Narrative Methods and Children: Theoretical Explanations and Practice Issues

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TOPIC: *The Narrative approach is an innovative way of working with children and adolescents experiencing mental health problems. This approach can be effectively integrated with the expressive arts and other nonverbal ways of accessing the life world of children. In addition, the approach promotes respect for and collaboration with the child in working towards healing and growth.*
PURPOSE: *In this paper core features of the narrative approach are described; the theoretical and philosophical and evidence base for this approach as well as its congruence with the special nature and needs of children will be explored. Finally, the benefits and challenges of this approach in relation to a specific clinical situation will be highlighted.*
SOURCES USED: *Published literature and the author's clinical experiences.*
CONCLUSION: *Narrative methods are ideally suited for addressing needs of children experiencing mental health problems and can enhance therapeutic effectiveness. Some of the challenges associated with its use include: finding creative ways to apply specific narrative concepts and methods with diverse clinical issues/problems; learning to collaborate with children and respect them as experts in their own lives; and shifting the nursing focus from a problem-focused orientation to a strength-oriented and child-centered approach.*
Search terms: *Children, mental health, narrative therapeutic methods, re-storying*

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Introduction

Learning to connect with children experiencing a range of emotional and behavioral difficulties in a way that is therapeutic, developmentally appropriate, and most importantly enjoyable is one of the most daunting challenges for clinicians working in the child and adolescent mental health field. The integration of narrative methods with the expressive arts is becoming an important and clinically significant way to meet this challenge. The purpose of this paper is to describe core features and theoretical background for the narrative approach; to discuss the suitability and evidence base for the use of narrative methods with children; to highlight issues and challenges in the implementation of these methods; and finally to discuss the application and relevance of this author's own practice through discussion and analysis of a specific clinical situation.

Theoretical Background for Narrative Therapy

Narrative methods have their origins in clinical work with children. Michael White's use of the techniques and methods in the narrative exploration with children was so beneficial and valued by clinicians and parents that he carried these ideas into work with adults (White, 2000; White & Epston, 1990).

Narrative therapy has been defined as "a respectful, nonblaming approach . . . , which centers people as the experts in their own lives. It views problems as separate from people and assumes people have many skills, competencies and beliefs, values, commitments, and abilities that will assist them to reduce the influence of problems in their lives" (Morgan, 2000, p. 2). Narrative methods are rooted in postmodernism, a world view that takes as its starting point a view of reality or truth as socially constructed with meaning negotiated in

dialogue with others and ourselves. Modernism, in contrast, holds that there is an objective world of facts and ideas that are real and whose truth-value we have access to and share with others (Freedman & Combs, 1996). Reality from a postmodern perspective is organized and supported through stories that shape who we are and will become. These stories may enhance our lives in the direction of health and well-being, may limit our potential, or may disable us. One of the primary goals of the narrative approach is to increase individuals' awareness of the dominant stories shaping their lives. For example, a dominant story about alcoholism, inadequacy, self-doubt, or bitterness may arise from a series of life experiences that are repeated time and again over a person's family history. These internalized story patterns may sabotage an individual's efforts to move forward in a way that is life affirming and self-actualizing. Narrative methods promote new stories and support respect for, and valuing of, the person's individual voice and meanings. Most importantly, this approach emphasizes personal strengths, resources, and personal agency (White, 2000; White & Epston, 1990).

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Evidence Base

How effective are narrative methods from an evidence-based perspective, especially with children and their families? The values and practices underlying research on narrative methods stress the importance of experience, individual perspectives, and the voice of the research participant over the voice of the researcher (West & Bubenzer, 2002). The knowledge we have about narrative methods relies primarily on qualitative research. A few studies have focused specifically on the use of narrative methods with children. A study by Besa (1994), using a single case methodology and a treatment package with parents comparing the behaviors of their children at baseline and following intervention, explored the effectiveness of Narrative Family Therapy on parent–child conflict. Narrative methods in the treatment package included externalization of the problem, homework tasks, and a focus on unique outcomes and reauthoring processes. Interestingly, improvement was noted in parent–child conflict between families only when narrative techniques were applied. Focht and Beardslee (1996) described another intervention study using a combination of psychoeducation and narrative processes to facilitate dialogue between parents and their children about the impact of depressive illness on the family. The findings suggested that this approach supported the development of shared meaning and significant changes in attitude and behavior associated with the illness and its impact. Larner (1996) used hermeneutic analysis of family therapy sessions that included both a play component and narrative techniques. Larner reported that the narrative approach augmented play sessions and enhanced understanding of the family presenting problems with both parents and children. A recent publication about narrative therapies with children makes a strong case for the effectiveness of narrative methods for a range of mental health problems in children, including depression, trauma, attachment issues, and family violence (Vetere & Dowling, 2005).

