Tell Me a Story: The Therapeutic Metaphor in the Practice of Pediatric Occupational Therapy

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In the crafting of therapeutic intervention, pediatric occupational therapists are challenged to provide therapeutic modalities that are as stimulating and imaginative as the child's world, while offering appropriate and meaningful solutions to the child's problems. Storytelling, coupled with the visual, auditory, and kinesesthetic stimulation of guided affective imagery, offers a stimulating treatment approach for both the child or adolescent and the occupational therapist. This paper provides an overview of the use of storytelling, metaphorical forms and expressions, and guided affective imagery in occupational therapy with children.

The story is one of the most powerful forms of communication. Oral and written traditions in the form of fairy tales and stories are evident in every culture's heritage. Over the years, stories have been used by human beings as a means of transmitting important sociological, cultural, and moral information from one generation to the next.

Fairy tales, poems, and parables all make use of a literary device known as metaphor to convey an idea in an indirect yet paradoxically meaningful way. Recognition of this special power of the metaphor has been used by every parent, grandparent, and teacher who, observing the saddened features of an unhappy child, sought to console and nurture by relating an experience with which the child could intuitively identify and thus feel better. Bettelheim (1975) examined the use and value of fairy tales. He maintained that the fairy tale was a unique art form. It not only entertained children, but also told them something about themselves, encouraged their personality development, and offered them meaning on many different levels. Bettelheim claimed that “children can learn more about human beings’ inner problems and about adaptive solutions to their predicaments from folk fairy tales than from any other type of story they can comprehend” (p. 11).

Fairy tales convey the advantages of moral behavior through stories that seem meaningful and right to the child. The fairy tale offers examples of both temporary and permanent solutions to problems. Bettelheim (1975) also pointed out that the characters in fairy tales are either good or bad, work hard or are lazy, are stupid or clever. Such polarization, which is characteristic of the young child’s own thinking, permits the child to understand the difference between the two extremes. Contemporary stories represented in such films as Star Wars (Lucas, 1977) and Batman (Burton, 1989) present the same conflict between good and evil, the same combination of fantasy and resourcefulness with which the heroes or heroines overcome their enemies, and the same ultimate triumph of good over evil that fairy tales have long offered. Motion picture cartoons, from “Mickey Mouse” (Walt Disney Company, 1930–Present) to “Ninja Turtles” (Barron, 1990), portray similar conflict resolution. Developmentally, the adolescent is better prepared for gradations in elements of good and evil and is more influenced by an explanation of complexities rather than direct polarization. Films and books written for teenagers, such as the films Rumble Fish (Coppola, 1983) and Pretty in Pink (Deutch, 1986), present examples of such material.

Characters from biblical stories, like the Good Samaritan and the Prodigal Son, have filtered into virtually everyone’s everyday linguistic and behavioral repertoire. Proverbs, which are brief metaphorical statements, are familiar to most of us. “People in glass houses shouldn’t throw stones” and “A rolling stone gathers no moss” are
examples. All proverbs make points in simple, oblique, and very effective ways.

Metaphorical statements in tales and stories tell listeners or readers about the human condition in particularly graphic ways. The story of *Cinderella* (Perrault, 1967) noted the subjects of child abuse and dysfunctional families, and *The Ugly Duckling* (Andersen, 1967) and *Rudolph, the Red-Nosed Reindeer* (May, 1958) described the cruelty of peers to the atypical child long before society offered any formal recognition of these conditions through protection or treatment. Each of the major characters in *The Wizard of Oz* (Baum, 1900/1969) carries an imagistic and potentially therapeutic message (i.e., the Cowardly Lion's search for courage). Metaphor can challenge the child and adult alike. Lewis Carroll was particularly astute at the delivery of complex metaphors to both children and adults in *Alice's Adventures in Wonderland* (Carroll, 1866/1969), as exemplified in the conversations between the March Hare, the Hatter, the Dormouse, and Alice.

