SMITH COLLEGE

Smith ScholarWorks

Theses, Dissertations, and Projects

2013

The use of storytelling in therapy with children

Michael Delaney Cantor

Follow this and additional works at: https://scholarworks.smith.edu/theses

Part of the Social and Behavioral Sciences Commons

Recommended Citation

Michael Delaney Cantor
The Use of Storytelling in
Therapy with Children

ABSTRACT

This study was a qualitative study that asked clinicians from any discipline to describe how they use storytelling in their clinical practices. Two primary research questions were addressed; the first being to ascertain whether or not clinicians are using storytelling and the second question was to learn how they are using this technique in practice. 13 subjects responded to an on-line electronic survey that was distributed using a snowball method of sampling. Several themes emerged through the narratives of the participants regarding how they use storytelling in their practices. These themes were: Conceptualization of storytelling; Choices of implementation; Content of stories; Importance of narrative; Population choices.

The findings of the research revealed that all 13 clinicians believed there are benefits to using storytelling in therapy with children, however there was significant variation in the conceptualization and application of therapeutic storytelling reported among the study participants, as well population choices deemed appropriate to receive a therapeutic storytelling technique. Participants reported benefits and obstacles to using storytelling in therapy with children. The research indicates social work graduate curricula should include information on the effective uses of storytelling in therapy, and evidence-based treatment research into storytelling would benefit the field of social work, as clinicians would be better informed as to the techniques they choose to employ.

THE USE OF STORYTELLING IN THERAPY WITH CHILDREN

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Michael Delaney Cantor

Smith College School for Social Work
Northampton, Massachusetts 01063

2007

ACKNOWLEDGMENTS

This thesis could not have been accomplished without the assistance of many people whose contributions are gratefully acknowledged and identities graciously protected.

I wish in particular to thank my thesis advisor, Dr. Melissa Grady; wellspring of maternal transference, proficiently idealized parent imago, thief in the night of rainbows; whose otherworldly patience cannot be quantified or rewarded or returned in a single lifetime, and the one above all, for all her gate-keeping, who persisted in telling me the story of how I could finish this thing, until I could hear it.

Listen. And understand. That advisor is out there. It can't be bargained with. It can't be reasoned with. It doesn't feel pity, or remorse, or fear. And it absolutely will not stop, ever, until you are done.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

"People create stories create people; or rather stories create people create stories."
Chinua Achebe (1986)

How do therapists engage in storytelling with children? Do they pick up a book with a therapeutic message off the shelf and presume it helps? Or do they pull out a game? Perhaps a fairytale is recounted, or an original story is co-created with the child in order to determine what archetypes or issues the child might choose to express? How does a therapist choose and upon what criteria do they base their choice? And what if storytelling just doesn't work with kids these days?

There are numerous formats that therapists prefer to use that may be considered storytelling, whether it is oral, written, or some other expressive hybrid of these basic forms, as well as numerous differences among therapists in the application and analysis of any given storytelling format. Fairy tales, for example, are among the oldest forms of storytelling known to human beings. These stories are commonly held to include messages or morals that speak to the problems experienced by humanity as well as offer its audience the right solutions of their predicaments in any society (Halprin, 1996). Yet, Halprin (1996) finds in therapists' analyses and the construction of the fairy tale itself, presumptions that are specific to very particular eras, individual and social interests, and aim at, or perhaps depend upon, the manipulation of the human experience they are

1

supposed to illuminate, thus bringing into question the tale's universality. Are fairytales, then, still relevant to today's children? Do therapists use them and are they aware of the many biases involved in their creation as well as in their utilization?

The importance of a client's story has been part of psychoanalytic practice since its inception. However, Schwartz (1973) predicted in 1973 that Freudian analysis would become less effective in treating mental health concerns due to the fact that a technologically advancing and therefore ever more stimulating culture would come to flood the impulse control disorders that concern many child clients. The reason for Freud's theoretical helplessness was alleged by Schwartz (1973) to be due to Freud's lack of attention to the client's functioning in the present over otherwise valuing developmental experiences, and Freud's reliance upon a systematic verbal recounting of this client's history. How does the use of storytelling in therapy with children encounter this issue 35 years later?

Perhaps what is needed is a technique of relating to children that encourages imagination, speaking and listening skills, while also attending to the interplay of how these strengths as well as deficits stem from environmental and developmental sources. Storytelling has been used in numerous therapeutic vehicles to target these issues. As Rose (1998) states, "storytelling is useful as a way of illustrating problem-solving concepts and making them real, concrete, and understandable to children" (p. 42-43).

One example of such an approach is discussed by Poda (2002) who described a short-term psychotherapy with a young girl (aged 7 years) stricken with a serious disease. The development of the therapy supported by a strong therapeutic alliance occurred through the evolution of a gentle ghost story, created and illustrated by the young patient

2

herself. As the story progresses, the patient's self-confidence was strengthened and the development of new, vital permissions was fostered. The key presenting symptoms of the client had been treated, including: exposing oneself to be seen, accepting oneself and being accepted, widening experiences, and changing and accepting change in others. A key component in this treatment concerns the collaborative nature between client and therapist in creating the story (Poda, 2002; Gardner, 1971).

Stories are wonderful ways of communicating with children in therapy. They use the natural ability of children to think in metaphors as a way of teaching them new attitudes, skills, perspectives, methods of solving problems, and patterns of thinking about relationships in a way that is indirect and avoids evoking their defenses. By inventing a story specifically for and with a child, the play therapist can convey a level of respect and concern that can help build a caring relationship and convey important messages of hope (Kottman & Ashby, 2002).

Where does storytelling fit within the psychotherapeutic tradition as it applies to the treatment of children? From the beginning of the practice of psychotherapy, play therapy has been recognized as an important part of the healing process for children (Webb, 1996). Play therapy is seen by many therapists as the primary means through which children "are best able to form therapeutic alliances, express themselves, relate to others, learn new knowledge and skills, boost their egos, master stress, and develop their sense of self" (Schaefer & Kaduson, 2006, p. xi). It has been used for decades to help children overcome their difficulties and used with a variety of diagnoses, treatment modalities and settings (Webb, 1996).

3

This thesis project aims to explore how contemporary clinicians are using storytelling in their work with children. It is divided into 4 additional chapters, beginning with a literature review that presents information as to how storytelling fits in with play therapy, followed by the methodology chapter, the findings and finally a discussion about what these findings mean and their implications for social work practice.

CHAPTER II

LITERATURE REVIEW

History of Play Therapy

The history of the use of play in therapy with children begins with the founders of

child psychotherapy. Most historical overviews begin with a look at Melanie Klein and

Anna Freud, who began working with children in the 1930s (Webb, 1996; British

Association of Play Therapy [BAPT], 2007). These two women built upon Sigmund

Freud's practice of psychoanalysis with adults, and adapted it for children. Although

Sigmund Freud himself did not treat children, he did recognize that play was often the

ego's attempt to master a traumatic event (NASC, 2005). Rather than using free

association as a way to reach the child's unconscious, play was also seen as an alternative

method of uncovering unconscious conflicts (BAPT, 2007). Although Klein and Anna

Freud disagreed on some principles, they did agree on the importance of the therapeutic

relationship and that play should be the primary technique used with children (Webb,

1996). Anna Freud emphasized the therapeutic relationship in her work, while Klein

focused on the importance of interpretations with children within the context of the use of

play to uncover unconscious material (NASC, 2005).

From these beginnings, other theorists and clinicians further developed the use of

play with children, and began to shift the understanding of how therapeutic play impacts

children. D.W. Winnicott wrote about play as not just a way of communicating the

internal world of the child, but he also felt it was the way through which children

5

managed the transition between their inner world and the outer reality in which they lived (NASC, 2005). Following Winnicott, Carl Rogers began to introduce the concept of "client-centered therapy," which emphasized the relationship between client and therapist and held the belief that through this relationship, psychological health and reparation would occur as the client experienced the therapist as accepting, trusting and genuine (BAPT, 2007).

Virginia Axline further developed the belief in the healing process through the therapeutic experience in the use of play therapy with children. She coined the phrase "non-directive play therapy," which means that the child in therapy has the freedom to "play out" their negative feelings within the context of an accepting and non-judgmental environment (NASC, 2005). She believed that children have the ability to solve their own problems if they are provided with the right environment. She created "Eight Principles of Practice" that are still used by many therapists today (BAPT, 2007). They are:

1. The therapist must develop a warm friendly relationship with the child, in which good rapport is established as soon as possible.

2. The therapist accepts the child exactly as she is.

3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express feelings completely.

4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back in a manner that gives the child an insight into her behavior.

5. The therapist maintains a deep respect for the child's ability to solve problems if given the opportunity. The responsibility to make changes and institute change is the child's.

6. The therapist does not attempt to direct the child's actions or conversations in any manner; the child leads the way; the therapist follows.

7. The therapist does not attempt to hurry the therapy along. It is a gradual process, recognized as such by the therapist.

