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Creative endeavors through therapy: How artistic expressions can help foster growth

Savannah Campbell
Eastern Kentucky University, savannah_campbell56@mymail.eku.edu

CREATIVE ENDEAVORS THROUGH THERAPY: HOW ARTISTIC EXPRESSIONS CAN HELP FOSTER GROWTH

BY

SAVANNAH CAMPBELL, M.S.

DOCTORAL SPECIALIZATION PROJECT APPROVED:

Dr. Theresa Botts, Ph.D

_____

Chair, Advisory Committee

Dr. Melinda Moore, Ph.D

_____

Member, Advisory Committee

Dr. Dustin Wygant, Ph.D

_____

Member, Advisory Committee

_____

Dean, Graduate School

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SAVANNAH CAMPBELL, M.S.

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ABSTRACT

A person's story is something that is very connected to who they are and the life they have led. It consists of many individualized characteristics and details of their experiences. This narrative is rooted in many different aspects the person creates for him or herself through interpersonal relationships and intrapersonal emotional experiences. The autobiographical interpretation a person creates is often divulged, examined, and utilized through the psychotherapeutic process. Expressive techniques often help tell a person's story the way he or she wants it to be told. The following research project examines many factors such as emotional well-being, posttraumatic growth, self-expression, and identity development that can influence such a tale and focuses on how allowing a person to creatively develop their story can foster resilience and inner support.

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I. Introduction of Topic and Personal Construct Theory

More often than not, the one true thing that belongs to a person is his or her stories. These narratives serve multiple purposes in the life of an individual. They are also parts of a person's life that do not make up their physical presence that have the strongest power in people's life. These influences can present themselves in a multitude of ways. More so, the powers of stories hold the ability to be greater than the concepts people possess or a tale they verbalize. The narratives that people have has for themselves can become the entire identities with which they see themselves to possess.

Where do these stories come from though? How are they developed in the first place? To understand the creation of people's stories and the identities they involve, many details need to be comprehended first. One of these ideas that need to be examined is the theory of personal constructs. This is a theory related to personality and self-development that was first studied and put forth by George Kelly in 1951.

According to Kelly, "people view the world as if they are scientists – constantly testing their theories by observing ongoing events, then revising those theories based on what they observe" (Gazzangia, 2008, p. 525). What this results in is a person developing and crafting a world for him or herself based on who and what he or she encounters. The ideas that form the basis of a person's constructs can be altered an infinite number of times depending on the situations he or she encounters and how he or

she relates to them. The constructs are interpretations and also serve as bases for a person's behaviors across environments and situations.

For example, a person has encounters with his or her parents that are dismissive and negative over an extended period of time. Following these interactions, the person forms a construct of a parent not being a validating presence in one's life. This idea then serves to underscore other constructs and ideas of relationships and interactions over time. Kelly called constructs like this and other situations the basis of how someone builds a life's ideas and described this creation of the constructs in a way that compares it to that of an architect. "He erects a structure within the framework of which the substance takes shape or assumes meaning (Kelly, 1991, p. 35).

Based on Kelly's theory, the idea is that these interpretations and foundational constructs are universal in that all people develop and use them. They are unique, however, in that everyone creates different constructs individualized to his or he own life. An individual begins to have predictions for how his or her lives are to occur based on the constructs and these theories are not limited to one domain. Constructs can also overlap in the sense that one person's idea of another person's does not exist in a vacuum. "Persons anticipate both public and private events. No two people can play precisely the same role in the same event, no matter how closely they are related (Kelly, 1991, p. 39).

This quote can be applied to the earlier example of the individual who developed a construct of a dismissive, unsupportive parent. For the person whose parent has been invalidating for years, he or she may have the perspective of the events to be one where he or she has struggled to find emotional connections. For the parent,

the events that are remembered and focused on may be the intermittent and few times when he or she was reliable in emotional ways. This concentration on the 'better days' may lead the parent to view the construct made from the interactions to be consistently positive and supportive overall.

Despite these differences in perception toward a given situation, people can find common ground and opinions in use of the constructs they develop in life. Kelly wrote of this idea as well. He described this happens by having people express their interpretations of the situation(s) at hand and then working with others in their interpretations to see details that may be shared. He did not write or detail how this discussion occurs. Nor did he describe standards to follow in the discussion for length, amount, etc. The main idea to grasp form the discussion and coming together over constructs would seem to be finding commonalities and understanding what the discovered constructs mean for each party involved.

One key point Kelly makes about the development, understanding, and application of constructs as developed by someone is that it is a process that does not end. He uses the metaphor of how these constructs are something that is built again and wrote, "The construction system does not stand still, although it is relatively more stable than the individual constructs of which it is composed" (Kelly, 1991, p. 40). Simply put, Kelly believed that the process by which an individual creates the constructs on which he or she bases one's life is more stable than the constructs that make up the life itself. Given that these constructs are constantly altered or adapted for better or worse by the experiences a person has, this makes sense. The process by which a task is done

has to be more reliable and stable in order to create its products, in this case personal constructs, for them to be used in consistent ways.

It is through this stable process that an individual not only creates constructs, but also rework them and realign them when needed. The constructs themselves must be malleable though in order to be readjusted. Thus, if they can be altered, this allows for new aspects of the constructs to be developed. Kelly explained that if a construct allows for new elements and details to be incorporated into it, then it is considered permeable. "A construct is considered permeable if it will allow to its range of convenience new elements which are not yet construed within its framework" (Kelly, 1951, p. 56). Using the example of the person with the construct of an invalidating parent, if that construct is to be permeable by Kelly's standards, it must allow for new details to alter it in some way. There is a limit to how appropriate the construct is to the person's life and how much it can be applied to their actions. Kelly theorized that if a construct has to be within a range of convenience, otherwise whoever is developing it will not find it useful in life.

From these permeable constructs, concepts known as roles form. That is why the construct has to be relevant because "A role is an ongoing pattern of behavior that follows from the person's understanding of how the others who are associated with him in his task think" (Kelly, 1991, p. 57). Without the relevance or comprehension a person has toward the construct, an individual's actions will not make sense to anyone, not even the person doing the action. The order by which constructs are placed allows a person to move through his or her life and interactions. This is a very personalized process and no two people use it in their roles the same way.

In describing that use, Kelly also compared the constructs to roads that people follow to craft their worlds. He called them "two-way streets along which one may travel to reach conclusions" (Kelly, 1951, p. 88). The roadways a person uses to build his or her mental constructs of life situations are the roles he or she forms. From there, the constructs serve another function since they are so prevalent in what they can do for a person. Constructs at this point even assist someone with making guesses for what he or she will encounter in the world so that he or she may be able to handle changes to his or her worlds as the alterations happen.

A person even gives him or herself a construct based on these encounters with the world and the ideas he or she has formed about it. This is what is known within Kelly's theory as well as other psychological areas as *the self*. It is a multi-faceted area in terms of what it does to describe a person. "The self is, when considered in an appropriate context, a proper concept or construct. It refers to a group of events which are alike in a certain way…The way in which events are alike is the self. That also makes the self an individual" (Kelly, 1991, p. 91).

Creation of a self through and with constructs is the foundation of how a person lives and acts. This development can be rooted in a story that is told in different ways and through different people. In telling the story, sometimes help is needed to guide the person along. This is where psychologists with therapeutic orientations related to construct theory are important. Kelly addressed this in his theory too.

Kelly noted that a psychologist may have specific tasks to accomplish if he or she is to assist a client through the lens of the constructs the person has created. The primary task that a psychologist does if working with a person and their constructs is to

form a general idea about them. Kelly explained that this is first done by finding both the differences between the constructs the person presenting before the psychologist has made. He also cautioned that without this, a psychologist should not form opinions and thoughts toward the person's concerns or presenting problems. "Until he has some notion of the contrast, he does not presume to understand the similarity. He would therefore seek to understand what his client has construed" (Kelly, 1951, p. 50).

Once the psychologist has started to understand the constructs, Kelly believed there were different tasks within therapy that can be done to help the client in his or her own comprehension of them as well. The psychologist also may assist the client to create new constructs for better management of life events and stressors. The primary method for doing this as described by Kelly was in the form of stories that the psychologist would help the client to create.

He made a point of writing that this is of particular help when conducting child psychotherapy, but he generalized that stories have great power in helping clients regardless of age. Kelly felt that stories are what can help rewrite constructs and identities for a client who presents for treatment so the person may find new ways of seeing him or herself and living in the world. "In the use of stories the self is only gradually involved and the new constructs which are developed are allowed to replace only gradually those undesirable role constructs which have continued to exercise control in the client's life having outlived their validity" (Kelly, 1951, p. 113).

II. Constructivist Therapy

Kelly's theory on personal constructs laid the groundwork for therapy to address how a person sees the world as a means to understand their distress. From this original information came the idea of constructivist theory and a resulting therapeutic orientation for psychologists to use. The general idea to constructivist psychotherapy is essentially one step forward from Kelly's theory in that its key focus is on the meaning people apply to their worlds.

In 2009, Robert Neimeyer wrote a book in which he describes the distinctive features of constructivist psychotherapy. He provides details about these features as well as how treatment works if a psychologist is to follow this orientation and details the work involved from initiating treatment through termination. He also includes information about assessment tools involved for a psychologist to gather personal data about the client presenting to him or her. He begins the book by writing that constructivist psychotherapy builds on the orientations of humanistic, feminist, and systematic treatment while being original in its own right.

Specifically, constructivist psychotherapy is postmodern in three specific ways. These ways are: the importance placed on the personal meaning of a client's life, the social identity he or she constructs, and the revision that can be done to the person's

narrative. The narrative and identity that a person creates are very important within constructivist psychotherapy but can be key aspects of a person's therapeutic journey overall. In his book, Neimeyer wrote that "therapy is more a matter of *intervening in meaning* than it is a procedure for ameliorating unwanted symptoms or training people in more adequate coping skills" (2009, p. 5). Neimeyer felt that constructivist psychotherapy is about assisting a client with making sense of his or her identity as he or she verbalizes it and what it would take or what it means to be able to go forward in his or her life. Further, he felt that a constructivist psychotherapist's primary task "is to help reveal the meanings behind the words, the deeper themes between the lines of the stories clients tell themselves…about what brings them to therapy (Neimeyer, 2009, p. 9).

By working to reveal meanings, constructivist psychotherapists find ways to assist a client with moving toward a life that better suits what he or she wants. Neimeyer explains about this assistance by writing "our goal as psychologists to understand not *why* they act in the first place, but rather in *what direction* their activity is likely to carry them" (Neimeyer, 2009, p. 11). These directions that a client takes often do not have a definite ending according to Neimeyer. This is related to Kelly's personal construct theory. Neimeyer agreed with Kelly in that he believed how constant the work needs to be to reframe and restructure ideas about one's world.

"We spend a lifetime looking for recurrent themes in events, using them to predict what will happen next, investing our time, effort, resources, and ultimately our lives…for better or for worse, we never arrive at a "cognitive Eden" in which we are forever secure, and where the terrain and rules of the game are stable and familiar"

(Neimeyer, 2009, p. 11). In other words, life is about finding connections between the situations one encounters, but it is not something that has a concrete final solution. That is why constructivist psychotherapy and the recreation of one's story within can be so valuable. When a client is able to develop his or her story with the understanding that it is not the only idea that defines his or her life, the result is a very emotionally freeing one. "…accepting the inevitable anxiety of facing continual novelty can be healthier, Kelly suggested," (Neimeyer, 2009, p. 12).

The concept of story is the foundation of how constructivists view their clients and their needs in therapy. "Constructivists…grow interested in how people use language in a way that shapes and delimits how people appraise themselves, others (especially vulnerable others), and life difficulties in ways that are problematic and disempowering" (Neimeyer, 2009, p. 17). This means that for psychotherapists who use constructivist techniques with their clients and their stories are very interesting in *how* a client describes his or her life experiences. A person's stories are the client and there is little to no separation of the two. Neimeyer wrote that according to Kelly's theory, people are the constructs they developed. "…personality can be seen as the composite our myriad ways of interpreting, anticipating, and responding to the social world" (Neimeyer, 2009, p. 20). According to Neimeyer, the personality one person may be known for having is now rooted in traits or qualities, it's rooted in those constructs. "...the "self" is…instead simply the represents the distillation of our shifting efforts to engage the social world" (Neimeyer, 2009, p. 20).

Being able to navigate through the world as this "self" requires understanding and maneuvering through the social context in which it was created in the first place.

Within the theory of constructivism, there is an emphasis for that understanding to be focused on the post-modern epigenetic model of systems. This model states that structures emerge from interactions between organisms and the environment. When this is applied to human interaction, this would mean "that meaning and action emerge from a similarly multi-layered system of systems which include bio-genetic, person-agentic, dyadic-relational, and cultural-linguistic levels" (Neimeyer, 2009, p. 23). Psychologically meaningful concepts and situations come from the interaction of these systems and constructivist psychotherapy works to mediate issues that occur from those contacts. Neimeyer believed that dealing with social interaction means dealing with the systems' intersections. "Human functioning always requires coordinating with the demands of this larger social context, as this evolves across the life span and across history" (Neimeyer, 2009, p. 23).

Constructivists do not let the diagnoses they find their clients to present with to be the only thing that they focus on in treatment. They also use the epigenetic system model and its multi-level approach to inform their treatment of clients. To do this, constructivists see how each level may play a part in what makes an individual who he or she is in coming into treatment. In this way, the levels of the epigenetic system model are constructs of their own which providers of constructivist psychotherapists use to understand their clients' needs.

They "recognize that some personal difficulties have physiological origins" (Neimeyer, 2009, p. 28) as a way to address the bio-genetic level. In acknowledgement of the personal-agentic level, constructivists pay attention to the how meaning is done in a personal way that was not edited to deal with how needs changed as life occurs. The

dyadic-relational level also relies on the meanings people attach to their situational encounters. "At the cultural-linguistic level, postmodern therapists pay particular attention to the cultural embeddedness of difficulties in a client's life" (Neimeyer, 2009, p. 30).

The tools used to assess clients from a constructivist approach also are not as concerned as providers from other orientations (i.e. cognitive-behavioral) with identifying which diagnoses of clients are a better fit for the work done. These assessment measures "seek to identify that distinctive set of resources and restrictions embodied in the client's activity, so that the client and therapist can draw on the former to address the latter" (Neimeyer, 2009, p. 31). These items that support or confine the client's behavior can be transformed through the reformation and reworking of the client's narrative or story within the concept of therapy. One such tool that looks at these items is laddering. This refers to a technique that is used to further understand a client's reason or need in seeking treatment. It helps to "reveal subtle ways in which a person's sense of self becomes tied up with a symptom" (Neimeyer, 2009, p. 35).

According to Neimeyer, laddering involves a set of upfront questions where the therapist first identifies a personal construct that is bipolar in nature. The therapist asks the client to which of the "poles" the client associates, then makes record of the construct in question and the client's preference before asking the reasons for the association. After making the connection between the preferred pole and its construct, the therapist asks for the opposite one and connects it to the earlier pole that was not preferred. This pattern is repeated until the client begins to give repeated answers or can not form a construct. The end result is a ladder which then is discussed with the

client which leads to “further mutual inquiry into this hierarchy of meanings and what they imply for his or her behavior” (Neimeyer, 2009, p. 35).

There is also a method first proposed by Kelly which allows for a more flexible way to elicit personal meanings of constructs made by a client. This is called the repertory grid technique. It is used by “eliciting those personal dimensions of meaning that a client uses to structure some domain of personal meaning” (Neimeyer, 2009, p. 45). This is a method that allows for a client to create his or her own survey of sorts in that he or she identifies the constructs that matter. Then, the client uses an order of the constructs to indicate the ideas that are relevant. This grid is a toll that allows for a more individualized understanding of the client’s world perception.

Homework assignments, while not the prevalent intervention used when implementing constructivist psychotherapy, are sometimes employed as means of assessment of the client as well. One example is that of mirror time and involves having a client view him or herself in a mirror and reflect on the image seen there. The idea behind this method is promotion of self-dialogue. The reflections that are expressed are allowed to be unrestricted or if preferred, can be structured through a set of guided instructions. The thoughts and feelings prompted by this exercise are then noted or recorded for therapeutic use in later sessions. This was the only assessment tool which Neimeyer wrote that research of its use had been conducted. When used with one hundred clients, the results indicated it was at times “strong medicine” (Neimeyer, 2009, p. 56). Reported reactions included physiological responses and when used in a directive way, it lessened self-criticism in one client. Overall, however, it is important to know that the assessment measures used by constructivist

psychotherapists are used to bring attention to more personal concerns of the client being treated. They show the importance of "personal, yet intricately social systems of emotionally resonant meanings…and life narratives that both shape and limit a client's engagement" (Neimeyer, 2009, p. 57).

Constructivist psychotherapy is also centered on tenants that guide providers of it to make sure a client's needs are of the prioritized focus. Therapists of this orientation are to not "crowd out attention to the client, or even to compete with it in a direct sense" (Neimeyer, 2009, p. 60). It is this consideration that makes constructivist psychotherapy an orientation that providers engage in emphatic and respectful engagement of a client's narrative(s) rather than having the other way around. Constructivist psychotherapists are not the people who create and decide what the meanings of a world is for a client. Instead, they are the individuals who help the client realize what meanings of his or her life encounters do not work to help him or her and then assist the client with finding new constructs that do.

Sometimes, however, the transfer of constructs from old encounters or relationships to new ones does not work. Neimeyer wrote that is happens often with a client who may have a disturbed personal history. Therapists who work with this type of individual are doing so to offer a person like this a relationship that is reparative in nature. This does not mean that therapists reveal personal details about themselves in sessions. Instead, therapy sessions are used as a process to bring about growth and awareness within the client.

There is a broader practice within constructivist psychotherapy which is based on Dialogical Self Theory (DST) which can help with building the growth focused

emotional processes. One art therapy/coaching method that is rooted in DST is composition work. This technique is "a creative way of working with the landscape of mind populated by the multiplicity of I-positions. It involves the identification of both *external* positions (e.g. my mother, nature) and *internal* positions (e.g. I am anxious, I as dreamer)—whether personal,…emotional…or social positions" (Konopka, Neimeyer, & Jacobs-Lentz, 2017). These I-positions are important to DST because of how they relate to remaking and creating a person's identity. Therapists work in roles which help integrate new positions for those identities. The therapist working with a particular client "can serve as an external promoter position contributing to development of an internal promoter position" (Konopka, Neimeyer, & Jacobs-Lentz, 2017). This development then adds to how a client reconfigures his or her self.