The metaphorical form may present new or alternative ways to approach information. Most occupational therapists working in pediatric settings are presented with a complexity of symptomatological behaviors that may or may not carry a specific diagnosis. The metaphor, then, offers a form that is familiar to the child and adolescent and one that can be used by the occupational therapist in virtually any therapeutic interchange to offer positive behavioral choices. Offered below are explanations of metaphorical forms and examples of therapeutic uses for a variety of clinical concerns seen in pediatric treatment settings.

**The Structure of Metaphor**

According to Winner (1988), “metaphor was often treated as a frill, a deviant, decorative aspect of language” (p. 5). In the 1940s and 1950s, metaphor attracted the interest of psychologists and linguists. In his 1957 text, Skinner described the metaphor in terms of reinforcement. He emphasized the sharing of sensory qualities between the old stimulus and the new stimulus provided by the metaphor. From that time and through the 1970s, the metaphorical form became a central theme of study. Hassibi and Breuer (1980) described the study of psycholinguistics as an effort to “dovetail what is known or postulated about human behavior with what is known or postulated about the composition and semantics of language” (p. 87). The field of psycholinguistics, therefore, provides us with a basis for understanding the potential influence of metaphor and the story form on behavior.

Metaphor, simply, is something that means something else. The speaker of the metaphor, according to Cooper (1986) “means metaphorically something different from what the sentence means literally” (p. 67). In its meaning, the phrase “The grass is always greener...” does not refer to the color of the grass, but to our frequent shared belief that unrealized opportunities are better than what we are presently experiencing.

Milton Erickson was extraordinarily skilled at crafting the metaphor for therapeutic outcomes. Rossi, in describing Erickson’s work, believed that the metaphor presented a means of communicating simultaneously with both the conscious and the unconscious minds (Rossi, O’Ryan, & Sharp, 1983). While the conscious mind is given one message in the form of a story or image, the unconscious mind may receive another message through implication. This message may be delivered either intentionally or unintentionally. Erickson’s metaphorical communications were often expressed in the form of a joke or abbreviated anecdote (Haley, 1967, 1973).

Linguists Bandler and Grinder (1975a) observed Erickson using storytelling with patients. From their observations, they developed a linguistically oriented framework to explain and understand how metaphor works therapeutically. An understanding of the potential therapeutic power of the metaphor can be aided by their analyses.

In their formulation, Bandler and Grinder (1975b) proposed that the metaphor operates on a kind of triadic principle by which its meaning moves through three different stages, as follows:

1. “The metaphor presents a surface structure of meaning in the actual words of a story,
2. which activates an associated deep structure of meaning that is indirectly relevant to the listener,
3. which activates a recovered deep structure of meaning that is directly relevant to the listener.”

(Bandler & Grinder, 1975b, p. 21)

This description of what occurs in response to a metaphor accounts for its therapeutic significance when the patient reaches Stage 3, at which time meaning is directly relevant to the listener.

**The Therapeutic Uses of Metaphor**

Grinder and Bandler (1976) discussed ways that people relate to their world. People seldom operate immediately upon the world they live in, but rather, they use a map or some kind of personal representation to guide their behavior. This representation is created through the dynamics of generalization, deletion, and distortion of experience. Children demonstrate these processes of human modeling early in their behavioral, linguistic, and cognitive development, and these processes of human modeling are adaptive for most. It is only when there is great distortion between the child’s or adult’s representation of the world and the real world that discomfort and dissatisfaction is observed through maladaptive behavioral changes.

Winner (1988) described research to indicate that
Children as young as 4 years of age are able to comprehend a metaphor if the comprehension task is made as easy as possible and if the child has some previous understanding of the topic. Children as young as 3 or 4 years of age are also able to produce simple metaphors themselves. Winner (1988) suggested that, if understood, metaphor serves the same cognitive function for children as for adults, that is, "to explain, clarify, and to illuminate" (pp. 184–185). To understand the speaker's meaning in delivering a metaphor requires only that the listener have enough knowledge of the topic and method of delivery to discover the match between them.