8. The therapist establishes only those limitations necessary to anchor the therapy to the world of reality and to make the child aware of her responsibility in the relationship. (NASC, 2005, p. 2)

Clark Moustakas built upon the work of Axline in so far as he too was interested in a child-centered play therapy model that provided a respectful and accepting environment for the child (NASC, 2005). Similar to Axline's guiding principles of practice for therapists approaching therapy with children, Moustakas identified four stages now within the therapeutic process for therapists to mark the child's progress, with an emphasis placed on the security of the child with the therapist. They are:

1. The child's emotions are diffused and feelings are generally negative.

2. The relationship develops and attitudes of hostility become more specific and anger is expressed against particular people/experiences. As the negative feelings are expressed and the therapist accepts them, they become less intense.

3. The child becomes less negative. S/he still has anger but is no longer ambivalent towards the people in her/his life.

4. Positive feelings emerge. The child sees her/himself and the relationship with others in a more balanced way. (NASC, 2005, p. 3)

Garry Landreth (2002) was another influential figure in play therapy, who emphasized the need to not focus on "the problem," whatever that problem may be, so as

to not lose sight of the child. He maintained that the relationship created with the child generates the change process, but that the process of change and growth preexists within the child. The therapist's role is to facilitate, not to create. Landreth promoted a series of therapeutic dimensions in the play therapy relationship, to include: "Belief in the child; Respect for the child; Acceptance of the child; Hearing the inner child; Acceptance of the child's will; Focus on the child's needs; Freedom for the child to set her own direction; Opportunity for the child to make choices; Respect for the child's boundaries; Patience with the process" (Landreth, 2002, p. 86).

Landreth (2002) maintains the focus on child-centered play therapy principles consistent with this tradition as set forth by Axline and Moustakas, whereby the overarching mandate for the therapist is to provide the child with positive growth experiences "in the presence of an understanding, supportive adult so the child will be able to discover internal strengths" (Landreth, 2002, p. 87). The hands-off therapist is not an authority, but rather a facilitative figure careful not to deprive the child of the benefit of discovering her own strengths. Furthering the Axline and Moustakas tradition, Landreth also provides a list of 10 objectives for the child-centered play therapist:

1. Develop a more positive self-concept.

2. Assume greater self-responsibility.

3. Become more self-directing.

4. Become more self-accepting.

5. Become more self-reliant.

6. Engage in self-determined decision making.

7. Experience a feeling of control.

8. Become sensitive to the process of coping.

9. Develop an internal source of evaluation.

10. Become more trusting of himself. (Landreth, 2002, p. 88)

Since the time of Klein and A. Freud, play therapy has developed into an integral component of child treatment. Although there are still numerous differences in how people approach play therapy, it has become a mainstay for training in child mental health, and a full body of research has developed to better understand what works within the context of play (Kazdin & Weisz, 2003). Since the 1970s during the time of Axline and Moustakas, play therapy has moved away from being strictly a psychoanalytic approach to an intervention technique that employs various models and theories (Webb, 1996).

Models of Play Therapy

As discussed above, the practice of play therapy has become more varied in the theories and techniques used with this modality. There are hundreds of different play therapy techniques and interventions now available to practitioners (Webb, 1996). However, despite the myriad of approaches available to practitioners today, the majority of these play therapy techniques tend to fall within four general theoretical approaches. These approaches are: child/client-centered; psychodynamic; cognitive-behavioral; and narrative (Webb, 1996).

Child/Client-Centered

Child-centered was built off the practices and writing of Carl Rogers and further developed with children by Axline, Moustakas (Shirk & Russell, 1996) and Landreth (Webb, 1996). The basic concepts of this model as described by Axline are:

9

- Establishment of a warm rapport with the child

- Empathic understanding and respect for the child's ability to solve his or her own problems

- A nondirective stance on the part of the therapist, who lets the child lead the way without directing the child in any manner, for as long as the child needs treatment. (Axline 1947, as cited by Webb 1996)

At the core of the child-centered approach to therapy is the belief that positive adjustment is based upon the unhindered expression of the client's inner sense of self, and that maladjustment stems from an experienced incongruence between that inner sense of self and the self presented as well as reflected back upon the child in everyday living (Shirk & Russell, 1996). Child-centered therapy works to realign or "heal" that split focus between behavior and self-concept, increasing self-esteem and self-acceptance as dictated by the self-esteem model within a validating therapeutic relationship that serves as the principal vehicle of change. Interpretation is not required to achieve emotional change; however empathic reflection and awareness of the child's experience are critical to the essence of this approach (Shirk & Russell, 1996).

Psychodynamic

Beginning with Freud with adults and adopted for children by his daughter Anna Freud and Melanie Klein among others, psychodynamic approaches often include a range of models under the heading of psychodynamic. However, they generally share the same set of principles and tenets regarding psychopathology, development and the curative process. These include recognition of the existence of internal instincts and conflicts as determinants of problematic behavior affecting the child's life, and that these

unconscious elements will be reflected in the child's play (Webb, 1996). Psychodynamic approaches to therapy are generally considered to be more directive than child-centered therapy (Webb, 1996). The psychodynamic approach involves the therapist acquiring as full an understanding as possible of the child's history as well as present life in order to make connections in play or other therapeutic interactions that are geared to relieve the child's anxieties. This approach is further augmented by verbalization and self-observation by the child, with increased understanding of the expressed material as a primary goal (Shirk & Russell, 1996).

Another psychodynamic approach initiated by Anna Freud involved a developmental model wherein parental deficits were considered as determinants of problematic personality issues with the child client (Shirk & Russell, 1996). At issue here is the environmental response to the needs of the child. So whereas interpretative interventions are considered critical therapeutic responses to internalized conflict, corrective interpersonal interventions aim to compensate for inadequate, inappropriate or otherwise damaging environmental influences (Shirk & Russell, 1996).

Cognitive-Behavioral

In contrast to child-centered or psychodynamic approaches to therapy, cognitive-behavioral therapy (CBT) prioritizes the child's thoughts and behaviors over the child's feelings (Webb, 1996). Interventions are designed to help change the child's maladaptive cognitions leading to maladaptive behaviors through implementation of more adaptive "self-talk" or self-instructional training strategies. Behavior modification plans are often employed in order to utilize the assistance and reinforcement by significant members of the child's environment (Webb, 1996).

Beck's influence on CBT approaches to therapy with children was significant (Shirk & Russell, 1996). The core of this theory accepts that the relationship between an event and an emotional reaction is determined by the interpretation of the individual, thus for Beck meaning is to be found in the cognition or the product of the individual's interpretation and emotional maladjustment results from one to a series of distorted interpretations (Shirk & Russell, 1996). There have been many authors who have adapted Beck's model to working with children, often using pictures rather than words (Beck, 1995) and discussed how to involve parents in the therapy as children learn to identify emotional and cognitive states (Deblinger, Thakkar-Kolar & Ryan, 2006).

Narrative

There is considerable variety in the ways in which clinicians have taken up the narrative metaphor in therapy. As some practitioners (Russell & van den Broek, 1988) have noted, the concept of narrative refers to the manner in which all human beings construct the story of their lives. It is a developmentally acquired command of a form of language structure, evident generally by age 4, used to describe experience and thus a cognitively founded ability, and as such this manner of narrative has long been used implicitly in clinical assessment instruments (Shirk & Russell, 1996). Narrative as the therapeutically valued, client expressed story of the self is key to the foundation of psychotherapy. In the context of play therapy, narrative approaches once again look to a form of expression that is not totally reliant upon language. As Landreth (2002) reminds us: "Toys are children's words, and play is their language" (p. 304). Therefore, a "narrative" approach to play therapy can be construed simply as play therapy itself,

wherein the therapist respects the forms of expression of that narrative that are available to the child client.

From a post-modern perspective, Narrative Therapy as described in the work of Michael White (1990; 1997), David Epston (1990) and Alice Morgan (2000) details Narrative therapy as that which seeks to be a respectful, non-blaming approach to counseling, centering all people as the experts in their own lives. It views problems as separate from people and assumes people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to change their relationship with the problems in their lives. Practicing curiosity and demonstrating a willingness to ask questions to which they genuinely don't know the answers are important principles of this work. These practitioners believe there are many possible directions that any conversation can take, and there is no single correct direction. The person consulting the therapist also plays a significant part in determining the directions that are taken in therapy (Morgan, 2000).

Narrative therapists seek to re-author the dominant problem-saturated stories in a client's life. Indeed, the study of therapeutic storytelling illuminates that for many clinical approaches, both classic and modern, storytelling frequently involves the creation of a new story.

Gardner

The modern wave of therapeutic storytelling began with Richard Gardner (1971) in the early 1970s. He was the first individual to develop a structured application of a storytelling technique in psychotherapy with children. His unique approach was to develop a mutual storytelling technique within the larger framework of therapeutic

13

storytelling (Gardner, 1971; 1993). This approach was different from previous theoreticians and clinicians in that the stories were client driven or created, rather than with prior methods wherein a clinician would provide the stories to the child for discussion. In other words, Gardner (1993) encouraged the child to develop his/her own story that was used in vivo within the therapeutic setting rather than relying on the previous methods of bibliotherapy.

Mutual Storytelling Technique

Gardner (1971; 1993) referred to his new approach as the Mutual Storytelling Technique (MST). MST is based on his belief that a child created story will contain the elements of the psychodynamic conflicts with which the child is currently struggling. Gardner's method is in essence to aid the child in creating such a story, determining, what the nature of the conflict is within the content of the story and how a modified version of the same story can be introduced with a different message or moral. The new story is retold by the clinician to the child with a different outcome, in hopes that this change will provide therapeutic material.