The activities involved in composition work involve finding symbols for the I-positions that are nonverbal in nature and arranging them into an artwork. The therapist working with the client who designs the creation explores details about them. This exploration can involve exploration "in terms of separate elements, their relations, and the overall patterns they create" (Konopka, Neimeyer, & Jacobs-Lentz, 2017). The discussions about the positions can also include giving it a voice. This can involve out loud talks about what the position would say for itself on various topics of emotional importance.

Composition work brings a focus to the ideas of constructivist psychotherapy about the uniqueness of a person's experience and identity. It is in this work that "this aspect comes to the fore in the creative at of composing one's inner world in a symbolic form as well as in its further differentiation through pictorial language of natural

metaphors" (Konopka, Neimeyer, & Jacob-Lentz, 2017). In other words, creating an artwork helps make known details that typical words and discussions may not be able to.

These details that are uncovered are often emotional in nature and they can also be tracked as a means to understand what the client is experiencing. Neimeyer referred to a therapist's actions in this way as to "follow the affect trail" (Neimeyer, 2009, p. 64) and studies have shown that certain oriented constructivist psychotherapists use it to focus on the internal emotional narrative process that occurs for a client in sessions. Constructivists also view the emotional story differently than other providers. They do not see any emotional expression as something that needs to be fixed or changed. Instead the focus is on the story it brings about within the therapeutic process.

The story and emotional journey that unfolds within therapy is not one that has a set course. Constructivist psychotherapy aligns with this idea in that it is very reflexive in nature. In other words, the sessions do not have a formal structure and also do not have to follow a specific order. They are designed to be tailored to work with client's needs as the needs arise. There is also a belief among those who provide constructivist psychotherapy that interventions delivered as part of this orientation are specialized based on client need(s). This in some ways connects to the idea of how the constructivist approach to psychotherapy also emphasizes helping a client discover and understand the meanings to his or her life constructs, stories, etc. The interventions are recommended to fit the client so that the meanings fit the client's experiences. These interventions are also not the actions that cause elicit the relief to client's presenting need(s) though. They are designed instead to assist the clients with discovering what

their life events hold for them and to "help elaborate personal meaning-making activities of the client" (Neimeyer, 2009, p. 83).

In regard to these meaning-making actions that Neimeyer refers to, an important tenant of constructivist psychotherapy that individualizes client work in it is how language is used. In therapy generally, following a client's approach to language and his or her phrasing or words for situations facilitates the process in effective ways. The step beyond this with regard to constructivism, however, is to go past the words used by a client to illuminate them into visuals and metaphors that help him or her to move forward in his or her work on his or her self. Neimeyer felt this illumination was the decisive result in a client engaging in constructivist psychotherapy and wrote about its providers being involved in "helping clients become *connoisseurs of their experience*, leaving them better positioned to grasp…their current self-narratives and to craft and perform new ones" (Neimeyer, 2009, p. 84).

With regard to these narratives, the constructivist approach also includes helping empower a client to see how he or she can control the difficulties he or she has faced while living his or her stories. A constructivist psychotherapist helps a client understand his or her problems are what is wrong instead of placing the blame on themselves, and assists the individual in actively working against the issues' influences. This is because constructivism views a client's emotional distresses not as personal deficits but as threats to the constructs and narratives he or she has crafted so far in his or her life. "*Anxiety* is experienced when someone faces an event…beyond anything he or she can meaningfully anticipate or control. *Threat* poses the…looming invalidation of our core sense of who we are" (Gabalda, Neimeyer, & Newman, 2010). These are

two of many examples that show the vital importance of therapists using constructivism to follow their clients' narratives without doing too much or too little with them. In this way, these providers are "doing just enough, but no more than required, to allow the client to move forward again with life in more satisfying ways" (Gabalda, Neimeyer, & Nemman, 2010).

There has not been a predominance of research conducted in determining how effective constructivist psychotherapy is in comparison to other therapeutic orientations. In fact, researchers who have looked into constructivism have also been found to be less interested in comparing how these approaches work compared to the others. According to Neimeyer (2009), "constructivist psychotherapy researchers have generally been…more oriented toward constructing basic research on those psychological structures and change processes that are relevant to refinement of all therapy, regardless of its pedigree." Despite this belief and practice, some work has been conducted in documenting the positive results constructivist psychotherapy has provided toward specific client populations.

One type of an individual who goes through drastic life changes is someone who has experienced abuse in one form or another. These occurrences lead to a range of reactions within the person who survive the abuse. The assaults can lead to changes in the survivor's life perceptions in ways that include how the meanings he or she attributes to previously created personal constructs. The abuse can also alter the survivor's narratives of his or her life leading to the abusive events and may skew the direction of his or her story moving forward. As a result, it would be reasonable to

examine how the constructivist orientation can impact psychotherapy with a survivor of childhood abuse.

When a person experiences invalidation, it becomes connected to the self-constructs he or she is developing. An individual who experiences abuse often experiences invalidation. When this abuse occurs at the hands of family members, the constructs are expressed as negative emotions such as anxiety and depression. This alteration of constructs is not limited to the emotional ones either. Sometimes, a client may not use the label of abuse to describe what he or she went through and when that label is used in therapy, it can impact constructs as well if the client adopts it. "If the client accepts the "abuse" label, core constructions of the relationship to the parent, the client's relationship to his or her children…may be invalidated" (Harter, 2001).

A client may also not remember the abuse until it is processed and labeled in therapy. This may lead to highly distressing experiences in his or her personal constructs as well. They may question his or her life stories and identities he or she has crafted to that point. Trauma may be one word used to describe this resulting distress, but trauma is not an objective definition or descriptive label. Often, the word trauma is used as a more conclusive description of what experiences of abuse causes within an individual. It is the "inter-relation between an event and a person's core constructions, which are unable to accommodate the event" (Harter, 2001). Experiencing abuse and the resulting trauma that occurs is not a life construct that is regular or normal. When a person has to re-orient his or her life after such events, it is often a struggle and distressful situation.

Therapy can then be used to assist with the work to re-orient a client. It is a collaborative partnership between the individual and the therapist(s) from whom he or she receives treatment. "The psychotherapy process becomes the co-creation of new possibilities…The psychologist brings professional constructions, hypotheses concerning meaning making processes…The client brings the expertise in his or her own life" (Harter, 2001).

Constructivist psychotherapy's grounding in meanings is well suited for this type of collaboration. A client is allowed to have a safe space to explore new meanings and discuss what they can offer them. There is a focus of validation for the client as a creator of those meanings and he or she is given the support to try them out in the reparative nature of therapy before applying them in his or her daily life.

This supportive work and the resulting relationship formed between a therapist and a client helps provide an example for how other social relationships may occur too. This relates to the reparative nature of the work that is completed. "In elaborating differentiated constructions of their relationship with the therapist, …clients may come to recognize their own value, the universality of their issues, and their capacity for connecting to others" (Harter, 2001). Allowing a client through constructivist psychotherapy to develop those recognitions also gives the individual power over his or her meanings that he or she may have lost during their abusive encounters. "Speaking and being heard validates the survivor as a meaning maker, as a namer of his or her own experience" (Harter, 2001). Doing this relies on the therapist to be the one who confirms that the client is the one who did the experiencing and so he or she knows he or she now has these powers over his or her meanings and life events.

Traumatic events often have a substantial impact on how a child develops, both behaviorally and emotionally. This is often due to more developmentally related components that are more unique to the child's younger age. In 1979, 1983, and 1985, Terr researched and found that children show traits of diagnoses of Posttraumatic Stress Disorder (PTSD) in different ways than that of adults. These characteristics can include but are not limited to: more frequent re-enactment of the traumatic events, more dramatic skews of their perceptions of time, and an impairment of their school performance for months following the event. In addition, "developmental components may create a situation where trauma occurs in situations that are unexpected by adults. Events such as losses or upheavals…may be construed as traumatic by some children" (Ronen, 2007). It is for these reasons that a constructivist approach may be needed as a means for conducting therapy with children.

As previously mentioned, constructivism is foundationally based on seeing the issues at hand through a client's eyes. This is especially true if the use of techniques of this therapeutic practice are to be used with a child. "The way children construe the event accounts for the difference between one child who overcomes the trauma and…another child who responds to the same traumatic event by developing symptoms and PTSD" (Ronen, 2007). Most research that has been conducted has focused on how children respond to the traumatic events with few focusing on how to help children cope and overcome the effects of the events.

The first way to utilize constructivist work as one that can positively facilitate child therapy is to engage the child by relating to the inner world he or she creates. This can involve a therapist understanding what the traumatic event meant to him or her

along with how the child feels toward it, the perception he or she has toward it, and how the child is construing his or her future reality as a result.

The therapeutic relationship within the constructivist work also may present an issue to address in the work done. Often, adults in a child's life discourage expressing problems faced in regard to the trauma and this can impair the work done in therapy. Constructivist therapy is one that can help children in becoming more in control of their experiences. The therapeutic relationship involved is one that utilizes the empowering collaboration between the child and his or her provider. Ronen (2007) wrote that constructivist therapy encourages the positive ability of children to change through various means such as role play, imagination, and the use of metaphors.

To allow for this ability to grow, there are three aims that a constructivist therapist should work to achieve. The therapist works to help a child who went through a traumatic event to accept the idea that he or she has had the experience in the first place. This involves allowing the child to show the reactions that the event brought out in them (i.e. thoughts and feelings). The next aim of using constructivist therapy with a child is to help him or her change the meaning of what the event is to his or her life. Last, the therapist is to help the child grow from the experience and become willing to live through other events in his or her life. Ronen (2007) describes five phases that are involved in achieving these goals. They involve starting with first changing the child's negative expressions of the event and working through the meanings attached to it and sensitivity or reactions to those meanings and lastly eliminating the traumatic reactions. All of this work is completed so to help the child re-construct his or her life events to

give him or her the control over their impacts on the ways he or she creates meanings and ideals in the future.

In addition to a child, an individual who experiences severe disturbances to his or her mental health is also a person with whom constructivist approaches offer promising results in therapy. One limitation in beginning constructivist psychotherapy with such a population, however, is related to the tenant of it being focused on the understanding of the client's personalized life meanings. To develop this part of the work, "an invitation to divulge particularly personal information must be extended, and subsequently accepted" (Leitner & Celentana, 1997). This invitation is one that would occur after trust and the alliance between client and provider that underlies a strong therapeutic relationship is built. Following the establishment of this collaboration, the task of constructivist's work is to understand that a client's personalized constructs is especially important. A therapist in this way is to adopt an attitude that is almost naïve in nature. Leitner and Celentana (1997) explained that the therapist's approach to the client's events are not to be understood as irrational thinking but unique, as if real to the individual who lived them.

To dismiss those situations would be to invalidate the client and would decrease the appreciation for his or her life meanings. Leitner and Celentana (1997) described what they refer to as an "invitational mode" with actions that can ensure a therapist uses constructivism in helpful ways with clients with disruptions to their mental health. This method is a way for a therapist to elicit "psychological intimacy while simultaneously respecting the client's needs for safety" (Leitner & Calentana, 1997). One aspect of this process is for the therapist to assure the client that the pace will be set by him or her.

This is a way for the reflexive nature of constructivist psychotherapy to be utilized while working with a specific client population. The client's journey and desired speed for going through is respected so that "the client is *invited* to go in certain directions, never *forced*" (Leitner & Calentana, 1997).

A therapist is also encouraged to maintain an understanding of what the client may be feeling but also recognize that these emotions are not his or her own. Adding to the collaborative support that a therapist provides through constructivism, he or she also works to recognize the client's struggles while finding ways to change these issues. A constructivist psychotherapist is already focused on the ascribed meanings and personal interpretations of the client he or she works with to help understand them. This does not change for a client who has disturbances and is in fact more important in the therapeutic work. For example, for a client who reports persecutory thinking in their delusions, "the therapist needs to listen to the *reality* of the persecution" (Leitner & Catentana, 1997). This can involve the therapist examining what it was that may have psychologically helped the client when he or she engaged in creating of their delusions and the constructs related to them.

Following that examination, a client can then be helped to see how to address life and engage in it in a more adaptive way. This can then help the client to "begin to experience the delusion as a creative way of solving horrendous problems that have outlived their usefulness" (Leitner & Catentana, 1997). More so, a therapist using constructivism can be helpful in assisting the client with conceptualizing the issue which led him or her into services. This may require the client to rely on the therapist's conceptualization while the issue(s) are reconstructed into ways the client can manage.

This dependence is one that can decrease over time as the client's work progresses. This can be comparable to constructivist psychotherapy that is implemented with clients who do not have disturbances and assist in their growth toward reconfiguring their identities and life meanings.

III. Narrative Therapy Uses, Benefits, and Effects

The stories themselves that are told by a client can hold importance within psychology as well. They are what a client uses to understand his or her world. "Any understanding we have of reality is in terms of our stories" (Mair, 1998). Whoever a person is, he or she is best understood by first learning his or her stories of life thus far. All stories that a person tells are ways, either big or small, that make the meanings he or she has toward situations known. Without being an author to one's own story, a lack of self-understanding may exist. Moreover, if the meaning and story that someone has made in their life is one that they did not have control over, it may need to be remade.

The recreation of life meanings and stories is a foundation of narrative therapy. The interventions which are used with narrative-based work can also be understood and utilized constructivist related approaches. The first idea that can help connect information between constructivism and narrative therapy is recognition of the continuity or of discontinuity that can exist in someone's life. This refers to the forward moving or disjointed nature of someone's experiences. Many times, however, "the narratives…clients tell…have been critically fragmented by some life event that has introduced an unexpected discontinuity in them" (Botella & Herrero, 2000).

These narratives are very closely tied to the identities that an individual may adopt or choose to claim as his or her own. "Self-narratives can be understood as being part of personal realities" (Jankowski, 1998). Emotions are also tied to these stories and

the realities on which they are based. This is similar to the tenant of constructivism which involves how a person chooses and creates the constructs which form his or her life. However, constructs as previously said, and identities are not set in stone. The narrative is what a person chooses to be his or her story and often when someone comes to therapy it is due to his or her story being disrupted in some way. The emotions involved here, like the narratives, can always be remade, reformed, and redeveloped. Therapy can be used to reformulate the narrative(s) and identities of the client through collaborative work. "There is always more than one way to tell one's life story, more than one voice to be heard, more than one plot to be voiced" (Botella & Herrero, 2000).

Narrative therapy involves putting a client in charge of reworking his or her constructs and meanings to rework and rewrite his or her stories. These reformed stories become the new tales which a person tells him or herself for living his or her life and for moving forward. "Exploring alternative meanings results in changes in their horizons or personal realities such that they begin to experience themselves…and their world differently" (Jankowski, 1998). These meanings can be examined through a social-constructivist approach by looking at the narrative(s) a person has of his or her life. The narrative(s) that are formed can be "used as a metaphor for understanding how individuals make sense of their lives" (Jankowski, 1998).

Narrative therapy practices are used to counter the stories of a person's life that may have been in the past seen as limiting. These interventions are used in order to promote change for a client and the change that is brought about is toward more than just the stories of the person. One of the tools that is used to handle "such life-limiting stories is that of externalizing conversations" (Hutto & Gallagher, 2017). This works in

part by changing how people cognitively view their problems. New solutions are brought out and new ideas for how to approach the stories being told come to light. Hutto and Gallagher (2017) wrote how the stories being told before the new ideas can either open or close possibilities to the telling parties.

When it comes to understanding how narratives can provide contradictory options to a person through growth and limitation, Hutto and Gallagher (2017) noted two factors for consideration. The first of these was the nature of a narrative, specifically the distance its creator has from it. This refers to how removed the narrator is from his or her story in either time, evaluation, or even the point of view (i.e. first or third) with which the story is being told. The second factor Hutto and Gallagher (2017) reported that needs consideration is that people are not only narrative selves. This means that a person's abilities to narrate his or her life is only part of his or her life experience. Narratives can give a person the power to change his or her life and to recreate his or her story, but a person needs support and encouragement to do so. This underlies why and how narrative therapy has its value for work with a client in mental health treatment.

A client's narratives are often changed when he or she experiences episodes or periods of abusive treatment. Previously mentioned research highlighted how constructivist approaches within therapy have shown promise in working with a client who has survived abuse. Multiple questions come up when using narrative therapy and narratives with this type of client. For example, are there specific types of narratives that occur when a person experiences trauma?

In 2017, Scheeringa, et al, researched to find information to determine if children and adolescents who were receiving Cognitive Behavioral Therapy (CBT) for PTSD made trauma narratives that were distinct in nature. They used participants ages seven to eighteen years of age. Narratives provided by the participants were recorded exactly as they were told. Data elements for traumatic elements were collected and these were defined "as the smallest piece of information about a traumatic event. For example, a "red car" is two data elements of unique information for "red" and "car" (Scheeringa, et al, 2017). The researchers also counted negative and positive emotion words and the Child PTSD Symptom Scale was administered to the youth involved and their caretakers pre and post-treatment. The treatment the participants received was "a 12- session manualized protocol…included components of CBT for childhood trauma, trauma narrative processing, and graded exposure. Clients recounted their traumas in sessions five through 10" (Scheeringa, et al, 2017).

Following completion of the treatment, raters read all of the narratives and created categories for them. Scheeringa et al (2017) labeled these categories as expressive, avoidant, undemonstrative, and fabricated. They reported the results to be that participants who were in the expressive group recalled significantly more elements in their narratives than those in the avoidant group. This group's participants also recounted more emotion words, either negative or positive, than that of the avoidant group. The last key finding was that "youth with avoidant and undemonstrative features…benefited from structured and directive therapy techniques" (Scheeringa, et al, 2017). This means, at least for the adolescents and children in this study, the results found that there is not one key way to recall traumatic events.

While the study conducted by Sheeringa, et al (2017) focused on children, there is still the question about if similar results would be found among adults who recalled their trauma narratives. In 2014, Jaeger, Lindbloom, Parker-Guilbert, and Zoellner examined the association between PTSD severity and the content within the structure of trauma narratives. They also researched how these factors were related to expressions of anger, anxiety, depression, dissociation, and guilt. Standardized psychopathology measures of these emotional experiences were used along with structured clinical interviews. For the narratives' content, the researchers used objective coding for language based dimensions such as word count and emotional words used. A subjective coding software was also used to determine how many words from the subjective categories of disorganization and fragmentation were used.