Children sometimes pretend before they can speak. They feed imaginary food to dolls or to imaginary playmates. They may pretend to be asleep or to cry. A length of modeling clay becomes a snake. A block of wood may be a truck. Children's ability to move comfortably between imagination, pretense, fantasy, and reality permits them to discover metaphorical meaning in a story.

Linguistic metaphors may function in therapy as educational tools. They provide options beyond the child's immediate experience and are most effective when cognitive systems are intact. According to Hassibi and Breuer (1980), the use of verbal direction and linguistic inuendo or metaphor with the child who exhibits severe disordered and distorted thinking through language and behavior is likely not to be the most effective therapeutic intervention. With this child, more concrete, active forms of metaphorical communication may prove more useful.

Occupational therapists, then, may find metaphors and metaphorical techniques useful as educational or teaching tools with which to provide options that the child may not have been aware of, as a means for therapeutic communication when direct communication is not effective; or as motivational tools to stimulate change in a positive direction. Because of their implicit indirectness, metaphors can be powerful tools for reaching even the most fearful, rigid, suspicious, or street-smart child. In some cases, the circumstances of the child's or adolescent's occupational index may be such that his or her world appears too varied and rich, thus assistance in narrowing choices and in selecting realistic options are needed. A too-rich universe of choices could be used to describe the perceptions of some adolescents who are suicidal. For these children, this richness of opportunity may be translated into their own perceptions of inadequacy and hopelessness.

For some children, it is necessary to provide a metaphor to define the problem in a personal way. This is particularly true when parents or society has identified the problem for the child, as in cases of truancy, substance abuse, or law breaking. The motivational metaphor provided to the child should then contain a symbolic representation of his or her hopes, as well as fears of the consequences of failure. For many of these children, hopes might be accurately translated as money, peer es-

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Metaphorical Forms in Therapy With Children

Mills, Crowley, and O’Ryan (1986) offered a comprehensive overview of the literature on the use of metaphor with children and adolescents. In their examples, metaphor and storytelling served as either the primary or ancillary treatment modality in cases dealing with an abusive parent; bed-wetting; negative classroom behaviors; foster placements; pediatric hospitalization; and generalized learning, behavioral, and emotional problems. These case examples reported the use of metaphor to be successful as a communication tool that appeared to mediate therapeutic change in a meaningful, imaginative way. They indicate that for the young child and often for the older child, a verbal story is reinforced by asking for description from the child or follow-up actions. Thus the term metaphorical form may be used to describe a multitude of variations that may enhance the verbal storytelling technique.

The following example from the work of Mills et al. (1986, pp. 30–32) demonstrates a metaphorical form in the guise of “The Monsters and the Cupcake.” The child described is 8 years old, and the focus of therapy is her fear of monsters in her bedroom, expressed as sleeplessness. The story recounts how monsters were really make-believe disguises for unhappy children who had no friends. These friendless children dressed up like monsters to create lots of attention in order to get the other children to notice and like them, but instead, they only succeeded in scaring the other children away. The child was then asked to describe how the monsters might feel from her observations of the movie E.T. (Spielberg, 1982) and how Elliott had given E.T. a gift so as to initiate friendship. The child was asked to go home and do the same for her monsters; thus the cupcake was chosen. Over the course of several weeks of verbal reminders and multiple cupcakes, the child was able to sleep.

Developmentally, children tend to focus earlier on seeing, hearing, and doing as means of receiving information. For young children and some older ones as well, verbally communicated metaphors may not be appropriate for the child’s representational system. Occupational therapists will recognize the use of dolls and doll play or drawings to depict peers or family members, which are examples of metaphorical forms or expressions. Psychodrama, sociodrama, and role-playing for adolescents could also be described in this way, particularly if the focus is on someone else’s problem. Efforts to relate the completion of a craft project to life behaviors uses metaphorical relationships. Living metaphors, such as planting and caring for a small garden or a plant or caring for a pet, can offer metaphorical meaning to a child who feels unable to control elements in his or her surroundings (e.g., loss of a parent through divorce or death, physical or sexual abuse, terminal illness such as leukemia or AIDS). A similarly effective metaphor described by Crowley and Mills (1986) might be kite flying to help the child graphically understand the emotional repercussions of what happens when one holds on or lets go. Other metaphorical games, such as tug of war, can present this same concept to a group of children.

