS

The therapist's role in using stories is not appreciably different than it would be for any other activity in the therapeutic playroom. Listening carefully while remaining empathically attuned, discerning meaning in the child's play and verbalizations, and conveying such understanding in a form that the child can grasp and ultimately internalize—all of these capacities apply equally to the storytelling process.

Composing make-believe stories—like drawing, painting, or clay modeling—involves the child's creative imagination. The story is, in this sense, a creative product that the child has shared with the therapist. It should also be humbling. No matter how skilled or clever the therapist's response to this creation of the patient's, the response must *always* be based on the *child's* material. Children recognize this connection right away and may even comment that the therapist's story sounds very much like their own (a creative debt that the therapist should graciously acknowledge).

As suggested earlier, it is important for the integrity of the storytelling process that such creative products not be approached via direct interpretation (except in highly unusual circumstances, as discussed in Chapter 2). In other words, the therapist should respond *within the*

child's story-metaphor rather than interpreting story themes, conflicts, or other content to the child. When the therapist's immediate response to the child's story is made outside the metaphor, not only are the "ground rules" violated and the therapist's trustworthiness called into question, but the child may become convinced that the therapist has special extrasensory abilities.

Nevertheless, it can be quite useful to engage in a sort of poststory dialogue in which the therapist seeks to clarify ambiguous elements of the child's story and also to establish parallels between the story characters or themes and experiences or issues in the child's life. Such discussion can occur immediately, later within the same session in connection with a different play activity, or even in a subsequent session.

Due to the reciprocal nature of this play technique, the child will expect to hear a therapeutic response to his or her story. Although it is clinically optimal for the therapist to offer a story-response within a few minutes of the conclusion of the child's presentation, this is not always possible. Sometimes, the content of the child's story will be ambiguous; at other times, the clinician, whether due to fatigue or perhaps a countertransference reaction, will simply be unable to grasp the meaning of a given story. Under such circumstances, the therapist might wish to consider three alternatives:

1. After the therapist explains that he or she is unable to tell a responding story right away, therapist and patient engage in a different activity and return to the storytelling at a later point in the treatment hour. Because the dynamic meaning of a child's story is often played out in other activities during the session, the therapist will have additional opportunities to apprehend whatever had proven elusive about the child's story earlier in the session.

2. Another technique involves asking the child to create a "commercial" (Gardner, 1977), the premise being twofold: (a) It permits the therapist to "stall for time," providing a few precious minutes to pore over the child's text in a search for meaning; and (b) whatever salient dynamic issues are contained in the autogenic story are also presumed to be present in the "commercial." This technique has proven beneficial at times, although nearly as often the child seems to view it as an open invitation to make undisguised use of actual television commercials. In consequence, it may frequently be more a source of distraction than a means of enhancing the therapist's understanding of the child's narrative.

3. A third solution is to admit defeat and not attempt a therapeutic response, at least within that particular therapy hour. In this instance,

the therapist may offer a simple apology for being unable to tell a good story in response to the child's offering. Important dynamic themes are, after all, likely to resurface in subsequent interviews. The frank admission of inability to come up with a story-response despite the desire to do so typically elicits a sympathetic reaction; it may even pave the way for less inherently ambiguous revelations from the child. Indeed, those children locked in competitive struggle with the therapist may welcome such an admission as confirmation of a successful sortie against the enemy. This development can be viewed as an opportunity to comment on the obvious pleasure the child appears to have derived from outwitting the therapist. Should the comment prove evocative for the child, the therapist may then wish to explore the transference meaning of such competitive behavior in further dialogue.

Also, there are times, typically near the end of a successful course of therapy, when the therapist finds it difficult to improve upon a child's story, in which case common sense dictates that the therapist not even try. Earlier in the course of therapy, too, the repertoire of strategies a child deploys to resolve conflict may include both maladaptive or conflict-laden elements as well as somewhat more adaptive solutions *in statu nascendi*. The latter, of course, should always be validated and supported in the therapist's story-responses. When, at a later point in treatment, these nascent adaptive solutions are more fully evolved and have supplanted less adaptive strategies, the therapist can simply explain that the child's story is so well told that it can stand fully on its own. This situation is golden: In fact, it is a goal of the whole treatment process that the child internalize new and increasingly adaptive strategies for solving conflicts, develop new capacities for emotional growth, and, in so doing, make the therapy and the therapist superfluous. Insofar as highly adaptive, well-told stories serve as evidence that the child has "brought it all together," they provide reassuring confirmation of his or her readiness to consider termination of therapy.[2] (See the case of Roberta in Chapter 4.)