Jaeger, et al (2014) found many trends related to the emotional components of words used by the participants. For example, positive emotion words were found to be more associated with both lowered severity of PTSD symptoms and lowered re-experiencing overall. However, when the researchers accounted for how participants recalled their narratives and anxiety, the use of positive and negative emotion words were associated with lower re-experiencing. If participants used pronouns, higher levels of dissociation were reported. These results indicate that it is what a person says in their narratives that may be more helpful or troublesome toward their trauma related symptoms rather than how they say it. These results also provide support toward the use and implementation of finding ways to allow adults to tell their stories as means to rework the meanings attached to their experiences.

If having options for telling one's story and the newly formed meanings behind the experiences in it has benefit, would tailoring the story to specific incidents of trauma provide clinical benefits? In 2001, Smyth, True, and Souto researched "whether narrative formation during writing about traumatic experiences is necessary for improvement." They used 116 undergraduate volunteers. The students completed the Impact of Event Scale (IES), which gave information about intrusion and avoidance as a measure of distress caused by trauma. Symptoms were also recorded through a self-report measure of common issues in that area. These symptoms included somatic ones and the students recorded if they had experienced them in the past seven days and to what severity. They recorded their affect before and after the writing exercises using adjectives for positive or negative emotional states that were then rated from not at all to extreme in severity. The students' essays of their traumatic events were rated for how emotional and personal they were as well as the amount of narrative structure displayed.

The students were assigned to either be in a control, fragmented or narrative group for their writings and mood assessments. Participants in both the fragmented and narrative groups were asked to write about the most stressful or traumatic event they had experienced. In the fragmented group, participants were told of how listing thoughts and feelings may provide help in doing this whereas the narrative group was specifically told to write it in narrative form. Five weeks after the writing, all participants were called and completed the IES and symptom report. Smyth, True, and DeSouto (2002) found that the writing resulted in significantly greater positive mood reductions and negative mood increases for both experimental groups. Participants in

the narrative experimental group also reported less activity restriction due to illness but also higher avoidant thinking. The main conclusion of this study was that simply expressing feelings and thoughts related to trauma may not provide therapeutic help. This connects to the work described by Jaeger, et al (2014) in that both studies concluded that a client's formation of a narrative in regard to a traumatic experience may be key to its help to the client.

Despite Jaeger, et al (2014) findings and their implications related to helping a client form his or her narrative related to trauma, it important to note, that not all experiences of trauma or distress lead to an individual meeting the criteria for a trauma-based diagnosis. As a result, the narrative that a client tells may not be one that reveals him or her as having experienced trauma. Even if this narrative is not an expression of a traumatic event, the story can still be expressed through narrative therapy and can be revised to help reform a client's identity. Stewart and Neimeyer (2001) discussed how to do these revisions. They described two levels of intervention, either or both of which may be areas of focus within narrative therapy. The first level involves working to intensely explore the sequence of how the traumatic events impacted the client. The other level works to involve the client to move in and out of his or her experiences to combine the identity created from the trauma with the identity not related to it.

Many narrative techniques allow work on two levels that "help trauma victims understand themselves in ways that are more…self-aware, with a greater sense of control over themselves" (Stewart & Neimeyer, 2001). This relates back to the control and reclamation of one's self-identity and life meanings that narrative therapy seeks to do. Some of these techniques include writing, drawing, or comparing life events. They

all share a similar process in that they allow for a focusing on what previously were seen as unconnected events in a life. This focus then allows for the "processing of experiences at multiple levels so that meaningful relationships are created" (Stewart & Neimeyer, 2001).

Narrative events in a person's life does not only involve the actions an individual does in reaction to the situations. They also do not only include the emotional changes that are stirred from the experiences. Situations that create narratives within someone's identity have impacts on the neuropsychological makeup in regard to how the events are interpreted. Narrative neurotherapy involves interventions that are in the middle of the spectrum of social constructivism and scientific theories and focuses primarily on the physiological domain and learning.

Ewing, Estes, and Like (2017) offer three suggested movements that can be done through narrative neurotherapy and involve conversations that work to promote changes in identity states. The movements also are not required to be followed in a set line and can be looped back from one another if needed. The first involves "separating from immediate problem-identity states" (Ewing, Estes, & Like, 2017). Activities of practice that can help with this movement involve a client making distinctions about physical sensations he or she experiences and associating these with identities while also inviting settled physiological states.

Ewing, Estes, and Like (2017) encourage a client in this movement to notice and name preferred identity states. The way that the physiological domain is engaged here is that when a person is in urgent states, it makes reflection and contemplation of identity harder. Urgent states can include many types of distressing events in a person's

life. In the cases of trauma, he or she can experience distress during the moment of abuse or attack as well as days after when triggering behaviors or emotions are prompted in a person.

Following the movement of separating from problem identity states, a client using narrative neurotherapy work to sustain his or her intentional identity states. These would be the identities that are more controlled and preferred by the client in treatment. Ewing, Estes, and Like (2017) recommend that a client in this movement make associations and evaluations of physiological sensations that are associated with the regulated states. A client is also encouraged to identify actions that support those states and to name interpretations that substantiate them. If problem identities recur at this point, a client can loop back to movement one.

The last movement prescribed by Ewing, Estes, and Like (2017) involves a client to work toward inhabiting his or her preferred identities. This can be done through revisiting physiological differences between current and past identity states. A client can also notice daily habits that support the preferred identity states and are allowed to make guesses about what would be involved in his or her future. These movements conclude by having a client having become more intentionally aware of his or her physiological experiences that underlie personal identities. He or she then can move forward with new, preferred identities that have been reworked in ways that utilize that awareness.

Working to redesign narratives and associated identities may also involve information that is not complete. This incomplete nature of the information may then result in questions about what would finish the narrative and treatment as a result. To

understand how and if a narrative as told in therapy can be deemed as complete, examination of the concept of a story should first be examined.

The biggest problem to narrative coherence for any story is for it to be understood in a social way. McAdams (2006) discussed there may be multiple ways for this to happen. He wrote that stories may defy expectations for their structure in regard to time, intention, goal, or closure. Using the concept of time in a story, an example may be a novel which has an opening scene depicts the characters in their final act of conflict with each other. A line may be written in the midst of the conflict of how one character remembers what led to fight and then the story switches back to a period before the final event. A narrative told in therapy that is out of order like this may be noted to be just as confusing for the client and the therapist. For example, a client may have experienced childhood trauma but lived his or her life without recognizing its existence until years into their adulthood when he or she is in therapy for a recent depressive episode.

"Coherence…may also pertain to a story's content" (McAdams, 2006). This means that even though the sequencing of events in a story may be in a proper chronological order, these events mean nothing if the details of what happens defies the expectations of the readers or listeners of the story. Knowing the standards for how a story has coherence or not, do these rules apply for a client's personal story as revealed in therapy? According to McAdams, what best helps make a life story coherent is that it integrates all of the events that made the person who he or she is at that time.

Different narrative therapy perspectives offer differing opinions on how those events are expressed however. Two main factors have been identified in terms of

characteristic life stories that come out from work in therapy and how they best fit the person who tells them. They first "must come to terms with the characteristic assumptions regarding what kinds of stories can and should be told in a given culture" (McAdams, 2006). This means that the story has to be in some agreement with the expectations for its details within the realm of the person's social world. The story is also often the result of interventions that a therapist implements for the client telling it and for the story to be suitable for its teller, the interventions "should also result in the story being adequately *organized"* (Dimaggio, 2006). This organization, while assisted in creation by the therapist, is at the discretion and decision of the client telling it.

As previously mentioned, the life story that a person creates is often deeply connected to the sense of self and the identity which he or she creates as a result. To have a sense of self involves a sense of unity within the person and is based on interacting components that form internal dialogues with each other. What happens when the stories developed from those dialogues are disrupted and go against the conditions described by Dimaggio and McAdams? This may occur when a client experiences symptoms of Schizophrenia or other types of psychosis.

Lysaker and Lysaker (2002) proposed that in the cases of individuals who experience these types of behavioral or emotional disruptions, the internal dialogue may be prohibited in a way. The prohibition is conducted by "an overwhelming presence of a rigid and inflexible hierarchy among self-positions" (2002). In other words, an individual who goes through difficulties from psychosis may never have been able to establish a way to give order to his or her inner thoughts and perceptions. This then results in the disrupted self and a disjointed life story.

When this occurs, Lysaker and Lystaker (2002) proposed that an individual could go through three possible experiences. Inner conversations could be very minimal in nature, which would lead to imagined dialogues to be absolutely vital. This means that a person was unable to have self-reflections of what makes up his or her identity and resorts to that of other entities that are not visibly or audibly perceived naturally. Another self could be created that an individual would be left to latch on to disjointed identities and reject ones that are socially accepted. The last self that Lysaker and Lysaker proposed would be one where the individual does create a consistent story. However, the story is so firm in its constructs, narrative growth is not possible and may be delusional in nature.

Viewing the disruptions that an individual with Schizophrenia experiences as issues with how he or she creates his or her self-concepts has implications for treatment if using constructivist approaches. Similar to how in narrative therapy work is done to help a client reclaim or rewrite his or her stories, Lysaker and Lysaker (2002) suggest that work with an individual who has Schizophrenia would involve helping the person recover his or her self-positions. This would be rooted in the communication that is done within therapy between the client and the provider. Dialogues from the client would be encouraged about him or herself. Also, since the interactions an individual with this diagnosis have with his or her families is so vital to recovery as well, the dialogues are recommended to occur at home as well. This is comparable to how when a person begins to reform his or her narratives in other therapeutic domains, he or she is encouraged to let others know how he or she has found his or her life story again.

The methods and interventions that are associated with narrative therapy have also been used with different populations of people who have not experienced the disruptions that are associated with psychotic disorders. For example, the concept of grief is one area that can provide experiences that shape a life narrative and identity. Among those who provide and study therapeutic interventions, there has been much support for using narrative based methods to allow a person to find ways to express his or her loss and find new meaning for his or her lives from it. Neimeyer, Torres, and Smith (2011) also added to these findings by describing how the virtual dream can continue to help process a client's loss narratives.

The virtual dream is a short narrative a person writes that has specific elements in it and is drafted quickly in order to ensure the spontaneity of the content included in it. The elements chosen for the virtual dream are related to the general topic that is being covered in it. Neimeyer, Torres and Smith (2011) described an example of a virtual dream focused on a traumatic loss that may include elements of the loss, a crying child, an empty house, a talking animal, a mountain, and a sunrise. They explained that the writer of this story is allowed to pick the structure for which these elements are used, but the person is encouraged to use them all to support the story overall.

The virtual dream helps a client to feel more comfortable divulging information about him or herself. If someone in therapy is directly asked about how he or she feels toward their recent loss, he or she may resist. In contrast, having someone disclose about his or her dreams is met with more acceptance. This has been found true for virtual dreams as well. "People often enjoy talking about their creative stories…that

often reflect their deepest yearnings, anxieties, and sensed possibilities" (Neimeyer, Torres, & Smith, 2011).

It is important to note though, that while a virtual dream is not fully autobiographical in regard to its author, themes can emerge that resonate with or for the writer. These themes are then what require additional discussion and processing within a therapeutic setting. By reviewing the themes in a more comprehensive way, aspects of the dreams can emerge and be examined for how the creator of them views his or her role(s) in his or her life.

Two of these are point of view and voice. The first of which is from whose perspective the dream is told. Voice indicates how it is expressed, such as in an angry tone, for example. This characteristic of a dream, and by extension, the story behind it helps the therapist working with a client significantly with his or her work within the sessions. It assists the therapist in determining the client's original voice within therapy and how to help direct movement toward utilizing another or to move past a problem toward a more helpful life. In the example of a client whose dream has an angry voice, the therapist may assist the client toward finding solutions for dealing with the things that elicit that emotion outside of therapy.

Other aspects of the dream are features which are commonly associated with fictional stories in general. These include: *setting*, which is where or when the story takes place; *characterization*, for who the people involved the story are; and *theme*, of the reasons why the plot events occur. Finally, the aspect of *fictional goal* is the one that is most tied to therapeutic work in that is the projected end result of the dream.

Continuing the angry voice example, the fictional goal would be what about the anger the therapist is helping the client to achieve.

Neimeyer, Torres, and Smith (2011) provided data on research they completed on common traits that occur in virtual dreams. They instructed 143 participants to write a virtual dream in eight to ten minutes using the six elements previously mentioned (crying child, traumatic loss, etc). A large amount of the completed dreams were written from an anonymous point of view that took place with characters experiencing despair due to a death. What is most interesting though, is that while "nearly 30% evoked a dominate theme of despair" there was also a positive emotion with "over 40% of the stories built to a theme of hopeful anticipation of the future" (2011).

These results indicate that even a narrative that is written to include elements that are not selected by its author can be helpful in emotional ways. The elements that are used in a virtual dream can be tailored to the theme or issue at hand within treatment. Neimeyer, Torres and Smith (2011) include a table of situations, figures/voices, and objects that can be selected from as elements. These, however, are only starting points for virtual dreams and for narratives created in therapy in general. The virtual dream is one strategy that can allow an individual to explore hypothetical themes of life to move potentially toward exploring themes he or she has encountered or created in his or her own life and its stories.

In addition to his collaborations in research on virtual dreams, Neimeyer (1999) also wrote of using narrative therapy to assist clients by way of grief counseling. He first described guidelines for a therapist to be mindful of when developing interventions in this capacity. Many, if not all of which relate back to tenants of constructivist

psychotherapy. These include the collaborative nature of the work and respecting the client's resistance. His advice to "respect the client's privacy," however, may be one that also relates to understanding the importance of a person's story is to his or her life. This area of respect instructs the therapist to be sure to honor how individualized a client's story is and why it matters for him or her to tell it when he or she decides to do. Neimeyer also described strategies or interventions that can be implemented while following those guidelines. Two of them involve writing (journals and epitaphs) because "a growing volume of research now supports the conclusion that writing…can have substantial positive implications for one's emotional and physical health" (1999, p. 72).

The research that Neimeyer alluded to has only grown since he published his 1999 article. In Norway, a case study was conducted to evaluate the use of narrative therapy techniques with one individual woman. The providers who worked with this woman used what they termed Narrative Exposure Therapy (NET). This was a type of CBT for PTSD which also uses interventions that involve a life review. Interventions involve psychoeducation on PTSD itself along with the creation of a creation of a "chronological physical lifeline that includes all significant memories…from birth to present" (Mørkved & Thorp, 2018). The woman whose case was presented in their study complained of many symptoms of PTSD as well as "feeling depressed…and difficulties regulating her emotions. She was not suicidal at intake nor during the course of treatment" (Mørkved & Thorp, 2018).

The woman completed a PTSD symptom scale as well as a Beck Depression Inventory II (BDI) (Beck, 1996). at the start of her treatment, after session four of NET,

following completion of treatment, and one month after her initial block of NET. Mørkved and Thorp (2018) wrote that the woman's sessions of NET involved using "a ball of yarn with rocks and flowers symbolizing significant events." Before treatment, the woman's symptoms on the PTSD symptom scale and the BDI were in the significant range. By post-treatment however, there was a decline in her PTSD, anxiety, and depressive symptoms and "she reported her experience of improvement before treatment was terminated" (Mørkved & Thorp, 2018). At follow-up, the client also maintained her gains in PTSD and depressive symptoms while her anxiety returned to moderate levels. These results show that one type of narrative therapy was able to be beneficial in some areas of functioning for a client in one specific case. The woman in Norway was able to create a visual representation of her life and to process the effects of the traumatic events she physically represented in it.

Narrative therapy techniques have been found to have potential benefits for groups of women who have experienced specific kinds of trauma. In 1998, Claire Druacker wrote an article with vignettes about multiple women who had experienced sexual violence abuse within their romantic relationships. Each of the six women highlighted in Druacker's article told their stories through narrative based interventions. The stories varied in terms of specific events the women faced, but Druacker posed the question of what narrative therapy could offer them or other individuals with similar clinical needs. According to her, narrative therapy "could serve the needs of such women by highlighting the oppressive forces that have dominated their lives and by nurturing their rebellious responses to such forces" (Druacker, 1998).

In 2017, Countryman-Roswurm and DiLollo provided a more detailed approach on how to follow the path of what Druacker (1998) wrote narrative therapy could offer women. The details they provided focused on how to utilize narrative focused interventions for females who have experienced sex trafficking. Countryman-Roswurm and DiLollo first acknowledged that if work is to be done, two challenges to it have to be addressed. These are technical and adaptive challenges. The first "tend to be the most obvious, surface issues faced by individuals or groups" (2017). They recommend that these are the areas best defined and addressed by an expert through interventions. Adaptive challenges, in comparison, "have no straightforward solution…require changes in ways of thinking, as well as behaviors" (2017). They also are difficult to identify and the process to achieving results with them takes extended time and effort.

There is also a way of thinking that may be present with individuals from the population of women who have experienced sex-trafficking according to Countryman-Roswurm and DiLollo (2017). Women who have experienced acts of sex-trafficking may hold conflicting self-perceptions in that they are highly moral due to their loyalty to their trafficker while also feeling shame and immoral due to having not resisted the acts involved in the trafficking. These may be similar to contrasting self-identities and constructs that individuals may have developed through other life experiences that did not include sex-trafficking. These thoughts and challenges may be why narrative therapy can provide vital interventions in therapy which can assist women who have been sex-trafficked.

The narrative therapy intervention of naming the problem is one that would have a therapist to invite a woman from this population to do this action by "using a single

word or phrase that she feels accurately describes or represents the problem for her" (2017). Next would be externalizing the problem. This relates to narrative therapy principles which help to bring about dialogues between a therapist and client about new ways of examining the story being told so that it is not the client's only identity. When applied to work with women who were sex-trafficked, this externalization is "designed to promote the implicit assumption that the problem is having an effect *on* the person as opposed to the problem existing *within* the person" (2017). Through the course of the client's discussion of how the problem influenced his or her life, a narrative therapist is to look for specific instances of when this was not true. These unique situations are then questioned with curiosity to help the client see moments of exception to his or her dominant narrative. These questions then "serve to "historicize the development of the alternative story, grounding it in preexisting characteristics of the person" (2017). By looking at previous and current abilities of the client, work can be done to see what he or she did to get the life he or she wanted. Then together, the client and therapist are able to create an alternate narrative for the individual.

