IT'S THE STORIES

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[Editor's note: The ILAIMH Board has asked Michael to write the cover articles for our Newsletter for 2009. This is the third in the series. Feedback is most heartily welcome, and can be directed to mtrout@infant-parent.com.]

The early intervention worker arrives, asks permission to sit at the kitchen table (where, Fraiberg taught us, the mysteries would unfold), opens her laptop, and begins to keystroke. She has many questions; all of them are closed-ended. She has electronic forms to fill out, state and federal standards to meet, funding to assure, and blanks to fill in. She means well.

Mom is compliant, eager for help and relieved that she doesn't have to reach too deep.

Sixty minutes later, the laptop is closed, the job is finished, and exit niceties are accomplished. Nothing of great substance has been learned. The family dynamic could have had a horn growing out of his head, and it may well have gone unnoticed. The worker meant well, but she didn't come prepared to hear the stories.

Referrals will be made, of course. Specialists will be sent; services will be dispensed. If the new visitors follow suit, they may not learn anything, either. Everyone is looking for what's broken. For the nail each perceives, each has a hammer.

Oh, mom had a story to tell, all right. In fact, she may well have tried, that day—and in some of those subsequent days, with all the various specialists—to "tell" the story by way of her interactions with her baby. But no one was looking, no one was listening, no one thought her stories were actually the heart of the matter. No one believed this mother already *knew* what was wrong, although not conscious of her own authority and her intelligence on the matter. No one asked, at least not so Mom knew someone really wanted to know. So Mom put her *knowing* away, and focused on broken things, and on practical fixes. She, too, is afraid of the story.

One of the things that impressed me—indeed, was seared into my brain—three-and-a-half decades ago, as I sat at the feet of Vivian Shapiro, Edna Adelson, Bill Schafer and Selma, was that the truth of the family lay in the stories that would be told by its members. As we stared at the old reel-to-reel videotapes, we discovered that the stories might be told in words, but not clear words, so we would have to listen very carefully; sometimes they would be "told" in behavior, usually of the interactive variety.

So we were taught to *witness.* And nothing has dissuaded me, since, from the lesson that *such witnessing is at the core of the scientific inquiry* into what is the matter with a particular baby, what is not right in a particular dyad, what troubles a particular home.

I fear we are letting the central role of witnessing slip. I fear we have been swept into *doing*, rather than *being*, when we are with families. We seem to increasingly think we are being more scientific, more practical, more responsive to the family's demands if we fix things. But what is scientific about missing the message? Have we helped just because we have *applied* methods, *dispensed* psychological wisdom, or *delivered* services, even if nobody got better?

When the middle-aged woman complains to her doctor about the recent uptick in her migraines, he can order up some tests, and prescribe some pills. Will he also look at the chart, so he might be reminded that she was here last year, and the year before that, on almost exactly the same date? And will he know his patient well enough (because he had been *witnessing* her, not just treating her) to remember that the date of her annual migraine assault corresponds to the date of her husband's unexpected demise, several years ago?

The five-year-old head-butts another little boy on the playground, and is disruptive in class. The school social worker orders mom to "get that boy on Ritalin", and threatens to call DCFS if she does not. Will anyone ask the open-ended question that might reveal the dinner-time conversation two weeks ago, the night before this child's behavior so markedly changed: the conversation in which the little boy, acutely aware of his HIV+ father's recent decline, glared at his dad, over the mashed potatoes, and said, "If you die, I won't ever get over it"?

This is about adequacy of practice. This is about scientific rigor in our assessment. This is about bothering to know what the problem is before we apply solutions. This is a plea to give attention to the stories, wherein the data often lie.

I see a little girl who watched as her mother's boyfriend murdered her baby brother. She was a toddler, at the time. She escaped with only a few cigarette burns, and everyone hoped she wouldn't remember, that the evidence of this awful time would drift away, once she was swaddled in the arms of a new family who could love her.

And she *has* thrived. She is an extraordinary first-grader, now, and I have been blessed by these years of looking after her adoptive family. Her acting out always skyrockets in June, as we approach the anniversary of her brother's death and her loss of the mother who just sat and watched it all. Her play reveals profound guilt that she did not save her brother, but no anger at her birthmother, and no memory of the man who wreaked havoc in this family.

But this year, in June, another element emerged in this child's story, and the adoptive family is finding it hard to take: She has begun to idealize her mother (whom she has not seen since she was a toddler). She speaks of her daily. She does not say she wants to see her; she merely notes that everything the adoptive family tries to do for her has already been done—and better, bigger, more wonderfully—by her birthmother. The trip to Disney World in August? "Oh, Monica already took me there, when I was a baby".

Monica didn't, of course, but that's not the point, is it? The defense is obvious to most of us. But the solution may not be. The doctor, of course, wants to increase her meds to control this new agitation. The school will undoubtedly want a new evaluation, if she is still confabulating and jumping around a month from now.

But the truth is that I need to help her more with this story of hers. Working through her adoptive parents, I have not done enough to help her develop a coherent one. She is struggling to create one that makes sense to her, that will help her survive the fear and rage and guilt and confusion that walk with her each day. Of course she has not been able to face a narrative that includes a mom who just sat there while a man burned her and killed her brother, but I have to find a way to help that part of the story become tolerable, and become an integrated part of the whole story. It's a tall order.

With every family, every baby, every situation: hearing the stories is our responsibility. It is one of the greatest contributions of the psychoanalytic roots of our field. Practical and theoretical advances in narrative medicine (Charon, 2006; Fadiman, 1997; Kleinman, 1988), and narrative therapy (Beels, 2001; Lacher, Nichols and May, 2005; White, and Epston, 1990) are emerging to encourage and guide us further.

I propose a basic re-commitment: to close the laptop, put away the bag of toys, and ditch the intervention strategy for long enough to *listen*, to fulfill our scientific and human obligation to *witness*.

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