❖ WHAT ARE THE MOST IMPORTANT COMPONENTS OF CHILDREN'S STORIES?

In every story, the child therapist should strive to identify the dynamic theme or issue; the object relations scenario and key self and object representations; the affective tone of the story; paralinguistic, visual, and kinesic cues; and, finally, the child's defensive behaviors, discrete defenses, defensive strategies, and conflict-free solutions.

- *The dynamic theme or issue*. What is the most salient issue, theme, or focal conflict appearing in the child's story? Childhood is filled with a range of normative crises and conflicts even when it is not disrupted by environmental crises or pathology. Various needs predominate at different phases of psychosocial and psychosexual development; they encompass everything from preschoolers' requirements for affirmation of their normal exhibitionism to the struggles of adolescents to combat the regressive pull of the nuclear family in an effort to extend their radius of social relationships. Typical focal conflicts revealed in the stories of children might be *hostility versus guilt*, the wish for *intimacy versus fear of engulfment*, the wish to be *assertive versus fear of criticism*, or the desire for *autonomy versus fear of abandonment/rejection*.

- *The object relations scenario and self and object representations.* Children's stories sometimes portray a unique object relational experience derived from important, affectively charged early encounters with parents, siblings, and others. Such an experience may then serve as a lens through which all subsequent object relations may be understood. For example, a 10-year-old boy whose mother tended to be overprotective, as well as somewhat intolerant of his efforts to achieve psychological autonomy, told stories in which a small, rather helpless character (usually depicted as a small animal) was dominated by a larger and more powerful character. Every autonomous effort of the smaller character was somehow thwarted or undermined by the larger one, who, like the patient's mother, tended to discourage the smaller character from venturing out, being more assertive, and so forth. Even when such an object relational scenario cannot reliably be identified, it is always useful to determine which character(s) may represent the storyteller and which character(s) appear to represent other important figures in the child's life (e.g., parents, siblings, or the therapist).

- *The affective tone of the story*. Another important element in a child's autogenic story is affective or hedonic tone. Is the story told with anticipatory pleasure, vigor, and enthusiasm? Or is it narrated in a monotone, perhaps with a hint of dysphoria? Does the child sound mildly annoyed, angry, hurt, frustrated, anxious, agitated, fatigued, or confused? Does the affective tone match the feelings of the story characters, the action, or the thematic content? Does the child's affect remain invariant throughout or does it shift mildly or even markedly? At times, a child's identification with a particular story character becomes clear only when the therapist realizes that the *storyteller's* affects are changing each time that character is described or speaks, in a manner somewhat analogous to the use of *leitmotif* in Wagnerian opera.

• *Paralinguistic, visual, and kinesic cues*. The narration of stories is usually accompanied by a variety of sublingual utterances, distinctive facial expressions, and other, sometimes quite revealing, bodily movements. Although such cues are generally consonant with the content of the story and simply serve to "drive home" particular themes or story action, they will occasionally be rather asynchronous or poorly matched with story content and theme. For instance, a very depressed 9-year-old girl, whose father abandoned the family, had quite a fanciful imagination. Her stories often had themes involving larger-than-life characters who embarked on high adventures in exotic locales. As she told these stories, however, her manner was remarkable for its *economy* of movement, and she looked and sounded depressed, her demeanor at striking variance with the imaginative tales she told.

• *The child's defensive behaviors, discrete defenses, defensive strategies, and conflict-free solutions*. According to a classic research investigation of normal 2- to 5-year-olds (Pitcher & Prelinger, 1963), autogenic stories, like dreams, contain compromise solutions to conflict. In stories, children struggle with unconscious wishes (generally of a disturbing libidinal or aggressive nature) that strive for direct expression or discharge. These wishes activate the synthetic function of the ego, which recognizes the danger of direct expression or fulfillment of the disturbing wish and seeks to disguise it, constructing a story that, according to these authors, both assuages the superego and appears to conform to accepted standards of realism and social acceptability. Ultimately, the autogenic story, in a manner analogous to the dream, attempts to resolve the conflict activated by the disturbing wish through whatever means are readily available to the ego. Among these are *defensive behaviors* in very young children (e.g., transformation of affect), *discrete defenses* (e.g., denial, undoing, isolation, or withdrawal), and *wishes used defensively* (e.g., hostility directed against the self, defensive intimacy, or defensive assertion). Relatively *conflict-free adaptive strategies* emerge as the child acquires more capacity for self-observation and insight, usually during the latter phases of treatment.

❖ WHICH THEORETICAL FRAMEWORKS ARE COMPATIBLE WITH RECIPROCAL STORYTELLING?