Asking a child in physical pain to create a pain-getting-better book was reported by Kelley, Jarvie, Middlebrook, McNer, and Drabman (1984). This activity involved three stages: (a) how the pain looks right now, (b) how the pain looks when it’s all better, and (c) what will help the first picture change to the second one. Scott (1978) described similar work dealing with the perceptions of pain as expressed through visualizations generated by children. I have found this technique effective with young children using finger paints on very large pieces of paper. I have invited the children to roll, jump, or run on the paper with their choice of bright (most often red or yellow) paint on their hands, feet, and body. The resulting paper was then ritually thrown away or destroyed. In one case, the paper was burned at the child’s request (the child stood close enough during the process to feel the heat and the cooling). These particular incidents were used to visually and kinesthetically depict the pain going away when there was recurrence.

Personalized, shared picture storybooks have been created and used in therapy with children who are terminally ill and with their siblings. Collecting and making photographs of the children in shared activities permits one to keep a metaphorical record of their relationship that can be used to provide closure for the surviving child and family. Robertson and Barford (1970) offered a case description of their use of story making in the therapy of a chronically ill child. A photo record is a graphic representation of story making.

The scripting, creation of a storyboard, and actual videotaping can be equally effective for the older child and adolescent when used in this way. Filmmaking, although a more enthusiastic therapeutic venture, is an extremely effective metaphorical visual, auditory, and kinesthetic project, as reported by Arnott and Gushin (1976). Audiocassette recordings of personalized stories and fairy tales for the child to imagine and visualize have been used by Levine (1980) to treat childhood sleep fears and insomnias. I have also found the use of audiocassettes to be effective in providing continuous reinforcement between therapy sessions, particularly in the recording of new stories that the child has not previously heard.

Living metaphors can be generated in direct relation to the presenting problem or can simply be a more generalized sensory assignment used for other therapeutic gains. Examples of sensory assignments, in addition to those already described, might be a photo album, journal or diary, and “me” visual collages. The use of the magazine collage to track progress through the therapeutic experience might be described as a metaphorical treatment tool.
The Brothers and Sisters Emergency Care Program Comic Book Project was described by Mills et al. (1986). The comic book, entitled “Gardenstones: Fred Protects the Vegetables,” was designed for use with children who had experienced serious physical or sexual abuse and had been removed from their homes. Kagan (1982) also reported success in storytelling and game therapy with children in foster placement. This kind of a project stimulates tremendous potential for group therapy with children experiencing environmental stress such as gang-boundary violence, peer pressure for substance use, and peer pressure for early sexual activity. The public message to “just say no” to these pressures is of little use to most children who live daily with such stressors. I have found the comic book project useful for young children with an alcoholic or abusive parent. Such a project can incorporate several elements: the child’s direct fears, such as physical or emotional punishment to self, the other parent, or siblings; self-imposed guilt and inappropriate owning of the problem; and realistic expected outcomes. The comic book or comic strip projects were also useful, in some cases, when shared with the parents. As an extension of this, Brink (1982) described the use of metaphorical intervention as a conjunctive technique in family therapy, particularly when the family has inappropriately targeted the child as the problem.

The young child and developmentally delayed older child may organize their experiences kinesthetically. These children may benefit more from playing out the metaphor or by seeing it being played out. Dramatic productions or puppetry may be used to enhance the story for these children. In my own work with children of all ages, I have found personalized one-dimensional puppets mounted on sticks that exhibit the child’s photographic image to be very successful.