These three studies highlight the benefits of utilizing narrative therapy in the treatment of women who have experienced intimate relationship violence, historical trauma, and sexually related assaults. Their results prompt questions about if narrative therapy would have any impact if used with other clinical populations. For example, would this approach be effective with adolescents who are in treatment? Is it even possible that individuals of that age even have concepts of what their stories are at that point? Habermas and Bluck (2002) looked into if and how life stories come about for adolescents.

Habermas and Bluck (2002) first began their work by defining three types of coherence that are relevant to a life story. They also recognized that while these types of coherence may be prototypical for a life narrative, they may not be present in all narratives of all people. These are temporal, casual, and thematic coherence. The first of these, along with the cultural concept of biography are what create the outline to how major life events as defined by someone's culture are sequenced. The term casual coherence relates to the idea of what cultural foundation to what events are included in the life story. An example may be that of someone who practices Christianity and is sure to include the date of his or her baptism as a life event. Casual coherence also is used "to explain changes in the narrator's values or personality as a result of events" (Habermas & Bluck, 2000). Continuing the example of the Christian, casual coherence may also be used to describe how or why the individual lost faith in God.

The questions then raised by Habermas and Bluck (2002) involve use or recognition of these types of coherence by adolescents. They reviewed prior research and found that there is a sequence to when children begin to formulate stories of events in their lives. The result was that "by the end of childhood, the understanding of simple casually structured, goal-directed stories is fully acquired." From this development, the next step of life story telling, according to Habermas and Bluck appeared to be formulating biographical data of one's story to separate it from that of others in one's life.

They questioned if adolescents had the cognitive mechanisms that would allow them to do such a task to result in a story which had the coherence previously addressed. What was found is that overall, the "cultural concept of biography

emergences in late childhood and early adolescence" (Habermas and Bluck, 2000). The data which formed this conclusion converged regarding specific details. It means that an individual of at least twelve years old may have the cognitive disposition to begin telling about at least some events in his or her life that he or she recognizes as his or her own. The main thing needed, according to Habermas and Bluck, is for the person to have that self-recognition. This also includes knowing the differences between current and past life events.

What can narrative therapy impact in an adolescent's life then, if those circumstances are met? Ghannadpour, Sams, and Garrison (2018) examined how narrative therapy impacted hopelessness and family communication among 39 clients receiving treatment on a child and adolescent psychiatric inpatient unit. The work they conducted included an interview, a write-up, and a sharing of the adolescents' narratives. The Parent-Adolescent Communication Scale, which measured degrees of openness and problems in family communication and the Hopelessness Scale for Children which measured children's levels of children's negative expectations themselves were before and after the intervention.

Ghannadpour, Sams, and Garrison (2018) reported that over half of their study's participants shared their narratives. The results showed that hopelessness scores decreased significantly after use of the narrative intervention. Communication with mothers did not significantly change, but communication with fathers showed a pattern of improvement from before to after the intervention. These results indicate that narrative therapy may be beneficial to be offered within the interventions used for psychiatric care delivered to adolescents in that type of setting.

Narratives can be formulated through work with individuals who are younger than the adolescent age that may be beneficial in facilitating therapeutic interventions. Habermas and Bluck (2000) described that if the direct questioning of children's life stories is conducted along with using visuals, such as a puppet to tell it, the narratives could be told.

Stutey, Helm, Losasso, and Kreider (2014) examined the use of interviews and photo-elicitation with children in telling their stories of grief. Photo-elicitation is a way to collect data from children where they showcase their emotional expressions through photographs. Stutey, et al used a sample of children who were ages "6 to 10 who had experienced the loss of a loved one in the last three months to two years" (2014). The children were asked to take pictures of anything that reminded them of the person who died or that would help the researchers understand how they have been doing since the death. Following the photos' being developed, the children were then interviewed in a semi-structured way with the children participating and using the pictures in their discussions.

The results of these interviews were presented in narratives which focuses on the themes that were present in them. One child discussed the death of her baby brother and talked about how hard it was to do so, but that the camera helped. She shared photos of art work she did for her brother and spoke of what her and her family's life would be like if he was still alive. She last said she was going to put the photos from the research that she liked best into a photo album.

This girl's story, like the others presented by Stutey, et al (2014) showed the extent to which "children understand death and interpret the actions of the adults around

them in reaction to that death." The children reported many stories and details related to their loved ones but had trouble expressing their words in emotional ways. Despite this, Stutey et al (2014) noted the emotional significances of the photos the children took and how this shows that there may be nonverbal ways that children express themselves. This is promising, they felt for interactive (play) related interventions and nonverbal work that could be done with children who are grieving. More so, these types of interventions may provide options for individuals of various ages who are not able to express their stories in the traditional verbal ways in therapy, and thus, potentially providing ideas for narrative based interventions.

Stiefel, Anson, and Hinchcliff (2017) examined the idea of how younger children could be participants in therapy with their families. They researched the factors that would need to be taken into account for if pre-school aged children were in treatment, for example. Their work focused on a family in which a four-year-old boy had started to show aggressive behaviors toward his parents and older sister when he did not get what he wanted. In work with the family, the boy's therapist first collected the parents' story of what they saw as the issue (the boy's tantrums). Then, the therapist explored how they viewed his tantrum behavior. The boy was asked if he could tell what one looked like for his developmental age (five years) and when he could not, the therapist gave an example of this action.

The therapist then used an externalizing technique to teach the client to engage in an action of how to "put" his more developmentally immature tantrum behavior into a safer space. The parents were included in this and offered praise for when he successfully did the action. Later sessions involved helping the client recognize and

utilize awareness of when these younger tantrum behaviors were to occur. Stiefel, Anson, and Hinchcliff (2014) offered ideas of how the externalizing technique used in narrative therapy can be adapted like this for inclusion of younger children in family work. Stories can be made which re-label the problem behavior and other creative actions can be used such as in this one where a tantrum is displayed as an acting type event.

"The language of the family is absorbed in developing the theme for externalization, however, in the work with children" (Stiefel, Anson, & Hinchcliff, 2014). This means that the facet from narrative therapy of making a conversation about the problem and developing new alternatives to its role in a client's life is based on how the family sees it. Other steps or facets of narrative therapy can also be reimagined according to Stiefel, Anson, and Hinchcliff when using a child of preschool age within family-based interventions. Following the recommendation of Bluck (2000) of using visual means in the forms of puppets or arts can help with children in narrative work within family therapy too. To implement the work of theme development as related to the client's identity both related to the problem in sessions and not, the child's interests can be helpful.

With the benefits that narrative therapy offer an individual with the stories he or she tells about the world, it may be possible that interventions from this domain also can help an individual within his or her social interactions. One way in which a person may struggle socially is if he or she has anxiety specific to that domain of their lives. Looyeh, Kamali, Ghasemi, and Tonawanik (2014) looked into the effectiveness of narrative therapy in mediating social phobia when used in a group setting. They used

24 boys randomly assigned to either a 14-session treatment group or a waiting list "control group."

In each session, the boys played different games that involved narratives and storytelling. These games followed a sequence that is similar to what has previously been described for the course of narrative therapy with adults. In the boys' treatment, they began with initial sessions that involved recognizing and talking about feelings they have gone through in social situations. From there, they progressed to building awareness of consequences to these feelings. The next three sessions involved having them tell stories of a fictional character dealing with an event in which the character was socially anxious and then found solutions for dealing with that problem. In the last sessions the participants listen to stories told by the facilitating therapist where characters encountered and mediated environments that would elicit social anxiety with successful work on that problem by the stories' ends. A symptom checklist was used to measure the boys' anxiety before and after treatment. Tests were done to examine symptom differences between the two groups and within the treatment group before and after treatment. The boys who had completed the treatment were noted to have "a significant decline in symptoms one week after the completion of treatment as reported by parents" (Looyeh, et al, 2014). The storytelling is what was found to be the most critical factor in the effectiveness of the study completed by Looyeh, et al in 2014. It allowed for the boys to feel safe and engaged them in their treatment in a fun way.

Social anxiety is not the only behavioral disruption that can cause difficulties for people in their interactions with others. The Diagnostic and Statistical Manual, Fifth Edition (DSM 5) lists characteristics of individuals with Autism Spectrum Disorder to

include trouble reading social cues, discriminating emotional actions, and regulating their behavior. Narrative therapy would allow for help with these problems through its focus on a specific area of distress a client is facing. Cashin, Browne, Bradbury, and Mulder (2012) worked with ten participants aged 10 to 16 through a pilot study of five therapy sessions across 10 weeks of time. Parent reports on the Total Difficulties Score (TDS) from the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) were used to measure the intervention's effectiveness. "There was a reduction of 3 points from baseline for the TDS on the SDQ after the intervention," (Cashin, et al, 2012). The authors indicate that this result was not statistically significant. The reports showed, however, that there was a reduction from baseline on many of the subscales of the TDS. These included emotional problems, peer problems, and conduct problems. In addition, the participants themselves completed self-reports of their psychological distress and hopelessness. These results "were consistent with the parent-observed behavioral improvements…a substantial reduction from baseline in psychological distress…a reduction of 2 points on the Beck Hopelessness Scale, although this difference was not statistically significant" (Cashin, et al, 2013).

Cashin, et al (2012) did not provide information about the nature or content of the sessions that were conducted with the participants. Their results indicate that narrative therapy may allow for one type of intervention that can be used with an individual who has traits of Autism Spectrum Disorder, but more details and careful consideration is needed. Narrative therapy is a collaborative effort between client and therapist at its core and if it is to be more successful with non-traditional populations or in unique settings, that collaboration is vital.

To collaborate with a client on narrative therapy interventions, the social community or domain in which he or she operates most often must be considered. One of these environments currently is that of video games and the 'online' world, such that the common phrase about there being an 'app' for everything. Among the individuals who make up the online video gaming community, the gaming environment is often the primary social environment in which these users are most comfortable. Narrative therapists can apply their curious approach to hearing and working with their clients' stories from in that domain. "Many of the most popular games involve creating a virtual avatar, character or persona. This is fertile opportunity for therapists to explore a client's online identity and perhaps their offline self as well" (Erickson and Monk, 2018).

This exploration of the virtual and non-virtual identities a client creates can help the therapist hear the individual's story as he or she wants it told. The client may have told the story virtually in ways that represents his or her ideal life. Collaborative work between the therapist and client can then be done to see how traits from that preferred existence may or may not line up with the non-virtual one. This can then lead to further alliance-based treatment where the client can incorporate what he or she wants from the desired identity into the one which brings him or her struggles outside of the game. The meeting of the client in his or her world, even if it is a virtual one, allows the client to set the language and the story and thus, create his or her new identity and its associated story.

Narrative therapy can also be used in working with clients whose needs are pressing at the moment of first discussion of them. Young (2008) provided "a specific

and detailed look at how narrative practice at a walk-in [clinic] can offer children and their parents immediate assistance." Specifically, Young examined how narrative work at a walk-in clinic addressed child anxiety. The first facet to how narrative therapy is implemented involves the provider adopting a specific narrative posture. Young's description of this concept is similar to the curious questioning that a provider engaging in curious questioning of an older client's story does in session. "Narrative posture or "way of being" in conversation with children creates a foundation for meaningful and collaborative conversations…providing immediate assistance—more than gathering information and assessment practices could provide alone" (2008). The instantaneous help in this case is important to access due to the nature of the walk-in clinic and how treatment is delivered in such an environment.

Curious questions are what the therapist uses to understand and conceptualize the child's worries. The therapist is able to understand what the child is doing already to handle these issues and what he or she can do to lessen the worries' impacting the child's functioning. "Questions that externalize the problem assist children to express "the Worry" in words or pictures that are meaningful to them" (Young, 2008). The therapist and child create stories and pictures together in this part which are focused on ways they can help him or her move forward in having ways to mediate the problems he or she faces when anxious. The child is then allowed to take the documents home and this helps to reinforce the work that was done and reminds the child of what he or she learned and skills he or she developed.

Young (2008) also provided two case studies of conversations she had with kids who came to the walk-in clinic for their worries toward attending school. Follow up

appointments occurred four months afterward. Anecdotal data was collected and details from the work the therapist completed with the boy child was described. The discussion that the child and therapist had was about separating the child's identity from his anxiety and what its results, standards, and how it elicited the feeling from him. The stories told illustrated that the boy had learned to grow a separate sense of self from his worries. He was figuring out that he was not his anxiety and he was working out ways to not feel it as much.

In addition to research that has been conducted for how narrative therapy has been implemented with different clinical populations, there has also been research which examined the effectiveness of it in comparison to other therapeutic orientations. (Lopes, R. T., Goncalves, M. M., Machado P. P., Sinai D., Bento, T., & Salgado, J. (2014; Da Silva, R. A., Cardoso, T. D., Mondin, T. C., Reyes, A. N., Bach, S. D., Souza, L. D., Jansen, K., 2017). One of the orientations that has been compared to narrative therapy is CBT. Some concepts of CBT are noted to have similarities to narrative therapy, such as the reframing of thoughts in CBT being alike the reframing of self-concepts in narrative therapy. One study (Azevedo da Silva, Cardoso, Mondin, Reyes, Bach, Souza, and Jansen, 2017). examined how effective narrative cognitive therapy (NCT) was in comparison to CBT in working with clients with Major Depressive Disorder to improve their perception of quality of life.

Individuals aged 18 to 29 were recruited from a community health center were randomly assigned to one of two groups of brief therapy (CBT or NCT). (Azevedo da Silva, Cardoso, Mondin, Reyes, Bach, Souza, and Jansen, 2017). The NCT sessions were designed to have a client "reconstruct personal narratives by writing biographies

and elaborating on life stories that have lost meaning and become incoherent" (Azevedo da Silva, Cardoso, Mondin, Reyes, Bach, Souza, and Jansen, 2017). Participants in both groups attended seven sessions, a number that was determined to be the least amount needed to elicit changes in behavior. The Hamilton Depression Rating Scale (HDRS) was used to assess the clients' depressive symptoms and the Medical Outcomes Survey Short-Form General History Survey (SF-36) was used to measure perceived quality of life. Measurements were taken at baseline of treatment, postintervention, and at a six and twelve month follow up. Analyses of data revealed "on average, the patients showed a reduction of depressive symptoms over time" (Azevedo da Silva, et al, 2017). Quality of life reports only showed differences at the twelve month follow up with CBT being more effective in multiple areas such as improving physical functioning, vitality, and mental health. This indicates that while narrative therapy may not provide improvements in perception of life, it is comparable in how it mediates overall depressive symptoms. This shows promise for use of narrative therapy in addressing emotional components of an affective disorder.

Lopes, et al (2014), also compared CBT to narrative therapy (NT) with adults. Their study looked at specifically how the two treatments mediated depressive symptoms through a randomized clinical trial in a university psychology clinic in Portugal. Clients' depressive symptoms were measured by the Beck Depression Inventory II (BDI II). An outcome questionnaire was used to measure clients' progress in the treatment sessions and after its completion. Participants completed 20 one-hour sessions of either CBT or NT. Lopes et al examined participants' post-treatment scores on the BDI II to determine if there was a reliable change from their results before

treatment. The results showed that "clients in both treatment groups scored significantly lower on all measures" (Lopes, et al, 2014). The researchers also make note that their study had significant drop out rates (35.5% overall) and this resulted in their data "not being consistent enough to ascertain the efficacy of Narrative Therapy for moderate depression. However, when clients completed treatment, it appears to be an effective treatment" (Lopes, et al, 2014, p. 673).

Mørkved, et al (2014) identified that there is a "relative novelty" to narrative exposure therapy (NET) and they compared NET to PE across different concepts. These details included but were not limited to: theoretical foundations, treatment components, and numbers of traumas addressed.

Prolonged exposure therapy (PE) is an intervention that has been developed for working with clients who have experienced trauma. A primary aim is to change how the event is emotionally processed and reduce the trauma related symptoms that a client experiences. As previously discussed, NET focuses on the creation of a coherent narrative of a client's life. Both interventions, however, "share a focus on improving the client's narrative cohesion and thus a better integration of the traumatic memory" (Mørkved, et al, 2014, p. 456). Sessions that clients attend for either NET or PE are similar in duration (approximately 90 minutes for PE and 90 to 120 minutes for NET) but may differ in overall number (ten to 15 for PE and five to ten for NET).

Exposure is used in both NET and PE with imaginal and vivo (live) exposures used in PE. NET, however, only uses imaginal exposure for a client in how he or she encounters his or her described events. Both treatments do use imagined exposures to past events in order to help a client reduce PTSD symptoms. The last difference

between NET and PE that Mørkved, et al (2014) discerned was that NET "addresses all of the client's traumatic memories chronologically while PE typically addresses a single event or the traumatic memory identified as the worse ("index event") by the client." It is important to note, however, that PE can address multiple traumatic events that clients experience. This would be in the event of exposure to the "index event" not intervening on the symptoms adequately and so the next traumatic memory is addressed.

IV. Expressive Narratives from Popular Art, Music, & Literature

Narratives that an individual tells sometimes are not expressed within a therapeutic capacity, but they can still offer catharsis or emotional relief. Sometimes a person may choose to create artistic expressions events in his or her life as well as his or her entire existences as means to cope with distresses he or she experiences. An individual who use these ways to cope channels his or her emotional energies use different artistic mediums such as the written word, visual art, and musical songs. To list the entire collection of people of these works would be never-ending as art has been created since the beginning of human existence and more artists create new works every day. For brevity purposes, the next paragraphs are going to highlight two examples of expressive works used to as coping and processing exercises from the domains of musical lyrics and creative writing, and one example from visual art. The following examples are also anecdotal in nature and do not have empirical support for the validity of the works completed. The section that follows this one will go into more depth in a review of empirically validated clinical studies of expressive therapies.