Although reciprocal storytelling is compatible with any of the major systems used in the practice of psychoanalytic child psychotherapy, the clinical illustrations provided in the examples throughout this book are

guided by two basic frameworks: (1) ego psychology informed by object relations theory; and (2) the psychology of the self. *Ego psychology* is principally concerned with the ego and its functions, and presumes the existence of intrapsychic conflict, which is mediated by the defenses as well as by various strategies and mechanisms of adaptation. It is rooted in the structural hypothesis of classical Freudian theory, although ego psychology takes greater account of the role of the environment than does classical psychoanalysis. The *psychology of the self* is a psychoanalytic psychology based on the contributions of Heinz Kohut (1977, 1984). In contrast to the conflict basis of ego psychology, self psychology is a deficit-based psychology, focusing far more on the availability of certain kinds of psychological supplies thought to be necessary for the evolution of a vital and harmonious or *cohesive self*.[3]

What follows introduces and illustrates the reciprocal storytelling process.

The Case of Tony

Eleven-year-old Tony, attractive if somewhat overweight, was originally referred for treatment because of poor academic performance and behavioral problems at home. His mother anxiously described their relationship as highly conflicted and admitted in a rush of words to feeling both helpless and exasperated in her attempt to parent him. Although Tony typically did not openly challenge her authority, he often subverted, ignored, or sabotaged her efforts; that pattern, and in particular its impact on his two younger siblings, had become a source of growing concern. Tony's almost characterological tendency to procrastinate had negative ramifications for his performance in school and especially irritated his mother. His father, an academician and research scientist, often worked long hours at his lab and traveled extensively to lecture at scientific conferences; he was, and always had been, much less involved with Tony than she.

Tony's mother's portrait of her son's infancy and early childhood contrasted markedly with the presenting picture: She remembered him as an active, happy toddler who smiled at strangers and was captured on home video repeatedly and gleefully running circles around his tired mother—but she now complained about his inactivity, passivity, and dislike of doing physical things. Tony had been a poor eater, and because he seemed to gain weight so slowly, his mother switched from breast milk to formula and began to force-feed him early on, although she admitted this was partly in response to pressure from her husband's extended family. By age two, Tony had become "a better eater"; but an early and significant pattern had clearly been forged in the relationship between mother and son.

Although later developmental milestones were unremarkable, Tony did not react well to the birth of his two siblings. His brother was born when Tony was 22 months old, and a sister came along some three years later. According to his mother, Tony's

problems at home often seemed connected to his dislike and jealousy of David and, to a lesser degree, Patty. By sixth grade, Tony's school performance had deteriorated so markedly that consideration was being given to either special class-room placement or grade retention. Because subsequent testing revealed Tony to be a very bright youngster whose intelligence clearly exceeded the cognitive and intellectual requirements of the work he was being asked to do, such solutions didn't seem particularly viable and, therefore, were dismissed.

Tony was a very agreeable patient and appeared to enjoy a number of activities in the playroom, though in his rather quiet and understated way. One of these playroom pursuits was reciprocal storytelling, an activity in which we engaged to very good effect over the entire course of his 16-month-long therapy. At the time that Tony told me the following story, approximately nine months into therapy, we had been discussing the anger and jealousy he felt toward his younger brother. Tony had made some progress in his school performance and there was moderate improvement in his relationship with his mother, but the rivalry with his younger siblings continued to be a problem.

Tony's Story

Once upon a time there was a fireplace, but it hadn't been used in a long time. These people who lived there were going to knock it down in order to put in a heat-ing system. Well, this builder came by and said to them, "Don't knock it down. I'll take it and put it in my house." Except he really didn't use it much. Well, one day, he was sitting by it, and it cracked, and the bricks started to fall. It was falling apart. He tried to fix it, but it just fell apart again. Finally, he sold it to some people who turned it into a new fireplace, one that was worth more money than the old fireplace.

Moral: Just because things are old doesn't mean they're worth a lot of money.

Analysis

Nowhere among Tony's remarks were the twin themes of sibling jealousy and narcissistic injury more poignantly expressed than in this story, although they were repeatedly reprised in Tony's other stories and play activities. The way in which he chose to represent himself here, as an old fireplace, makes for a densely packed metaphor really quite ingenious in its economy of expression. It emblematizes at once his passivity, his seething anger, and his desire to "shine brightly" before an admiring mother and father.