The older child, and sometimes younger ones, may benefit from telling a story or by creatively enhancing a known fairy tale or story in his or her own words, rather than just listening. Gardner (1971, 1972, 1974) and Schooley (1976) described this as mutual storytelling. The stories may be elicited from the child’s own imagination and may be enhanced by the therapist as well. An extension of this form is the group storytelling experience in which each child in the group is invited to tell a piece of the story if he or she wishes to do so. Allan (1978) described his approach to this technique as serial storytelling. This can be a very effective way for group members to share experiences with their peers and thus encourage group cohesiveness. The children’s own stories or pieces of stories can provide a wealth of indirect information on family systems, relationships at school or play, concepts of self, and personal expectations. From this information, the therapist can develop a scenario of desirable circumstances and alternatives for the building of further metaphors.

The Provision of Verbal Metaphors Through Guided Affective Imagery

Once ostracized as a contrived mechanism of the magician, imagery has again become familiar to us through a recognition of the basis for relaxation, biofeedback procedures, and counterconditioning. It has been used effectively in the treatment of chronic pain and to enhance cancer therapy (Achterberg & Lawlis, 1984). The use of guided affective imagery and fantasy with metaphorical forms may provide opportunities for children whose normal developmental patterns have been altered through physical, emotional, and cognitive disability. Providing therapeutic experiences to assist the child to learn, explore, and be effective has been recognized as an appropriate and necessary goal of pediatric occupational therapy treatment (Adelstein, Barnes, Murray-Jensen, & Baker-Skaggs, 1989; Florey, 1989; Kielhofner, 1989). For the dysfunctional child who may be restricted from the development of environmental exploration, substitute exploration through imagery and metaphor may provide valuable experiences. For these children and for many others, the coupling of the metaphorical story with guided affective imagery and fantasy may help protect against distraction and may be more engaging for the child and therefore more effective. Assisting through imagery with an enactment or replay of an experience or fantasy is a useful visual, and sometimes auditory, device. Engagement in fantasizing and exploratory play is certainly an important aspect of every child’s occupational behavior. Not only can free exploration occur through imagery, but also, the child can safely express fears and act out problems through fantasizing his or her own experiences or those of a character in a metaphorical story. The older child can benefit from imaged opportunities to practice social experiences and peer interactions without fear of being ostracized.

The term guided affective imagery indicates that the therapist assumes direction and provides control to the fantasy or metaphorical expression. Fantasy and metaphorical storytelling are not necessarily synonymous. Opportunity for fantasy is presented when the story permits the child to enter the scene and participate. This is more easily done when the circumstances are controlled and the child is protected from environmental distractions.

Classically, guided affective imagery has been more widely practiced in Europe than in the United States. Leuner, Horn, and Klessmann (1983) offered the explanation that European children have a more extensive exposure to the imagery provided by fairy tales, reading, and parental or family narration. American children may be losing the practice of reading or of storytelling in favor of the visual and auditory continuous storytelling experience of television and videos. Visual storytelling experiences prevent the child from creating his or her own
visualization of what is an auditory experience. Although many children appear to use television characters for their own fantasy experiences in free play, I have found the guided affective imagery technique effective for perhaps the reason that it is novel for many children. It is accepted and welcomed as an innovative approach by children who may not read or read well or who have not been the recipient of creative storytelling or of a story read to them.

Although guided affective imagery has not been directly linked to therapeutic metaphorical expressions in the literature, it is often described in a similar fashion. Leuner et al. (1983) referred to filmsstrip thinking, in which the therapist suggests imaginal motifs and can further intervene by suggesting the direction and flow of images. He or she can direct the symbolic processes and can help to interpret meaning. Elkins and Carter (1981) reported their use of science-fiction-based imagery as the primary treatment technique for children and adolescents between the ages of 6 and 13 years. In their approach, the child was invited to go for an imaginary ride on a spaceship. In the course of the trip, the therapist introduced those characters and events which were needed to help resolve the child’s problems. Success with the use of this particular technique was reported in the treatment of adverse reactions to chemotherapy, anorexia-associated symptoms, and school phobias. Developmentally and experientially, children will respond at differing levels to the use of guided affective imagery and metaphorical problem solutions.

