

Utilizing Storytelling to Promote Emotional Well-Being of Children With a Distinct Physical Appearance: The Case of Children Who Wear Eyeglasses

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Abstract

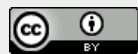
This study explored the effectiveness of storytelling in supporting children with unusual physical traits. Participants were forty-eight children, aged 9 – 12 who, due to various eye diseases, wear eyeglasses. They completed various standardized self-report measures, both before and after participation, in one of the six intervention groups. The measures assessed shyness and social anxiety symptoms, loneliness and social dissatisfaction, perception of negative evaluation, satisfaction with one's appearance, and anxiety regarding physical appearance. The intervention consisted of six 90-min group sessions and included both individual and group activities. The results lend support to the hypothesis that storytelling can significantly contribute to the emotional well-being of children, with a distinct physical appearance.

Keywords: children, emotional health, eye diseases, Group Narrative Intervention

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Introduction

According to the theory of social constructivism, the concept of identity formation is to be found within the social realm. That is, our identities are not fixed but fluid and they arise, not from inside us, but from the interactions and discourses that we encounter on a daily basis (Burr, 1995). Inevitable, in such a context, dominant cultural discourses have the power to shape identities. Thus, people who deviate from some social norm, might get trapped into internalizing deficit-based descriptions as authoritative versions of who they are. On the other hand, from an information processing perspective, we are inclined to jump to conclusions about the underlying personality of other people based on limited or biased information about them (Dion, Berscheid, & Walster, 1972; Pronin, 2007). Specifically, according to Pronin (2008), we tend to judge others either based on external appearances and behavior, or according to how we think we might feel if we were in their position. Thus, both perspectives demonstrate the disadvantaged position in which children with a special trait in their appearance, might find themselves. They also highlight the need for novel and effective preventive interventions for those who are more likely to become targets of discrimination, prejudices and negative stereotypes within school settings.

Many children can be cruel toward the peer who deviates even slightly from some social norm, whether of appearance, ability or ethnicity (Macklem, 2012). For example, they are notably judgmental towards other children with unusual physical traits (such as obesity, macrotia, growth retardation, children who wear glasses, braces, etc.), as they tend to confuse those traits with personality traits (Janssen, Craig, Boyce, & Pickett, 2004). In addition, research conducted to study the phenomenon of verbal victimization shows that children who are less physically attractive, have visible abnormalities, are overweight and have some sensory disadvantages (vision, speech, etc.) are more likely to be targets of teasing, name calling and bullying than their peers. These risk factors are deemed important regardless of gender and nationality (Sweeting & West, 2001).

There is a consensus among studies regarding the negative impact that stigmatization has on the life and emotional well-being of the affected individuals (Houbre, Tarquinio, Thuillier, & Hergott, 2006; Kumpulainen et al., 1998). In many cases, children with an unusual physical appearance are likely to have low self-image and self-esteem (Rigby & Slee, 1993), since peers' critical comments about their external appearance make them think and believe that they are indeed "weird" or "different" in some way. Furthermore, there are often clear indications of psychological problems in stigmatized individuals, such as stress, depression, shyness, social anxiety and anxiety regarding physical appearance, and dissatisfaction regarding their external image (Glaser, Prior, & Lynch, 2001; Rigby & Slee, 1993).

As far as children and adolescents who wear glasses are concerned, the available evidence rather suggests that the negative stereotypes that adults attribute to those who wear eyeglasses tend to generalize to primary school children (Jellesma, 2013; Terry & Macy, 1991; Terry & Stockton, 1993). For example, primary school children were presented with pairs of slides of similar aged children, photographed with and without eyeglasses (Terry & Macy, 1991). It was found that eyeglasses increased negative judgments and decreased positive judgments, especially when they were worn by girls, regardless of whether the child making the judgment was in the 1st or 3rd grade (Terry & Macy, 1991). Jellesma (2013) conducted a literature review and arrived at the conclusion that children have positive and negative stereotypes of peers with eyeglasses; however, wearing eyeglasses can negatively affect physical self-esteem. In a UK study examining data from a national representative sample of more than 6,500 children (Horwood, Waylen, Herrick, Williams, & Wolke, 2005), it was reported that children currently wearing eyeglasses or with a history of wearing eye patches were 35% to 37% more likely to be victims of physical or verbal bullying, even after adjustment for social class and maternal education. The authors conclude: "For those children who require glasses, opticians should be aware of the risks of bullying, and strategies should be developed and discussed that help reduce their vulnerability" (Horwood et al., 2005, p. 1177).