> The therapist's story utilizes the same characters in a similar setting, but introduces healthier resolutions and adaptations of the conflicts present in the child's story. Because the therapist is speaking in the child's own language – the language of allegory – he or she has a better chance of "being heard" than if the messages were transmitted directly. (Gardner, 1993, p. 5)

The therapist uses the child's narrative and symbolic material in the "new" story identifying and sometimes retaining pathological content to some degree in order to maintain the story's psychological relevance to the child.

Gardner (1971; 1993) believes that a clinician can and should make use of storytelling in this way due to the fact that stories are a favored mode of communication among children. Through stories, the child will become engaged in the therapeutic process, so that the conflicts of the child can be processed in a way that s/he can internalize more adaptive outcomes. The package of storytelling attracts the child so that s/he can begin to internalize a new resolution as part of their psychic structure.

How MST Is Used With Children

The original method designed by Gardner was relatively simple (Gardner, 1971). He would simply ask the child to tell him a story. One method he utilized to encourage the child to adopt a storytelling frame of mind was to dramatize the storytelling as if it were part of an ongoing radio or television show. Using this stage, Gardner would show the child that he was audio and/or video taping the "performance". He attempted to normalize this process by letting them know that this was a routine event when children came to see him in therapy. The tapes were displayed to demonstrate how common this was. He found that children often responded well to this introduction/frame and were eager to participate. Through the existence of the recordings, both the therapist and the child were able to return to the material to deepen and reinforce the more therapeutic value and effect (Gardner, 1993).

As the child is developing the initial story, the therapist listens for conflicts and themes relevant to the child's psychosocial history and/or current conflicts. After the child has finished telling the story, the clinician analyzes the story and identifies one theme that best exemplifies the psychic conflict the clinician wishes to adapt into a more therapeutic alternative. In Gardner's method, he always elicits a moral of every story

15

from the child in order to have a "teaching point" as part of the therapeutic message. The clinician then creates a new story that incorporates the "renovated" moral. The moral or message of the new story becomes part of the therapeutic message once it becomes adapted into the new story (Gardner, 1993).

Bibliotherapy

Another form of storytelling is bibliotherapy defined by Tussing and Valentine (2001) as, "The usage of literature to assist individuals in understanding and treating their problems, generally through the aid of a social worker or therapist" (p. 457). Literature is defined rather broadly including self-help, fiction and non-fiction books poetry. Many clinicians believe that through the use of bibliotherapy, clients are able to address therapeutic issues by noting how characters in the book experience and resolve similar problems. For example, the clinician may read and then discuss stories with a child and therefore help the child to gain empathy for the feelings and issues experienced by another person as well as gain insight into their own feelings and issues (Jackson, 2001). As Kramer (1999) reports, bibliotherapy allows people to "walk in the shoes" of another person and to see themselves from the outside.

In 1916, the term bibliotherapy was coined by Samuel Crothers to refer to the therapeutic use of books (Pardeck, 1994). Seventy years after its conception, Lenkowsky (1987) comments on the paucity of research on bibliotherapy, stating, "The absence of systematic, objective, comparative research, however, suggests that while many believe in bibliotherapy and are using it, sufficient substantiated evidence of how it works, why it works, or if it works, is not yet available" (p. 128).

Hynes and Hynes-Berry (1986) recognize four major goals that a clinician can assist a client to achieve with the utilization of books. These goals are:

1. To improve the capacity to respond by stimulating and enriching mental images and concepts and by helping the feelings about these images to surface.

2. To increase self-understanding by helping individuals value their own personhood and become more knowledgeable and more accurate about self-perceptions.

3. To increase awareness of interpersonal relationships.

4. To improve reality orientation. (p. 24)

Books may also provide the reader with illustrations to assist the child in handling certain situations the child encounters. The use of books enables the reader to assume new roles and identities and try out different lifestyles vicariously (Coleman & Ganong, 1990). The client may also be able to better understand his or her own reactions or feelings by reading about character's conflicts, emotional responses, and cognitions (Hynes & Hynes-Berry, 1986). As Coleman and Ganong (1990) note, "The advantage of adolescent or children's fiction for shared family reading experience is its clarity and brevity. More books can be shared in a short time" (p. 330). Clinicians are able to utilize books with subject matters pertaining to presenting problems in an effort to convey acceptance of the client and concern for them (Jackson, 2001). Jackson (2001) further suggests:

> The therapist can use bibliotherapy to encourage clients to examine personal perceptions within the supportive social context of counseling. Clients can understand their actions and put themselves in a better position to identify and consider alternative points of view and behaviors needed to grow and develop.

Using bibliotherapy, the therapist can help clients gain insight into their lives. (p. 293)

McDaniel (2001) argues that children's literature may be used to help prevent child sexual abuse if the literature is selected carefully. Mc Daniel believes that, "The best literature speaks to us individually yet holds universal appeal, connects with out lives, remains fresh and alive with subsequent reading – it delights and informs us" (p. 203). Many people are not able to identify specifically why a book impacted them as it did; rather they are able to remember how they felt when they read the literature (McDaniel, 2001).

McDaniel (2001) recognizes that literature can assist children in identifying dangerous circumstances, to recognize their own unfair treatment, to help validate that they are not strange or so different from others, and to ask for support as needed. McDaniel further believes that literature can be a powerful tool in decreasing children's feelings about being "the only one." Children can read about examples of others coping with similar issues and situations. McDaniel (2001) notes, "More modern literature reflects current norms and gender roles, providing children with relatively accurate depictions of every day life" (p. 204).

McDaniel (2001) recognizes, however, that in using literature to instill healthy attitudes in children toward themselves and others, it is pertinent to be mindful that literature often contains stereotypical or negative messages. Topics relevant to a child's everyday life must be presented in order to assist children to comprehend their world and empower them to take care of themselves.

McDaniel (2001) also discusses ways in which children's books may be utilized in an effective manner. She believes that in utilizing rhyme in conjunction with a serious topic, children will want to read or have books read to them. A rhythmic style enables children to more easily remember the words and they will be more likely to participate. Another method that she believes to be effective is literature that enables the child to engage in an interactive manner. One example of this would be having the author interact with the reader within the text of the story. McDaniel (2001) also mentions the importance and use of pictures in children's books, therefore recognizing that "visual depictions can invoke emotional responses, which may or may not coincide with the text, and illustrations can introduce ideas that are seemingly unrelated to the story" (p. 220).

Bettelheim

Bruno Bettelheim (1976) was an Austrian-born writer and Freudian psychologist originally known for his studies of autism and for his discussions of the therapeutic use of fairy tales. Bettelheim was the author of *The Uses of Enchantment*, published in 1976, in which he discussed the meaning and importance of fairy tales, such as those collected and published by the Brothers Grimm. He suggested that if children were allowed to read and interpret these fairy tales in their own way, they would gain a greater sense of meaning and understanding about the issues in their lives (Bettelheim, 1976).

The fairy tale is therapeutic because the patient finds his own solutions, through contemplating what the story seems to imply about him and his inner conflicts at this moment in his life. The content of the chosen tale usually has nothing to do with the patient's external life, but much to do with his inner problems, which seem incomprehensible and hence unsolvable. (Bettelheim, 1976, p. 25)

Bettelheim (1976) posits that if children are allowed to read about the trials, tribulations, successes and failures encountered by the heroes of fairy tales, this will better prepare them for the trials, tribulations, successes and failures that they will encounter in their own lives.

Bettelheim (1976) maintained that fairy tales inform us about life's struggles, hardships and the reality of death. From Bettleheim's point of view, the fairy tale is a "manifold form" that communicates to the child, educates them, about life's vagaries and realities, which are the unavoidable aspects of our existence. More specifically, the fairy tale is an educational tool to help children grow and develop into adults as well as instruct children how to behave cooperatively within a social context. He goes on to say that the child needs to be given suggestions in symbolic form about how he may deal with these issues and, via this therapeutic exposure, develop safely into maturity. Only through exposure to images that speak directly to the unconscious will the child's unconscious processes become clarified. (Bettelheim, 1976)

Outcome Studies

Literature review has provided a wealth of information on the scope of ST in a therapeutic setting with children; its various definitions, traditions and applications. However, a thorough literature search has not been as forthcoming regarding outcome studies or evidence-based research on the efficacy of ST. A number of qualitative and anecdotal studies have been undertaken and are available for the researcher to peruse at length (Franzke, 1989; Gardner, 1971; Malgady, Rogler, & Costantino, 1990). However as Russell, van den Broek, et al. (1993) have noted:

20

Given that narratives are (a) deemed essential for our functioning as human beings, (b) considered theoretically important by psychotherapy theorists, (c) used routinely in standard assessment batteries, (d) recognized by practicing psychologists as useful, and (e) incorporated into the clinical treatment armamentarium, it is surprising that little clinical research on narratives has been undertaken. (p. 339)

Malgady & Costantino (2003) continue this observation 10 years later in their analysis of evidence-based psychotherapy and research noting that there has been a lack of "attention to outcomes of services for children or adolescents" (p. 427) regardless of the types of intervention.