Jackson Browne is a singer-songwriter who first gained attention for his work in the 1970s with his self-titled album. The album included the song *Doctor My Eyes*,

which went on to be his first top ten hit in popular music. Starting with that album and song, Browne produced music that was known for its "introspective, literate lyrics" (Artist biography by Stephen Thomas Erlewine, retrieved from allmusic.com). Many of his earlier songs provide examples of his use of music and lyrics to reflect on life situations he has encountered and to foster emotional growth within himself. These works also "provided a touchstone for a generation of maturing baby boomers coming to terms with adulthood" (Erlewine, allmusic.com). Browne felt that in the case of one of his songs, *Fountain of Sorrow*, he could not make it too focused on himself and to only be about his life. Instead, the song needed to be about other people. Specifically, he made this song more about the subject, the identity of whom he has yet to name. "If you write a song about anything specific to your experience it's going to go beyond that. It can't be you relating your exploits to other people" (J. Browne, website interview, October 7, 2014).

Browne himself is also on record as stating about the emotional growth that is at the root of *Fountain of Sorrow*. "This talks about disappointment, but in a forgiving way. It acknowledges that people are always looking for something in each other they may not find, and says not only is that OK, but what's more enduring is the goodwill and acceptance of each other's rights to…make your own choices" (UnmaskUs, 2019). Browne also addresses a theme that has previously been discussed in relation to the individualized narrative of one's life story. He explains that someone who is looking at another from the outside, even if they are in a relationship, can never really know what the other is going through in life. Of his song, *In the Shape of a Heart,* he called it "probably my most personal. It's about…whether we know what's going on at a

particular time, whether we recognize people for who they are, whether we know what people are talking about when we're in a relationship with them" (UnmaskUs, 2019).

Amanda Palmer, a singer-songwriter who first gained attention for her work as part of the Dresden Dolls also wrote of the difficulty in knowing one's identity in the context of a relationship. She took the perspective though that it is one's own identity that is hard to know in the relationship, not one's partner. "I'm pretty sure the seed of "Ampersand" was fejust the image of the ampersand as a symbol that happens to people when they cease being Mary. They turn into this really irritating relationship people who'll only ever say "we" (UnmaskUs, 2019). Lyrics from the song describe her growth in being comfortable with her own individual identity and refusing to sacrifice it by becoming part of a romantic couple. "And I'm not gonna live my life on one side of an ampersand And even if I went with you I'm not the girl you think I am And I'm not gonna match you 'Cause I'll lose my voice completely yeah" (Palmer, 2007).

Palmer is also known for using her entire life experiences as fuel for her art, both musically and visually at times. She repeatedly lets her fans know through her website of the connectiveness of art to the events she lives through in her life and what this connection means to her. "These songs are the most vulnerable and personal I've ever recorded, and they all provided some kind of relief from each life-situation I was facing over the last seven years…it was just non-stop, the gamut of human emotion and highs and lows" (Palmer, 2019).

Mary Shelley is a fiction author who is best known for possibly being the first female science fiction author. She and her husband, Percy Blythe Shelley had difficulties having children and Mary went through multiple pregnancies that she did

not carry to term or that died in infancy. In February 1815, Mary gave birth to a girl who was two months premature. Twelve days later, the baby died during the night. It has been found that on March 1815, Mary wrote in her journal of a dream she had. The details were of her baby coming back to life after she rubbed the baby before a fire. She also described the distressed feelings she experienced after waking up from the dream to find it not to be reality.

This dream made Mary "more conscious of her agonizing feelings of loss…more aware of the reality of her child's death" (Buckley, 2012). This dream also provided Mary with other inspirational feelings that she fueled into a creative outlet. The summer after giving birth to a son in January 1816, Mary and her husband visited with Lord Byron in Switzerland and Mary "conceived the idea for her first novel, "Frankenstein, or, the Modern Prometheus"" (Buckley, 2012). The novel reflected Shelley's wish to bring her dead child back to life. More than this though, the story was a way for her to process her grief toward the circumstances of that death. It also "prompted a transformative deepening of her awareness of the creative tension between life and death" (Buckley, 2012).

Sylvia Plath's novel, *The Bell Jar*, is known for being an expression of her depressive states as she navigated her adult life. It has been studied for years for how she used these works as means to express and understand her emotional distress. In that novel, Plath portrays a semi-autobiographical portrait of a protagonist struggling with depression and how she is treated for it. Plath also used poetry as a means to express herself and to cope with her mental distress. These works are not as widely published

or known as her novel but still offer great insight into how she viewed herself, her life experiences, and what these events and that identity meant to her.

"Her work….exhibits a rebellion against the confinement of "self" in the bondage of conformity…the bulk of Plath's work signifies development and transition, emerging from the person's experiences of estrangement and entrapment" (Ghasemi, 2008). This means that Plath used her poetry to fight against the limitations and structure to her identity that others were placing on her. Some poems specifically can be viewed for their darkness in imagery and tone. Her poem *Daddy* can be seen as autobiographical in its narrator expressing dissonant feelings of love and hate toward a father figure. "Considering this poem as an allegorical or symbolic work of art, "Daddy" is a young woman's articulation of her inner conflicts, as a daughter, a wife…and a victim in contrast to the powerful male oppressors" (Ghasemi, 2008).

Plath's struggles that she illustrated in her writing mirrored her own in regard to finding her voice and her identity. She used poetry to express her emotions in other situations as well. Ghasemi wrote that Plath's demonic Ariel poems were her ways to let out her anger and frustration with her mother's attachment to her. Plath also writes of the cycle of life, death, and rebirth as a way to conceptualize her own feelings toward her existence. This was evident in *The Bell Jar,* with her main character going through "alienation…leading to Esther's breakdown and suicide attempt" before having a "symbolic rebirth" (Bonds, 1990). It can also be observed in her poem, *Lady Lazarus,* "…a poem of personal pain, suffering, and revenge" (Ghasemi, 2008).

The movie *Alien,* which was released in 1979 is regarded by fans and movie critics as one of the most terrifying horror films ever made. The monsters featured in it

and sequels that went on to make up the series of films based on it were designed by the late Hans Ruedi Giger (1940-2014), a Swiss painter. Giger's work from the *Alien* series along with other artworks, both physical and visual, that he created in his life are chronicled in the documentary, *Dark Star: H.R. Giger's Welt.* The documentary features interviews with Giger himself along with many people from his life to explain his work. According to the film, the general theme of what he used his work for was to process the distressing and frightening emotions that he felt in life. He also wanted to help normalize the experience of such feelings in others.

Giger says in the documentary he remembers being given a skull from his father when he was a child and the experience scared him for what it meant to "hold death like that…" (Hoehn and Sallin, 2014). Giger went on to say that through is art, he wanted to prove that death did not scare him. Among the people in film are his wife at the time of his death, Carmen Maria Giger. She states that her late husband draws what scares him from his dreams and other experiences and does so until he reaches a satisfying point. "He keeps drawing it until it [the fear] goes away or he gets it right" (Hoehn and Sallin, 2014).

Giger began his work in art in the 1960s when posters were used in Switzerland as a way to express oneself. In Hoehn and Sallin's (2014) film, he said, "Waking up can be an upsetting experience sometimes." Giger followed this comment with his opinion about how so many people dream but how rare the occurrence is that these dreams are told to other people or even depicted for them to see. Giger's romantic relationship in the 1970s also influenced his art for an extended period. He dated Li, a woman who would later complete suicide while they were together.

Giger states in the documentary that a lot of things from his relationship with Li went into his art. He recalls that she struggled with depression and he feels he did not help with his paintings. Giger describes her death as "overwhelming" (2014) and how he did not think he would ever be able to cope with it at first. By painting again, Giger reports that he felt it helped him distance himself from the death. "It is a horrible experience to think you're responsible for a partner's death" (Hoehn and Sallin, 2014).

Giger's work also has helped others with their emotional functioning as well. His assistant, Thomas Gabriel Fischer, states in the documentary "His art reveals a lot fears we have in society. It's like a bridge to my own emotions," (Hoehn and Sallin, 2014). In this way, Giger's art is one example of how creating an expression of one's emotional journey can help not only the artist grow but to foster support and encourage the same development in others.

V. Effectiveness of Expressive Therapy and Fostering Emotional Growth

Expressive therapy, also known as art therapy includes interventions that "combine psychology and the creative process to promote emotional growth and healing" (Psychology Today). The interventions that can be incorporated through expressive therapy can use one or many types of art mediums with a client in sessions. The techniques involved in expressive therapy are ways a client can use artistic mediums to work through his or her own emotional and psychological struggles.

One of the interventions that can be used as part of expressive therapy is one that involves use of a sandtray where a client is given a container filled with sand "along with a set of miniatures – small items or toys selected to represent people, places, or concepts from the client's world. The client then builds a scene in the sand, and this is typically processed verbally within the counseling session" (Garrett, 2014). This can be compared to having a client draw a picture to facilitate emotional discussions within therapy. Sandtray work is not limited in terms of the theoretical orientation of the therapist involved in using it. While it may be more suited for a

person who considers him or herself more creatively minded, it can be utilized for various other individuals as well. It can also be a helpful tool to assist with rapport building in therapy sessions.

Sandtray work in a therapy session "allows for a wide variety of both verbal and non-verbal expression" (Garrett, 2014). The expressed thoughts and feelings that are brought about through sandtray work can be shown in a three-dimensional way and are easily adapted or changed based on the client's desires. One of the best-known details about the value of sandtray work is that it "allows for therapeutic distance through symbolic representation" (Homeyer & Sweeney, 2011). This means that there is space allowed between the client and the issues he or she is discussing with the tray. The space adds to the safety clients feel and allows them to tell the stories they want told. The miniatures used to tell the story are also ones that the clients choose themselves. The final creation is the story that the client creates and the scene within the sandtray is one that can be remade and continued to be discussed as therapy continues. Garrett (2014) also discussed, however, that the tray can be made into a "transitional object." This involves taking a photograph of the created tray and sending the photograph home with the client. This would then help emphasize the growth that client has made through therapy and the use of the sandtray therein.

"The fact that the sandworld should not be considered a permanent work of art…seems to connect with another feature of both sandplay and constructivism" (Dale & Lyddon, 2000). As a result, sandplay may help a client make connections between the meanings he or she has developed instead of having to rely on those that others make for him or her. "Any sandtray object can have many meanings, and it is helpful

for the therapist to check with clients about their unique meanings before sharing ideas" (Dale & Lyddon, 2000). There are changes within a person that constructivist work can elicit and these have been found to be similar to transformations that sandtray work provides. In "first-order change…knowledge is reorganized and assimilated into existing assumptions…while second-order change involves reorganizing the structure of information and knowledge via accommodation into novel and alternative assumptions (Dale & Lyddon, 2000). These changes are similar to the abilities a person may built through sandtray where he or she creates perceptions of an issue in the tray. Then, he or she reorganizes the perception of it as new or different hypotheses about it are made through the tray work.

The new perceptions that are made by the client can help him or her to gain more possessive control of his or her life narrative, and by extension, an identity. These narratives are ones that can then be found and processed within therapy. Garrett (2014) also highlighted the fact that these stories being told with the sandtray can also being done in third person, again adding distance clients may need until they are ready to "place themselves in a tray." The figures used in the tray can also be used by the therapist to introduce metaphors. This may involve using a figure who is symbolic in the social context of the client's life such as a police officer representing power or authority.

Use of sandtray, like any intervention in therapy, and especially those related to expressive arts work, should not be one used under coercion to the client. Addressing a client's questions about the intervention and its value are vital. "It may be important to spend more preparatory time addressing the client's potential questions…and how it

may be helpful to him or her specifically" (Garrett, 2014). Clear expectations for client who is to be using sandtray are also very helpful and recommended.

Sandtray work has been used to help adolescent students who have struggled in a traditional school environment as it "may provide the opportunity they need to redirect their behavior" (Draper, Ritter, and Willingham, 2003). There were three parts used to this group intervention where the clients built their worlds, photographed them, and shared them with others. "These groups clearly provided students with an opportunity to experience each other in a different way" (Draper, Ritter, & Willingham, 2003). Similar to what Garrett (2014) later reported about the help sandtray work offers in fostering rapport with adult clients, Draper, Ritter, and Willingham (2003) found that group sandtray work "is one way of circumventing initial resistence…that provides engaging activity for the group."

In addition to sandtray related interventions, there is an Expressive Therapies Continuum (ETC) that can be followed when using other arts-based tasks. In 2015, Lisa Hinz described the structure to the ETC and provided details on how methods used from it can provide a framework to discussion points and actions taken within therapy. "The ETC is a transtheoretical organizing system that provides a language to facilitate communication across diverse approaches to art therapy" (Hinz, 2015, p. 47). Each component of the ETC involves different types of processing for clients based on the work conducted in it.

"The Kinesthetic/Sensory level of the ETC provides experiences through vigorous movement and various sensory activities" (Hinz, 2015). This component is based on inhibitory or disinhibited behaviors and tasks used here can help a client to

address his or her levels of control over situations. It also helps him or her to discover internal behaviors that he or she may go through in life. Activities that utilize this component may be appropriate for a certain client who has experienced issues where he or she struggles with regulation of behaviors that are addressed. For example, this may include a client who has experienced trauma that resulted in his or her feeling dysregulated in response to prompting events.

"The Perceptual/Affective level represents the interaction between awareness and use of formal art elements…and the experience of emotions" (Hinz, 2015). Interventions that can be used in this level assist a client to express and experience soothing emotions through art interventions. For a client who has experienced trauma or distress, these activities may help them to de-escalate his or her emotional experiences in addition to the dysregulation that is addressed in the kinetic level.

Hinz reported that the Cognitive/Symbolic level is the most complex one due to the work that is involved is focused on predicting concepts that are more abstract and involve predicting their occurrences. Healing that occurs in this level focuses on a client's ability to "understand and profit from personal and symbolic meaning" (2015). Constructivist interventions such as a client designing a collage of meaningful items to his or her identity could be used in this level. According to Hinz, (2015), creative activity is something that occurs at any of the levels in the ETC or that covers functioning from all of them.

Like with other therapy interventions that are not expressive or creative in nature, Hinz (2015) emphasizes the individualized nature of the level chosen from the ETC. A client is allowed to choose which component he or she wants to do first.

"Therapeutic movement can proceed in a top-down directions as clients who are overly cerebral are invited to gain greater access to emotion, change typical perceptions or value wisdom of the body" (Hinz, 2015, p. 47). The reverse can also be used in following a bottom-up approach, which "can help overly active or emotional clients gain more cognitive control over their feelings" (Hinz, 2015, p. 47). Overall, the ETC helps a client to have discussions both in general and in regard to his or her needs within therapy.

One of the unspoken needs a client may have in therapy is a lack of feeling of resilience to their past distressful experiences. Macpherson, Hart, and Heaver (2016) studied 10 weekly visual arts workshops in spring 2012. The workshops introduced the 10 participants who were young people facing "mental health complexities and/or learning difficulties" to a variety of visual art abilities and basic ideas of the Resilience Framework. The young people were then interviewed to help them reflect on their resilience and benefits related to it from the workshops.

"The Resilience Framework provides practitioners who deliver part of a young person's care plan opportunities and routes to intervene" (Macpherson, Hart, & Heaver, 2016, p. 550). This method is designed to address different aspects of a person's life and recognizes how the areas are inter-related. The workshops in this study used tasks that helped the participants work on areas related to "their core self and sense of belonging" (Macpherson, Hart, & Heaver, 2016). The researchers' findings were organized by using quotes from the participants of the study and their own notes toward the work that was completed. One young woman reported she felt like she belonged in the environment where she did the art work.

"Participants also developed a sense of responsibility toward the group, and were motivated to return, knowing they were working toward a final exhibition" (Macpherson, Hart, & Heaver, 2015, p. 551). The researchers also found that participants who did not feel as comfortable with verbal expression "could share enjoyment with others through acts of making, doing and assisting each other" (2015). In addition to that help, participants like one young woman in the study felt the artwork she was able to do helped her express feelings she could not say aloud. She is quoted by Macpherson, Hart, and Heaver (2016) as saying, 'Emotions aren't always verbal things so doing art is a really useful way of expressing those things.'

Resilience in teens has also been found to develop when they utilize expressive writing interventions. Greenbaum and Javdani (2017) used WRITE ON, a trauma informed intervention that "seeks to foster youth dignity, autonomy and resilience." Fifty-three participants who were detained juveniles participated in the study where 30 were in the WRITE ON condition and 23 were in a comparison support group (CSG). The WRITE ON group members were given prompts that encouraged "emotional and cognitive reflection" (2017) with both conditions lasting six weeks. After each of the first four sessions, a Brief Resilience Scale of a six-item self-report measure about respondents' reactions to stress was given. The State Shame and Guilt Scale-Revised was also given after each of the first four sessions. "WRITE ON participants reported a significant increase in positive mental health attributes compared to the CSG participants" (Greenbaum & Javdani, 2017). These participants reported increases in resilience but also increases in feelings of shame. Greenbaum and Javdani concluded that the increase in both of these aspects in tandem may indicate that the worsening of

one's shame in this type of intervention is part of the recovery process. It may mean that expressive writing is an arts intervention that helps an individual reflect on his or her life and confront the emotional distress of his or her past in order to move forward with stronger resolve for negative events in the future. This may lead to overall emotional relief.

Catharsis is an example of emotional relief that is a behavior that can result from the work that a client does with expressive art therapies. It refers to the release of and subsequent relief from strong emotions. "…participants went through…8 expressive arts therapy group counseling. Counseling sessions namely the techniques of Collage Name, Map of Life Sketches, Extreme Negative Feelings and Thinking, Butterfly Story, Wave Painting and Expressive Writing Using Diary were used (Adibah and Zakaria, 2015). These techniques involved different ways for the participants to express their emotions through artistic means. "Collage Name was…an ice breaking session. Participants were asked to produce a name or photo collage representing them" (Adibah and Zakaria, 2015). The Sketch Map of Life and Butterfly Stories techniques were more focused on the participants looking at their lives and what the journeys they have completed thus far meant to them. The Butterfly Stories "were for…the hardships, challenges and obstacles they have had with the analogy of a butterfly."

Following the ten sessions, Adibah and Zakaria conducted in depth interviews and document analysis for data collection. "Six out of seven participants professed that the use of art and creativity in group counseling sessions enabled and helped them to reduce the stress they had" (2015). The participants also reported feeling that the group

counseling “was able to stabilize their emotions” and they “had gained new meaning toward interpreting the pain that they had endured all this while.”