Other studies focusing on children and adolescents with reduced vision show that they tend to be lonely and isolated from their sighted peers. They have fewer friends and dating experiences, more problems in their relationships with peers, and fewer opportunities to develop their interpersonal skills than do children who are sighted (Huurre & Aro, 1998, 2000; Huurre, Komulainen, & Aro, 1999; Kef, 2002; Lifshitz, Hen, & Weisse, 2007; McGaha & Farran, 2001; Rosenblum, 1998). As a result, they may be at increased risk for developing feelings of inferiority and low self-esteem, depressive symptoms or psychological problems (Abolfotouh & Telmesani, 1993; Beaty, 1992). Although some children with low vision appear to be relatively well integrated and accepted by their sighted peers, others fail to do so. Thus, researchers and clinicians alike, have recognized the need to develop interventions to aid visually impaired children who are unsuccessful in the interpersonal domain (Rosenblum, 1998). In this article, we present a unique research intervention that promotes the wellness of children who wear eyeglasses through the use of storytelling.

As a fundamental technique of the narrative approach, story-telling is frequently used to give clients an internal experience of something that they are struggling to comprehend or to provide a road map of their life. In the case of children, stories can have the following advantages: (a) hearing a story about a character might be easier for the children to digest than something directly related to their life, (b) stories enable clarity on a problem that the children are struggling to understand and (c) there are many ways to perceive and interpret a story, thus leaving the child free to construct the meaning of the story from their own perspective. In that way, stories help the child reconstruct meaning for personal growth and solve problems in a constructive way. In addition, they act therapeutically because, as children identify with the story's main characters, they process the hidden meanings of the story in the light of their inner conflicts or consider what they would do if they were in their characters' shoes. To sum up, stories could be used to stimulate insight and behavior change, communicate subtle messages to children, and help them externalize and resolve internal conflicts or shake off labels that have been attached to them by peers and adults over the years (Divinyi, 1995; Lévi-Strauss, 1974).

Empirical evidence supports the efficacy of storytelling for addressing the needs of children with emotional and behavioral problems. These include: decreasing intensity and frequency of non-compliance in young boys (Painter, Cook, & Silverman, 1999), working with pediatric oncology patients or older children who are critically ill (Freeman, 1991; Krietemeyer & Heiney, 1992), reducing vulnerability in high-risk Hispanic children and adolescents (Costantino, Malgady, & Rogler, 1994), and dealing with the trauma of abuse in sexually abused children (Rhue & Lynn, 1991).

Yoosefi Looyeh, Kamali, Ghasemi, and Tonawanik (2014) applied narrative group intervention to a group of boys aged 10-11 years old with social anxiety. The children were randomly assigned to the intervention and control groups. Boys in the intervention group, received fourteen 90-minute sessions of narrative therapy twice a week, in which storytelling constituted one of the main therapeutic techniques. Parents and teachers reported significant improvements in the social anxiety symptoms of the children in the intervention group compared to children that participated in a wait-list group. This was the first study demonstrating that primary school children with high levels of social anxiety, undergoing a narrative group intervention, can evidence significant changes during that experience.

The current study utilized a one-group pretest-posttest design to explore the degree to which well-being is bolstered among school-aged children wearing glasses, after having participated in a storytelling counseling intervention. It was hypothesized that greater levels of well-being and lower levels of shyness and social anxiety would be observed from pre-intervention (Time 1) to post-intervention (Time 2). For the measurement of childhood social anxiety and shyness, two scales were used [i.e., the Social Anxiety Scale for Children-Revised (SASC-R) and the Shyness Negative Affect Scale (SNAS)]. For the measurement of children's general well-being, several scales were used [i.e., the Illinois Loneliness Questionnaire (ILQ), the Self-Perception Profile for Children (SPPC), the Other As Shamer Scale (OAS) and the Social Physique Anxiety Scale (SPAS)].