In their review of the current state of outcome studies within narrative themed therapeutic interventions, Malgady & Costantino (2003) examined the *Cuento* Therapy developed by Costantino et al. (1986), the Hero/Heroine Therapy developed by Malgady et al. (1990), and the TEMAS Storytelling Therapy (Costantino et al., 1994) based upon the "Tell-Me-A Story" (TEMAS) Thematic Apperception Test (Costantino, Malgady, & Rogler, 1988). While this is encouraging work and a promising approach to the treatment of emotional and behavioral problems specifically among Hispanic children and adolescents, it remains a relatively insufficient effort when compared against the therapeutic needs of the larger child population, the best-practice standards of social work, as well as in light of the larger body of ST literature as exists and as is applied by therapists working today.

Rationale for Current Study

Despite this long history there are many variations on how it is used therapeutically, including bibliotherapy (Pardeck, 1994; Lenkowsky, 1987) and mutual storytelling (Gardner, 1971; Gardner, 1993). Although there is a body of literature about the types of storytelling and how to use it within a clinical process, there is little literature about whether clinicians are actually using it as part of an intervention and also how they are using it. As a result, little is known about the current state of storytelling in a therapeutic intervention. This study was undertaken to evaluate how exactly contemporary clinicians are using storytelling within their practices with children and to help·fill that gap in the literature.

It is clear from the literature that there are a number of definitions, methods, and approaches to working with children, yet there are no current studies that identify how ST is actually operationalized and implemented in practice. As a result, it was expected that there would be significant varieties of techniques, modalities and theoretical formulations among the study's participants as to what informs their use of therapeutic storytelling with children and adolescents. It was also anticipated that the majority of participants would demonstrate a preference to utilize bibliotherapy, defined here as therapeutically employing the assistance of literature with intervention or guidance from the therapist, and oftentimes the literature of therapist choice would prioritize "helping books" written for use with specific child or adolescent populations to address specific issues affecting mental health and development. In addition, it was expected that a significant percentage of participants would demonstrate a preference for bibliotherapy correlating with low levels of familiarity and comfort with other therapeutic storytelling techniques, however

this preference would be increasingly less in evidence as therapist level of clinical experience increased.

This study benefits the field of Social Work in several ways. These benefits include a review of relevant literature within a specific area of psychotherapy with children and adolescents towards an understanding of best evidence approaches to therapeutic storytelling. Best evidence approaches to therapeutic storytelling as identified in this study would also attempt to be mindful of practices most consistent with NASW Standards for Cultural Competence in Social Work Practice as approved by the NASW Board of Directors on June 23, 2001. The findings also serve to illuminate the usefulness of personal clinical experience in addition to external evidence in the definition of best evidence approaches to therapeutic storytelling, and will serve the continuing education of any Social Worker wishing to work with children and adolescents.

CHAPTER III

METHODOLOGY

Design

This was a qualitative study that aimed to investigate how child therapists are

using story telling in therapy with children. It was designed to answer the questions of

whether or not they use storytelling in therapy with children, how they use it, and their

beliefs about it as a therapeutic technique. Data was gathered through a survey, using an

on-line survey through SurveyMonkey.com [See Appendix B].

Sample

The intended sample included clinicians of any discipline (social workers,

psychologists, psychiatrists, psychiatric nursing, licensed professional counselors, etc.)

whose practice was at least one-third children and who identified as using therapeutic

storytelling in their practice. Therapeutic storytelling was defined in this study as: *The*

process of constructing, co-constructing, or otherwise utilizing a narrative or anecdote

with a client in the interest of achieving a therapeutic goal. This definition tied in most

closely to the definitions as utilized in the research on bibliotherapy (Pardeck, 1994;

Lenkowsky, 1987), mutual storytelling (Gardner, 1971; Gardner, 1993), therapeutic fairy

tale application and analysis (Bettelheim, 1975), and Narrative theory (White & Epston,

1990; Morgan, 2000), while attempting to not define storytelling in a way that might

exclude any one theory or technique.

There were no restrictions regarding the clinicians' theoretical orientation or training background. However, participants must have had at least 5 years post-medical or graduate school experience to ensure for a well-experienced group of clinicians who have thought about their practice. There were no limitations regarding language used in therapy, though the study did target English-speaking participants. A snowball sampling method was used to recruit a desired sample size of 50 subjects.

Following the snowball recruitment of study participants, an unknown number of clinicians were invited to participate in the study. Of the 21 participants who began the study survey, 13 met the exclusionary criteria and completed the survey including the final section containing open-ended questions concerning storytelling theory, practice, experience, etc. 21 surveys were initiated, and of these 21 surveys, 13 survey participants qualified to complete the latter half of the study including the 8 open-ended questions, a 62% return. All completed surveys contained useable data.

The 13 participants who completed the survey were between 30 and 72 years of age (Mean: 50.5 years; Median: 50; Mode: Not unique; Range: 42; SD = 12.6 years), marking a significant age range [See Table 1]. 38% had experience of 25 years or more, 31% of between 11-24 years, and 31% of between 5-10 years. 46% were Social Workers, 31% Psychologists, 15% Psychiatrists, and 8% Marriage and Family Therapists. These participants were however otherwise fairly homogeneous, in that 100% identified as White/Caucasian, and 69% female and the average percentage of children to overall practice for these participants was 76%.

Table 1

Characteristics of Survey Participants

CHARACTERISTIC	Mean	Range: Lowest	Range: Highest
Age	50.5	30	72

The Recruitment Process

Using the snowball method, recruitment of study participants began with contact of the researcher's colleagues in the mental health field via email, including former coworkers, family members, former students in the researcher's graduate program, and friends or colleagues of the above mentioned recruits as well. As stated above, the initial email went to 21 individuals and was sent to practitioners of psychiatry, psychology and social work. The researcher explained his study in the email [See Appendix A] and included a description of the study and an informational letter including informed consent information [See Appendix C] and a link to the SurveyMonkey website [http://www.surveymonkey.com/]. The initial contact was asked to pass on the initial email to any potentially qualifying subjects. Once a participant elected to be part of the study, the participant was instructed to click on the link to SurveyMonkey.com thus taking the participant to the survey where any identifying information was not collected, including email or ISP address, and therefore further safeguarded the confidentiality of the participant. One feature of SurveyMonkey was its ability to screen for participants based on the responses given to questions regarding the exclusionary criteria. Recruitment of participants took place through email only.

It was the hope of the researcher that individuals who were forwarded the initial email inviting participants to take part in the study would be members of professional organizations such as the Association of Play Therapy, thus broadening the pool of participants. The researcher did not actively recruit participants around issues of diversity other than professional discipline, as the aim of the study was not focused on how diversity affects a clinician's use of storytelling. Copies of recruitment materials are attached. [See Appendixes A & C]

Data Collection

Participants were asked to complete a survey [See Appendix B]. Participants were asked to click on a link in an email and then complete the survey that opened at the SurveyMonkey.com website. Once the study was approved, the survey was set up on SurveyMonkey. The current attachment is exactly what was entered into the SurveyMonkey site. Demographic data was collected. No interviews or other personal contact took place. Participation in completion of the survey was estimated to take up to 30 minutes. Data from completed surveys was collected from the SurveyMonkey.com website.

Risks of Participation

No risks to the participants were anticipated in participation in the research other than the cost of the time required to complete the survey. All information has been held in confidence, and anonymity concerning participation in this study was and will be assured. For further discussion of this point, please see below.

Benefits of Participation

There were no monetary benefits to participation in this study. Participants may have enjoyed gaining new perspectives or the opportunity to share their experiences, as well as enjoyed a sense of contributing to the advancement of the field. Participants may have come to be more reflective of their clinical practice and thoughtful of how they used and use storytelling techniques.

Informed Consent Procedures

An informational letter presented to subjects prior to participation offered further protection to the subjects, and their participation was deemed an expression of their informed consent. This study utilized an anonymous survey via email and therefore it was not necessary to obtain signed informed consent, however, attached to the email was an informational sheet [See Appendix C] that included mention of anticipated risks and benefits and information on how to contact the researcher if they wanted more information about the study. No minor participants were involved in this study.

Precautions Taken to Safeguard Confidentiality and Identifiable Information

There were several active steps the researcher took in order to safeguard confidentiality and identifiable information. First, a snowball recruitment method was utilized and as a result the researcher did not know to whom the emails were sent beyond the researcher's primary contacts. If any of the researcher's primary contacts chose to complete a survey, identifying information was not collected, as was the intention with any participants. SurveyMonkey.com was set up to not collect email addresses or ISP information of study participants. The absence of a signed consent further safeguarded the identities of study participants.

No other individual beyond the researcher was used in the data collection or data analysis process. The researcher endeavored to assure anonymity of all study participants utilizing the methods mentioned above as well as participant responses to the survey. Participants were asked not to include any identifying information about themselves or their clients in their responses.

Any data concerning participants is presented in this thesis as a group as will also be in any presentation or publication produced by the researcher from this study. Illustrative vignettes and quoted comments are not identified as to which participants they originated.

SurveyMonkey.com guaranteed anonymity through technology, including data encryption for the survey link and survey pages during transmission, locked and protected servers, firewall restrictions and network monitoring protocols, protected hardware, and software updates and routine data backup.

All data will be kept secure for three years as required by Federal regulations and after that time all data will be destroyed or continue to be kept secured as long as needed. When the data is no longer needed, the data will be destroyed.

The survey was in English, but if a non-English speaker had been contacted, the researcher would have made an effort to get the survey translated. However, no one contacted the researcher for this process to be completed.