“Art therapy facilitates the clarification of imagery and memory disruptions associated with posttraumatic stress disorder (PTSD)” (Appleton, 2001). It allows clients to explore new aspects of their lives and by creating an art while around a therapist “provides a safe haven for the exploration of overwhelming material as it emerges from memory” (2001). In her article, Appleton outlines four stages that are part of a model for using art therapy in this way. These stages start with addressing the impact of the traumatic event before building a therapeutic alliance and then acknowledging the trauma’s effects, and finally reconstructing the event’s role and fostering meaning from it. The main theme that Appleton (2001) found to what the use of art does is that its processes “facilitate the appropriate projection of regressive feelings.” Put another way, art therapy techniques allow for a client who uses them to put out his or her emotions from his or her experiences into an entity. This item or outlet is often one he or she creates. This outlet found to be safer, healthier, and centered on his or her growth forward from the experience that led him or her into treatment in the first place.

Participants who were given the chance to utilize art therapy techniques in a situation where they previously may not have had hope found emotional growth through their expressive works. Twenty individuals who utilized services at “one of the largest youth homeless shelters in Canada” (Schwan, Fallon, & Milne, 2018) and three of the staff who worked at the center were interviewed in a semi-structured way about an art creation program that was delivered there. Thirty-three youth had participated in the

program and for data collection, 20 were randomly chosen to interview. Three program staff involved in the workshop were also interviewed in a semi-structured way. The youth participants were asked about "changes in themselves since they began…and if they attributed any outcomes to program participation."

There were many themes that emerged from the youth participants' answers. There were some answers that described the art making the individuals engaged in as more than just a helping aspect to their mental health, "but as absolutely essential for maintaining" (Schwan, Fallon, & Milne, 2018) this part of their life. One young man reported how anxious he got when he could not access the art materials at the shelter. It was also revealed through analysis of the youths' answers that there was a strategy to how they used the art for their health. This was noted when many of the participants used specific materials to address certain issues with one young woman doing so because "different art does different kinds of things" (2018). This gives support to an idea that not only doing art can help with therapeutic and emotional growth but there is a sense of connection one makes to the art created due to its benefits for him or her. In this way, participants in Schwan, Fallon, and Milne's study gave other details that were individualized to their experiences with the art. This was found in the reports from one youth calling the art creation "a form of, like, active mindfulness" and another stating that he found himself through the work he did, "It's like I'm creating a tiny world here, so when I look at it, 'Oh gosh, this is like a paradise!'" (2018).

The use of expressive art therapies can also have positive impacts on the observed traits of mental health of children in a primary school setting. McDonald, Holttum, and Drey (2019) analyzed results of teacher reports of students' difficulties

before and after engagement in three years of art therapy. The children involved in the art therapy were also questioned about the helpfulness of their experiences, what it was about the experience that helped, and changes they went through that art therapy was helpful toward or not. The teachers' responses on the Strengths and Difficulties Questionnaire (SDQ) showed a medium Cohen's d effect on how art therapy influenced the children's overall stress. "The change in rating of impact of the children's difficulties on their lives represented a large effect…medium effects were indicated on conduct, hyperactivity and prosocial behaviour" (McDonald, Holttum, & Drey, 2019). The children's responses most revealed that the art therapy sessions helped with their feelings and that the therapy brought about them feeling "calmer, more relaxed…felt safer, supported" (2019).

Children who were in the foster care system were found to develop emotional growth from expressive art techniques. Coholic, Lougheed, and Lebreton (2009) conducted six, two-hour sessions of a holistic arts based group. The group had the "goal…based on the belief that there is a connection between developing self-awareness and improving self-esteem." One example of the activities that was done to encourage mindful attention to feelings involved the children participants being asked to draw a circle of the feelings and "to indicate how much time they spend during the day feeling each emotion" (2009). Following their experiences in the group, the children's caregivers were interviewed about their time spent in the group. They also completed the Piers-Harris Children's Self-Concept Scale, Second Edition before and after their time in the group. This questionnaire had descriptions to which the children marked yes or no to identify if it matched them. From the in the interviews with their caregivers,

the children were reported to be "feeling happier and more confident…greater comfort in one's body, improved familial relationships" (2009). The children themselves stated they felt they could use their imagination more to find solutions to problems outside the group work. This gives support that expressive arts therapies can not only provide emotional group but it also provides intellectual skill building in creative ways.

Art therapy techniques can help improve areas of interpersonal functioning which can sometimes be difficult for children who have been diagnosed with Autism Spectrum Disorder. D'Amico and Lalonde (2017) administered Parent and Student Forms of the Social Skills Improvement System Rating Scales (SSIS-RS) to the 6 participants (5 boys, 1 girl aged 10 to 12 years old) in their study. The SSIS-RS includes subscales which measures of an individual's "Cooperation, Assertion, Responsibility, Empathy, Engagement, Self-Control" (2017). After these reports were gathered, the participants were enrolled in 75-minute group sessions of art therapy that occurred one day a week for 21 weeks. These sessions "employed art-based interventions focused on developing self-expression, creativity, and the consolidation of social skills through art making, discussion, play" (D'Amico & Lalonde, 2017). Parents and participants completed the SSIS-RS following the completion of the 21 sessions as well. The reports showed that with the exception of one subscale scores of the SSIS-RS scales were not statistically significant from before the interventions to after their use. The one score that significantly changed was the one on the Hyperactivity/Inattention scale which was significantly lower from pre- to posttest. Despite these results, D'Amico and Lalonde (2017) make the point of drawing attention to observations made of the children's behavior following the interventions. "The therapists noted that

through the process of art-making, the children seemed to demonstrate a shift in their self-image…it appeared they were more confident and assured of their skills" (2017). The therapists who made these observations also noted the children appeared to get along more cooperatively and were more assertive in expressing their needs as the sessions progressed. While this study did not find support that art therapy overall improves the social skills of children with Autism Spectrum Disorder, it does show that art therapy interventions help with some areas of the children's abilities in self-regulation and behavioral skills management in a group setting. This would indicate that art therapy interventions may provide supplemental skills training for children with Autism and be used in conjunction with other behavioral modification work.

Younger children who are vulnerable have also been found to show benefits from using art therapy techniques. Cumming and Visser (2009) conducted an "evaluation study of…workshops within the context of…self-esteem of the refugee children, and why art should be used above any other type of intervention." The children in this study were from Afghanistan and Kosovo and attended school in southwest England. The four workshops occurred across six months. The children "had witnessed traumatic events related to the war-torn nature and political instability of their home countries" (Cumming & Visser, 2009). They were told that there was no correct way to complete the art-based tasks in each session. Teachers completed self-esteem measures about the children's behavior when starting school, before the workshop and after two sessions of it. The results on these reports showed "a dramatic change in all areas…indicating noticeable growth in confidence after the workshops" (2009).

The authors of this study also made specific mention that the art therapy interventions were not the only supports the children received while in school. They also received care from a nurturing based group. This was thought to provide supplemental support for the work being done through art therapy. This implies that while art therapy techniques offer many benefits to a client, supplemental treatment and supports are recommended to be included to fully assist a client in his or her therapeutic processes.

Play therapy interventions have been found to be beneficial supplements to expressive art therapies. Perryman, Moss, and Cochran (2015) examined the effects of incorporating expressive arts work with client-centered play therapy groups for at-risk adolescent girls. The participants in this study were female students between 13 and 14 years old who had never engaged in other therapy sessions and were referred by their teachers due to "behavior issues…low grades, difficulty forming and maintaining relationships, and/or difficult home environments" (2015). Each group session involved a check-in where the girls discussed "high and low points of their weeks" before they were given time to "process any homework assigned the previous week as part of the expressive arts group" (2015). An hour was then used for the conducting of the expressive arts activity.

The activities involved in this group each had a specific purpose for what they provided to the girls. Introductory activities of a bud vase for the girls to design and a mandala for them to create served to give them the sense of accomplishment and to get to know each other better respectively. Other sessions discussed dreams the girls had for their future, their families of origin, and significant events in their lives. The girls

also completed weekly journals about their work in the group and these entries along with video tapes of the sessions were transcribed and coded for data use in the study.

Themes emerged from the coded data related to the girls' emotional experiences. Most notable were their "stress relief…increased self-awareness…and awareness of behavioral changes outside of group" (Perryman, Moss, & Cochran, 2015). One girl wrote that the group "was fun. It helped me take my mind off problems I was having at home" (2015). One girl whose journal showed her increased self-awareness wrote that the group "made me feel better about myself…Before the group, I felt like nobody liked me or was paying attention to me" (2015). The detail that showed the awareness of change outside the group was observations of the girls' work and observations that "Many talked about learning more positive coping skills and ways of dealing with their problems" (2015). The fact that an expressive arts group provided increased self-awareness is very important for it being used with adolescents. This is the life stage for many when self-reflection and understanding of one's behavior is limited due to developing cognitive functioning in these areas. Expressive arts therapy techniques can not only offer ways for a teenager to mediate and regulate his or her emotional functioning, but they can also help a student in this stage of his or her life develop insight into the causes of, consequences to, and solutions for such distressing situations.

Play therapy is not the only domain from which interventions can be added to expressive art techniques to foster emotional growth for a client. Otting and Prosek (2016) researched the benefits gained and resulting behaviors when feminist therapy techniques are used in conjunction with expressive art therapy. The initial step to using feminist therapy is for the clients and their therapists to develop an egalitarian

relationship. Following this, they work to "assess and analyze ways the clients are oppressed or disempowered on multiple axes" (2016). These axes can then be used as ways to integrate expressive techniques as a bridge between art and feminist therapy.

"The primary focus of the somatic axis of personal power is connection and compassion for the physical body" (Brown, 2010). Physically based concern may be what bring clients into treatment before any other distress, trauma, or emotional issue is identified. An expressive intervention that can address the physical aspects of a client's functioning is to have counselors trace the body shape of the individual on butcher paper. The client then writes "skills or tasks that can be accomplished with each part of the body" (Otting & Prosek, 2016). The client and counselor then collaborate to review the drawing. This work helps the client "gain more appreciation for…resilience and increased self-awareness" (2016).

There is also an intrapsychic axis which focuses on internal and external data of the client. This axis is similar to the Perceptual/Affective level of the Expressive Therapy Continuum. Both of these areas of functioning are designed to work with a client's self-soothing and finding present focusing interactions with his or her emotions. This may be an area a client may have previously not been allowed to control on his or her own and may benefit from re-learning how to do through therapy. Otting and Prosek (2016) recommend journaling with relaxation techniques to address this axis through a combined expressive and feminist intervention.

According to Brown (2010), the social-contextual axis gives specific attention personal boundaries, personal roles within multiple contexts, and differentiation of self. Trepal and Duffey (2011) provide an expressive technique that can be used with this

axis that results in a playlist that a client creates that serves as a "musical chronology…of songs associated with life events." The playlist is created by the client and counselor discussing its possibility first. Then, they together work to identify important events in the client's life and what songs he or she associates with them. Following that, the sessions involve discussions of thoughts, feelings, and social contexts within the songs. In this stage, "client insight about interpersonal behaviors and feelings associated with interpersonal relationships" is vital. The final part of this intervention has the client name two songs from the playlist that "best represent….current interpersonal-contextual position and…the client associates with a hopeful future" (2011). The use of this intervention gives the client power to retake the information that makes up his or her history and to find empowerment in doing so.

The last axis Brown (2010) describes is the spiritual one which involves making meaning in one's life and the purpose of his or her past, present, and future. This can be addressed in creative interventions based in gardening. This allows for "counselors and clients…to discuss the context in which they live and the purpose for growth" (Otting & Persek, 2016). Feminist therapy focuses on empowerment of clients involved in it and combined with the internal growth that can be fostered with expressive arts, this combination can foster strengths within a client's overall behavioral and emotional functioning.

King and Miner (2000) researched how physical health can be fostered as part of a client working with expressive art therapy. Their study examined the self-regulatory processes offered by such interventions. King and Miner (2000) researched these effects of expressive writing because past studies where participants wrote about their

distressing experiences had participants being instructed to "really let go and experience the emotion associated with the trauma." King and Miner wanted to determine if telling participants to find the positives of their traumatic events would help with their health.

There were 118 participants aged 18 to 36 who completed a study conducted by King and Miner (2000). The participants were randomly assigned to either a trauma, no trauma, perceived benefits or no perceived benefits groups. All participants wrote for a set amount of time (20 minutes) a day for three days. The trauma group members wrote only about their distressing events and the perceived benefits group were to "think about a trauma and then write about only the positive aspects of that trauma" (King and Miner, 2000). These participants' time was divided in half so that ten minutes were spent focusing on the trauma and ten minutes were focused on the positive aspects. The participants that did not write about trauma or perceived benefits were used as a control group.

The King and Miner (2000) study found that writing about perceived benefits led participants to use more words that showed insight and more positive emotions. No significant effects on mood were found from the groups' results after ratings of this were averaged from the three days of writing. Writing was not found to have a significant main effect on how it impacted participants physical functioning either. One important finding from this study was that the examining clients engaged in toward their lives allowed them to reflect on the impacts of life events on their functioning. This is consistent with what Abidah and Zakaria (2015) later found with art therapy allowing for participants to re-interpret and gain insight toward the pain they experienced in life.

The use of expressive art therapies has been implemented with many different clinical populations. These implementations have had various results depending on the population in which they were used. Stuart and Tuason (2008) used an expressive arts therapy group with African-American girls who were attending an after-school program for minority youth in the southeastern United States. Various activities such as "psychodrama, sculpting…and dance" were used in order to start "discussions concerning stressors, levels of anxiety and fear…feelings of self-efficacy and self-esteem" (2008). Measures were administered before and after the interventions were completed to determine the ten-session group's effectiveness.

The participants reported that the sessions "aided them in expression of real feelings more in later sessions" (Stuart and Tuason, 2008). More so, results from evaluations used after the group concluded showed for five of the six group participants, they felt the work "allowed them to…feel accepted, and experience happiness" (2008). This indicates that the group helped participants to view their life events as normal and they were validated for having gone through them. The normalization and validation of a client who uses expressive arts therapies is very important. It allows the client to feel that the work he or she is doing is viewed as being important no matter the product(s) that is/are created by therapy's end.

Sporild and Bonsaksen (2014) designed and implemented an expressive arts group for patients who received treatment on the Unit for Eating Disorders (UED) at the Lavenger hospital in Norway. The two-hour group occurred weekly and had four to eight patients as members but it was an open group to include new patients consecutively. In each session, patients were given the chance to talk about how they

felt being in the group before being told the theme of the week to use as a focus for the pictures they were told to create. "Each patient presents his or her picture…following the presentation, the other group members share their immediate thoughts, emotions, and associations linked to it" (2014). The members were also given time in each group to discuss their feelings about the group process and how they were handling it.

Sporlid & Bonsaksen's (2014) findings from the study also included case study examples from group members' work with protection taken to mask their identities. One woman drew a picture of a girl with a crown on her head that had the word SHAME written on it. The other members showed curiosity toward the picture and the discussion that followed was about what it represented for the client and how this was reflective of behaviors in their lives. These reactions "may have provided her with a sense that her picture was valued among the group members…may have strengthened her bond to the group" (2014). The groups may also allow for self-revelation among the patients involved. This occurs from their creation of images which then helps them to "let go of defenses and barriers so that emotions can be expressed" (2014).

In Sporild and Bonsaksen's expressive arts group, the leaders facilitated the themes on which the art was based in order to facilitate treatment. However, research has also found that patients in a psychiatric unit may also benefit from expressive arts work that does not follow a pattern or theme. Chiu, Hancock, and Waddell (2015) designed a study "to examine the impact of participation in single sessions of an Open Studio-Based Expressive Arts Therapy Group." Participants in this study were from the Toronto General Hospital site of the University Health Network in Toronto, Ontario,

Canada. Due to the group being open, participants did not require a referral from their providers.

In the Chiu, Hancock, and Waddell (2015) study, of the 85 patients eligible to do so, 36 consented to be in the study. The studio for arts therapy was kept open for a two-hour period and participants were free to come in or leave of their own choice. Musical instruments were available as well as other art media for painting or drawing. "Some patients would stand at the door and dance, some would stand and tap their feet" (2015). The Profile on Mood States, Brief (POMS-B) was used to evaluate patients' emotional state after participating in the open studio group. "Significant improvement in Total Mood Disturbance" (2015) was found. This "can reflect a reduction in negative mood states or an increase in positive mood states" (2015). Patients also gave qualitative evaluations of their involvement in the group with "almost all" giving a report the group "allowed them to express things they could not express verbally" (2015). One patient reported that they were given "a sense of worth today" and another who sang a song she created and stated that "using her own voice was "very powerful"" (2015).

Outside of inpatient or psychiatric hospitals, art therapy interventions have been utilized to help clients with specific psychological diagnoses. David Henley (2007) created an expressive arts intervention that he used with children who had been diagnosed with comorbid conditions that included Bipolar Disorder. "Over the course of 2-1/2 years of art therapy I conducted a total of 184 sessions with 16 children treated for…early onset bipolar disorder" (2007). For 32 of the children, Henley used "Naming" interventions which he used to "further each child's therapeutic process"

(2007). These interventions were adapted from an intervention called "Naming the Enemy" from Fristad, Gavazzi, and Soldano (1998) that is used to "disentangle symptoms and help a child gain some awareness and objective distance from his or her core self."

Henley (2007) modified this intervention in two ways. First, he engaged the child in discussion about the Enemy/Friend characteristics. Then, he used minimal discussions and let the child create artwork without openly discussing those concepts. He also included a reflection time after the child makes his or her art. At that time, "the therapist may probe…the relevant metaphors of the child's friend and/or enemy frame of reference" (2007). This reflection can help raise the child's self-awareness toward his or her diagnosis and what impact(s) it has on his or her functioning.