A few studies have examined client experiences and responses to narrative methods. For example, O'Connor, Meakes, Pickering, and Schuman (1997) reported on helpful aspects of narrative approaches reported by families whose clinicians used these methods. These aspects included: not being blamed

for the problems with their children and being treated as "experts" in their lives with the capacity to bring about change in themselves. Interestingly, O'Connor, Meakes, Pickering and Schuman (2004) observed that few studies have examined clinicians' experiences with using narrative methods. The use of this approach in a clinical situation study reported on here provides one example of a nurse clinician's experience using these methods with children that will add to the knowledge base in this area.

The Narrative Method and Relevance to Nursing Practice

There are indications that nurses are drawing on the knowledge base of narrative ideas to broaden their scope of practice, particularly in work with families (Wright & Leahey, 2005; Wright, Watson, & Bell, 1996; see also Moules & Streitberger, 1997). More discourse in the literature highlighting specific applications of this approach with different populations could encourage nurses to use these methods in their clinical work. What is happening at the clinical level in terms of effectiveness is essential given the current emphasis on evidence-based practice.

When this author began her career in nursing, the focus of her practice was on adults in general health settings. Specialization in child and adolescent mental health and subsequently family mental health, particularly the transition to working with children experiencing a range of emotional and behavioral difficulties, brought new challenges. Clinical involvement with children is a significant aspect of the author's faculty practice role at a community agency as a component of her work as Associate Professor of Nursing with Memorial University of Newfoundland School of Nursing. The transition to work with children has included the integration of a broad range of the expressive arts such as art therapy, puppetry, and other projective methods (Bennett, 1997). The author's model for practice was influenced strongly by the work of Virginia Axline (1964). Axline's model conveys respect for the child's frame of reference, a pace of therapy that supports the child's comfort and emotional security and is based on the belief that "all people proceed (in therapy) with a caution that protects the integrity of the personality" (p. 44). More recent continuing education and practice experience has included the application and integration of narrative theory and methods.

Core Concepts of the Narrative Method

The following are the core concepts and ideas underpinning this approach:

1. Narrative ideas are informed first and foremost by the role of the narrative or story for describing and interpreting life experiences. The telling of stories is a way of organizing the events and happenings in our lives and for finding meaning in these experiences. Narratives are fundamental to therapeutic work with both children and adults primarily because they facilitate the discussion of lived experiences (Bruner, 1991; Rustin & Rustin, 2005).
2. Narratives are shaped and defined by dominant stories or the primary problems pertaining to a person's life (Morgan, 2000, p. 5). Deconstruction of these stories is a way of making explicit the assumptions and beliefs which support the story (White, 1991, p. 275). Deconstruction is essentially a process of paying attention to the ordinary occurrences of day-to-day life over time which provides evidence for the dominant story and makes room for a new more preferred story or perspective on a problem.
3. The practice of identifying and building on "unique outcomes" or situations and responses which demonstrate exceptions to the beliefs, ideas, and events which have shaped the dominant story serves as the logical point of entry for the "re-storying" and shaping of an alternative more preferred story about a problem or an experience (White & Epston, 1990, p. 55; White, 1995, p. 25).

4. The practice of externalizing the main problem associated with a dominant story involves engaging in externalizing conversations about the problem for the purpose of coming into a new relationship with a problem that facilitates tracking the history of the effects as well as strategies for avoiding the influence and negative impact of the problem (Epston, 1993, p. 161). From a clinical perspective the problem is discussed as something outside the individual and over which the person may have influence and control (White & Epston, 1990).