Method

Participants

Participants were forty-eight children (30 girls, 18 boys) 9 – 12 years old ($M = 10.02$, $SD = .91$), attending mainstream primary schools in the municipality of Western - Central Macedonia, Greece. They were quasi-randomly assigned to 6 mixed-gender small intervention groups ($N = 8$), according to the geographical area of their residency.

A great effort was made to include both city residents (urban centers) and residents from the outskirts of the city (rural areas). No exact information was obtained on the socio-economic background of each individual child, but it should be noted that participating schools in urban centers were mainly attended by children from a middle to middle-high class background, whereas participating schools in rural areas were mainly attended by children from a middle to middle-low class background. Qualifying criteria for participation in the study were that the child: (a) wears eyeglasses to correct the reduced vision due to an eye disease (see [Table 1](#)), (b) did not have severe psychological or medical problems and were not on medication during the group intervention and (c) is cognitively able and emotionally ready to participate. All children provided assent before participating on a voluntary basis in the intervention program. Also, their parents were fully informed about the purpose of the study and procedures and provided their written consent.

Table 1

Gender and Eye-Disease by Group (Total N = 48)

Characteristic	n					
	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Gender (female:male)	2:5	7:1	4:2	5:5	6:3	6:2
Eye-Disease						
Myopia	3	3	5	6	8	5
Strabismus	0	0	0	0	1	0
Hypermetropia	1	1	0	0	0	1
Astigmatism	3	4	1	4	0	2

Instrumentation

Social Anxiety Scale for Children-Revised (SASC-R)

Participants' social anxiety was measured with the Greek version of the SASC-R ([La Greca & Stone, 1993](#)). The SASC-R is a 22-item scale that assesses children's subjective feelings of social anxiety during various social situations and its correlates, including avoidance and inhibition. Children are asked to state, on a 5 point Likert type scale, how often each statement was true for them (1 = never, 2 = almost never, 3 = sometimes, 4 = most times, and 5 = always). The factor analysis of the SASC-R has identified 3 factors: (a) Fear of Negative Evaluation from Peers (FNE), which includes 8 items (e.g., "I feel that kids are making fun of me"), (b) Social Avoidance and Distress Specific to New Situations (SAD-New), which includes 6 items (e.g., "I only talk to kids I know really well"), and (c) Generalized Social Anxiety and Distress (SAD-G), which includes 4 items (e.g., "It's hard for me to ask other kids to play with me"). For the present study, Cronbach's alphas were .77, .56, .52 at pre- assessment and .76, .61, .53 at post- assessment for the FNE, SAD-New, and SAD-G subscales, respectively. Children in the current sample scored approximately one standard deviation above the mean for non-clinical populations (as found in a prior study; see [Vassilopoulos, Brouzos, Moberly, Tsorbatzoudis, & Tziouma, 2015](#)), suggesting the presence of social anxiety symptoms (see [Table 3](#)).

The Illinois Loneliness Questionnaire (ILQ)

Participants' feelings of loneliness and social dissatisfaction were measured with the ILQ ([Asher, Hymel, & Renshaw, 1984](#)). This 24-item self-report measure contains 16 primary items that focus on: (a) children's feelings of loneliness

(e.g., “I feel alone”), (b) subjective estimations of peer status (e.g., “I have lots of friends”), or (c) feelings of social adequacy versus inadequacy (e.g., “I can easily work as a team with the other children”). The remaining 8 filler items focused on children’s hobbies or preferred activities (e.g., “I like painting”). Previous research has shown that the present scale has satisfactory psychometric properties (Hymel et al., 1983, as cited in [Hymel & Franke, 1985](#)).

Self-Perception Profile for Children (SPPC)

For the measurement of the concept of self, the Greek standardized version of the SPPC was used ([Makri-Botsari, 2001](#)). SPPC ([Harter, 1985](#)) consists of six separate subscales reflecting five specific domains (social acceptance, school capacity, athletic competence, physical appearance, and behavioral conduct) as well as global self-esteem. In the current study, only the subscale of physical appearance was administered. Participants answered on a four-point scale, where a score of 1 indicates low physical appearance satisfaction and a score of 4 reflects high physical appearance satisfaction. Cronbach’s alpha for the subscale of physical appearance in a Greek population is .74 ([Makri-Botsari, 2001](#)).