Expressive arts therapies have also shown promise for their use in working with adult clients with more severe mental illnesses. In 2009, Lamont, Brunero, and Sutton presented a case study on the use of art therapy with a client diagnosed with Borderline Personality Disorder. The client was a female who was 46 years old who "was reported to have a long history of borderline personality disorder, deliberate self-harm behavior, and extensive history of admission and engagement with mental health services in New Zealand" (2009). Within the course of art therapy that the woman completed, she created a portfolio of art that consisted of 11 works. Within each session, the client created an artwork based on a specific topic, experience, or theme. For example, the artwork the client made in the first session helped her to "relive an extremely painful event from the past" as she "described being able to express…fear, anger, and humiliation" (2009). In another session, the client talked about a need she felt to self-

harm. In the eleventh and last session, the client reflected on her work in therapy. She thanked the therapist for listening to her and that the therapist "let me think about my life" (2009). The arts the client created followed a theme of her thoughts and feelings being externalized through them. The willingness the client showed in working with such therapies "allowed for the creation of a more purposeful treatment alliance" (2009). This alliance can be of great support to allow clients to know that when they are creating art in therapy it will not be criticized or judged for quality.

Clients with other personality disorders have also been found to benefit from art therapy-based interventions. Haeyen, Hooren, Veld, and Hutschemaekers (2018) studied the effects of art therapy with individuals who had been diagnosed with cluster B or C personality disorders. They measured psychological flexibility of the participants through their answers to the Acceptability and Action Questionnaire Second Edition (AAQ-II). Mental functioning was evaluated by the Outcome Questionnaire 45 (OQ 45). Participants were randomly assigned to receive ten sessions lasting 1.5 hours each of art therapy or to be in a control group waiting list where they received none. The interventions used were assignments from the book, *Don't Act Out but Live Through Art Therapy for Personality Disorders* by Suzanne Haeyen.

Repeated measures analyses were conducted showed differences in the means of each group which "indicates that patients improve with treatment; however, patients on the waiting list deteriorate over time on most outcomes" (Haeyen, Hooren, Veld, and Hutschemaekers, 2018). Different characteristics of the clients who with the diagnosed personality disorders were observed in these improvements. "Adaptive modes have

strengthened (pleasant feeling and self-regulation)…unpleasant inner experiences…are more easily accepted" (2018).

In their 2013 article, Hanevik, et al, described using an art therapy group with five women who were diagnosed with psychotic disorders and recorded the women's responses to the work. The group met weekly "from September 2006 to June 2007" (2013) and followed a set structure. Each session involved the members hearing music and a poem before being asked about their previous week. The participants then engaged some forms of movement therapy "to connect to their bodies" (2013) before working with art forms. Data was collected "from the therapeutic process and…from the interviews conducted 8 months after the conclusion of the group" (2013). Hanevik, et al found that "all of the patients…were able to explore their psychotic experience through art therapy" (2013). One participant reported that the group "helped her recognize stress and the first signs of psychosis" and two others said the group "helped them escape from the frozen state of mind, connecting to themselves in a better way" (2013). These results indicate that the self-awareness and emotional connectiveness that expressive arts therapies provide can occur for clients whose diagnoses may limit their awareness and interactions that are reality based.

Thirty participants in a study conducted by Mohamad, Mohamad, Ismail, and Adawiah (2013) were randomly assigned to either receive expressive arts therapy or not receive those types of interventions as part of their treatment for drug use. Interviews, observations of participants' behavior, and information they provided in journals they kept as part of their treatment were used for data collection in this study. Three major

themes emerged from the participants' involvement in the art therapy interventions. These were: gaining meaning, experiencing catharsis, and healing.

The meanings that the participants gained were evident in the words they chose to express themselves in the sessions or in the colors some of them used in their artworks. One participant chose bright colors for use in the butterfly he created in sessions because he wanted "people to see that I am good…approachable" (2013). The catharsis that the participants felt from working with art was expressed in different emotions. One individual expressed positive feelings and showed them through his drawing and "was able to express pent-up feelings through trees painting" (2013). Another participant reported decreasing levels of anger through the course of his treatment. Healing was observed through the clients' reports and commitments to changing their behaviors as a result of what they learned in treatment. "Subjects…were able to think logically in order to transform themselves or make decisions" (2013). Interpersonal growth self-awareness are two areas of emotional development that help foster committed success within treatments for substance use disorders. This study that Mohamad et al 2013 completed shows that these traits could be fostered and strengthened through expressive arts interventions.

Meshberg-Cohen, Svikis, and McMahon (2014) found support for implementing expressive writing tasks as supportive treatments to interventions that addressed emotional distress in women who have substance use disorders (SUDs). These interventions were considered for use because of the high rates of comorbidity of distress and substance use. The participants were "149 women admitted to a gender-specific residential SUD treatment facility from June 17, 2007 to November 6, 2008"

(Meshberg-Cohen, Svikis, & McMahon, 2014). The PDS, a "49-item self-report measure focused on PTSD symptom severity and diagnosis" was used along with a self-report measure of depression. Meshberg-Cohen, Svikis, and McMahon also assessed the participants' negative and positive affect before and after the writing sessions. "Women providing informed consent were randomly assigned to one of two conditions: (a) expressive writing (emotional topic) or (b) control writing (neutral topic)" (2014). The results showed that the participants who were in the expressive writing condition showed "a significant decrease from baseline to one-month follow-up" on their reported symptoms of trauma (2014). These participants also showed significant improvements in their depression as well.

Expressive arts therapies can also involve interventions that utilize journaling activities that do not primarily use writing. Vela, Ikonomopoulos, Dell'Aquila, and Vela (2016) designed a single-case research design using three female survivors of intimate partner violence to examine how creative journaling impacted their emotional functioning as measured by their reports on the Hope Scale and the Rosenberg Self-Esteem Scale (RSES). The women were first connected to their inner child by drawing with their non-dominant hand and then embracing that figure through work with various art mediums such as sculpting clay, drawing doodles, and bubble blowing. "Sessions 3 and 4 focused on helping clients accept their angry child by journaling…and water painting feelings" (Vela, et al, 2016). Breathing mediations, dance movements, and writing letters to people who hurt them were used next. The final sessions with the women involved them engage in tasks that "focused on…personal wellness through mask making, and collage making" (2016).

Following the sessions' completion, the women completed the scales measuring hope and self-esteem. One woman's result on the Hope Scale showed the interventions were "debatably effective" (Vela, et al., 2016). However, her self-esteem showed improvement with her improved scores on items such as "I feel I have a number of good qualities" and "I take a positive attitude toward myself" (2016). For the other two women in this study, their results showed that the interventions were "moderately effective" (2016) for improving their Hope Scale scores. This was observed in one woman's improved scores on items related to thinking of new ways to handle situations in her life. The third participant's improved scores on the Self-Esteem score were noted in her having better results on items related to how she viewed herself and her personal traits. Overall, these results, while limited to having only three participants, indicate that creative arts journaling and the incorporation of arts therapies in treatment for survivors of intimate violence is beneficial to individuals' outcomes in treatment.

Jamie Bird (2018) found that collecting arts-based information can serve as a viable methodology for understanding the stories and themes of the lives of women who have experienced domestic violence. Bird had small groups of women who had experienced domestic violence make "visual images that represented their responses to thoughts and feelings about the past, present, and the future in relation to ideas such as home and support" (2018). Three themes of "*escape and harmony*; *relationships and social support*; and *agency and resistance*" emerged from the ladies' stories and images. The women's images of wanting to leave their distressful situations while finding environments that were peaceful showcased the first them. The theme of relationships and social support was observed in the women's works that highlighted

their connections to others and by whom they felt helped. The last theme related to agency and resistance was observed more in how the women talked about their images.

One figure showed how a woman (Emma) said she "had to work hard on maintaining her sense of having made the right decision in choosing to leave when she did" (Bird, 2018). The art works and stories the women like Emma created are viewed as transitional stories which refers to the movements they are making through their lives' relationships, places, etc. Bird's findings show that even if expressive arts are not used to help foster emotional growth, emotional meaning can be gleaned from the creations. These meanings can then be used as foundations for work within therapy sessions.

"Therapeutic doll making offers potential benefits for treating complex trauma due to the plasticity of materials…that assist clients in attuning to their physical experiences…as well as cognitive, emotional, and sensorimotor processing" (Stace, 2014). In her work with a client named Jess, Stace approached her with the idea of therapeutic doll-making after Jess described "her relationship with her grandmother and the connection she felt as a result" (2014). The client responded favorably to the intervention and created six total figures. She "felt it was important to express herself in a three-dimensional way in a pliable human form" (2014). Through her creation of the dolls, Jess was able to live through and manage her emotions and to understand the traumatic events she encountered through her childhood sexual abuse. This intervention is one that may allow other clients to process their emotional distress rooted in past experiences in a creative way.

Doll making is not the only expressive arts therapy intervention that allows for clients to create a physical form to illustrate and process their emotional work in treatment. Steinhardt (1994) found that puppet theatre and art therapy offers benefits in treatment. "The important and decisive factor, which tremendously deepened the experience and heightened the intensity of cathartic revelation…is felt by the author to be the building of an…environment for each person's puppets" (1994). This is similar to what Stace (2014) found in her work with Jess in how the individualized creation of the human-like figure (either doll or puppet) allows for clients to play out their emotions physically in a safe way to eventually process them in treatment.

Steinhardt (1994) allowed participants three options of puppets to use. These were a three-dimensional newspaper and string female one, a two-dimensional moveable acetate one, or an ice cream stick puppet. Within the second session of puppet work, "the group had already sensed the metaphoric potential…and directives were now personally focused" (1994). Session four was when the participants performed with their puppets and in sessions five and six, the group shared their reactions to the acts and processed what they meant to them and each other. "The social interaction of the group at each phase of the sequence enabled feelings of support…with respect and validation for each person's autonomous process in the total event" (1994). The puppet theatre in this group found what has been identified in many other expressive arts therapies work in how supportive it is to clients' spontaneously experiencing and processing their emotional reactions to their own and others' stories. Self-awareness, insight, and acceptance are also built and fostered as well.

Not only do distressing events in life alter the behavioral and emotional reactions a person may have, but they can have impacts on his or her physical body as well. "Artistic mediums…externalize the inner and often unconscious experience of the client and…opens the doorway for inter-communication. The intra communication that happens…makes visible to the client his inner world" (Sherwood, 2008). By using expressive art therapies, Sherwood suggest that a client can change his or her thoughts and feelings toward an event through reworking of the physical body's movements during them. Sherwood described different activities that can help with this rewiring but highlighted one that can be "done in many mediums but must involve the bodily movement in the activity" (2008). This is to reconnect the client's mind to his or her body and among the examples provided are creating a piece out of clay, building a garden, or writing a poem.

Self-awareness through expressive art therapy does not always have to developed and strengthened through expressive arts that are presented in visual ways. "Music is often used instinctively for cathartic expression, providing an outlet for stifled or repressed emotions" (Leferve, 2004). Leferve primarily described the use of music with children and provided recommendations on how to ease their worries in sessions that utilize music therapy. "Children often have introjects about believing they should only be making vocal sounds which are aesthetically pleasing. It will be important...to model relaxing and experimenting with sounds…about expression rather than performance" (2004). This relates to other arts therapies conducted with adults where the works they create are what matters despite the artistic merit of the end products. "Songs can be invented about stages in the session…words may be chosen to provide

comfort…Some children will be able to invent not just words but original melodies and rhythms of their own, creating…external expression of their inner world" (Leferve, 2004). Musical tones and rhythms can help reflect moods that a client has experienced and help support the stories they tell in sessions. By allowing a client to create his or her own lyrics and instrumental works, he or she would be able to tell his or her stories in an artistic way without it being completely verbal or visual in nature.

Teague, Hahna, and McKinney (2006) examined the effects of using group music therapy with other expressive arts therapies with women who have experienced intimate partner violence and found the interventions to impact some areas of emotional functioning. The group of seven women "met for six sessions…over a period of three months. The goal areas addressed increasing self-esteem…decreasing anxiety, decreasing depression, and increasing social support" (2006). Each session included a check-in where the members described their emotional states before they journaled, and then participated in group experiences. These experiences included specific music therapy tasks such as working with clay while listening to certain music and talking about women related issues they have faced and listening to and analyzing a song about leaving an abuser and the difficulty of such actions. (Teague, Hahna, and McKinney, 2006). Self-esteem and other emotionally based traits were measured from answers the participants gave on a follow-up questionnaire. Statistical results showed that the sessions had "a marginally significant effect on anxiety" and "a significant effect on depression" (2006), but self-esteem was not impacted by the interventions. Multiple participants also listed "the use of creative arts with music" as the most helpful intervention (2006).

Another expressive therapy technique that involves clients to engage in activities that result in more than visual works is psychodrama. This intervention is used to help "people explore their issues by using role playing and dramatic self-presentation" (Staff, 2018). The main tenants of psychodrama are to help clients build insight into their lives by gaining perspective in a safe and trusted environment. It was created by the psychiatrist J. Moreno in the early 1900s and "it came to be recognized as the first established method of group psychotherapy" (Staff, 2018). Moreno also developed certain techniques that are a part of psychodrama that help clients utilizing it to gain its benefits.

"The *substituting role technique* provides participants to take on symbolic roles very distant from their own selves if they are unable to play the role of themselves or those very close to them" (Yiftach Ron, 2018). There is also the mirror technique and this helps participants in the intervention to "see themselves on stage using another group member who acts as an auxiliary ego" in their place" (Ron, 2018). The mirror technique has a different person play the role of the client who wishes to have his or herself portrayed but does not feel comfortable doing so. Similar to this is the doubling technique. This is where the client whose story is being displayed through psychodrama to present his or her role while another client or "double" echoes the words to ensure the first individual's thoughts, emotions, etc are heard.

In his study, Ron (2018) conducted a case study of residents at an inpatient psychiatric ward who utilized services through an open psychodrama group. The group sessions occurred once a week in the morning 40 times over an almost year period from 2011-2012. The therapist who led the group was Ron and his observations along with

transcripts of the sessions and drawings and letters created by the participants were used as materials for data analysis of the work. The study's findings were presented in three thematic ways: "(a) encountering and coping with manifestations of distress in the group, (b) the doubling technique in the therapeutic process, and (c) the role of group sharing" (Ron, 2018).

The encountering and coping with distress theme was observed through various clients' reports. One client, Daniel, shared a story about his depression and this tale was followed by another client's similar story. "It was an opportunity for both of them to see themselves in each other's story" (Ron, 2018). Another client reported that a letter he was allowed to write himself helped him to "experience a new perspective using role playing" (Ron, 2018). The client David also used the doubling technique in his work within the psychodrama group and this opportunity gave him a way to look at his own behavior and to make sense of his thoughts. The group members' sharing of their distress "enabled an experience of universality and mutual support in the group" (Ron, 2018). This study found that group therapy which uses the psychodrama technique allows for emotional growth for its clients who also can find support within themselves and each other through the expressive work they complete. Clients who are able to use psychodrama can find ways to express their feelings in ways they may not have been able to through traditional psychotherapy sessions. Those skills may be especially helpful to clients within a psychiatric inpatient ward due to the psychological issues which lead to their placements there for treatment.

The commitment to engage with work in a therapy session is sometimes the main variable that impacts a client's progression and success with therapy. Orkibi,

Azoulay, Regev, and Snir (2017) conducted a process study on the impact of having adolescents engage in psychodrama to evaluate how this involvement impacted their engagement with therapy in general. Sixteen adolescents participated in a weekly drama therapy process group while at school. The participants' behaviors in the group were evaluated by the therapists leading the group through recording of each sessions' "issues, themes, images and metaphors, conflicts, characters…dramatic activity and action" (Orkibi, et al, 2017) in addition to ratings of how present each of these items were in the session on a zero (not at all) to five (very much present) scale. The students' involvement or participation in each of the sessions were evaluated using a six-item scale. The study's results show that over time the "trajectories in dramatic engagement and client involvement…showed a positive trend over sessions" (Orkibi, et al, 2017).

In the Orkibi, et al. (2017) study, the adolescents were also found to show an overall decrease in their resistance toward the therapeutic process over time through use of psychodrama. This decease may be due to the explorative nature of psychodrama and the support it allows clients engaged in to feel toward their investigating of their emotional and behavioral experiences through acting based means. This indicates that psychodrama may provide opportunities for clients to explore their emotions with distance from them but support from the clinician working with them while beginning to work on their mental health needs.

Psychodrama work may provide options as a type of intervention that can be used when working with a client who has a specific diagnosis in an outpatient setting. For example, a psychodrama group may be a helpful way to provide treatment for

relapse prevention of clients with substance use diagnoses. Somov (2008) proposed a group format for relapse prevention that was piloted at a "residential non-medical drug and alcohol correctional treatment program housed in a county jail." While his article did not include data to validate the use of psychodrama as an expressive intervention for relapse prevention, it does describe many details needed to implement the group in general. Somov wrote that this type of group treatment provides opportunities for clients "to practice their use prevention and use termination plans through…role plays and recovery vignettes" (2008). Clinicians facilitating the group would also be able to give direct feedback to the clients' practices. Somov's design laid out details for where the group would be held (ideally a theater or stage arena), the roles of the therapist(s) involved, the group's ideal size, the protagonists their stories of use and other assigned roles within the group. Somov also outlined twenty vignettes that could possibly be acted out through such a group. This example shows that expressive interventions through psychodrama can be used within more that just individual therapy sessions.

Keisara and Palgi (2017) worked with 55 individuals with a mean age of 78.4 in a before and after study that used life-review and drama-based interventions. The study consisted of a control group who did not receive these interventions along with the experimental one who did. The life-review interventions were conducted to "provide individuals with an opportunity to experience new perspectives and make new choices…that strengthens their sense of meaning in life" (Keisara & Palgi, 2017). Two case stories from the experimental group were shared in Keisara and Palgi's article. One client recommitted herself to emotionally connecting to her grandchildren from

whom she had previously been distanced. Another client found meaning in his life choices once he reviewed his earlier life experiences.

Keisara and Palgi (2017) measured participants' meaning in life, psychological well-being, and depressive symptoms within their study. All of these characteristics were found to have increased after the clients who were part of the experimental group completed their participation. These results indicate that like with other expressive and narrative therapy-based interventions, psychodrama helps a client to reflect on a lived life. With the found result in Keisara and Palgi's (2017) study that showed clients experienced a decrease in depressive symptoms, psychodrama may also be found to be an expressive-based intervention that helps clients with emotional growth and regulation as well.