Data Analysis

All completed surveys were maintained by an Internet-based electronic survey company, which facilitated the process of conducting a content analysis of the survey data. Each survey was given a unique identification while preserving the participant's

anonymity. Each survey was transcribed completely by the researcher and reviewed for themes and uniqueness. Data from this study required coding of narrative data gathered through open-ended question responses within the survey. This data was coded using thematic codes. This coding scheme utilized themes as the coding category unit rather than single words or phrases. Themes were defined as responses classified on the basis of common ideas. Next, each participant's responses were sorted and recorded in list form on a Word document. This recording process facilitated the process of conducting content analysis of the data gathered in the surveys. Continual identification of emerging common themes occurred simultaneously as new data was added. Similarities and differences were noted.

The information gathered from this flexible method study was used to make inferences about the sample used. As with any study employing inferential statistics, Anastas (1999) reports, "...all results in inferential statistics are presented in terms of possibilities because there is no certainty about inferences made even though there are guidelines for making them (p. 467)."

Data was obtained in 7 categories from the survey responses. These categories were developed based on the literature review. The categories were: a) demographics, b) common themes, c) benefits of using therapeutic storytelling with children, d) participants' conceptualizations of storytelling, e) influential theoreticians and theories listed, f) professional interest in using therapeutic storytelling, and g) obstacles to the use of therapeutic storytelling with children.

A large portion of the data was therefore presented in anecdotal form in order to depict the diversity of the participants' words and experiences as well as provide

examples of salient themes. With these detailed examinations of participants' thoughts, themes will emerge from which more research may be inspired.

CHAPTER IV

FINDINGS

Introduction

This study was an exploratory study designed to describe how therapeutic

storytelling is used by clinical therapists working with child and/or adolescent

populations. The data presented in this chapter reflects the range in experience and

training of 13 clinicians covering a variety of mental health disciplines and working

within a variety of settings. The initial part of the survey entailed 11 questions for the

collection of demographic data and concluded with 8 open-ended questions

As discussed in the methodology chapter, a number of steps were taken to identify

the themes that emerged within the responses on the 8 open-ended questions, as well as

identify the frequency that these themes were identified. The themes that emerged within

the narratives of the participants fit into five main categories, namely: conceptualization

of story telling; choices of implementation; content of stories; importance of narrative;

and population choices. The remainder of this chapter will discuss the content of the

themes, as well as provide examples of how the participants characterized these concepts

within their own therapeutic work with children in their practices. Within this chapter, the

narratives of the participants are in italics.

Conceptualization of Story Telling

Within this theme, several aspects of how the participants conceptualized ST

developed. One of these is the role or use of theory in how the individuals thought about

ST. For some (n=7), there were clear theoretical frameworks that they used to help guide their understanding of the use of this technique, and for others (n=6), no particular theory was either identified or stated as useful in their understanding of this technique.

For example, two participants identified Gardner as an important figure or theoretician representing therapeutic ST. One listed Gardner as the singular influential theoretician by name and specifically referenced his Mutual Storytelling Technique – "Along the lines of Gardner's mutual story telling technique" – while the other participant listed Gardner along with Sigmund and Anna Freud and Franz Alexander, suggesting this participant believes Gardner to fall in line with a general tradition of psychodynamic play theory. One participant listed Charles Schaefer and three participants identified Anna Freud specifically and play theory in general, suggesting work on play theory has become conflated with these participants' conceptualizations of ST:

Encouraging children (or adults) to tell their perception of their life experience, often through play, sand tray or art.

The story telling part of my practice usually occurs in two ways. One is when children have drawn pictures and I ask them to tell me about the picture. I do not require the children to draw pictures. The other way in which I use story telling is when I ask them what they think is happening in their family. Their story is their view or their perception or interpretation of their family and themselves.

One participant listed Jung, suggesting his work on narrative and psychological archetypes as an influence on this participant's conceptualization of ST, while two participants referenced CBT and the field of neuropsychology as primary influences,

33

specifically citing the work of Daniel Siegel and Allan Schore. Creating or otherwise facilitating some manner of therapeutic narrative was common among participants' responses (n=9):

> *Using a story format to help a child create a literal or metaphoric tale for the telling or writing. It can also include retelling a known tale/fable, etc. with insertion of self or others known to the child into the story as a method for communicating thoughts, fears, situations, with the goal of creating a narrative or written means for healing from a lived experience.*

However, only two participants specifically referenced Narrative theory and the work of Paul White and David Epston, and only one participant sited the sensory-based work with victims of trauma and abuse of Jan Hindman and Nancy Davis.

Choices of Implementation

The second theme that emerged was around their choice of how they implemented ST into their practices. Some participants (n= 3) described their choices concerning the implementation of ST techniques in ways that indicated a preference for facilitating client-driven exercises:

> *Usually I give children the opportunity to act out stories through sandtray or art. I do not give specific instructions; the resulting stories always reflect the salient issues in the children's' lives.*

> *Letting children create stories on the computer or paper, in which they have control over the whole creative process, and then add "chapters" weekly. We can then review together how the story has evolved since the beginning of therapy and*

this allows for the children to recognize parallel processes that occur with their

main characters.

The use of client-driven techniques is consistent with less hands-on theoretical approaches, such as play and narrative therapy. Conversely, more participants (n=6) described their choices for implementation of ST in ways that appeared to demonstrate a preference for more therapist-driven interventions:

I often tell a story to make a clinical point or to interpret.

Sometimes I will draw a large picture or graph or symbols on a large pad, to

illustrate the story or point. Sometimes I will have a child read a story for a

"homework" assignment and ask how it relates to their life.

The use of therapist-driven techniques is consistent with more hands-on theoretical approaches, such as bibliotherapy, CBT and Gardner's MST. And a few participants (n=4) offered no distinct preference in their choice of ST implementation, indicating this aspect of "who's driving" the therapeutic encounter was considered to be of little importance, or perhaps had received minimal consideration, or perhaps the participant's conceptualization of ST was indistinguishable from a general sense of a therapeutic narrative, i.e. simply, "the client's story":

I use story-telling (stories created by myself, others, the child/client, or the child

and myself) to illuminate issues for the child, to enable them to find a metaphor in

which to work, to offer a healing, reparative way of thinking about their situation,

and to find a means for a therapeutic end.

35

Some examples: reading stories that have a distinct message, or creating stories with clients - either directive or non-directive.

On an impromptu basis as indicated nor as means of "jump starting" stalled therapy.

Content of Stories

The third theme that emerged centered around the actual content of the stories. Participants referenced the use of several different materials in the application of therapeutic ST, not limiting the use of stories to only through the use of books or other written materials. Many participants (n=6) reported using traditional play materials at some point such as toys, figurines and drawing, characterized by a desire to allow for the child's free expression.

Figurines, dolls, paper/pencil/markers, stuffed animals, etc.

I use puppets, dolls, drawings, pictures and considerable imitation.
Participants (n=3) also chose to provide more structured exercises that combined play elements such as drawing with talk therapy.

I talk to the children about who and what is in the picture and how it feels to be in the picture and what the expressions or gestures depicted in their pictures mean. When their are no pictures and I ask the children to tell me about their family and what is happening in the family I also ask them how they and other members of the family feel and how they interact. The strategies that I use are to ask open ended questions, to accept everything they say without hesitation or judgment, to

be honest when I ask them a question to state that I do not understand when I do

not understand and to ask them to tell me a little more about what I do not

understand. I support, clarify and validate. I respect their limitations.

Write books on the computer child may illustrate (paper, markers) child

participates to fill in blanks, relate narrative (usually with fill-in details from

parent) regular story reading from a book, pointing at pictures, discussing.

Participants (n=3) also referenced more traditional bibliotherapy but specific references

to the use of fairy tales and mythology were noticeably absent.

Classic stories and books for resources, reading books to children, writing

created stories on paper, and bookmaking in my office.

Books with therapeutic stories, taking turns adding a few sentences at a time

(helps with following directions, staying focused), drawing while verbal story is

being told.

Only one participant referenced the use of video in ST but did so in a manner indicating

this tool was an adjunct strategy rather than a primary technique.

There was a video/cartoon for young children of alcoholics produced by

SAHMSA I believe that was very effective; couldn't locate title but came in a free

kit for treatment providers.

And two participants indicated no use of tools or story aids in their ST work, perhaps

indicating a preference for an oral narrative approach independent of the assistance of the

above techniques.

37

I often tell a story to make a clinical point or to interpret.

Importance of Narrative

The fourth theme that emerged addressed the level of importance that providing a space or forum for a narrative has for their clients. All participants (n=13) agreed that the creation, protection, and therapeutic use of narrative are important aspects of ST. Indeed, though there was a range of responses concerning the conceptualization and application of ST, this point seems to indicate unanimity of opinion concerning the importance of psychotherapy with children itself.

> *It is a gentle and humane way to help children and sometimes adults to cope with having to reveal things about themselves and their families, which may be too threatening in another context. It may be a less threatening first approach which can lead to trust and more overt context.*

> *An imaginative approach that allows a child to solve their problems thru the resolution of unconscious conflict with out conscious awareness of what is being revealed.*

> *The use of established and created narratives to support a child in recognizing feelings and emotions, normalizing experiences and providing a safe setting to talk about issues related to trauma or maltreatment. Additionally the use of narratives to anchor memories and create concrete perceptions of past trauma or maltreatment.*

Given how universal this theme was, it was evident that narrative as the therapeutically valued, client expressed story of the self is key to the foundation of psychotherapy as well as the application of ST. Whether in the context of play therapy, psychodynamic, cognitive-behavioral or bibliotherapy, the concept of providing a space where the child's narrative can be understood and protected was of critical importance.