Value of the Narrative Approach with Children and Clinical Implications

What distinguishes the narrative approach with children from the narrative approach with adults? Smith and Nylund (1997) maintain that there are a few differences. First, the largely nonverbal ways of working with children are consistent with the methods associated with the narrative approach. Freeman, Epston, and Lobovits (1997) point out that children are responsive to narrative approaches because these methods fit with children's needs for a playful attitude towards serious problems. Narrative techniques actively employ the full arsenal of nonverbal approaches typically used with children. These include puppet work, dollhouse play, sand play, drama, and art therapy. Another benefit of this approach with children is the focus on the perspective of the child. Children's voices often fade into the background when clinicians work with the adults in a family. The clinician who uses narrative methods is less likely to fall into this trap (Smith & Nylund, 1997). A narrative stance facilitates and respects the inclusion of children's voices. It was the discovery of the power of the narrative, in its many forms, for example, using sand play stories with children and adolescents who had been sexually victimized, that inspired this author to think about using narrative methods in a more deliberate way to access the life world of children. Larner (1996) observed that, "stories give meaning and direction to our lives, structuring the past into the present in a new description of the future" (p. 425). This is especially true for children whose notions about the passage of time, transition, change, and the future are less well developed.

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In addition, children view their family's situation very differently than adults do. They make sense of family events and happenings in ways that help them cope with the experience more constructively sometimes than the adults in their lives do. They feel comfortable with discussions of magic, fantasy, and their hopes and dreams, very much in keeping with the naming and externalizing of problems. White (2000) referred to the changing fluid nature of childhood that is so amenable to the narrative approach. He noted that one of the privileges of working with children is that often they see the world through fresh eyes and are discovering new ideas and have questions every day about how they fit into the world and their influence in it. White observed:

> In children's lives, the negotiation of meaning is a highly visible achievement, one that is often hard won. For young children . . . there is so much about

> the world that is novel, so many new experiences to be negotiated, so many gaps to be filled in their understandings of life. Nowhere is recourse to narrative structures in achieving all of this more manifestly apparent then it is in children's efforts to understand their experiences of life. (White, 2000, p. 10)

Most importantly, narrative methods facilitate children's delight in imaginative, playful approaches to difficult challenges. Therapy is challenging; daunting at times. Keeping fun in the process is necessary to balance the challenging work of therapy for both child and clinician (James, 1989). Narrative methods take the focus off the child as the problem and place emphasis on the child's strengths and abilities to deal with the problem. This approach also promotes an interplay of the child and the clinician's imaginations in the coauthoring of meaning in the search for solutions (Freeman et al., 1997).

Relevance and Application of Core Concepts to Work With Children

In narrative terms the dominant story refers to the core family or individual beliefs and well-entrenched ideas underpinning a family problem or situation (White & Epston, 1990). Morgan (2000) describes the dominant story as the beliefs and personal meanings arising from "events linked in sequence," and "occurring across time according to a plot" (p. 5). Think of problems in families that repeat themselves or that are ongoing in terms of their impact on the family. For example, consider a family dealing with an adolescent experiencing addiction problems, the family of a child with attention deficit disorder, or an adolescent girl with a life-threatening eating disorder where the dominant story for the family has been described by the family or healthcare providers as one of despair or defeat. Exploration with a family around what would be or could be different if the dominant story was altered in some way is the beginning of "deconstructing" this story and assisting the family in the process of re-storying the familiar story so that an alternative reality becomes not only believable but possible (White, 1991).

The stories dominating the lives of children like those of adults are often shaped by the significant others in their lives. For children these are parents, peers, and teachers. Deconstructing these stories begins with asking questions aimed at making explicit those events and problems that give rise to beliefs, ideas, and self-identities that are less than affirming. Questions used to deconstruct the dominant stories of adults include different levels and sequences of questions designed to encourage a description of the dominant story as well as the meanings that determine current realities (Freedman & Combs, 1996). Similarly, if the dominant story for a child involves a problem with temper, deconstruction questions include questions aimed at tracing the history of the problem, the situations that are likely to generate the appearance of the problem, and the ways the problem affects the everyday life and happiness of the child.

Re-storying a new understanding of the problem would include asking questions designed to identify the times when the problem might have presented itself but did not. These times/events or exceptions to the dominant story are referred to as "unique outcomes" (White & Epston, 1990, p. 41; Freedman & Combs, 1996, p. 125). Similarly, hypothetical or "what if" questions assist the child to imagine a different outcome related to the problem as a way of shaping a different reality or story about the problem. New or alternative descriptions about the dominant story are constructed using the evidence from the child's responses to these re-storying questions. This is more than building on strengths or looking for a positive reframing of a situation. It is paying attention to the events, behaviors, values, and surprising or unexpected statements of the child or other family members which provides a window for assisting children and families to bring forth new meanings and more preferred ways of being in the world (White, 1991).