Other As Shamer Scale (OAS)

OAS ([Goss, Gilbert, & Allan, 1994](#)) includes 18 items and measures external shame (i.e., beliefs about how people think about the self). An example of an OAS item includes “I feel other people see me as not good enough” and “Other people see me as small and insignificant.” Children answered on a five-point Likert scale (1-5) (1 = Never True, 2 = Rarely True, 3 = Sometimes True, 4 = Often True, 5 = Almost Always True). OAS was translated into Greek by the authors and back-translated by another bilingual researcher. Satisfactory psychometric properties of OAS have been demonstrated in various studies ([Benn, Harvey, Gilbert, & Irons, 2005](#); [Gilbert, Allan, & Goss, 1996](#); [Gilbert & Miles 2000](#)).

Social Physique Anxiety Scale (SPAS)

The SPAS ([Hart, Leary, & Rejeski, 1989](#)) measures the extent to which a person experiences anxiety regarding his/her physique in social situations ([Hart et al., 1989](#)). It includes 12 items constituting a single factor. Participants rated each item using a five-point Likert scale (1 = Not True At All to 5 = Very True). An example of an SPAS item includes “I wish I wasn’t so uptight about my physique/figure.” SPAS was also translated into Greek by the authors and backtranslated. Inter-item reliability with student samples is high, according with [Hart et al. \(1989\)](#), with 12 item-total correlations at .50 or higher and a Cronbach’s alpha coefficient of .90.

Shyness Negative Affect Scale (SNAS)

The SNAS ([Henderson, Banerjee, & Smith, 1999](#)) was used to evaluate the negative affective states related to social anxiety. The scale includes 12 items and they constitute a single factor. Children are asked to state how often they experience an emotion, that is described in the statement, on a scale of 1 to 3 (1 = Never or Almost Never, 2 = Sometimes, 3 = Most of the Times or Always). Ten of the items of the scale refer to negative situations (e.g., guilty or feeling embarrassed) and two of them are filler items. [Banerjee and Henderson \(2001\)](#) reported satisfactory psychometric properties (Cronbach’s alpha = .74).

Group Leader

Group leader was one female PhD student in the Department of Primary Education, University of Ioannina. She had attended a post-graduate level group counseling and person-centered counseling course and was a career

counsellor by profession with counseling experience mainly in secondary schools. Supervision, which was provided by the first author on a regular basis, helped to ensure that the leader was appropriately following the protocol.

Throughout the intervention, the group leader implemented a person-centered way of facilitating the groups (Rogers, 1970), i.e., she was responsible for the development of a warm, friendly and tolerant group climate, showed deep respect for the child's abilities, and acceptance of his or her initiatives.

Procedure

Participants completed a battery of measures during the initial group session (Time 1) and completed the identical battery once again during the final group session (Time 2). We also obtained data regarding their gender, age, weight, height, and diagnosis associated with their eye disease.

The intervention sessions were conducted in an easily accessible, central location (e.g., local library, community center, etc.) that was comfortable visiting. In addition, the group room was spacious enough for the leader and participants to gather comfortably in a circle for discussion and sharing. Group participants received six sessions of approximately 90 minutes on a weekly basis. The group leader followed the same format for each session – an icebreaker game, followed by one or two group activities and their ensuing processing: however, the group program was not manualized.

The intervention was a storytelling intervention group designed to: (a) increase the emotional wellness of children wearing glasses due to low vision, and (b) decrease their levels of shyness/social anxiety or anxiety regarding physical appearance that can result from discrimination, social isolation, and negative stereotypes. In particular, we used a storytelling technique to help children (i) alter the way they perceive social interactions, (ii) explore, identify, and express their emotions in response to the emotions displayed by the story's main character, and (iii) explore issues that often make life difficult for people with low vision and develop problem solving skills.