Population Choices

The final theme that emerged concerned their views on their decisions regarding which clients are appropriate for using ST. All participants (n=13) agreed that ST was an appropriate therapeutic technique with some children; however, there were differing ideas about which specific child populations their preferred ST approaches best suited. Participants differed according to age of the child, with some participants (n=10) indicating that as soon as a child had a basic mastery of spoken narrative at an average minimum age of 3 years of age – "With children who can speak and convey their impressions…" – ST approaches were appropriate. Three participants preferred using ST with children of at least latency age or a minimum of 5 years old. Only one participant referenced the use of ST specifically with adolescents, while five participants indicated a preference to not use ST with adolescents, preferring once again latency age children for this approach with an average maximum age of 12 years old.

There was again a variety of response concerning diagnoses appropriate for a ST intervention. Six participants declared no diagnostic restriction in their application of ST, while six participants specifically referenced diagnostic issues such as anxiety, depression, PTSD and behavioral concerns.

PTSD, foster/residential, children of mentally ill/abusive/ substance abusers,

anxiety and mood disorders, oppositional/ conduct disordered, disassociative

conditions.

A few participants (n=2) applied ST only within short-term therapeutic interventions, while 6 participants indicated that both short and long-term therapy were appropriate for using ST, and 5 participants offered no preference.

One clear contraindication expressed by participants, involved clients with some form of thought impairment. 9 participants referenced issues such as psychotic disorders, low IQ or developmental disability, mental retardation and autism, or an overall "difficulty discerning reality from fiction." 2 participants could report no contraindication to their ST approach whatsoever, while 1 other participant described clients for whom only the most supportive and non-anxiety producing work would be indicated:

Since it is a range of story techniques, it really isn't--if they are interested and like

stories, and if I can figure out what kind of story or book might illustrate and help

process issues, I might go for it--the child has to agree or think it's neat or

whatever, of course.

With clients who are so fragile that they need and can only tolerate support and

reassurance. Anything else is so threatening that one is placing them in jeopardy

if anything else is done.

Interestingly, one participant chose to report that evidence-based treatment might be preferable to ST, indicating perhaps a lack of familiarity with the research on the effectiveness of ST or a basic preference for other therapeutic interventions.

Children that come in with very specific issues that have other evidence based treatments such as bedwetting.

As shown, the 13 clinicians who participated in this study were diverse in terms of their age, discipline and experience, yet all confirmed that they find ST to be a useful and common feature of and adjunct tool in therapy with children and described several ways in which they find ST to be beneficial. Although the 13 clinicians believed there are benefits to using storytelling in a therapeutic setting, the results of this study show significant variation in individual conceptualization of ST and in its application. The meaning of these results and the implications of what their responses mean will be discussed further in the following Discussion chapter.

CHAPTER V

DISCUSSION

Summary of Findings

It was clear from the previous Findings chapter that there were a variety of
conceptualizations of storytelling (ST) based on the participant responses. However, in
spite of the number of differences in how the clinicians define and utilize ST, all
participants appeared to be positive concerning the value of ST in so far as they
understand it. Some trends appeared according to age, training/discipline, experience,
setting.

As discussed in the Findings chapter, several themes emerged from the responses.
These included:

I. Conceptualization of story telling; i.e. the role or use of theory in how the
participants thought about ST. For some participants there were clear
theoretical frameworks that they used to help guide their understanding of
the use of this technique, and for others no particular theory was either
identified or stated as useful in their understanding of this technique.

II. Choices of implementation; some participants described their choices
concerning the implementation of ST techniques in ways that indicated a
preference for facilitating client-driven exercises or less hands-on
theoretical approaches, while more participants described their choices for
implementation of ST in ways that appeared to demonstrate a preference

for more therapist-driven interventions or more hands-on theoretical approaches. No preference was also thematic.

III. Content of stories; participants referenced the use of several different materials in the application of therapeutic ST such as traditional play materials, structured exercises that combined play elements with talk therapy, traditional bibliotherapy minus references to the use of fairy tales and mythology, and the rare use of video. No preference for story aids was also thematic.

IV. Importance of narrative; all participants agreed that the creation, protection, and therapeutic use of narrative are important aspects of ST, a point seeming to indicate unanimity of opinion concerning the importance of psychotherapy with children itself.

V. Population choices; all participants agreed that ST was an appropriate therapeutic technique with some children, however participants differed according to age of the child, diagnoses appropriate for a ST intervention, short-term versus long-term therapy, and level of cognitive functioning.

Interpretation of Findings

How do contemporary clinicians use ST?

The process of undertaking this research gave exposure to the variety of ways clinicians conceptualize and use ST with children in therapy. The findings in this study confirmed that clinicians do use ST in therapy and discussed the different ways that clinicians across discipline, across practice environment, and across levels of experience in the field utilize ST in their practice. It appears that ST is still an active part of many

43

people's practices and is used in a variety of way, as described in the previous chapter. What clearly emerged, however, was the variety of how it is used, the range of populations with which it is used, the role of a narrative and the content of the stories. Clinicians utilize this technique very differently, even among such a small sample size.

Lack of Conceptual Framework

Part of what may have contributed to the variety of ways that ST is used among clinicians may be due to the lack of a consistent definition among the participants. Some participants appear to be unclear as to any distinctive definition of ST, while some participants appear to feel clear conceptually as to what ST means to them as individual clinicians, but few if any of the participants in this study appear to have a full sense of all that ST can and does mean across the spectrum of literature and practice on the subject of ST. Given that there is little consistency among the clinicians in this area, it could mean that there is little being taught within graduate schools that would offer clinicians the theoretical basis of this technique, and its use, within a therapeutic context. While this variation in application may be a feature notable for the flexibility of ST as well as the natural discretion of clinicians differing from each other in significant demographic categories, it may also be indicative of conceptualizations limited by a working familiarity of all that ST is and can be. This therefore raises the question: How do clinicians who self-report as applying ST in their practice with children make the determination that ST is indicated? How do they determine the specific ST technique they will use? And if a therapist does not possess a working familiarity with the body of literature concerning ST and yet chooses to apply a ST technique as they have come to understand it, what is being missed and how shall these choices be justified? It appears

44

that for many, there is a lack of training on the specific techniques and theoretical principles described in Chapter II.

Related to this lack of connection between what the clinicians are doing and the literature is the surprising finding regarding that no references were made to traditional fairy tales and mythology or the work of Bruno Bettelheim, whose work in 1976 on the uses of fairy tales and mythology was so popular and well received that he was awarded the U.S. Critic's Choice Prize for criticism in 1976 and the National Book Award in the category of Contemporary Thought in 1977. Given his popularity, the lack of acknowledgment was unexpected.

For the essayist and critic Sven Birkerts (1994), the difference between reading a book – a physical structure with both substance and texture – and reading the same material in an on-line format is the way in which the reader can and will interact with that material. The author argues that the difference is not just one of experience and style, but that the physics and form of on-line presentation make sustained focus and contemplation nearly impossible. There are significantly different underlying mechanisms, both physical and psychological, which directly influence what is being learned and how (Birkerts, 1994).

Following Birkerts' argument further, a life lived via email, television, Internet, gaming, or teaching and stimulating children relentlessly through these forms of communication and entertainment, is a life lived significantly through mediated interactions which, due to their nature of instantaneous, electronic result, often lead to a sense of subjective dissolution and disconnection from other people. The result is a loss of a sense of psychological connection to others, as well as to a perception of a time of

duration (Birkerts, 1994), where such a sense of connection to the self and connection to others is nurtured. A state of such disconnection does not lend itself to the preservation of a mutual narrative, either through the simple cathexis with other human beings in the world, or to the self, especially in the face of personal struggles. This argument toward the difficulty and importance of a physical grounding of the narrative in a dialogic discourse, whatever the technique, helps to inform how storytelling as a narrative device in therapy provides a form of communication lacking in the worlds of many children today. Furthermore, an approach in therapy with children that values narrative would likely appeal to therapists who grew up in a time that was increasingly less electronic and less instantaneous, as well as appeal to therapists who have chosen to work in a field that values narrative as highly as psychotherapy. This study demonstrates how therapists practicing in the Internet Age also value narrative precisely because it is increasingly encumbered, and how the investigation of the limits of personal myth and metaphor, language and listening skills, are of critical importance to children today.

Limitations of Study

There were several limitations of this study, which makes it difficult to generalize the results to the population of clinicians who work with children. Only 13 clinicians participated in the study, and they were self-selected in terms of whether or not they use storytelling, so it was a relatively skewed sample due to the selection criteria. It is unclear as to how many subjects were actually reached by this study due to the snowball method of recruitment. This method does not provide a thorough account of who was actually contacted and who chose not to respond versus whether or not the survey was extended to all potential respondents, therefore, this method limited the potential reach of the study.