The final core concept is externalizing, or more specifically externalizing conversations. This concept is

viewed as the hallmark of narrative work. Externalizing is defined as "an approach to therapy that encourages the person to objectify and at times to personify the problem or experience as oppressive" (White & Epston, 1990, p. 38). This is achieved through the imaginative and focused use of complex sequences and categories of questions aimed at obtaining a detailed description of the problem and its influence as well as the person's influence on the problem (Freedman & Combs, 1996; Roth & Epston, 1996). These questions make use of metaphors, symbolic language, and imagery and are designed to facilitate discussion about the problem as an externalized entity with a life of its own. Clearly, it is less possible to use questions with a high level of abstraction that are developmentally appropriate for children. Moreover, complex sequences of questions sometimes used with adults may be confusing for children. Children do not have the cognitive and abstract ability and social maturity to respond to these questions (Vetere & Dowling, 2005; Weston, Boxer, & Hetherington, 1998). Externalizing conversations integrated with the expressive arts and implemented in a playful way have more value in terms of therapeutic potential for children. These conversations can be created naturally as part of the dialogue one might have with a child using art therapy, sand play, or puppetry as the medium for initiating these conversations (Freeman et al., 1997).

Using Externalization With Children

Having externalizing conversations with children starts with how we listen to children (Madsen, 1999). As children tell their stories, we reframe their statements about a problem in such a way that they are assisted to view the problem as something outside themselves and over which they can have control or influence. It is useful to speak of the child's influence in terms such as "you can be the boss of the problem" or "you can teach it to be more polite or not so rude." Children can easily connect with this view of the problem and their role in it. Marner (2000) provides specific guidelines for the application of the externalization process. For example, he recommends using the child's language where possible to name the problem. Examples of names children have chosen in this author's practice are "fire tantrum" for anger; "Mr. Willie Nillie" for anxiety; and "soul bruiser" for grief. Another suggestion by Marner is to encourage the child to describe how the problem has made the child's life difficult up to this point. Asking the child to give examples of ways he or she has been able to "outsmart" or "trick" the problem to diminish its influence is another helpful way to further engage the child in externalizing conversations (White, 1989, p. 10). Most importantly we are interested in a description of the problem from the child's own experience. The dialogue is give-and-take, comfortable, and invites reflection. Typical questions this author uses include: "How did you do this?", "Were you surprised that you could achieve this?", and "What do you think that this says about you that you could be happy about?" Typically as clinicians we frequently draw conclusions, evaluate, and offer praise. This can limit the child's own ideas, impressions, and experience. Using a curious, caring, and watchful stance in the externalization process allows the child's imagination and capacity to be fully engaged.

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The externalization process is not without its challenges. Madsen (1999) pointed out that "militaristic

metaphors" such as "fighting" or "beating" or doing battle with the problem are patriarchal and aggressive in tone. He argues that this may not be the most appropriate way of encouraging children to manage or cope with a problem. In addition, although one of the advantages of the externalizing stance is that it assists the child to feel less guilty and defensive about the issue, this may serve to minimize personal accountability for particular problems such as aggressive behavior. Problems are multidimensional; thus, encouraging the child to treat the problem as an adversary may not be serving the interests of the child. For example, there are both positive and negative aspects of anger and of depression. Anger can be a righteous or a just anger and can be a positive rather than a negative life response. In the same way, children come to understand that some problems may continue to be a part of their lives such as chronic pain or an ongoing disability of some kind. Teaching a child new ways to live alongside, or make peace with, the problem may be more appropriate in these instances. Other clinicians dealing with the use of externalization have referred to the risk of trivializing or minimizing serious problems such as anorexia nervosa, family violence, or an experience with sexual abuse (Freeman et al., 1997). Perhaps the biggest leap for the nurse working with Narrative methods is learning to work more collaboratively with the child in determining the meaning of the experience from the child's own frame of reference. Narrative work can complement and support comprehensive assessment of the child because it allows access to dimensions of the child's total experience not always possible through a nursing history. The building of a meaningful narrative through externalizing dialogues using the therapeutic relationship as the vehicle to support this process can facilitate healing and recovery.