The first session commenced with a discussion of rules including regular attendance and privacy issues, as well as with a team building activity ("name collage", "saying my name in different ways", "guess who" etc.), before the six self-report measures were administered. Several role play and psychoeducational activities drawn from various sources (e.g., Bacchilega, 1997; Bolton & Heathcote, 1999; Plummer, 2006) were adopted for use in the intervention sessions. The activities were introduced during the sessions in the following order:

1. An extract from the fairytale "*Malena's little eyeglasses*" (Artzanidou, 2009) was used in Sessions 2 and 3. To counterbalance female students' identification with the protagonist, for half of the groups the same story was slightly modified to present a male character "*Aristos' little eyeglasses*." The story is suitable for children aged over 7 years old and it is about a young child that wears eyeglasses too and, because of them, is the target of teasing and name calling at school. However, the story was further modified to avoid arousing unpleasant emotions in children. After the story is told, fun games and empathy activities were introduced ("pantomime", "painting", "captions", "rhymes", etc) and an effort was made to empathize with the story's main character. Both sessions terminated with fun activities ("one, two, three, stop" and "the game of words") which allowed the "emotional discharge" of the participants.
2. In fourth and fifth session, the group attempted, via various activities and group games ("article in a children's newspaper", "narrating and completing a story", etc) to retell the story in a problem-solving way by helping the story's character overcome the troubles that are related to his/her unusual physical trait. To this aim, the story's character reflected on and evaluated various strategies for dealing with the problems. The story

ended with the character feeling good about successful strategies, which resulted in positive changes in his or her life. The group leader helped children identify how they would act in similar situations and how their action might affect their lives. The sessions, once again, ended with fun activities (“the broken phone” and “the target”) which helped children relax and leave the session in an emotion-free state.

3. In the last session, group activities were introduced (“slogan- poster”, “the cover of the story” etc), that helped members organize and summarize ideas for taking responsibility and behaving differently in social interactions. The ensuing conversation focused on describing how new plans could affect children’s lives and how they could apply the alternative strategies in their interpersonal situations. There was also one last activity that involved saying goodbye to the group (“holding hands”). Finally, the same pre-test self-report measures were administered for a second time in order to detect any pre-post difference or improvement in children’s well being and emotional state.

Data Analytic Strategy

We conducted a 2 (Time 1 vs. Time 2) x 6 (measure type) repeated measures MANOVA using SPSS (v. 21) to determine whether there was an overall change from pre- to post-intervention on outcome measures. This was followed up with paired-sample *t*-tests on the change in overall scores on each of the six man measures. Where applicable, a Bonferonni correction for multiple comparisons was used to control for the family-wise error rate (Type I error). For effect sizes, we report [Cohen's \(1988\)](#) *d* statistics (computed by dividing pre- and post-test differences by the pre-test standard deviation), who also proposed the following conventional cutoffs: <.20 (small effect), .50 (medium effect), and >.80 (large effect; [Cohen, 1988](#)).

Results

All 48 participants finished the program, resulting in almost complete pre- and post-test data. Skewness and kurtosis statistics yielded non-significant results, indicating that the data are normally distributed and that parametric statistics are appropriate.

First, correlations among the variables of interest at pre-test were examined. As expected, social anxiety symptoms at pre-test (SASC-R) correlated significantly with children’s feelings of loneliness and social dissatisfaction (ILQ), $r = .55$, $p < .001$ as well as with perceptions of being negatively evaluated by others (OAS), $r = .64$, $p < .001$. In addition, satisfaction with one’s appearance (SPPC-PA) was negatively related to anxiety regarding physical appearance (SPAS), $r = -.68$, $p < .001$, and shyness (SNAS), $r = -.43$, $p = .002$. However, the magnitude of these associations ranged from moderate to highly correlated, suggesting that most of the scales measured different group outcomes. See [Table 2](#) for a complete description of correlations at pre-test.