An additional limitation to the recruitment method is that there are many clinicians who practice who do not use email, especially older practitioners, and this study's use of an email form of gathering information may have missed a large number of the therapists who use ST; in particular therapists who, based on their training in the 1970s when Gardner was most prominent, would be especially likely to have experience with ST and perhaps least likely to have adopted the technology of email and the Internet. A paper survey might have reached a more accurate representative sample.

Another potential obstacle to the successful collection of participants may be one of how the researcher as well as participants defines the terminology of the study. Specifically, participants may be involved in the application of MST but may not call their technique MST. Postmodern schools and/or practitioners may prefer to use different terms to describe their work, and so self-reports by participants are perhaps as likely to be improperly coded, as participants are to misunderstand the terms used within the study. However, the investigator stresses that the survey emphasized participants' freedom to self-define their work and their terms, so the responsibility would appear to be on the researcher to understand the data and the likelihood of participant confusion should be minimal. Further concerns and limitations to this study are discussed below.

Another limitation to the study was that 100% of the participants racially identified as White, and 69% gender identified as Female, thus the views and experiences of a more diverse sample insofar as Race and Gender are concerned are not represented. Had an equal number of men and women or a more racially and culturally diverse clinical sample been obtained, perhaps these perspectives would have altered the results and perhaps then the potential validity of the findings would have been strengthened.

47

Future Research

The exploration of the use of ST with children is at a preliminary stage and there are a number of areas that should be explored in future studies. It is evident that clinicians, particularly the ones that participated in this study, are clinically inclined to support the use of ST. However, it is further evident that these same clinicians draw their justifications for the use of ST, the conceptualizations of ST, and the actual application of ST with which they practice from numerous sources. The reasons for this disparity are equally numerous, but they include: availability of ST resources; knowledge of and training in effective intervention; and a lack of commitment by training programs, graduate programs, professional organizations, and clinical agencies to aid clinicians by formalizing the use of ST as an adjunct tool in therapy. An effort by clinicians to gather the pertinent clinical history of ST as well as the evidence-based research into this area of therapy and provide it in a singular, definitive text and a unified definition of ST would be of enormous assistance to this endeavor.

Another useful study would be to expand the inclusion criteria to include all clinicians who work with children. By broadening the definition, a more complete picture might emerge as to the number of clinicians and the breadth of clinicians who are using ST in their practices. As stated previously, many clinicians may not have recognized their use of ST due to the definition or construct used within this study. This expansion might also include a paper survey to ensure that clinicians who do not use email would be potentially reached more effectively.

While qualitative studies allow for the narratives of the participants and provide a forum for more in depth responses to questions, they do not allow for definitive

48

conclusions on efficacy, therefore future research needs to be conducted on the efficacy of ST by quantitative controlled studies with a large and diverse sample. These studies might entail pre- and post-test measures examining the impact of the use of ST in therapy. Research conducted to examine systemic effects such as practice milieu on the use of ST in therapy with children might be an interesting area of inquiry for future research. Also, a qualitative study wherein clinicians provide examples of how ST is used, or the use of one form of ST like fairy tales versus another form of ST such as MST might provide interesting and helpful data to clinicians and the field. Future studies might attempt to use specific ST techniques as isolated interventions and thus better understand through evidence-based study how effective these interventions are. Evidence-based studies of ST could further justify a greater inclusion of these techniques in the training of current and future practitioners.

Also, it would be interesting to survey clinicians who do not believe it is appropriate to use ST in therapy with children, and to therefore gain a fuller sense of how ST is perceived by clinicians practicing today.

Implications for Social Work Practice

The concept of making use of ST in therapy with children would benefit the social work field by enabling clinicians to expand their tools in their work with clients. This study allowed clinicians to communicate the ways in which they have found storytelling to be functional, or therapeutic or useful, in their work with clients. The culmination of the ideas put forth by these clinicians will be of assistance to other clinicians, as well as students, through training and continuing education in heightening their awareness of the benefits of the utilization of storytelling in their clinical work with children.

49

The clinicians surveyed in this study all indicated that they are inclined to integrate the use of ST into their practice. Therefore it stands to reason that these clinicians might be more inclined to integrate ST into their practice if clinical training programs, supervisors, or other clinicians studied, published and talked about ST more. Supervision, clinical meetings and trainings would be appropriate opportunities to integrate dialogue among clinicians regarding the use of ST.

All the clinicians surveyed indicated ST is useful in therapy. The current study demonstrates that clinicians need to be aware of ways that ST can be used as an adjunct tool in therapy with children and families. Social workers are in a position to provide children and families the opportunity to expand their ways of coping with difficult issues. Ideally, in staff meetings, clinicians should discuss and share ways in which ST might be integrated into therapeutic practice.

Some suggestions would be for supervisors to allow time in clinical meetings for clinicians to share ST techniques that they have found useful, perhaps compiling a list of resources and literature, case studies, etc., organized by themes, issues or presenting problems. Another measure taken might include financial commitments to purchase and make available ST resources to clinicians in their agency, insuring that clinicians might easily access such materials.

One clinician mentioned a somewhat vague memory of exposure to ST techniques in school by her instructors. It might benefit the social work field if classes on ST were made available in clinical training programs. Social work graduate curricula should include information on the effective use of ST in therapy, current literature as well as historical antecedents, and ways to incorporate these techniques into clinical practice.

Evidence-based treatment research into ST could also benefit the field of social work, as clinicians would be better informed as to the ST techniques they choose to employ. Social workers should be encouraged to engage in researching and publishing on the clinical application of ST, to the benefit of the field and the clients they serve.

Conclusion

In conclusion, the investigator of the present study believes that the findings in this study indicate that ST techniques are useful tools in therapy and diversely utilized by clinicians working with children today. However, there is a need for further research in this area. The information gained from the surveys completed by 13 participants in the present study identified a variety of ways ST can be defined and applied in a therapeutic setting. The findings from this study need to be applied to future clinical education, ongoing training, and the professional advancement of social work.

References

Achebe, C. (1986). Award Lecture, *What Has Literature Got to Do With It?* In *Sokoto*, August 23, 1986.

Anastas, J. W. (1999). *Research design for social work and the human services* (2nd ed.). New York, NY: Columbia University Press.

Beck, J. (1995) *Cognitive therapy: Basics and beyond.* New York, NY: Guilford Press.

Bettelheim, B. (1976). *The uses of enchantment.* New York, NY: Alfred A Knopf, Inc.

Berzoff, J., Melano Flanagan, L., & Hertz, P. (1996). *Inside out and outside in: Psychodynamic theory and practice in multicultural settings.* Northvale, NJ: Jason Aronson, Inc.

Birkerts, S. (1994). *The gutenberg elegies: The fate of reading in an electronic age.* Boston: Faber and Faber.

British Association of Play Therapy [BAPT]. (2007). *A history of play therapy.* Retrieved June 7, 2007, from http://www.bapt.info/historyofpt.htm

Brody, M. (2003). Kid's popular culture: The selling of childhood. *Brown University Child and Adolescent Behavior Letter.* 19(1), 8.

Coleman, M., & Ganong, L. (1990). The uses of juvenile fiction and self-help book with stepfamilies. *Journal of Counseling and Development.* 68(3), 327-331.

Costantino, G., Malgady, R. G., & Rogler, L. H. (1986). Cuento therapy: A culturally sensitive modality for Puerto Rican children. *Journal of Consulting and Clinical Psychology*, 54, 739-746.

Costantino, G., Malgady, R. G., & Rogler, L. H. (1988). *The TEMAS thematic apperception test: Technical manual.* Los Angeles, CA: Western Psychological Services.

Costantino, G., Malgady, R. G., & Rogler, L. H. (1994). Storytelling-through-pictures: Culturally sensitive psychotherapy for Hispanic children and adolescents. *Journal of Clinical Child Psychology*, 23, 13-20.

Deblinger, E., Thakkar-Kolar, R., & Ryan, E. (2006). Trauma in childhood. In Follette, V. & Ruzek, J. (Eds.), *Cognitive-Behavioral Therapies for Trauma.* (2nd ed.). New York, NY: The Guilford Press.

Epston, D., & White, M. (1990). Story, knowledge, power. In Epston, D., & White, M.,

Narrative Means to Therapeutic Ends. New York, NY: Norton.

Franzke, E. (1989). *Fairy tales in psychotherapy: The creative use of old and new tales*. Lewiston, NY: Hogrefe & Huber.

Gardner, R. (1971). *Therapeutic communication with children: The mutual storytelling technique*. New York: Science House, Inc.

Gardner, R. (1993). *Storytelling in psychotherapy with children*. Northvale, NJ: Jason Aronson, Inc.

Halprin, L. S. (1996). The goose girl. *Psychoanalysis & Contemporary Thought*, 19(1), 85-123.

Hynes, A., & Hynes-Berry, M. (1986). *Bibliotherapy: The interactive process*. Colorado: Westview Press, Inc.

Jackson, S. A. (2001). Using bibliotherapy with clients. *Journal of Individual Psychology*, 57(3), 289-298.

Kazdin, A., & Weisz, J. (2003). *Evidence-based psychotherapies for children and adolescents*. New York, NY: Guilford Press.

Kottman, T., & Ashby, J. (2002). Metaphoric stories. In Schaefer, C., & Cangelosi, D. (Eds.), *Play therapy techniques* (2nd ed.). Northvale, NJ: Jason Aronson, Inc.

Kramer, P. A. (1999). Using literature to enhance inclusion. *Contemporary Education*, 70, 34-37.