Specific Clinical Application

John is a 10-year-old academically gifted boy who taught this author a great deal about what it means to be a child in our world today and in particular the value of externalizing conversations. Externalization of the problem proved to be most helpful in the process of engaging him in the therapeutic process, building a therapeutic relationship and supporting collaboration with both John and his family. His referral to a Mental Health Community Agency came about in response to concerns expressed by his school and subsequently by his parents about a class writing exercise in which he had distinguished between his "inside" and "outside" self in a troubling way. His "outside" self included descriptors such as, "keen dude," "funky shoes," and "blond hair." His "inside" self-description included the following: "On the inside I can get discouraged. I'm not really a bully but on the inside I am. In my head I'm a big killing machine." Behavioral issues identified by the school included aggression, frustration, and noncompliance. His self-portrait drawing included bars covering a stick figure of himself. In the first session John presented as sensitive (cried easily), articulate, and cooperative in his attitude. He felt his parents and teachers had overreacted to his note (the class writing exercise). He expressed difficulty with peer relationships at times, and had been bullied on a few occasions. In the first session he tried to defend and explain his behavior concerning the writing exercise. He said he sometimes had a problem with anger and often felt excluded from his peer group.

His academic capability was viewed by John as both an asset and a curse as it was valued by some peers but not by others. He had experienced peer rejection on a few occasions because he was in the habit of "telling on bullies." His mother said he had a strong sense of justice but sometimes missed basic social cues and did not always avoid potentially negative interpersonal situations. In addition, he also had issues with his parents over what he perceived to be their overprotectiveness. For example, not being permitted to watch horror movies limited his peer contacts with the more popular kids who were well-versed in the latest horror films. In John's school a child could easily be ostracized for not knowing the right discussion

points about a popular movie. The fundamental problem for John, however, was learning how to manage his anger, and the difficulties this created for him in his social context. John described his problem with anger as like "meteorites from the sky . . . you never know when one might fall." He traced the history of the problem as arising from an experience with other children in his neighborhood the previous summer where bullying and aggression were part of the typical way of dealing with conflict among the children.

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Deconstruction of the dominant story or problem and the re-storying of a new story are not linear processes but interrelated and overlapping components of externalizing dialogue. With children there is often less attention to deconstructing the dominant story and greater focus on the constructing of a new relationship with the problem. Zimmerman and Bedoin (2002) outline a process for re-storying a problem that offers structure and guidance that is consistent with children's cognitive abilities and ways of relating to a problem. They stress the importance of first describing the problem from their own perspective and then asking children to identify ways they engage with the problem already to lessen its influence. The ideas the child has for minimizing the problem are used to help cocreate new meanings about the influence of the problem and ways to manage it. This kind of dialogue with the child provides evidence of unique outcomes and serves as the entry point for re-storying a new meaning about the problem and the child's ability to effect change with respect to the problem.

The externalizing conversations began with John very early in the therapeutic process. Engaging in narrative language at the outset of the sessions helped to support and orient John to a unique way of dealing with the problem from the beginning of therapy. He found it difficult to name the problem but eventually decided on "That Thing." Initially, he spoke in terms of his "goodness" and "badness" as it related to the problem. Thus it was important to reframe the problem in more neutral terms. The early externalization facilitated this goal. He was invited to tell a story in the sand that could explain his perspective of how "That Thing" influenced his life. Interestingly, he chose to depict his daily life world at school in terms of a battle, not unusual in terms of the play choices of boys his age.

John set up the figures in the sand in such a way that there was a leader of the good side (his interests) and a leader of the bad side led by a troll-like figure chosen to represent "That Thing." He buried some of the army figures and others he placed at the front lines. He said the buried figures were the camouflage forces. These were forces that came to his aid when "That Thing" was inciting him to argue, especially with his peers or his parents. The example he used was having a bad attitude about doing homework he did not like. He said camouflage forces were the good feelings he had about himself. These give him confidence. Later he included his knowledge of martial arts (he was enrolled in a children's martial arts program) as a force for the good side. He believed the figures representing his knowledge of martial arts appealed to his logic and reason and helped him to avoid making bad judgments in social situations. He included toy surveillance planes as representing supernatural forces or his understanding of a loving

God. He pointed out that these planes could fly undetected by radar and thus were a significant source of influence and support. He used other figures to represent family support. Knights and cowboys initially symbolized different family members. Later he used war equipment. His mother was depicted as a huge tank, his father as smaller support equipment carrier; his brothers as smaller tanks.