Table 2

Intercorrelations Between Variables of Interest at Pre-Test

	1	2	3	4	5	6
1. SASC-R	—	.55***	-.38**	.64***	.58***	.61***
2. ILQ		—	-.42**	.79***	.49***	.71***
3. SPPC-PA			—	-.42**	-.68***	-.43***
4. OAS				—	.54***	.68***
5. SPAS					—	.50***
6. SNAS						—

Note. $N = 48$. SASC-R = Social Anxiety Scale for Children-Revised; ILQ = Illinois Loneliness Questionnaire; SPPC-PA = Self-Perception Profile for Children-Physical Appearance; OAS = Other As Shamer; SPAS = Social Physique Anxiety Scale; SNAS = Shyness Negative Affect Scale.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Following the analysis suggested by [Howell, Jacobson, and Larsen \(2015\)](#), we first conducted a 2 (Time 1 vs. Time 2) $\times$ 6 (measure type) repeated measures MANOVA to determine whether there was a pre-post difference on the outcome measures taken as a whole. As hypothesized, the main effect of Time was significant, Hotelling's Trace = 14.44, $F(1, 44) = 124.90$, $p < .001$, $\eta_p^2 = .74$, such that Time 2 scores consistently differed from Time 1 scores. [Table 3](#) also provides results of paired t tests regarding the change in overall scores on each of the six main measures from Time 1 to Time 2. Overall scores on the Social Anxiety Scale for Children became significantly lower from Time 1 to Time 2, with a large effect size. The Illinois Loneliness Questionnaire's overall scores showed a significant change in the direction of lower loneliness and social dissatisfaction, with a large effect size. Overall scores on the Physical Appearance subscale (SPPC-PA) became significantly higher from Time 1 to Time 2; the magnitude of this effect was medium. Overall scores on the Other As Shamer Scale became significantly lower across time, with an effect size that was medium to large. The change in Social Physique Anxiety scores was also significant and in the expected direction; the magnitude of this effect was medium. Finally, overall scores on the Shyness Negative Affect Scale showed a significant decrease over time, with an effect size that was large.

Table 3

Descriptive and Inferential Statistics

Variable	Time 1 (pre-intervention)				Time 2 (post-intervention)				Time 1 vs. Time 2	
	n	M	SD	α	n	M	SD	α	t	p
SASC-R	48	14.98	3.43	.62	48	10.58	2.81	.63	17.48	.001 (1.28)
ILQ	48	29.58	8.73	.86	48	21.79	5.83	.85	9.56	.001 (.89)
SPPC-PA	48	13.31	3.17	.81	48	15.15	2.57	.67	11.00	.001 (.57)
OAS	47	34.93	9.82	.83	47	27.42	7.12	.77	8.87	.001 (.76)
SPAS	46	29.30	8.57	.85	46	24.96	6.55	.78	7.61	.001 (.69)
SNAS	48	16.13	3.55	.75	48	12.77	2.53	.64	9.57	.001 (1.09)

Note. SASC-R = Social Anxiety Scale for Children-Revised; ILQ = Illinois Loneliness Questionnaire; SPPC-PA = Self-Perception Profile for Children-Physical Appearance; OAS = Other As Shamer; SPAS = Social Physique Anxiety Scale; SNAS = Shyness Negative Affect Scale. Numbers in parentheses are Cohen's d effect sizes.

In order to increase statistical power, we used the combined data from the six groups to perform the initial analyses. However, to investigate the efficacy of the intervention for each group separately the analyses were re-examined at the individual group level. Similar effects were found for each individual group (see Table 4).

There is evidence suggesting that fear of negative evaluation by others is a core feature of pathological shyness (Chavira, Stein, & Malcarne, 2002; Jackson, Towson, & Narduzzi, 1997). In a final exploratory analysis, we examined whether perceptions of being negatively evaluated (as assessed by Other As Shamer Scale) were predictive of outcomes related to childhood shyness (as assessed with Shyness Negative Affect Scale). We conducted a regression analysis predicting post-intervention shyness, in which pre-intervention shyness scores were entered in the first step, followed by a step in which pre-intervention OAS scores and an index representing change in OAS scores were entered. Results of the first step showed that pre-intervention shyness scores predicted post-intervention shyness scores, $\beta = .74$, $t(46) = 7.37$, $p < .001$, $R^2 = .55$. In the second step, both pre-intervention OAS scores, $\beta = .38$, $t(46) = 2.47$, $p = .01$, and OAS change scores, $\beta = .31$, $t(46) = 2.37$, $p = .02$, were predictive of reduced shyness (R^2 change = .07).