Landreth, G. (2002). *Play therapy: The art of the relationship*. New York, NY: Brunner-Routledge.

Lenkowsky, R. S. (1987). Bibliotherapy: A review and analysis of the literature. *Journal of Special Education*, 21(2), 123-132.

Malgady, R. G., & Costantino, G. (2003). Narrative therapy for Hispanic children and adolescents. In Kazdin, A. & Weisz, J. (Eds.), *Evidence-based psychotherapies for children and adolescents*. New York, NY: Guilford Press.

Malgady, R. G., Rogler, L. H., & Costantino, G. (1990). Hero/heroine modeling for Puerto Rican adolescents: A preventive mental health intervention. *Journal of Consulting and Clinical Psychology*, 58, 469-474.

McDaniel, C. (2001). Children's literature as prevention of child sexual abuse. *Children's Literature in Education*, 32(3), 203-224.

Morgan, A. (2000). *What is narrative therapy? An easy-to-read introduction.* Adelaide, South Australia: Dulwich Centre Publications. Retrieved November 1, 2007, from http://www.dulwichcentre.com.au/alicearticle.html

Newbridge After School Club [NASC]. (2005). *A (very) brief history of play and play therapy theories.* Retrieved October 21, 2005, from http://www.geocities.com/Wellesley/9158/play.htm

Pardeck, J. T. (1994). Using literature to help adolescents cope with problems. *Adolescence*, 29, 421-427.

Poda, D. (2002). Little Pipa and other ghosts: Short-term psychotherapy with a child. *Transactional Analysis Journal*, 32(4), 223-233.

Rose, S. (1998). *Group work with children and adolescents.* California: Sage Publications, Inc.

Russell, R. L., & van den Broek, P. (1988). A cognitive-developmental account of storytelling in child psychotherapy. In Shirk, S. R. (Ed.), *Cognitive development and child psychotherapy.* New York, NY: Plenum Press.

Russell, R. L., van den Broek, P., Adams, S., Rosenberger, K., & Essig, C. (1993). Analyzing narratives in psychotherapy: A formal framework and empirical analysis. *Journal of Narrative and Life History*, 3, 337-360.

Schaefer, C., & Kaduson, H. G. (2006). *Contemporary play therapy: Theory, research, and practice.* New York, NY: Guilford Press.

Schwartz, T. (1973). *The responsive chord.* New York, NY: Anchor Press/Doubleday.

Shirk, S., & Russell, R. (1996). *Change processes in child psychotherapy: Revitalizing treatment and research.* New York, NY: Guilford Press.

SurveyMonkey website, http://www.surveymonkey.com/

Tussing, H., & Valentine, D. (2001). Helping adolescents cope with the mental illness of a parent through bibliotherapy. *Child and Adolescent Social Work Journal*, 18(6), 455-469.

Webb, N. B. (1996). *Social work practice with children.* New York, NY: Guilford Press.

White, M. (1997). *Narratives of Therapists' Lives.* Adelaide: Dulwich Centre Publications.

APPENDIX A

Recruitment Email

Dear Potential Research Participant:

My name is Michael Cantor, and I am a graduate student at Smith College School for Social Work. I am conducting a study on the use of storytelling with children in therapy. This study is being conducted in partial fulfillment of the Master's of Social Work degree at Smith College School for Social Work.

You are being asked to participate because of your experience as a psychotherapist with children in a therapeutic setting. If you are a mental health clinician of any discipline (social worker, psychologist, psychiatrist, psychiatric nurse, licensed professional counselor, etc.) whose practice is at least one-third children and who identifies as using therapeutic storytelling in your practice, please consider taking a few minutes to participate in this study. Therapeutic storytelling shall be defined in this study as "the process of constructing, co-constructing, or otherwise utilizing a narrative or anecdote with a client in the interest of achieving a therapeutic goal." There will be no restrictions regarding any clinicians' theoretical orientation or training background. However, participants must have at least 5 years post-medical or graduate school experience.

If you choose to participate in this study, you will be asked to read the attached consent form that also includes additional information about the study. Next, please follow the link below in order to complete a two-page electronic questionnaire hosted at SurveyMonkey.com.

http://www.surveymonkey.com/

Thank you for your help.

Michael Cantor

APPENDIX B

Thesis Survey

In addition to the collection of demographic and professional information, survey participants will be given adequate space to respond in an open-ended format within this survey.

Demographic information:

- Age? (Numeric value, not range)
- Gender?
    - Male
    - Female
    - Transgender
    - Other
- Race?
    - American Indian or Alaska Native
    - Asian
    - Black or African American
    - Native Hawaiian or Other Pacific Islander
    - White
    - Multiracial
    - Some other race
- Ethnicity?
    - Hispanic or Latino
    - Not Hispanic or Latino
- Discipline?
    - Psychiatry
    - Psychology
    - Social Work
    - Psychiatric Nursing
    - Licensed Professional Counseling
    - Other (please list)
- Years of Experience post-medical or graduate school? (Numeric value, not range)
- Do you use therapeutic storytelling with children in your practice?

If participant responds with ≥5 years of post-medical or graduate experience and that they use therapeutic storytelling in their practice, survey may continue...

- Percentage of child clients to overall practice clientele?
- Type of practice base:
    - Short-term
    - Long-term
    - Community clinic

- o Private
- o Hospital
- o Health facility
- o Other mental health setting

Open-ended questions (PLEASE DO NOT INCLUDE ANY IDENTIFYING INFORMATION ABOUT YOUR CLIENTS OR YOURSELF):

- ➢ How do you define therapeutic storytelling?
- ➢ In what ways do you use therapeutic storytelling in your practice?
- ➢ What tools and/or strategies do you use in your work with this technique (i.e. story aids)?
- ➢ With what clients do you use this technique (i.e. age groups; certain diagnoses; modalities; length of treatment, treatment goals)?
- ➢ With what clients do you believe that this technique is contraindicated?
- ➢ What theories or theoreticians have informed your practice with this technique?
- ➢ Are there any other materials, sources, or trainings received and not yet mentioned that you utilize in therapeutic storytelling? If so, please elaborate.
- ➢ Are there any other comments you would like to add that has not yet been covered concerning therapeutic storytelling?

APPENDIX C

Informed Consent

Dear Potential Research Participant:

My name is Michael Cantor, and I am a graduate student at Smith College School for Social Work. I am conducting a study on the use of storytelling with children in therapy. Your perspective is important and valuable to further the development of research on utilizing storytelling as a tool in psychotherapy. This study is being conducted in partial fulfillment of the Master's of Social Work degree at Smith College School for Social Work, and for future presentation and publication on the topic.

You are being asked to participate because of your experience as a psychotherapist with children in a therapeutic setting. If you are a mental health clinician of any discipline (social worker, psychologist, psychiatrist, psychiatric nurse, licensed professional counselor, etc.) whose practice is at least one-third children and who identifies as using therapeutic storytelling in your practice, please consider taking a few minutes to participate in this study. Therapeutic storytelling shall be defined in this study as "the process of constructing, co-constructing, or otherwise utilizing a narrative or anecdote with a client in the interest of achieving a therapeutic goal." There will be no restrictions regarding any clinicians' theoretical orientation or training background. However, participants must have at least 5 years post-medical or graduate school experience. If you choose to participate in this study, you will be asked to complete a two-page electronic questionnaire, which will then automatically return the completed questionnaire to the researcher by email. The average time required to complete the questionnaire is 30 minutes, depending on your responses. The questionnaire will ask for demographic information as well as your views on utilizing storytelling with children in therapy. You have the right not to participate as well as not to answer any questions in the questionnaire.

Participant confidentiality will be assured by assigning the submitted questionnaires a number and removing any identifying names, email addresses, ISP information, or physical locations from the form. Some illustrative quotes may be used for publication and/or presentation, but will be reported without connection to identifying information in order to protect confidentiality. My research advisor and I will be the only handlers of the data including submitted questionnaires, any transcription of data, and I will keep these materials in confidence for three years, consistent with federal regulations in a locked cabinet for hardcopy materials and locked servers for storage of electronic data, using SSL encryption for the survey link and survey pages during electronic transmission of data. After the three-year period has expired, all material including questionnaires and transcription data will be destroyed. The data will be used only for my thesis and may be used for future presentations and/or publications.

There will be no financial benefit for participating in this study. However, participation will allow you to share your views on and/or experiences with utilizing storytelling with children and provide important insight for other professionals who seek to add tools to their psychotherapy work with children.

There are no foreseeable risks to participants in this study other than the cost of the time required to complete the survey. Although your confidentiality will be protected, the information you provide in the questionnaire will be used as data in this project.

You have the right not to complete the questionnaire in part or in full. However, once a survey has been submitted at SurveyMonkey.com, any individual survey cannot be identified due to the anonymity protocol of the study and therefore cannot be withdrawn.

YOUR PARTICIPATION IN AND SUBMISSION OF THIS SURVEY INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION INCLUDING THE TERMS OF THE STUDY, AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION AND YOUR RIGHTS AS A STUDY PARTICIPANT.

Thank you for your help.

IF YOU HAVE ANY QUESTIONS CONCERNING THE STUDY, PLEASE CONTACT:

Michael Cantor
mcantor@email.smith.edu

Please keep a copy of this form for your records.