The author's questions such as "I'm curious about how you will keep that from happening—what will you do if this or that should happen?" were posed in such a way as to invite him to build his own story about "That Thing" so that he could build a case fueled by his own imagination describing himself as having personal agency and some personal control. The questions encouraged a description of his experience for the purpose of cocreating ideas about the role and meaning of different resources and events, as well as a way of generating his own ideas about solutions. Freeman et al. (1997) refer to this process as follows:

> The interplay between adults and children allows for the enrichment of narratives. Instead of simply reflecting a child's language or listening and making theoretically based interpretations, we seek to be welcomed as an active participant in the child's world of meaning . . . allowing our own imagination to be sparked, we join children and family members in the generation of new choices and possibilities. (p. 7)

Re-storying from his own perspective rather than deconstructing his parent's and teachers' views of the problem was the focus of the dialogue with John. The sand story about a battle between two forces, one side representing the challenges he faced (primarily in school) and the other side representing his resources for dealing with the problem, served as the background context for deconstructing but primarily for authoring a new story about and ways to manage the problem. Finding exceptions was not difficult as John had unique ways of dialoging about his experiences and depicting these in the sand figure descriptions. Indeed, his articulate, observant commentary on his day-to-day world combined with his intellect and imagination allowed access to his experience in a way that supported the re-storying and the formation of new meanings about the problem and its impact. Re-storying also involved a focus on perceptions of himself that provided new more affirming evidence concerning his self-identity. For example, he commented in one session that he was surprised that his in-class presentations about different topics were sometimes valued by peers and respected by teachers. He commented that on a few occasions when he was in front of the class he believed he was perceived as interesting, funny, and knowledgeable. This provided an opportunity to comment on what this said about him as a student in terms of his status with peers and his potential contribution in the future. These reflections were consistent with re-storying the old story and building toward the new.

Anderson and Levin (1997) observe that the clinician using a narrative approach assumes the role of curious learner and the child guides the learner in the process of cocreating meaning. Using a nonexpert stance means that in working with John, his comments about the battle moment-to-moment provided the basis for the questions essential to re-storying his experiences. For example, John was asked at one point during the discussion about the battle depicted in the sand, how he knew that the camouflage forces were being adequately mobilized for his benefit in battling anger. He responded that he knew this to be the case because now he was less irritated by the little things at home and at school that normally would make him angry. He described again the various resources that represented the camouflage forces such as encouraging words from others or awards and accolades he had received on previous school occasions. He added that "the fall of the main leader" on the negative side also ensured the camouflage forces could work for his benefit. When questions were used to encourage his own description of the problem and his ways of

coping, it seemed his imagination knew no bounds. His response about "the fall of the main leader" reflected his growing confidence and belief that he was mastering the problem with anger.

Narrative values and principles involve the nurse clinician as a caring coach allowing the child to set the pace in moving forward in the process of self-discovery.

John's story in the sand evolved and expanded from one session to the next allowing him to develop a stronger sense of personal agency and influence over the externalized problem. Indeed it was a challenge to find all the play pieces to set up the story again from the previous session! The building of a sand play narrative was a valuable process on a number of counts. It allowed him to be aware of the range of resources both internal and external accessible to him. The rich dialogue arising from the externalizing questions was engaging, affirming, and developmentally appropriate for a school-aged child who is able to use language in helpful ways but who needs assistance in this process for therapeutic purposes. Narrative values and principles involve the nurse clinician as a caring coach allowing the child to set the pace in moving forward in the process of self-discovery. Externalizing questions such as "How can that force (good friends) in your life make it easier or harder to put 'That Thing' in its place?" or "Which of those forces was harder to win over?" facilitated the creation of a comprehensive narrative for healing purposes. Most importantly, building stories in the sand supported the externalization process in a creative, meaningful way and assisted John to deal effectively with a difficult life challenge.

Concluding Remarks

Using narrative methods, in particular externalizing conversations, has the potential to change the way we work with children in diverse practice settings. The primary advantage of this approach is that it is a way of being with children that gives primary value to how the child views his or her experience and responds to it. The nurse clinician assumes a nonexpert position that seeks to expand on the usual social construction of events and happenings in the child's life and in a way that expands the child's understanding about the meaning of events and personal agency for influencing a problem and finding solutions. Narrative methods are integrated with the expressive arts for the purpose of engaging the child and generating a rich description of experience as well as the imaginative cocreation of new meanings to facilitate healing in a fun context. The therapeutic relationship serves and at the same time is served by the application of narrative methods and therefore both supports and enhances therapeutic goals and outcomes.

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