An old fireplace is scheduled for demolition, to be replaced by a newer, more modern heating system (Tony's younger siblings). Tony believes that the birth of his younger siblings has made him obsolete, like the old fireplace; not only does his mother seem endlessly preoccupied with the needs of his younger brother and sister, but his father is similarly unavailable, running laboratory experiments or away from home at professional conferences. Tony has suffered a series of narcis-sistic and oedipal defeats in relation to both siblings, although his "fall from grace" is more clearly connected to David's birth when Tony was not quite two. Although there is a certain degree of *secondary gain* to be extracted from his school-related problems and his conflicts with his siblings and his mother, the gratifications prove to be fleeting.

Interestingly, the "builder" in his story, who appears to have been introduced as a therapist-representative, seems at first quite genuinely interested in the fireplace. He prevails upon the house owners, the parent-representatives in this story, to permit him to take the fireplace home with him, thereby rescuing it. Sadly, however, the fireplace once again falls into disuse. The transference significance of this plot development is inescapable: The old fireplace is simply incapable of evoking any sustained interest, even from the well-meaning builder-therapist. Tony will eventually suffer the same sort of oedipal and narcissistic defeats with the therapist as he has experienced with his own parents.

In his story, the most prominent maladaptive solution the fireplace adopts is to shake itself apart.[4] Not even the builder is able to repair the fireplace, so he sells it to someone else, who proceeds to turn the old fireplace into a new one, enhancing its value in the process. The story's moral simply repeats the passive and masochistic solutions present in the story itself: Old things (fireplaces, older siblings) aren't worth very much to anyone and, sooner or later, will need to be replaced or rebuilt. In keeping with the helpless and passive voice that pervades the story, it seems almost futile to attempt to counteract this eventuality.

[Based on this understanding, I responded with a story of my own, using many of the same story elements. But there are also critical differences.]

Therapist's Response

Once upon a time, there was a fireplace that used to be the center of attention. Then the people who owned it decided to create a new heating system. The fireplace became neglected, and no one sat by it anymore. One day, a builder saw that the fireplace wasn't doing well and suggested that the fireplace come to his shop so that he could repair it. Well, the fireplace worked better for a while, but then it started to fall apart again. The fireplace felt neglected and displaced by the heating system, and didn't even care anymore, although it didn't know why it wasn't working well.

However, there were things about the fireplace that made it unique. First, it could burn logs, and the heating system couldn't. That meant that even if there was a power failure, the fireplace could always provide warmth to the family as long as they brought logs in from the outside. The fireplace was also unique in that it was really cozy on cold nights, and people liked to curl up next to it as long as its flame didn't burn too brightly. People actually seemed to enjoy spending time at the fireplace, but it is true that the heating system demanded more attention from the family at times.

Anyway, the builder told the fireplace that it needed to remember that it couldn't always provide all the heat for the house, but it certainly could sometimes. He also said that if the fireplace could control its flame better, then people would probably be more likely to want to sit near it. Sometimes, of course, it's important to burn brightly so that people know you're still there, as long as your sparks don't fly out of the fireplace (since that can upset or scare people). The fireplace found these ideas interesting, and agreed to try the builder's suggestions.

Moral: If you're a fireplace and people neglect you, try doing these things: Remember that you have to share heating the house with the more modern heating system; try to control your flame so that people will want to sit by you; and, if you're

feeling like people aren't paying enough attention to you, try burning brightly for a little while, but without making sparks fly since that upsets or even scares people.

Discussion

In my story-response, I attempted to address several interrelated story elements. First, while preserving the fireplace metaphor, I tried to confer a sense of *agency* on the fireplace. In effect, a fireplace doesn't have to be completely passive or helplessly dependent upon others all of the time, as the fireplace in Tony's story was. The fireplace can work with the builder in arriving at a better and more adaptive solution for its problems. Second, it is possible for a fireplace to use aggression constructively (heating up the room for the rest of the family), rather than for the purpose of acting out against others (letting sparks fly), or defensively (punishing itself by shaking apart). I believe that this idea, even after many months of therapy, remained a relatively novel one for Tony and was obviously a perspective he had yet to internalize fully. Finally, my builder counseled the fireplace to "burn brightly" as a way of vigorously announcing its needs, suggesting—aside from the issue of how aggression can be harnessed and used adaptively—that the fireplace *deserves* and *is entitled to* the appreciation of others. Others will admire its warmth and uniqueness, at least some of the time. By the same token, one cannot always be the center of attention; sometimes others will have the spotlight, and one must be tolerant and sufficiently flexible to sustain the corresponding narcissistic slights.