Table 4

Pre- to Post-Test Change and Effect Sizes for Variables of Interest for the Six Groups

Measure	Difference of pre- to post-test mean (Effect size)					
	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
SASC-R	4.14 (1.68)***	4.45 (1.12)***	3.55 (.97)**	4.13 (.93)***	4.66 (1.65)***	5.25 (1.89)***
ILQ	11.14 (.86)**	5.50 (1.06)**	4.00 (.53)*	8.60 (1.01)***	6.33 (.85)**	10.62 (1.17)**
SPPC-PA	-2.00 (.39)**	-1.75 (.48)**	-1.50 (.60)**	-1.50 (.55)***	-2.00 (.58)***	-2.25 (1.13)***
OAS	8.28 (.75)**	7.14 (.76)*	5.83 (.54)*	10.20 (.97)***	4.88 (.91)**	8.00 (.78)**
SPAS	5.57 (.43)*	4.25 (.73)**	4.33 (.47)*	3.77 (.44)*	2.66 (.32)	6.14 (.97)***
SNAS	4.14 (2.70)**	4.00 (.89)**	2.66 (.73)*	4.40 (1.79)***	1.88 (.47)	2.87 (.93)**

Note. SASC-R = Social Anxiety Scale for Children-Revised; ILQ = Illinois Loneliness Questionnaire; SPPC-PA = Self-Perception Profile for Children-Physical Appearance; OAS = Other As Shamer; SPAS = Social Physique Anxiety Scale; SNAS = Shyness Negative Affect Scale. Numbers in parentheses are Cohen's d effect sizes.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Discussion

Results of this pilot study suggested that pre-adolescents with a distinct physical appearance, undergoing a storytelling psychological intervention, evidenced significant changes during that experience. As predicted, the intervention had significant effects over time on reducing symptoms of shyness and social anxiety, feelings of loneliness and social dissatisfaction, as well as perceptions of negative evaluation by others in children who wear eyeglasses due to an eye disease. In addition, the group participants reported a significant reduction in anxiety regarding physical appearance and there was a significant increase in physical appearance satisfaction. Moreover, effects were large in magnitude. Overall, these results support our hypothesis that the storytelling intervention in a supportive group setting has beneficial effects on the emotional well-being of participants. They also corroborate the results reported by Yoosefi Looyeh et al. (2014), according to which, the group narrative therapy (in which

storytelling was one of the main therapeutic tools) is effective in reducing symptoms of social phobia among primary school children diagnosed with the disorder.

In addition, regression analyses showed that the baseline Other As Shamer Scale scores and change in Other As Shamer Scale scores predicted decreased shyness. Importantly, decreased perceptions of negative judgments by others, predicted change in shyness above and beyond baseline shyness, explaining a significant amount of additional variation in post-intervention shyness. In line with self-representational theories of shyness (Leary & Kowalski, 1995), this pattern of findings suggests the possibility that changes in perception of negative social evaluation, induced by the intervention, contributed to the significant changes observed for shyness. Further intervention studies are needed to determine the causal nature of the relationship between changes in perception of social evaluation and changes in shyness.

Our study has interesting implications for counseling practice. First, the storytelling-based intervention is congruent with counseling psychologists' preference for creative and powerful intervention methods to guide and direct clients through the healing process. It is also a tool for imparting new information in a way that makes the circumvention of deeply entrenched psychological defenses possible (Divinyi, 1995). This medium is well suited for promoting healing, providing support or education, and improving self-understanding and interpersonal efficacy (Grossman Dean, 1998). In the case of children, it allows them to understand the meaning of stories from multiple perspectives and use the same stories to promote growth and change. In addition the storytelling process facilitates the projection of conflicting feelings and repressed needs and wishes onto the story's character. It is well known that stories and fairytales work according to the mechanisms of projection (psychological process through which individuals project, onto a story, elements from their own life and inner world) and identification (the individuals experience the same feelings and emotions as the characters who they identify with). Both processes play an important therapeutic role, since they create the conditions under which individuals unconsciously identify and deal with conflicting parts of their psyche (Lévi-Strauss, 1974).