Poetry is an expressive art therapy that has helped at-risk youth to "learn about themselves…build self-esteem, and strengthen interpersonal relationships" (Mazza, 2012). The interventions used in Mazza's study involved three major dimensions from his R.E.S. poetry therapy model. These were Receptive, which introduced the material; Expressive, which involved written and oral expression; and Symbolic, which involved symbols and ceremonies. The participants were first introduced to a poem and a song and then asked to respond to them. Following these events, the students were taught about the "six-word story" where they had to "write a story in six words about themselves" (Mazza, 2012). In the Symbolic dimension, students were asked to make a poem about good days but were not allowed to use words. They were then "given personal journals so that they could write about their experiences…over the next 2 weeks" (Mazza, 2012). The students found outlets through the poetry work to express

their experiences with different life events. "Hope was instilled for personal, physical, and educational/career development" (Mazza, 2012). This indicates that poetry is one artistic way to build hope and self-confidence in young people through expressive means and could potentially be interventions that are delivered before clinical therapy to be preventive supports.

Martin et al, (2012) explored the effectiveness of 10 sessions of voice movement therapy as a support to routine care for females who engage in non-suicidal self-injury (NSSI). Voice movement therapy "incorporates sound making, singing, expressive writing tasks, massage, movement, and drama to improve self-awareness. This type of expressive therapy "explores the range and subtlety of the human voice and the way the body reacts to vocal sound" (Martin, et al, 2012). The tasks in sessions of VMT involve vocal sounds used to express feelings, which are then linked to body feeling and movement "using the group to expand…also join in, the experience" (2012). This study evaluated participants' emotional functioning responses on a difficulties in emotional regulation scale (DERS), the Rosenburg self-esteem scale (RSES), and the Toronto alexithymia scale (TAS) which measured their having "no words for feelings" (2012). A "nonsignificant trend for NSSI to reduce over the course of VMT" was found at the end of the study. What was found to be significant through the 10 weeks of VMT was the participants' emotional regulation measured on the DERS. "Statistically significant improvement in scores was found following VMT on TAS total score" (Martin, et al, 2012). Self-esteem reports on the RSES also significantly improved. While VMT did not substantially reduce the clients' engagement in NSSI, it did result in decreased risk factors associated with those behaviors. This indicates that there may be audial ways to

help a client express him or herself and his or her emotional experiences in safer ways than those that involve self-injury or physical harm.

Expressive arts therapies can be especially helpful if the ones being used are chosen by the clients. "Twenty undergraduate students (men and women) ranging in age from 22 to 31…were asked to participate in the study" (Wiesel & Doran, 2004). The participants were given information about and a short session of each of five types of nonverbal creative arts therapy. They were then "asked to select their therapy of choice" (2004). The five types of therapy in this study were art, drama, journal writing, bibliotherapy, and dance. The participants were given this choice because "clients may perceive the opportunity to choose a nonverbal modality as an appreciation of their own competence" (2004).

Wisel and Doran found three major themes in regard to the process. These were: "difficulty in revealing one's hidden feelings and conflicts, self-disclosure as an enriching, inspiring, stirring experience, and the learning process through reflection on one's life" (2004). Participants chose their selected modality for different reasons but these reasons appear related to the control or the emotional benefit gained from using them. One client reported choosing art therapy "felt I gained control" (2004) whereas a client who chose drama therapy felt they were "enabled…to reach a deeper significant understanding."

The chosen modality that a participant chose was also found to be related to a connection he or she chose and how it provided a symbol in his or her life. Wisel & Doran reported that all of the participants in their study reported their chosen art therapy modality added to their lives. "Some clients indicated…better understanding of

self…other clients emphasized the positive change in their interpersonal relationships" (2004). By having the choice to pick their modality, participants are given control over the process itself and allow them to gain additional emotional benefits from expressive art therapies.

VI. Introduction to Personalized Story Intervention

A novel expressive therapy intervention that would allow a client to develop his or her emotional strength and to promote his or her resilience would be to allow the individual to produce an artwork that illustrates his or her life story. A therapist who uses this intervention is encouraged to introduce the idea of this creation to the client with the information that it would not be something the client has to create immediately. The therapist is to also tell the client that when he or she completes this intervention he or she will be allowed to choose the medium or modality which he or she uses to create the final product. This allows the client to begin to feel in control of his or her emotional journey from the beginning of the work through its completion.

In order to begin introducing the value of artistically creating one's story to a client, the therapist is recommended to foster the individual's belief in that the work on it will bring about change and growth. Holmqvist, Jormfeldt, Larrson, and Perrson (2017) found that the specifics that foster that change are: trust in the therapist with whom clients are working, belief in the method or intervention being used, and the creative impulse the work helped them to foster. These factors were identified from interviews they conducted with 21 women who had received art therapy and the image they created as part of the treatment. The interviews were about the women's therapy experiences and the image. The trust these clients had in their therapists was described to build over time in the sessions and included being validated for having feelings that

the images elicited. If a client believes in what the intervention can do and has a commitment to engage in its work, the treatment will also be more helpful. These are two reasons why the personalized story intervention should be implanted in treatment when the client decides he or she is ready to do it. Last, for the creative impulse to be used by clients in art therapy, it must be given opportunities to foster its actions. Holmqvist, et al, (2017) provided examples of these types of opportunities such as "the suggestion to paint with the left hand or to paint a self-portrait."

VII. Use of ACT skills in adjunct to personalized story

When the therapist who uses the intervention to have a client artistically create his or her story, it is recommended to follow the suggestions of Homqvist et al (2017) to develop the client's creative impulse. During the sessions that the client works on these artistic tasks, the therapist is recommended to process emotions, thoughts, and reactions the client has to the experience and within him or herself. These moments of processing will help to strengthen the trust and alliance between the client and therapist. In order to help the client engaging in this intervention to commit to the work involved, the therapist is recommended to use Acceptance and Commitment Therapy (ACT).

Often a client comes into therapy because efforts he or she has made to mediate his or her emotional distress on their own have not been as successful as he or she would like. This may decrease his or her desires to want to continue to work on such issues. "ACT proposes…that trying to directly reduce or eliminate distress can itself become a problem" (Chin & Hayes, p. 162, 2017). A client at this point is questioned about how the life he or she has would look if he or she were better, what he or she has done to achieve that life, and how successful those approaches have been up until his or her current involvement in therapy.

These questions are used to help a client consider an alternative for dealing with his or her issues in that he or she is encouraged to adopt behaviors that are the

cornerstones of ACT based living. Acceptance is one of these principles and in terms of ACT, it is the "active, voluntary embracing of moment-to-moment experience" (Chin & Hayes, p. 163, 2017). When working with a client on the principles of ACT, explanations are to be given that acceptance is not just taking what happens as it is, rather, it is the willingness to experience emotions as emotions, situations as situations, etc. This willful living is a "building out a heightened awareness of the contingencies, both positive and negative, that act as context for a behavior" (Chin & Hayes, p. 163, 2017). Acceptance will be the first and most important principle of ACT for a client who is creating his or her story through art therapy to master and adopt in his or her life. Without acceptance toward his or her life and the art he or she is creating, the client will approach the work and him or herself by extension with judgement and criticism.

Another principle of ACT is defusion. Chin and Hayes (2017) note this component involves helping a client defuse from or separate from his or her thoughts and emotions. This behavior works to change the context of language to alter what automatic functions it causes in context. This is essentially helping a client to recognize that just because he or she has thoughts of being worthless does not make the individual what the thought says him or her to be. One way to enable this defusion is to assist a client with adopting the metaphor of his or her thoughts being similar to leaves in a stream that flow on as he or she continues to live. The ACT component of present focused awareness involves helping a client to increase how much he or she focuses on the here and now of his or her life both in external and internal ways. This can often be used as an extension of the defusion skills a client develops through ACT in that it allows the person to experience the positive and negative of a situation without either

characteristic being the dominant influencing factor. By processing the emotional and cognitive reactions that creating his or her art stirs in a client and experiencing them as they are, the client's journey toward creating his or her art will be impactful and help foster resilience toward other emotional and cognitive experiences.

Chin and Hayes (2017) wrote that the primary focus of the ACT model is that it proposes "the *context* surrounding verbal/cognitive activity rather than the *content* of verbal/cognitive activity itself that is key in producing or reducing human suffering." This means that how a client views his or her situations rather than the situations themselves are what influence the client's emotional states. Applied to expressive arts work, this means that the details the client utilizes in his or her creations does not lessen his or her distress but how the story is told and what the meanings behind them are and what those connections to the creator are matter more.

With acceptance, a client can be able to view the works he or she creates as something he or she has made without judgment toward its quality. The individual can learn to focus on the context from which the art came rather than the content involved in it. A client can also utilize his or her skills in defusion to see the arts may be what he or she has used to show his or her stories in therapy, but they are not who they are overall. By adopting a present focused mindset with regard to expressive arts, a client may begin to focus on the current lives he or she is leading and how the feelings or stories he or she told through art has influenced him or her. The client can also be aware that these experiences do not have to impact his or her future as those events have not yet occurred.

VIII. Client and Clinician Characteristics

The client must be the one to verbalize when he or she is ready to begin work on the artistic story. If the therapist who works with him or her is he one to initiate the storytelling, it will not be as meaningful. It also will take away the emotional power and growth the client is likely to gain from creating the story. The therapist who uses the personalized story intervention with a client does not have to be a certified or licensed art therapist for it to be used. Instead, once the client has started to create the work that will tell his or her story, the therapist serves as a facilitator in some ways. The therapist is the one who helps reflect the information that the client tells so that he or she can begin to or better understand the emotions and thoughts that the story elicits from the client.

If the clinician who employs the personalized story intervention wishes to be a certified or licensed art therapist, he or she is encouraged to do so through official steps. According to the Art Therapy website on becoming an art therapist, these steps involve completing a master's degree of "graduate level coursework that includes training in the creative process, psychological development, group therapy, art therapy assessment, psychodiagnostics, research methods, and multicultural diversity competence" (Becoming an art therapist, 2017). At least 100 hours of clinical practicum and 100

hours of internship is also required along with "preparatory training in studio art…and foundation areas of study in psychology" (2017). Licensure for art therapists varies within the United States. Certain states (Connecticut, Delaware, Kentucky, Maryland, Mississippi, New Jersey, New Mexico, and Oregon) regulate these professionals' work through a professional licensing board. In New York, Pennsylvania, Texas, Utah, and Wisconsin, art therapy is regulated under a different professional license. Last, in Arizona, Louisiana, and New Hampshire, art therapists are recognized for state hiring and/or title protections.

The personalized story intervention is one that can be used with a client who presents with many different mental health related diagnoses. However, some characteristics of the client as well as other traits that may or may not relate to his or her presenting issue(s) may limit the effectiveness of the intervention. In addition, the client may be limited in his or her engagement or abilities to complete the work as well.

A client with an intellectual disability for example that is identified to be below the mild specifier range may present with or show difficulty with the more verbally heavy work in this intervention. Similar issues may occur for an individual who presents with characteristics that are in line with a diagnosis of Autism Spectrum Disorder that require larger levels of support or assistances in communication. As part of this intervention, the art and expressive techniques that are used and serve as its basis may still help clients from these populations to find outlets and skills for their emotional expressions.

The population of individuals who present with diagnoses that include psychotic features (i.e. Schizophrenia) may also present with or show difficulty with some aspects

of this intervention. If a therapist chooses to use the personalized story intervention with an individual from this clinical population, careful consideration and evaluation of the client's stability as well as his or her awareness and perception of reality is recommended. The final decision to use the personalized story intervention in all of the previously mentioned cases is the therapist's discretion. It is also recommended to include the client's choice and interest toward it. This recommendation is to honor a client's personal and cultural background in case his or her background does not condone or allow such disclosure of history.

The last consideration a therapist is to consider when presenting the personalized story to a client as a possible treatment option is the age of the client. Like with a client who presents with a substantial intellectual, developmental, or behavioral disability that limits his or her verbal abilities, a younger client may be limited in his or her verbal abilities. This limitation may decrease the client's engagement and work within this intervention. Again, the therapist's discretion and judgement along with the child or adolescent and his or her parent or guardian's willingness and engagement level with the work are to be considered. An informal standard in this case may involve following some of the criteria for being able to identify and verbalize autobiographical story details that Habermas and Bluck (2000) described in their study.

When introducing the personalized story intervention, the therapist is encouraged be informed about the different types of mediums or formats through which a story can be told. This is so that the professional can then properly inform the client of his or her options when the time is appropriate.

Wisel and Doran (2004) explained five types of expressive techniques in their study where clients selected by clients as their preferred nonverbal modalities. These were art therapy, drama therapy, bibliotherapy, journal writing therapy, and dance therapy. Art therapy involves "the creation and the discovery of its meaning" (2004). "Drama therapy uses drama/theater processes to achieve the therapeutic goals of symptom relief, emotional and physical integration, and personal growth" (Couroucli-Robertson, 2001). Bibliotherapy is using books to structure therapeutic interactions or to solve clients' problems (Wisel & Doran, 2004). Journal writing works to help clients discover themselves through a personal journal. Dance therapy "uses movement to further the social, cognitive, emotional, and physical development of the individual" (2004). These five techniques that Wisel and Doran provide in their study are not the only ones that are possible for a client to use in creating his or her personalized expressive story. A therapist who employs the personalized story intervention is encouraged to collaborate with the client and elicit his or her own ideas about the type(s) of expressive techniques desired to use in the work. This choice can be from the previously described options or from the client's own ideas.

When the client decides to create his or her personalized expressive story, it is important for the client to choose the artistic method he or she wants to use. This provides the client with the agency and empowerment to the idea of the story being his or her own to not only create but to possess. The client's therapist is also the one who provides the materials which the client uses in his or her design of the story's work. The client is allowed to bring their own materials if he or she wishes to do so but is not to be pressured to financially provide for the work in this way.

A therapist who uses the personalized story intervention with a client will also need to be educated on the principles of ACT so that he or she can help train the client in it as well. This training can be in the form of a formal workshop. There are also multiple workbooks which can help the therapist in this way if he or she does not have the financial ability or access to such trainings. These workbooks include but are not limited to: *The ACT Approach: A Comprehensive Guide for Acceptance and Commitment Therapy*, *Learning ACT: An Acceptance and Commitment Therapy Skills Training Manual for Therapists*, and *The Essential Guide to the ACT Matrix: A Step-by-Step Approach to Using the ACT Matrix Model in Clinical Practice*.

The personalized story intervention is complete when the client feels it to be so. Work on completing the product can be done within or out of therapy sessions. The emotional discussions, processing, and reflecting of the work's meaning, themes, etc however, are conducted within therapy. This allows the client to have a safe environment and stability in order to access the support of the therapist and to assist his or her building of resilience and emotional growth. As work is done on the product, the client is allowed to share what he or she is doing with others, just like the topics of his or her therapy would be normally. Once the artwork is complete, the client can share the completed product with anyone he or she feels necessary to do so. This can be the therapist, the client's family, and/or anyone else the client wishes to hear the story. The main idea behind the choice of the art's audience as it were is that it is at the discretion of the client who created it. Once the client finishes the artwork and the emotional processing of it within therapy sessions is complete, he or she is given

permission to decide what happens to it. Again, this decision being the client's gives him or her possession and the control over his or her story to the client.

IX. Conclusions and Contributions of Personalized Story Intervention

The personalized story intervention is one that allows for a client to reclaim his or her story in a way that makes in an expression of him or herself. The work is individualized in many ways, from the time it is told to how the client delivers its details. This intervention is one that incorporates the personal constructs drawn from discussions and reflections of the past experiences of the client who creates it. It allows for narrative techniques to be used and utilizes for the emotional development of the client. The personalized story is a method in which a client can find and tap into resilience he or she may not have been aware was in his or her internal possession. It includes development and fostering of non-judgmental and a present-focused living and mindset for the client.

A personalized artistic story allows the client to gain perspective toward his or her story in a way that emotionally connects him or herself to it. In addition, the story gives a client the validation that this story is not the only idea that makes him or her who he or she is overall. The personalized story is an intervention that can support a

client in knowing that he or she is not alone in the experiences that he or she has had in life. The personalized story intervention is one that is truly tailored and individualized to the client who completes it while being based on empirically based principles from other therapeutic domains and theories. This intervention is one that can be used with clients of a variety of ages and who are using mental health therapy and counseling for nearly any issue and/or diagnosis. It is an important one that can add to the spectrum of treatment and offers hope, support, and encouragement for a client who uses it with his or her therapist.

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APPENDICES

Appendix A:

Personal Construct Theory & Constructivist Therapy Tasks

Appendix A: Personal Construct Theory & Constructivist Therapy Tasks

Personal Construct Theory Terms and Therapy Task

- Construct: ideas, interpretations, and beliefs about life details a person encounters
- Permeable: construct trait that allows it to have a range of new elements to be incorporated into it
- Roadways: roles a person fills in his or her life that are based on and related to individual constructs
- Self: group of events that are alike in some way; also the individual
- Task: Helping the client create new constructs through stories

Constructivist Therapy Key Details

- Client helped to find importance or influence of these meanings
- Client's needs are prioritized focus within treatment, less focus on presenting diagnosis
- Dialogical Self Theory (DST): composition-based task using positions in client's life both external and internal to compose narrative with them
- Emphasis on client's personal meaning, social identity, and revisions to his or her narrative
- External position: others in life such as parent or work
- Internal position: client-focused position (such as I am nervous)
- Laddering: technique where client works to repeatedly identify constructs with 2 extremes until construct can't be formed

Appendix B:

Recommended Client and Clinician Characteristics for Intervention

Appendix B: Recommended Client and Clinician Characteristics for Intervention

Recommended Characteristics of Client for Using Personalized Story Intervention

- Adequate verbal skills to express desire for intervention
- Intellectual abilities with no lower than a mild impairment
- Stability in regard to psychosis related diagnoses (i.e. Schizophrenia) by clinician's discretion
- At least pre-adolescent in age but at clinician's discretion

Recommended Clinician Characteristics for Using Personalized Story Intervention

- Familiar with art therapy techniques
- Licensed within his or her discipline (not limited to psychology)
- Trained in or familiar with ACT therapy interventions and skills

Appendix C:

Focus Areas and Skills of ACT to Develop Within Intervention

Appendix C: Focus Areas and Skills of ACT to Develop Within Intervention

- Acceptance: active and voluntary embracing of one's moment-to-moment experiences
- Context over Content: principle of ACT based on client's meaning attached to an experience rather than its details overall
- Defusion: being able to separate or defuse from one's thoughts or emotions
- Present-focused awareness: how much a person focuses on the here and now of his or her life