As he had countless times before, Tony participated in this storytelling exchange in a quiet, intently focused manner. He received my story-response with interest, although in our poststory discussions it was rarely possible to make direct connections between our narrative exchanges and his experiences outside of therapy. Tony would simply shrug, indicating that he had "made up a story" in accordance with the rules I had introduced in our very first session. In essence, the stories were "make-believe," having nothing to do with him—a claim made relatively often by children when asked about the relationship of their stories to events or circumstances in their lives (Gardner, 1993). Nevertheless, Tony gradually became quite invested in his therapy. This wasn't always clear from his predictably low-key presentation during our treatment hours; however, he often arrived early for his sessions, and he became far more interactive as we neared the termination phase of his therapy (occasioned by a family move out of state). Although Tony's treatment ended prematurely, he had already begun to show considerable improvement in his academic performance, and his mother reported significant strides in his tolerance for his younger siblings as well as in his relationship with her.

SUMMARY

Although stories and storytelling have long been utilized as a means of therapeutic communication with children, storytelling activities have generally not been formalized, usually occurring in conjunction with

other therapeutic activities such as doll play, puppetry, or therapeutic board games. Storytelling, however, can be used to considerable therapeutic advantage when it involves autogenic content and occurs within a reciprocal exchange. In such a procedure, the therapist must identify the most salient dynamic issues or themes in the child's version, offering a therapeutic rendering of the child's story that preserves the basic theme, plot elements, and characters from the child's autogenic story. The therapist's story is intended to offer dynamic interpretations of the child's original version, *within the metaphor*. Such a procedure establishes safety in the therapeutic dialogue, permitting the child therapist to make important dynamic communications and to suggest increasingly adaptive alternatives for the resolution of conflict without educing the resistance that so often accompanies more direct interpretation of dynamic issues and intrapsychic conflicts.

Reciprocal storytelling is most valuable as a *technique* rather than a *method* of child treatment. Other playroom activities, including those traditionally associated with psychoanalytic child psychotherapy, are no less generative or useful; the process of child treatment can be enhanced by the addition of reciprocal exchanges *per metaphor*, however.

DISCUSSION QUESTIONS

1. What is the difference between a stimulus-dependent story and an autogenic story? Which kind of stories may be more useful in dynamic child psychotherapy? Please elaborate.

2. What are some of the therapeutic media most often associated with storytelling in dynamic child treatment?

3. Please discuss the essential difference between primary process and secondary process. How do these concepts help us to understand the stories children tell in therapy?

4. What is "reciprocal storytelling"? How does it differ from other forms of storytelling that the child therapist might use?

5. When should reciprocal storytelling be used? With which clients is it most suitable?

6. Please name and briefly describe the five basic components of children's stories.

NOTES

1. Note, however, that in the clinical examples that follow, some of the children assigned titles to their stories, some supplied morals, some furnished both, and others did neither. It may be a measure of the elasticity of this technique that the child's disinclination to title a story or include a lesson or moral rarely has a negative consequence for the therapeutic discourse. An analogy can be drawn to the use of dreams in the psychotherapy of adults, whereby the raw data—the dream content and dreamer's associations—are far more valuable than the need for imposing an invariant set of organizing principles to aid in their interpretation. In effect, then, the therapist works with the child's stories in the form that the child is most comfortable with and capable of supplying.

2. Of course, there are many other important indices for assessing a child's readiness to terminate, among them amelioration of the presenting symptoms, the reports of parents and teachers, the therapist's general observations, and the child's subjective report.

3. Kohut and his followers believed that such developmental supplies are made available through three major kinds of relational configurations, termed *selfobject relationships*, so named because they refer to a particular kind of relationship in which the object is actually experienced as an extension of the self, without psychological differentiation. The three selfobject experiences are *mirroring*, *idealizing*, and *partnering*. Each corresponds to a particular domain of self experience: Mirroring experiences are associated with an intrapsychic structure known as the *grandiose-exhibitionistic self*, reflecting the need for approval, interest, and affirmation; idealizing experiences, with the *idealized parent imago*, reflecting the developmental need for closeness and support from an omnipotent and idealized other; and partnering experiences, with the *alter ego*, reflecting the need for contact with others who are felt to bear an essential likeness to the self. Collectively, these three domains are called the *tri-polar self*, and each is also linked to a particular transference configuration. Self psychology places great emphasis on the role of empathy in human development, imputing a special significance to traumatic breaches or disruptions in empathic attunement between self and selfobject. Not only the original, thwarted selfobject needs but also the ensuing

empathic ruptures are often recapitulated in the child's evolving transference relationship.

4. Although one might argue that this element represents the experience of disintegration anxiety, I am more inclined to view it as an example of self-directed hostility owing to Tony's relatively stable self-cohesiveness.