Second, young children with unusual physical traits (such as obesity, macrotia, children who wear glasses, braces, etc.), are more likely to be targets of teasing, name calling, and bullying, than their peers (Horwood et al., 2005). As a result, they tend to develop many behavioral and emotional difficulties, such as low self-esteem, dissatisfaction with their physical appearance, social isolation, and anger or anxiety (Glaser et al., 2001; Rigby & Slee, 1993). The relatively high levels of social anxiety observed in the current sample (about one standard deviation above the population mean) appear to attest to this possibility. Within the school setting, in-class group work may prove to be valuable in the prevention of emotional and behavioral difficulties and promotion of health and well-being in at-risk children. In addition, using storytelling techniques to assist pre-adolescent children in coming to grips with their anxieties, fears, and concerns, while developing effective ways of coping with stress and negative experiences within and outside their school environment, is one possible strategy for reducing their vulnerability. Although further investigation is needed, the current findings represent the first demonstration of preventive counseling for school age children with a special trait in their appearance.

Third, the changes demonstrated on measures of shyness and social anxiety suggest that including storytelling techniques within a group counseling intervention for those who display heightened fear of negative evaluation and interpersonal rejection, is fruitful. Participating in a counseling group is particularly anxiety-provoking for shy individuals, in the sense that it involves multiple and intense interpersonal interactions and the disclosure of personal information. No wonder, shy group members are particularly likely to either remain silent during the sessions

(thus minimising the opportunity to benefit from the group process) or terminate the group prematurely (Vassilopoulos & Brouzos, 2012). For those members who feel reluctant to self-disclose, it can be very effective to use an 'indirect' method such as "other people's stories" (Divinyi, 1995). Therefore, the story-telling technique utilized in the current study might have made them feel more comfortable, as they realized that they are not required to expose very personal material to the group, at least not from the outset. It also helped them realize and change the way they perceived various social situations as well as develop alternative narratives to empower behavioral flexibility and interpersonal effectiveness. Again, this is possible if you initially encourage shy group members to work on "other people's stories" rather than on their personal stories, since in the former case, the maladaptive and self-defeating cognitions characteristic of social anxiety appear to be less salient (for an experimental demonstration of self-referent but not other-referent biases in shy children see Vassilopoulos & Banerjee, 2012). These benefits, in combination with the opportunities offered to children to share feelings and thoughts without fearing criticism or negative evaluation, may have contributed to the reduction of shyness and social anxiety symptoms, as the regression analysis has demonstrated.

Limitations

One clear limitation is that, due to the exploratory nature of the study, no control group was included. However, the use of multiple dependent measures in the current study could help minimize internal validity threats (Coryn & Hobson, 2011). Nevertheless, the inclusion of a placebo control or an alternative intervention condition would help rule out the possibility that factors, other than the storytelling intervention, contributed to the program's efficacy. A second limitation is that our study did not include a post-intervention, follow-up period; as such, the long-term effects of the intervention remain unknown. A third limitation is that this study relied exclusively on self-report, so it is possible that demand characteristics could have played a role in the effects of the intervention (although similar results were observed in each of the six individual groups). Future studies should include multi-informant and/or behavioral measures in order to evaluate the impact of the group intervention on children's emotional well-being. Finally, all six groups were facilitated by the same person, so it is not clear whether the positive results observed were due to the use of the storytelling technique per se or from the leader's ability to establish solid relationships with others (Riva, Wachtel, & Lasky, 2004). Future studies should either attempt to measure leadership behavior in order to explore its association with counseling outcome (e.g., Brouzos, Vassilopoulos, & Baourda, 2015) or employ various group leaders to counterbalance the effect of the leader's personality on the group's performance and well-being.

It is hoped that these limitations will be addressed in future research in other contexts. Future studies will be necessary, to replicate and determine the effectiveness of storytelling group intervention, particularly in group and school settings for children who are less satisfied with their body image and overall appearance or suffer from different types of self-esteem disorders (e.g., depression, eating disorders, narcissism, etc.).

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