A Model for Application of Auditory Metaphorical Expression and Guided Affective Imagery

Because most children are not accustomed to the techniques of guided affective imagery and may not initially be able to direct their attention and concentration to the imagery, one must establish an appropriate practice atmosphere for the learning of these skills. In developing therapeutic readiness with children, I have found it necessary to provide a relaxing, nonthreatening setting with limited distractions. Children and adolescents are particularly receptive to the idea of a therapeutic situation involving an altered environment. Subdued lighting, comfortable positioning, and closed eyes (or sleep masks) can become recognizable indicators of a “readiness for therapy.” When treatment has been with an individual child, it has been helpful to physically cradle the child and sit on the floor or assume the positioning the child seems to find most comfortable. With a small group, it has been most comfortable to sit or recline on floor mats. The children are then asked to visualize in their mind’s eye a countdown procedure akin to their previous experiences. Therapists who have used relaxation techniques will recognize this as an approach to a relaxed state of readiness for the receiving of therapeutic messages. Some children have verbalized that they see themselves walking down a flight of stairs to a pleasant place from their memory or present experience; one child reportedly counted clouds while lying on his back after a soccer match. Individualized counting such as this seems to be more effective for the older child; for the younger child, the therapist may wish to prescribe the count, as is done with the large, primary colored numbers used on “Sesame Street” presentations. The therapist counts slowly from 1 to 10 in a subdued but clearly audible tone while interjecting short relaxation instructions. The children are asked to see the numbers as they are counted aloud by the therapist. At the count of 10, the scene is set. When group members have had several sessions, the therapist may instruct them to create their own fantasy scene (i.e., their private and safe place). However, maximum structure is offered in the initial sessions until the children feel safe and comfortable and to ensure against random daydreaming.

I have found the use of a tactile object helpful to set the scene for the story. Most children have some associated memory with the glass snow domes, and one of these is passed around the group before the session. They are easy props to acquire and are an excellent shared experience with which to initiate therapy. The particular dome I favor exhibits a miniature village with lighted windows in the cottages.

When we have completed the countdown and the children are in a relaxed state, they are asked to come with the therapist inside the dome. We go as a group, but it is suggested that if the children find they are uncomfortable, they may image themselves standing outside with their noses pressed to the cool smooth glass and watch (this is a role they may have become accustomed to, particularly if they are emotionally, cognitively, or physically dysfunctional). They are then asked to walk together down the path. As we move along, we “feel” the snow on our faces and “taste” it on our tongues. We can “hear” snow crunch under our feet, and occasionally we will “hear” a car in the distance or a plane overhead. There may be other sights or sounds suggested by one of the children. As we begin to feel cold, each child is asked to select a house that he or she likes and is invited to go inside. The children then remove their coats and sit close to the fire, “feeling” the warmth on their faces and “seeing” the little streams of water as the snow melts on their mittens. They may “smell” the smoke from the fire. One child consistently introduced the “smell” of baking cookies coming from the kitchen. At this point and at other points in the imagery, the children who may be watching from the outside are invited to come in and walk or sit by the therapist. Occasionally, a child will physically move closer to the therapist following one of these suggestions. The therapist should constantly be attentive to the movement of group members and sensitive to their nonverba-
Iized needs. Again, the time spent in readiness is determined by the needs and tolerance of the child or group.

When everyone is comfortably settled, the telling of the story begins. It is sometimes a story told by someone the child images in the room (e.g., a family member, a favorite teacher, a television character, a fantasy figure). Some children prefer to "see" the story unfold on a screen or in a picture book. Others, particularly older children, see themselves and others as actors in a play.

The most effective story is told with multiple options. If the children share sufficient experience to make it meaningful for more than one, it can be individualized. Adolescent boys and girls are engaged by differing kinds of stories, and it is sometimes difficult to tell a story with the proper mix of action and romance favored by both sexes. A story that does seem to engage both groups has been Shakespeare's (1594-1595/1978) Romeo and Juliet. This particular story has been represented in stories, in plays, and on film. It has been popularized through time in a multitude of ways and can easily be adapted to the culture and social norms of the group. Hero or heroine stories are also popular. A contemporary version of Beauty and the Beast (Anonymous, 1889/1967) is another story that mixes action, romance, and morality. The older child seems to respond well to consciousness-raising or values-clarification stories, particularly when such stories deal with relevant issues.

Young children seem to prefer to find their message in stories of fantasy characters or personified animals. Again, mixed groups of boys and girls are more difficult to engage than single-sex groups, but in many instances, the social mix of the group and the sharing of a story, particularly concerning values, is more relevant when boys and girls are together.

Following the telling of the story by the therapist, each child prepares to join the others on the path and all exit the dome together. The reverse count of 10 to 1 is then given with accompanying relaxation messages. The sessions are usually 30 minutes but can be longer for older children. Adolescents frequently want to discuss the story, particularly the actions of the characters. These communications are integral to the therapy and are always encouraged. With very young children, the story is often the therapeutic intervention and the child is then observed in play and in peer and family interaction for any changes in behavior that may be related to the therapy. Actions of kindness may be observed as a response to stories representing kindness to animals. These stories share an important element of meaningful reward for good behaviors, and this is very important to the young child. Aggressive actions may also be witnessed following a story. Because each child finds his or her own meaning in the particular story, it is often helpful to ask the child, individually, to retell the story when one observes negative behaviors. The story can then be retold later by the therapist in what would be a more therapeutic way for the particular child. In the young child, the therapeutic process unfolds most often without verbal interpretation.

A review of the previously described experience will denote a mix of visual, auditory, and kinesthetic cues used throughout the session. Metaphorical storytelling, fantasy, and shared group experience are also key elements of the process. The approach is both fun and effective because it taps the resources of each child to initiate a quest for answers, and it does so within the context of shared experience. The perceptive reader will recognize throughout this description the importance of the group and the child's membership in this shared experience. Even if the child is seen individually, the therapy is supplemented by play and social or skills groups to observe behaviors and interactions. The use of the group process is integral to successful pediatric practice in almost all circumstances, whether the child has an emotional, cognitive, or physical disability. Storytelling sessions with the use of guided affective imagery or storytelling alone can easily be coupled with other forms of metaphorical expressions, such as doll play, fantasy-oriented board games, and the graphic representations mentioned earlier. These can be accomplished in dyads or individually to supplement the larger group process.

Summary

Occupational therapy is essentially a process of providing people of any age with more options and choices in the matter of how they behave or respond in various life-challenge situations. Therapeutic metaphors and guided fantasy offer choices to children in an appealing and effective form without verbal or behavioral prescription. Those to whom stories are told can use the content in their own ways and can take from them those meanings that are particularly applicable to their present circumstances. Therapy seldom consists of simply telling or showing people what to do. Occupational therapy, particularly, is more a matter of helping people to see things differently, to present them with options, and to help them feel differently about the things they see. For the child or adolescent, the presentation of choices in the guise of a story, based on the therapist's greater information, experience, and craft, is often enough to mediate change. To be effective as a pediatric occupational therapist, one must be particularly aware of the unique organizing principles of occupational behavior (Kielhofner, 1985) viewed within the prescriptive domain of the cognitive and developmental configuration. In addition, the therapist must subscribe to behavioral, developmental, and cognitive approaches to treatment. Perhaps in no other area of occupational therapy is there an emphasis more closely aligned to what could be described as an eclectic model of practice.

Children and adolescents offer a challenge to the occupational therapist in any treatment setting, but most
certainly where psychodynamics and behaviors are targeted for treatment. Traditional modalities and play techniques are often not enough to interest the child or to note significant differences in the child’s behavior or state of comfort and well-being. The child’s daily environment is often rich in imagery; it is necessary that modalities keep pace with that richness while developing new challenges for the child.

This paper has provided a discussion of optional techniques useful in therapeutic intervention with children and adolescents. These techniques have been presented not as ends unto themselves but as stimuli to guide the occupational therapist’s creative imagination toward more meaningful therapeutic outcomes.

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